



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Olympia, Washington 98504

APPLICATION FOR CERTIFICATE OF NEED
Health Care Facility Projects
(excluding nursing home, hospital, or CCRC related projects)

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer:  Sandy Melzer, MD MBA Executive Vice President, Networks and Population Health	Date: December 14, 2018 Telephone Number: (206) 987-2622
Legal Name of Applicant: Seattle Children's Hospital Address of Applicant: 4800 Sand Point Way NE Seattle, WA 98105	Type of Application: [X] Ambulatory Surgical Facility [] Kidney Disease Treatment Center Type of Project (check all that apply) [] New Health Care Facility [] Capital expenditure over expenditure minimum [] Pre-development Expenditure [] Increase in the number of dialysis stations in a kidney disease center
Intended date of incurring contractual obligation to construct, acquire, lease or finance capital asset: Estimated capital expenditure: <u>\$4,000,000</u>	Intended date of undertaking project: Upon certificate of need approval Intended date for beginning to offer services or operate completed project: October 2019 Project Summary: Add a 4 th OR to existing Seattle Children's Bellevue ASC



December 14, 2018

Janis Sigman, Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Ms. Sigman:

Enclosed, please find a copy of Seattle Children's Hospital (Seattle Children's) certificate of need application, proposing to add one operating room to its existing Ambulatory Surgery Center (ASC) in Bellevue, Washington. As detailed in the application, the need for this operating room is compelling. Seattle Children's needs the additional capacity immediately in order to care for its patients who need the unique and highly specialized services we provide.

Enclosed is the review and processing fee of \$20,427.

Thank you for your interest, support, and assistance in this matter. Should you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Sanford Melzer", followed by a horizontal line and a small flourish.

Sanford Melzer, MD MBA
Executive Vice President, Networks and Population Health



Seattle Children's[®]
HOSPITAL • RESEARCH • FOUNDATION

**CERTIFICATE OF NEED APPLICATION
FOR
EXPANSION OF BELLEVUE AMBULATORY SURGERY CENTER
IN EAST KING**

December 2018

SECTION 1

Applicant Description

A. Legal name(s) of applicant(s).

The legal name of the applicant is Seattle Children's Hospital (Seattle Children's). Seattle Children's is controlled by its sole corporate member, Seattle Children's Healthcare System, and is a not for profit organization exempt from federal taxation under IRC Section 501 (c)(3).

B. Name and address of the proposed/existing facility.

The address of Seattle Children's is:

4800 Sand Point Way NE
Seattle, WA 98105

The address of the Seattle Children's Bellevue ASC (the Bellevue ASC) is:

1500 116th Ave NE
Bellevue, WA 98004

C. Type of ownership (public/private/corporation, etc.).

Seattle Children's is a not for profit organization.

D. Name and address of owning entity at completion of project (unless same as applicant).

Seattle Children's will be the owning entity.

E. Name, title, address and telephone number of the person to whom questions regarding this application should be directed.

Questions regarding this application should simultaneously be addressed to:

Sandy Melzer, MD MBA
Executive Vice President, Networks and
Population Health
Seattle Children's Hospital
4800 Sand Point Way NE M/S RB.2.419
Seattle, WA 98105-0371
(206) 987-2622
Email: sandy.melzer@seattlechildrens.org

Jody Carona
Health Facilities Planning & Development
120 1st Avenue West, Suite 100
Seattle, WA 98119
(206) 441-0971
Email: healthfac@healthfacilitiesplanning.com

F. Corporate structure and related parties. Attach chart showing organizational relationship to related parties.

Exhibit 1 contains an organizational chart for the Bellevue ASC.

G. Name and address of operating entity at completion of project (unless same as applicant).

The operating entity is the same as the applicant.

H. General description and address of each facility owned and/or operated by applicant.

Seattle Children's does not operate any other healthcare facilities that have unique Medicare and/or Medicaid provider numbers.

The Medicare provider number of Seattle Children's is:

50-3300

The Medicaid provider number of Seattle Children's is:

3306206

I. Facility licensure/accreditation status.

Seattle Children's, including the Bellevue ASC, is accredited by DNV GL. The effective date of accreditation is July 22, 2016, and the expiration date is July 22, 2019.

J. Is applicant reimbursed for services under Titles V, XVIII, and XIX of Social Security Act?

Seattle Children's is reimbursed for services provided under Titles V, XVIII, and XIX of the Social Security Act.

K. Geographic identification of primary service area.

Per WAC 246-310-270, the primary service area for the Bellevue ASC is the East King Secondary Health Services Area (East King). However, the actual experience of the Bellevue ASC is that patients come from other planning areas, in addition to East King, including a number of counties in Western Washington. Table 1 details the percentage of patients from East King and from other adjacent planning areas for the last five years. As Table 1 indicates, the percentage of families using the Bellevue ASC that do not reside in East King has increased from 76% to 82% since FY2014.

Table 1
Seattle Children's Bellevue ASC
Percentage of Patients By Planning Area, FY2014-FY2018

Planning Area	FY2014	FY2015	FY2016	FY2017	FY2018
East King	24.0%	22.2%	19.2%	20.4%	17.9%
Southeast King	13.2%	13.6%	13.3%	13.0%	12.0%
Southwest Snohomish	10.3%	8.6%	8.6%	9.7%	10.0%
Central Snohomish	8.8%	9.2%	9.5%	9.4%	9.9%
North King	7.3%	7.5%	7.3%	7.8%	8.3%
Central King	5.0%	4.7%	5.2%	5.0%	6.1%
Southwest King	4.7%	5.7%	5.5%	5.1%	5.7%
East Snohomish	3.6%	3.4%	3.1%	3.0%	3.2%
North Snohomish	1.3%	2.3%	2.1%	1.7%	2.5%
Other Western Washington ¹	14.3%	15.3%	19.3%	18.6%	18.9%
Western WA, Non-East King	68.6%	70.3%	73.9%	73.5%	76.6%
Other	7.4%	7.5%	6.9%	6.1%	5.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Applicant

¹ Includes all planning areas in Western Washington from Whatcom County to Clark County in Southwest Washington.

L. List physician specialties represented on active medical staff and indicate number of active staff per specialty.

Seattle Children's has 1,638 providers on its medical staff, of which 1,018 have active status.²

Of the providers on its medical staff, Table 2 provides detail on the number, by specialty, that provide services at the Bellevue ASC.

Table 2
Seattle Children's Bellevue ASC,
Providers by Specialty as of November 17, 2018

Specialty	No. of Physicians
Craniofacial	6
General Surgery	9
Ophthalmology	6
Orthopedics	6
Otolaryngology (including audiology)	16
Urology	7
Other	11
Total	61

Source: Applicant

The Bellevue ASC employs two medical directors. Information regarding each is included in Table 3.

Table 3
Seattle Children's Bellevue ASC
Medical Directors

Medical Director Position	Medical Director Name	Department of Health License Number
Clinical Director of Surgery, Bellevue Surgery Center	Sanjay R. Parikh, MD	MD60184145
Clinical Director of Anesthesia Services, Bellevue Surgery Center	Lynn D. Martin, MD	MD00030635

Source: Applicant

Copies of the medical director job descriptions are included in Exhibit 2.

² As of November 1, 2018. Active status includes those providers with active membership and privileges.

M. List all other generally similar providers currently operating in the primary service area.

Other providers of surgical and procedural services within the East King are detailed in Table 4.

Table 4
East King ASC Providers and Certificate of Need (CN) Status as of November 15, 2018

Facility	CN Status
Hospitals	
Overlake Hospital Medical Center	CN Approved
Evergreen Health Medical Center	CN Approved
Snoqualmie Valley Hospital	CN Approved
Swedish Medical Center, Issaquah Campus	CN Approved
ASCs (CN Approved)	
Seattle Children's Bellevue ASC	CN Approved
Bel Red Ambulatory Surgery Center	CN Approved
Eastside Surgery Center	CN Approved
Evergreen Surgical Center (Evergreen Hospital)	CN Approved
Northwest Nasal Sinus Center	CN Approved
Overlake Surgery Center	CN Approved
Proliance Eastside Surgery Center	CN Approved
Bellevue Surgery Center	CN Approved
Proliance Highlands Surgery	CN Approved
Redmond Ambulatory Surgery Center	CN Approved
Virginia Mason Bellevue	CN Approved
Retina Eye Surgery	CN Approved
ASCs (CN Exempt)	
Aesthetic Eye Associates	CN Exempt
Aesthetic Facial Plastic Surgery PLLC	CN Exempt
Allure Laser Center	CN Exempt
Aysel K Sanderson	CN Exempt
Anderson Sobel Cosmetic Surgery	CN Exempt
Athenix Body Sculpting	CN Exempt
Bellevue (Newvue)Plastic Surgery & Skincare	CN Exempt
Bellevue Spine Specialist	CN Exempt
Cosmetic Surgery & Dermatology of Issaquah	CN Exempt
David R Stephens Center for Plastic Surgery	CN Exempt
John H. Brunsman	CN Exempt
Naficy Plastic Surgery & Rejuvenation	CN Exempt
North Pacific Dermatology	CN Exempt
Northwest Center for Aesthetic Plastic Surgery	CN Exempt
Northwest Laser and Surgery Center	CN Exempt
Overlake Reproductive Health Inc PS	CN Exempt
Pacific Cataract & Laser	CN Exempt

Facility	CN Status
Plastic Surgery Northwest	CN Exempt
The Retina Surgery Center	CN Exempt
Remington Plastic Surgery	CN Exempt
Sammamish Center for Facial Plastic Surgery	CN Exempt
Sephehr Egrari MD FACS (Egrari Plastic Surgery)	CN Exempt
SoGab Surgery Center	CN Exempt
Sono Bello (Aesthetic Physicians)	CN Exempt
Stern Center for Aesthetic Surgery	CN Exempt
Washington Sports Medicine Associates	CN Exempt
Washington Institute Orthopedic Ctr	CN Exempt
Washington Urology Associates PLLC	CN Exempt
Washington Urology Associates	CN Exempt
Yarrow Bay Plastic Surgery Center	CN Exempt
ASCs (Excluded – Endoscopy Only)	
Eastside Endoscopy Bellevue	Excluded -Endo only
Eastside Endoscopy Issaquah	Excluded-Endo only
Evergreen Endo Center	Excluded-Endo only
Kaiser Permanente (Bellevue)	Excluded-Endo only
Virginia Mason Issaquah	Excluded-Endo only

Source: Applicant and Department of Health CN Program Information

Despite this long list of providers of surgical services, when Seattle Children's received its initial CN approval in 2009 to establish the Bellevue ASC, the Certificate of Need Program (the CN Program) defined *similar providers* as those that offered pediatric surgery (which only included patients age 0-14) and demonstrated available capacity for additional pediatric cases. Using this definition, the CN Program determined, at that time, that the similar providers to Seattle Children's proposed Bellevue ASC were limited to Overlake Surgery Center and Evergreen Healthcare. While Seattle Children's expects the list to be very similar today, the CN Program neither requests nor tracks ages served, or the percentage of pediatric patients in its ASC survey. As such, updated information is not available.

- N. For existing facilities, provide applicant's overall utilization for the last five years, as appropriate.**

Table 5 details the historical number of surgical and procedural cases at the Bellevue ASC in each of the last five fiscal years.

Table 5
Seattle Children's Bellevue ASC
Surgical and Procedural Cases, FY2014-FY2018³

	FY2014	FY2015	FY2016	FY2017	FY2018
Cases	3,249	3,873	4,328	4,070	4,360

Source: Applicant

- O. Describe the history of applicant entity with respect to criminal convictions related to ownership/operation of health care facility, license revocations, and other sanctions described in WAC 246-310-230 (5)(a). If there have been no such convictions or sanctions, please state.**

Seattle Children's has no history with respect to the actions described in the Certificate of Need criterion WAC 246-310-230 (5)(a).

³ Fiscal year is October 1 – September 30.

SECTION 2

Project Description

A. Describe the project for which Certificate of Need approval is sought.

For more than 100 years, Seattle Children's has been delivering superior patient care, advancing new discoveries and treatments through research, and serving as an important educational resource for parents and healthcare professionals. Specializing in meeting the unique physical, emotional, and developmental needs of children, from infancy through young adulthood, Seattle Children's is consistently ranked by *U.S. News & World Report* as one of the nation's best children's hospitals and is also one of only three hospitals in Washington state to receive Magnet Recognition for excellence in nursing services. Most recently, in 2018, Seattle Children's received rankings in all 10 specialties evaluated by *U.S. News & World Report* and was the only pediatric medical center in Washington State to be ranked.

Seattle Children's serves as the pediatric and adolescent academic medical center for Washington, Alaska, Montana and Idaho (WAMI) – the largest region of any children's hospital in the country. In this role, Seattle Children's has established a regional network with over 40 regional and outreach clinics to provide care to its patients, closer to home. Since 2000, Seattle Children's has operated a pediatric outpatient specialty clinic in Bellevue. In July 2010, Seattle Children's relocated its clinic from leased space at Overlake Hospital Medical Center to its own facility, Seattle Children's Bellevue Clinic and Surgery Center. This allowed for an expansion of ambulatory clinic services and the establishment of an ASC, so that an increased number of patients could receive more services closer to home.⁴ In addition, the new facility helped to mitigate some of the ever-increasing pressures experienced on Seattle Children's main campus in Laurelhurst.

When the Bellevue ASC opened in 2010, it had two operating rooms and shelled space for two additional operating rooms or procedure suites. Though Seattle Children's originally planned to open the Bellevue ASC with two operating rooms and one GI procedure suite, the decision was made to expand *procedural* capacity at its Laurelhurst campus and the GI procedure suite at the Bellevue ASC was not opened. In the first full fiscal year of operation (FY2011), 2,447 cases were performed. Case volumes quickly surpassed the capacity of the two operating rooms and in February 2015, Seattle Children's built-out one of the shelled spaces as an operating room to support the increasing demand.⁵

⁴ The certificate of need (CN #1395) to establish a 2 OR ambulatory surgery center was approved March 10, 2009.

⁵ At the time that the 3rd OR was added, there was no requirement for an existing ASC to file a CN to expand ORs.

Since FY2011, cases performed at the Bellevue ASC have grown at a rate of nearly 9% per year and today, the Bellevue ASC is operating at 93% capacity with 4,360 cases performed in the last fiscal year (FY2018). At the same time that the Bellevue ASC is nearing 100% capacity, the operating rooms at Seattle Children's Laurelhurst campus are experiencing unprecedented demand and are running at nearly 100% capacity, with more and more cases being scheduled into the evenings and after hours. While Seattle Children's has commenced construction on a 300,000 square foot facility addition on its Laurelhurst campus that will add operating room capacity (and other clinical services), this building is not scheduled to open until the second quarter of 2022 and additional operating room capacity is needed within the Seattle Children's system immediately.

This project proposes to build-out the final shelled space, adding one additional operating room to the existing capacity at the Bellevue ASC. At project completion, the Bellevue ASC will have four operating rooms.

B. Total estimated capital expenditures.

The total estimated capital expenditure is \$4,000,000.

C. Total estimated operating expenses for the first and second years of operation (shown separately).

The first two full years of operation are expected to be 2020 and 2021. The direct and indirect operating expenses are as follows:

2020: \$26,356,474
2021: \$27,037,797

D. New services/changes in services represented by this project.

This project is an expansion project only. No new services or changes in services are anticipated.

E. General description of types of patients to be served by the project.

The Bellevue ASC is designed for children and adolescents who need outpatient surgery but are otherwise healthy. Predictors of anesthetic and surgical risk include the patient's age, the type of surgery, the nature of the surgery, and the preoperative physical status of the patient as defined by the American Society of Anesthesiologists (ASA) classification. Patients who meet the criteria of ASA class I (a normal, healthy patient) or class II (a patient with mild systemic disease), are planned to be discharged home after the surgery, and in need of the following specialty care, may have their surgery performed at the Bellevue ASC for the following specialties:

Craniofacial
General Surgery
Ophthalmology
Orthopedics

Other (Dental, Dermatology,
Gynecology, Neurology)
Otolaryngology (including Audiology)
Urology

F. Projected utilization of service(s) for the first and second years of operation following project completion (shown separately). This should be expressed in appropriate workload unit measures.

Table 6 details the project utilization by year:

Table 6
Seattle Children's Bellevue ASC
Projected Cases by Specialty, FY2019-FY2022

Specialty	FY2019	FY2020	FY2021	FY2022
Craniofacial	283	284	284	284
General Surgery	449	455	460	463
Ophthalmology	144	170	170	170
Orthopedics	619	722	722	722
Other	135	135	135	135
Otolaryngology (incl. Audiology)	2,394	2,777	3,144	3,144
Urology	845	940	959	978
Total	4,870	5,483	5,873	5,896

Source: Applicant

G. A copy of the letter of intent, per WAC 246-310-080.

A copy of the letter of intent is included in Exhibit 3.

H. Sources of patient revenue (Medicare, etc.) with anticipated percentage of revenue from each source. Estimate the percentage of change for each of the sources of revenue by payer that will result from this project.

Current and projected sources of revenue by payer are:

Medicaid	40.3%
Medicare/Other Government	1.9%
Commercial	57.6%
Other	<u>0.3%</u>
TOTAL	100.0%

I. Source(s) of financing.

Existing reserves will be used to fund this expansion project.

J. Equipment proposed:

- 1 Description of equipment proposed.**
- 2. Description of equipment to be replaced, including cost of the equipment, and salvage value (if any) or disposal, or use of the equipment to be replaced.**

The equipment list is included as Exhibit 4.

K. Drawings:

- 1. Single line drawings at least approximately to scale of current locations which identify current departments and services.**

A single line drawing of the existing Bellevue ASC is included in Exhibit 5.

- 2. Single line drawings at least approximately to scale of proposed locations which identify proposed services and departments.**

A single line drawing of the Bellevue ASC upon project completion is also included in Exhibit 5.

3. Total net and gross square feet of project.

The square footage of the project is included in Table 7.

Table 7
Seattle Children's Bellevue ASC
Current and Project Net and Gross Square Footage

	Current Bellevue ASC Square Footage	Project Bellevue ASC Square Footage
Gross Square Footage	21,053 sf	3,412 sf
Net Square Footage	19,312 sf	3,412 sf (same as gross as it does not include any infrastructure items)

Source: Applicant

4. Describe any changes in dialysis station capacity proposed as part of this project.

This question is not applicable to this project.

L. Anticipated dates of both commencement and completion of project.

The projected timeline for the proposed project is as follows:

Activity	Completion Date
Obtaining construction financing	N/A
Obtaining permanent financing	N/A
Obtaining funds necessary to undertake project	N/A
Completion and submittal to Consultation and Construction Review Section of preliminary drawings	1/20/2019
Completion and submittal to Consultation and Construction Review Section of final drawings and specifications	2/28/2019
Construction contract award	10/1/2018
25% completion of construction	4/15/2019
50% completion of construction	5/30/2019
75% completion of construction	7/15/2019
Completion of construction	8/14/2019
Obtaining licensure approval	8/30/2019
Occupancy/offering of service(s)	10/1/2019

*Occupancy/move-in: 8/15/19 - 9/30/2019

M. Describe the relationship of this project to the applicant's long-range plan and long-range financial plan (if any).

As described in response to an earlier section, Seattle Children's is proposing the project described in this application due to the high utilization of the operating rooms throughout its system; both those located at the Bellevue ASC and at the Laurelhurst campus. As discussed earlier, when the Bellevue ASC was constructed, it contained shelled space for two additional operating rooms or procedure suites. One of the shelled spaces was built-out and made operational in 2015 (the 3rd OR) and this project proposes to complete the final shelled space as an operating room (the 4th OR). Due to changes in CN rules in 2017, Seattle Children's understands it must now obtain CN review and approval prior to adding the 4th OR. As with the original CN application and the build-out of the 3rd OR, expanding outpatient surgical capacity at the Bellevue ASC will: 1) provide the dedicated outpatient operating room capacity Seattle Children's needs within its system to care for its patients, 2) continue to make care more convenient and accessible, and 3) afford some relief prior to the addition of the new operating rooms on Seattle Children's Laurelhurst campus.

N. Describe any of the following which would currently restrict usage of the proposed site and/or alternate site for the proposed project: (a) mortgages; (b) liens; (c) assessments; (d) mineral or mining rights; (e) restrictive clauses in the instrument of conveyance; (f) easements and right-of-ways; (g) building restrictions; (h) water and sewer access; (i) probability of flooding; (j) special use restrictions; (k) existence of access roads; (l) access to power and/or electricity sources; (m) shoreline management/environmental impact; (n) others (please explain).

None of the above will restrict usage of the proposed site.

O. Provide documentation that the proposed site may be used for the proposed project. Documentation may include, but not limited to a letter from any appropriate municipal authority, zoning information, and signed letter from leasing agent or realtor attesting to appropriate usage.

The Bellevue ASC is currently operational and no change in square footage is necessary. All required zoning approvals were received prior to construction of Seattle Children's Bellevue Clinic and Surgery Center, which commenced in March 2009. Should the CN Program require any additional information, Seattle Children's requests that it be allowed to provide it in screening.

- P. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "*Sufficient interest*" includes but not limited to one of the following:**
- a. clear legal title to the proposed site;**
 - b. a lease for at least one year with, options to renew for not less than a total of five years**
 - c. a draft lease for at least one year with, options to renew for not less than a total of five years. A draft is acceptable only if all parties identified in the draft agreement provide a signed "Letter of Intent to finalize" the agreement.**
 - d. an earnest money agreement provided all parties identified in the agreement have signed it.**
 - e. a letter signed by a duly authorized representative of the property owner attesting to the property owners intent to sale the site as represented in the application.**

Seattle Children's owns the site. Included in Exhibit 6 is documentation from the King County Assessor's office documenting ownership. Should the CN Program require any additional documentation of site control, Seattle Children's requests that it be allowed to provide it in screening.

SECTION 3 Project Rationale

NEED

1. **Identify and analyze the unmet health services needs and/or other problems to which this project is directed.**
 - a. **Unmet health services needs of the defined population should be differentiated from physical plant and operating (service delivery) deficiencies which are related to present arrangements.**
 - b. **The negative impact and consequences of unmet needs and deficiencies should be identified.**

As described earlier in this application, the operating rooms at the Bellevue ASC and the Laurelhurst campus are running at 93% and nearly 100% capacity, respectively. Knowing that Seattle Children's patients and referring providers are negatively impacted by this high occupancy, Seattle Children's has made several operational improvements in order to mitigate these capacity constraints, including expanding hours and scheduling cases in the most appropriate setting. However, even with these improvements, Seattle Children's does not have the capacity it needs to care for its patients, including dedicated outpatient surgical capacity.

As described previously, when the Bellevue ASC opened in 2010, it contained two operating rooms and shelled space for two additional operating rooms or procedure suites. Table 8 compares the projected to actual utilization.

Table 8
Seattle Children's Bellevue ASC
Case and Utilization Projections (Actual vs. Projected), FY2011-FY2018

FY	2008 CN Projected Bellevue ASC Cases⁶	Actual Bellevue ASC Cases	% that Actual Volume Exceeded Estimated	Actual Year-over- Year % Change
FY2011	1,808	2,447	35.3%	
FY2012	2,007	2,704	34.7%	10.5%
FY2013	2,027	3,137	54.8%	16.0%
FY2014	2,047	3,249	58.7%	3.6%
FY2015	2,067	3,870	87.2%	19.1%
FY2016		4,328		11.8%
FY2017		4,070		-6.0%
FY2018		4,360		7.1%
Average				8.9%

Source: Applicant and Seattle Children's Bellevue ASC 2008 CN application.

⁶ In its 2008 application, Seattle Children's assumed that it would operate 2 ORs and one GI procedure room at opening. The 2008 CN Projected Cases in Table 8 exclude GI procedures as the GI procedure suite at the Bellevue ASC was not opened.

As Table 8 documents, the Bellevue ASC's utilization exceeded its original CN projections in each of the first five years of operation, and by FY2015 (the third year of projections from the original CN) and the year that Seattle Children's built-out and made operational the 3rd OR, the utilization was 87% higher than projected. The success of the Bellevue ASC has been driven by several factors, three of which are summarized below:

- Only outpatient surgical and procedural cases are performed. As a result, there is no rescheduling to accommodate emergent, urgent, or other unscheduled cases, reducing operational inefficiencies.
- The Bellevue ASC was designed with induction rooms. These rooms allow parents to be with their child as anesthesia is initiated. In addition, the induction room design allows patients to be in the operating room only during the surgery, shortening the time the operating room is in use, which results in increased throughput and maximum utilization of space.
- For a significant patient population, the Bellevue ASC is more accessible than the Laurelhurst campus. For example, patients residing in Southeast King County, Eastern Washington (traveling via I-90), and north of Seattle, including Snohomish County, can access the Bellevue ASC without needing to manage the traffic and parking challenges many patients and families experience when traveling through Seattle to the Laurelhurst campus for care.

Looking into the future, as the pediatric population continues to grow, as surgical and procedural care continues to shift to the outpatient setting, and as payers and families continue to seek out safe, convenient, high-quality care and a remarkable experience, we expect demand for the services provided in the Bellevue ASC to increase. Accordingly, Seattle Children's is requesting CN approval to add the 4th OR that was shelled when the Bellevue ASC was constructed. This additional OR will provide Seattle Children's with the additional dedicated outpatient operating room capacity it needs to care for its patients.

To estimate ASC need for East King, Seattle Children's applied the methodology contained in WAC 246-310-270(9) and also reviewed recent East King ASC CN decisions. Specifically, Seattle Children's reviewed two decisions from 2017 and the most recent decision from October 2018.⁷ In each of these evaluations, the CN Program found numeric need for additional dedicated outpatient operating rooms beyond what the applicant was requesting. Subsequent to the October 2018 evaluation being released, the CN Program collected 2018 ASC surveys (which includes 2017 utilization data). Seattle Children's has updated the methodology using the 2018 survey data (2017 utilization data). With this updated methodology, Seattle Children's has identified a need for 12 additional dedicated outpatient ORs in East King. A copy of the methodology applied to East King is included as Exhibit 7.

⁷ While the CN Program determined need for additional outpatient ORs in the October 2018 evaluation, there were several errors in their application of the methodology. One particular error was the inclusion of three mixed use operating rooms and three dedicated outpatient operating rooms at Seattle Children's Bellevue ASC. As noted in this application, there are only three dedicated outpatient operating rooms at Seattle Children's Bellevue. However, even correcting for these errors there is still demonstrated need.

As noted earlier in this application, when the CN Program issued its analysis in 2009 for the establishment of the Bellevue ASC, it modified the methodology and attempted to project need for pediatric patients. Seattle Children's attempted to replicate the methodology and for this purpose, defined pediatrics as patients age 0-21. However, because of a lack of data (the CN Program's Annual ASC survey does not request data on pediatric volumes or dedicated capacity), Seattle Children's methodology includes only the volumes and capacity at the Bellevue ASC.⁸ The result, based upon a CN Program capacity threshold (68,850 minutes per outpatient OR) demonstrates a infinitesimal surplus in 2022. This is because the methodology assumes no increase in use rate and no increase in in-migration; any growth is simply due to increases in population. The methodology does not take into account several other factors, including demonstrated growth in volumes at the Bellevue ASC (which has averaged 9% per year since 2011), as well as the expected shifting of "Bellevue ASC eligible" cases from the Laurelhurst campus to the Bellevue ASC in order to support scheduling cases in the most appropriate setting.

The ASC methodology in WAC 246-310-270(9) and as prepared by Seattle Children's, identifies the need for 11 additional ORs in East King, beyond the one OR that Seattle Children's is requesting. In the highly unlikely event that the CN Program does not find numeric need, WAC 246-310-270(4) allows an applicant, absent numeric need, to demonstrate that circumstances outside of the ordinary, exist in the market, that warrant granting of a CN. Seattle Children's has identified several reasons why its request for the 4th OR in the Bellevue ASC should be approved, even absent numeric need:

1. **Capacity dedicated for pediatrics.** The Bellevue ASC is the only dedicated pediatric outpatient surgical and procedural capacity in East King, and, in fact, in the entirety of the Puget Sound Region and it is currently operating at capacity. Table 9 details the overall utilization and minutes for the Bellevue ASC and occupancy with and without additional capacity. Without the addition of the 4th OR, the Bellevue ASC will be operating in excess of 100% occupancy by the end of FY2019. This means that Seattle Children's will need to either extend hours of operation, which is challenging for pediatric patients, and/or delay care for surgical and procedural cases, which is very concerning from a clinical quality perspective. Furthermore, because Seattle Children's operating rooms at its Laurelhurst campus are running at maximum capacity, these patients who need the unique and highly-specialized services Seattle Children's provides, have no other place to go.

⁸ While the CN Program used the 0-14 age cohort to estimate pediatric OR need, in 2009, CN #1395 limited service to pediatric patients but did not limit the age to 0-14. Furthermore, because no statutory, regulatory, or clinical definition exists for the pediatric age range, it is important to note that Seattle Children's clinical practice reflects patients in need of our services, which is primarily patients age 0-21. Therefore, in the pediatric use rate calculation, Seattle Children's used the 0-21 age cohort.

Table 9
Seattle Children's Bellevue ASC
Actual and Projected Occupancy, FY2018-FY2022

Year	In Room Minutes	Occupancy with 3 ORs at annual capacity (68,850 min/OR)	Occupancy with 4 ORs at annual capacity (68,850 min/OR)
FY2018	192,536	93%	N/A
FY2019	210,811	102%	N/A
FY2020	236,655	115%	86%
FY2021	245,751	119%	89%
FY2022	247,039	120%	90%

Source: Applicant

The ASC methodology in WAC 246-310-270(9) as well as the pediatric methodology referenced above, are both based on current use rates and utilization for East King providers. In other words, the use rate assumes that the utilization of providers (either existing East King or the Bellevue ASC) will continue at current levels. As Seattle Children's demonstrated in Table 1, the utilization of the Bellevue ASC from non-East King residents has increased from 76% in 2014 to 82% in 2018.

2. **Accessibility to the underserved.** Every day, Seattle Children's provides compassionate care, regardless of a family's ability to pay, and has demonstrated its commitment to outreach and service provision to the underserved. Seattle Children's provided almost \$165 million in uncompensated care and over \$12 million in community programs and services in 2017. Together with families, community-based organizations and providers, donors, public health departments, and others, Seattle Children's seeks to:
 - Enhance access to mental and behavioral health
 - Improve coordination of care for children with chronic conditions
 - Expand access to health eating and active living, including fighting food insecurity
 - Decrease incidents of suicide and increase violence prevention

In addition to the above, Seattle Children's, by the nature of the patients it serves, is the largest individual provider of pediatric specialty and inpatient care to the Medicaid population in Washington.

3. **Outcomes.** Seattle Children's has a long-standing history, recognized internationally and nationally for its outcomes. As noted earlier, Seattle Children's is consistently ranked by *U.S. News & World Report* as one of the nation's best children's hospitals and in 2018, Seattle Children's received rankings in all 10 specialties – Cancer, Cardiology & Heart Surgery, Diabetes & Endocrinology, Gastroenterology & GI Surgery, Neonatology, Nephrology, Neurology & Neurosurgery, Orthopedics, Pulmonology, and Urology – and was the only pediatric medical center in Washington State to be ranked.

In addition to direct patient care, Seattle Children's Research Institute is ranked as one of the nation's top five pediatric research institutions. Internationally recognized for advancing discoveries in cancer, genetics, immunology, infectious disease, and injury prevention, Seattle Children's researchers have pioneered groundbreaking cystic fibrosis treatments, leading-edge cancer therapies that help a child's immune system defeat cancer, and made other major contributions to pediatric medicine. Today, Seattle Children's Research Institute includes more than 607,000 square feet of clinical , laboratory, and office space, a workforce of over 1,600 people, and over \$120 million in total extramural funding, all to help children, adolescents, and young adults, live better, healthier lives and work towards the next wave of lifesaving discoveries.

Furthermore, Seattle Children's is the pediatric teaching hospital for the University of Washington School of Medicine, whose Department of Pediatrics is consistently ranked by *U.S. News & World Report* as one of the best Medical School Pediatric Programs in the country. Seattle Children's is also home to fellowships in almost 40 specialties including, Adolescent Medicine, Anesthesia, Craniofacial Surgery, Dermatology, Neurology, Orthopedic Surgery, Otolaryngology, Regional Anesthesia, Surgery, and Urology.

- 2. Define the population that is expected to be served by the project. The specific manner of definition is of necessity based on the specific project proposed, and may require different definitions for different elements of the project.**

In the case of an existing facility, include a patient origin analysis for at least the most recent three-month period, if such data is maintained, or provide patient origin data from the last statewide patient origin study. Patient origin is to be indicated by zip code, zip codes are to be grouped by city and county, and include a zip code map illustrating the service area.

Patient origin data was provided on Table 1.

Per WAC 246-310-270, the appropriate planning area for this project is East King. Seattle Children's need projections are calculated based on the East King population only. As shown in Table 10, East King's pediatric population (age 0-21) now totals 167,000 and will grow by more than 6%, or nearly 11,000 children, over the next 5 years. This growth will be led by the 15-17 age cohort, which is expected to expand by more than 12%.

Table 10
East King Population by Age Cohort
2010, 2017 and 2022

	2010	Pct of Tot Pop	2017 Est	Pct of Tot Pop	Pct Chg 2010- 2017	2022 Proj	Pct of Tot Pop	Pct Chg 2017- 2022
Tot. Pop.	541,571	100.0%	611,365	100.0%	12.9%	658,613	100.0%	7.7%
Pop. By Age								
0-4	35,011	6.5%	38,375	6.3%	9.6%	39,470	6.0%	2.9%
5-9	37,110	6.9%	38,661	6.3%	4.2%	40,857	6.2%	5.7%
10-14	36,234	6.7%	39,187	6.4%	8.1%	41,008	6.2%	4.6%
15-17	21,940	4.1%	22,876	3.7%	4.3%	25,648	3.9%	12.1%
18-21	20,337	3.8%	22,279	4.5%	36.6%	30,637	4.7%	10.3%
Subtotal 0- 21	150,632	27.8%	166,878	27.3%	10.8%	177,620	27.0%	6.4%
18-44	198,759	36.7%	218,412	35.7%	9.9%	222,325	33.8%	1.8%
45-64	152,167	28.1%	170,644	27.9%	12.1%	183,429	27.9%	7.5%
65-74	32,616	6.0%	50,437	8.2%	54.6%	65,587	10.0%	30.0%
75-84	18,342	3.4%	22,213	3.6%	21.1%	29,480	4.5%	32.7%
85+	9,392	1.7%	10,560	1.7%	12.4%	10,809	1.6%	2.4%
Tot. 0-64	481,221	88.9%	528,155	86.4%	9.8%	552,737	83.9%	4.7%
Tot. 65 +	60,350	11.1%	83,210	13.6%	37.9%	105,876	16.1%	27.2%

Source: Nielsen Claritas

3. **Provide utilization forecasts for each service included in the project. Include the following:**
 - a. **Utilization forecasts for at least five years following project completion.**
 - b. **The complete quantitative methodology used to construct each utilization forecast.**
 - c. **Identify and justify all assumptions related to changes in use rate, market share, intensity of service and others.**
 - d. **Evidence of the number of persons now using the service(s) who will continue to use the service(s). Utilization experience for existing services involved in the project should be reported for up to the last ten years, if available. Such utilization should be reported in recognized units of measure appropriate to the service.**
 - e. **Evidence of the number of persons who will begin to use the service(s).**

Seattle Children’s projected future surgical and procedural cases for the Bellevue ASC (detailed in Table 11), factoring in provider recruitment and deployment and patient demand for each specialty. In addition, for General Surgery, Otolaryngology, and Urology, it was assumed that more “Bellevue ASC eligible” cases could shift from the Laurelhurst campus to the Bellevue ASC in order to support scheduling cases in the most appropriate setting and mitigating some of the capacity constraints experienced at Laurelhurst.

Table 11 identifies projected case volumes by specialty.

Table 11
Seattle Children’s Bellevue ASC
Actual and Projected Volumes (Cases), FY2018-FY2022

Specialty	Actual FY2018	Projected FY2019	Projected FY2020	Projected FY2021	Projected FY2022
Craniofacial	283	283	284	284	284
General Surgery	443	449	455	460	463
Ophthalmology	122	144	170	170	170
Orthopedics	530	619	722	722	722
Other	158	135	135	135	135
Otolaryngology (incl. Audiology)	2,064	2,394	2,777	3,144	3,144
Urology	760	845	940	959	978
Total	4,360	4,870	5,483	5,873	5,896

Source: Applicant

In addition, Seattle Children’s financial schedule assumes a without scenario (CN project is not approved). In the ‘without’ scenario, Seattle Children’s has assumed that the 4th OR is completed and its use is limited to non-GI, non-Pain procedures. Utilization projections for the ‘without’ scenario are detailed in Table 12:

Table 12
Seattle Children’s Bellevue ASC (Without the Project)
Actual and Projected Volumes (Cases), FY2018-FY2022

	Actual FY2018	Projected FY2019	Projected FY2020	Projected FY2021	Projected FY2022
Surgical Volumes	3,560	3,957	4,085	4,183	4,180
Procedural Volumes	800	912	1,043	1,170	1,170
Total	4,360	4,870	5,128	5,353	5,350

Source: Applicant

4. a. **Provide information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on the facilities and services which "compete" with the applicant.**
 - i. **Identify all existing providers of services similar to those proposed and include sufficient utilization experience of those providers that demonstrates that such existing services are not available in sufficient supply to meet all or some portion of the forecasted utilization.**
 - ii. **If existing services are available to the defined population, demonstrate that such services are not accessible to that population. Time and distance factors, among others, are to be analyzed in this section.**
 - iii. **If existing services are available and accessible to the defined population, justify why the proposed project does not constitute an unnecessary duplication of services.**

The methodology in WAC 246-310-270(9) identifies the need for additional dedicated outpatient operating rooms in East King. In addition, and based on the high utilization of its existing Bellevue ASC, Seattle Children's has demonstrated that there is also need for additional dedicated pediatric operating room capacity. As noted in Seattle Children's 2008 CN application, there is no existing facility in East King or in the greater Puget Sound area (with the exception of Seattle Children's itself and Mary Bridge in Tacoma) that provides outpatient surgical services exclusively for pediatric patients.

The expansion of the Bellevue ASC will have a two-fold benefit on access and availability. First, it will allow Seattle Children's to increase access for the patients and families who reside in East King and adjacent planning areas, who often have to travel to Seattle Children's Laurelhurst campus for surgery. Second, it will allow Seattle Children's to shift more "Bellevue ASC eligible" surgical and procedural cases from its Laurelhurst campus to the Bellevue ASC, thereby supporting scheduling cases in the most appropriate setting, reducing some of the pressures experienced in the Laurelhurst operating rooms and pre-operative and post-operative areas, and freeing-up capacity for the inpatient and complex patients that can only be cared for at the Laurelhurst campus.

b. In the context of the criteria contained in WAC 246-310-210(1)(a) and (b), document the manner in which:

i. Access of low-income persons, racial and ethnic minorities, women and mentally handicapped persons and other underserved groups to the services proposed is commensurate with need for the health services.

Seattle Children's prohibits discrimination on the basis of race, color, creed, national origin, religion, sex, gender identity, sexual orientation, or disability consistent with requirements defined by the US Department of Health and Human Services Office for Civil Rights and the Washington State Department of Social and Health Services. All patients who enter the Seattle Children's system are carefully assessed at the time of entry and appropriately placed in a patient care area that most meets their assessed needs. Copies of the Seattle Children's policies related to admission, charity care policy and non-discrimination are included in Exhibit 8.⁹

Seattle Children's has a long history of providing services to patients, largely ages 0-21, throughout the WAMI region and, as a result, is the largest individual provider of pediatric specialty and inpatient care to the Medicaid population in Washington. In addition, Seattle Children's serves as a critical "safety net" role by remaining committed to providing the best medical care to every child in the WAMI region – regardless of insurance coverage or financial circumstances.

Seattle Children's bases its services on the patient's clinical needs and provides services to patients without regard to their family's financial resources. For hospital charity care reporting purposes, the Department of Health (Department) divides Washington State into five regions. Seattle Children's is located in the King County region. According to 2015-2017 charity care data (the latest data available) produced by the Department, the three-year charity care average for King County, excluding Harborview Medical Center, was 0.87% of gross revenue and 1.89% of adjusted revenue. Seattle Children's provided charity care at 1.17% of gross revenue and 2.2% of adjusted revenue during this period. For the Bellevue ASC proforma financials, Seattle Children's has assumed charity to be 1.35% of gross revenue.

In addition to traditional charity care and serving as the region's "safety net" provider for pediatric care, Seattle Children's reaches beyond its hospital walls every day to provide programs and services to make children, adolescents, and their families safer and healthier where they live. Seattle Children's commitment to caring for the community is its passion, duty, and privilege. A highlight of its community benefit activities outside of Seattle Children's uncompensated care program includes:¹⁰

⁹ Please note that Seattle Children's does not have a separate non-discrimination policy. However, on the Department's website, our Financial Assistance policy is posted and identified as the non-discrimination policy.

¹⁰ Content from Seattle Children's 2017-2018 Community Benefit Report

Community Programs and Services

- *Putting research into schools.* High school students at the Puget Sound Skills Center (PSSC) in the Highline School District are experiencing first-hand the research done at Seattle Children's Research Institute. Dr. Amanda Jones, director of Seattle Children's Science Education Department, collaborated with a science, technology, engineering and math (STEM) specialist at the school district to create the Biomedical Research and Global Health program — part of a plan to build a pipeline of science education programs that spans elementary school through college. Dr. Noelle Machniki, a member of the institute's Science Education Department, teaches the year-long program, held in the PSSC's new Health Sciences Building. The PSSC draws students from 22 high schools in the Highline, Federal Way, Tukwila and Tahoma school districts. The 19 students enrolled in the program meet in a lab with state-of-the-art equipment rarely seen outside a professional facility. The curriculum is based on the cutting-edge research done at the Institute. By building a strong foundation in biological and laboratory sciences and addressing emerging technologies, the program prepares students for many career opportunities in biomedical research and healthcare.
- *Gender Clinic meets growing needs.* A recent study shows the number of people who identify as transgender is growing — now about one in every 200 people in the U.S. The new Gender Clinic at Seattle Children's is one of a growing number of pediatric clinics around the country that provide gender-affirming treatment for young people whose gender identity is different from their sex assigned at birth. The clinic received 550 referrals in its first year of opening. Few pediatric providers are prepared to meet all of the complex needs of transgender youth. Led by Dr. David Inwards-Breland, the Gender Clinic brings together providers with expertise in adolescent medicine, endocrinology and behavioral medicine who work closely to coordinate care and follow consistent guidelines. Services include readiness discussion, pubertal blockers and cross-sex hormones. Requests for surgery are referred to external providers.

- Additional highlights of Community Program and Services include:
 - 850 youth received care at school-based health centers run by Seattle Children's Odessa Brown Children's Clinic
 - 3,518 children and teens received free bike helmets and were individually fit
 - 426 children received low cost car or booster seats
 - 91,00 youth athletes cared for by athletic trainers across the region
 - 1,285 safe firearm storage devices distributed
 - 241 children, teens, and adults received free or low-cost life jackets
 - 243 children and families who are homeless received free health-care at Wellspring Family Services and Country Doctor Community Clinic in partnership with Seattle Children's
 - 5,007 took part in programs about eating health and staying active
 - 1,772 individuals received healthcare-related legal advice from the Washington Medical-Legal Partnership (MLP) and 340 hours of pro-bono legal advice given by MLP attorneys
 - 2,255 people served through the Journey Program, which provides grief and loss services
 - 1,463 rides to and from the airport for patients and families

Research

- *Diet quells Crohn's without medication.* Inflammatory Bowel Disease (IBD), both Crohn's and Ulcerative colitis, strikes when the immune system attacks the digestive tract. This can sap a child's energy, halt growth and spark incessant diarrhea. Standard treatment for inflammatory bowel disease includes medications that suppress the immune system. But those medications don't always work and can leave patients vulnerable to infections and other serious conditions. Dr. David Suskind is leading research on the specific carbohydrate diet (SCD), which has helped some IBD patients achieve remission without medication. Suskind is conducting a study which examines the effect of different versions of the SCD in patients with IBD. In addition, patients' gut bacteria are being examined before and after the diet. This could help his team pinpoint which specific bacteria contribute to IBD.
- *Better diets for refugees through data.* Between 2,000 and 3,000 refugees settle in Washington every year — nearly half under the age of 20. Many arrive with at least one form of malnutrition. Dr. Beth Dawson-Hahn and Dr. Anisa Ibrahim are working to better understand the nutritional risks of child refugees before and after resettlement, how they change as they get used to their new environment and how to teach refugee families about introducing new foods to their infant children, including finding familiar foods and identifying new foods. Dawson-Hahn co-led a study that analyzed government height and weight data collected from refugees before leaving their home country. "We found that nearly one-half of all refugee children had at least one form of malnutrition, and there was, as we suspected, a double burden of some children being underweight and others being overweight," she says. Data from the study will help healthcare providers and nutrition programs like Women, Infant and Children (WIC) understand the differences and similarities between refugees from different countries — and between children who already live here.

- Additional highlights of Research include:
 - 269 student interns and 48 postdoctoral fellows hosted by the research institute
 - 7 interdisciplinary centers dedicated to researching pediatric health
 - Seattle Children's is ranked 5th among pediatric institutions in National Institutes of Health (NIH) funding
 - 484 studies sponsored by 201 different entities; each study furthers Seattle Children's goal of identifying new approaches for preventing, diagnosing, and treating childhood disease
 - 7,599 students received science education from the Science Adventure Lab
 - 180 national and international providers, ethicists, and trainees attended the annual Bioethics Conference
 - 175 areas of clinical, translational, and community research
 - 336 principal investigators on staff who are leading research studies

Health Professions Education

- *Supporting first-year nurses.* Starting a new career is never easy, but when the job involves caring for seriously ill children, it can be especially challenging. That is why Seattle Children's launched a Nurse Residency Program for registered nurses hired with less than one year of experience. Nurses attend 21, four-hour classes where they work on different skills, run through case scenarios, learn about policies and procedures, listen to speakers, and participate in simulation training. Nurses also discuss coping skills for dealing with the emotions that can arise from caring for kids with life-threatening conditions.
- *Providing specialized experience.* The Advanced Practice Provider (APP) Fellowship Program at Seattle Children's provides specialized training to nurse practitioners and physician assistants who are new to working with pediatric patients in the APP role. During the one-year program, fellows spend 70% of their time providing clinical care alongside an experienced nurse practitioner, 20% of their time observing in a clinical area and 10% of their time attending a weekly lecture series. The goal is to hire the fellows by the end of the program.
- Additional highlights of Health Professions Education include:
 - 834 professionals trained in suicide prevention
 - 65 medical, nursing and psychiatry Grand Rounds lectures given to community providers and offered to a worldwide audience via Seattle Children's video library
 - 518 students participated in healthcare job shadows
 - 3,440 healthcare providers and state employees were educated on child abuse and neglect prevention
 - Over 4m300 healthcare professionals participated in continuing education events
 - Providers in training: 897 physicians, 660 nursing students, 48 advanced practice provider students, 132 pharmacy, social work, dentistry, and other students, 718 medical students

- ii. **In the case of the relocation of a facility or service, or the reduction or elimination of a service, the present needs of the defined population for that facility or service, including the needs of under-served groups, will continue to be met by the proposed relocation or by alternative arrangements.**

This project does not involve the relocation, reduction, or elimination of any service. As such, this question is not applicable.

c. Applicants should include the following:

**copy of admissions policy,
copy of community service policy,
reference appropriate access problems identified in State and regional health
council planning documents and discuss how this project addresses such
problems,
other information as appropriate.**

A copy of Seattle Children's admission and charity care policies are included in Exhibit 8. Also included in Appendix 2 is a copy of Seattle Children's 2016 Community Health Needs Assessment.

5. **As applicable, substantiate the following special needs and circumstances which the proposed project is to serve.**
- a. **The special needs and circumstances of entities such as medical and other health professions' schools, multi-disciplinary clinics and specialty centers which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas.**
 - b. **The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.**
 - c. **The special needs and circumstances of osteopathic hospitals and nonallopathic services with which the proposed facility/service would be affiliated.**

Seattle Children's is the pediatric teaching hospital for the University of Washington School of Medicine, the only allopathic medical school in the five state region (Washington, Wyoming, Alaska, Montana, and Idaho) and whose Department of Pediatrics is consistently ranked by *U.S. News & World Report* as one of the best Medical School Pediatric Programs in the country. An integral part of the mission of Seattle Children's is to serve as a resource for teaching and education, helping to ensure that children of future generations will have access to highly trained professionals specializing in pediatric care. The establishment of the Bellevue ASC has created training and educational opportunities for residents and fellows.

SECTION 4 Project Rationale

FINANCIAL FEASIBILITY

1. **Proposed capital expenditures should be broken out in detail and should account for at least the following:**

The capital expenditure for the proposed project is detailed in Table 13:

**Table 13
Estimated Capital Expenditure**

	Description	Estimated Cost
a.	Land Purchase	\$0
b.	Land/Building Improvements	\$0
c.	Building Purchase	\$0
d.	Residual Value of Facility	\$0
e.	Building Construction	\$1,376,054
f.	Moveable Equipment	\$1,932,243
g.	Fixed Equipment	Incl. in construction
h.	Architect/Engineer Fees	\$192,732
I	Consulting Fees	\$144,549
J	Site Preparation	\$0
K	Supervision and Inspection	\$6,570
L	Cost of securing financing	\$0
m.	Costs Associated with Financing to Include Interim Interest	\$0
n.	Sales Tax Building Equipment	\$139,073 \$167,545
o.	Other Project Costs	
	Permits and Fees	\$9,856
	Moving and Cleaning Costs	\$4,380
	Artwork	\$6,571
	CN Review Fees	\$20,427
p.	Total Estimated Costs	\$4,000,000

Source: Applicant

2. The method and sources for calculating construction costs and other estimated capital expenditures should be fully explained.

The estimated capital expenditure was prepared by Seattle Children's facility management team in coordination with the architect, general contractor, medical equipment planners, and other consultants. Included in Exhibit 9 is a non-binding cost estimator letter from Sellen Construction.

3. Documentation of project impact on (a) capital costs, and (b) operating costs and charges for health services.

The capital expenditure for this project was detailed in response to Question #1 above. As was documented in earlier sections of this CN application, the establishment of the Bellevue ASC has been successful in terms of utilization, as demand for the Bellevue ASC outpaced initial projections. As with the original Bellevue ASC CN application, this project is also expected to free-up capacity on Seattle Children's Laurelhurst campus to some degree, thereby, increasing the number of surgical and procedural cases that can be performed in the operating rooms on the Laurelhurst campus.

Furthermore, bringing services closer to where many of Seattle Children's patients and families reside, increases overall patient satisfaction.

4. Source(s) of financing (loan, grant, gifts, etc.). Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, maintenance repair contracts should be provided. The proposed lease should be capitalized with interest expense and principal separated. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

Seattle Children's will utilize reserves for the financing of this project. Included in Exhibit 10 is a letter from Suzanne Beitel, Seattle Children's Chief Financial Officer, confirming this intent. Appendix 1 includes audited financial statements for Seattle Children's documenting the availability of reserves.

5. Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board-designated reserves, interfund loan or bank loan. Provide the rationale for choosing the financing method selected.

This project will be funded using existing capital reserves of Seattle Children's which eliminates costs associated with debt financing.

- 6. Provide a pro forma balance sheet and the accounting statement, statement of changes in financial position of unrestricted fund and changes in components of working capital.**

The requested financial statements are included in Exhibit 11.

- 7. Provide a capital expenditure budget through the project completion and for three years following completion of the project.**

This project requires no capital expenditures beyond those identified in the proposal. Therefore, this question is not applicable.

- 8. The expected sources of revenues for the applicant's total operations (e.g., Medicaid, Blue Cross, Labor and Industries, etc.) with anticipated percentage of revenue from each source.**

The current and expected payer mix is as follows:

Medicaid	40.3%
Medicare/Other Government	1.9%
Commercial	57.6%
Other	<u>0.3%</u>
TOTAL	100.0%

- 9. Expense and revenue statements for the last three full years.**

The Bellevue ASC historical financials are included in Appendix 1.

- 10. Cash flow statement for the last three full years.**

The Bellevue ASC historical financials are included in Appendix 1.

- 11. Balance sheets detailing the assets, liabilities, and net worth of facility for the last three full years.**

The Bellevue ASC historical financials are included in Appendix 1.

12. Indicate the reduction or addition of FTEs with the salaries, wages, employee benefits of each FTE affected.

Table 14 details and current and projected staffing. Salaries, wages and benefits are provided in Exhibit 11.

Table 14
Seattle Children's Bellevue ASC
Current and Projected Staffing, FY2018-FY2022

Position	Current-FY 2018	FY2019	FY2020	FY2021	FY2022
Supervisor: RN	0.7	0.7	1.0	1.0	1.0
Anesthesia Technician	1.7	1.7	3.0	3.0	3.0
Charge Specialist	0.6	0.6	0.8	0.8	0.8
Charge RN	1.9	1.9	3.0	3.0	3.0
Manager: RN	1.0	1.0	1.0	1.0	1.0
RN (PACU and Circulating)	20.0	22.9	27.0	27.0	27.0
Surgical Technician	5.3	6.1	6.3	6.3	6.3
Sterile Processing Supervisor	1.0	1.0	1.0	1.0	1.0
Sterile Processing Technician	2.6	2.8	3.0	3.6	3.6
Per Diem	0.4	0.4	0.4	0.4	0.4
Pharmacy Technician	2.5	2.6	3.6	3.6	3.6
Pharmacist	2.6	2.3	2.3	2.3	2.3
Child Life	1.0	1.0	1.6	1.6	1.6
ES Support Technician	4.5	4.5	6.1	6.1	6.1
Family Service Coordinator	1.0	1.0	1.4	1.4	1.4
Total	46.8	50.4	61.4	62.0	62.0

Source: Applicant

SECTION 5

Project Rationale

Structure and Process (Quality) of Care

Document the following:

- 1. The availability of sufficient numbers of qualified health manpower and management personnel. If staff availability is a problem, describe the manner in which the problem will be addressed.**

Seattle Children's reputation as a nationally recognized provider of high-quality tertiary and quaternary services for pediatric patients, coupled with its status as a leading research and teaching facility has, over the years, greatly assisted its recruitment efforts and minimized difficulty in attracting qualified personnel. Since this project is simply an expansion of an existing facility, it will allow for increased staff efficiencies. To support the additional operating room, for an organization the size of Seattle Children's, the incremental staffing needs are very small. Therefore, Seattle Children's does not anticipate any difficulty in filling these positions.

In addition, Seattle Children's has striven over the years to ensure that it provides a supportive work environment for its clinical staff. Seattle Children's recognizes that meeting the care needs of its young patients can be demanding and has worked to have a very reasonable patient to staff ratio. Again, all of this has been done in an effort to ensure that the recruited staff become the retained staff.

- 2. Identify the facility's Medical Director, Director of Nursing, and other key staff. For each provide their professional license number for Washington. If they are also licensed in other states, provide their license number for those states.**

Information regarding the medical directors is provided in Table 3. Information for the other key staff are included in Table 15:

Table 15
Seattle Children’s Bellevue ASC
Key Clinical Staff

Name	Title	License Number
Kristin Blasko	RN Supervisor, Bellevue Surgery Center	RN00158441
Chris Hunt	Sr. Director, Associate Chief Nurse, Surgical Services	RN00161195
Kayla Reece	Nurse Manager, Bellevue Surgery Center	RN60403512

Source: Applicant

A listing of all credentialed staff is included in Exhibit 12.

- 3. For the Medical Director indicate if he/she will be an employee of the facility or contractual. If performing his/her duties through a contract, provide a copy. A draft is acceptable only if all parties identified in the draft agreement provide a signed “Letter of Intent to finalize” the agreement and all terms and costs are included.**

Information regarding the medical directors is provided in an earlier section. The medical directors are employed and their job descriptions are included in Exhibit 2.

- 4. The relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.**

As described previously, the existing Bellevue ASC is part of a larger outpatient specialty center, Seattle Children’s Bellevue Clinic and Surgery Center, that includes on-site diagnostic, therapeutic, and support services, including laboratory, pharmacy, radiology, and orthotics, among others, and is able to provide patients and families a ‘one stop shopping’ healthcare experience.

In addition, all of the services provided at Seattle Children’s Bellevue Clinic and Surgery Center, including the Bellevue ASC, are operated as departments of the Hospital, and are under the license of the Hospital. This ensures strong oversight and consistent care delivery and quality. The Bellevue ASC is, and will continue to be with the expansion, staffed to handle all complications and enjoys rapid access to Seattle Children’s specialty providers, facilities, including inpatient, and the full-spectrum of ancillary and support services if needed. The Bellevue ASC uses the same electronic medical record and data systems as the rest of the Seattle Children’s organization, which allows for immediate, seamless management of all care-related information.

5. **The specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes and other health services resources serving your primary service area. This description should include recent, current and pending cooperative planning activities, shared service agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.**

This expansion project was developed specifically to address the fact that the Bellevue ASC is currently nearing 100% capacity. This project will not only expand the Bellevue ASC capacity it will provide capacity within Seattle Children's system, as the Laurelhurst campus is increasingly running at capacity. While new operating room capacity is currently being developed on the Laurelhurst campus, it will not be available until the second quarter of 2022. This project will ensure access to services and will simultaneously promote continuity of care. Pediatric patients will continue to be cared for by Seattle Children's staff and providers and, if necessary, can receive inpatient care at Seattle Children's Laurelhurst campus. No changes are anticipated to Seattle Children's current formal and informal relationships.

6. **Fully describe any history of the applicant entity with respect to the actions noted in Certificate of Need rules and regulations WAC 246-310-230 (5) (a). If there is such history, provide clear, cogent, and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.**

Seattle Children's does not have any history with respect to the actions noted in CN regulations described in the CN criterion referenced above.

7. **Services to be provided will be provided (a) in a manner that ensures safe and adequate care, and (b) in accord with applicable federal and state laws, rules and regulations.**

Seattle Children's operates all existing programs in conformance with applicable federal and state laws, rules, and regulations.

SECTION 6 Project Rationale

COST CONTAINMENT

Document the following:

- 1. Exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, merger, contract services, and different methods of service provision, including spatial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:**
 - Decision making criteria (e.g. cost limits, availability, quality of care, legal restrictions, etc.)**
 - Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweigh each other by application of the decision-making criteria**
 - Capital costs**
 - Staffing impact**

Seattle Children's considered the following options:

1. Do nothing;
2. Establish a procedure suite only; and
3. Add a 4th OR

The do nothing option was ruled out immediately due to occupancy constraints for surgical services within Seattle Children's system (Laurelhurst campus and Bellevue ASC). Establishing a procedure suite has a number of limitations and operational challenges. Not all cases can be performed in a procedure suite and it requires accommodations to scheduling and provider deployment in order to ensure that only cases appropriate for a procedure suite are properly scheduled. Based on FY2018 Bellevue ASC volumes, roughly 18% of total cases were eligible for a procedure suite. Therefore, this option would result in a situation where Seattle Children's is unable to meet its surgical demand in the existing three operating rooms and the procedure suite would be operating at a lower utilization, causing space and staffing inefficiencies. In addition, the capacity of the Bellevue ASC Post Anesthesia Care Unit (PACU) would inform the maximum throughput of the procedure suite, knowing that the average minutes per case for a procedure is much shorter than the patient's recovery time.

Lastly, and what is the most significant impact, is that patients who need surgery or a procedure would likely experience delayed care and wait longer, as surgery would be limited to the existing three operating rooms, which would be running at 100% capacity, and procedures would be limited to the procedure suite in order to maximize the capacity of the existing three operating rooms for surgery.

Given the above limitations and challenges and the need for additional capacity, Seattle Children's opted to apply for a CN to build-out the 4th OR. Need for additional dedicated outpatient operating room capacity is demonstrated per the methodology in WAC 246-310-270(9) and Seattle Children's has also demonstrated internal need for additional capacity.

2. The specific ways in which the project will promote staff or system efficiency or productivity.

This project will promote overall internal (Seattle Children's) system efficiency. It will do so by providing additional operating room capacity and ensuring continued access to outpatient surgery in Bellevue, thereby addressing capacity issues at both the Bellevue ASC and the Laurelhurst campus (until the planned additional capacity there is completed in the second quarter of 2022).

Seattle Children's used a lean design process for the original establishment of the Bellevue ASC and will do the same for the addition of the 4th OR. This process promotes staff efficiency by streamlining care and eliminating the waste of space and transportation. With separate induction rooms for administration of anesthesia and emergence in the PACU, patients are only in the operating room for the actual surgery, shortening the time the operating room is in use, which results in increased throughput and maximum utilization of space.

3. In the case of construction, renovation or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.

This project proposes to build-out the final shelled space in the Bellevue ASC, adding one operating room to the existing capacity. At project completion, the Bellevue ASC will have four operating rooms. As described above, the Bellevue ASC is part of the larger outpatient facility, Seattle Children's Bellevue Clinic and Surgery Center, and as part of the original design process, Seattle Children's included features that allow maximum flexibility and maximization of space. In addition, because the Bellevue ASC is part of a larger facility, there are several important services that can be shared, significantly enhancing the efficiency of overall operations for both the Bellevue ASC and the broader facility. These include, but are not limited to, laboratory, pharmacy, imaging and support services.

4. **In the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.**

Seattle Children's proactively evaluated alternative sources of energy management and supply for this project prior to the original construction of the space. The selected systems met or exceeded all code requirements at the time of shell and core construction.

Exhibit 1
Organizational Chart



Exhibit 2
Medical Director Job Descriptions

MANAGEMENT JOB DESCRIPTION

Job Code: _____ **Job Title:** CLINICAL DIRECTOR OF ANESTHESIA, BELLEVUE SURGERY CENTER

Department: Surgical Services

Reports to Job Title: Director, Anesthesiology and Pain Medicine

Supervises: None

<u>Approvals</u>	Effective Date:	Next Review Date:
SIGNATURES:		
Supervisor:	_____	Next Level Approval:
Human Resources:	_____	_____

<u>SECTION I: Job Information</u>	Job Family: MDD FLSA Status: Exempt	ASC Code: 3 ADA Profile: MD 3
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JOB SUMMARY:

The Clinical Director of Anesthesia Services, Bellevue Surgery Center has the general responsibility for overseeing the clinical practice of anesthesia patient care at the Bellevue Surgery Center, which encompasses pre-operative, intra-operative and post-operative care. Works in cooperation with the Vice President and Medical Director, Surgical Services (Medical Director of Children's Surgery); Division Chief, General Anesthesia Services (Medical Director of Children's Anesthesia); Clinical Director of Surgery, Bellevue Surgery Center; and nursing administration to support nursing needs of children with surgical problems, develop ambulatory surgery treatment protocols along with the surgical teams, and help coordinate the performance improvement for the ambulatory patient. Maintains alignment with clinical practice between Seattle Children's Bellevue Surgery Center and Seattle Children's Laurelhurst campus.

SECTION II: QUALIFICATIONS

The **minimum** qualifications listed below (along with education/experience) are representative of the knowledge, skills and abilities needed to perform this job successfully. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential duties and responsibilities of this position.

Job Code:

Job Title: CLINICAL DIRECTOR OF ANESTHESIA, BELLEVUE SURGERY CENTER

Minimum Education and Experience: *(Identify only education requirements that are legally defensible – e.g., an attorney needs a Juris Doctor)*

Required:

- Degree of doctor of medicine (MD) or osteopathy (DO)
- Licensed as a Physician in the State of Washington
- Board eligibility or certification by the American Board of Anesthesiology (or equivalent)
- Federal DEA Registration
- Medical Staff membership and appropriate clinical privileges at Seattle Children's
- UW SOM faculty appointment
- Active clinical anesthesiologist

Preferred:

- Pediatric anesthesiology board certification or equivalent experience
- Membership and active participation in national and/or regional children's anesthesiology organizations
- Prior managerial experience in Anesthesiology

Knowledge, Skills, and Abilities:

- Educational and learning competencies
- Demonstrated leadership competencies
- Familiarity with LEAN processes and continuous performance improvement systems
- Knowledge of basic computer applications and ability to learn and apply new technologies and skills; proficiency using EPIC and MS Office (Outlook, Word, etc.)
- Excellent interpersonal and verbal communication skills
- Excellent written communication skills
- Excellent problem-solving skills
- Excellent customer service skills
- Demonstrated creativity and innovation skills
- Skill in supervising, evaluating and guiding other care providers
- Demonstrated ability to lead and manage change
- Ability to understand and interface with our broad spectrum of clinical services
- Ability to work effectively in a team environment
- Ability to adapt to changes in the work environment and to shifts in organizational philosophy and expectations

Clinical Knowledge, Skills & Abilities:

- Knowledge of human growth and development to modify diagnoses to the age and development status of the patient population served

SECTION III: PRIMARY JOB RESPONSIBILITIES AND ACCOUNTABILITIES: *(Please list no more than 10 primary job responsibilities). The primary job responsibilities and accountabilities listed below represent work performed by this position and are not all-inclusive. The omission of a specific accountability will not preclude it from the position if the work is similar, related, or a logical extension of the position.*

Provide leadership to develop, implement and evaluate the efficacy of safety and medical standards of clinical care and research activities at the Bellevue Surgery Center. Employ CII methodologies to identify and implement continual improvement in the safety, delivery and quality of care. Develop, implement and regularly review departmental policies and procedures to guide the provision of clinical services. Work closely with administrative counterparts at Seattle Children's Bellevue Clinic and Surgery Center and Seattle Children's Laurelhurst campus to develop, improve and monitor performance improvement and utilization management programs, as outlined in the hospital's Quality Improvement Plan, including the monitoring of department-specific performance measures and to ensure that annual Medical Staff goals are attained. Ensure that departmental services comply with all legal and regulatory requirements including DNV, Washington State Department of Health, NCQI and others.

Collaborate with Seattle Children's leadership to plan, oversee and evaluate related activities within Seattle Children's Bellevue Surgery Center including ambulatory, satellite and other service modalities. Define appropriate scope and services of the department required to meet current and anticipated needs of patients and families and to ensure appropriate coordination and integration with other services. Regularly review services offered, including those provided by external parties, to assess effectiveness and recommend changes or enhancements to clinical services as required to improve overall quality and delivery of clinical services to patients and families. Work closely with administrative counterparts at Seattle Children's Bellevue Clinic and Surgery Center and Seattle Children's Laurelhurst campus to develop and implement Quality Assessment and Performance Improvement plan encompassing metrics, trended data, and data driven improvements.

Assist in recruitment, orientation, and development of the highly competent, qualified and high-performing staff required to deliver quality care. Continually assess operational objectives, organizational structures and work processes to assure optimum skill mix and staffing levels. Implement consistent performance management practices by defining and communicating goals and performance objectives to all appropriate parties and regularly monitor, evaluate and improve individual and team performance of those individuals having clinical privileges. Determine and implement required continuing education activities designed to maintain and enhance competencies.

Work closely with administrative counterparts and Seattle Children's leadership to ensure effective and efficient utilization of all departmental resources including staff, facilities and space, financial and supplies.

Section II – Leadership Competencies

Children's continuous performance improvement (CPI) philosophy promotes a culture of never-ending improvement at all levels in the organization. Children's management system is designed to ensure the ultimate goal of patient and family satisfaction, based on continuous improvement in quality, cost, delivery, safety, and engagement (QCDSE). As leaders, management staff at Children's must demonstrate competency in each of these areas. The following are examples of observable behaviors and performance indicators that demonstrate the relevant CPI leadership competency.

Leadership Competencies

QUALITY: Customer Service: Develops and maintains systems and practices that are consistently responsive to the needs of patients, families and coworkers.

- Executes essential functions in a manner consistent with the practice of Family-Centered Care, whenever applicable.
- Ensures employees' adherence to Children's Customer Service Standards; models these standards and holds staff accountable for similar behaviors.
- Demonstrates continuous improvement in customer service indicators, such as FES scores where applicable, or other internal customer service survey scores.
- Identifies customer needs and delivers quality and timely solutions to meet them.
- Responds in a timely and thorough manner to customer complaints and concerns, as measured by eFeedback indicators and other customer service indicators.
- Adjusts systems as needed to deliver best possible internal and/or external customer service.
- Maintains patient privacy and other work-related confidentiality; does not discuss patients, other staff members, or hospital business inappropriately or in public places.

COST: Financial Stewardship: Manages organization's assets (including its human resources) and/or budget in a manner that derives maximum value from resources.

- Develops and uses work methods that reduce complexity, errors, steps and cost.
- Develops and monitors effective system of internal controls that safeguard hospital assets and accuracy of financial reporting.
- Where applicable, ensures proper pricing and coding of services in compliance with federal and state regulations.
- Translates financial data into useful information for decision-making.
- Manages department financial resources at or below budgeted FTEs and other expense categories.
- Quantifies savings from waste reduction activities.
- Appropriately monitors and oversees staff productivity, position control, time reporting, and adherence to all applicable federal, state, and local regulatory requirements with respect to compensation (FLSA) and benefits (FMLA/ADA).

DELIVERY: Operations Management: Provides leadership and management oversight to ensure that operational outcomes achieve measurable results in support of hospital goals and business objectives.

- Acts strategically; organizes and prioritizes resources in areas most likely to impact hospital goals/business objectives.
- Manages multiple projects efficiently, and in compliance with all relevant regulatory requirements.
- Anticipates trends in areas of responsibility and makes recommendations to senior management to address those issues in a proactive manner.
- Proactively implements operational improvements.
- Makes sound decisions in a timely manner.
- Ensures "continuous readiness" for all accreditation surveys, including 100% compliance with mandatory training and certification.
- Utilizes 5S tools to organize work areas; sustains progress as measured by 3rd party 5S audit.

DELIVERY: Change Management: Ensures that improvement objectives are achieved and are implemented in a planned, controlled and sensitive fashion with minimal negative impact

- Builds and maintains cooperative working relationships with individual, inter-disciplinary, and group stakeholders.
- Implements strategies to align departmental operations and activities with changing hospital goals and initiatives.
- Mobilizes energy and commitment to change by communicating rationale, vision, progress, and results.
- Monitors and adjusts strategies in response to problems in the change process.
- Understands and responds appropriately to employees' reactions to change.

Leadership Competencies (continued)

SAFETY: Continuously improves patient and staff safety within areas of responsibility, and as applicable, ensures all staff in area of responsibility understands and comply with all National Patient Safety Goals.

- Provides leadership and support for safe work environment, including compliance with all regulatory requirements and CHPMC policies for employee safety.
- Staff is trained to perform duties in a safe manner, and their compliance with safe work environment practices is evaluated.
- Systems are introduced to reduce errors and defects in work and care delivery practices.
- Patient and staff safety incidents are investigated in a timely and thorough manner.
- Staff are provided the materials and equipment they need to perform their jobs safely, as demonstrated by continuous improvement in safety indicators such as loss time due to on the job injuries, number of safety incidents in dept., etc.
- Patient and staff safety trends are monitored and appropriate action is initiated in response to data about risks in the environment.

ENGAGEMENT: Performance Management: Develops and maintains a work environment that enables individuals and teams to fully optimize their performance toward departmental and organizational goal achievement.

- Recruits and hires qualified, engaged employees.
- Actively seeks to build a diverse staff; acts in a non-discriminatory manner in hiring, promotion and other personnel decisions.
- Ensures adequate orientation, training and development opportunities.
- Ensures that employees have the tools and information they need to succeed in their jobs.
- Demonstrates continuous improvement in staff engagement indicators, including workplace survey scores, turnover statistics and employee absenteeism.
- Provides timely and honest confirming and corrective performance feedback.
- Conducts thorough and timely performance evaluations.

ENGAGEMENT: ARTful Management: Personally models Accountability, Respect and Teamwork; displays leadership attributes that stimulate employee engagement.

- Delegates appropriately to share responsibility and authority; credits others' contributions and achievements.
- Rewards appropriate risk-taking by employees despite results.
- Applies HR and other policies, regulatory requirements, and management practices of Children's Hospital fairly and consistently.
- Takes accountability for own decisions regardless of results.
- Makes ethical choices and exhibits sound judgment.
- Communicates consistently, frequently, and clearly, especially regarding organizational mission, vision, and initiatives.
- Values and promotes diversity of perspective, opinion and approach. Facilitates conflict resolution in a positive and productive manner.
- Honors and seeks to better understand individual differences based on nationality, gender, race, sexual orientation, age, etc.; i.e. is culturally competent.
- Confronts problems in timely and effective manner; does not allow uncomfortable or unproductive situations to linger in unresolved fashion.
- Assumes responsibility for own learning and career growth.

MANAGEMENT JOB DESCRIPTION

Job Code: _____ **Job Title:** CLINICAL DIRECTOR OF SURGERY, BELLEVUE SURGERY CENTER

Department: Surgical Services

Reports to Job Title: VP, Medical Director of Surgical Services

Supervises: None

<u>Approvals</u>	Effective Date:	Next Review Date:
SIGNATURES:		
Supervisor:	_____	Next Level Approval:
Human Resources:	_____	_____

<u>SECTION I: Job Information</u>	Job Family: MDD FLSA Status: Exempt	ASC Code: 3 ADA Profile: MD 3
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JOB SUMMARY:

The Clinical Director of Surgery, Bellevue Surgery Center has the general responsibility for overseeing the clinical practice of surgical patient care at Seattle Children's Bellevue Surgery Center, which encompasses pre-operative, intra-operative and post-operative care. Works in cooperation with the Vice President and Medical Director of Surgical Services (Medical Director of Children's Surgery); Division Chief, General Anesthesia Services (Medical Director of Children's Anesthesia); Clinical Director of Anesthesia, Bellevue Surgery Center; and nursing administration to support nursing needs of children with surgical problems, develop ambulatory surgery treatment protocols along with the surgical teams, and help coordinate the performance improvement for the ambulatory patient. Maintains alignment with clinical practice between Seattle Children's Bellevue Surgery Center and Seattle Children's Laurelhurst campus.

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The **minimum** qualifications listed below (along with education/experience) are representative of the knowledge, skills and abilities needed to perform this job successfully. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential duties and responsibilities of this position.

Job Code:

Job Title: CLINICAL DIRECTOR OF SURGERY, BELLEVUE SURGERY CENTER

Minimum Education and Experience: *(Identify only education requirements that are legally defensible – e.g., an attorney needs a Juris Doctor)*

Required:

- Degree of doctor of medicine (MD) or osteopathy (DO)
- Licensed as a Physician in the State of Washington
- Board eligibility or certification by the American Board of Surgeons
- Federal DEA Registration
- Medical Staff membership and appropriate clinical privileges at Seattle Children's
- UW SOM faculty appointment
- Active clinical surgeon

Preferred:

- Pediatric surgery board certification or equivalent experience
- Membership and active participation in national and/or regional children's surgery organizations
- Prior managerial experience in Surgery

Knowledge, Skills, and Abilities:

- Educational and learning competencies
- Demonstrated leadership competencies
- Familiarity with LEAN processes and continuous performance improvement systems
- Knowledge of basic computer applications and ability to learn and apply new technologies and skills; proficiency using EPIC and MS Office (Outlook, Word, etc.)
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- Develops and monitors effective system of internal controls that safeguard hospital assets and accuracy of financial reporting.
- Where applicable, ensures proper pricing and coding of services in compliance with federal and state regulations.
- Translates financial data into useful information for decision-making.
- Manages department financial resources at or below budgeted FTEs and other expense categories.
- Quantifies savings from waste reduction activities.
- Appropriately monitors and oversees staff productivity, position control, time reporting, and adherence to all applicable federal, state, and local regulatory requirements with respect to compensation (FLSA) and benefits (FMLA/ADA).

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- Mobilizes energy and commitment to change by communicating rationale, vision, progress, and results.
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- Understands and responds appropriately to employees' reactions to change.

Leadership Competencies (continued)

SAFETY: Continuously improves patient and staff safety within areas of responsibility, and as applicable, ensures all staff in area of responsibility understands and comply with all National Patient Safety Goals.

- Provides leadership and support for safe work environment, including compliance with all regulatory requirements and CHRMC policies for employee safety.
- Staff is trained to perform duties in a safe manner, and their compliance with safe work environment practices is evaluated.
- Systems are introduced to reduce errors and defects in work and care delivery practices.
- Patient and staff safety incidents are investigated in a timely and thorough manner.
- Staff are provided the materials and equipment they need to perform their jobs safely, as demonstrated by continuous improvement in safety indicators such as loss time due to on the job injuries, number of safety incidents in dept., etc.
- Patient and staff safety trends are monitored and appropriate action is initiated in response to data about risks in the environment.

ENGAGEMENT: Performance Management: Develops and maintains a work environment that enables individuals and teams to fully optimize their performance toward departmental and organizational goal achievement.

- Recruits and hires qualified, engaged employees.
- Actively seeks to build a diverse staff; acts in a non-discriminatory manner in hiring, promotion and other personnel decisions.
- Ensures adequate orientation, training and developmental opportunities.
- Ensures that employees have the tools and information they need to succeed in their jobs.
- Demonstrates continuous improvement in staff engagement indicators, including workplace survey scores, turnover statistics and employee absenteeism.
- Provides timely and honest confirming and corrective performance feedback.
- Conducts thorough and timely performance evaluations.

ENGAGEMENT: ARTful Management: Personally models Accountability, Respect and Teamwork; displays leadership attributes that stimulate employee engagement.

- Delegates appropriately to share responsibility and authority; credits others' contributions and achievements.
- Rewards appropriate risk-taking by employees despite results.
- Applies HR and other policies, regulatory requirements, and management practices of Children's Hospital fairly and consistently.
- Takes accountability for own decisions regardless of results.
- Makes ethical choices and exhibits sound judgment.
- Communicates consistently, frequently, and clearly, especially regarding organizational mission, vision, and initiatives.
- Values and promotes diversity of perspective, opinion and approach. Facilitates conflict resolution in a positive and productive manner.
- Honors and seeks to better understand individual differences based on nationality, gender, race, sexual orientation, age, etc.; i.e. is culturally competent.
- Confronts problems in timely and effective manner; does not allow uncomfortable or unproductive situations to linger in unresolved fashion.
- Assumes responsibility for own learning and career growth.

Exhibit 3
Letter of Intent

November 08, 2018

Janis Sigman, Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Ms. Sigman:

In accordance with WAC 246-310-080, Seattle Children's Hospital (Seattle Children's) hereby submits this letter of intent to apply for a certificate of need to add one operating room to its existing Ambulatory Surgery Center (ASC) in Bellevue, Washington. In conformance with WAC, the following information is provided:

1. A Description of the Extent of Services Proposed:

Seattle Children's proposes to add one operating room to its existing ASC located in Bellevue, Washington. Upon project completion, the ASC will have four operating rooms.

2. Estimated Cost of the Proposed Project:

The estimated capital expenditure is \$4,000,000.

3. Description of the Service Area:

Per WAC 246-310-270, the primary service area is the East King County Secondary Health Service Area. However, because Seattle Children's serves as the pediatric and adolescent academic medical center for Washington, Alaska, Montana, and Idaho, Seattle Children's anticipates that a number of patients will come from other areas of King County as well as Pierce, Snohomish and other counties throughout Western Washington.

Thank you for your interest in this matter. Please contact me directly with any questions.

Sincerely,



Sanford Melzer, MD MBA
Executive Vice President, Networks and Population Health
Seattle Children's

Exhibit 4
Equipment List

Item	Location	Quantity	Cost
TABLE, HAND SURGERY, STERIS #BF435	OR	1	\$ 2,150.07
ELECTROSURGICAL UNIT	OR	1	\$ 22,776.21
VIDEO SYSTEM COMPONENT (SDC ULTRA) AND PRINTER FOR ENDOSCOPY	OR	1	\$ 36,554.68
MONITOR, FLAT PANEL	OR	2	\$ 20,498.59
COVER, MONITOR	OR	2	\$ 5,238.53
TRANSMITTER, WIRELESS	OR	1	\$ 1,138.81
LIGHT SOURCE, LED	OR	2	\$ 19,359.78
ACCESSORIES, BOOM W/ SURGICAL LIGHT (STRYKER)	OR	1	\$ 51,246.48
PUMP, SYRINGE	OR	2	\$ 6,832.86
ACCESSORY, ANESTHESIA MACHINE ANES GAS MODULE MONITOR (ASK AARON)	OR	3	\$ 37,580.75
MONITOR, PHYSIOLOGICAL MP50 ON ANES MACHINES	OR	3	\$ 68,328.63
ACCESSORY, SURGICAL TABLE ANES ARM BOARD	OR	2	\$ 136,657.27
TABLE, OPERATING	OR	1	\$ 68,328.63
DISPOSAL UNIT, WASTE ROVER 2 NEPTUNE, STRYKER	OR	1	\$ 18,790.37
MACHINE, ANESTHESIA FABIUS GS PREMIUM (UPGRADED ANES MACHINES TO PERSEUS)	OR	1	\$ 76,300.31
UNIT, ULTRASOUND HAND HELD	OR	1	\$ 11,388.11
THERMOMETER, ELECTRONIC	OR	3	\$ 1,366.57
KICK BUCKET WITH CASTERS	OR	1	\$ 284.70
RING STAND, OR BASIN SINGLE	OR	2	\$ 797.17
TABLE, INSTRUMENT	OR	1	\$ 683.29
STAND, MAYO WITH CASTERS	OR	2	\$ 1,024.93
STAND, IV 5 LEG STAND 4 HOOK	OR	2	\$ 911.05
TABLE, INSTRUMENT 72" LONG	OR	1	\$ 888.27
ACCESSORY, OR TABLE RAIL CLAMP, STERIS #BF462	OR	2	\$ 163.99
ACCESSORY, OR TABLE CLARK SOCKET, STERIS BF083 (PAIR)	OR	2	\$ 972.54
CLAMP, UNIVERSAL ACCESSORY, STERIS #BF133 (PAIR)	OR	2	\$ 341.64
STIMULATOR, NERVE	OR	1	\$ 1,138.81
ELECTRO SURGERY UNIT, BIPOLAR SYNERGY PRECISION	OR	1	\$ 6,832.86
HEADLIGHT, FIBEROPTIC	OR	2	\$ 3,416.43
STOOL, ENTROLL SURGICAL (USED FOR EYE AND EAR	OR	1	\$ 569.41
SYSTEM, IPC AND ENDOSCRUB 2 ACCESS - ENT	OR	1	\$ 27,135.58
CONSOLE, CORE STRYKER	OR	1	\$ 10,249.30
FOOTSWITCH, TPS	OR	1	\$ 1,010.12
STRYKER EQUIPMENT BOOM (1) AND LED LIGHTS (2) MONITOR ARMS (2)	OR	1	\$ 95,090.68
STRYKER CROSSFIRE 2	OR	1	\$ 9,002.30
STRYKER PNEUMOSURE	OR	1	\$ 9,028.49
STRYKER LED LIGHT SOURCE (L9000)	OR	1	\$ 9,505.65
CABLE FOR STRYKER LED LIGHT SOURCE L9000	OR	2	\$ 1,366.57
STRYKER HD CAMERA (1288HD)	OR	1	\$ 14,235.13
DEPUY MITEK VAPRVUE CONSOLE	OR	1	\$ 20,498.59
TRANSFER DEVICE, PATIENT SLIDER BOARD	OR	1	\$ 284.70
CART, SUTURE	OR	2	\$ 1,571.56
STOOL, STEP	OR	4	\$ 911.05
TRUCK, GAS CYLINDER	OR	1	\$ 227.76
CART, STANDARD DUTY UTILITY LAKESIDE	OR	1	\$ 398.58
ACCESSORY, SURGICAL TABLE EXTENSION, STERIS #BF578	OR	1	\$ 3,599.78
ACCESSORY, SURGICAL TABLE RESTRAINT STRAP, STERIS #BF363	OR	2	\$ 758.45
REGULATOR, VACUUM, CONTINUOUS	OR	2	\$ 637.73
SET, WALL MOUNTED TRANSFORMER OTO/OPHTHALMOSCOPE	OR	2	\$ 1,594.33
BRACKET, WALL MOUNTING FOOT PUMP FOR 3M PRODUCT	OR	1	\$ 56.94
WALL MOUNT FOR SURGICAL SCRUB BOTTLE	OR	2	\$ 113.88
CART, STANDARD DUTY UTILITY LAKESIDE 322	OR	1	\$ 421.36
PHONE	OR	3	\$ 1,024.93
COW (NURSING)	OR	1	\$ 4,555.24
OMNICEL (NURSING)	OR	1	\$ 34,164.32
GLOVE BOX HOLDER	OR	1	\$ 45.55
TIME OUT POSTER HANGER	OR	1	\$ 34.16
RECYCLE BINS	OR	3	\$ 68.33
SOILED LINEN BASKET	OR	1	\$ 455.52

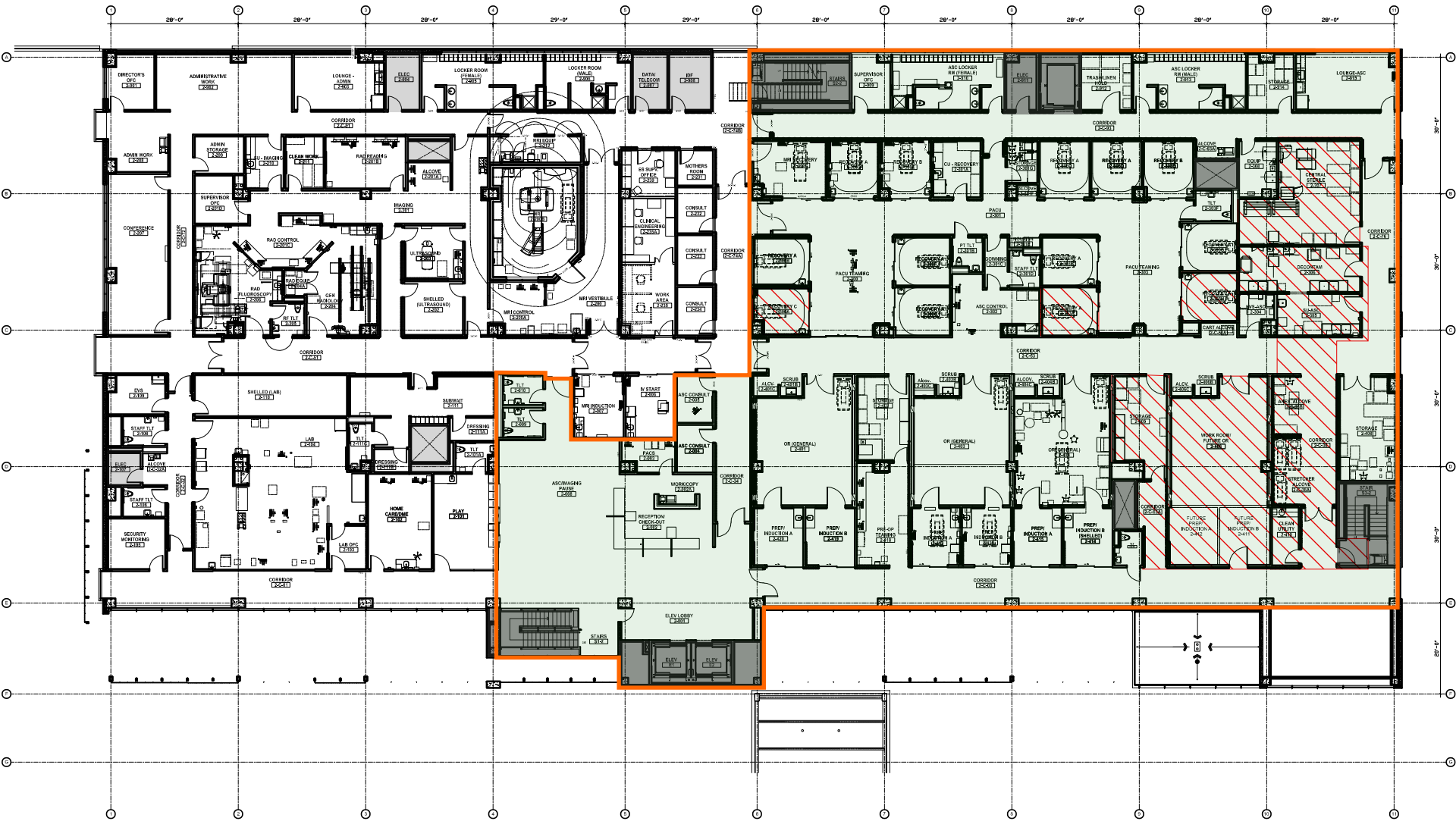
Item	Location	Quantity	Cost
GARBAGE RING STAND	OR	1	\$ 341.64
COMPUTER & PRINTER	OR	1	\$ 1,708.22
FLAT SCREEN TV, MEDICAL GRADE	OR	1	\$ 10,249.30
SPEAKER SYSTEM	OR	1	\$ 341.64
MINI C-ARM	OR	1	\$ 113,881.06
LARGE MICROSCOPE (ENT) ZEISS PINTERO 800	OR	1	\$ 284,702.64
SMALL MICROSCOPE (ENT) ZEISS 1FC	OR	1	\$ 34,164.32
STOOLS	Induction	4	\$ 3,644.19
CHAIRS	Induction	4	\$ 2,960.91
SUCTION REGULATOR	Induction	2	\$ 728.84
OXYGEN FLOWMETER	Induction	2	\$ 56.94
LOCK BOX, NARCOTIC	Induction	2	\$ 1,138.81
DISPENSER, GLOVE, TRIPLE	Induction	2	\$ 91.10
THERMOMETER, TEMPORAL	Induction	2	\$ 819.94
PRINTER	Induction	2	\$ 911.05
WORK CARTS (ANESTHESIA) ARMSTRONG MEDICAL	Induction	3	\$ 19,815.30
RECYCLE BIN	Induction	2	\$ 56.94
TRASH CAN	Induction	2	\$ 56.94
CLOCK	Induction	2	\$ 239.15
CURTAIN	Induction	2	\$ 4,555.24
PHONE	Induction	2	\$ 683.29
TV MONITOR	Induction	2	\$ 341.64
ANESTHESIA MACHINE FABIVS TIRO	Induction	2	\$ 86,549.60
ANESTHESIA GAS MODULE (ASK AARON)	Induction	2	\$ 25,053.83
MONITOR	PACU	3	\$ 30,747.89
SUCTION	PACU	3	\$ 1,024.93
COMPUTER	PACU	3	\$ 3,416.43
KEYBOARD	PACU	3	\$ 341.64
PHONE	PACU	3	\$ 1,024.93
ASCOM PHONES	PACU	10	\$ 3,416.43
THERMOMETER	PACU	3	\$ 632.04
RECLINING CHAIR	PACU	3	\$ 10,249.30
BED STAND	PACU	3	\$ 1,195.75
WHITE BOARDS	PACU	2	\$ 227.76
BEDSIDE CHAIRS/NOT RECLINER - REGULAR	PACU	3	\$ 683.29
EXERGEN THERMOMETERS WITH WALL MOUNTS	PACU	3	\$ 1,229.92
STRETCHERS	PACU	3	\$ 27,331.45
2ND LARGE SIZE BLANKET WARMER WITH 4 SHELVES	PACU	1	\$ 10,249.30
AMSCO® WASHER DISINFECTOR 5052,	Sterile Processing	1	\$ 90,674.00
AMSCO 400 SERIES® MEDIUM REPLACEMENT STEAM STERILIZER	Sterile Processing	1	\$ 146,629.83
CCPS319635 DECON SINK	Sterile Processing	1	\$ 12,837.81
AMSCO 400 SERIES® MEDIUM STEAM STERILIZER	Sterile Processing	1	\$ 146,629.83
Total (Excluding Tax)			\$ 1,932,243.43

Exhibit 5
Existing & Proposed Single Line Drawing

Date: November 7, 2018

Area: Bellevue Clinic Level 2

Drawing: Square Footage Diagram



- ASC on Level 2 of
Seattle Children's
Bellevue Clinic**
- ASC Square Footage / Area
- 21,053 Gross square footage
 - 19,312 Net square footage
- Project Scope Area
- 3,412 Gross /Net (same square footage, no infrastructure items)
- Items/ Space Excluded from Net Area: Shafts, Electrical, Mechanical, Stairs, Elevators, Tele/Data and exterior building wall

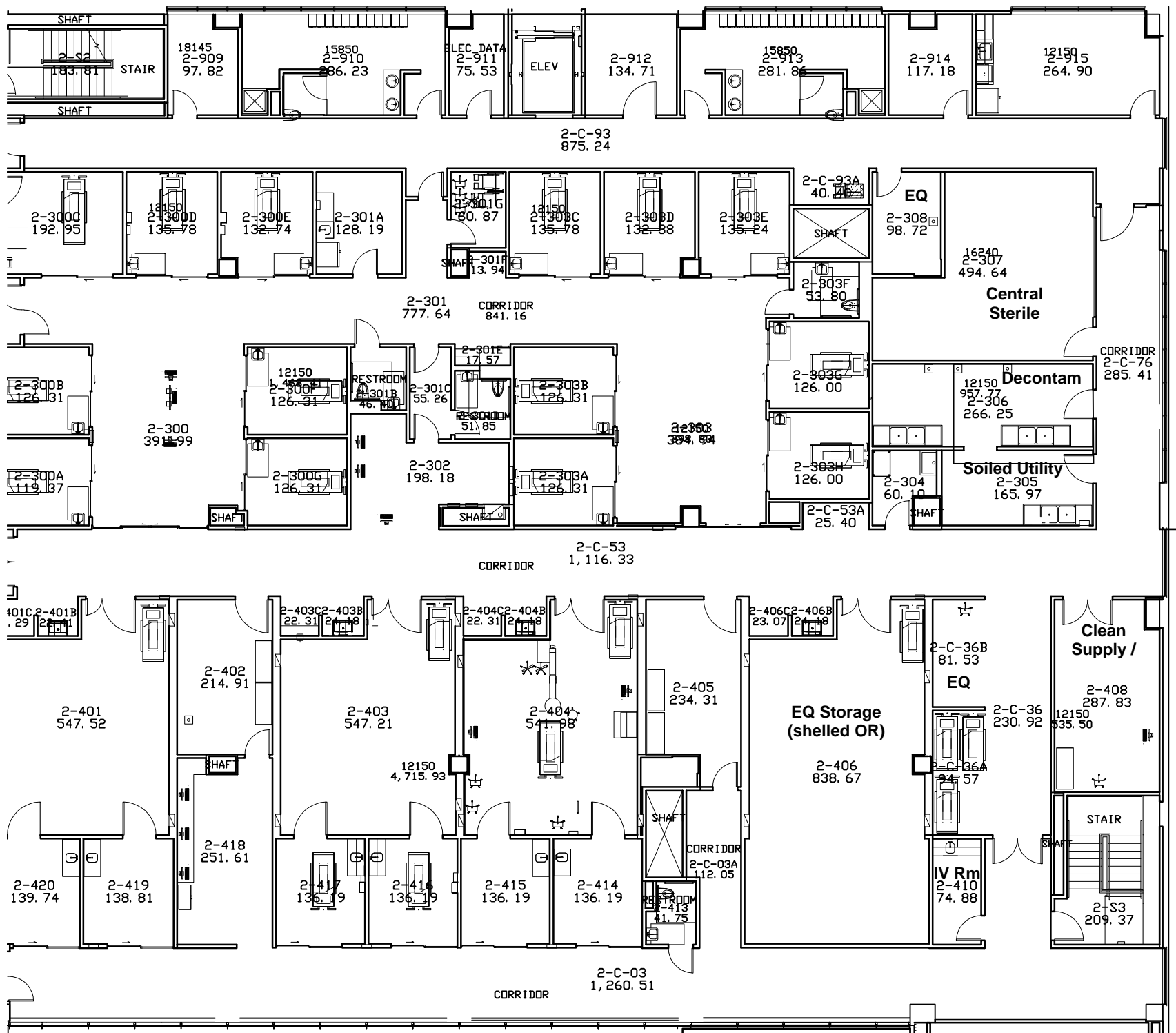


Exhibit 6
King County Assessor Information

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[Property Tax Bill](#)
[Map This Property](#)
[Glossary of Terms](#)
[Area Report](#)
[Print Property Detail](#)


PARCEL DATA

Parcel	282505-9291
Name	CHILDRENS HEALTHCARE SYSTEM
Site Address	1500 116TH AVE NE 98004
Geo Area	80-70
Spec Area	
Property Name	SEATTLE CHILDREN'S BELLEVUE

Jurisdiction	BELLEVUE
Levy Code	0330
Property Type	C
Plat Block / Building Number	
Plat Lot / Unit Number	
Quarter-Section-Township-Range	SW-28-25-5

Legal Description

LOT 3 LESS S 10 FT THOF OF CITY OF BELLEVUE SHORT PLAT #78-43 REC UNDER AF # 7807030722 SD SHORT PLAT DAF SLY 200 FT AS MEAS ALG WLY LN OF THAT POR OF SW 1/4 OF NW 1/4 SEC 28 TWP 28 RNG 5 LY WLY OF NP R/R R/W EXCEPT CO RD & EXCEPT ANY POR LY WITHIN N 2408.68 FT OF NW 1/4 SD SEC ALSO NLY 367.10 FT AS MEAS ALG WLY LN OF POR OF NW 1/4 OF SW 1/4 SEC 28 TWP 25 RNG 5 LY WLY OF NP RR R/W EXCEPT CO RD TAXABLE PORTION PER RCW 84.36.040 REG #02490-015

Plat Block:
Plat Lot:

LAND DATA

Highest & Best Use As If Vacant	COMMERCIAL SERVICE
Highest & Best Use As Improved	PRESENT USE
Present Use	Medical/Dental Office
Land SqFt	148,975
Acres	3.42

Percentage Unusable	
Unbuildable	NO
Restrictive Size Shape	NO
Zoning	MI
Water	WATER DISTRICT
Sewer/Septic	PUBLIC
Road Access	PUBLIC
Parking	ADEQUATE
Street Surface	PAVED

ADVERTISEMENT**Views**

Rainier	
Territorial	
Olympics	
Cascades	
Seattle Skyline	
Puget Sound	
Lake Washington	
Lake Sammamish	
Lake/River/Creek	
Other View	

Waterfront

Waterfront Location	
Waterfront Footage	0
Lot Depth Factor	0
Waterfront Bank	
Tide/Shore	
Waterfront Restricted Access	
Waterfront Access Rights	NO
Poor Quality	NO
Proximity Influence	NO

Designations

Historic Site	
Current Use	(none)
Nbr Bldg Sites	
Adjacent to Golf Fairway	NO
Adjacent to Greenbelt	NO
Other Designation	NO
Deed Restrictions	NO
Development Rights Purchased	NO
Easements	NO
Native Growth Protection Easement	NO
DNR Lease	NO

Nuisances

Topography	
Traffic Noise	
Airport Noise	
Power Lines	NO
Other Nuisances	NO

Problems

Water Problems	NO
Transportation Concurrence	NO
Other Problems	NO

Environmental

Environmental	NO
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BUILDING

Building Number	1
Building Description	SEATTLE CHILDREN'S BELLEVUE CLINIC

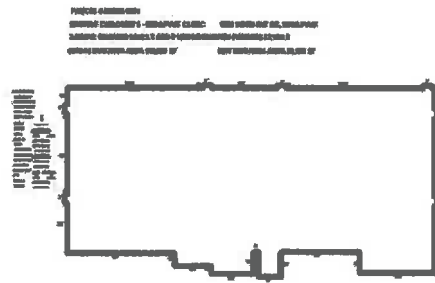
 Click the camera to see more pictures.

Picture of Building 1

Number Of Buildings Aggregated	1
Predominant Use	MEDICAL OFFICE (341)
Shape	Rect or Slight Irreg
Construction Class	MASONRY
Building Quality	GOOD
Stories	2
Building Gross Sq Ft	186,000
Building Net Sq Ft	73,100
Year Built	2010
Eff. Year	2010
Percentage Complete	100
Heating System	FORCED AIR UNIT
Sprinklers	Yes
Elevators	Yes



Floor plan of Building 1



Section(s) Of Building Number: 1

Section Number	Section Use	Description	Stories	Height	Floor Number	Gross Sq Ft	Net Sq Ft
2	PARKING STRUCTURE (345)		2	9		112,900	0
1	MEDICAL OFFICE (341)		2	14		73,100	73,100

TAX ROLL HISTORY

Account	Valued Year	Tax Year	Omit Year	Levy Code	Appraised Land Value (\$)	Appraised Imps Value (\$)	Appraised Total Value (\$)	New Dollars (\$)	Taxable Land Value (\$)	Taxable Imps Value (\$)	Taxable Total Value (\$)	Tax Value Reason
282505929103	2018	2019		0330	95,400	79,200	174,600	0	95,400	79,200	174,600	
282505929194	2018	2019		0330	11,822,600	9,814,500	21,637,100	0	0	0	0	NP
282505929103	2017	2018		0330	83,500	68,600	152,100	0	83,500	68,600	152,100	
282505929194	2017	2018		0330	10,344,700	8,503,200	18,847,900	0	0	0	0	NP
282505929103	2016	2017		0330	70,700	89,600	160,300	0	70,700	89,600	160,300	
282505929194	2016	2017		0330	8,867,800	11,246,400	20,114,200	0	0	0	0	EX
282505929103	2015	2016		0330	70,700	81,900	152,600	0	70,700	81,900	152,600	
282505929194	2015	2016		0330	8,867,800	10,274,900	19,142,700	0	0	0	0	EX
282505929103	2014	2015		0330	0	0	0	0	53,000	83,200	136,200	
282505929103	2013	2014		0330	0	0	0	0	53,000	76,400	129,400	
282505929103	2012	2013		0330	0	0	0	0	53,000	71,400	124,400	
282505929103	2011	2012		0330	0	0	0	0	53,000	59,700	112,700	
282505929103	2010	2011		0330	0	0	0	0	58,900	85,500	144,400	
282505929103	2009	2010		0330	7,448,700	0	7,448,700	0	7,448,700	0	7,448,700	
282505929103	2008	2009		0330	7,448,700	0	7,448,700	0	7,448,700	0	7,448,700	
282505929103	2007	2008		0330	2,979,500	0	2,979,500	0	0	0	0	EX
282505929103	2006	2007		0330	2,383,600	0	2,383,600	0	0	0	0	EX

282505929103	2005	2006	0330	2,085,600	0	2,085,600	0	0	0	0	EX
282505929103	2004	2005	0330	1,936,600	0	1,936,600	0	0	0	0	EX
282505929103	2003	2004	0330	1,936,600	0	1,936,600	0	0	0	0	EX
282505929103	2002	2003	0330	1,936,600	0	1,936,600	0	0	0	0	EX
282505929103	2001	2002	0330	1,936,600	0	1,936,600	0	0	0	0	EX
282505929103	2000	2001	0330	1,787,700	0	1,787,700	0	0	0	0	EX
282505929103	1999	2000	0330	1,787,700	0	1,787,700	0	0	0	0	EX
282505929103	1997	1998	0330	0	0	0	0	1,787,700	0	1,787,700	
282505929103	1996	1997	0330	0	0	0	0	1,787,700	0	1,787,700	
282505929103	1994	1995	0330	0	0	0	0	1,787,700	0	1,787,700	
282505929103	1992	1993	0330	0	0	0	0	1,787,700	0	1,787,700	
282505929103	1990	1991	0330	0	0	0	0	1,489,700	0	1,489,700	
282505929103	1988	1989	0330	0	0	0	0	1,489,700	0	1,489,700	
282505929103	1986	1987	0330	0	0	0	0	1,340,800	0	1,340,800	
282505929103	1984	1985	0330	0	0	0	0	1,132,500	0	1,132,500	
282505929103	1982	1983	0330	0	0	0	0	968,000	0	968,000	

SALES HISTORY

Excise Number	Recording Number	Document Date	Sale Price	Seller Name	Buyer Name	Instrument	Sale Reason
<u>2383295</u>	<u>20090316000956</u>	3/16/2009	\$0.00	BELLEVUE CITY OF	SEATTLE CHILDREN'S HOSPITAL	Bargain and Sales Deed	Other
<u>2054182</u>	<u>20040712003666</u>	7/8/2004	\$0.00	KING COUNTY	BELLEVUE CITY OF	Statutory Warranty Deed	Other
<u>1469899</u>	<u>199602151189</u>	2/2/1996	\$4,110,000.00	CHAFFEY CORPORATION	KING COUNTY	Statutory Warranty Deed	Other

REVIEW HISTORY

PERMIT HISTORY

Permit Number	Permit Description	Type	Issue Date	Permit Value	Issuing Jurisdiction	Reviewed Date
<u>17118978</u>	Renovate existing spaces within the hospital to provide work spaces for orthotics and clinical engineering.,	Remodel	11/15/2017	\$250,000	BELLEVUE	8/1/2018
<u>14143643</u>	TI of existing spaces to add storage and consultation rooms. Demo of existing changing room to create open desk area and treatment space.,	Remodel	11/26/2014	\$200,000	BELLEVUE	7/8/2015
<u>08133754</u>	Construct 2 story medical office building and 2 levels of underground parking garage.	Building, New	3/19/2009	\$20,216,886	BELLEVUE	7/25/2011
<u>08129313</u>	Shoring work for 83,000 square foot ambulatory care center and 110,000 square feet of underground structured parking.	Other	2/20/2009	\$1,500,000	BELLEVUE	6/8/2009

HOME IMPROVEMENT EXEMPTION

New Search	Property Tax Bill	Map This Property	Glossary of Terms	Area Report	Print Property Detail	
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Exhibit 7
WAC 246-310-270(9) Methodology

2018 Service Area Population 658,613
 Surgeries @ 141.27/1,000 93,043

a.i. 94,250 minutes/year/mixed-use OR
 dedicated outpatient OR

a.ii. 68,850 minutes/year/mixed-use OR

a.iii. 40 dedicated outpatient OR's x 68,850 minutes = 2,754,000 minutes dedicated OR capacity 49,193 Outpatient surgeries
 OR's x 94,850 minutes =

a.iv. 39 mixed-use OR's 3,675,750 minutes mixed-use OR capacity 34,631 Mixed-use surgeries

b.i. projected inpatient surgeries= 28,832 = 3,060,276 minutes inpatient surgeries
 projected ii outpatient surgeries= 64,210 = 3,594,723 minutes outpatient surgeries

b.ii. Forecast # of outpatient -
 64,210 49,193 = 15,017 outpatient surgeries

b.iii. average time of impatient surgeries = 106.14 minutes
 average time of outpatient surgeries = 55.98 minutes

b.iv. inpatient surgeries average time = 3,060,276 minutes
 remaining outpatient surgeries (b.ii.)* ave time = 840,723 minutes
 3,900,999 minutes

c.i. if b.iv. < a.iv., divide (a.iv.-b.iv.) by 94,250 to determine surplus of mixed-use OR's
 3,675,750
 3,900,999
 - -225,249 / 94,250 **-2.39**

c.ii. if b.iv. > a.iv., divide (inpatient part of b.iv.-a.iv.) by 94, 250 to determine shortage/surplus of inpatient OR's
 3,060,276 /
 3,675,750
 615,474 / 94,250 **6.53 (surplus)**

divide outpatient part of b.iv. By 68,850 to determine shortage of dedicated outpatient OR's
 840,723 / 68,850 = **12.21 shortage**

East King Operating Room Capacity by Facility												
								Utilization Data				Notes
Facility	Source of OR Data	Dedicated OP	Mixed Use	Endo Only	Pain Only	Endo or Pain	Total	Inpt	Inpt Min	Outpt	Outpt Min	
Hospitals												
EvergreenHealth Medical Center	2017 DOH Survey		8	2	3	0		7341	821,606			
Snoqualmie Valley Hospital Clinics	2018 DOH Survey			1		1						
Swedish Medical Center - Issaquah Campus	2018 DOH Survey		12	6	1			7,522	605,289			
Overlake Hospital Medical Center	2018 DOH Survey		19	2				11,901	1,413,841			
Subtotal		0	39	11	4	1	55	26,764	2,840,736	0	0	
CN Approved ASCs												
Bellevue Surgery Center (Wash Center for Pain Management)	ILERS 2018	2								1800	90000	default minutes
Bel-Red Ambulatory Surgical Facility	2018 DOH Survey	2								359	64620	
Eastside Surgery Center	2018 DOH Survey	2								5027	115168	
Northwest Nasal Sinus Center	2017 DOH Survey	2								1681	75462	
Overlake Surgery Center	2018 DOH Survey	4		1	2					4521	290437	
Proliance Eastside Surgery Center	2018 DOH Survey	4								5003	321061	
Proliance Highlands Surgery Center	2018 DOH Survey	4								5246	374249	
Proliance Redmond Surgery	ILERS 2018	3								3000	150000	use default minute:
Seattle Children's Bellevue	2018 DOH Survey (pa	3								4022	177958	
The Retina Surgery Center	2017 DOH Survey	2								1524	66069	
Virginia Mason Bellevue	CN Application/Decis	3										

Facility	Source of OR Data	Dedicated OP	Mixed Use	Endo Only	Pain Only	Endo or Pain	Total	Inpt	Inpt Min	Outpt	Outpt Min	
Hospitals												
Evergreen Surgical Center	From hospital survey	9								6185	385,295	
Subtotal		40	0	1	2	0	43	0	0	38,368	2,110,319	
							0					
Non CN Approved ASCS							0					
The Stern Center for Aesthetic Sur	2018 ILERS	1								74	9943	
Allure Laser Center	2018 ILERS	2								873	803.72	
Eastside Endoscopy Center	2018 DOH Survey			3		3						
Gaboriau Center												
Cosmetic Surgery and Dermatolog	2018 DOH Survey	2								561	33660	
Kaiser Permanente Bellevue Ambu	2018 ILERS	7								5445	272250	use default minute:
Evergreen Surgical Clinic Ambulatory Surgery Center												
Pacific Cataract and Laser Institute	2018 DOH Survey	2								5315	265750	use default minute:
Washington Institute Orthopedic C	2018 DOH Survey	1								716	42000	
Northwest Center for Aesthetic Pl	2018 DOH Survey	1								250	2500	
Virginia Mason Bellevue Ambulat	2018 DOH Survey			1								
Virginia Mason Issaquah Ambulat	2018 DOH Survey			1								
Aysel K Sanderson MD	2018 ILERS	1								132	6600	use default minute:
Naficy Plastic Surgery and Rejuver	2018 ILERS	2								565	45000	
Plastic Surgery North West Surger	2018 ILERS	2								203	10150	use default minute:
Evergreen Endoscopy Center	2018 ILERS	3										use default minute:
Remington Plastic Surgery	2018 DOH Survey	1								198	26640	
Pratt Plastic Surgery	2018 DOH Survey	1								120	6000	use default minute:
Stephens Plastic Surgery	2018 DOH Survey	1								177	38241	
Washington Urology Associates Pl	2018 DOH Survey	2								2600	78000	
Northwest Laser and Surgery Cent	2018 DOH Survey	1								756	12795	
Anderson Sobel Cosmetic Surgery	2018 DOH Survey	1								129	15475	
Sono Bello	2018 ILERS	3								958	97552	

Facility	Source of OR Data	Dedicated OP	Mixed Use	Endo Only	Pain Only	Endo or Pain	Total	Inpt	Inpt Min	Outpt	Outpt Min	
Hospitals												
Egrari Plastic Surgery Center	2018 DOH Survey	1								338	41344	
Yarrow Bay Plastic Surgery Center	2018 DOH Survey	1								109	26160	
Newvue Plastic Surgery	2018 ILERS	1								450	22500	use default minute:
Athenix Body Sculpting	2018 DOH Survey	2								682	102300	
Overlake Reproductive Health Inc	2018 DOH Survey	1								260	11000	
Aesthetic Facial Plastic Surgery PL	2018 DOH Survey	3								215	54360	
Northwest Spine Center	2018 ILERS	1								110	5500	use default minute:
Subtotal		44	0	5	0	3	52			21236	1226523.72	
Total		40	39	12	6	1	79	26,764	2,840,736	59,604	3,336,843	
Average Min/Case								106.14		55.98		

Exhibit 8
Seattle Children's Hospital Policies



Originated: 7/1/2005
Last Approved: 3/22/2017
Last Revised: 3/22/2017
Next Review: 3/21/2020
Owner: Sara Dunn: Dir, Pat Access,
Main Campus
Document Area: Administrative
Document Type: P&P

Admission Access to Seattle Children's, 10025

Policy/Procedure

PURPOSE:

To describe our commitment to serve all children in our region seeking our care.

POLICY:

Seattle Children's provides health care appropriate for the special needs of children up to 21 years of age who are residents of Washington, Alaska, Montana, or Idaho, regardless of their ability to pay. Children's **Administrative P&P**, Financial Assistance provides further details about how this objective is effectively achieved for this patient population. Additionally, the **Administrative P&Ps**, International Patients (Patients Living Outside of the United States), Financial Clearance for Patients Living in the US Outside of the WAMI Region, and Patient 21 years or Older detail Children's requirements for funding non-emergency care for other patient populations.

Children's complies with Emergency Medical Treatment and Active Labor Act (EMTALA) regulations which require all patients presenting for care in the Emergency Department (ED) to be medically screened and stabilized, regardless of patient age or residency.

Admission of patients needing medically necessary care occurs without discrimination on the basis of race, color, creed, national origin, religion, sex, gender identity, sexual orientation, or disability, consistent with requirements defined by the US Department of Health and Human Services Office for Civil Rights and the Washington State Department of Social and Health Services.

All patients who enter the Children's system are carefully assessed at the time of entry, and appropriately placed in a patient care area that most meets their assessed needs.

REFERENCES:

Centers for Medicare & Medicaid Services (CMS). (1986). Emergency Medical Treatment & Labor Act. Retrieved February 5, 2014 from: <http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/>

US Department of Health & Human Services (HHS). Office for Civil Rights. Retrieved February 5, 2014 from: <http://www.hhs.gov/ocr/office/index.html>

Washington Administrative Code (WAC). (2013, December 23). WAC 246-320-141, Patient rights and organizational ethics. Retrieved February 5, 2014 from: <http://search.leg.wa.gov/search.aspx#results>

Washington State Department of Social & Health Services (DSHS). (2010). Chapter 5, Affirmative Action and Nondiscrimination. Retrieved February 5, 2014 from: <https://www.dshs.wa.gov/search/site/nondiscrimination>

Reviewed by:

- Suzanne Vanderwerff, Senior Director Revenue Cycle
- Dan Tisch, Manager, Registration & Admission Services

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Release for Publication	& Procedures Policies: Policies & Procedures	3/22/2017
	Cindy Gazecki: Sr VP, Hospital Operations	3/17/2017
	Sara Dunn: Dir, Pat Access, Main Campus	3/17/2017



Originated: 5/1/1996
Last Approved: 8/16/2017
Last Revised: 8/16/2017
Next Review: 8/15/2020
Owner: Laura Crooks: Senior Director,
Patient & Family Experience
Document Area: Administrative
Document Type: P&P

Patient Rights and Responsibilities, 10793

Policy/Procedure

PURPOSE:

Patient safety is enhanced when patients and their families are partners in the health care process. Partnerships are stronger when the parties have a clear understanding of their rights and responsibilities.

POLICY:

Seattle Children's assists the patient and family in understanding and exercising their rights and responsibilities in the care delivery process.

PROCEDURE:

I. Patient Access to Notice of Rights and Responsibilities

- A. Whenever possible, patients/representatives should be provided notice of patient rights prior to the delivery of care.
 1. Rights and Responsibilities signs or brochures are displayed at main patient entrances or near patient registration areas.
 2. Admission Services Coordinators or Family Services Coordinators will:
 - a. Offer each patient or representative a copy of the "Rights and Responsibilities" brochure at the time of obtaining consent during admission or registration (see **Administrative P&P, Consent for Care and Treatment**), and
 - b. Document in Epic every time that the brochure has been offered.
 3. Services and programs may provide additional rights and require additional responsibilities that are shared at the point of care.
- B. The "Rights and Responsibilities" brochure, which is stored on the Patient and Family Education database, lists patient rights and responsibilities that by reference are incorporated into this policy and procedure. For database access or ordering help, contact the Family Resource Center at 206-987-2201.

II. Patient Understanding of Rights and Responsibilities

- A. The communication of rights and responsibilities needs to be provided to patients/representatives in

a manner that meets their needs for understanding.

- B. If a patient/representative has alternative communication needs, interpretation and translation services should be provided in accordance to the **Clinical P&P**, Interpreter and Translation Services.
1. The Rights and Responsibilities brochure is a significant communication subject to civil rights protected under Section 1557 of the Patient Protection and Affordable Care Act. The brochure includes the Nondiscrimination Statement and translated taglines in multiple languages.
- C. Staff should offer to answer questions about rights and responsibilities, acknowledge when they are uncertain of an answer, and seek further information from Patient and Family Relations at 206-987-2550 (between 8 am and 5 pm) or follow **Clinical P&P**, Escalation Protocol for Patient Care or Safety Concerns when needed.

REFERENCES:

Code of Federal Register Title 42 Part 482 (42 CFR 482). CMS Hospital Conditions of Participation: Patient Rights; Final Rule section 482.13 and Interpretative Guidelines A-0115 – 0217. Rev. 151, effective 11-20-15.

National Integrated Accreditation for Healthcare Organizations (NIAHO). (2016, December). *Interpretive Guidelines and Surveyor Guidance, Version 16*. Patient Rights, PR.1 – PR.8, pp. 102-125.

Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance, 91 Fed. Reg. 31465 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

Washington Administrative Code. WAC 246-320-141 (2009) (patient rights and organizational ethics).

REVIEWED BY:

Laura Crooks, OTR, MHA, Senior Director, Patient & Family Experience

Sara Dunn, MHA, Director, Patient Access

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Release for Publication	& Procedures Policies: Policies & Procedures	8/16/2017
	Cindy Gazecki: Sr VP, Hospital Operations	8/15/2017
	Rebecca Muld: Accred & Compl Analyst	8/15/2017

Applicability

Seattle Children's Hospital



Originated: 5/1/2000
Last Approved: 10/9/2018
Last Revised: 10/9/2018
Next Review: 10/8/2021
Owner: Suzanne Vanderwerff: Senior
Director, Revenue Cycle
Document Area: Administrative
Document Type: P&P

Financial Assistance, 10226

Policy/Procedure

PURPOSE:

To outline Seattle Children's Hospital's requirements and practices with respect to the provision of financial assistance (charity care).

POLICY:

Seattle Children's provides health care appropriate for the special needs of Pediatric Patients (as defined below) who are residents of Washington, Alaska, Montana, or Idaho, regardless of their ability to pay. Financial Assistance (charity care) is provided to these patients based upon family need and hospital resources. Seattle Children's has established criteria for providing Financial Assistance in accordance with applicable law, including the requirements of Chapter 246-453 Washington Administrative Code (WAC), RCW 70.170.060, and § 501(r) of the Internal Revenue Code and its implementing regulations. Eligibility decisions for Financial Assistance are made without regard to race, color, religion (creed), sex, gender identity or expression, sexual orientation, national origin (ancestry), disability, age, genetic information, marital status, citizenship, pregnancy or maternity, protected veteran status, or any other status protected by applicable national, federal, state, or local law.

Seattle Children's complies with Emergency Medical Treatment and Active Labor Act and its implementing regulations (EMTALA), providing appropriate medical screening examination and stabilizing treatment, regardless of an individual's ability to pay.

DEFINITIONS:

Appropriate Hospital-Based Medical Services: Those services that are reasonably calculated to diagnosis, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service.

Financial Assistance (Charity Care): Medically necessary hospital health care rendered to indigent persons when third-party coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductibles or co-insurance amounts required by a third-party payer.

Pediatric Patient: A patient up to age 21 who is receiving care at Seattle Children's, or a patient who is 21 years or older who has received Clinical Coverage Approval for a specific course of care best treated at Seattle Children's through the process outlined in the **Patients 21 Years or Older** policy.

Resident: An individual who (a) is living in Washington, Alaska, Montana or Idaho (WAMI) for the majority of a calendar year; and (b) intends to continue to live in the WAMI region subsequent to treatment being complete.

Sliding Fee Schedule: A Seattle Children's-determined, publicly available schedule of discounts to charges for patients/families deemed eligible for Financial Assistance.

Third-Party Coverage: An obligation on the part of an insurance company, health care service contractor, health maintenance organization, group health plan, government program, tribal health benefits, or health care sharing ministry as defined in 26 U.S.C. Sec. 5000A to pay for the care of covered patients and services, and may include settlements, judgments, or awards actually received related to the negligent acts of others which have resulted in the medical condition for which the patient has received hospital health care service.

PROCEDURE:

I. Access to Emergency Services:

- A. Access to a medical screening examination and appropriate stabilizing treatment will not be delayed or denied based on an individual's ability to pay for services or determination of an individual's insurance coverage or financial assistance eligibility.

II. Scope of Financial Assistance:

- A. **Operations:** For purposes of this policy, Financial Assistance entails granting a full or partial write-off of any patient balance from Seattle Children's Hospital remaining after applicable third party processing for an eligible patient/family. Financial Counselors can also provide estimates upon request, assistance with Medicaid and Qualified Health Plan (QHP) applications, and creation of interest free payment plans. Financial Counselors can be reached at (206) 987-3333.

- B. **What charges Financial Assistance covers:** Financial assistance will be applied to Appropriate Hospital-Based Medical Services. .

1. Charges for services that are cosmetic or elective are not eligible for Financial Assistance. (See examples in APPENDIX I)
2. Financial Assistance is not a program to fund services that (a) can be provided by an alternate provider within a patient's insurance network; and (b) have not been approved by that insurance to be provided in network at Seattle Children's.

- C. **Which providers Financial Assistance covers:**

1. Seattle Children's Inpatient Providers:
 - a. Seattle Children's facility charges;
 - b. Professional charges from providers employed by or under contract with Seattle Children's or Children's University Medical Group (CUMG) when CUMG bills for inpatient services provided at Seattle Children's or at a community hospital; and
 - c. Professional charges from providers employed by or under contract with Seattle Children's when Seattle Children's bills for inpatient services at Seattle Children's or at a community hospital.
2. Seattle Children's Outpatient Providers:

- a. Facility charges from Seattle Children's hospital or clinics;
 - b. Professional charges from providers employed by or under contract with CUMG when CUMG bills for outpatient services at a Seattle Children's clinic, outpatient department, or community site;
 - c. Professional charges from providers employed by or under contract with Seattle Children's, when Seattle Children's bills for outpatient services at a Seattle Children's clinic, outpatient department, or community site; and
 - d. All eligible services provided by Seattle Children's providers at Garfield High School Teen Clinic (based on the presumed income of minors consenting to their own care).
3. Non-covered providers:
- a. Community providers with admitting privileges at Seattle Children's who bill their own professional charges and who choose whether to grant financial assistance for their own bills commensurate with Seattle Children's financial assistance policy. See Appendix II for a list of those community providers with admitting privileges at Seattle Children's by name and practice who do not follow Seattle Children's financial assistance determinations.

D. **Duration** – Financial assistance is generally granted in six month increments, **provided**, however, that Financial Assistance granted for an emergency course of care will be approved only for the dates of that course of care; and administrative and presumptive approvals made will be for the period of time determined by the approver. Patients or responsible parties can reapply at any time.

III. Eligibility Criteria for Financial Assistance:

Patients must meet **all** the following criteria in order to be eligible for Financial Assistance:

A. **Residency** –Patient must be a Resident of Washington, Alaska, Montana, or Idaho (as defined above).

1. Exceptions:

- a. Seattle Children's may grant limited-duration Financial Assistance to patients who reside outside of these states when such patients have an unanticipated, emergency onset of illness.
- b. Solid organ transplant patients who reside in Oregon or Hawaii may qualify for Financial Assistance due to these states being part of Seattle Children's Hospital UNOS transplant region.
- c. The Chief Financial Officer or delegate may exercise discretion to waive the residency requirement on a case by case basis for situations where care is only available at Seattle Children's. It is expected that such waivers will be granted infrequently.

B. **Age** – The patient must be a Pediatric Patient (as defined above).

1. Exceptions:

- a. Adults who are being tested or treated at Seattle Children's to further the care of a Seattle Children's Pediatric Patient (for example, testing for the presence of tuberculosis or genetic testing) may qualify for Financial Assistance. This includes adults who receive care for a prenatal condition.
2. Patients 21 years and older may qualify for Financial Assistance when (a) they have received Clinical Overage Approval for a specific course of care best treated at Seattle Children's as

outlined in the **Patients 21 Years or Older** policy; or (b) they receive a medical screening examination and/or stabilizing care in the Emergency Department (ED).

- C. Alternate Funding** – Seattle Children's Financial Assistance is a secondary funding source after all other Third Party Coverage and funding options, including but not limited to group or individual health insurance, eligible government programs including Medicaid, third party liability or workers' compensation programs, designated grant or trust funds, or any other persons or entities with a responsibility to pay for medical services.

Patients with no other source of funding, including those who (a) are uninsured; (b) do not have insurance coverage for the services provided or to be provided; or (c) have insurance coverage with significantly limited benefits based on the assessment by Seattle Children's, will be required to apply for Medicaid before Financial Assistance is granted. Patients who have enrolled in a health care sharing ministry for health care expenses are considered to be uninsured. A patient may choose to purchase a Qualified Health Plan (QHP), if applicable, in lieu of enrolling in Medicaid. Seattle Children's financial counselors are available to assist families with the Medicaid application process or with a QHP application. Financial counselors may waive the Medicaid application requirement if, for example, they determine during their screening process that a patient would not be eligible for Medicaid. Seattle Children's reserves the right to require written confirmation that a patient is ineligible for alternate funding sources.

If a patient/family has a philosophical, religious, or other personal objection to applying for Medicaid, and is between 134% and 599% FPL, the maximum financial assistance that will be granted is 50% Sliding Fee Schedule. Families with scheduled services whose income is above 200% FPL may be required to provide an advance deposit.

- D. Income** - Patients may be eligible for full Financial Assistance if the patient or responsible party meets the application requirements and has a gross family income at or below 400% of the Federal Poverty Guidelines, as adjusted for family size. If self-employed, the net (take home) income information is used. Seattle Children's will deduct from its calculation of gross family income the amounts that a family personally pays toward medical insurance premiums for coverage of their beneficiaries who are under the age 21. Income documentation to verify information indicated on the application form may be requested, including pay stubs and/or income tax returns.

Responsible parties whose income is between 400% and 599% of Federal Poverty Guidelines may be eligible for Sliding Fee Schedule Financial Assistance whereby they would be responsible for a percentage of the amount owed. In this case they are responsible for the applicable portion of the outstanding amount owed, and Seattle Children's Financial Assistance covers the remaining account balance.

Income documented at the time clinical services were provided will be used for making Financial Assistance determinations. **Exception:** If income documented at the time of application would result in the family being approved rather than denied financial assistance, that lower income will be used.

In cases where a responsible party would otherwise qualify for either an uninsured discount or an employee discount and also qualifies for Sliding Fee Schedule Financial Assistance, the responsible party will receive only the Sliding Fee Schedule Financial Assistance, which is the most generous discount. Multiple discounts are not applied to the same account.

E. Application –The patient or their responsible party must submit an application form by:

- i. completing the online form on www.seattlechildrens.org;
- ii. printing a paper form from this same website and mailing or faxing it as instructed on such form; or
- iii. completing a paper application, which can be picked up from any Seattle Children's registration desk or obtained by mail from a financial counselor, and mailing or faxing it as instructed in such application packet.

Applications can be submitted prior to the provision of services, during the course of care, or after services have been provided.

- F. Presumptive Eligibility** - In cases where a patient can be reasonably presumed to qualify for Financial Assistance, and the standard application processes are not likely to be completed due to socioeconomic or other factors, Seattle Children's Medical Director, Chief Financial Officer, or Senior Director of Revenue Cycle, or their designee, may administratively designate a patient as qualifying for Financial Assistance in the absence of receiving all required information. Additionally, when a family includes additional information about their financial situation with their application, these same individuals can administratively make a Financial Assistance determination using this information. Seattle Children's may review relevant and publicly available information about a family's financial situation, other than their credit report, in cases when the family is unresponsive to a bill for an outstanding balance, and may grant presumptive Financial Assistance for that outstanding balance eligibility based on this information. All presumptively granted Financial Assistance will only apply to balances already owed.

IV. Financial Assistance Determination Process:

- A. Documentation** – All information relating to the application will be kept confidential. Determination of eligibility will be made by Seattle Children's within fourteen (14) days of receipt of all required information. Seattle Children's will not initiate extraordinary collection efforts while in the process of reviewing the application.

1. **Approvals** – A letter communicating an approval of Financial Assistance and the applicable eligibility period will be sent to the applicant.
2. **Pending** – In the event incomplete information is received on the application, or a patient/family has not completed the Medicaid eligibility process when required, the application will be pended and a letter communicating why the application has been pended will be sent to the applicant. If responsive information is not received within 14 days of such notice, the application may be denied.
3. **Denials** – In the event Seattle Children's determines a patient is not eligible for Financial Assistance, a written denial will be provided to the applicant and will include the reason(s) for denial, the date of the decision, and the instructions for appeal or reconsideration.
4. **Appeals** - The applicant may appeal a denial of eligibility for financial assistance by providing additional information about the family's income, size, other financial liabilities, or other pertinent factors to the Senior Director of Revenue Cycle or Director of Revenue Cycle Operations. The Senior Director of Revenue Cycle or Director of Revenue Cycle Operations will review all appeals for final determination. If this final determination affirms the previous denial of financial assistance, written notification will be sent to the applicant and the Department of Health in accordance with state law.

In the event that a patient/family or other responsible party makes a payment toward Appropriate Hospital Based Medical Services and the patient/family is subsequently found to have met Financial Assistance criteria, patient payments applied to facility services in the 90 days preceding the eligibility determination will first be applied to other outstanding balances, and any remaining funds will then be refunded within thirty (30) days. Payments applied to professional services will only be refunded upon request. In the event a patient/family is denied eligibility for Financial Assistance and has no third party funding source or discount, a 25% discount will be automatically applied to the patient's facility and professional charges. The patient or responsible party is not billed full charges. This discount level is equal to or greater than the average discount negotiated with all major non-Medicaid payers.

B. Sliding Fee Schedule Financial Assistance :

When a responsible party qualifies for Sliding Fee Schedule Financial Assistance , Seattle Children's will not charge the patient more than the average amount paid by all payers (Medicare, Medicaid and commercial payers) during the last complete hospital fiscal year. This is also called the "amounts generally billed" or AGB.

See Appendix III for the current maximum amount of financial responsibility under Sliding Fee Schedule Financial Assistance.

V. Staff Training

- A. Appropriate staff in roles most likely to engage in discussions with families about financial assistance, including all those in registration, admission or revenue cycle roles, must participate in an annual training module regarding financial assistance, including how to access language resources to be able to assist families with limited English proficiency or who are Deaf or Hard of Hearing.

VI. Communications to the Public:

Information about Seattle Children's Financial Assistance policy is made publicly available as follows:

- A. Public Notice/Interpretation – A notice is displayed in key public areas of the hospital, including primary public registration locations and the Emergency Department, in languages spoken by more than 10% of the population of the hospital service area: English, Spanish, Vietnamese, Russian and Somali. Additionally, Seattle Children's Financial Assistance policy, a plain language summary of the Financial Assistance policy, and the Financial Assistance application form in these same languages is on Seattle Children's website at www.seattlechildrens.org. An additional option is available on the website to translate any or all of these documents into any other language spoken in the community within 7-10 days.
- B. Individual Notification – Seattle Children's will make reasonable effort to both determine the existence of any third party responsible to cover the charges for Appropriate Hospital Based Medical Services in full or part, and to assess whether families checking in at Seattle Children's sites of care would like information about or screening for Financial Assistance. Paper application forms in English, Spanish, Vietnamese, Russian or Somali are available for pick up at registration desks at all Seattle Children's clinics.
- C. Financial Counselors – Financial Counselors, who have access to interpreter services for languages other than English, are available in person and by telephone (206-987-3333) to assist with completion of the application.
- D. Patient bills will include a statement on the first page of the bill in both English and Spanish, or in Somali, Vietnamese, or Russian if that is the family's registered primary language, that

communicates the availability of financial assistance, whether or not insurance coverage is present, and the email or phone number to contact for further assistance.

Approved by Washington State Department of Health: Oct 9, 2018

APPENDIX I:

Services that Seattle Children's has determined are elective or cosmetic and therefore are not eligible for Financial Assistance include, but are not limited to:

1. Orthodontia services for malocclusion in the absence of an underlying medical condition
2. Adults seeking genetic testing for purposes of determining whether a genetic condition could be transmitted to future children OR genetic testing of a patient when such testing will not provide information that contributes to the patient's care plan
3. Earwell cosmetic ear reshaping procedure
4. Laser surgery performed for cosmetic purposes only
5. Otoplasty for cosmetic purposes
6. Replacement of lost dental retainers
7. Elective mental health programs/classes

APPENDIX II:

Community providers with admitting privileges who bill professional charges for services provided at Seattle Children's from their own office, and who do not grant financial assistance commensurate with Seattle Children's determinations to their own bills, are listed below.

A provider with an asterisk is one who works for or is contracted with Children's and who also refers patients from their community practice to have services at Children's. Financial Assistance is granted only when the provider is seeing patients as an employee or contractor for Children's.

This list is subject to change quarterly, and is updated on www.seattlechildrens.org.

Practice or Provider Name
Allegro Pediatrics
Dr. Senait Abraham Sea Mar Medical Clinic
Dr. David Atherton Dentistry for Children & Adolescents
Dr. Molly Capron Neighborcare - Columbia City
Dr. Felix Chu The Polyclinic - First Hill
Dr. Daniel Downey Downey Plastic Surgery
Dr. Mary Farrington Virginia Mason Medical Center
Dr. Julie Francis Eastside Dermatology Inc.
Dr. Heather Henne Neighborcare - Columbia City
Dr. Robin Hornung Everett Clinic
Dr. Shayan Irani Virginia Mason Medical Center
Dr. David Jeong Virginia Mason Medical Center*
Dr. Neil Kaneshiro Woodinville Pediatrics

Dr. Richard Kozarek Virginia Mason Medical Center
Dr. Thomas Lenart Children's Eye Doctors
Dr. John Liu Eastside Pediatric Dental Group
Dr. Sally Sue Lombardi Eastside Pediatric Dental Group
Dr. Kimberly McDermott Neighborcare - Columbia City
Dr. Craig Murakami Virginia Mason Medical Center
Dr. Michael Nuara Virginia Mason Medical Center
Dr. Hee-Jung Park Virginia Mason Medical Center
Dr. Mary Pew Neighborcare - Meridian*
Dr. Donna Quinby Eastside Pediatric Dental Group
Dr. Seth Schwartz Virginia Mason Medical Center
Dr. Peter Shelley Federal Way Eye & Laser Center
Dr. Jessica Tarantino ABCD, Inc.
Dr. Cornelius Van Niel Sea Mar Comm Health Center
Dr. Michael Whelan Sound Surgery*
Dr. Bryan Williams Seattle Special Care Dentistry*
Dr. Dali Wu Sea Mar Comm Health Center

APPENDIX III

Based on the completion of fiscal year 2017, the maximum amount a patient with Sliding Fee Schedule financial assistance will be charged is 50%. The average generally billed or AGB for fiscal year 2017 for all payers was 50%.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Release for Publication	& Procedures Policies: Policies & Procedures	10/9/2018
	Russell Williams: Sr. Vice President & COO	10/9/2018
	Suzanne Vanderwerff: Senior Director, Revenue Cycle [P]	10/8/2018

Applicability

Seattle Children's Hospital

Exhibit 9
Cost Estimator Letter

November 30, 2018

Janis Sigman, Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Ms. Sigman:

I am writing regarding the certificate of need application submitted by Seattle Children's Hospital, proposing to add one operating room to its Bellevue Clinic and Surgery Center, and the related, estimated capital expenditures. Based upon our experience in construction projects and cost estimation, we have reviewed the following estimated capital expenditures and believe them to be reasonable:

Description	Estimated Capital Expenditures
Building Construction	\$1,376,053.87
Moveable Equipment	\$1,932,243.43
Fixed Equipment (included in Building Construction)	\$0
Consulting Fees	\$144,548.76
Site Preparation	\$0
Supervision and Inspection	\$6,570.40
Total	\$3,459,416.46

Please do not hesitate to contact me if you have any questions or require additional information.

Sincerely,



Dave Scalzo
Senior Vice President
Sellen Construction
206-682-7770

Exhibit 10
Financing Letter

December 11, 2018

Janis Sigman, Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Ms. Sigman:

I am writing to confirm that Seattle Children's Hospital is using reserves to fund the capital cost associated with the addition of one operating room to our Bellevue ASC, proposed in our certificate of need (CN) application. The capital cost is estimated to be \$4,000,000.

Our 2017 audited financial statements, included in the CN application, identified more than \$974,000,000 in cash and investments as of September 30, 2017.

Please do not hesitate to contact me if you have any questions or require additional information.

Sincerely,



Suzanne Beitel
Senior Vice President, Chief Financial Officer

Exhibit 11
Pro Forma Financials and Assumptions

BCSC 4th OR Certificate of Need Application

Financial Assumptions

With and Without Scenarios

1. FY2016 – FY2018 revenues and expenses are actual.
2. FY2019 – FY2022 Revenue Assumptions
 - a. Inflation of gross and net revenues is excluded.
 - b. Gross revenue is based on actual specialty-specific gross revenue/case for Bellevue ASC and also includes Pharmacy and Lab related revenues, FY2018 data.
 - c. Net revenue is based on actual collection rate for Bellevue ASC, FY2017 and FY2018 data.
 - d. Payer mix is based on historical payer mix for Bellevue ASC, FY2017 and FY2018 data.

Medicaid	40.3%
Medicare/Other Government	1.9%
Commercial	57.6%
Other	<u>0.3%</u>
TOTAL	100.0%

3. FY2019 – FY2022 Expense Assumptions
 - a. Inflation of expenses is excluded, except where noted below.
 - b. Staffing requirements are based on hours of operation, number of ORs in operation and case volumes.
 - c. Salaries and wages are specific to each role and are calculated on an hourly basis based on Seattle Children's FY2018 compensation structure.
 - d. Inflation of salaries and wages is excluded except for Surgical Technician and Anesthesia Technician roles which are under union contract and are assumed to increase 4%/year.
 - e. Benefits were calculated based on Seattle Children's average rate of total salaries and wages.
 - f. Allocated Labor Expense includes salaries, wages, and benefits for support staff that reside in cost centers outside of the Bellevue ASC cost center, but are needed to support operations of the Bellevue ASC (e.g. Child Life Specialist, Pharmacist, Environmental Support Technician).
 - g. Medical Supplies are estimated to be 3.9% of gross revenue, average of FY2017 and FY2018 data.
 - h. Other Supplies are estimated on a cost per case basis based on cases performed at Bellevue ASC, FY2018 data.
 - i. Maintenance and Repairs include equipment maintenance and repairs specific to the Bellevue ASC and are estimated to be comprised primarily of fixed expenses with the remaining portion being variable expenses based on projected case volumes, FY2018 data.

- j. Purchased Services include expenses such as courier service and document storage and are estimated to be comprised primarily of fixed expenses with the remaining portion being variable expenses based on projected case volumes, FY2018 data.
- k. Other Expenses include miscellaneous expenses such as telephone bills and taxi fares and are estimated to be comprised primarily of fixed expenses with the remaining portion being variable expenses based on projected case volumes, FY2018 data.
- l. Utilities and Building Expenses include utilities, building maintenance and repairs, and building purchased services. These expenses are estimated based on Bellevue Clinic and Surgery Center actuals and are proportioned based on square footage as the Bellevue ASC is part of a larger building.
- m. Provider Expenses includes net expenses for CRNAs, anesthesiologists, medical direction, academic support, and program support for surgical and procedural specialties.
- n. Indirect Expenses include information technology, finance, revenue cycle, human resources, health information management, and supply chain/purchasing, and are estimated to be comprised of primarily of fixed expenses with the remaining portion being variable expenses based on projected case volumes, FY2018 data.
- o. Depreciation includes existing depreciation of the building and purchased equipment which is proportioned as the Bellevue ASC is part of a larger building. Depreciation also includes additional depreciation associated with the build-out of the additional operating room and associated capital expenditures (e.g. equipment).

Pro Forma Financials: “With Scenario”

HOSPITAL INFORMATION
DEDUCTIONS FROM REVENUE- PROJECT SPECIFIC (WITH SCENARIO)

[illegible]

**Bellevue ASC 4th OR - WITH SCENARIO
CONSOLIDATED PROFORMA**

					Year 1	Year 2	Year 3
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Volume Projections							
Craniofacial	286	248	281	283	284	284	284
General Surgery	373	389	443	449	455	460	463
Ophthalmology	96	95	122	144	170	170	170
Orthopedics	547	514	530	619	722	722	722
Other	160	122	160	135	116	116	116
Otolaryngology (incl. Audiology)	2,076	1,834	2,064	2,394	2,777	3,144	3,144
Urology	790	860	760	845	940	959	978
TOTAL CASES	4,328	4,062	4,360	4,870	5,464	5,854	5,877
Gross Revenue	\$ 38,140,964	\$ 37,709,321	\$ 43,338,010	\$ 48,510,228	\$ 54,510,527	\$ 57,230,155	\$ 57,496,599
Deductions from Revenue	\$ 18,038,954	\$ 18,129,206	\$ 20,826,299	\$ 23,311,835	\$ 26,195,308	\$ 27,502,239	\$ 27,630,280
NET REVENUE	\$ 20,102,010	\$ 19,580,115	\$ 22,511,711	\$ 25,198,394	\$ 28,315,218	\$ 29,727,916	\$ 29,866,318
Operating expenses							
Salaries & Wages	\$ 2,440,660	\$ 2,711,861	\$ 3,142,693	\$ 3,460,198	\$ 4,162,194	\$ 4,188,572	\$ 4,216,006
Employee Benefits	\$ 659,089	\$ 739,471	\$ 805,187	\$ 989,617	\$ 1,190,388	\$ 1,197,932	\$ 1,205,778
Allocated Labor Expense	\$ 1,227,366	\$ 1,264,187	\$ 1,269,568	\$ 1,231,633	\$ 1,461,143	\$ 1,497,062	\$ 1,497,062
Contract Labor	\$ 127,610	\$ 234,517	\$ 272,833	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000
Medical Supplies	\$ 1,349,514	\$ 1,446,478	\$ 1,695,008	\$ 1,897,301	\$ 2,131,981	\$ 2,238,349	\$ 2,248,770
Other Supplies	\$ 35,336	\$ 41,303	\$ 54,758	\$ 61,158	\$ 68,618	\$ 73,522	\$ 73,809
Maintenance and Repairs	\$ 104,613	\$ 62,238	\$ 74,775	\$ 76,960	\$ 79,507	\$ 81,181	\$ 81,279
Purchased Services	\$ 3,141	\$ 1,142	\$ 3,948	\$ 4,063	\$ 4,197	\$ 4,286	\$ 4,291
Other Expenses	\$ 4,396	\$ 8,108	\$ 7,823	\$ 8,051	\$ 8,318	\$ 8,493	\$ 8,503
Utilities & Building Expenses	\$ 141,557	\$ 141,557	\$ 141,557	\$ 168,936	\$ 168,936	\$ 168,936	\$ 168,936
Provider Expenses	\$ 5,704,702	\$ 5,708,326	\$ 6,307,353	\$ 6,854,344	\$ 8,146,184	\$ 8,477,006	\$ 8,599,171
Total Direct Expenses	\$ 11,797,984	\$ 12,359,188	\$ 13,775,503	\$ 14,952,261	\$ 17,621,466	\$ 18,135,338	\$ 18,303,604
CONTRIBUTION MARGIN	\$ 8,304,026	\$ 7,220,927	\$ 8,736,208	\$ 10,246,133	\$ 10,693,753	\$ 11,592,578	\$ 11,562,715
Indirect Expenses	\$ 5,122,105	\$ 5,012,625	\$ 5,839,689	\$ 6,030,842	\$ 6,285,591	\$ 6,453,042	\$ 6,462,856
Depreciation	\$ 2,061,522	\$ 1,982,581	\$ 1,850,425	\$ 1,850,425	\$ 2,449,417	\$ 2,449,417	\$ 2,449,417
Total Indirect Expenses	\$ 7,183,627	\$ 6,995,206	\$ 7,690,114	\$ 7,881,267	\$ 8,735,008	\$ 8,902,459	\$ 8,912,272
NET OPERATING INCOME	\$ 1,120,399	\$ 225,721	\$ 1,046,094	\$ 2,364,866	\$ 1,958,745	\$ 2,690,119	\$ 2,650,443

Pro Forma Financials: “Without Scenario”

HOSPITAL INFORMATION
DEDUCTIONS FROM REVENUE- PROJECT SPECIFIC (WITHOUT SCENARIO)

[illegible]

**Bellevue ASC 4th OR - WITHOUT SCENARIO
CONSOLIDATED PROFORMA**

					Year 1	Year 2	Year 3
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Volume Projections							
Craniofacial	286	248	281	283	266	258	257
General Surgery	373	389	443	449	422	412	413
Ophthalmology	96	95	122	144	157	152	151
Orthopedics	547	514	530	619	667	645	641
Other	160	122	160	135	108	105	105
Otolaryngology (incl. Audiology)	2,076	1,834	2,064	2,394	2,639	2,924	2,914
Urology	790	860	760	845	869	856	869
TOTAL CASES	4,328	4,062	4,360	4,870	5,128	5,353	5,350
Gross Revenue	\$ 38,140,964	\$ 37,709,321	\$ 43,338,010	\$ 48,510,228	\$ 50,706,641	\$ 51,637,279	\$ 51,617,075
Deductions from Revenue	\$ 18,038,954	\$ 18,129,206	\$ 20,826,299	\$ 23,311,835	\$ 24,367,332	\$ 24,814,555	\$ 24,804,846
NET REVENUE	\$ 20,102,010	\$ 19,580,115	\$ 22,511,711	\$ 25,198,394	\$ 26,339,309	\$ 26,822,724	\$ 26,812,230
Operating expenses							
Salaries & Wages	\$ 2,440,660	\$ 2,711,861	\$ 3,142,693	\$ 3,460,198	\$ 3,849,359	\$ 3,873,354	\$ 3,898,308
Employee Benefits	\$ 659,089	\$ 739,471	\$ 805,187	\$ 989,617	\$ 1,100,917	\$ 1,107,779	\$ 1,114,916
Allocated Labor Expense	\$ 1,227,366	\$ 1,264,187	\$ 1,269,568	\$ 1,231,633	\$ 1,414,380	\$ 1,450,298	\$ 1,450,298
Contract Labor	\$ 127,610	\$ 234,517	\$ 272,833	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000
Medical Supplies	\$ 1,349,514	\$ 1,446,478	\$ 1,695,008	\$ 1,897,301	\$ 1,983,206	\$ 2,019,604	\$ 2,018,814
Other Supplies	\$ 35,336	\$ 41,303	\$ 54,758	\$ 61,158	\$ 64,401	\$ 67,228	\$ 67,193
Maintenance and Repairs	\$ 104,613	\$ 62,238	\$ 74,775	\$ 76,960	\$ 78,067	\$ 79,032	\$ 79,021
Purchased Services	\$ 3,141	\$ 1,142	\$ 3,948	\$ 4,063	\$ 4,121	\$ 4,172	\$ 4,172
Other Expenses	\$ 4,396	\$ 8,108	\$ 7,823	\$ 8,051	\$ 8,167	\$ 8,268	\$ 8,267
Utilities & Building Expenses	\$ 141,557	\$ 141,557	\$ 141,557	\$ 168,936	\$ 168,936	\$ 168,936	\$ 168,936
Provider Expenses	\$ 5,704,702	\$ 5,708,326	\$ 6,307,353	\$ 6,854,344	\$ 7,768,308	\$ 7,927,674	\$ 8,022,343
Total Direct Expenses	\$ 11,797,984	\$ 12,359,188	\$ 13,775,503	\$ 14,952,261	\$ 16,639,863	\$ 16,906,346	\$ 17,032,267
CONTRIBUTION MARGIN	\$ 8,304,026	\$ 7,220,927	\$ 8,736,208	\$ 10,246,133	\$ 9,699,447	\$ 9,916,379	\$ 9,779,962
Indirect Expenses	\$ 5,122,105	\$ 5,012,625	\$ 5,839,689	\$ 6,030,842	\$ 6,141,602	\$ 6,238,115	\$ 6,236,941
Depreciation	\$ 2,061,522	\$ 1,982,581	\$ 1,850,425	\$ 1,850,425	\$ 2,449,417	\$ 2,449,417	\$ 2,449,417
Total Indirect Expenses	\$ 7,183,627	\$ 6,995,206	\$ 7,690,114	\$ 7,881,267	\$ 8,591,019	\$ 8,687,532	\$ 8,686,357
NET OPERATING INCOME	\$ 1,120,399	\$ 225,721	\$ 1,046,094	\$ 2,364,866	\$ 1,108,428	\$ 1,228,847	\$ 1,093,605

Exhibit 12
List of Credentialed Staff

Specialty / Group	Name	License Number 1
Craniofacial	Birgfeld, Craig Brendon, MD	MD00046247
	Gruss, Joseph S, MD	MD00028034
	Hopper, Richard Alan, MD	MD00039704
	Susarla, Srinivas Murthy, DMD, MD, MPH	MD60628000
	Tse, Raymond W, MD	MD60107020
	Whelan, Michael F, MD, DDS	MD00036275
Others	Boos, Markus Daniel, MD, PhD	MD60558381
	Brandling-Bennett, Heather A, MD	MD60076854
	Debiec, Katherine E, MD	MD60077687
	Francis, Julie S, MD	MD00023006
	Gupta, Deepti, MD	MD60509703
	Hornung, Robin L, MD, MPH	MD00037807
	Lopez, Jonathan Peter, MD	MD60476381
	Novotny, Edward J, Jr MD	MD60078540
	Randle, Stephanie Carapetian, MD, MS	MD60292559
	Sidbury, Robert, MD, MPH	MD00039165
	Susarla, Srinivas Murthy, DMD, MD, MPH	MD60628000
	Drugas, George T, MD	MD60037717
General Surgery	Goldin, Adam B, MD, MPH	MD00040335
	Gow, Kenneth W, MD	MD00048323
	Javid, Patrick J, MD	MD60026908
	Ledbetter, Daniel J, MD	MD00020078
	Meehan, John J, MD	MD00048944
	Riehle, Kimberly J, MD	MD00042569
	Smith, Caitlin Annette, MD	MD60566005
	Waldhausen, John H T, MD	MD00029723
Ophthalmology	Baran, Francine M, MD	MD00047342
	Cabrera, Michelle Trager, MD	MD60469095
	Herlihy, Erin P, MD	MD00046416
	Lenart, Thomas D, MD, PhD	MD00037554
	Park, Hee-Jung S, MD	MD60407543
	Tarczy-Hornoch, Kristina, MD, DPhil	MD60310357
Orthopedics	Bouchard, Maryse, MD	MD60349185
	Hanel, Douglas P, MD	MD00029673
	Mosca, Vincent S, MD	MD00022798
	Saper, Michael Garrett, DO, ATC, CSCS	OP60709060
	Schmale, Gregory A, MD	MD00038448
	Steinman, Suzanne E, MD	MD60110118
	Bikhazi, Paul H, MD	MD00038274
Otolaryngology (incl. AUC)	Bly, Randall August, MD	MD60671186
	Dahl, John Patrick, MD, PhD, MBA	MD60439886
	Formsma, Paige Danielle, AUD, CCC-A	LD60617309
	Gaddam, Anupa, AUD, CCC-A	LD00004077
	Inglis, Andrew F, Jr MD	MD00019970
	Johnson, Kaalan E, MD	MD60340296
	Kidd, Whitney Baker, AUD, CCC-A	LD60486450

Specialty / Group	Name	License Number 1
Urology	Manning, Scott C, MD	MD00032980
	Ou, Henry C, MD	MD00043898
	Parikh, Sanjay R, MD	MD60184145
	Perkins, Jonathan A, DO	OP00001440
	Sie, Kathleen C Y, MD	MD00023324
	Susarla, Srinivas Murthy, DMD, MD, MPH	MD60628000
	Thomas, Herbert C, Jr MD, MS	MD00011640
	Yamaguchi, Lisa, AUD, CCC-A	LD60169600
	Ahn, Jennifer Jihyun, MD	MD60550682
	Berrondo, Claudia, MD	MD60727876
	Joyner, Byron D, MD, MPA	MD00036343
	Kieran, Kathleen, MD, MSc, MME	MD60542619
	Lendvay, Thomas Sean, MD	MD00043654
	Merguerian, Paul A, MD, MS	MD60238195
Anesthesia	Shnorhavorian, Margaret, MD, MPH	MD00045698
	Bastien, John, MD	MD00041128
	Bernardo-Ocampo, Carmen, MD, DPBA	MD00047364
	Budac, Stefan, MD	MD60001034
	Chiem, Jennifer, MD	MD60523062
	Flack, Sean, MB ChB, DA, FCA	TR00043838
	Latham, Greg, MD	MD60076907
	Liston, David, MD	MD60035791
	Low, Daniel, BMedSci, BM BS, MRCPCH, FRCA	TR00047907
	Martin, Lynn, MD, MBA	MD00030635
	Richards, Michael, BM, MRCP, FRCA	TR00042839
	Verma, Shilpa, MD	MD60097762
	Allen, Travis, CRNA	RN00173919
	Alley, Connie, CRNA	RN00093152
	Bean, Malika, CRNA	RN60483938
	Budac, Laura, RN, MSN, CRNA	RN60017084
	Kammer, Paul, MS, CRNA	RN00077255
	Kirchmeier, Kelly, CRNABSN,	RN00146199
	Lynch, Dayna (Seguin), CRNA	RN60742581
	Manion, Anisa, MSN, CRNA	RN00167846
	Mendel, Shaun, CRNA	RN60620363
	Miller, Krista, CRNA	RN60659214
	Nguyen, Anthony, CRNA	RN60066998
	Powers, George, CRNA	RN00112076
	Taam, Sarah, CRNA	RN00149240
	Tang, Jinny, CRNA	RN00152139
	Watts, Rheana, CRNA	RN60192123
Registered Nurses & Surgeons	Aguilar, Stanley	ST00000642
	Ajaib, Julianne	RN60073325
	Albright, Merrie	RN60022989
	Alvani, Lindsay	RN60682954
	Ballard, Angela	ST60670353

Specialty / Group	Name	License Number 1
	Barber, Melissa	RN00152896
	Barthel, Kerry	RN6056118
	Beltran Kolene	RN60206972
	Benito, Quentin	ST60168554
	Blasko, Kristin	RN00158441
	Brooks, Cynthia	RN00134013
	Campbell, Scott	RN00171301
	Carlini, Stephanie	RN60869056
	Corin, Amy	RN00164868
	Davis, Casi	RN60218473
	Durham, Julie	RN00169523
	Evans, Tori	RN00166587
	Evans, Tracey	RN60720717
	Flickinger, Danielle	RN60002071
	Frankhouser, Ginger	RN00077405
	Gipson, Stevie	RN60521574
	Halverson, Trisha	RN00150910
	Hansen, Catherine	RN00065242
	Hightower, Sarah	RN60196681
	Hoagland, Emma	RN60797441
	Hoefker, Megan	RN60728143
	King, Cristi	RN60183253
	Kode, Mangesh	ST00003291
	Lagomarsino, Courtney	RN00173429
	Laux, Laurel	RN00061358
	Mathis, Sarah	RN60670921
	Munro, Sarah	RN00160715
	Nelsen, Callie	RN00163311
	Parks, Janette	RN00152756
	Pease, Jennifer	RN60518905
	Peterson, Christiana	RN001528755
	Phillips, Jaenice	ST6014819
	Reddy, Rhonda	RN00156906
	Reece, Kayla	RN60403512
	Rochon, Jane	RN00067369
	Sebelova, Pavla	RN00161109
	Stout, Lori	ST60281855
	Stromberg, Connie	RN00138688
	Takahashi, Atsuko	RN60397848
	Vinarao, Donavi	RN60039962

Appendix 1
Audited Financials

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SEATTLE CHILDREN'S HOSPITAL

Financial Statements

September 30, 2015 and 2014

(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Trustees
Seattle Children's Hospital:

Report on the Financial Statements

We have audited the accompanying financial statements of Seattle Children's Hospital (a Washington not-for-profit corporation and a controlled affiliate of Seattle Children's Healthcare System) (the Hospital), which comprise the balance sheets as of September 30, 2015 and 2014, and the related statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Seattle Children's Hospital as of September 30, 2015 and 2014, and the results of its operations and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

January 19, 2016

SEATTLE CHILDREN'S HOSPITAL

Balance Sheets

September 30, 2015 and 2014

(In thousands of dollars)

Assets	2015	2014
Current assets:		
Cash and cash equivalents	\$ 29,521	25,812
Accounts receivable, net of allowance for uncollectible accounts of \$1,215 in 2015 and \$1,089 in 2014	188,653	180,143
Other current assets	56,191	54,849
Current portion of assets whose use is limited	19,487	17,926
Total current assets	293,852	278,730
Assets whose use is limited:		
Investments	706,021	633,296
Pooled investments held at SCHS	423,445	338,153
Investments under bond indentures and other agreements, noncurrent portion	19,073	2,395
	1,148,539	973,844
Beneficial interest in SCHS	132,277	124,455
Land, buildings, and equipment, at cost, less accumulated depreciation of \$613,210 in 2015 and \$555,139 in 2014	969,912	870,803
Other assets, net	44,566	49,253
Total assets	\$ 2,589,146	2,297,085
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	\$ 8,575	8,575
Accounts payable	58,230	58,634
Accrued salaries, wages, and benefits	71,304	65,998
Other payables	29,234	33,321
Interest payable	10,987	9,463
Total current liabilities	178,330	175,991
Long-term debt, net of current portion	638,375	522,989
Other long-term liabilities	37,608	39,043
Total liabilities	854,313	738,023
Commitments and contingencies (note 14)		
Net assets:		
Unrestricted	1,363,937	1,201,828
Temporarily restricted	116,088	116,657
Permanently restricted	254,808	240,577
Total net assets	1,734,833	1,559,062
Total liabilities and net assets	\$ 2,589,146	2,297,085

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL
Statements of Operations and Changes in Net Assets
Years ended September 30, 2015 and 2014
(In thousands of dollars)

	<u>2015</u>	<u>2014</u>
Operating revenues:		
Net patient service revenues (net of contractual allowances and discounts)	\$ 1,088,906	984,788
Provision for uncollectible accounts	<u>(2,106)</u>	<u>(1,332)</u>
Net patient service revenues	1,086,800	983,456
Research revenues	77,382	64,851
Other operating revenues	27,760	38,966
Net assets released from restriction for operations	<u>69,082</u>	<u>44,001</u>
Total operating revenues	<u>1,261,024</u>	<u>1,131,274</u>
Operating expenses:		
Salaries, wages, and benefits	540,210	496,500
Purchased services	220,212	204,630
Supplies and other expenses	225,868	188,396
Depreciation	66,313	62,069
Interest	<u>20,306</u>	<u>23,002</u>
Total operating expenses	<u>1,072,909</u>	<u>974,597</u>
Operating income	<u>188,115</u>	<u>156,677</u>
Nonoperating (expense) income:		
Interest and dividend income	13,583	7,741
Realized gains on trading securities, net	7,249	1,042
Unrealized (losses) gains on trading securities, net	(24,571)	13,209
Change in valuation of interest rate swap agreements	(3,584)	(233)
Other nonoperating expenses, net	(414)	(307)
Loss on refinancing of debt	(31,094)	—
Gain on forgiveness of debt	<u>9,790</u>	<u>—</u>
Net nonoperating (expense) income	<u>(29,041)</u>	<u>21,452</u>
Excess of revenues over expenses	<u>159,074</u>	<u>178,129</u>

SEATTLE CHILDREN'S HOSPITAL
Statements of Operations and Changes in Net Assets
Years ended September 30, 2015 and 2014
(In thousands of dollars)

	<u>2015</u>	<u>2014</u>
Excess of revenues over expenses, brought forward	\$ 159,074	178,129
Other changes in unrestricted net assets:		
Net assets released from restriction for capital and other	3,257	4,040
Other	<u>(222)</u>	<u>176</u>
Increase in unrestricted net assets	<u>162,109</u>	<u>182,345</u>
Changes in temporarily restricted net assets:		
Net investment income and unrealized gains on investments	7,220	22,356
Restricted contributions	66,247	43,330
Net assets released from restriction	(72,339)	(48,041)
Change in beneficial interest in SCHS	<u>(1,697)</u>	<u>1,958</u>
(Decrease) increase in temporarily restricted net assets	<u>(569)</u>	<u>19,603</u>
Changes in permanently restricted net assets:		
Investment change, restricted by donors	—	(68)
Restricted contributions	4,712	3,411
Change in beneficial interest in SCHS	<u>9,519</u>	<u>76,582</u>
Increase in permanently restricted net assets	<u>14,231</u>	<u>79,925</u>
Increase in net assets	175,771	281,873
Net assets, beginning of year	<u>1,559,062</u>	<u>1,277,189</u>
Net assets, end of year	<u>\$ 1,734,833</u>	<u>1,559,062</u>

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL

Statements of Cash Flows

Years ended September 30, 2015 and 2014

(In thousands of dollars)

	<u>2015</u>	<u>2014</u>
Cash flows from operating activities:		
Increase in net assets	\$ 175,771	281,873
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	64,643	61,423
Provision for uncollectible accounts	2,106	1,332
Realized gains on investments, net	(17,962)	(13,452)
Unrealized losses (gains) on investments, net	32,985	(18,886)
Restricted contributions	(4,712)	(3,411)
Equity (earnings) losses on investments in joint venture, net of cash distributions	(450)	654
Change in beneficial interest in SCHS	(7,822)	(78,540)
Change in valuation of interest rate swap agreements	3,584	233
Loss on refinancing of debt	31,094	—
Gain on forgiveness of debt	(9,790)	—
Changes in assets and liabilities:		
Accounts receivable, net	(10,616)	(43,674)
Other current assets	(1,342)	(17,019)
Other assets	7,159	(6,798)
Payables and other liabilities	(2,680)	14,143
Net cash provided by operating activities	<u>261,968</u>	<u>177,878</u>
Cash flows from investing activities:		
Capital expenditures	(165,423)	(68,334)
Proceeds from sale of investments	2,281,880	1,589,943
Purchases of investments	(2,473,158)	(1,701,646)
Net cash used in investing activities	<u>(356,701)</u>	<u>(180,037)</u>
Cash flows from financing activities:		
Restricted contributions	4,712	3,411
Repayment of long-term debt	(8,575)	(8,275)
Proceeds from long-term debt	272,226	—
Advance repayment of long-term debt	(167,355)	—
Payment of deferred financing costs	(2,566)	—
Net cash provided by (used in) financing activities	<u>98,442</u>	<u>(4,864)</u>
Net increase (decrease) in cash and cash equivalents	3,709	(7,023)
Cash and cash equivalents, beginning of year	25,812	32,835
Cash and cash equivalents, end of year	<u>\$ 29,521</u>	<u>25,812</u>
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest (net of capitalized interest)	\$ 20,031	23,394

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

Seattle Children's Hospital (the Hospital) is a not-for-profit regional pediatric medical center and research institute.

The Hospital is a member of a group of controlled corporations that have common representation on certain boards of governance. The memberships of the boards of trustees of the Hospital and Seattle Children's Healthcare System (SCHS) are currently identical.

The following are affiliates of the Hospital, each of which is a Washington not-for-profit corporation and a 501(c)(3) organization:

Seattle Children's Healthcare System (SCHS) – The parent corporation of the Hospital and affiliated-controlled corporate entities.

Seattle Children's Hospital Foundation (the Foundation) – A corporation established to support SCHS and its affiliates, primarily the Hospital, through fundraising activities.

Seattle Children's Hospital Guild Association (the Guild Association) – A corporation established to support SCHS and its affiliates, primarily the Hospital, through fundraising events and memberships.

Seattle Children's Retail (Retail) – A corporation established to support SCHS, through the operation of thrift stores.

Substantially all the unrestricted contributions raised by the Foundation, the Guild Association and Retail are transferred to the Hospital or to SCHS on a discretionary basis. Restricted contributions are distributed to the Hospital and are classified to comply with the purposes specified by donors. During the years 2015 and 2014, the Foundation, the Guild Association and Retail transferred contributions of \$60,383 and \$54,162 to the Hospital, respectively.

(b) Tax Exemption

The Internal Revenue Service has granted the Hospital exemption from federal income taxes under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) of the IRC formed to operate a hospital for charitable, educational, scientific, and medical purposes. The Financial Accounting Standards Board (FASB) issued Accounting Standards Codification (ASC) Topic 740, *Accounting for Uncertainty in Income Taxes*, which prescribes a comprehensive model for how a company should recognize, measure, present, and disclose in its financial statements uncertain tax positions that the company has taken or expects to take on a tax return. During the years, the Hospital did not record any liability for unrecognized tax benefits.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

(c) *Use of Estimates*

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. The most significant estimates relate to the fair value of investments, allowances for contractual allowances, uncollectible accounts on patient accounts receivable, and self-insurance reserves.

(d) *Cash and Cash Equivalents*

Included in cash and cash equivalents were cash equivalents of \$7,026 and \$2,875 as of September 30, 2015 and 2014, respectively, invested in money market funds, which are highly liquid investments that are readily convertible to known amounts of cash.

(e) *Assets Whose Use Is Limited*

Assets whose use is limited includes unrestricted assets designated by the Board of Trustees for future capital and various program purposes, over which the Board of Trustees retains control and may, at its discretion, subsequently use for other purposes. Assets whose use is limited also includes temporarily and permanently restricted assets, based on donor restriction, and assets held by trustees under bond indentures and other agreements.

Investments under bond indentures and other agreements primarily include assets held by trustees under the terms of the Revenue Bonds and certain deferred compensation arrangements. Amounts required to meet current liabilities of the Hospital have been classified as current assets in the accompanying balance sheets at September 30, 2015 and 2014.

The Hospital classifies its investment portfolio as a trading portfolio, and as such, all unrestricted unrealized gains or losses are recorded in nonoperating income in the accompanying statements of operations and changes in net assets, in the period in which they occur.

Interest and dividend income and realized gains or losses are included in nonoperating income in the accompanying statements of operations and changes in net assets, unless the income or gain (loss) is restricted by donor. Such restricted investment income is included in the increase (decrease) in temporarily restricted net assets in the statements of operations and changes in net assets.

Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risks associated with certain investment securities, it is reasonably possible that changes in the value of investments could occur in the near term and that such changes could materially affect the amounts reported in the accompanying balance sheets.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

Pooled Investments Held at SCHS

Pooled investments held at SCHS represent the Hospital's interest in a pool of investments held and managed by SCHS, which are recorded at fair value. Investment income, net and unrealized gains or losses from the SCHS investment pool were allocated between SCHS and the Hospital based upon respective investment balances. The Hospital recognizes the changes in its interest in the SCHS investment pool using a method that approximates the equity method of accounting.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, less accumulated depreciation. Maintenance and repairs are expensed as incurred. Interest costs incurred during construction are capitalized under applicable accounting guidance. In addition, interest is capitalized on those assets that require a period of time to get them ready for their intended use. The Hospital capitalized \$2,924 and \$829 of interest cost in 2015 and 2014, respectively. Depreciation is computed using the straight-line method, which allocates the cost of the asset ratably over its estimated useful life. An estimated life of 40 years is used for buildings and 8 to 15 years for building and land improvements. Various lives ranging from 3 to 20 years are used for furniture and equipment. Leasehold improvements are depreciated over the shorter of the remaining life of the lease or the useful life of the asset.

(g) Joint Ventures and Investments in Affiliated Companies

The equity method of accounting is used for joint ventures and investments in affiliated companies in which the Hospital has significant influence, but does not have control. Significant influence is deemed to exist when the ownership interest in the investee is at least 20% and not more than 50% of net assets, although other factors may be considered in determining whether the equity method of accounting is appropriate.

(h) Deferred Financing Costs

Deferred financing costs are included in other assets in the accompanying balance sheets and are amortized using the effective interest method over the term of the related outstanding obligation.

(i) Net Assets and Endowments

Contributions are reported at fair value at the date of donation. Such amounts are reported as unrestricted, temporarily restricted, or permanently restricted net assets, based on donor stipulations (if any) that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the accompanying statements of operations and changes in net assets as net assets released from restriction.

Endowment fund balances, including funds functioning as endowments, are classified and reported as permanently restricted, temporarily restricted, or unrestricted net assets in accordance with donor or Board specifications. Funds functioning as endowments include Board-designated named endowments and other Board-designated funds. See note 7 for additional information on endowments.

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(j) Net Patient Service Revenues and Patient Accounts Receivable

Net patient service revenues are reported at the estimated net realizable amounts from patients and third-party payers. Retroactive adjustments, under reimbursement agreements with third-party payers, are estimated and accrued in the period in which the related services are rendered, and adjusted in future periods as final settlements are determined.

Patient accounts receivable are recorded on an accrual basis at established billing rates. The allowances for contractual adjustments and uncollectible accounts are recorded on an accrual basis, using established billing and contracted rates and historical experience. In evaluating the collectibility of patient accounts receivable, the Hospital estimates the allowance for uncollectible accounts by major payer type based on historical experience for each payer type. Primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. For uninsured patients who do not qualify for the Hospital's charity care, the Hospital provides a discount from its standard rates. Management regularly reviews data about the major payer sources of revenues in evaluating the sufficiency of the allowance for contractual adjustments and uncollectible accounts.

(k) Other Operating Revenues

Other operating revenues primarily include revenues from a federal graduate medical education grant, Hospital's equity earnings from its participation in a joint venture, rental income, and amounts received from Children's University Medical Group (CUMG) and other contracted services.

(l) Excess of Revenues over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over expenses, consistent with industry practice, primarily include net assets released from restriction for capital.

(m) Subsequent Events

The Hospital has performed an evaluation of subsequent events through January 19, 2016, which is the date these financial statements were issued.

(n) New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. ASU 2014-09 was originally effective for annual reporting periods beginning after December 15, 2016, including interim periods within that reporting period, but has now been delayed one year by ASU 2015-14. The Hospital is

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evaluating this guidance and the impact that the adoption of this update will have on its financial statements and related disclosures.

In March 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. This update changes the presentation of debt issuance costs in the financial statements. Under the ASU, an entity presents such costs in the balance sheet as a direct deduction from the recognized liability rather than as an asset. Amortization of the costs is reported as interest expense. The ASU is effective for fiscal years beginning after December 15, 2015, and interim periods beginning after December 15, 2016, and early adoption is permitted. Debt issuance costs as of September 30, 2015 were \$4,676, which would be reclassified from an asset to a contra-debt liability in the accompanying balance sheets.

In May 2015, the FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820) – Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, which eliminates the requirement to categorize investments in the fair value hierarchy if their fair value is measured at net asset value (NAV) per share (or its equivalent) using the practical expedient in the FASB's fair value measurement guidance. The guidance is effective for annual fiscal periods beginning after December 15, 2016; however, early adoption is permitted. Management does not believe this will have a material impact on the financial statements.

(2) Uncompensated and Undercompensated Care and Other Community Benefits

The mission of the Hospital is to provide excellent patient care for children, to engage in innovative research that will improve the health of children, to train the next generation of physicians, other healthcare workers and scientists who will advance the health of children, and to advocate for the healthcare needs of children. As part of its mission, the Hospital is committed to caring for children in its service area irrespective of ability to pay and to otherwise identify and help to meet the healthcare needs of children in the community. The estimated costs include, but are not limited to, the following for the years ended September 30:

	2015	2014
Medicaid payment shortfall	\$ 102,224	109,392
Charity care	9,594	11,195
Total uncompensated and undercompensated care	111,818	120,587
Other community benefits:		
Research	30,341	29,930
Health professional education	24,522	22,919
Other community benefits	8,668	9,941
Total other community benefits	63,531	62,790
Total uncompensated and undercompensated care and other community benefits	\$ 175,349	183,377

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Medicaid payment shortfall represents the estimated cost of providing services to patients covered under Medicaid in excess of payments received. The estimated cost of services provided to Medicaid patients is based on a ratio of Hospital total patient care costs as a percentage of Hospital total gross patient care charges. This cost ratio is applied to gross charges related to services provided to Medicaid patients, resulting in the estimated cost of providing care to these patients.

Charity care represents the estimated cost of care provided to children who are uninsured or underinsured and whose families cannot afford to pay for their medical care. The Hospital provides charity care in accordance with its charity care policy based on family need and maintains records to identify the level of charity it provides. The determination of family need is evaluated during a patient's course of care and can be updated after care is complete. Because the Hospital does not pursue collection of these amounts determined to qualify as charity care, they are not reported as revenue. The estimated cost of charity care provided is based on a ratio of Hospital total patient care costs as a percentage of Hospital total gross patient care charges. This cost ratio is applied to gross charges related to charity care services, resulting in the estimated cost of providing charity care.

Other community benefits represent the costs of providing programs, net of direct offsetting revenues of \$105,661 and \$90,249 in 2015 and 2014, respectively, for the benefit of the entire community. These benefits include research, health professional education, and various other community-based healthcare programs.

(3) Assets Whose Use Is Limited

As of September 30, the fair value of assets whose use is limited was as follows:

	2015	2014
Pooled investments held at SCHS	\$ 423,445	338,153
Board-designated investments	363,214	289,315
Board-designated endowments	179,657	176,801
Donor-restricted endowments	163,150	167,180
Investments held under bond indentures and other	38,560	20,321
	<u>\$ 1,168,026</u>	<u>991,770</u>

(4) Investments, Fair Value Measurements, and the Fair Value Option

ASC Topic 820, *Fair Value Measurement*, establishes a three-tier hierarchy to maximize the use of observable market data and minimize the use of unobservable inputs, and to establish classification of fair value measurements for disclosure purposes. Inputs refer broadly to the assumptions that market participants would use in pricing the asset or liability, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset or liability developed based upon market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing the asset or liability developed

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based on the best information available. The three-tier hierarchy of inputs is summarized in the three broad levels below:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Pricing inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly, and the fair value is determined through the use of models or other valuation methodologies.

Level 3 – Significant unobservable inputs, including assets and liabilities that are traded infrequently.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The fair value hierarchy does not necessarily correspond to a financial instrument's relative liquidity in the market or to its level of risk.

The following is a description of valuation inputs and techniques that the Hospital utilizes to determine the fair value of each major category of assets and liabilities:

Mutual Funds – Registered with the Securities and Exchange Commission as mutual funds under the Investment Company Act of 1940. To the extent valuation adjustments are not applied, mutual funds are categorized as Level 1.

United States (U.S.) Equity Securities – Equity securities that are actively traded on a securities exchange are valued based on quoted prices from the applicable exchange, and to the extent valuation adjustments are not applied to these securities, they are categorized as Level 1. Equity securities traded on inactive markets are valued using other observable inputs and are categorized as Level 2.

Debt Securities (U.S. and Foreign Corporate Fixed Income, and Commercial Paper) – Investment-grade bonds are valued using inputs and techniques, which include third-party pricing vendors, dealer quotations, and recently executed transactions in securities of the issuers or comparable issuers. Adjustments to individual bonds can be applied to recognize trading differences compared to bonds issued by the same issuer. Values for high-yield bonds are based primarily on pricing vendors and dealer quotations from relevant market makers. The dealer quotations received are supported by credit analysis of the issuer that takes into consideration credit-quality assessments; daily trading activity; and the activity of the underlying equities, listed bonds, and sector-specific trends. To the extent that these inputs are observable and timely, the values of these debt securities are categorized as Level 2.

Debt Securities (U.S. Municipal Debt) – U.S. Municipal debt securities are valued using inputs and techniques, which include identification of similar issues and bond market activity. Prices are determined taking into account the bond's terms and conditions, including any features specific to that issue, which may influence risk, and thus, marketability. To the extent that these inputs are observable and timely, the values of U.S. Municipal debt are categorized as Level 2.

Debt Securities (Notes issued by the U.S. Government and U.S. Government Agencies) – U.S. Notes and Government Agencies notes are valued based on pricing provided by third-party vendors that obtain feeds

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from a number of live data sources, including active market makers and interdealer brokers. To the extent that these inputs are observable and timely, the values of U.S. Notes and Government Agencies are categorized as Level 2.

Pooled Investments – Primarily valued based on the Hospital's share of the value of the underlying assets, as held and provided by the Health System. The values of Pooled Investments are categorized as Level 3.

Derivative Instruments – The fair values of interest rate swaps are estimated using various inputs, including quotations from various dealers and counterparties, and pricing models that use certain observable inputs, such as the creditworthiness of the counterparties, default probabilities, yield curves, and credit curves. The pricing models utilized generally do not entail material subjectivity because the methodologies employed do not necessitate significant judgments. If the pricing inputs are observed from activity quoted markets, the derivative values are categorized as Level 2. Interest rate swaps are valued in accordance with the terms of each contract based on current interest rate spreads. Market standard pricing models are used for valuing interest rate swaps.

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The following table presents assets and liabilities that were measured at fair value on a recurring basis (including items that were required to be measured at fair value and items for which the fair value option was elected) at September 30:

	2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Assets:				
Investments:				
Money market	\$ 81,413	65,185	16,228	—
Commercial paper	77,183	—	77,183	—
U.S. equity securities	4,990	4,990	—	—
U.S. corporate fixed income securities	262,158	—	262,158	—
Foreign corporate fixed income securities	38,056	—	38,056	—
Notes issued by the				
U.S. government and				
U.S. government agencies	30,501	—	30,501	—
U.S. municipal securities	4,150	—	4,150	—
Mutual funds:				
Global (U.S. and Foreign) equity funds	507	507	—	—
U.S. corporate fixed income funds	207,063	207,063	—	—
Pooled investments	423,445	—	—	423,445
Trustee-held funds	36,355	36,355	—	—
Deferred compensation:				
Mutual funds	2,205	2,205	—	—
Total assets	<u>\$ 1,168,026</u>	<u>316,305</u>	<u>428,276</u>	<u>423,445</u>
Liabilities:				
Interest rate swap agreements	\$ 24,217	—	24,217	—
Total liabilities	<u>\$ 24,217</u>	<u>—</u>	<u>24,217</u>	<u>—</u>

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	2014	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Assets:				
Investments:				
Money market	\$ 63,991	50,113	13,878	—
Commercial paper	139,907	—	139,907	—
U.S. equity securities	5,107	5,107	—	—
U.S. corporate fixed income securities	79,322	—	79,322	—
Foreign corporate fixed income securities	15,507	—	15,507	—
Notes issued by the U.S. government and U.S. government agencies	132,467	—	132,467	—
U.S. municipal securities	4,503	—	4,503	—
Mutual funds:				
Global (U.S. and Foreign) equity funds	534	534	—	—
U.S. corporate fixed income funds	191,958	191,958	—	—
Pooled investments	338,153	—	—	338,153
Trustee-held funds	17,926	17,926	—	—
Deferred compensation:				
Mutual funds	2,395	2,395	—	—
Total assets	\$ 991,770	268,033	385,584	338,153
Liabilities:				
Interest rate swap agreements	\$ 20,633	—	20,633	—
Total liabilities	\$ 20,633	—	20,633	—

Pooled investments held at SCHS are recorded at the Hospital's share of the fair value of the SCHS investment pool. The SCHS investment pool was invested as follows at September 30 (in percentages):

	2015	2014
Mutual funds:		
Global (U.S. and Foreign) equity	18%	19%
U.S. corporate fixed income	9	10
Alternative investments	73	71
	100%	100%

Alternative investments included within pooled investments held at SCHS, include limited partnerships, limited liability corporations, investment trusts, institutional funds, and offshore investment funds. Included in these funds are certain types of financial instruments, including, among others, futures and forward contracts, options, swaps, and securities sold not yet purchased, intended to hedge against changes in the market value of investments. These financial instruments involve varying degrees of risk. Because

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alternative investments are not readily marketable, their estimated value is subject to uncertainty and, therefore, may differ from the value that would have been used had a ready market for such investments existed. Such differences could be material. As of September 30, 2015 and 2014, 45% and 36%, respectively, of the alternative investments within the SCHS investment pool were classified as Level 3 securities and subject to liquidity limitations.

The following table presents the Hospital's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC Topic 820 for the years ended September 30, 2015 and 2014:

	Pooled investments	
	2015	2014
Beginning balance at September 30	\$ 338,153	313,227
Investment income and unrealized (losses) and gains, net	(7,086)	29,414
Additions	89,142	—
Other changes	3,236	(4,488)
Ending balance at September 30	<u>\$ 423,445</u>	<u>338,153</u>

Net unrealized (losses) and gains included in income, relating to pooled investments held at September 30, 2015 and 2014 were \$(23,691) and \$11,747, respectively.

The carrying amounts reported on the accompanying balance sheets for cash and cash equivalents, patient accounts receivable, other current assets, accounts payable, and accrued expenses approximate the fair value because of their short-term nature.

The fair value of long-term debt, estimated based on the quoted market prices for similar issues, considered a Level 2 measure, was \$657,003 and \$562,238 at September 30, 2015 and 2014, respectively. The carrying value was \$646,950 and \$531,564 at September 30, 2015 and 2014, respectively.

(5) Beneficial Interest in Seattle Children's Healthcare System

The Hospital recognizes an interest in a portion of the net assets of SCHS representing certain temporarily and permanently restricted funds that will ultimately benefit the Hospital. At September 30, 2015 and 2014, the Hospital recorded a beneficial interest in SCHS of \$132,277 and \$124,455, respectively, which corresponds to temporarily and permanently restricted net assets held by SCHS on the Hospital's behalf. The Hospital recognizes changes in this beneficial interest as a change in temporarily and permanently restricted net assets.

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(6) Land, Buildings, and Equipment

Land, buildings, and equipment consist of the following at September 30:

	2015	2014
Land and improvements	\$ 182,696	182,724
Buildings and improvements	887,184	789,026
Furniture and equipment	471,464	408,198
Construction in progress	41,778	45,994
	<u>1,583,122</u>	<u>1,425,942</u>
Less accumulated depreciation	<u>(613,210)</u>	<u>(555,139)</u>
	<u>\$ 969,912</u>	<u>870,803</u>

Construction in progress primarily relates to certain facility renovations and information technology projects. The Hospital has commitments for future construction and development totaling \$38,142 as of September 30, 2015.

(7) Endowment Funds and Temporarily and Permanently Restricted Net Assets

The endowment funds consist of numerous individual funds established for a variety of purposes. They include donor-restricted endowments and funds functioning as endowments, which include Board-designated named endowments and other Board-designated endowments. Net assets associated with these funds are classified and reported based on the existence or absence of donor-imposed restrictions.

The Hospital has interpreted the Washington State Uniform Prudent Management of Institutional Funds Act (WA-UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment; (b) the original value of subsequent gifts donated to the permanent endowment; and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund.

The remaining portion of the donor-restricted endowment funds that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standards of prudence prescribed by WA-UPMIFA.

In making a determination to appropriate or accumulate donor-restricted endowment funds, the Hospital considers (a) the duration and preservation of the fund; (b) the purposes of SCHS and the donor-restricted endowment; (c) general economic conditions; (d) the appreciation of endowment investments; (e) other resources of the Hospital; and (f) the investment policy of the Hospital. From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor

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or WA-UPMIFA requires the Hospital to retain as a fund of perpetual duration. Deficiencies of this nature are reflected as a reduction in unrestricted net assets.

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation intended to achieve its long term return objectives within prudent risk constraints.

The Hospital has a spending policy of appropriating 5% of its endowment funds' twelve-quarter average market value of donor-restricted and Board-designated named endowments. In establishing this policy, the Hospital considered the long term expected return on its endowment funds.

The endowment net assets composition by type as of September 30, 2015 and 2014 were as follows:

	<u>Unrestricted</u>	<u>Temporarily restricted</u>	<u>Permanently restricted</u>	<u>Total</u>
September 30, 2015:				
Donor-restricted	\$ (503)	28,633	135,020	163,150
Board-designated:				
Named endowment funds	8,894	—	—	8,894
Other endowment funds	170,763	—	—	170,763
Total funds	<u>\$ 179,154</u>	<u>28,633</u>	<u>135,020</u>	<u>342,807</u>
September 30, 2014:				
Donor-restricted	\$ (255)	37,646	129,789	167,180
Board-designated:				
Named endowment funds	4,483	—	—	4,483
Other endowment funds	172,318	—	—	172,318
Total funds	<u>\$ 176,546</u>	<u>37,646</u>	<u>129,789</u>	<u>343,981</u>

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The changes in endowment net assets for 2015 and 2014 were as follows:

	September 30, 2015			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2014	\$ 176,546	37,646	129,789	343,981
Investment return:				
Net interest and dividends	2,174	2,181	—	4,355
Net depreciation (realized and unrealized)	(4,113)	(3,399)	—	(7,512)
Total investment return	(1,939)	(1,218)	—	(3,157)
Contributions	5,025	—	5,231	10,256
Appropriation of endowment assets for expenditure:				
Donor-restricted	(136)	(7,795)	—	(7,931)
Board-designated named	(342)	—	—	(342)
Total appropriations	(478)	(7,795)	—	(8,273)
Endowment net assets, September 30, 2015	\$ 179,154	28,633	135,020	342,807
	September 30, 2014			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2013	\$ 161,077	30,692	126,450	318,219
Investment return:				
Net interest and dividends	2,078	2,071	—	4,149
Net appreciation (realized and unrealized)	13,722	12,120	—	25,842
Total investment return	15,800	14,191	—	29,991
Contributions	—	—	3,339	3,339
Appropriation of endowment assets for expenditure:				
Donor-restricted	(125)	(7,237)	—	(7,362)
Board-designated named	(206)	—	—	(206)
Total appropriations	(331)	(7,237)	—	(7,568)
Endowment net assets, September 30, 2014	\$ 176,546	37,646	129,789	343,981

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Temporarily restricted net assets are available for the following purposes at September 30:

	<u>2015</u>	<u>2014</u>
Healthcare services:		
Purpose restrictions	\$ 36,503	37,092
Unappropriated endowment earnings	28,633	37,646
Research	50,675	41,294
Capital projects	277	625
	<u>\$ 116,088</u>	<u>116,657</u>

Permanently restricted net assets are restricted to investments in perpetuity, the income from which is expendable to support the following at September 30:

	<u>2015</u>	<u>2014</u>
Healthcare services	\$ 119,582	100,347
Research	135,226	140,230
	<u>\$ 254,808</u>	<u>240,577</u>

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(8) Long-Term Debt

Long-term debt obligation consists of the following at September 30:

	2015	2014
Revenue Bonds, Series 2008C, refinanced in February 2015 with 2015B series	\$ —	90,277
Revenue Bonds, Series 2009, partially refinanced in February 2015 with 2015B series, interest paid semiannually at rates ranging from 3.50% to 5.00% with principal payments ranging from \$915 in 2016 to \$1,070 in 2020, net of unamortized discount of \$35 in 2015 and \$872 in 2014	4,905	83,543
Revenue Bonds, Series 2010A, interest paid semiannually at the rate of 5% with principal payments ranging from \$1,670 in 2032 to \$30,255 in 2041, net of unamortized premium of \$1,969 in 2015 and \$2,053 in 2014	76,970	77,053
Revenue Bonds, Series 2010B, interest paid semiannually at the rate of 5% with principal payments ranging from \$3,075 in 2016 to \$4,330 in 2023, net of unamortized premium of \$1,953 in 2015 and \$2,473 in 2014	31,333	35,119
Revenue Bonds, Series 2012A, interest paid semiannually at the rate of 5% with principal payments ranging from \$22,600 in 2042 to \$23,735 in 2043, net of unamortized premium of \$3,264 in 2015 and \$3,388 in 2014	49,599	49,723
Revenue Bonds, Series 2012B, interest paid semiannually at rates ranging from 3% to 5% with principal payments ranging from \$40 in 2016 to \$2,890 in 2035 net of unamortized premium of \$1,888 in 2015 and \$2,033 in 2014	29,863	30,048
Revenue Bonds, Series 2012C, interest paid monthly at variable rates ranging from 1.04% to 1.08% for the fiscal year ended September 30, 2015 with principal payments ranging from \$1,600 in 2016 to \$8,935 in 2029	63,645	65,195
Revenue Bonds, Series 2012D, interest paid monthly at variable rates ranging from 0.71% to 0.74% for the fiscal year ended September 30, 2015 with principal payments ranging from \$2,945 in 2016 to \$5,255 in 2032	67,905	70,750
Revenue Bonds, Series 2015A, interest paid semiannually at rates ranging from 4.00% to 5.00% with principal payments ranging from \$4,055 in 2042 to \$31,845 in 2046 net of unamortized premium of \$4,766 in 2015	104,766	—

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Revenue Bonds, Series 2015B, interest paid semiannually at rates ranging from 2.00% to 5.00% with principal payments ranging from \$35 in 2017 to \$24,695 in 2039, net of unamortized premium of \$30,657 in 2015	\$	198,007	—
Notes payable with U.S. Bank, interest paid quarterly at 1.5% through 2038 with principal due in full at the maturity date of December 31, 2038; secured by a leasehold deed of trust and assets of a special purpose LLC		<u>19,957</u>	<u>29,856</u>
		646,950	531,564
Less current portion		<u>(8,575)</u>	<u>(8,575)</u>
	\$	<u>638,375</u>	<u>522,989</u>

The Revenue Bonds are collateralized by a pledge of gross revenues and secured by interests in certain bond funds.

Scheduled principal repayments as of September 30, 2015 on the long-term debt are due as follows:

2016	\$	8,575
2017		8,955
2018		9,345
2019		9,740
2020		10,160
Thereafter		<u>555,712</u>
		602,487
Add unamortized net premiums		<u>44,463</u>
	\$	<u>646,950</u>

In 2015, the Hospital issued \$100,000 of Series 2015A Bonds and \$167,350 of Series 2015B Bonds. The Series 2015A Bonds were issued to fund or reimburse portions of future capital projects as part of the Hospital's multi-phased capital plan. The Series 2015B Bonds provided funds necessary to advance refund and defease a portion of the Series 2009 Bonds and all of the Series 2008C Bonds. The 2015B advance refunding generated a \$31,094 noncash loss on refinancing that is recorded in nonoperating income in the accompanying statements of operations and changes in net assets.

In 2008, the Hospital entered into a New Markets Tax Credit (NMTC) financing to develop and construct a portion of the Hospital's research facility. The compliance period (NMC tax credit period) of the transaction was for a seven-year period beginning on the date on which the certain special purpose vehicles received equity investments from the investment funds. The first phase of the transaction ended in 2015. As a result of the completion of the compliance period for the first phase of this NMTC financing, the

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

Hospital recorded a \$9,790 noncash gain on forgiveness of debt, which is recorded in nonoperating income in the accompanying statements of operations and changes in net assets.

The members of the Obligated Group established under the Master Indenture include the Hospital and SCHS. As of September 30, 2015, total assets, total liabilities, and total unrestricted net assets of the Obligated Group constituted approximately 99%, 98%, and 99%, respectively, of the respective SCHS's totals. For 2015, the total operating revenues, operating income, and excess of revenues over expenses, from all sources attributable to the Obligated Group were 99%, 100%, and 98%, respectively, of the respective SCHS's consolidated totals.

Under the terms of the Revenue Bonds and related indenture agreements, the Obligated Group is required to comply with various covenants, including income available for debt service.

Accounting for Derivative Instruments

Interest rate swap contracts are used to manage the net exposure to interest rate changes in attempting to reduce the overall cost of borrowing over time. Interest rate swap contracts generally involve the exchange of fixed and floating interest rate payments without the exchange of underlying principal (the swap of fixed or floating rates are on a notional amount). The Hospital accounts for its interest rate hedging transactions in accordance with ASC Topic 815, *Derivatives and Hedging*. Topic 815 requires that derivative instruments be recorded on the balance sheet as either an asset or liability measured at its individual fair market value. Changes in the derivative instrument's fair market value are recognized in earnings unless certain specific hedge accounting criteria are met. Management has not designated their interest rate swap agreements as cash flow hedges, and therefore, this specific criteria has not been met. As such, all changes in the valuation of the interest rate swaps are recognized in the accompanying statements of operations and changes in net assets as a component of nonoperating income (expenses).

The Hospital entered into two interest rate swap agreements (Swap Agreements) with two separate counterparties. Under each Swap Agreement, the Hospital is obligated to pay a fixed rate per annum (3.48% on the Series 2012C Bonds and 3.69% on the Series 2012D Bonds) on a notional amount equal to the outstanding principal amount of the applicable series of bonds and receives a variable payment computed as 68% of the one-month LIBOR. The bonds' variable-rate coupons are based upon rates calculated as a percentage of one-month LIBOR plus a credit spread as defined in the respective financing agreements.

The following table presents the fair value of interest rate swap contracts on the balance sheet:

	Balance sheet location	September 30	
		2015	2014
Interest rate swaps not designated as hedges	Other long-term liabilities	\$ 24,217	20,633

To comply with Topic 815, the Hospital has incorporated its own nonperformance risk and the respective counterparty's nonperformance risk in the fair value measurements.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

The two Credit Support Annexes for the interest rate swaps require either party to post collateral if the fair market value of the swap is negative to them and exceeds the minimum threshold as defined in each respective Credit Support Annex. The amount of collateral required to be posted is equal to the difference of the fair market value over the minimum threshold. As of September 30, 2015, the Hospital was not required to post collateral for either swap.

(9) Net Patient Service Revenues and Concentrations of Credit Risks

A significant portion of the Hospital's patient service revenues is derived from Washington State's Medicaid program, including Medicaid managed care (Medicaid). Payments from Medicaid for services rendered to inpatients are based upon prospective diagnosis related groups (DRGs) and other payment programs, while Medicaid outpatient payments are based upon prospective enhanced ambulatory payment groups (EAPGs) and other payment programs. Commercial insurer payments are based upon terms of contractual agreements.

The following table summarizes gross patient revenue by payer for the years ended September 30:

	2015	2014
Commercial Insurers:		
Premera Blue Cross	12%	12%
Regence Blue Shield	13	13
Other	22	23
Medicaid managed care:		
Community Health Plan of Washington	7	7
Molina Healthcare	15	14
Other	12	9
Medicaid	13	15
Medicare	1	2
Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS)	4	4
Other	1	1
	100%	100%

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

The concentrations of credit risk by payer as measured by patient accounts receivable were as follows at September 30:

	2015	2014
Commercial Insurers:		
Premera Blue Cross	10%	8%
Regence Blue Shield	11	11
Other	25	27
Medicaid managed care	31	32
Medicaid	14	13
Medicare	1	1
CHAMPUS	5	5
Other	3	3
	100%	100%

(10) Hospital Safety Net Assessment

In 2013, the State of Washington enacted legislation that provides for supplemental Medicaid payments to certain hospitals funded by assessments paid by these hospitals as well as matching federal funds (the safety net program). The supplemental payments include fee-for-service payments received directly from Washington State as well as payments processed through managed care plans. Each of the fee-for-service and managed care segments require separate Centers for Medicare and Medicaid Services (CMS) approval. Supplemental payments received and assessments paid are recognized upon approval of each program segment by CMS. In 2014, CMS approved the fee-for-service segment of the program. In 2015, CMS approved the managed care segment of the program. As the managed care segment was not approved as of September 30, 2014, supplemental payments of \$17,000 were recorded in other payables and assessments of \$12,100 were recorded in other assets in the accompanying balance sheets. As of September 30, 2015, no supplemental payments were recorded in other payables or assessments recorded in other assets in the accompanying balance sheets.

The following revenue and expense are recognized in the accompanying statements of operations and changes in net assets for the years ended September 30:

	Revenues		Expenses	
	2015	2014	2015	2014
Fee-for-service segment of the program	\$ 16,430	19,599	6,215	10,431
Managed care segment of the program	48,345	—	22,150	—
Total	\$ 64,775	19,599	28,365	10,431

The \$48,345 recorded for the managed care segment in 2015 includes supplemental payments of \$23,364 related to 2014. The \$22,150 recorded in 2015 includes assessments of \$12,124 related to 2014.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

Supplemental payments are recorded in net patient service revenues and assessments are recorded in other operating expenses in the accompanying statements of operations and changes in net assets.

(11) Related-Party Transactions

The Hospital and SCHS participate in joint ventures with organizations that engage in the delivery of healthcare-related services. The Hospital participates in a joint venture with Providence Health & Services – Washington (PHSW), which is an affiliate of Providence Health & Services and owns and operates Providence Regional Medical Center Everett located in Everett, Washington. SCHS and PHSW each own a 50% interest in Providence-Children's Neonatal Services, LLC (PNCS). SCHS and the University of Washington (UW) jointly control Children's University Medical Group (CUMG), which is a pediatric practice plan that employs and manages the clinical practices of its members who are medical staff at both the Hospital and faculty at the UW. SCHS has a 33% ownership interest in the Seattle Cancer Care Alliance (SCCA), a not-for-profit corporation, organized by SCHS, the UW and Fred Hutchinson Cancer Research Center to provide a comprehensive program of integrated cancer care services. The Hospital and SCHS account for their respective ownership interests in these joint ventures under the equity method of accounting.

During 2015 and 2014, the Hospital provided healthcare services, at cost, totaling \$9,262 and \$7,398 to these joint ventures, respectively. The revenues from these services were included in other operating revenues in the accompanying statements of operations and changes in net assets. The Hospital purchased healthcare services of \$94,799 and \$84,107 in 2015 and 2014, respectively. The expenses were included in purchased services in the accompanying statements of operations and changes in net assets. Earnings from these joint ventures in 2015 and 2014 of \$450 and \$346, respectively, were included in other operating revenues in the accompanying statements of operations and changes in net assets. As of September 30, 2015 and 2014, the Hospital's investment in the PCNS joint venture totaled \$5,825 and \$5,376, respectively, which was included in other assets in the accompanying balance sheets.

(12) Retirement Plan and Deferred Compensation

The Hospital offers a defined-contribution plan to substantially all of its employees. The Hospital's contribution to the plan is discretionary. For 2015 and 2014, the discretionary employer contribution based on participant's years of vested service was 4.0% for less than 5 years and 6.0% for more than 5 years. The Hospital also offers an employee contribution match of up to 25% of the first 4% of eligible compensation. Contribution expense during 2015 and 2014 totaled \$22,787 and \$20,751, respectively.

Deferred compensation arrangements are maintained by the Hospital for the benefit of eligible employees. Substantially all amounts deferred under these arrangements are held until such time as these funds become payable to the participants. Assets related to deferred compensation totaling \$2,205 and \$2,395 at September 30, 2015 and 2014, respectively, were available to general creditors of the Hospital and were included within assets whose use is limited in the accompanying balance sheets. The deferred compensation liability is included within other liabilities in the accompanying balance sheets.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

(13) Self-Insurance

The Hospital has purchased professional and general liability insurance on a claims-made basis. The Hospital is self-insured for the deductible portion of its insurance coverage and for unreported incidents and accrues an actuarial estimate for claims within its deductible portion and for unreported incidents. At September 30, 2015 and 2014, the gross liability before insurance receivable for future costs of professional and general liability claims was \$7,764 and \$9,215, respectively. At September 30, 2015 and 2014, \$6,312 and \$7,097, respectively, of this liability was included as long term within other long-term liabilities with the remainder within other payables in the accompanying balance sheets. At September 30, 2015 and 2014, the Hospital also recorded an insurance receivable of \$1,275 and \$2,142, respectively. At September 30, 2015 and 2014, \$972 and \$1,425, respectively, of this receivable was included as long term in other assets and with the remainder within other current assets in the accompanying balance sheets.

The Hospital is self-insured for workers' compensation. The Hospital also carries an excess coverage policy for its workers' compensation program. The Hospital has accrued an actuarial estimate for claims and unreported incidents. At September 30, 2015 and 2014, the workers' compensation obligation included within accrued salaries, wages, and benefits was \$2,911 and \$3,066, respectively, in the accompanying balance sheets.

The Hospital is self-insured for medical, dental, and vision insurance plans. At September 30, 2015 and 2014, the obligation for medical, dental, and vision insurance included within accrued salaries, wages, and benefits was \$3,723 and \$3,379, respectively, in the accompanying balance sheets.

(14) Commitments and Contingencies

(a) Operating Leases

The Hospital leases various equipment and facilities under operating leases expiring at various dates. Total rental expense in 2015 and 2014 was \$12,869 and \$11,200, respectively.

Operating lease commitments for future years are as follows:

2016	\$	7,997
2017		7,958
2018		7,315
2019		6,561
2020		5,542
Thereafter		21,308
	\$	<u>56,681</u>

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2015 and 2014

(In thousands of dollars)

(b) Regulatory Environment and Litigation

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Hospital, in all material respects, is in compliance with the fraud and abuse regulations, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

(c) Other Litigation

The Hospital is subject to litigation arising in the normal course of business. After consultation with legal counsel, management believes that these matters will be resolved without material adverse effect on the Hospital's future financial position or results of operations.

(15) Functional Expenses

Functional expenses were as follows for the years ended September 30:

	2015	2014
Healthcare services	\$ 867,786	804,553
Research	129,466	111,316
General and administrative	75,657	58,728
Other nonoperating expense, net	414	307
	<u>\$ 1,073,323</u>	<u>974,904</u>



SEATTLE CHILDREN'S HOSPITAL

Financial Statements

September 30, 2016 and 2015

(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Trustees
Seattle Children's Hospital:

Report on the Financial Statements

We have audited the accompanying financial statements of Seattle Children's Hospital (a Washington not-for-profit corporation and a controlled affiliate of Seattle Children's Healthcare System) (the Hospital), which comprise the balance sheets as of September 30, 2016 and 2015, and the related statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.



Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Seattle Children's Hospital as of September 30, 2016 and 2015, and the results of its operations and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Seattle, Washington
January 25, 2017

SEATTLE CHILDREN'S HOSPITAL

Balance Sheets

September 30, 2016 and 2015

(In thousands of dollars)

Assets	2016	2015
Current assets:		
Cash and cash equivalents	\$ 43,520	29,521
Accounts receivable, net of allowance for uncollectible accounts of \$1,819 in 2016 and \$1,215 in 2015	185,581	188,653
Other current assets	65,612	56,191
Current portion of assets whose use is limited	19,860	19,487
Total current assets	314,573	293,852
Assets whose use is limited:		
Investments	895,504	706,021
Pooled investments held at Seattle Children's Hospital System (SCHS)	490,145	423,445
Investments under bond indentures and other agreements, noncurrent portion	2,264	19,073
	1,387,913	1,148,539
Beneficial interest in SCHS	138,187	132,277
Land, buildings, and equipment, at cost, less accumulated depreciation of \$654,766 in 2016 and \$613,210 in 2015	1,021,051	969,912
Other assets, net	34,439	44,566
Total assets	\$ 2,896,163	2,589,146
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	\$ 8,955	8,575
Accounts payable	65,539	58,230
Accrued salaries, wages, and benefits	62,717	71,304
Due to brokers for securities purchased	48,267	—
Other payables	29,985	29,234
Interest payable	10,905	10,987
Total current liabilities	226,368	178,330
Long-term debt, net of current portion	606,917	638,375
Other long-term liabilities	40,559	37,608
Total liabilities	873,844	854,313
Net assets:		
Unrestricted	1,618,581	1,363,937
Temporarily restricted	139,915	116,088
Permanently restricted	263,823	254,808
Total net assets	2,022,319	1,734,833
Total liabilities and net assets	\$ 2,896,163	2,589,146

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL
Statements of Operations and Changes in Net Assets
Years ended September 30, 2016 and 2015
(In thousands of dollars)

	<u>2016</u>	<u>2015</u>
Operating revenues:		
Net patient service revenues (net of contractual allowances and discounts)	\$ 1,136,802	1,088,906
Provision for uncollectible accounts	<u>(2,901)</u>	<u>(2,106)</u>
Net patient service revenues	1,133,901	1,086,800
Research revenues	80,962	77,382
Other operating revenues	<u>113,978</u>	<u>96,842</u>
Total operating revenues	<u>1,328,841</u>	<u>1,261,024</u>
Operating expenses:		
Salaries, wages, and benefits	586,778	540,210
Purchased services	246,619	220,212
Supplies and other expenses	231,213	225,534
Depreciation and amortization	73,764	64,625
Interest	<u>24,854</u>	<u>22,328</u>
Total operating expenses	<u>1,163,228</u>	<u>1,072,909</u>
Operating income	<u>165,613</u>	<u>188,115</u>
Nonoperating income (expense):		
Interest and dividend income	16,492	13,583
Realized gains on trading securities, net	1,687	7,249
Unrealized gains (losses) on trading securities, net	27,496	(24,571)
Change in valuation of interest rate swap agreements	(1,823)	(3,584)
Loss on refinancing of debt	—	(31,094)
Gain on forgiveness of debt	19,740	9,790
Other nonoperating expense, net	<u>(1,461)</u>	<u>(414)</u>
Net nonoperating income (expense)	<u>62,131</u>	<u>(29,041)</u>
Excess of revenues over expenses	<u>227,744</u>	<u>159,074</u>

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL
Statements of Operations and Changes in Net Assets
Years ended September 30, 2016 and 2015
(In thousands of dollars)

	<u>2016</u>	<u>2015</u>
Excess of revenues over expenses, brought forward	\$ 227,744	159,074
Other changes in unrestricted net assets:		
Net assets released from restriction for capital and other	1,304	3,257
Other	<u>25,596</u>	<u>(222)</u>
Increase in unrestricted net assets	<u>254,644</u>	<u>162,109</u>
Changes in temporarily restricted net assets:		
Investment income, net	23,737	7,220
Restricted contributions	53,930	66,247
Net assets released from restriction for operations	(55,297)	(72,339)
Change in beneficial interest in SCHS	<u>1,457</u>	<u>(1,697)</u>
Increase (decrease) in temporarily restricted net assets	<u>23,827</u>	<u>(569)</u>
Changes in permanently restricted net assets:		
Restricted contributions	4,562	4,712
Change in beneficial interest in SCHS	<u>4,453</u>	<u>9,519</u>
Increase in permanently restricted net assets	<u>9,015</u>	<u>14,231</u>
Increase in net assets	287,486	175,771
Net assets, beginning of year	<u>1,734,833</u>	<u>1,559,062</u>
Net assets, end of year	<u>\$ 2,022,319</u>	<u>1,734,833</u>

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL
Statements of Cash Flows
Years ended September 30, 2016 and 2015
(In thousands of dollars)

	<u>2016</u>	<u>2015</u>
Cash flows from operating activities:		
Increase in net assets	\$ 287,486	175,771
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	73,764	64,625
Transfer from SCHS	(35,528)	—
Provision for uncollectible accounts	2,901	2,106
Realized gains on investments, net	(14,124)	(17,962)
Unrealized (gains) losses on investments, net	(33,755)	32,985
Restricted contributions	(4,562)	(4,712)
Equity earnings on investments in joint venture, net of cash distributions	222	(450)
Change in beneficial interest in SCHS	(5,910)	(7,822)
Change in valuation of interest rate swap agreements	1,823	3,584
Loss on refinancing of debt	—	31,094
Gain on forgiveness of debt	(19,740)	(9,790)
Changes in assets and liabilities:		
Accounts receivable, net and other assets	113	(5,133)
Payables and other liabilities	519	(2,328)
Net cash provided by operating activities	<u>253,209</u>	<u>261,968</u>
Cash flows from investing activities:		
Capital expenditures	(91,596)	(165,423)
Proceeds from sale of investments	1,551,197	2,281,880
Purchases of investments	<u>(1,694,798)</u>	<u>(2,473,158)</u>
Net cash used in investing activities	<u>(235,197)</u>	<u>(356,701)</u>
Cash flows from financing activities:		
Restricted contributions	4,562	4,712
Repayment of long-term debt	(8,575)	(8,575)
Proceeds from long-term debt	—	272,226
Advance repayment of long-term debt	—	(167,355)
Payment of deferred financing costs	<u>—</u>	<u>(2,566)</u>
Net cash (used in) provided by financing activities	<u>(4,013)</u>	<u>98,442</u>
Net increase in cash and cash equivalents	13,999	3,709
Cash and cash equivalents, beginning of year	<u>29,521</u>	<u>25,812</u>
Cash and cash equivalents, end of year	<u>\$ 43,520</u>	<u>29,521</u>
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest (net of capitalized interest)	\$ 27,266	20,031

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2016 and 2015

(In thousands of dollars)

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

Seattle Children's Hospital (the Hospital) is a not-for-profit regional pediatric medical center and research institute.

The Hospital is a member of a group of controlled corporations that have common management and representation on certain boards of governance. The membership of the Board of Trustees of the Hospital and Seattle Children's Healthcare System (SCHS) are identical.

The following are affiliates of the Hospital, each of which is a Washington not-for-profit corporation and a 501(c)(3) organization:

Seattle Children's Healthcare System (SCHS) – The parent corporation of the Hospital and affiliated-controlled corporate entities.

Seattle Children's Hospital Foundation (the Foundation) – A corporation established to support SCHS and its affiliates, primarily the Hospital, through fundraising activities.

Seattle Children's Hospital Guild Association (the Guild Association) – A corporation established to support SCHS and its affiliates, primarily the Hospital, through fundraising events and memberships.

Seattle Children's Retail (Retail) – A corporation established to support SCHS, through the operation of thrift stores.

Substantially all the net fundraising revenues and support raised by the Foundation, the Guild Association and Retail are transferred to the Hospital or to SCHS on a discretionary basis. Contributions are distributed to the Hospital and are classified to comply with the purposes specified by donors. During 2016 and 2015, the Foundation, the Guild Association, and Retail transferred contributions of \$70,386 and \$60,383 to the Hospital, respectively.

The 1915 Terry property was transferred from SCHS to SCH in 2016. This resulted in an intercompany equity transfer from SCHS to SCH of \$35,528 reflected in unrestricted net assets in the line item other.

(b) Tax Exemption

The Internal Revenue Service has granted the Hospital, and each of the affiliated corporations listed above, exemption from federal income taxes under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) of the IRC formed to operate a hospital for charitable, educational, scientific, and medical purposes. The Financial Accounting Standards Board (FASB) issued Accounting Standards Codification (ASC) Topic 740, *Income Taxes*, which prescribes a comprehensive model for how an organization should recognize, measure, present, and disclose in its financial statements uncertain tax positions that the organization has taken or expects to take on a tax return. During 2016 and 2015, the Hospital did not record any liability for unrecognized tax benefits.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2016 and 2015

(In thousands of dollars)

(c) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(d) Cash and Cash Equivalents

Cash and cash equivalents including highly liquid instruments that are readily convertible to known amounts of cash are recorded at cost, which approximates fair value. This includes money market funds and deposits held by creditworthy, high-quality financial institutions.

(e) Assets Whose Use Is Limited

Assets whose use is limited includes unrestricted assets designated by the Board of Trustees for future capital and various program purposes, over which the Board of Trustees retains control and may, at its discretion, subsequently use for other purposes. Assets whose use is limited also includes temporarily and permanently restricted assets, based on donor restriction, and assets held by trustees under bond indentures and other agreements.

Investments under bond indentures and other agreements primarily include assets held by trustees under the terms of the Revenue Bonds and certain deferred compensation arrangements. Amounts required to meet current liabilities of the Hospital have been classified as current assets in the accompanying balance sheets at September 30, 2016 and 2015.

The Hospital classifies its investment portfolio as a trading portfolio, and as such, all unrestricted net unrealized gains or losses are recorded in nonoperating income in the accompanying statements of operations and changes in net assets in the period in which they occur.

Investment income (which includes interest and dividends and realized and unrealized gains and losses) is included in nonoperating income in the accompanying statements of operations and changes in net assets, unless the income or gain (loss) is restricted by donor. Restricted investment income is included in the increase (decrease) in temporarily restricted net assets in the accompanying statements of operations and changes in net assets.

Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risks associated with certain investment securities, it is reasonably possible that changes in the value of investments could occur in the near term and that such changes could materially affect the amounts reported in the accompanying balance sheets.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2016 and 2015

(In thousands of dollars)

Pooled Investments Held at SCHS

Pooled investments held at SCHS represent the Hospital's interest in a pool of investments held and managed by SCHS, which are recorded at fair value. Investment income, net and unrealized gains or losses from the SCHS investment pool were allocated between SCHS and the Hospital based upon respective investment balances. The Hospital recognizes the changes in its interest in the SCHS investment pool using a method that approximates the equity method of accounting.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, less accumulated depreciation. Maintenance and repairs are expensed as incurred. Interest costs incurred during the time required to get the asset ready for its intended use, are capitalized. The Hospital capitalized \$2,412 and \$2,924 of interest cost in 2016 and 2015, respectively. Depreciation is computed using the straight-line method, which allocates the cost of the asset ratably over its estimated useful life. An estimated life of up to 40 years is used for buildings and 8 to 15 years for building and land improvements. Various lives ranging from three to 20 years are used for furniture and equipment. Leasehold improvements are depreciated over the shorter of the remaining life of the lease or the useful life of the asset.

(g) Other Current Assets

Other current assets primarily include prepaid expenses, nonpatient accounts receivable, safety net assessment receivable, and inventory. Inventories are stated at the lower of cost or market method. At September 30, 2016 and 2015, SCH had \$12,551 and \$10,503, respectively, in inventory.

(h) Joint Ventures and Investments in Affiliated Companies

The equity method of accounting is used for joint ventures and investments in affiliated companies in which the Hospital has significant influence, but does not have control. Significant influence is deemed to exist when the ownership interest in the investee is at least 20% and not more than 50% of net assets, although other factors may be considered in determining whether the equity method of accounting is appropriate.

(i) Deferred Financing Costs

Deferred financing costs are included in other assets in the accompanying balance sheets and are amortized using the effective-interest method over the term of the related outstanding obligation.

(j) Net Assets and Endowments

Contributions are reported at fair value at the date of donation. Such amounts are reported as unrestricted, temporarily restricted, or permanently restricted net assets, based on donor stipulations (if any) that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the accompanying statements of operations and changes in net assets as other operating revenues and net assets released from restriction.

SEATTLE CHILDREN'S HOSPITAL

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Endowment fund balances, including funds functioning as endowments, are classified and reported as permanently restricted, temporarily restricted, or unrestricted net assets in accordance with Board or donor specifications. Funds functioning as endowments include Board-designated named endowments and other Board-designated funds. See note 7 for additional information on endowments.

(k) Net Patient Service Revenues and Patient Accounts Receivable

Net patient service revenues are reported at the estimated net realizable amounts from patients and third-party payers. Retroactive adjustments, under reimbursement agreements with third-party payers, are estimated and accrued in the period in which the related services are rendered, and adjusted in future periods as final settlements are determined.

Patient accounts receivable are recorded on an accrual basis at established billing rates. The allowances for contractual allowances and discounts and uncollectible accounts are recorded on an accrual basis, using established billing and contracted rates and historical experience. In evaluating the collectibility of patient accounts receivable, the Hospital estimates the allowance for uncollectible accounts by major payer type based on historical experience for each payer type. Primary collection risks relate to uninsured patients and the portion of the bill, which is the patient's responsibility, primarily copayments and deductibles. For uninsured patients who do not qualify for the Hospital's charity care, the Hospital provides a discount from its standard rates. Management regularly reviews data about the major payer sources of revenues in evaluating the sufficiency of the allowance for contractual allowances and discounts and uncollectible accounts.

(l) Other Operating Revenues

Other operating revenues primarily include revenues from a federal graduate medical education grant, Hospital's equity earnings from its participation in a joint venture, rental income, and amounts received from Children's University Medical Group (CUMG), other contracted services, and net assets released from restriction for operations.

(m) Excess of Revenues over Expenses

The accompanying statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over expenses, primarily include the transfer of the 1915 Terry property, and net assets released from restriction for capital.

(n) Reclassifications

Prior period financial statement amounts have been reclassified to conform to current period presentation.

(o) Subsequent Events

The Hospital has performed an evaluation of subsequent events through January 25, 2017, which is the date these financial statements were issued.

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(p) New Accounting Pronouncements

In May 2014, the FASB issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. ASU 2014-09 was originally effective for annual reporting periods beginning after December 15, 2016, including interim periods within that reporting period, but has now been delayed one year by ASU 2015-14. The Hospital is evaluating this guidance and the impact that the adoption of this update will have on its financial statements and related disclosures.

In March 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. This update changes the presentation of debt issuance costs in the financial statements. Under the ASU, an entity presents such costs in the balance sheet as a direct deduction from the recognized liability rather than as an asset. Amortization of the costs is reported as interest expense. The ASU is effective for fiscal years beginning after December 15, 2015. Debt issuance costs as of September 30, 2016 were \$4,350, which would be reclassified from an asset to a contra-debt liability in the accompanying balance sheets.

In May 2015, the FASB issued ASU 2015-07, Fair Value Measurement (Topic 820), *Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, which eliminates the requirement to categorize investments in the fair value hierarchy if their fair value is measured at net asset value (NAV) per share (or its equivalent) using the practical expedient in the FASB's fair value measurement guidance. The guidance is effective for annual fiscal periods beginning after December 15, 2016; however, early adoption is permitted. The Hospital is evaluating this guidance and the impact that the adoption of this update will have on its financial statements and related disclosures.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right to use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale leaseback transactions. The guidance is effective for fiscal years beginning after December 15, 2019. The Hospital is evaluating this guidance and the impact that the adoption of this update will have on its financial statements and related disclosures.

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In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, to reduce diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit financial statements. This ASU contains the following key aspects: (A) Reduces the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions; (B) Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements; (C) Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) Retains the option to present operating cash flows in the statement of cash flows using either the direct or indirect method. The Hospital is currently evaluating the impact of ASU 2016-14, including the methods of implementation, which is effective for the fiscal year beginning October 1, 2018.

(2) Uncompensated and Undercompensated Care

The Hospital is committed to caring for children in its service area irrespective of ability to pay. The estimated costs of that care were as follows for the years ended September 30:

	2016	2015
Medicaid payment shortfall	\$ 116,471	102,224
Charity care	10,212	9,594
Total uncompensated and undercompensated care	\$ 126,683	111,818

Medicaid payment shortfall represents the estimated cost of providing services to patients covered under Medicaid in excess of payments received. The estimated cost of services provided to Medicaid patients is estimated based on the ratio of Hospital total patient care costs to Hospital total patient care charges applied to charges related to services provided to Medicaid patients.

Charity care represents the estimated cost of care provided to children who are uninsured or underinsured and whose families cannot afford to pay for their medical care. The Hospital provides charity care in accordance with its charity care policy based on family need and maintains records to identify the level of charity it provides. The determination of family need is evaluated during a patient's course of care and can be updated after care is complete. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The estimated cost of charity care provided is estimated based on the ratio of Hospital total patient care costs to Hospital total patient care charges applied to gross charges related to charity care services.

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(3) Assets Whose Use Is Limited

As of September 30, the fair value of assets whose use is limited was as follows:

	2016	2015
Board-designated investments	\$ 527,363	363,214
Pooled investments held at SCHS	490,145	423,445
Board-designated endowments	194,915	179,657
Donor-restricted endowments	173,226	163,150
Investments held under bond indentures and other	22,124	38,560
	<u>\$ 1,407,773</u>	<u>1,168,026</u>

(4) Investments, Fair Value Measurements, and the Fair Value Option

In determining the fair value of investments, the Hospital utilizes valuation techniques to maximize the use of observable market data and minimize the use of unobservable inputs. Inputs refer broadly to the assumptions that market participants would use in pricing the asset or liability, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset or liability developed based upon market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the Hospital's own assumptions about the assumptions market participants would use in pricing the asset or liability developed based on the best information available.

Assets and liabilities that are recorded at fair value are grouped into three levels, based on the markets in which assets and liabilities are traded and the observability of the inputs used to determine fair value. The three levels are:

Level 1 – Quoted prices in active markets for identical assets or liabilities. An active market for the asset or liability is a market in which transactions for the asset or liability occur with sufficient frequency and volume to provide pricing information on an ongoing basis.

Level 2 – Pricing inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly, and the fair value is determined through the use of models or other valuation methodologies.

Level 3 – Significant unobservable inputs, including assets and liabilities that are traded infrequently.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The fair value hierarchy does not necessarily correspond to a financial instrument's relative liquidity in the market or to its level of risk.

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The Hospital accounts for its investments on a trade-date basis. Investment sales and purchases initiated prior to the balance sheet date and settled subsequent to the balance sheet date result in amounts due from and to brokers. Changes in these assets and liabilities represent noncash investing activities excluded from the statements of cash flows. The cost of investments sold is determined in accordance with the specific identification method, and realized gains and losses are included in investment income in the accompanying statements of operations and changes in net assets. As of September 30, 2016, the Hospital recorded a \$48,267 payable for investments purchased but not settled as due to brokers for securities purchased in the accompanying balance sheets.

The following tables present assets and liabilities that were measured at fair value on a recurring basis (including items that were required to be measured at fair value and items for which the fair value option was elected) at September 30:

		Fair value measurements at reporting date using		
	2016	Level 1	Level 2	Level 3
Assets:				
Investments:				
Money market and other	\$ 120,430	95,704	24,726	—
Commercial paper	39,036	—	39,036	—
U.S. equity securities	4,822	4,822	—	—
U.S. corporate fixed-income securities	307,980	—	307,476	504
Foreign corporate fixed-income securities	155,650	—	155,650	—
Notes issued by the				
U.S. government and				
U.S. government agencies	54,444	47,443	7,001	—
U.S. municipal securities	2,341	—	2,341	—
Mutual funds:				
Global (U.S. and Foreign) equity funds	552	552	—	—
U.S. corporate fixed income funds	210,249	210,249	—	—
Pooled investments	490,145	—	—	490,145
Trustee-held funds	19,860	19,860	—	—
Deferred compensation:				
Mutual funds	2,264	2,264	—	—
Total assets	\$ 1,407,773	380,894	536,230	490,649
Liabilities:				
Interest rate swap agreements	\$ 26,041	—	26,041	—
Total liabilities	\$ 26,041	—	26,041	—

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2016 and 2015

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	2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Assets:				
Investments:				
Money market and other	\$ 81,413	65,185	16,228	—
Commercial paper	77,183	—	77,183	—
U.S. equity securities	4,990	4,990	—	—
U.S. corporate fixed-income securities	262,158	—	262,158	—
Foreign corporate fixed-income securities	38,056	—	38,056	—
Notes issued by the U.S. government and U.S. government agencies	30,501	—	30,501	—
U.S. municipal securities	4,150	—	4,150	—
Mutual funds:				
Global (U.S. and Foreign) equity funds	507	507	—	—
U.S. corporate fixed income funds	207,063	207,063	—	—
Pooled investments	423,445	—	—	423,445
Trustee-held funds	36,355	36,355	—	—
Deferred compensation:				
Mutual funds	2,205	2,205	—	—
Total assets	\$ 1,168,026	316,305	428,276	423,445
Liabilities:				
Interest rate swap agreements	\$ 24,217	—	24,217	—
Total liabilities	\$ 24,217	—	24,217	—

There were no transfers between Level 1 and Level 2 during 2016.

Pooled investments held at SCHS are recorded at the Hospital's share of the fair value of the SCHS investment pool. The SCHS investment pool was invested as follows at September 30 (in percentages):

	2016	2015
Mutual funds:		
Global (U.S. and Foreign) equity	20%	18%
U.S. corporate fixed income	9	9
Alternative investments	71	73
	100%	100%

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Alternative investments included within pooled investments held at SCHS, include limited partnerships, limited liability corporations, investment trusts, institutional funds, and offshore investment funds. Included in these funds are certain types of financial instruments, including, among others, futures and forward contracts, options, swaps, and securities sold not yet purchased, intended to hedge against changes in the fair value of investments. These financial instruments involve varying degrees of risk. Because alternative investments are not readily marketable, their estimated value is subject to uncertainty and, therefore, may differ from the value that would have been used had a ready market for such investments existed. Such differences could be material. As of September 30, 2016 and 2015, 39% and 45%, respectively, of the alternative investments within the SCHS investment pool were classified as Level 3 securities and subject to liquidity limitations.

The following table presents the Hospital's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the years ended September 30, 2016 and 2015:

	Pooled investments	Other	Total 2016
Beginning balance at September 30, 2015	\$ 423,445	—	423,445
Investment income and unrealized gain, net	38,954	4	38,958
Additions	32,000	—	32,000
Purchases	—	500	500
Other changes	(4,254)	—	(4,254)
Ending balance at September 30, 2016	\$ 490,145	504	490,649
	Pooled investments	Other	Total 2016
Beginning balance at September 30, 2014	\$ 338,153	—	338,153
Investment income and unrealized losses, net	(7,086)	—	(7,086)
Additions	89,142	—	89,142
Other changes	3,236	—	3,236
Ending balance at September 30, 2015	\$ 423,445	—	423,445

Net unrealized gains (losses) included in income, in the table above, relating to assets held at September 30, 2016 were \$15,498 and \$4 for pooled investment and other, respectively.

The carrying amounts reported on the accompanying balance sheets for cash and cash equivalents, patient accounts receivable, other current assets, accounts payable, and accrued expenses approximate the fair value because of their short-term nature.

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The fair value of long-term debt, estimated based on the quoted market prices for similar issues, considered a Level 2 measurement, was \$646,000 and \$657,003 at September 30, 2016 and 2015, respectively.

(5) Beneficial Interest in Seattle Children's Healthcare System

The Hospital recognizes an interest in a portion of the net assets of SCHS representing certain temporarily and permanently restricted funds that will ultimately benefit the Hospital. At September 30, 2016 and 2015, the Hospital recorded a beneficial interest in SCHS of \$138,187 and \$132,277, respectively, which corresponds to temporarily and permanently restricted net assets held by SCHS on the Hospital's behalf. The Hospital recognizes changes in this beneficial interest as a change in temporarily and permanently restricted net assets.

(6) Land, Buildings, and Equipment

Land, buildings, and equipment consist of the following at September 30:

	2016	2015
Land and improvements	\$ 218,239	182,696
Buildings and improvements	902,218	887,184
Furniture and equipment	472,190	471,464
Construction in progress	83,170	41,778
	1,675,817	1,583,122
Less accumulated depreciation	(654,766)	(613,210)
	\$ 1,021,051	969,912

Construction in progress primarily relates to certain facility renovations and information technology projects. The Hospital has commitments for future construction and development totaling \$43,650 as of September 30, 2016.

(7) Endowment Funds and Temporarily and Permanently Restricted Net Assets

The endowment funds consist of numerous individual funds established for a variety of purposes. They include donor-restricted endowments and funds functioning as endowments, which include board-designated named endowments and other board-designated endowments. Net assets associated with these funds are classified and reported based on the existence or absence of donor-imposed restrictions.

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The Hospital has interpreted the Washington State Uniform Prudent Management of Institutional Funds Act (WA-UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment; (b) the original value of subsequent gifts donated to the permanent endowment; and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund.

The remaining portion of the donor-restricted endowment funds that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standards of prudence prescribed by WA-UPMIFA.

In making a determination to appropriate or accumulate donor-restricted endowment funds, the Hospital considers (a) the duration and preservation of the fund; (b) the purposes of SCHS and the donor-restricted endowment; (c) general economic conditions; (d) the appreciation of endowment investments; (e) other resources of the Hospital; and (f) the investment policy of the Hospital. From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or WA-UPMIFA requires the Hospital to retain as a fund of perpetual duration. Deficiencies of this nature are reflected as a reduction in unrestricted net assets.

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation intended to achieve its long term return objectives within prudent risk constraints.

The Hospital has a spending policy of appropriating 5% of its endowment funds' 12-quarter average market value of donor-restricted and board-designated named endowments. In establishing this policy, the Hospital considered the long-term expected return on its endowment funds.

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The endowment net assets composition by type as of September 30, 2016 and 2015 were as follows:

	<u>Unrestricted</u>	<u>Temporarily restricted</u>	<u>Permanently restricted</u>	<u>Total</u>
September 30, 2016:				
Donor-restricted	\$ (353)	33,985	139,594	173,226
Board-designated:				
Named endowment funds	9,196	—	—	9,196
Other endowment funds	185,719	—	—	185,719
Total funds	<u>\$ 194,562</u>	<u>33,985</u>	<u>139,594</u>	<u>368,141</u>
September 30, 2015:				
Donor-restricted	\$ (503)	28,633	135,020	163,150
Board-designated:				
Named endowment funds	8,894	—	—	8,894
Other endowment funds	170,763	—	—	170,763
Total funds	<u>\$ 179,154</u>	<u>28,633</u>	<u>135,020</u>	<u>342,807</u>

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The changes in endowment net assets for 2016 and 2015 were as follows:

	September 30, 2016			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2015	\$ 179,154	28,633	135,020	342,807
Investment return:				
Net interest and dividends	2,256	2,169	—	4,425
Net appreciation (realized and unrealized)	13,778	11,272	—	25,050
Total investment return	16,034	13,441	—	29,475
Contributions	—	—	4,574	4,574
Appropriation of endowment assets for expenditure:				
Donor-restricted	(163)	(8,089)	—	(8,252)
Board-designated named	(463)	—	—	(463)
Total appropriations	(626)	(8,089)	—	(8,715)
Endowment net assets, September 30, 2016	\$ <u>194,562</u>	<u>33,985</u>	<u>139,594</u>	<u>368,141</u>

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(In thousands of dollars)

	September 30, 2015			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2014	\$ 176,546	37,646	129,789	343,981
Investment return:				
Net interest and dividends	2,174	2,181	—	4,355
Net depreciation (realized and unrealized)	(4,113)	(3,399)	—	(7,512)
Total investment return	(1,939)	(1,218)	—	(3,157)
Contributions	5,025	—	5,231	10,256
Appropriation of endowment assets for expenditure:				
Donor-restricted	(136)	(7,795)	—	(7,931)
Board-designated named	(342)	—	—	(342)
Total appropriations	(478)	(7,795)	—	(8,273)
Endowment net assets, September 30, 2015	\$ 179,154	28,633	135,020	342,807

Temporarily restricted net assets were available for the following purposes at September 30:

	2016	2015
Healthcare services:		
Purpose restrictions	\$ 38,647	36,503
Unappropriated endowment earnings	33,984	28,633
Research	65,948	50,675
Capital projects	1,336	277
	\$ 139,915	116,088

Permanently restricted net assets were restricted to investments in perpetuity, the income from which is expendable to support the following at September 30:

	2016	2015
Healthcare services	\$ 124,034	119,582
Research	139,789	135,226
	\$ 263,823	254,808

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September 30, 2016 and 2015

(In thousands of dollars)

(8) Long-Term Debt

Long-term debt obligation consisted of the following at September 30:

	Maturing through	Interest rates	Unpaid principal	
			2016	2015
Revenue Bonds				
Fixed:				
Series 2009	2020	4.00% – 5.00%	\$ 4,025	4,940
Series 2010A	2041	5%	75,000	75,001
Series 2010B	2023	5%	26,305	29,380
Series 2012A	2043	5%	46,335	46,335
Series 2012B	2035	4.00% – 5.00%	27,935	27,975
Series 2015A	2046	4.00% – 5.00%	100,000	100,000
Series 2015B	2039	3.00% – 5.00%	167,350	167,350
Total fixed			446,950	450,981
Variable:				
Series 2012C	2029	1.07% – 1.31%	62,045	63,645
Series 2012D	2032	0.73% – 0.96%	64,960	67,905
Total variable			127,005	131,550
Notes payable	2038	1.50%	—	19,957
Unpaid principal, long-term debt			573,955	602,488
Unamortized premiums and discounts, net			41,917	44,462
Long-term debt, including premiums and discounts			615,872	646,950
Less current portion			8,955	8,575
Long-term debt, net of current portion			\$ 606,917	638,375

The Revenue Bonds are collateralized by a pledge of gross revenues and secured by interests in certain bond funds.

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Scheduled principal repayments as of September 30, 2016 on the long-term debt are due as follows:

2017	\$	8,955
2018		9,345
2019		9,740
2020		10,160
2021		10,585
Thereafter		<u>525,170</u>
		573,955
Add unamortized net premiums and discounts		<u>41,917</u>
	\$	<u><u>615,872</u></u>

In 2015, the Hospital issued \$100,000 of Series 2015A Bonds and \$167,350 of Series 2015B Bonds. The Series 2015A Bonds were issued to fund or reimburse portions of future capital projects as part of the Hospital's multi-phased capital plan. The Series 2015B Bonds provided funds necessary to advance refund and defease a portion of the Series 2009 Bonds and all of the Series 2008C Bonds. The 2015B advance refunding generated a \$31,094 noncash loss on refinancing in 2015 that was recorded in nonoperating income in the accompanying statements of operations and changes in net assets.

In 2008, SCHS entered into a New Markets Tax Credit financing to develop and construct a portion of the Hospital's research facility. The compliance period of the transaction was for seven year periods that ended in 2015 and 2016. As a result of the completion of the compliance periods, the Hospital recorded \$19,740 and \$9,790 as noncash gains on forgiveness of debt in 2016 and 2015, respectively, in nonoperating income (expense) in the accompanying statements of operations and changes in net assets.

The members of the Obligated Group established under the Master Indenture include the Hospital and SCHS. As of September 30, 2016, total assets, total liabilities, and total unrestricted net assets of the Obligated Group constituted approximately 99%, 99%, and 100%, respectively, of the respective SCHS's consolidated totals. For 2016, the total operating revenues, operating income, and excess of revenues over expenses, from all sources attributable to the Obligated Group were 99%, 100%, and 98%, respectively, of the respective SCHS's consolidated totals.

Under the terms of the Revenue Bonds and related indenture agreements, the Obligated Group is required to comply with various covenants, including income available for debt service.

Accounting for Derivative Instruments

Interest rate swap contracts are used to manage the net exposure to interest rate changes in attempting to reduce the overall cost of borrowing over time. Interest rate swap contracts generally involve the exchange of fixed and floating interest rate payments without the exchange of underlying principal (the swap of fixed or floating rates are on a notional amount). The Hospital records derivative instruments on the accompanying balance sheet as an asset or liability measured at its individual fair market value. Changes in the derivative instrument's fair market value are recognized in earnings unless certain specific

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hedge accounting criteria are met. The Hospital has not designated its interest rate swap agreements as cash flow hedges, and therefore, this specific criteria has not been met. As such, all changes in the valuation of the interest rate swaps are recognized in other nonoperating expenses, net, in the accompanying statements of operations and changes in net assets.

The Hospital entered into two interest rate swap agreements (Swap Agreements) with two separate counterparties. Under each Swap Agreement, the Hospital is obligated to pay a fixed rate per annum (3.48% on the Series 2012C Bonds and 3.69% on the Series 2012D Bonds) on a notional amount equal to the outstanding principal amount of the applicable series of bonds and receives a variable payment computed as 68% of the one-month LIBOR. The bonds' variable-rate coupons are based upon rates calculated as a percentage of one-month LIBOR plus a credit spread as defined in the respective financing agreements.

The fair value of interest rate swap contracts was recorded in other long-term liabilities on the accompanying balance sheet. Interest rate swaps not designated as hedges were \$26,040 and \$24,217 as of September 30, 2016 and 2015, respectively. The Hospital has incorporated its own nonperformance risk and the respective counterparty's nonperformance risk in the fair value measurements.

The two Credit Support Annexes for the interest rate swaps require either party to post collateral if the fair market value of the swap is negative to them and exceeds the minimum threshold as defined in each respective Credit Support Annex. The amount of collateral required to be posted is equal to the difference of the fair market value over the minimum threshold. As of September 30, 2016, the Hospital was not required to post collateral for either Swap Agreement.

(9) Net Patient Service Revenues and Concentrations of Credit Risks

A significant portion of the Hospital's patient service revenues is derived from Washington State's Medicaid program, including Medicaid managed care (Medicaid). Payments from Medicaid for services rendered to inpatients are based upon prospective diagnosis related groups and other payment programs, while Medicaid outpatient payments are based upon prospective enhanced ambulatory payment groups and other payment programs. Commercial insurer payments are based upon terms of contractual agreements.

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The following table summarizes gross patient revenue by payer for the years ended September 30:

	2016	2015
Commercial Insurers:		
Premera Blue Cross	13%	12%
Regence Blue Shield	12	13
Other	22	22
Medicaid managed care organizations:		
Community Health Plan of Washington	7	7
Molina Healthcare	16	15
Other	11	12
Medicaid	13	13
Other	6	6
	100%	100%

The concentrations of credit risk by payer as measured by patient accounts receivable were as follows at September 30:

	2016	2015
Commercial Insurers:		
Premera Blue Cross	9%	10%
Regence Blue Shield	11	11
Other	26	25
Medicaid managed care organizations	29	31
Medicaid	16	14
Other	9	9
	100%	100%

(10) Hospital Safety Net Assessment

In 2013, the state of Washington enacted legislation that provides for supplemental Medicaid payments to certain hospitals funded by assessments paid by these hospitals as well as matching federal funds (the safety net program). The supplemental payments include fee-for-service payments received directly from Washington State as well as payments processed through managed care organizations. Each of the fee-for-service and managed care segments required separate Centers for Medicare and Medicaid Services (CMS) approval. Supplemental payments received and assessments paid were recognized upon approval of each program segment by CMS.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2016 and 2015

(In thousands of dollars)

The following revenue and expense are recognized in the accompanying statements of operations and changes in net assets for the years ended September 30:

	Revenues		Expenses	
	2016	2015	2016	2015
Fee-for-service segment of the program \$	17,001	16,430	6,580	6,215
Managed care segment of the program	24,784	48,345	12,189	22,150
Total	\$ 41,785	64,775	18,769	28,365

The \$48,345 recorded as revenues for the managed care segment in 2015 included \$23,364 in payments approved by CMS in 2015 that related to 2014. The \$22,150 recorded as expense in 2015 included \$12,124 in assessments of related to 2014. All amounts recorded in 2016 relate to current year supplemental payments and assessments. Supplemental payments are recorded in net patient service revenues and assessments are recorded in supplies and other expenses in the accompanying statements of operations and changes in net assets.

(11) Related-Party Transactions

The Hospital and SCHS participate in joint ventures with organizations that engage in the delivery of healthcare-related services. The Hospital participates in a joint venture with Providence Health & Services – Washington (PHSW), which is an affiliate of Providence Health & Services and owns and operates Providence Regional Medical Center Everett located in Everett, Washington. SCHS and PHSW each own a 50% interest in Providence-Children's Neonatal Services, LLC (PCNS). SCHS and the University of Washington (UW) jointly control CUMG, which is a pediatric practice plan that employs and manages the clinical practices of its members who are medical staff at both the Hospital and faculty at the UW. SCHS has a 33% ownership interest in the Seattle Cancer Care Alliance (SCCA), a not-for-profit corporation, organized by SCHS, the UW, and Fred Hutchinson Cancer Research Center to provide a comprehensive program of integrated cancer care services. The Hospital and SCHS account for their respective ownership interests in these joint ventures under the equity method of accounting.

During 2016 and 2015, healthcare services provided by the Hospital to these joint ventures totaled \$9,608 and \$9,262, respectively. The revenues from these services were included in other operating revenues in the accompanying statements of operations and changes in net assets. The Hospital purchased healthcare services of \$104,012 and \$94,799 in 2016 and 2015, respectively. The expenses were included in purchased services in the accompanying statements of operations and changes in net assets. As of September 30, 2016 and 2015, the Hospital's investment in the PCNS joint venture totaled \$5,825, and is included in other assets in the accompanying balance sheets.

(12) Retirement Plan and Deferred Compensation

The Hospital provides a defined-contribution plan to substantially all of its employees. The Hospital's contribution to the plan is discretionary. For 2016 and 2015, the discretionary Hospital contribution based on participants' years of vested service was 4.0% of eligible compensation for less than five years and 6.0% of eligible compensation for more than five years. The Hospital also offers a match of up to 25% of

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2016 and 2015

(In thousands of dollars)

the first 4% of eligible employee compensation. Retirement plan contribution expense during 2016 and 2015 totaled \$24,512 and \$22,787, respectively.

Deferred compensation arrangements are maintained by the Hospital for the benefit of eligible employees. Substantially all amounts deferred under these arrangements are held until the funds become payable to the participants. Assets related to deferred compensation totaled \$2,264 and \$2,205 at September 30, 2016 and 2015, respectively, and were included in assets whose use is limited in the accompanying balance sheets. The deferred compensation liability is included in other liabilities in the accompanying balance sheets.

(13) Self-Insurance

The Hospital has purchased professional and general liability insurance on a claims-made basis. The Hospital is self-insured for the deductible portion of its insurance coverage and for unreported incidents and accrues an actuarial estimate for claims within its deductible portion and for unreported incidents. At September 30, 2016 and 2015, the gross liability before insurance receivable for future costs of professional and general liability claims was \$9,196 and \$7,764, respectively. At September 30, 2016 and 2015, \$7,321 and \$6,312, respectively, of this liability was included as long term within other long-term liabilities with the remainder within other payables in the accompanying balance sheets.

(14) Commitments and Contingencies

(a) Operating Leases

The Hospital leases various equipment and facilities under operating leases expiring at various dates. Total rental expense in 2016 and 2015 was \$12,752 and \$12,869, respectively.

Operating lease commitments for future years are as follows:

2017	\$	8,667
2018		7,819
2019		6,756
2020		5,526
2021		5,198
Thereafter		15,992
	\$	<u>49,958</u>

(b) Labor Organizations

Approximately 27% of the Hospital's employees are represented by labor organizations. None of the labor agreements expire within one year.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2016 and 2015

(In thousands of dollars)

(c) Regulatory Environment and Litigation

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Hospital, in all material respects, is in compliance with the fraud and abuse regulations, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. The Hospital is subject to litigation arising in the normal course of business. After consultation with legal counsel, management believes that these matters will be resolved without material adverse effect on the Hospital's future financial position or results of operations.

(15) Functional Expenses

Functional expenses were as follows for the years ended September 30:

	2016	2015
Healthcare services	\$ 934,606	867,786
Research	145,099	129,466
General, administrative, and other, net	84,984	76,071
	<u>\$ 1,164,689</u>	<u>1,073,323</u>



SEATTLE CHILDREN'S HOSPITAL

Financial Statements

September 30, 2017 and 2016

(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Trustees
Seattle Children's Hospital:

We have audited the accompanying financial statements of Seattle Children's Hospital (a Washington nonprofit corporation and a controlled affiliate of Seattle Children's Healthcare System) (the Hospital), which comprise the balance sheets as of September 30, 2017 and 2016, and the related statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Seattle Children's Hospital as of September 30, 2017 and 2016, and the results of its operations and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Seattle, Washington
December 21, 2017

SEATTLE CHILDREN'S HOSPITAL

Balance Sheets

September 30, 2017 and 2016

(In thousands of dollars)

Assets	2017	2016
Current assets:		
Cash and cash equivalents	\$ 60,168	43,520
Accounts receivable, net of allowance for uncollectible accounts of \$1,606 in 2017 and \$1,819 in 2016	226,611	185,581
Other current assets	111,397	65,612
Current portion of assets whose use is limited	22,796	19,860
Total current assets	420,972	314,573
Assets whose use is limited:		
Investments	914,762	895,504
Pooled investments held at Seattle Children's Healthcare System (SCHS)	576,020	490,145
Investments under bond indentures and other agreements, noncurrent portion	69,701	2,264
	1,560,483	1,387,913
Beneficial interest in SCHS	150,859	138,187
Land, buildings, and equipment, at cost, net	1,103,367	1,021,051
Other assets, net	23,521	30,088
Total assets	\$ 3,259,202	2,891,812
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	\$ 9,345	8,955
Interest payable	13,518	10,905
Accounts payable	67,004	65,539
Accrued salaries, wages, and benefits	75,725	62,717
Due to brokers for securities purchased	48,084	48,267
Other payables	37,897	29,985
Total current liabilities	251,573	226,368
Long-term debt, net of current portion	715,789	602,566
Other long-term liabilities	32,477	40,559
Total liabilities	999,839	869,493
Net assets:		
Unrestricted	1,803,308	1,618,581
Temporarily restricted	182,177	139,915
Permanently restricted	273,878	263,823
Total net assets	2,259,363	2,022,319
Total liabilities and net assets	\$ 3,259,202	2,891,812

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL
Statements of Operations and Changes in Net Assets
Years ended September 30, 2017 and 2016
(In thousands of dollars)

	<u>2017</u>	<u>2016</u>
Operating revenues:		
Net patient service revenues (net of contractual allowances and discounts)	\$ 1,184,425	1,136,802
Provision for uncollectible accounts	<u>(1,168)</u>	<u>(2,901)</u>
Net patient service revenues	1,183,257	1,133,901
Research revenues	92,251	80,962
Other operating revenues	<u>118,900</u>	<u>113,978</u>
Total operating revenues	<u>1,394,408</u>	<u>1,328,841</u>
Operating expenses:		
Salaries, wages, and benefits	651,797	586,778
Purchased services	281,578	246,619
Supplies and other expenses	259,525	231,213
Depreciation	80,068	73,439
Interest and amortization	<u>25,062</u>	<u>25,179</u>
Total operating expenses	<u>1,298,030</u>	<u>1,163,228</u>
Operating income	<u>96,378</u>	<u>165,613</u>
Nonoperating income (expense):		
Interest and dividend income	26,188	16,492
Realized gains on trading securities, net	13,231	1,687
Unrealized gains on trading securities, net	37,016	27,496
Change in valuation of interest rate swap agreements	8,252	(1,823)
Gain on forgiveness of debt	—	19,740
Other nonoperating expense, net	<u>(499)</u>	<u>(1,461)</u>
Net nonoperating income	<u>84,188</u>	<u>62,131</u>
Excess of revenues over expenses	<u>\$ 180,566</u>	<u>227,744</u>

SEATTLE CHILDREN'S HOSPITAL

Statements of Operations and Changes in Net Assets (continued)

Years ended September 30, 2017 and 2016

(In thousands of dollars)

	2017	2016
Excess of revenues over expenses, brought forward	\$ 180,566	227,744
Other changes in unrestricted net assets:		
Net assets released from restriction for capital and other	3,865	1,304
Other	296	25,596
Increase in unrestricted net assets	<u>184,727</u>	<u>254,644</u>
Changes in temporarily restricted net assets:		
Investment return, net	32,242	23,737
Restricted contributions	67,575	53,930
Net assets released from restriction	(61,607)	(55,297)
Change in beneficial interest in SCHS	4,052	1,457
Increase in temporarily restricted net assets	<u>42,262</u>	<u>23,827</u>
Changes in permanently restricted net assets:		
Restricted contributions	1,435	4,562
Change in beneficial interest in SCHS	8,620	4,453
Increase in permanently restricted net assets	<u>10,055</u>	<u>9,015</u>
Increase in net assets	<u>237,044</u>	<u>287,486</u>
Net assets, beginning of year	<u>2,022,319</u>	<u>1,734,833</u>
Net assets, end of year	\$ <u><u>2,259,363</u></u>	<u><u>2,022,319</u></u>

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL

Statements of Cash Flows

Years ended September 30, 2017 and 2016

(In thousands of dollars)

	<u>2017</u>	<u>2016</u>
Cash flows from operating activities:		
Increase in net assets	\$ 237,044	287,486
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation	80,068	73,439
Transfer from SCHS	—	(35,528)
Provision for uncollectible accounts	1,168	2,901
Realized gains on investments, net	(26,234)	(14,124)
Unrealized gains on investments, net	(51,436)	(33,755)
Restricted contributions	(1,435)	(4,562)
Equity earnings on investments in joint venture, net of cash distributions	—	222
Change in beneficial interest in SCHS	(12,672)	(5,910)
Change in valuation of interest rate swap agreements	(8,252)	1,823
Gain on forgiveness of debt	—	(19,740)
Changes in assets and liabilities:		
Accounts receivable and other assets	(52,638)	113
Payables and other liabilities	15,943	844
Net cash provided by operating activities	<u>181,556</u>	<u>253,209</u>
Cash flows from investing activities:		
Capital expenditures	(155,541)	(91,596)
Proceeds from sale of investments	1,562,110	1,551,197
Purchases of investments	<u>(1,688,907)</u>	<u>(1,694,798)</u>
Net cash used in investing activities	<u>(282,338)</u>	<u>(235,197)</u>
Cash flows from financing activities:		
Restricted contributions	1,435	4,562
Repayment of long-term debt	(8,955)	(8,575)
Proceeds from long-term debt	126,646	—
Payment of deferred financing costs	<u>(1,696)</u>	<u>—</u>
Net cash provided by (used in) financing activities	<u>117,430</u>	<u>(4,013)</u>
Net increase in cash and cash equivalents	16,648	13,999
Cash and cash equivalents, beginning of year	<u>43,520</u>	<u>29,521</u>
Cash and cash equivalents, end of year	\$ <u><u>60,168</u></u>	<u><u>43,520</u></u>
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest (net of capitalized interest)	\$ 29,141	27,266
Construction in process included in accounts payable	9,565	—

See accompanying notes to financial statements.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2017 and 2016

(In thousands of dollars)

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

Seattle Children's Hospital (the Hospital) is a nonprofit regional pediatric medical center and research institute.

The Hospital is a member of a group of controlled corporations that have common management and representation on certain boards of governance. The membership of the Board of Trustees (the Board) of the Hospital and Seattle Children's Healthcare System (SCHS) are identical.

The following are affiliates of the Hospital, each of which is a 501(c)(3) and a Washington nonprofit corporation, with the exception of the Children's Clinically Integrated Network which is structured as a Washington limited liability corporation (LLC):

Seattle Children's Healthcare System (SCHS) – The parent corporation of the Hospital and affiliated-controlled corporate entities.

Seattle Children's Hospital Foundation (the Foundation) – A corporation established to support SCHS and its affiliates, primarily the Hospital, through fundraising activities.

Seattle Children's Hospital Guild Association (the Guild Association) – A corporation established to support SCHS and its affiliates, primarily the Hospital, through fundraising events and memberships.

Seattle Children's Retail (Retail) – A corporation established to support SCHS, through the operation of thrift stores.

Children's Clinically Integrated Network – A LLC established to develop, coordinate and administer a clinically integrated pediatric network to promote collaboration to enhance the quality and cost effectiveness of pediatric care.

Substantially all the net fundraising revenues and support raised by the Foundation, the Guild Association and Retail are transferred to the Hospital or to SCHS on a discretionary basis. Contributions are distributed to the Hospital and are classified to comply with the purposes specified by donors. During 2017 and 2016, the Foundation, the Guild Association, and Retail transferred contributions of \$80,268 and \$70,386 to the Hospital, respectively.

The 1915 Terry property was transferred from SCHS to the Hospital in 2016. This resulted in an intercompany equity transfer from SCHS to the Hospital of \$35,528 reflected in unrestricted net assets in the line item other.

(b) Tax Exemption

The Internal Revenue Service has granted the Hospital, and each of the affiliated corporations listed above, exemption from federal income taxes under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) of the IRC formed to operate a hospital for charitable,

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2017 and 2016

(In thousands of dollars)

educational, scientific, and medical purposes. During 2017 and 2016, the Hospital did not record any liability for unrecognized tax benefits.

(c) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(d) Cash and Cash Equivalents

Cash and cash equivalents including highly liquid instruments that are readily convertible to known amounts of cash are recorded at cost, which approximates fair value. This includes money market funds and deposits held by creditworthy, high-quality financial institutions with original maturities of three months or less.

(e) Assets Whose Use Is Limited and Investments

Assets whose use is limited includes unrestricted assets designated by the Board of Trustees for future capital and various program purposes, over which the Board of Trustees retains control and may, at its discretion, subsequently use for other purposes. Assets whose use is limited also includes temporarily and permanently restricted assets, based on donor restriction, and assets held by trustees under bond indentures and other agreements.

Investments under bond indentures and other agreements primarily include assets held by trustees under the terms of the revenue bonds. Amounts required to meet current liabilities of the Hospital have been classified as current assets in the accompanying balance sheets at September 30, 2017 and 2016.

Investments are stated at fair value. The Hospital classifies its investment portfolio as a trading portfolio, and as such, all unrestricted net unrealized gains or losses are recorded in nonoperating income in the accompanying statements of operations and changes in net assets in the period in which they occur.

Investment income (which includes interest and dividends and realized and unrealized gains and losses) is included in nonoperating income in the accompanying statements of operations and changes in net assets, unless the income or gain (loss) is restricted by donor. Restricted investment income is included in the increase (decrease) in temporarily restricted net assets in the accompanying statements of operations and changes in net assets.

Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risks associated with certain investment securities, it is reasonably possible that changes in the value of investments could occur in the near term and that such changes could materially affect the amounts reported in the accompanying balance sheets.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2017 and 2016

(In thousands of dollars)

The Hospital accounts for its investments on a trade-date basis. Investment sales and purchases initiated prior to the balance sheet date and settled subsequent to the balance sheet date result in amounts due from and to brokers. Changes in these assets and liabilities represent noncash investing activities excluded from the statements of cash flows. The cost of investments sold is determined in accordance with the specific identification method, and realized gains and losses are included in investment income in the accompanying statements of operations and changes in net assets. As of September 30, 2017 and 2016, the Hospital recorded payables of \$48,084 and \$48,267, respectively, for investments purchased but not settled as due to brokers for securities purchased in the accompanying balance sheets. As of September 30, 2017 and 2016, the Hospital recorded a receivable of \$28,778 and \$0, for investments sold but not settled and interest receivable, included in other current assets in the accompanying balance sheet.

Pooled Investments Held at SCHS

Pooled investments held at SCHS represent the Hospital's interest in a pool of investments held and managed by SCHS, which are recorded at fair value. Investment income, net and unrealized gains or losses from the SCHS investment pool were allocated between SCHS and the Hospital based upon respective investment balances. The Hospital recognizes the changes in its interest in the SCHS investment pool using a method that approximates the equity method of accounting.

(f) Pledges Receivable

Pledges receivable consist of private gifts and grants promised from individuals, corporations, foundations or other organizations and are reported at fair value at the date the promise is received. Restricted promises are reported as either temporarily or permanently restricted net assets if they are received with donor stipulations that limit the use of the donated assets to a specific time period or purpose.

The schedule of future pledge payments, which are included in other current assets and other assets, in the accompanying balance sheets were as follows at September 30:

	<u>2017</u>	<u>2016</u>
Receivable in:		
Less than one year	\$ 5,356	2,736
One to five years	13,950	3,574
Over five years	<u>300</u>	<u>—</u>
	19,606	6,310
Less discount and allowance	<u>(784)</u>	<u>(374)</u>
	<u>\$ 18,822</u>	<u>5,936</u>

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2017 and 2016

(In thousands of dollars)

(g) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, less accumulated depreciation. Maintenance and repairs are expensed as incurred. Interest costs incurred during the time required to ready the asset for its intended use are capitalized. Interest costs of \$4,418 and \$2,412 were capitalized in 2017 and 2016, respectively. Depreciation is computed using the straight-line method, which allocates the cost of the asset ratably over its estimated useful life. An estimated life of up to 40 years is used for buildings and 8 to 15 years for building and land improvements. Various lives ranging from 3 to 20 years are used for furniture and equipment. Leasehold improvements are depreciated over the shorter of the remaining life of the lease or the useful life of the asset.

(h) Other Current Assets

Other current assets primarily include prepaid expenses, nonpatient accounts receivable, receivables for securities sold but not settled, and inventories. Inventories are measured at the lower of cost or market value. At September 30, 2017 and 2016, SCH had \$12,843 and \$12,551, respectively, in inventories.

(i) Joint Ventures

The equity method of accounting is used for joint ventures in which the Hospital has significant influence, but does not have control. Significant influence is deemed to exist when the ownership interest in the investee is at least 20% and not more than 50% of net assets, although other factors may be considered in determining whether the equity method of accounting is appropriate.

(j) Deferred Financing Costs

Deferred financing costs are included as a direct deduction from the carrying amount of the Hospital's long-term debt in the accompanying balance sheets and are amortized using the effective-interest method over the term of the related outstanding obligation.

(k) Net Assets

Contributions are reported at fair value at the date of donation. Such amounts are reported as unrestricted, temporarily restricted, or permanently restricted net assets, based on donor stipulations (if any) that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the accompanying statements of operations and changes in net assets as other operating revenues and net assets released from restriction.

Endowment fund balances, including funds functioning as endowments, are classified and reported as permanently restricted, temporarily restricted, or unrestricted net assets in accordance with Board or donor specifications. Funds functioning as endowments include Board-designated named endowments and other Board-designated funds.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2017 and 2016

(In thousands of dollars)

(l) Net Patient Service Revenues and Patient Accounts Receivable

Net patient service revenues are reported at the estimated net realizable amounts from patients and third-party payers. Retroactive adjustments, under reimbursement agreements with third-party payers, are estimated and accrued in the period in which the related services are rendered, and adjusted in future periods as final settlements are determined.

Patient accounts receivable are recorded on an accrual basis at established billing rates. The allowances for contractual allowances and discounts and uncollectible accounts are recorded on an accrual basis, using established billing and contracted rates and historical experience. In evaluating the collectibility of patient accounts receivable, the Hospital estimates the allowance for uncollectible accounts by major payer type based on historical experience for each payer type. Primary collection risks relate to uninsured patients and the portion of the bill which is the patients' responsibility, primarily copayments and deductibles. For uninsured patients who do not qualify for the Hospital's charity care, the Hospital provides a discount from its standard rates. The Hospital regularly reviews data about the major payer sources of revenues in evaluating the sufficiency of the allowance for contractual allowances and discounts and uncollectible accounts.

(m) Other Operating Revenues

Other operating revenues primarily include revenues from a federal graduate medical education grant, Hospital's equity earnings from its participation in a joint venture, amounts received from Children's University Medical Group (CUMG), net assets released from restriction for operations, and other.

(n) Excess of Revenues over Expenses

The accompanying statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over expenses, are primarily net assets released from restriction for capital in 2017, and include the transfer of the 1915 Terry property in 2016.

(o) Reclassifications

Prior period financial statement amounts have been reclassified to conform to current period presentation.

(p) Subsequent Events

The Hospital has performed an evaluation of subsequent events through December 21, 2017, which is the date these financial statements were issued.

(q) New and Pending Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers*. ASU No. 2014-09 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2017 and 2016

(In thousands of dollars)

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract.

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

Among other provisions and in addition to expanded disclosure about the nature, amount, timing, and uncertainty of revenue, as well as certain additional quantitative and qualitative disclosures, ASU No. 2014-09 changes the health care industry's specific presentation guidance previously under ASU No. 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*. ASU No. 2014-09 is now effective for fiscal years beginning after December 15, 2017, and interim periods thereafter. Early application is permitted only for fiscal years beginning after December 15, 2016, including interim periods within that reporting period, but has now been delayed one year by ASU No. 2015-14, *Revenue from Contracts with Customers (Topic 606)*. The Hospital is evaluating this guidance and the impact that the adoption of this ASU will have on its consolidated financial statements and related disclosures.

In March 2015, the FASB issued ASU No. 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. This ASU changes the presentation of debt issuance costs in the financial statements. Under the ASU, an entity presents such costs in the consolidated balance sheet as a direct deduction from the recognized liability rather than as an asset. Amortization of the costs is reported as interest expense. The ASU is effective for fiscal years beginning after December 15, 2015. The Hospital adopted the standard effective October 1, 2016 and the prior year debt issuance costs of \$4,351 have been reclassified from other assets, net to long-term debt, net of current portion in the accompanying balance sheets.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right to use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale leaseback transactions. The guidance is effective for fiscal years beginning after December 15, 2019. The Hospital is evaluating this guidance and the impact that the adoption of this ASU will have on its financial statements and related disclosures.

In August 2016, the FASB issued ASU No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, to reduce diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit (NFP) financial statements. This ASU contains the following key aspects: (A) Reduces the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions; (B) Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements; (C) Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) Retains the option to present operating cash flows in the statement of cash flows using either the

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(In thousands of dollars)

direct or indirect method. The guidance is effective for fiscal years beginning after December 15, 2017. The Hospital is evaluating this guidance and the impact, including the methods of implementation, that the adoption of this ASU will have on its financial statements and related disclosures.

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash*, which requires organizations to include cash and cash equivalents that have restrictions on withdrawal or use in total cash and cash equivalents on the statement of cash flows. The guidance is effective for fiscal years beginning after December 15, 2018 and early adoption is permitted. The Hospital is evaluating this guidance and the impact that the adoption of this ASU will have on its financial statements and related disclosures.

(2) Uncompensated and Undercompensated Care

The Hospital is committed to caring for all children in its service area irrespective of ability to pay. The estimated costs of that care were as follows for the years ended September 30:

	<u>2017</u>	<u>2016</u>
Medicaid payment shortfall	\$ 155,437	116,471
Charity care	<u>9,168</u>	<u>10,212</u>
Total uncompensated and undercompensated care	<u>\$ 164,605</u>	<u>126,683</u>

Medicaid is a government sponsored healthcare program for low income individuals. The Medicaid payment shortfall represents the estimated cost of providing services to patients covered under Medicaid in excess of payments received. The estimated cost of services provided to Medicaid patients is estimated based on the ratio of Hospital patient care costs to Hospital patient care charges applied to charges related to services provided to Medicaid patients. Funds received to offset or subsidize charity and Medicaid payment shortfalls were \$14,113 and \$15,612 for the years ended September 30, 2017 and 2016, respectively.

Charity care represents the estimated cost of care provided to patients who are uninsured or underinsured and whose families cannot afford to pay for their medical care. The Hospital provides charity care in accordance with its charity care policy based on family need and maintains records to identify the level of charity it provides. The determination of family need is evaluated during a patient's course of care and can be updated after care is complete. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, these amounts are not reported as revenue. The estimated cost of charity care provided is estimated based on the ratio of Hospital total patient care costs to Hospital total patient care charges applied to gross charges related to charity care services.

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(3) Assets Whose Use Is Limited

As of September 30, the fair value of assets whose use is limited was as follows:

	2017	2016
Board-designated investments	\$ 504,903	527,363
Pooled investments held at SCHS	576,020	490,145
Board-designated endowments	221,065	194,915
Donor-restricted endowments	188,794	173,226
Investments held under bond indentures and other	92,497	22,124
	<u>\$ 1,583,279</u>	<u>1,407,773</u>

(4) Investments and Fair Value Measurements

In determining the fair value of investments, the Hospital utilizes valuation techniques to maximize the use of observable market data and minimize the use of unobservable inputs. Inputs refer broadly to the assumptions that market participants would use in pricing the asset or liability, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset or liability developed based upon market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the Hospital's own assumptions about the assumptions market participants would use in pricing the asset or liability developed based on the best information available.

Assets and liabilities that are recorded at fair value are grouped into three levels based on the markets in which assets and liabilities are traded and the observability of the inputs used to determine fair value. The three levels are as follows:

Level 1 – Quoted prices in active markets for identical assets or liabilities. An active market for the asset or liability is a market in which transactions for the asset or liability occur with sufficient frequency and volume to provide pricing information on an ongoing basis.

Level 2 – Pricing inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly, and the fair value is determined through the use of models or other valuation methodologies.

Level 3 – Significant unobservable inputs, including assets and liabilities that are traded infrequently.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The fair value hierarchy does not necessarily correspond to a financial instrument's relative liquidity in the market or to its level of risk.

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The following tables present assets and liabilities that were measured at fair value on a recurring basis (including items that were required to be measured at fair value and items for which the fair value option was elected) at September 30:

		Fair value measurements at reporting date using		
	2017	Level 1	Level 2	Level 3
Assets:				
Investments:				
Money market and other	\$ 115,785	66,031	49,754	—
Commercial paper	17,444	—	17,444	—
U.S. equity securities	4,786	4,786	—	—
U.S. corporate fixed-income securities	294,908	—	294,406	502
Foreign corporate fixed-income securities	161,941	—	161,941	—
Notes issued by the				
U.S. government and				
U.S. government agencies	54,834	54,834	—	—
Mutual funds:				
Global (U.S. and foreign) equity funds	790	790	—	—
U.S. corporate fixed income funds	264,202	264,202	—	—
Other	2,391	2,391	—	—
Pooled investments	576,020	—	—	576,020
Trustee-held funds	90,178	90,178	—	—
Total assets	\$ 1,583,279	483,212	523,545	576,522
Liabilities:				
Interest rate swap agreements	\$ 17,789	—	17,789	—
Total liabilities	\$ 17,789	—	17,789	—

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September 30, 2017 and 2016

(In thousands of dollars)

	2016	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Assets:				
Investments:				
Money market and other	\$ 120,430	95,704	24,726	—
Commercial paper	39,036	—	39,036	—
U.S. equity securities	4,822	4,822	—	—
U.S. corporate fixed-income securities	307,980	—	307,476	504
Foreign corporate fixed-income securities	155,650	—	155,650	—
Notes issued by the				
U.S. government and				
U.S. government agencies	54,444	47,443	7,001	—
U.S. municipal securities	2,341	—	2,341	—
Mutual funds:				
Global (U.S. and foreign) equity funds	552	552	—	—
U.S. corporate fixed income funds	210,249	210,249	—	—
Other	2,264	2,264	—	—
Pooled investments	490,145	—	—	490,145
Trustee-held funds	19,860	19,860	—	—
Total assets	\$ 1,407,773	380,894	536,230	490,649
Liabilities:				
Interest rate swap agreements	\$ 26,041	—	26,041	—
Total liabilities	\$ 26,041	—	26,041	—

There were no transfers between Level 1 and Level 2 during 2017 or 2016.

Pooled investments held at SCHS are recorded at the Hospital's share of the fair value of the SCHS investment pool. The SCHS investment pool was invested as follows at September 30 (in percentages):

	2017	2016
Mutual funds:		
Global (U.S. and Foreign) equity	24%	20%
U.S. corporate fixed income	8	9
Alternative investments	68	71
	100%	100%

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(In thousands of dollars)

Alternative investments included within pooled investments held at SCHS, include limited partnerships, limited liability corporations, investment trusts, institutional funds, and offshore investment funds. Included in these funds are certain types of financial instruments, including, among others, futures and forward contracts, options, swaps, and securities sold not yet purchased, intended to hedge against changes in the fair value of investments. These financial instruments involve varying degrees of risk. Because alternative investments are not readily marketable, their estimated value is subject to uncertainty and, therefore, may differ from the value that would have been used had a ready market for such investments existed. Such differences could be material.

The following table presents the Hospital's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the years ended September 30, 2017 and 2016:

	Pooled investments	Other	Total 2017
Beginning balance at September 30, 2016	\$ 490,145	504	490,649
Investment income and unrealized gain, net	67,718	(2)	67,716
Additions	25,000	—	25,000
Other changes	(6,843)	—	(6,843)
Ending balance at September 30, 2017	\$ 576,020	502	576,522
	Pooled investments	Other	Total 2016
Beginning balance at September 30, 2015	\$ 423,445	—	423,445
Investment income and unrealized gain, net	38,954	4	38,958
Additions	32,000	—	32,000
Purchases	—	500	500
Other changes	(4,254)	—	(4,254)
Ending balance at September 30, 2016	\$ 490,145	504	490,649

Net unrealized gains (losses) included in income, in the table above, relating to assets held at September 30, 2017, were \$42,851 and (\$2) for pooled investment and other, respectively. Net unrealized gains (losses) included income relating to assets held at September 30, 2016 were \$15,498 and \$4 for pooled investment and other, respectively.

The carrying amounts reported on the accompanying balance sheets for cash and cash equivalents, patient accounts receivable, other current assets, accounts payable, and accrued expenses approximate the fair value because of their short-term nature.

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The fair value of long-term debt, estimated based on the quoted market prices for similar issues, considered a Level 2 measurement, was \$741,870 and \$646,000 at September 30, 2017 and 2016, respectively.

(5) Beneficial Interest in Seattle Children's Healthcare System

The Hospital recognizes an interest in a portion of the net assets of SCHS representing certain temporarily and permanently restricted funds that will ultimately benefit the Hospital. At September 30, 2017 and 2016, the Hospital recorded a beneficial interest in SCHS of \$150,859 and \$138,187, respectively, which corresponds to temporarily and permanently restricted net assets held by SCHS on the Hospital's behalf. The Hospital recognizes changes in this beneficial interest as a change in temporarily and permanently restricted net assets.

(6) Land, Buildings, and Equipment

Land, buildings, and equipment consist of the following at September 30:

	2017	2016
Land and improvements	\$ 232,991	218,239
Buildings and improvements	973,128	902,218
Furniture and equipment	492,775	472,190
Construction in progress	101,251	83,170
	1,800,145	1,675,817
Less accumulated depreciation	(696,778)	(654,766)
	<u>\$ 1,103,367</u>	<u>1,021,051</u>

The Hospital has commitments for construction contracts totaling \$61,521 as of September 30, 2017.

(7) Endowment Funds and Temporarily and Permanently Restricted Net Assets

The endowment funds consist of numerous individual funds established for a variety of purposes. They include donor-restricted endowments and funds functioning as endowments, which include board-designated named endowments and other board-designated endowments. Net assets associated with these funds are classified and reported based on the existence or absence of donor-imposed restrictions.

The Hospital has interpreted the Washington State Uniform Prudent Management of Institutional Funds Act (WA-UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment; (b) the original value of subsequent gifts donated to the permanent endowment; and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund.

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The remaining portion of the donor-restricted endowment funds that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standards of prudence prescribed by WA-UPMIFA.

In making a determination to appropriate or accumulate donor-restricted endowment funds, the Hospital considers (a) the duration and preservation of the fund, (b) the purposes of SCHS and the donor-restricted endowment, (c) general economic conditions, (d) the appreciation of endowment investments; (e) other resources of the Hospital, and (f) the investment policy of the Hospital. From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or WA-UPMIFA requires the Hospital to retain as a fund of perpetual duration. Deficiencies of this nature are reflected as a reduction in unrestricted net assets.

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation intended to achieve its long term return objectives within prudent risk constraints.

The Hospital has a spending policy of appropriating 5% of its endowment funds' 12-quarter average market value of donor-restricted and board-designated named endowments. In establishing this policy, the Hospital considered the long-term expected return on its endowment funds.

The endowment net assets composition by type as of September 30, 2017 and 2016 were as follows:

	<u>Unrestricted</u>	<u>Temporarily restricted</u>	<u>Permanently restricted</u>	<u>Total</u>
September 30, 2017:				
Donor-restricted	\$ (57)	47,775	141,076	188,794
Board-designated:				
Named endowment funds	9,968	—	—	9,968
Other endowment funds	211,097	—	—	211,097
Total funds	<u>\$ 221,008</u>	<u>47,775</u>	<u>141,076</u>	<u>409,859</u>
September 30, 2016:				
Donor-restricted	\$ (353)	33,985	139,594	173,226
Board-designated:				
Named endowment funds	9,196	—	—	9,196
Other endowment funds	185,719	—	—	185,719
Total funds	<u>\$ 194,562</u>	<u>33,985</u>	<u>139,594</u>	<u>368,141</u>

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The changes in endowment net assets for 2017 and 2016 were as follows:

	September 30, 2017			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2016	\$ 194,562	33,985	139,594	368,141
Investment return:				
Net interest and dividends	2,238	2,115	—	4,353
Net appreciation (realized and unrealized)	24,799	20,205	—	45,004
Total investment return	27,037	22,320	—	49,357
Contributions	2	—	1,522	1,524
Appropriation of endowment assets for expenditure:				
Donor-restricted	(128)	(8,530)	(40)	(8,698)
Board-designated named	(465)	—	—	(465)
Total appropriations	(593)	(8,530)	(40)	(9,163)
Endowment net assets, September 30, 2017	\$ 221,008	47,775	141,076	409,859

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September 30, 2016				
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets, September 30, 2015	\$ 179,154	28,633	135,020	342,807
Investment return:				
Net interest and dividends	2,256	2,169	—	4,425
Net appreciation (realized and unrealized)	13,778	11,272	—	25,050
Total investment return	16,034	13,441	—	29,475
Contributions	—	—	4,574	4,574
Appropriation of endowment assets for expenditure:				
Donor-restricted	(163)	(8,089)	—	(8,252)
Board-designated named	(463)	—	—	(463)
Total appropriations	(626)	(8,089)	—	(8,715)
Endowment net assets, September 30, 2016	\$ 194,562	33,985	139,594	368,141

Temporarily restricted net assets were available for the following purposes at September 30:

	2017	2016
Healthcare services:		
Purpose restrictions	\$ 60,321	38,647
Unappropriated endowment earnings	47,775	33,984
Research	71,604	65,948
Capital projects	2,477	1,336
	\$ 182,177	139,915

Permanently restricted net assets were restricted to investments in perpetuity, the income from which is expendable to support the following at September 30:

	2017	2016
Healthcare services	\$ 132,654	124,034
Research	141,224	139,789
	\$ 273,878	263,823

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(8) Long-Term Debt

Long-term debt obligation consisted of the following at September 30:

	Maturing through	Interest rates	Unpaid principal	
			2017	2016
Revenue Bonds				
Fixed:				
Series 2009	2020	5.00 – 5.625%	\$ 3,095	4,025
Series 2010A	2041	5.00%	75,000	75,000
Series 2010B	2023	5.00%	23,075	26,305
Series 2012A	2043	5.00%	46,335	46,335
Series 2012B	2035	4.00 – 5.00%	27,895	27,935
Series 2015A	2046	4.00 – 5.00%	100,000	100,000
Series 2015B	2039	3.00 – 5.00%	167,315	167,350
Series 2017A	2048	3.00 – 5.00%	114,080	—
Total fixed			556,795	446,950
Variable:				
Series 2012C	2029	1.32 – 1.85%	60,370	62,045
Series 2012D	2032	0.97 – 1.47%	61,915	64,960
Total variable			122,285	127,005
Unpaid principal, long-term debt			679,080	573,955
Unamortized premiums, discounts and debt issuance costs, net			46,054	37,566
Long-term debt, including premiums, discounts, and debt issuance costs			725,134	611,521
Less current portion			9,345	8,955
Long-term debt, net of current portion			\$ 715,789	602,566

The Revenue Bonds are collateralized by a pledge of gross revenues and secured by interests in certain bond funds.

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Scheduled principal repayments as of September 30, 2017 on the long-term debt are due as follows:

2018	\$	9,345
2019		11,000
2020		11,455
2021		11,940
2022		12,465
Thereafter		622,875
		<hr/>
		679,080
Add unamortized premiums, discounts and debt issuance costs, net		46,054
		<hr/>
	\$	<u>725,134</u>

In 2017, the Hospital issued \$114,080 of Series 2017A Bonds, refinanced \$60,400 in Series 2012C Bonds, and \$61,900 in Series 2012D Bonds.

In 2008, SCHS entered into a New Markets Tax Credit financing to develop and construct a portion of the Hospital's research facility. The compliance period of the transaction ended 2016. As a result of the completion of the compliance period, the Hospital recorded \$19,740 as a noncash gain on forgiveness of debt in 2016, in nonoperating income (expense) in the accompanying statements of operations and changes in net assets.

The members of the Obligated Group established under the Master Indenture include the Hospital and SCHS. As of September 30, 2017, total assets, total liabilities, and total unrestricted net assets of the Obligated Group constituted approximately 100%, 100%, and 100%, respectively, of the respective SCHS's consolidated totals. For 2017, the total operating revenues, operating income, and excess of revenues over expenses, from all sources attributable to the Obligated Group were 99%, 100%, and 100%, respectively, of the respective SCHS's consolidated totals.

Under the terms of the Revenue Bonds and related indenture agreements, the Obligated Group is required to comply with various covenants, including income available for debt service.

Accounting for Derivative Instruments

Interest rate swap contracts are used to manage the net exposure to interest rate changes in attempting to reduce the overall cost of borrowing over time. The Hospital records these derivative instruments on the accompanying balance sheet as an asset or liability measured at its individual fair market value – the fair value of interest rate swap contracts is included in other long-term liabilities on the accompanying balance sheet. Changes in the derivative instrument's fair market value are recognized in earnings unless certain specific hedge accounting criteria are met. The Hospital has not designated its interest rate swap agreements as cash flow hedges, and all changes in the valuation of the interest rate swaps are recognized in other nonoperating expenses, net, in the accompanying consolidated statements of operations and changes in net assets. Interest rate swaps not designated as hedges represented liabilities of \$17,789 and \$26,041 as of September 30, 2017 and 2016, respectively.

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The Hospital has two swap agreements (Swap Agreements) with two separate counterparties. Under each Swap Agreement, the Hospital is obligated to pay a fixed rate per annum (3.48% on the Series 2012C Bonds and 3.69% on the Series 2012D Bonds) on a notional amount equal to the outstanding principal amount of the applicable series of bonds and receives a variable payment computed as 68% of the one-month LIBOR. The bonds' variable-rate coupons are based upon rates calculated as a percentage of one-month LIBOR plus a credit spread as defined in the respective financing agreements. The two Credit Support Annexes for the interest rate swaps require either party to post collateral if the fair market value of the swap is negative to them and exceeds the minimum threshold as defined in each respective Credit Support Annex. The amount of collateral required to be posted is equal to the difference of the fair market value over the minimum threshold. As of September 30, 2017, the Hospital was not required to post collateral for either Swap Agreement.

(9) Net Patient Service Revenues and Concentrations of Credit Risks

A significant portion of the Hospital's patient service revenues is derived from Medicaid programs, including Medicaid managed care (Medicaid). Payments from Medicaid for services provided to inpatients are based upon prospective diagnosis related groups and other payment programs, while Medicaid outpatient payments are based upon prospective enhanced ambulatory payment groups and other payment programs. Commercial insurer payments are based upon terms of contractual agreements.

The following table summarizes gross patient revenue by payer for the years ended September 30:

	2017	2016
Commercial Insurers:		
Premera Blue Cross	12%	13%
Regence Blue Shield	13	12
Other	20	22
Medicaid managed care organizations:		
Community Health Plan of Washington	7	7
Molina Healthcare	17	16
Other	13	11
Medicaid	11	13
Other	7	6
	100%	100%

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The concentrations of credit risk by payer as measured by gross patient accounts receivable were as follows at September 30:

	2017	2016
Commercial Insurers:		
Premera Blue Cross	11%	9%
Regence Blue Shield	11	11
Other	23	26
Medicaid managed care organizations	33	29
Medicaid	14	16
Other	8	9
	100%	100%

(10) Hospital Safety Net Assessment

The state of Washington provides for supplemental Medicaid payments to certain hospitals funded by assessments paid by these hospitals as well as matching federal funds (the safety net program). The supplemental payments include fee-for-service payments received directly from Washington State as well as payments processed through managed care organizations.

The following revenue and expense are recognized in the accompanying statements of operations and changes in net assets for the years ended September 30:

	Revenues		Expenses	
	2017	2016	2017	2016
Fee-for-service segment of the program	\$ 14,892	17,001	6,707	6,580
Managed care segment of the program	20,225	24,784	12,541	12,189
Total	\$ 35,117	41,785	19,248	18,769

Supplemental payments are recorded in net patient service revenues and assessments are recorded in supplies and other expenses in the accompanying statements of operations and changes in net assets.

(11) Related-Party Transactions

The Hospital and SCHS participate in joint ventures with organizations that engage in the delivery of healthcare-related services. The Hospital participates in a joint venture with Providence Health & Services – Washington (PHSW), which is owned by Providence St. Joseph Health (PSJH). PHSW owns and operates Providence Regional Medical Center Everett located in Everett, Washington. The Hospital and PHSW each own a 50% interest in Providence-Children's Neonatal Services, LLC (PCNS). SCHS and the University of Washington (UW) jointly control CUMG, which is a pediatric practice plan that employs and manages the clinical practices of its members who are medical staff at both the Hospital and faculty at the UW. SCHS has a 33% ownership interest in the Seattle Cancer Care Alliance (SCCA), a nonprofit corporation, organized by SCHS, the UW, and Fred Hutchinson Cancer Research Center to provide a

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comprehensive program of integrated cancer care services. The Hospital and SCHS account for their respective ownership interests in these joint ventures under the equity method of accounting.

During 2017 and 2016, healthcare services provided, at cost, by the Hospital to these joint ventures totaled \$9,952 and \$9,608, respectively. The revenues from these services were included in other operating revenues in the accompanying statements of operations and changes in net assets. The Hospital purchased healthcare services of \$120,993 and \$104,012 in 2017 and 2016, respectively from their joint ventures. The expenses were included in purchased services in the accompanying statements of operations and changes in net assets. As of September 30, 2017 and 2016, the Hospital's investment in the PCNS joint venture totaled \$5,825, and is included in other assets in the accompanying balance sheets.

(12) Retirement Plan and Deferred Compensation

The Hospital provides a defined-contribution plan to substantially all of its employees. The Hospital's contribution to the plan is discretionary. For 2017 and 2016, the discretionary Hospital contribution based on participants' years of vested service was 4.0% of eligible compensation for less than five years and 6.0% of eligible compensation for more than five years. The Hospital also offers a match of up to 25% of the first 4% of employee compensation. Retirement plan contribution expense during 2017 and 2016 totaled \$26,276 and \$24,512, respectively.

(13) Self-Insurance

The Hospital has purchased professional and general liability insurance on a claims-made basis. The Hospital is self-insured for the deductible portion of its insurance coverage and for unreported incidents and accrues an actuarial estimate for claims within its deductible portion and for unreported incidents. At September 30, 2017 and 2016, the estimated gross liability before insurance receivable for future costs of professional and general liability claims was \$8,800 and \$9,196, respectively. At September 30, 2017 and 2016, \$7,099 and \$7,321, respectively, of this liability was included as long-term within other long-term liabilities with the remainder within other payables in the accompanying balance sheets.

(14) Commitments and Contingencies

(a) Operating Leases

The Hospital leases various equipment and facilities under operating leases expiring at various dates. Total rental expense in 2017 and 2016 was \$12,737 and \$12,752, respectively, and was included in the supplies and other expense in the accompanying statements of operations and changes in net assets.

SEATTLE CHILDREN'S HOSPITAL

Notes to Financial Statements

September 30, 2017 and 2016

(In thousands of dollars)

Operating lease commitments for future years are as follows:

2018	\$	10,930
2019		11,550
2020		10,289
2021		10,082
2022		8,888
Thereafter		40,635
	\$	<u>92,374</u>

(b) Labor Organizations

Approximately 27% of the Hospital's employees are represented by labor organizations. None of the labor agreements expire within one year.

(c) Regulatory Environment and Litigation

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Hospital, in all material respects, is in compliance with the fraud and abuse regulations, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. The Hospital is subject to litigation arising in the normal course of business. After consultation with legal counsel, management believes that these matters will be resolved without material adverse effect on the Hospital's future financial position or results of operations.

(15) Functional Expenses

Functional expenses were as follows for the years ended September 30:

	2017	2016
Healthcare services	\$ 1,033,650	934,606
Research	172,545	145,099
General and administrative	92,334	84,984
	<u>\$ 1,298,529</u>	<u>1,164,689</u>

Appendix 2
Community Health Needs Assessment

2016

Community Health Assessment



Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION



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Introduction

At Seattle Children's, our commitment to caring for the community is our passion, our duty, and our privilege. We serve as the pediatric and adolescent medical center for the largest landmass of any children's hospital in the country, which includes Washington, Alaska, Montana and Idaho (the WAMI region). We reach beyond our hospital every day to provide programs and services to make children, teens and families safer and healthier in the communities where they live, based on identified community needs.

The Patient Protection and Affordable Care Act (ACA) requires non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years to understand the most significant needs impeding health in their area and examine ways to address them. At Seattle Children's we call this process a Community Health Assessment (CHA), and intentionally drop the word "needs" from our report. We do this purposefully because the communities that we serve are so much more than a list of needs; they are intricate places with assets, challenges, and moreover, places that are actively developing and harnessing their own capabilities and strengths. Our CHA aims to provide important and useful information to the hospital, public health, and local organizations interested in improving the health and safety of the community. Included assessments guide community benefit priorities and subsequent implementation and evaluation plans for our hospital.

Seattle Children's joined Public Health - Seattle and King County and 11 other hospitals and health systems in King County (Washington) on a collaborative project called "Hospitals for a Healthier Community" (HHC), publishing our second comprehensive CHNA in 2015. The current Seattle Children's CHA is tailored to focus more heavily on the pediatric and

adolescent populations, as well as community input, and to include data and information about the WAMI region when available.

This report provides qualitative and quantitative information about:

- **A Description of Our Community:** Seattle Children's serves the WAMI region, with the majority of our patients located in King County, WA.
- **Life Expectancy and Leading Causes of Death and Hospitalization:** Life expectancy in King County neighborhoods can vary by up to 10 years. Injuries are the leading causes of death among children, teens and young adults in King County and throughout Washington state. The leading causes of hospitalizations for children and teens are asthma and injuries.
- **The following identified health needs:**
 - Children with special healthcare needs and chronic conditions (CSHCN)
 - Access to care
 - Mental and behavioral health
 - Maternal and child health
 - Preventable causes of death
 - Violence and injury prevention

Each profile of health need includes key indicators of relevant health outcomes, which describe the population health status of a county, and the factors that could influence health outcomes, such as access to quality healthcare, health behaviors, social factors, and the physical environment. This assessment embraces a broad concept of health that includes social determinants so that, working collaboratively both within and outside the health system environment, Seattle Children's can help build on expertise and resources to address critical health needs and address the "triple aim" of health care: enhancing the

patient experience of care, improving the health of populations and reducing the per capita cost of healthcare. Social factors and the physical environment are especially important because they represent the conditions in which people are born, work and play. Neighborhoods with affordable healthy food, safe and accessible housing, and quality employment opportunities facilitate healthy lifestyles. The World Health Organization and others call the living conditions that can affect health and quality of life the “social determinants of health”. Our CHA highlights the importance of addressing the social determinants of health by including data about these determinants and then crafting strategies and tactics to address the needs related to the social and physical environment.

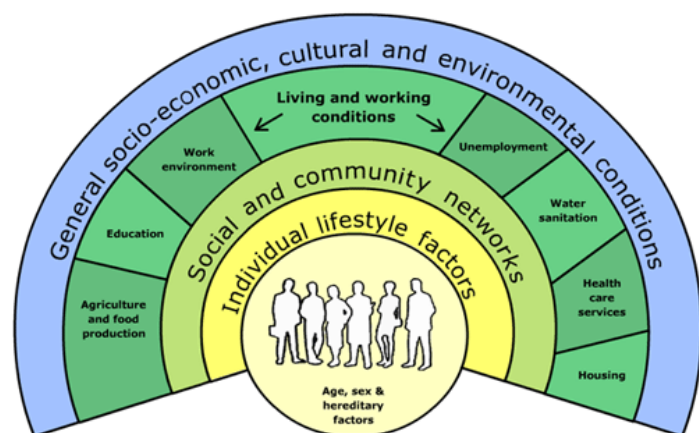


Figure 1: General Socioeconomic, Cultural and Environmental Conditions that Impact Health

1 Dahlgren, Göran and Whitehead, Margaret, (1991), Policies and strategies to promote social equity in health. Background document to WHO - Strategy paper for Europe, No 2007:14, Arbetsrapport, Institute for Futures Studies.

Social Determinants of Health

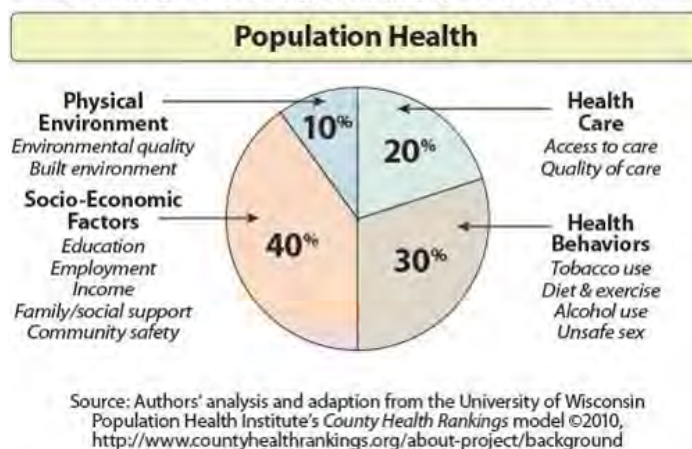


Figure 2: Impact on Population Health²

Supplemental data for the indicators of health outcomes are presented in Appendix C. Detailed data are reported, when available, for neighborhoods, cities and regions of King County, and by race/ethnicity, age, income/poverty, gender or other important demographic breakdowns. When possible, comparisons are also made to the Washington state average and national Healthy People 2020 objectives.

Each identified health need has a corresponding section and each section is organized by epidemiological data, followed by community input, as well as an assets and opportunities section. This report is a blend of qualitative and quantitative data. An executive summary of this report is available here or by visiting: <http://www.seattlechildrens.org/about/community-benefit/community-health-assessment>.

2 Source: <https://sph.uth.edu/dotAsset/d30b9171-5f3a-4b9e-826f-b000a82c8914.jpg>.

About Seattle Children's

Founded in 1907, Seattle Children's is a licensed specialty hospital for children, with more than 700 hospital-based physicians and more than 60 pediatric subspecialties. The 334-bed hospital is ranked the sixth best children's hospital in the country and the top children's hospital on the West Coast, according to U.S. News and World Report. Seattle Children's is also the primary teaching, clinical and research site for the Department of Pediatrics at the University of Washington School of Medicine. Seattle Children's is the largest, most comprehensive craniofacial center in the United States, with more than 50 healthcare providers from 19 specialty areas. The hospital also offers Washington's largest children's cancer center, which has five-year survival rates above the national average for most types of cancer. Seattle Children's Research Institute is one of the nation's top five pediatric research centers.

We provide inpatient, outpatient, diagnostic, surgical, rehabilitative, behavioral, emergency and outreach services. Moreover, we reach beyond our hospital every day to provide programs and services and partner with communities to make children, teens and families safer and healthier where they live based on identified community needs.

Opportunities for Better Health

In King County — as in communities across the nation — neighborhood conditions, race, income, language and education are highly correlated with disease burden and life expectancy. Community health data consistently show that these determinants of health — shaped by local distributions of money, power and resources — cannot be ignored if we hope to improve individual healthcare and health outcomes.

Our Mission

We provide hope, care and cures to help every child live the healthiest and most fulfilling life possible.

Our Vision

Seattle Children's will be an innovative leader in pediatric health and wellness through our unsurpassed quality, clinical care, relentless spirit of inquiry, and compassion for children and their families.

Our founding promise to the community is as valid today as it was over a century ago. We will care for all children in our region, regardless of their family's ability to pay.

We will:

- Practice the safest, most ethical and effective medical care possible.
- Discover new treatments and cures through breakthrough research.
- Promote healthy communities while reducing health disparities.
- Empower our team to reach their highest potential in a respectful work environment.
- Educate and inspire the next generation of faculty, staff and leaders.
- Build on a culture of philanthropy for patient care and research.

Our Values

- Compassion
- Excellence
- Integrity
- Collaboration
- Equity
- Innovation

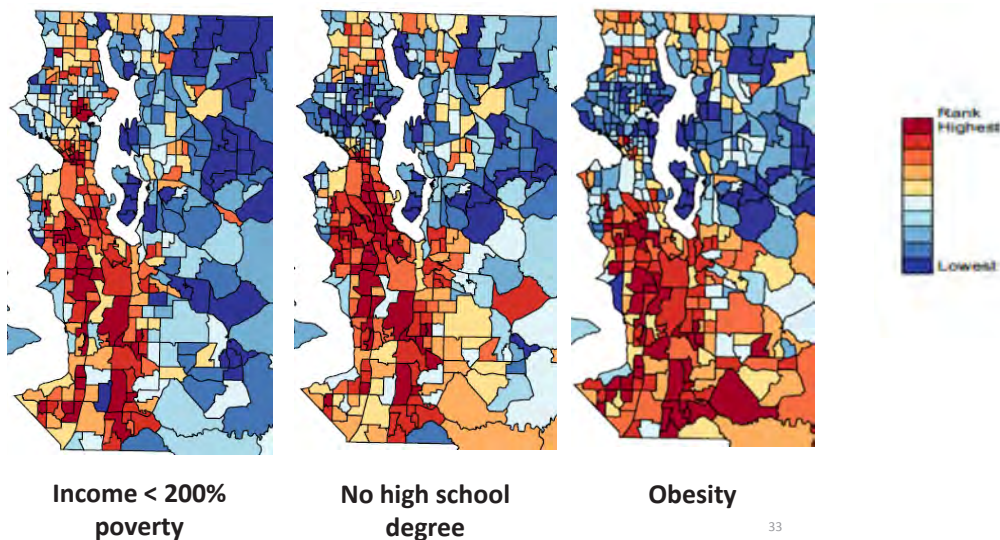


Figure 3: King County Poverty, Education and Obesity Map by Area³

The relationship between lack of opportunities and poor health is clear: King County neighborhoods with the lowest educational attainment and highest levels of poverty are also the areas with the greatest concentrations of obesity, diabetes and many other adverse health outcomes. Equal access to opportunities, such as education, housing and jobs, is necessary for all people to thrive and achieve their full potential.

Because health services account for only about 20% of overall health, this report highlights community health needs that will require nonclinical as well as clinical approaches by hospitals, health systems, and their partners.⁴

Working Together Toward Healthier Communities

Across the region, healthcare reform is catalyzing new levels of collaboration among hospitals and health systems, public health, social services, housing, community development and other sectors that address the underlying determinants of health for residents.

There is widespread recognition that achievement of the Triple Aim will require new bridges across systems that have been historically siloed.⁵

Seattle Children's is involved in a number of initiatives that help accelerate the goals of local and state health transformation plans. The King County Health and Human Services Transformation Plan calls for a shift from what today is a crisis- and sick-care oriented system, to one focused on prevention, wellness, and the elimination of disparities. Community partnerships that address the upstream, non-medical drivers of health are a key part of ultimately achieving the Triple Aim.

Washington state's roadmap for health transformation, "Healthier Washington," also recognizes that health happens at the local level and that communities are at the core of bringing about the changes that will improve the health of their residents. As a foundational piece of health assessment work that can be built upon in the years ahead, this CHA helps lay the groundwork for future community partnerships and well-aligned strategies that will succeed in responding to the identified community needs.

³ U.S. Census Bureau, BRFSS, CHARS, data, map produced by Public Health-Seattle & King County.

⁴ Schroeder, S. (2007, September 20). We Can Do Better – Improving the Health of the American People. The New England Journal of Medicine. 357, 1221-1228.

⁵ Institute for Healthcare Improvement. (2016). Retrieved from <http://www.ihl.org/offering/Initiatives/TripleAim/Pages/default.aspx>.



Methods

Design

Most of the data referenced in this CHA were collected as part of the comprehensive King County 2015 CHNA referenced above, or more recent data were obtained using the same methods. In crafting their approach to the CHNA, HHC members defined health broadly and used a population-based community health framework to identify health needs and establish criteria for selecting key indicators within each health topic. To identify community concerns and assets, for both the King County CHNA and this Pediatric Community Health Assessment, we interviewed stakeholders, consulted recent community-based reports, and pulled information from previous hospital CHNAs.

The King County and this Pediatric Community Health assessment uses a data collection approach that includes primary data, such as key informant interviews, community listening sessions or focus groups, and a community assets assessment. Secondary data gathering includes epidemiologic data on health outcomes as well as demographic, behavioral and environmental data.

Recognizing that the jointly authored 2015 CHNA and this 2016 Pediatric Community Health Assessment is not intended to provide comprehensive data for each health topic, indicators of relevant health outcomes were selected according to the following criteria:

1. Ability to address health equity, particularly by age, gender, race/ethnicity, geography and socioeconomic status, although not all demographic breakdowns may be available for all indicators.
2. Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable and regularly updated. Data should focus on rates rather than counts.

3. Ability to make valid comparisons to a baseline or benchmark.
4. Prevention orientation with clear sense of direction for action by hospitals for individual, community, system, health service or policy interventions that will lead to community health improvement.
5. Ability to measure progress of a condition or process that can be improved by intervention, policy or system change, and whether a capacity to affect change exists.
6. Alignment with local and national healthcare reform efforts, including the Triple Aim.

Indicators that satisfied these criteria were statistically analyzed by Public Health — Seattle & King County for both reports.

Data Sources

Data were compiled from local, state and national sources, such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Washington State Department of Health and Public Health – Seattle and King County. Input was also gathered from people representing the broad interests of the communities we serve through different methods including: interviews with stakeholder coalitions; interviews with community leaders; listening groups with youth, parents and caregivers, and experts in specific topics; an online survey; and a review of recent reports on local health needs.

The following interview questions were used for the in-person interviews and online survey:

1. What are the main concerns you [or your organization] have about the health and well-being of youth in your community/communities?

2. What are the people, places and things that make your community healthy, safe and strong, and tell us why these people, places and things are important? These could include organizations, leaders, coalitions, initiatives, policies or physical/environmental attributes.
3. What programs or projects that are happening or planned are most relevant to the identified needs?
4. How can Seattle Children's be involved in addressing the issues you have identified?
5. What are the most significant gaps in resources, coordination, etc. in this area?
6. Is there anything else you would like to add?

Limitations

Key limitations of this report include incomplete or inadequate quantitative data on some topics of interest and our inability to summarize every asset and opportunity in the communities we serve. For example, although we report data on fruit/vegetable consumption, comprehensive population-based data on healthy eating are simply not available. In addition, resource limitations prevent us from mentioning all of the valuable organizations and assets in our communities.

CHNA and CHA data were collected from agencies that use varying data sets. A particular challenge was inconsistent age groupings in epidemiological and outcome data. Data were also inconsistent in defining life-stage categories, such as when a child is considered an adult. Also, inconsistencies in terminology and definitions made it difficult to make side-by-side comparisons. For example, the definition of "Hispanic" varies from one community to another. The definition of "community" also varies. Individuals participating in a CHNA and CHA likely define their community differently; a community can be a geographic area, a racial group, a school or

a religious affiliation. This poses problems when analyzing interview and survey results.

We had fewer connections to community leaders in other areas of Washington state, so most of our respondents were from King County. While we gathered a great deal of community input from a wide range of stakeholders, limited resources made it impossible to reach all of our constituents. While we were able to conduct listening groups with multiple communities and interview several community members, these qualitative results should be interpreted as the perspective of the people who participated.

Unfortunately, these limitations may inadvertently reinforce health inequalities. We look forward to continuing to learn more about community strengths and resources. More details about the CHA methodology are included in Appendix A.

Definition of Community

Although Seattle Children's serves the entire WAMI region, for the purposes of this CHA we defined our community as the children and youth in Washington state with a focus on King County. However, in addition, the report provides a general overview of the status of regional healthcare access issues.

The definition of our community is due, in part, to our patients' origins in 2015/2016: 19% came from Seattle, 34% from other places in King County, 44% from other locations in Washington, 2% from Alaska, Montana and Idaho, and 1% from outside the WAMI region.



Community Health Assessment Focus Area



Figure 4: Community Health Assessment Focus Area

What We Heard From the Community – Key Findings

This section reports on common themes and issues that arose in our conversations with community coalitions, community organizations, families, youth, and subject matter experts. Additional community input can be found in individual chapters of this report.

Basic Needs

Residents voiced the importance of meeting basic needs if they are to fulfill the potential for a healthy life. The basic needs most frequently mentioned included affordable housing, transportation, access to care (behavioral health especially), public safety, living wages, and opportunities to access healthy food and be physically active.

Poverty emerged throughout these conversations, most often as a barrier to improved health. Community members identified access to safe and affordable housing as a major concern. Questions raised include: What is being done to improve and preserve existing affordable housing stock and what is being done to encourage new affordable housing? If affordable housing is not preserved, residents may be uprooted from their communities and risk losing long-standing social and emotional connections, as well as ties to important social and cultural institutions.

Accessible and affordable transportation was identified as an essential component of healthy communities. Ample research supports the notion that reliable transportation to job and education centers can make the difference between poverty and economic stability. King County residents, especially in suburban cities, rely on public transportation to not only get to their jobs but also to access healthy food and participate safely in physical activities.

Community members identified the need for more efficient bus services and improved connections to multiple parts of the county.

Respondents asked us to use our influence not only to promote and protect good health and prevent ill health, but also to work collaboratively across all sectors to develop systems to address basic needs and reduce health inequities. While these issues may seem beyond the realm of Seattle Children's mission, they impact families' ability to reach their healthiest potential.

Cultural Competency

Multiple service providers, community members and strategic plans called out the importance of providing culturally competent and respectful services to all people regardless of their race, income, language, beliefs or the complexity of their situation. Community members expressed the importance of cultural and linguistic competency and that it must be taken into account when designing new interventions, practices and services. Community members expressed concerns about systemic or institutional racism impacting their families health and well being. Seattle Children's has many opportunities to partner with organizations that can help us offer culturally specific services.

A shortage of bilingual and bicultural behavioral health service providers in King County and Washington state emerged as a significant workforce capacity issue. This issue has been acknowledged by policy-makers at various levels. The Governor's Interagency Council on Health Disparities in Washington state has called for increased attention to cultural competency and diversity in the healthcare

workforce. A new guide released by the Equity of Care initiative called “Becoming a Culturally Competent Health Care Organization,” outlines steps and educational techniques.⁶ Additional guidance on providing culturally and linguistically appropriate services is available from the federal Office of Minority Health.⁷

Community Input and Inclusiveness

Stakeholders wanted assurance that traditionally unrepresented and under-represented communities will be at the table during community health assessments and improvement processes. Community engagement and empowerment is considered essential to improving the health and wellness of the communities we serve.

Community representatives view hospitals as “major forces in the community” and would like them to welcome community members as full partners in making decisions to improve community conditions. Many expressed a desire for an ongoing, two-way conversation with hospitals instead of one-time meetings. Many believe that ongoing communication between hospitals and community groups will yield more relevant information about community needs than fixed-interval, formal assessments. Several different approaches to dialogue were suggested, for example having hospital staff attend community-based coalition meetings on a regular basis. Another suggestion was for hospitals to partner with existing community organizations to offer programs jointly. An important take-home message was, “Don’t recreate what already exists, but collaborate.”

6 Health Research & Educational Trust. (2013, June). Becoming a culturally competent health care organization. Chicago: Health Research & Educational Trust. Retrieved from http://www.hpoe.org/Reports-HPOE/becoming_culturally_competent_health_care_organization.PDF.

7 U.S. Department of Health and Human Services: Office of Minority Health. (2013, May). The national CLAS standards. Washington, DC: U.S. Department of Health and Human Services: Office of Minority Health.

Health Insurance Coverage, Health Literacy and Navigating Healthcare Services

These three issues were repeatedly highlighted as continuing challenges to improving the community’s health. Respondents stressed that some people will always “fall through the cracks” and remain uninsured. They expressed concern about people with incomes just above the federal poverty level who did not enroll in health insurance because they could not afford the premiums, and about those who enrolled but may fall behind in paying their premiums.

As one participant said, “Access requires more than health insurance.” People also need to understand basic health issues and know how to navigate the healthcare system. Understanding how the health system works, including the specific services and benefits people are eligible for, was identified as a continuing challenge. Patients are afraid of the cost of care. Respondents reported that many people do not know how to shop for health insurance that enables them to continue receiving care from their current provider. Community health workers, patient navigators, and in-person assisters were perceived as helpful in addressing all three concerns.

Community Assets and Resources

Although never all-inclusive, identification of community assets and resources is essential to a community health improvement process. We invited stakeholders to tell us about the people, places, policies and programs that help their community thrive. Community strengths relevant to identified health needs are highlighted in each of the subsequent sections, so here we present just a few of the frequently mentioned assets.



- **Partnerships, coalitions and collaborations:**

Across the board, whether the focus was mental health, violence and injury prevention, healthy eating and active living, or infant mortality, existing partnerships and coalitions were identified as key assets that are essential for success in improving the health and well being of King County communities. At the same time, many respondents believed coordination among community-based organizations could be improved. They stressed the need for increased collaboration between community-based organizations, governmental agencies, advocacy organizations, hospitals and health systems, and the private sector.

- **Faith-based institutions and committees,**

like the Eastside Interfaith Social Concerns Council, were recognized for their tireless efforts to address homelessness, food insecurity, and other basic needs.

- **Community health centers,** particularly clinics that specialize in providing culturally sensitive and appropriate care, were respected for their outreach to and care for hard-to-reach, underserved, and marginalized communities.

- **Food banks and other food-related programs,** such as Fresh Bucks, were recognized as valued resources for families struggling with food insecurity, which is a key health concern.

Community Social and Economic Context

Child and teen health are influenced by a variety of environmental and social factors. Social risk factors, such as poverty, a lack of health insurance coverage and racial/ethnic minority status, are associated with poorer health outcomes for children. In this section we present quantitative data on a variety of demographic characteristics that are considered social determinants of health. (See Figures 1 and 2 on page 5 for a listing).

Overview of Washington State and King County

Of the more than 7 million residents of Washington state, nearly 27% are under 20 years old.⁸ Washington state data also shows 13% of the population as foreign-born, with 18% speaking a language other than English at home.⁹ Of the 1.6 million children under 18 years old in Washington state, 21% of them are of Hispanic or Latino origin.¹⁰ Also, 18% of children

in Washington state (15% in King County) live in poverty, meaning a family of four earns \$24,000 or less a year in net income, while 7% in Washington (5% in King County) live in extreme poverty, which is less than \$12,000 in net income for a family of four.¹¹ Almost half of all Washington residents on Medicaid are children or teens.

King County is the 13th most populated county in the United States. With an estimated population of 2.1 million people in 2015,¹² King County is home to one-third of Washington state's population and is growing. Children and teens represent 21% of the King County population.

In King County, 15% of children live in poverty and 5% in extreme poverty. King County includes Seattle and 38 other cities, plus unincorporated and rural areas. The county is also home to 19 school districts and 12 hospitals and health systems. The South Region has an estimated 704,000 residents, which is larger than Seattle's 617,000 residents. The East

8 U.S. Census Bureau. (2016). American Fact Finder 2015 5-year ACS. Retrieved from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_S0501&prodType=table.

9 Ibid.

10 Ibid.

11 Ibid.

12 USDA Economic Research Service. (2015). Retrieved from: <http://www.ers.usda.gov/data-products/county-level-data-sets/population.aspx>.

Region has a population of about 514,000, and the North Region is home to about 122,000 people. More detailed demographic information about King County and the four regions is located in Appendix C.

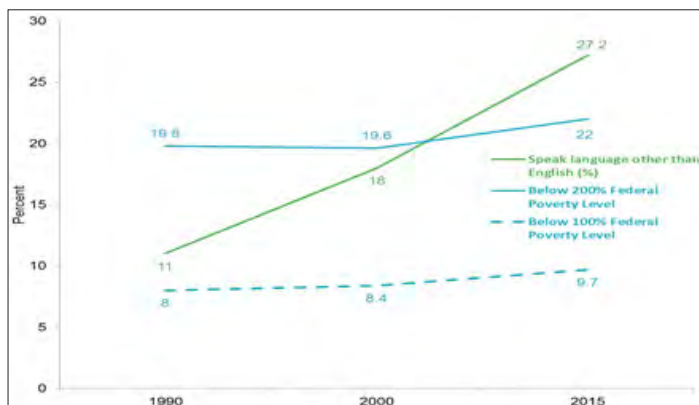


Figure 5: Demographic Trends in King County¹³

King County Demographics

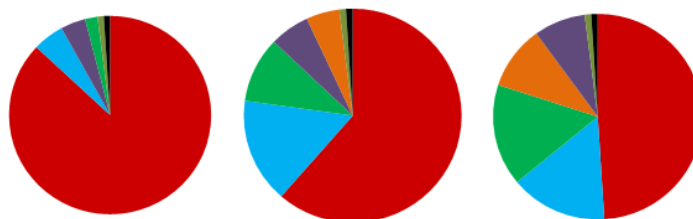
As the population of King County grows, there have been demographic shifts, including an increase in diversity. Successive waves of immigrants and refugees from Asia, the Horn of Africa (Somalia, Djibouti, Eritrea and Ethiopia), Mexico, Central America and the former Soviet Union now make King County and Washington state their home. Many refugees arrive with complex needs. As they integrate into society, these new residents can face enormous challenges, including language barriers, isolation, past trauma, poverty, and disability. They also come with many strengths, including resilience and adaptability.

In King County, more than one out of every three residents — and almost half of children — is a person of color, and the diversification trend is expected to continue. The county's fast-growing southern suburbs include several cities and school districts where people of color make up more than half the population. South King County has some of the largest health inequities of anywhere in the United States.

¹³ American Community Survey, US Census (2016). Prepared by Public Health - Seattle & King County Assessment, Policy Development & Evaluation. Retrieved from: <http://kingcounty.gov/depts/health/data/community-health-indicators.aspx>.

Approximately 170 languages are spoken in King County, and one out of every four King County residents speaks a language other than English at home — more than twice the rate 20 years ago. Students at area school districts speak dozens of different languages.¹⁴ The Tukwila School District, for example, has been dubbed “the most diverse school district in the nation.”¹⁵ In King County, Spanish is the most frequently spoken language other than English. Vietnamese, Russian, Chinese, Korean, Tagalog and African languages (primarily Somali) are also common.¹⁶

King County, 1980	King County, 2015	Population under age 18 King County, 2015
Population: 1,269,898	Population: 1,931,249	Population: 432,471



White/non-Hispanic	87%	White/non-Hispanic	62%	White/non-Hispanic	49%
Asian/Pacific Islander	5%	Asian/non-Hispanic	16%	Asian/non-Hispanic	15%
Black/African American non-Hispanic	4%	Hispanic/Latino	10%	Hispanic/Latino	16%
Hispanic/Latino	2%	Black/African American non-Hispanic	6%	Multiple race	10%
American Indian/Alaska Native	1%	Multiple race	5%	Black/African American non-Hispanic	8%
Some other race	1%	American Indian/Alaska Native/non-Hispanic	1%	American Indian/Alaska Native/non-Hispanic	1%

Figure 6: King County Population Breakdown Overall (1980 vs. 2015) and Population of Children Under Age 18 in 2015¹⁷

Poverty Improves

There have been recent improvements in poverty levels in Washington state. The number of children living in poverty had increased

¹⁴ Washington Superintendent of Public Instruction. (2011, January). Educating English language learners in Washington state, 2009-10: Report to legislature. Retrieved from <http://www.k12.wa.us/LegisGov/2011documents/EducatingEnglishLanguageLearners.pdf>.

¹⁵ Diversity in the Classroom. (2016). Retrieved from <http://projects.nytimes.com/immigration/enrollment>.

¹⁶ King County (s.f.) Retrieved from http://www.kingcounty.gov/-/media/operations/policies/documents/inf142aao_appxc.aspx?la=en.

¹⁷ US Census Bureau, Census 1980; WA Office of Financial Management 2015. Percentages may not add up to 100% due to rounding.

steadily since 2008 from 14.3% to 18.6% in 2013. In 2014, we saw our first drop in the number of children living in poverty to 17.5%.

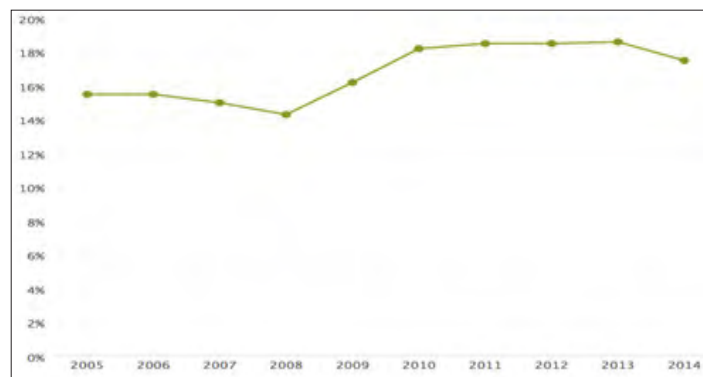


Figure 7: Percentage of Children Under 18 in Poverty in Washington State (2005-2014)

The 2016 Federal Poverty Level (FPL) threshold for a family of four is \$24,300 (100% FPL).²⁰ Nearly one out of every five residents in King County — more than 500,000 adults and children — now live in or near poverty, which is defined as below 200% of the federal poverty level. In King County, the percentage of children under age 18 who live in poverty grew from 14.5% in 2011 to 15.7% in 2013, and dropped to 13.6% in 2014.

Although the trend is improving, many families still live in economic hardship, which has negative effects on children. Children who experience economic instability at home have a harder time concentrating at school. This can undermine children's progress in the earliest

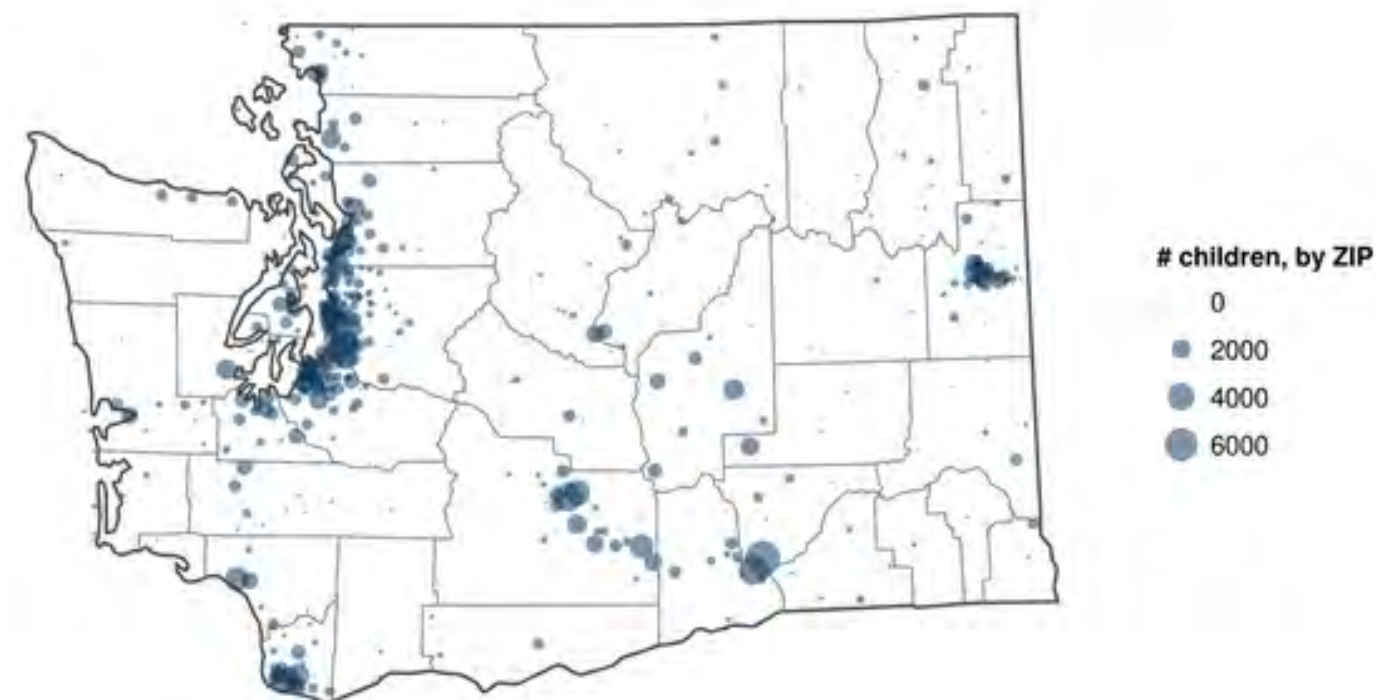


Figure 8: Density of Children Living in Poverty by Washington State Zip Code

¹⁸ Kids Count Data Center: A Project of the Annie E. Casey Foundation. (2013). Children under 18 in poverty. Retrieved from <http://datacenter.kidscount.org/data/line/3298-children-under-18-in-poverty?loc=49&loct=2#2/any/false/869,36,868,867,133,38,35,18,17,16/asc/any/6800>.

¹⁹ Seattle Children's with 2013 5-year ACS data. (2015). Children Living in Poverty: Washington. This graph was created by Dr. John Mosser in r-studio using 2013 5-year ACS data, and represents the location of children living in poverty in Washington (absolute numbers). Each point represents a zip code, and the # of children living in poverty is concordant with the size of the circle.

²⁰ Obamacare Facts. (2016). Federal Poverty Level. Retrieved from <http://obamacarefacts.com/federal-poverty-level>.

stages of their education by impeding their cognitive, social, and emotional development.²¹ Additionally, stressful events experienced in childhood, known as adverse childhood experiences (ACES), including sustained economic hardship, are linked to poor health later in life, such as obesity, alcoholism, and depression.²²

Stress experienced by parents living in poverty can also negatively impact engagement and bonding with their children, which affects children's healthy growth and development. Therefore, creating environments for kids to thrive requires policies that improve the economic well-being of parents and children.²³

As poverty shifts from inner-city Seattle to the margins of Seattle and the suburban areas in the south, the prevalence of chronic diseases and associated risk factors are also seen increasing in those areas, mirroring what is happening across the nation.²⁴ For poverty in particular, looking at King County as a whole masks huge disparities. One indicator of poverty is the eligibility for the free or reduced-price meal program in schools. The eligibility rates of the program varied widely during the 2014 to 2015 school year, from 4% of students in Mercer Island to 78% in Tukwila. All districts with 50% or more students in the free or reduced-price meal programs were located in South King County.²⁵

Housing Affordability

As housing rental and purchase prices increase, families have less to spend on other necessities. In analyzing housing affordability, experts rely on the rule of thumb that renters should spend no more than 30% of their before-tax income

21 Ibid.

22 Washington State Budget and Policy Center. (2016). Raising the Minimum Wage is an Investment in Washington's Kids. Retrieved from <http://budgetandpolicy.org/schmudget/raising-the-minimum-wage-is-an-investment-in-washington2019s-kids>.

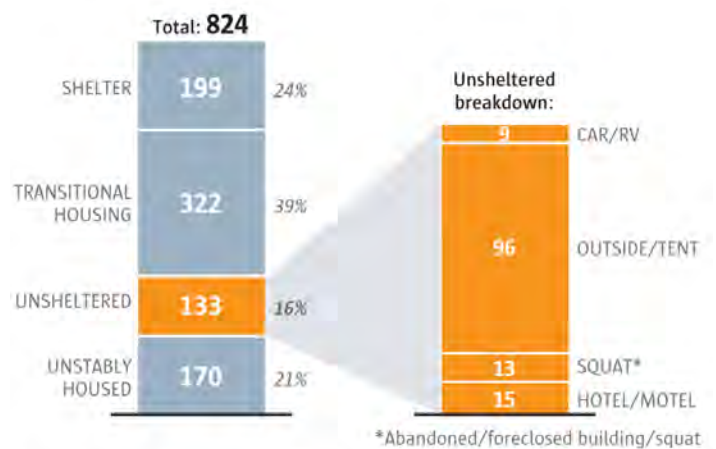
23 Ibid.

24 Kneebone, E. (2009, October 19). The Suburbanization of American Poverty. Brookings. Retrieved from http://www.brookings.edu/opinions/2009/1019_poverty_kneebone.aspx.

25 Communities Count. (2015). Low-income students by school district, King County (2006-07 school year to 2014-15 school year). Retrieved from <http://www.communitiescount.org>.

on rent and utilities.²⁶ In Washington state, the median gross rent as a percentage of household income is 30.6%.²⁷ In King County, almost half of renters and 40% of owners with a mortgage are paying more than the affordability threshold of 30% of their household income on housing.²⁸

Since 2008, the number of homeless children is up by nearly 15,000 and is particularly high for children of color.²⁹ During the 2014 to 2015 school year, there were 35,511 homeless students in Washington state.³⁰ In King County in 2016, 824 youth between the ages of 12 to 25 were homeless or unstably housed. Of these, 13% were under the age of 18, and 38% were enrolled in school.³¹ Also in King County, 778 families with children slept in emergency shelters and 2,148 lived in temporary transitional housing in 2016.³²



Source: King County's Point-In-Time Count, 2015 report

THE SEATTLE TIMES

Figure 9: Housing Status of Homeless Youth in King County, 2015

26 Rolf, P. (2012, March 5). Rental affordability: Multiple measures for a complex concept.

27 U.S. Census Bureau. (2014). Census 2010 (adjusted). Brief, Housing Costs of Renters. American Community Survey.

28 2016 King County Comprehensive Plan Update. Technical Appendix B (Housing) as gathered from: <http://www.kingcounty.gov/-/media/Council/documents/CompPlan/2016/2016-0155/AppendixBHousing.ashx?la=en>.

29 State of Washington's Kids. (2016). Retrieved from kidscountwa.org/wp-content/uploads/2016/06/State-of-Washingtons-Kids-2016.pdf.

30 Ibid.

31 Count Us In. (2016). Retrieved from <http://allhomekc.org/wp-content/uploads/2016/03/Count-Us-In-2016-Report-final-1.pdf>.

32 Seattle/King County Coalition on Homelessness. One Night Count. (2016).

33 Seattle Times. (2015). Children on the street slip through the cracks; state has misplaced priorities. Retrieved from <http://www.seattletimes.com/opinion/editorials/editorial-homeless-youth-children-seattle-king-county-dshs>.

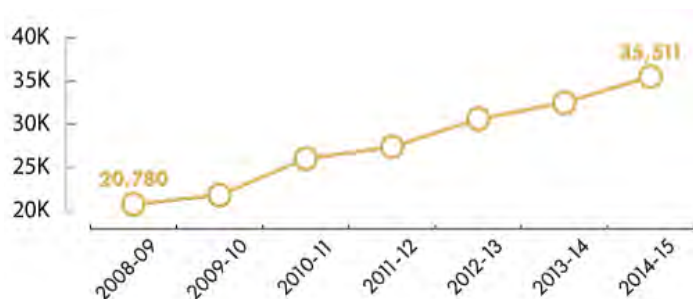


Figure 10: Number of Homeless Children in Public Schools, Washington state, 2008 to 2014³⁴

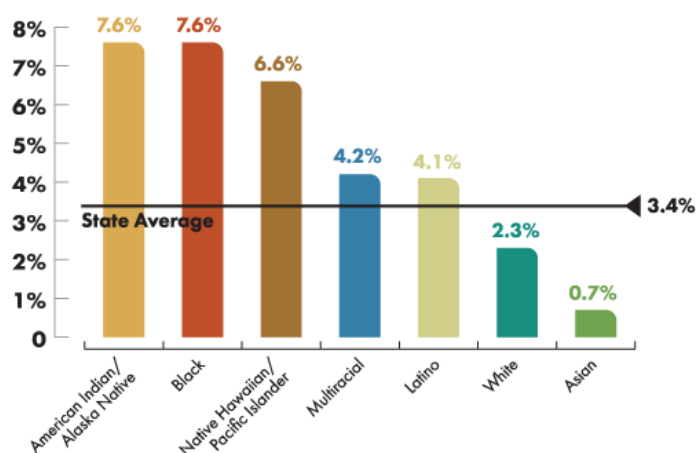


Figure 11: Percentage of Students who are Homeless by Race and Ethnicity, Washington State, 2008 to 2014³⁵

Stark Disparities by Place, Race and Income

Healthy People 2020 defines a “health disparity” as “a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”³⁶

Healthy People 2020 defines “health equity” as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally and will require focused and ongoing efforts to address avoidable inequalities, and historical and contemporary injustices to end health and healthcare disparities.”³⁷ Equity does not mean equal treatment: some populations may need more or different services to achieve health equity.

Health disparities are evident in Washington state based on data from adult populations. Though Washington state has some of the lowest death rates due to pneumonia, heart disease, colorectal cancer and influenza compared to other U.S. states, these low rates are not consistent across all of the state’s communities.³⁸ Among all ages, Washington state has some of the lowest smoking and physical inactivity rates compared to other states, but smoking rates are higher among the American Indian/Alaska Native population and rates of physical inactivity are much higher for people who are Black or of African heritage, American Indian/Alaska Native, and Hispanic populations.³⁹ In terms of health insurance coverage and dental visits, Washington state ranks in the middle range of states, but in the low range of states related to routine check-ups and cholesterol screenings.⁴⁰

³⁴ State of Washington’s Kids. (2016). Retrieved from kidscountwa.org/wp-content/uploads/2016/06/State-of-Washingtons-Kids-2016.pdf.

³⁵ Ibid.

³⁶ Healthy People 2020. (2016). Disparities. Retrieved from <http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>.

³⁷ Ibid.

³⁸ The Office on Women’s Health. (2012). Health disparities profiles: Washington state. Retrieved from http://www.healthstatus2020.com/disparities/ChartBookData_list.asp.

³⁹ Ibid.

⁴⁰ Ibid.

Overall, King County has a strong economy and ranks among the top counties in the nation on indicators of health and well-being. As with poverty, however, these averages mask stark differences by place, race and income. People of color, people living in poverty and those living in communities with few opportunities also experience the health-related impacts of inequity. Any efforts to improve the health of the community and to successfully achieve the Triple Aim of better health, better care and lower healthcare costs will require strategies that acknowledge and tackle these disparities.

Partly due to high levels of immigration, King County is home to some of the most diverse communities in the United States. The unique cultural strengths and assets of these communities benefit the entire region. We also benefit from strong institutional assets, including faith communities, governments, hospitals and health systems, universities, philanthropic organizations, and non-profits. In addition, many small programs help our communities thrive, and individuals come together to create support networks for friends, family and neighbors.

	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/Alaskan Native	Asian/Pacific Islander	State Total	Healthy People 2020 National Target	State Rank
Population (2014) (all ages)	73.5	4.4	11.7	2.2	9.2	7,061,530		
Major causes of death (rate per 100,000)§								
All cause	703.2	746.1	441.1	826.6	415.5	681.5	=	11
Heart disease	144.1	151.6	84.0	187.4	73.4	139.3	=	9
Coronary heart disease	99.5	99.4	61.7	135.1	52.0	96.3	103.4	17
Total cancer	166.1	189.2	96.6	151.3	118.2	161.4	161.4	20
Colorectal cancer	13.7	15.2	*	*	9.5	13.2	14.5	7
Lung cancer	44.1	36.7	21.7	36.5	30.0	42.3	45.5	19
Stroke	34.4	31.2	32.2	32.5	27.7	34.3	34.8	18
Chronic obstructive pulmonary diseases (age 45 & over)	121.6	61.0	48.8	127.9	31.6	113.2	102.6	21
Diabetes-related	74.8	135.4	87.4	129.0	58.9	76.2	66.6	36
Influenza and pneumonia	9.7	*	8.9	*	9.1	9.9	=	5
Unintentional injuries	40.7	30.9	25.2	70.3	19.3	38.3	36.4	16
Suicide	16.5	8.7	6.9	15.7	6.2	14.5	10.2	32
Health risk factors (percent) §								
Diagnosed high blood pressure (2013)	29.8	41.1	33.7	39.2	23.9	30.2	26.9	22
Obesity (2014) (age 20 & over)	27.9	30.5	35.4	43.6	10.7	27.4	30.5	14
No leisure-time physical activity (2014)	15.9	27.8	23.6	31.0	18.0	17.9	32.6	4
Smoking currently (2014)	15.7	17.7	11.8	31.4	9.7	15.6	12	10
Eats 5+ fruits and vegetables a day (2009)	24.9	26.0	20.4	24.7	31.7	25.0	=	18
Preventive care (percent) §								
Cholesterol screening in past 5 yrs. (2013)	73.6	77.1	58.5	73.7	78.7	72.9	82.1	35
Routine check-up in past 2 yrs. (2014)	70.7	84.1	73.5	81.5	82.1	78.0	=	26
Dental visit within the past year (2014)	69.7	61.0	52.5	53.6	64.7	66.5	=	21
Health insurance coverage (percent)								
Health insurance coverage (2014) (ages 18-64)	90.9	87.9	61.1	81.6	88.9	86.0	100	19

§ Estimate age-adjusted and for all ages unless noted.
§ Estimate age-adjusted and for 18 years of age and over unless noted.
* Figure does not meet standard of reliability or precision.
= No Healthy People 2020 target associated with this health indicator.

NOTE: All data are from 2012 unless noted.
NOTE: Low numerical rankings indicate better relative health status.
NOTE: State rank includes the 50 states, the District of Columbia, Guam, Puerto Rico and the US Virgin Islands, where data are available and reliable.
NOTE: Healthy People targets correspond with the Healthy People 2020.

Figure 12: King County Health Disparities Profile, All Ages, 2014⁴¹

41 The Office on Women's Health. (2014). Health disparities profiles: Washington state. Retrieved from http://www.healthstatus2020.com/disparities/ChartBookData_list.asp & http://52.207.219.3/qhdo/disparities/ChartBookData_search.asp.

POPULATION MEASURES

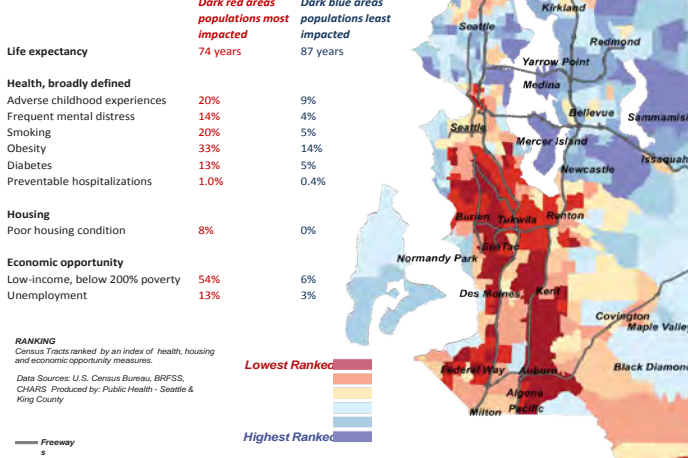


Figure 13: King County Population Measures

However, not all people in the county experience the same benefits of our strong and healthy county. Across the region, communities differ in their assets and their opportunities for improvement. Displaying data by census tract helps identify neighborhoods with the greatest opportunities for improving health. The map shows that areas in the southern part of the county and South Seattle, along with pockets in the East and North regions, generally fare worse than other areas.

For example, the average life expectancy for King County residents is 82 years, three years longer than the national average of 79 years. However, life expectancy within King County varies by almost 10 years — from 77 years in South Auburn to 86 years in West Bellevue. Many other health and social indicators — such as housing quality, alcohol-related deaths, obesity, lack of health insurance and smoking — show similar patterns of inequity.

Employment and Income

In 2015, 5.7% of Washingtonians were unemployed. The average unemployment rate for King County was 4.4% in 2015. Across the state, 67,000 children live in homes with no working adults.⁴² The median income for Washington families with children was \$69,300 in 2014.⁴³ While the median income is slightly higher in King County, there are disparities by place and race, with those in South King County and of Hispanic/Latino ethnicity earning the least.



Figure 14: Percent of Washington State Children Living in Low-Income Households without a Working Adult, 2010-2014

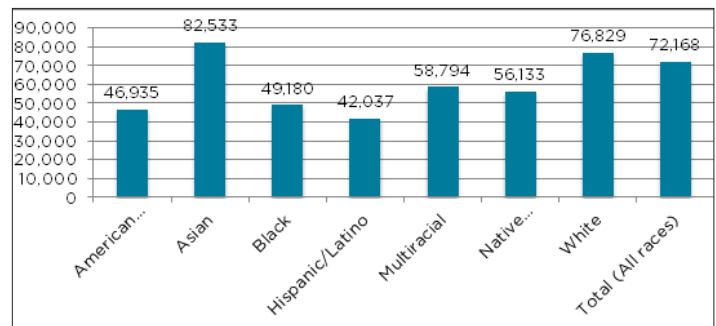


Figure 15: Median Income by Race/Ethnicity in King County, 2009-2013

42 Kids Count Data Center. (2016, March). Washington indicators. Retrieved from <http://datacenter.kidscount.org/data#WA/2/0/char/0>.

43 Ibid.

44 Ibid.

45 Kids Count Data Center. (2013). Median family income by race and ethnicity (5-year average). Retrieved from <http://datacenter.kidscount.org/data/Tables/4682-median-family-income-by-race-and-ethnicity-5-year-average?loc=49&loct=2#detailed/2/any/false/1376/437,172,133,12,4100,826,816,13/10944>.

	Median Income in Dollars	90% Margin of Error
King County	\$73,035	+/-697
Seattle	\$67,365	+/-1,101
Auburn	\$57,635	+/-2,066
Burien	\$52,140	+/-2,586
Des Moines	\$58,308	+/-3,420
Federal Way	\$54,186	+/-2,378
Kent	\$57,490	+/-2,551
Renton	\$62,949	+/-2,763
SeaTac	\$46,595	+/-4,153

Table 1. Median Household Income in King County Region, 2010-2014

Education and Early Childhood Development

Childhood health is influenced by social factors, including the education level attained by parents and the quality of educational experiences children have themselves.

In Washington state, the federally-funded Head Start program is available to meet the early childhood education needs of low-income children, 12,423 of whom were enrolled in 2014.⁴⁷ In King County in 2014, 25% children were eligible for Head Start or the Early Childhood Education and Assistance Program (ECEAP). The rate varied by school district from 48% in Vashon Island and 38% in Seattle to 15% in Federal Way, 12% in Renton, 11% in Tahoma, and 7% in Issaquah.⁴⁸ However, thousands of children who are eligible for the program do not get in due to limited availability.⁴⁹

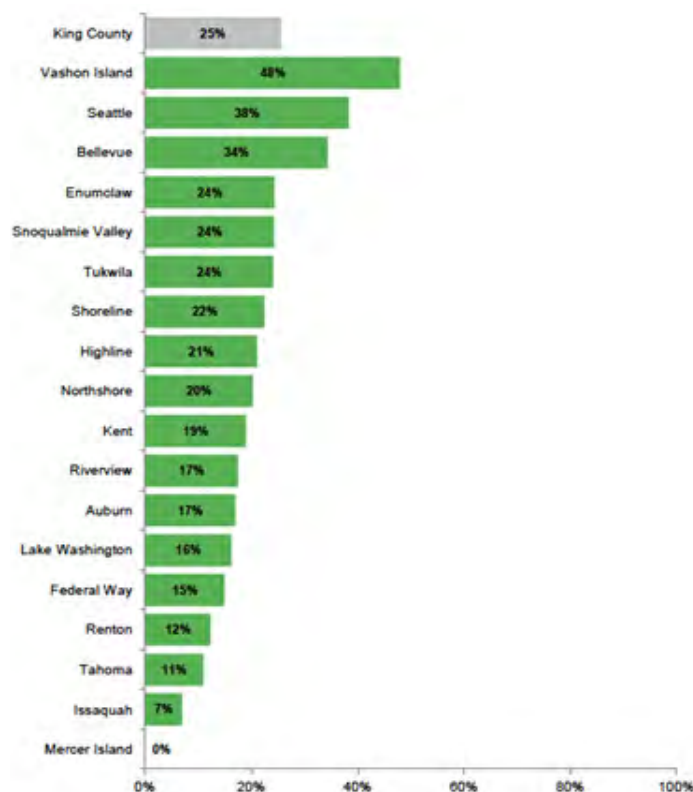
46 U.S. Census Bureau. (2014). 2010-2014 American Community Survey 5-Year Estimates. Retrieved from <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>.

47 Head Start. (2014). Head Start program facts fiscal year 2014. Retrieved from <http://eclkc.ohs.acf.hhs.gov/hslc/data/factsheets/docs/hs-program-fact-sheet-2014.pdf>.

48 Public Health-Seattle & King County. (2014). Head Start and Early Childhood Education and Assistance Program (ECEAP) enrollment King County, 2014. Retrieved from <http://www.kingcounty.gov/healthservices/health/data/-/media/health/publichealth/documents/indicators/Demographics/HeadStartECEAPCapacity2013-2014.ashx>.

49 Ibid.

High school graduation (or equivalency) is a necessary step in the transition to college. Washington ranks 36th in the nation in public school graduation rates and 46th in the number of high school graduates attending college directly from high school. The on-time high school graduation rate in the 2015-16 school year was 73% for all students in Washington state and 80% in King County. Out of 100 high school graduates (from either public or private high schools) in Washington state, 48 enroll in college directly from high school.⁵⁰



Source: Puget Sound Educational Service District, Office of the Superintendent of Public Instruction, Dept Early Learning

Figure 16: Estimated Percent of Children Eligible for Head Start and ECEAP Served in King County, 2014

Graduation rates are lower for students with limited English proficiency (53.8%), students with disabilities (55.8%), and low-income students (66.8%) in Washington state.⁵¹ Since 2005, graduation rates have increased across

50 National Information Center for Higher Education Policymaking and Analysis. (2016). Educational attainment. Retrieved from <http://www.higheredinfo.org>.

51 U.S. Department of Education. (2014). Washington state snapshot. Retrieved from <http://eddataexpress.ed.gov/state-report.cfm/state/WA>.

all ethnicities in Washington state and King County, yet American Indian/Alaska Native, black and Hispanic youth still have lower graduation rates than their Asian and white counterparts. During the 2015 school year, on-time graduation rates varied by school district, with lowest rates in Tukwila (70%, up from 57.3% in the 2012-2013 school year) and Highline (70.3%), which are both in South King County, and the highest rates in Mercer Island (93.9%) and Vashon Island (93.2%).⁵²

Foster Care

Foster placement services are provided when children need short-term or temporary protection because they are abused, neglected or involved in family conflict. Of the approximately 1.6 million children who lived in Washington in 2014, 8,942 were in foster care in 2013 (1,275 from King County);⁵³ 1,359 were adopted from foster care;⁵⁴ and about 41,000 were being raised by their grandparents.⁵⁵ The greatest number of foster children in Washington live in King, Spokane, Pierce and Clark counties.⁵⁶ More than half of children in foster care (51.4%) turn 18 years old without a permanent home.⁵⁷

LGBTQ Youth

It is difficult to accurately estimate the number of lesbian, gay, bisexual, transgender or questioning (LGBTQ) youth because most national, state and local surveys do not collect information on sexual

orientation. Adding to the complexity of gathering such data is the lack of standardized measures to assess sexual orientation, societal stigmatization, and the fact that many adolescents are unsure of their sexual orientation.

Adolescents face many challenges during their transition into adulthood. LGBTQ youth face additional challenges due to social stigma, which causes varying degrees of psychosocial stress.⁵⁸ LGBTQ youth are:⁵⁹

- Two to three times more likely to attempt suicide.
 - In one statewide representative survey of high school students, more than 30% of LGBTQ youth had attempted suicide within the past year, and 50% had considered suicide.
 - LGBTQ youth who are bullied or rejected by their families after coming out are at even greater risk.
 - Protective factors for LGBTQ youth include family connectedness, caring adults, and school safety.
- Significantly more likely to be homeless (20% to 40% of homeless youth identify as LGBTQ).
- More likely to skip school, drop out of school and get poor grades.
- Have increased rates of sexual intercourse, and use of alcohol, tobacco and illicit drugs.
- Report higher rates of verbal, physical and sexual harassment and violence.

Rural Washington

People living in rural areas experience distinct benefits and challenges to health from those living in urban areas. Across the U.S., many living in rural areas share similar advantages such as dense social networks, shared life

52 Office of Superintendent of Public Instruction. (2016). Graduation rates. Retrieved from <http://k12.wa.us/DataAdmin/PerformanceIndicators/DataAnalytics/GraduationRates4Year.xlsx>.

53 Kids Count Data Center. (2013). Children in foster care placement. Retrieved from <http://datacenter.kidscount.org/data/tables/5223-children-in-foster-care-placement?loc=49&loc=2#ranking/5/any/false/36/any/11702>.

54 Kids Count Data Center. (2013). Children exiting foster care by exit reason. Retrieved from <http://datacenter.kidscount.org/data/tables/6277-children-exiting-foster-care-by-exit-reason?loc=49&loc=2#detailed/2/49/false/36,868,867,133,38/2629,2630,2631,2632,2633,2634,2635,2636/13050,13051>.

55 Kids Count Data Center. (2014). Grandchildren in the care of grandparents. Retrieved from <http://datacenter.kidscount.org/data/tables/108-grandchildren-in-the-care-of-grandparents?loc=49&loc=2#detailed/2/49/false/869,36,868,867,133/any/433,434>.

56 Kids Count Data Center. (2013). Children in foster care placement. Retrieved from <http://datacenter.kidscount.org/data/tables/5223-children-in-foster-care-placement?loc=49&loc=2#ranking/5/any/true/36/any/11702>.

57 Children's Administration. (2015). Washington state 2016 annual progress and services report. Retrieved from <https://www.documentcloud.org/documents/2997392-2016-Wash-Annual-Progress-and-Services-Report-9.html#document/p19/a309585>.

58 Ibid.

59 Garofalo, R., et al. (1999, May). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatrics and Adolescent Medicine*. 153(5):487-93.

experiences, high quality of life and reciprocity among community members.⁶⁰ On the other hand, less availability of sidewalks, streetlights and access to facilities contribute to the higher proportion of sedentary time experienced by rural residents.⁶¹ These residents often have less access to healthy foods and exercise opportunities than their urban counterparts. Even for rural residents living closer to farming areas, some live in food deserts, which is defined as an area where the population is mostly low-income and lives 10 miles or more from a large supermarket.⁶² In rural areas, there may not be enough residents to support a grocery store that carries healthy food options at affordable costs. Additionally, across the U.S., food insecurity is higher in rural areas than in urban areas.⁶³

Such conditions contribute to the health disparities experienced by rural families. Children living in rural areas are at an increased risk of poverty, more likely to be overweight or obese, and have lower access to healthcare.⁶⁴ The scarcity of primary care physicians in rural areas coupled with the long distances needed to travel to receive healthcare pose additional challenges for rural families.⁶⁵ There is often a lack of adequate transportation, which limits the accessibility of obstetric, mental health, dental health, and substance abuse services.⁶⁶

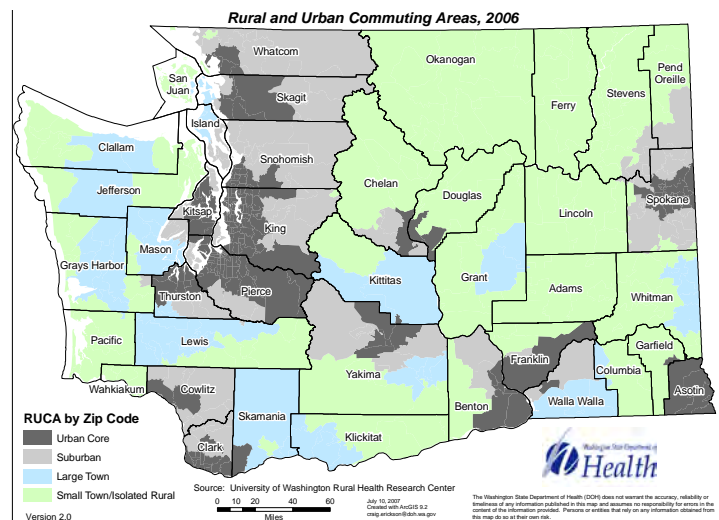


Figure 17: Urbanicity of Washington State According to the U.S. Census

Approximately 10% of Washington state's 7 million residents live in rural areas.⁶⁸ Across numerous social determinants of health, residents in rural Washington face greater disparities than their urban counterparts. In 2015, the unemployment rate in rural Washington was 7.1% compared to 5.5% in urban Washington.⁶⁹ Based on 2010-2014 American Community Survey data, of those 25 and older, 12.2% of rural Washington residents did not complete high school compared to 9.5% in urban Washington.⁷⁰ In the same period, only 23% of rural residents completed college compared to 33.4% of urban residents.⁷¹

The 2010-2014 poverty rate was also higher in rural Washington (17.8%) than in urban Washington (13.1%).⁷²

60 Unite for Sight. (2015). Urban Versus Rural Health. Retrieved from http://www.uniteforsight.org/global-health-university/urban-rural-health#_ftn9.

61 Ibid.

62 Sightline Institute. (2011). Northwest Food Deserts? They may not be where you think. Retrieved from <http://www.sightline.org/2011/06/02/northwest-food-deserts>.

63 Rural Health Information Hub. (2015). Rural Hunger and Access to Healthy Food. Retrieved from <https://www.ruralhealthinfo.org/topics/food-and-hunger>.

64 Altarum Institute. (2014). Barriers to Healthy Country Living: Child Obesity in Rural America, Part 1. Retrieved from <http://altarum.org/health-policy-blog/barriers-to-healthy-country-living-child-obesity-in-rural-america-part-1>.

65 Unite for Sight. (2015). Urban Versus Rural Health. Retrieved from http://www.uniteforsight.org/global-health-university/urban-rural-health#_ftn9.

66 Rural Health Information Hub. (2014). Healthcare Access in Rural Communities. Retrieved from <https://www.ruralhealthinfo.org/topics/healthcare-access>.

67 Washington State Department of Health. Retrieved from ftp://ftp.doh.wa.gov/geodata/layers/maps/ruca_zip_06.pdf.

68 Rural Health Information Hub. (2016). Retrieved from <https://www.ruralhealthinfo.org/states/washington>.

69 USDA Economic Research Service. (2016). Washington State Fact Sheet. Retrieved from <http://www.ers.usda.gov/data-products/state-fact-sheets/state-data.aspx?StateFIPS=53&StateName=Washington>.

70 Ibid.

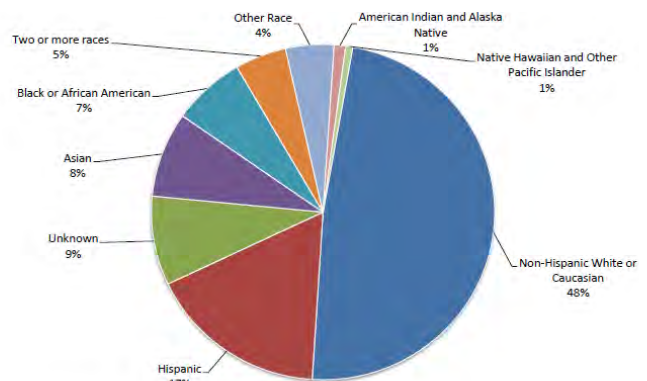
71 Ibid.

72 Ibid.

Seattle Children's Patient Demographics

In 2015-2016, Seattle Children's recorded 405,817 patient visits. This included 332,286 outpatient visits, 42,414 Emergency Department visits, and 15,947 hospital admissions. The hospital reported a total of 87,750 inpatient days, with an average length of stay of 5.08 days per patient. The top reason for inpatient admissions in 2015 was asthma at 715 visits, and the top outpatient service by volume was psychiatry with 45,019 visits.

The ethnic/racial diversity of our patients reflects the diversity of our region. At Seattle Children's, 52% of the children we serve are non-white or Latino. One in eight of our families prefer to communicate about their healthcare in a language other than English, and 13% of patient-families at Children's have limited English proficiency.



Unknown includes Patient Refused (8.4%) and Unknown (0.2%)

Figure 18: Race/Ethnicity of Seattle Children's Patients, 2015-2016

Life Expectancy and Leading Causes of Death and Hospitalization

Life expectancy and leading causes of death and hospitalization are broad foundational health measures often used by local, state and federal public health agencies to monitor progress in promoting well-being, preventing disease and disability, and reducing health disparities.

Life expectancy is defined as the number of years a newborn can expect to live if current death rates remain the same during their lifetime. While King County's life expectancy exceeds the national average, the county average masks broad disparities by place and race/ethnicity.

Life Expectancy

In 2016, the average life expectancy for newborns in Washington state was 82.6 years. In 2009-2016, the average life expectancy for King County newborns was 81.8 years.

Residents of the South Auburn neighborhood are expected to live an average of 10 fewer years than those in the West Bellevue neighborhood.⁷³

Leading Causes of Death

In 2014, the top three leading causes of death in Washington state for children and youth ages 1 to 24 were unintentional injuries, cancer and suicide.⁷⁴ From 2009 to 2013, motor vehicle crashes, drowning and poisoning were ranked in the top three leading causes of injury deaths for most age groups under age 24.

⁷³ Washington Tracking Network (2016) Life Expectancy at Birth. Retrieved from <https://fortress.wa.gov/doh/wtn/WTNPortal#!q0=655>.

⁷⁴ Washington State Department of Health. (2013). Washington state injury data table. Retrieved from <http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/Data/WashingtonStateInjuryDataTables>.

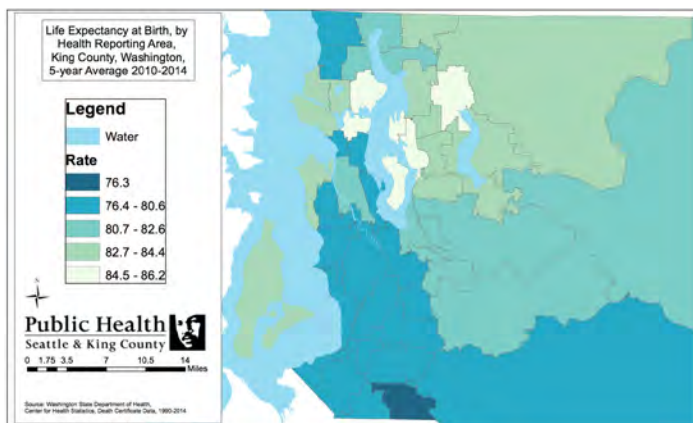


Figure 19: Life Expectancy at Birth by Health Reporting Areas, King County, 2009-2014

Rank	Age Groups				
	<1	1-4	5-9	10-14	15-19
1	Congenital Anomalies 94	Unintentional Injury 20	Unintentional Injury 14	Malignant Neoplasms 13	Unintentional Injury 79
2	Short Gestation 53	Congenital Anomalies 11	Malignant Neoplasms ---	Suicide 10	Suicide 57
3	SIDS 47	Malignant Neoplasms ---	Congenital Anomalies ---	Unintentional Injury ---	Homicide 12
4	Maternal Pregnancy Comp. 30	Homicide ---	Perinatal Period ---	Congenital Anomalies ---	Malignant Neoplasms ---
5	Placenta Cord Membranes 23	Influenza & Pneumonia ---	Anemias ---	Cerebrovascular ---	Heart Disease ---
6	Unintentional Injury 20	Perinatal Period ---	Chronic Lower Respiratory Disease ---		Meningitis ---
7	Necrotizing Enterocolitis ---	Heart Disease ---	Meningitis ---		Cerebrovascular ---
8	Respiratory Distress ---	Acute Bronchitis ---			Congenital Anomalies
9	Intrauterine ---	Chronic Lower Respiratory Disease			Influenza ---
10	Atelectasis & Circulatory System Disease (tie) ---	Diseases of Appendix ---			Pneumonitis ---

Note: counts less than 10 are suppressed as --- to prevent identification of individual cases.

Table 2. 10 Leading causes of death in Washington state by youth age, 2013

75 <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/population-maps/life-expectancy-at-birth-HRA.ashx>

76 Centers for Disease Control and Prevention. (2016). Injury prevention and control. Retrieved from http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_lcd.html.

Leading Causes of Hospitalization

Hospitalization data offer another perspective on the health of residents. Here are a few takeaways in King County:⁷⁷

- For infants under age 1, newborn delivery (referring to the routine hospitalization of a newborn infant after birth), respiratory

infections, jaundice and congenital anomalies were the leading causes of hospitalizations from 2010 to 2014.

- For children ages 1 to 14 over that same time period, the leading causes of hospitalization were asthma, respiratory infections, unintentional injuries and lower gastrointestinal disorders. Major sub-causes of unintentional injuries include falls, burns, motor vehicle crashes and poisoning.

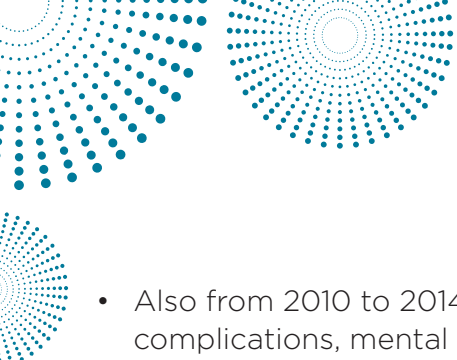
Rank	Infants (<1 year)			Age 1-14			Age 15-24		
		Rate (per 100,000)	Count (per year)		Rate (per 100,000)	Count (per year)		Rate (per 100,000)	Count (per year)
	<i>All causes</i>	102635.5	25502	<i>All causes</i>	1396.4	4563	<i>All causes</i>	3862.8	9469
1	Newborn delivery	97142.8	24137	Asthma	163.2	533	Pregnancy / childbirth complications	1609.6	3946
2	Respiratory infections	1514.8	376	Respiratory infections	158.7	519	Mental illness	717.0	1758
3	Jaundice	1332.1	331	Unintentional injuries	119.4	390	Unintentional injuries	222.3	545
4	Congenital anomalies	982.8	244	Lower gastrointestinal disorders	93.2	305	Lower gastrointestinal disorders	166.1	407
5	Urinary tract infections	317.1	79	Mental illness	92.4	301	Cancer and benign tumors	93.9	230
6	Unintentional injuries	257.6	64	Cancer and benign tumors	77.8	254	Infectious and parasitic diseases	79.1	194
7	Infectious and parasitic diseases	182.7	45	Epilepsy, convulsions	69.2	226	Self-inflicted injuries	74.0	181
8	Short gestation & low birth weight	165.8	41	Congenital anomalies	63.5	208	Diabetes with complications	66.2	162
9	Upper gastrointestinal disorders	137.6	34	Skin infections	36.4	115	Normal pregnancy & delivery	55.2	135
10	Fever of unknown origin	124.0	31	Infectious and parasitic diseases	29.4	96	Skin infections	51.6	127

Source: Washington State Department of Health, Office of Hospital and Patient Data Systems, Hospital Discharge Data. Data Prepared By: Public Health - Seattle & King County; Assessment, Policy Development, & Evaluation, 11/2016

Table 3. Leading Causes of Hospitalization by Age, King County, 2010-14 average

⁷⁷ Public Health-Seattle & King County. (2016). Leading causes of hospitalization by age, King County, 2010-2014 average.

⁷⁸ Ibid.

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- Also from 2010 to 2014, pregnancy/childbirth complications, mental illness, unintentional injuries and lower gastrointestinal disorders topped the list of the leading causes of hospitalization for teens and young adults ages 15 to 24. Major pregnancy and childbirth complications include prolonged pregnancy, high blood pressure, and conditions like preeclampsia or eclampsia. Major sub-causes of mental illness include bi-polar disorder,

depression, schizophrenia, and alcohol and substance-related disorders. Major sub-causes of injury include motor vehicle crashed, suicide, homicide and poisoning.

At Seattle Children's, the top reason for emergency department and urgent care visits in 2015-16 was respiratory problems, followed by diarrhea/vomiting/dehydration and fever/infection.

Children and Youth with Special Health Care Needs and Chronic Conditions

Children with special healthcare needs are infants, children and youth up to age 18 years who are defined as having or are at risk for chronic physical, developmental, behavioral, or emotional conditions. They require health and related services of a type or amount beyond what is generally needed. Chronic illnesses (e.g. asthma, diabetes, cancer, heart disease) are among the leading causes of death, disability and hospitalization in King County, Washington state, and the United States. They are generally characterized by multiple risk factors, a long period of development, prolonged course of illness, and increased incidence with age. We use two phrases interchangeably to describe children with complex chronic conditions: children and youth with chronic conditions and children with special health care needs (CSHCN).

Overview of Children and Youth with Special Health Care Needs/Chronic Conditions

In the U.S. and Washington state, about 20% and 18% of children have special healthcare

needs, respectively.^{79 80} In Washington, 27.6% of these children have health conditions that greatly affect their daily activities, and 6.3% experienced a period of time without insurance at some point during the past year.⁸¹ Of CSHCN families in Washington, 25.5% pay \$1,000 or more in medical expenses per year, and 24.5% report one or more unmet needs for specific healthcare services.⁸² Additionally, 9.4% of caregivers spend 11 or more hours per week providing and/or coordinating healthcare for their child.⁸³

Care Coordination

Care coordination, also known as care or case management, "is the set of activities which occurs in the space between visits, providers, and hospital stays."⁸⁴ It has been identified as

79 Kids Count Data Center. (2011-2012). Children with special health care needs. Retrieved from <http://datacenter.kidscount.org/data/tables/29-children-with-special-health-care-needs#detailed/1/any/false/1021,18,19,12/any/298,299>.

80 Kids Count Data Center. (2011-2012). Children with special health care needs. Retrieved from <http://datacenter.kidscount.org/data/tables/29-children-with-special-health-care-needs#detailed/2/49/false/1021,18,19,12/any/298,299>.

81 Washington State Department of Health. (2009-2010). Washington state children and youth with special health care needs: Data report. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/970-197-CYSHCNDataReport2012.pdf>.

82 Ibid.

83 Ibid.

84 Antonelli RA. Achieving optimal outcomes of care: Supporting the medical home team. October 2014. Retrieved from <http://www.childrenshospital.org/-/media/care-coordination/aap-symposium/achieving-optimal-outcomes-of-care.ashx?la=en>.

a key issue and high priority for Medicaid and the pediatric and adolescent population. Care coordination within healthcare systems involves deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care.

For CSHCN and their families, care coordination can be critical for linking them to needed medical and non-medical services, and for providing logistical assistance and emotional support. These children, their families, and their providers face myriad challenges including coverage of specialty items, access to pediatric specialists, and navigating the various health and non-health systems. This can be very time consuming and frustrating. As a result, CSHCN receive fragmented or duplicative services and typically have many more unmet medical needs than other children.⁸⁵ Research has demonstrated that care coordination decreases unmet specialty care needs among CSHCN and that the effect of care coordination is greater among low-income families.⁸⁶ For parents of CSHCN, it is often overwhelming to manage their children's entire universe of care, from traveling to appointments with multiple providers, to administering treatments and medicine, to managing educational needs and making sense of insurance coverage. This is even more challenging among non-English speaking families.

Therefore, care coordination is seen as essential to ensuring children and families get the right care, at the right time, in the right setting, which is the basis for achieving the Triple Aim. In a 2012 survey, families with CSHCN identified care coordination as their top priority. At its best, care coordination should be a covered service that addresses the interrelated medical, social, developmental, behavioral, educational, and financial needs of children and their families.

Currently, there is great confusion over who is responsible for providing care coordination services, who should pay, and how to get reimbursed for such services. In Washington state, there is a Medicaid investment in care coordination. Through the Department of Social and Health Services (DSHS), there are home- and community-based case management services that provide some level of care coordination, and there are expectations of Medicaid managed care plans that care coordination is provided for CSHCN.

Nevertheless, in Washington state, 47.1% of CSHCN reported that they received effective care coordination compared to 75.2% of non-CSHCN children.⁸⁷ Moreover, care coordination is often fragmented and limited, with minimal linkages across systems (e.g., social services and the medical home; home and community case management and hospitals). For families, the vast majority of care coordination is provided telephonically with no connection to a trusted person in the community or from the health care setting.

Another potential community resource are locally based CSHCN coordinators, who ensure that a child's and family's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.⁸⁸ Although they are not placed in a practitioner's office, they are uniquely qualified to provide care coordination. Historically, this service has been largely provided by the local health jurisdictions (LHJs) or other local organizations. With budget cuts and changes in the public health delivery system, access to a CSHCN coordinator is limited.

85 Mayer ML, Skinner, AC, and Slifkin, RT Unmet need for routine and specialty care: Data from the National Survey of children with special health care needs. *Pediatrics*, 2004, 113_ 109-115.

86 Boudreau, Goodman, Kurowski, Perrin, Cooley, & Kuhlthau (2014). Care coordination and unmet specialty care among children with special health care needs. *Pediatrics*. Retrieved from <http://pediatrics.aappublications.org/content/early/2014/05/20/peds.2013-2174.abstract>.

87 Data Resource Center for Child & Adolescent Health. (2007). 2007 NSCH child health and system performance profile. Retrieved from <http://childhealthdata.org/browse/data-snapshots/nsch-profiles/performance>.

88 Agency for Healthcare Research and Quality. Retrieved 04/02/2014. <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>.

Adolescent Transition

Medicaid and Children's Health Insurance Program (CHIP) serve a disproportionately large and ever-increasing number of children with special health care needs (CSHCN), who will likely remain publicly insured when they become young adults. These CSHCN, along with their healthier peers, will need to transition from pediatric to adult healthcare. Of youth ages 12 to 17 with special needs, only half received services needed for transition to adult life, adult healthcare, work, and independence. This lack of transition support is disproportionately experienced by publicly insured CSHCN, 75% of whom are not receiving needed transition support, a rate almost 50%⁸⁹ higher than among privately-insured CSHCN.

In 2013, Medicaid and CHIP covered 7.8 million adolescents ages 12 to 17,⁹⁰ and 38.4%⁹¹ or 3 million of these have a special health care need. Over time, the proportion of CSHCN who are publicly insured has increased dramatically – from 25.8% in 2005/2006⁹² to 38.4% in 2011/2012.⁹³ Medicaid covers an additional 4.8 million young adults, ages 18 to 25.⁹⁴ Prevalence estimates of chronic conditions for this age group are unavailable. The population of CSHCN is approximately 60,000 for 14 to 17 year olds and about 84,000 for 18 to 25 year olds.⁹⁵ This assumes that 38% of Medicaid clients have a special healthcare need. Certain youth and young adults covered by Medicaid are particularly vulnerable during the

transition period from early adolescence into young adulthood, including the 1.2 million SSI recipients between the ages of 13 and 25.⁹⁶

The benefits for adolescent transition are documented with many cited on the Got Transition/Center for Health Care Transition Improvement site funded through Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health. Furthermore, adolescent transition is highlighted in the national "Standards for Systems of Care for Children and Youth with Special Health Care Needs."⁹⁷ Since the release in 2011 of the new transition model - the Six Core Elements of Health Care Transition - states are refining and updating their transition objectives and strategies. A total of 32 states, including the District of Columbia, selected transition as a priority for their Title V State Action Plans. Of the states in the WAMI region, only Montana selected transition as a priority for its Action Plan.⁹⁸ The Washington State Department of Health offers information and resources for families through The Center for Children with Special Needs Website's Teens and Young Adult section. It includes materials to keep track of medical information, age-specific transition booklets, advocacy tips and resources to help teens plan for the future.

Transition planning between youth, family, and provider has been associated with improvements in satisfaction, continuity of care, and greater adherence to care.⁹⁹⁻¹⁰⁰ Yet most pediatric providers have no organized clinical process for transition, which should include a description of the practice transition policy and recommended age for transfer,

89 McManus MA, Pollack LR, Cooley WC, McAllister JW, Lotstein D, Strickland B, Mann MY. Current status of transition preparation among youth with special needs in the United States. *Pediatrics*. 2013; 131:1090-1097.

90 Special tabulations prepared by the State Health Access Data Assistance Center (SHADAC) from the 2013 American Community Survey.

91 Special tabulations prepared by the Data Resource Center for Child and Adolescent Health from the 2011/12 National Survey of Children's Health.

92 2005/06 National Survey of Children with Special Health Care Needs. Available at www.childhealthdata.org/browse/suirvey/results?q=479&g=45. Accessed on June 5, 2015.

93 Special tabulations prepared by the Data Resource Center for Child and Adolescent Health from the 2011/12 National Survey of Children's Health.

94 Special tabulations prepared by the State Health Access Data Assistance Center (SHADAC) from the 2013 American Community Survey.

95 WA State Health Care Authority-Medicaid Program. Received 01/11/16.

96 SSI Annual Statistical Report, 2013. Washington, DC: Social Security Administration.

97 Standards for Systems of Care for Children and Youth with Special Health Care Needs. <http://www.lpfch.org/publication/standards-systems-care-children-and-youth-special-health-care-needs>.

98 Got Transition (2016). State Title V Health Care Transition Performance Objectives and Strategies: Current Snapshot and Suggestions. Retrieved from: <http://www.gottransition.org/resourceGet.cfm?id=407>.

99 McDonagh JE. Transition of care from paediatric to adult rheumatology. *Archives of Disease in Childhood*. 2007;92 (9):802-807.

100 Wojciechowski EA, Hurtig A, Dorn L. 2002. A natural history study of adolescents and young adults with sickle cell disease as they transfer to adult care: A need for case management services. *Journal of Pediatric Nursing* 17(1):18-27.

a method for assessing youth's transition readiness or self-care skills, a plan of care that incorporates the youth's transition goals, a current medical summary and emergency care plan, a list of vetted adult providers a plan to communicate with adult providers and sharing of up-to-date medical information, and a mechanism to confirm transfer and consumer feedback. Similarly, most adult providers have no organized clinical process for identifying clinicians in their practice interested in caring for young adults, overseeing transfer information and communication with past pediatric providers, welcoming new young adults, tracking young adults in their patient population, assessing their self-care skills, and providing consumer feedback.

Without adequate support, CSHCN transitioning to adult health are at increased risk for poor health outcomes, dissatisfaction with care, and higher costs.^{101 102} The literature shows that youth and young adults are often unable to name their health condition, relevant medical history, prescriptions and insurance. Their adherence to care is lower, medical complications are increased, and emergency room and hospital care use is higher. Further, many young adults and families are dissatisfied with their lack of preparation, information about adult care, vetted adult providers, communication between pediatric and adult providers, and sharing of medical information. In addition, many report having difficulty finding an adult provider willing and interested in accepting them as a new patient, particularly those with developmental disabilities, mental health conditions, and complex medical conditions.^{103 104} Therefore, the need for adolescent transition support is highly important.

In 2002 and again in 2011, the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) published joint clinical reports and consensus statements regarding transition for youth/children with special health care needs (YSHCN/CSHCN), calling for sweeping but simple improvements to a well-recognized issue. In its HealthyPeople 2020 objectives, the US DHHS specifically identified improvements in transition for YSHCN as a public health goal. A recent study also showed racial and socioeconomic disparities in transition services: patients who are white (non-Hispanic ethnicity), have income four times the poverty level, privately-insured, and whose condition has little or no daily impact on activities were more likely to receive transition services.¹⁰⁵ Improving transition represents not only a medical and public health priority, but one issue of equity.

Recent studies show that CSHCN continue to experience worse outcomes specifically at the time of transition. As a result, they frequently undergo delayed transitions, staying with their pediatric providers into young adulthood. Ultimately, some of them receive worse care when treated as young adults in pediatric environments. Only 47% of CSHCN in Washington reported receiving effective care coordination during transition.

As stated earlier, in Washington, 14-17% of children aged 0-17 years have special health care needs. Historically, many children would pass away from special health care conditions like cystic fibrosis, blood cancers, congenital heart disease, and premature birth. However, now more than 90% of CHSCN survive past into adulthood. At Seattle Children's, 70% of our patients are CSHCN, two-thirds of whom are considered complex CSHCN. We have done well to help them survive we are now in a position to help them launch into adulthood as well.

105 [McManus 2013].

101 Evidence of Transition Planning Impact on Population Health, Patient Experience, and Cost of Care. Washington, DC; Got Transition, 2014. Available at www.gottransition.org. Accessed on June 5, 2015.

102 Prior M, McManus M, White P, Davidson L. Measuring the "Triple Aim" in transition care: a systematic review. *Pediatrics*.134; e1648-e1661.

103 Evidence of Transition Planning Impact on Population Health, Patient Experience, and Cost of Care. Washington, DC; Got Transition, 2014. Available at www.gottransition.org. Accessed on June 5, 2015.

104 Prior M, McManus M, White P, Davidson L. Measuring the "Triple Aim" in transition care: a systematic review. *Pediatrics*.134; e1648-e1661.

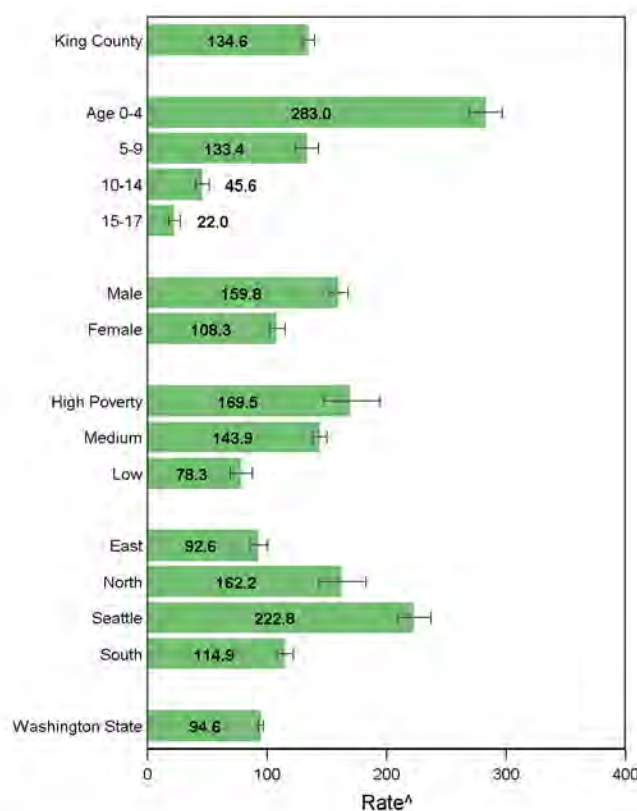
Fortunately, national organizations have been beginning to address this problem. One notable organization is GotTransition, a collaboration of the non-profit National Alliance to Advance Adolescent Health and the Department of Health and Human Services Maternal and Child Health Bureau. They outline Six Core Elements of transition, which provide a national standard for the framework of adolescent transition care:

- 1. Transition policy:** Develop policy statements, educate staff, share with youth and families
- 2. Transition tracking and monitoring:** Identify youth, track progress, and incorporate into electronic medical record
- 3. Transition readiness:** Regular readiness assessments, develop shared goals/actions
- 4. Transition planning:** Develop provider transfer package, develop youth transfer plans, counsel on “care at 18”, provide linkages
- 5. Transfer of care:** Confirm providers, complete transfer packages, first full adult appointment
- 6. Transfer completion:** Confirm and elicit feedback, build collaboration.

Childhood Asthma

In King County, 5% of children from birth to age 17 had asthma in 2016,¹⁰⁶ compared to 6% of children in Washington state and 8.6% of children throughout the United States in 2014.¹⁰⁷ Only one third of Washington youth with asthma report having a written asthma plan to help them control their medications and exposures.¹⁰⁸

Asthma is the leading cause of hospitalization for children ages 1 to 14 in Washington state. In 2014, hospitalization rates for asthma were 123 per 100,000 children in King County compared to 79 per 100,000 children in Washington state.¹⁰⁹ Males, young children, and children who live in high or medium-poverty areas all have higher rates of asthma hospitalization.¹¹⁰ At Seattle Children’s, asthma was the number one reason for hospital admission in 2015.



Source: WA State DOH, Office of Hospital and Patient Data Systems.
 Prepared by Public Health - Seattle & King County, APDE, 08/2016.
 Rate = cases per 100,000 population, age-adjusted to the 2000 US population.
 Confidence interval shows range that includes true value 95% of the time.
 * Too few cases to protect confidentiality and/or report reliable rates.
 † Too few cases to meet precision standard, interpret with caution.
 Data by race/ethnicity not available.
 Poverty = Neighborhood poverty levels defined by median household income.

Figure 21: Asthma Hospitalizations Rates Among Subgroups of Children in King County

¹⁰⁶ Public Health-Seattle & King County. (2016). You otter know (Public Health Insider). Retrieved from <https://publichealthinsider.com/2016/05/17/you-otter-know-about-asthma>.

¹⁰⁷ Centers for Disease Control and Prevention (2016) 2014 National Current Asthma* Prevalence. Retrieved from http://www.cdc.gov/asthma/most_recent_data.

¹⁰⁸ Washington State Department of Health. (2013, February). The Burden of Asthma in Washington State. 2013 Update. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/345-240-AsthmaBurdenRept13.pdf>.

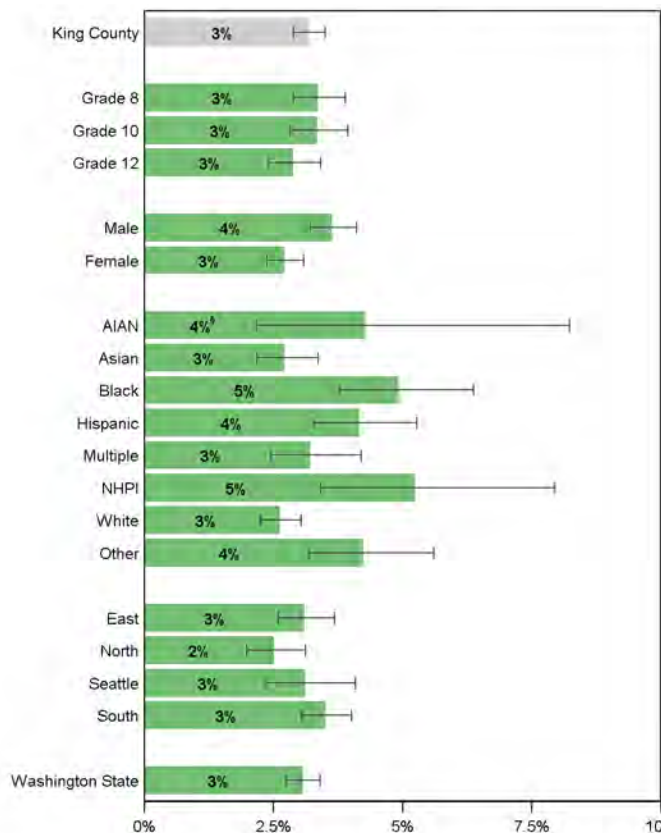
¹⁰⁹ Public Health-Seattle & King County. (2012). Child asthma hospitalizations (age 0-17). Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/chronic-illness/asthma-prevalence-children.ashx><http://www.kingcounty.gov/depts/health/data/community-health-indicators.aspx>.

¹¹⁰ Ibid.

¹¹¹ Ibid.

Childhood Diabetes

In 2014, 3% of Washington state and King County students in eighth, 10th and 12th grades had doctor-diagnosed diabetes, which includes type 1 and type 2 diabetes.¹¹² Native Hawaiian/Pacific Islander and black students were almost two times as likely as white students to have been diagnosed with diabetes. In contrast to adult diabetes, children's diabetes rates declined from 2006 to 2014, for the county as a whole and in Seattle and the southern part of King County.



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 08/2016.
[---] Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

Figure 22: Rates of Diabetes Among Subgroups of School-age Children in King County, 2014 Average

112 Public Health-Seattle & King County. (2010). Diabetes (school-age, King County, 2008 and 2010). Retrieved from <http://www.kingcounty.gov/healthservices/health/data/%7e/media/health/publichealth/documents/indicators/ChronicIllness/DiabetesSchAgeYth.ashx>.

Cancer

Cancer incidence in children from birth to age 20 in Washington state (2009 to 2013) was 17.6 per 100,000, comparable to the U.S. incidence of 17.4 per 100,000.¹¹³ Skagit and Benton Franklin counties had the highest cancer incidence rates at 21.6 per 100,000 and 20 per 100,000, respectively.¹¹⁴ King County had a cancer incidence of 18.8 per 100,000 in children birth to age 20.¹¹⁵ On average, there are 313 cases of childhood cancer per year in the state.¹¹⁶

Teens and young adults with cancer have different needs and treatment challenges than children or older adults.¹¹⁷ Many teens fall into a gap between cancer treatment programs designed for children and those created for adults, increasing the time it takes for diagnosis and treatment. Teens and young adults are much less likely than children to get the most advanced treatments by taking part in research studies. For certain cancers, teens and young adults have much better results when they are treated at a pediatric hospital.

About 70,000 teens and young adults ages 15-39 are diagnosed with cancer each year in the United States. This accounts for 5% of cancer diagnoses in the country.¹¹⁸ Cancer is the leading cause of disease-related death for young adults, outpaced only by accidents, suicide and homicide.¹¹⁹

113 National Cancer Institute. (2012). State cancer profiles: Washington. Retrieved from <http://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=washington>.

114 Ibid.

115 Ibid.

116 Ibid.

117 Seattle Children's Hospital. (2016). Childhood cancer and blood disorders program. Retrieved from <http://www.seattlechildrens.org/clinics-programs/cancer>.

118 National Cancer Institute (2014). Adolescents and young adults with cancer. Retrieved from <https://www.cancer.gov/types/aya>.

119 Park, Eliza and Rosenstein, Donald (2015). Depression in adolescents and young adults with cancer. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4518700>.

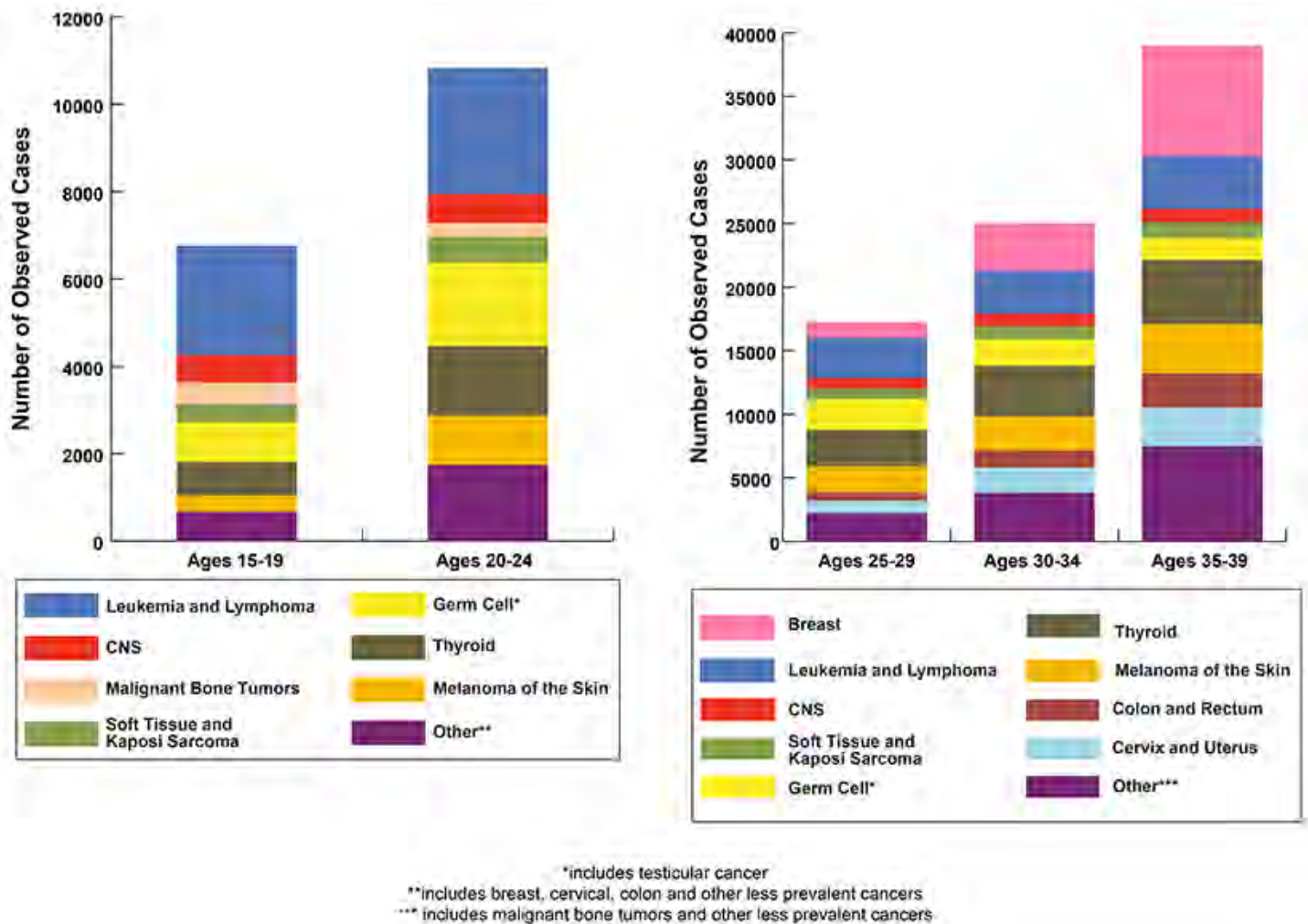


Figure 23: Common Types of Cancer Affecting AYAs

In Washington state, the incidence rate for all cancers among young adults ages 15-39 across all genders and races is 420.3 per 100,000.¹²¹ In comparison, the incidence rate for all cancers across all ages was 450.3 per 100,000 in 2013.¹²² In 2015, cancer was the second leading cause of death for children ages 1-14, the fourth cause of death for people ages 15-24 and the third cause for young adults ages 24-35.¹²³

Children who survive cancer need careful attention for the rest of their lives. Up to two-thirds of childhood cancer survivors have treatment-related side effects months or even years later. These include organ damage, second cancers and problems with mental tasks that can impact school and work performance.

Teachers and future employers may not understand the unique needs of childhood cancer survivors, or may have misconceptions about survivors' abilities. Community physicians may also have limited knowledge of cancer survivors' needs.

¹²⁰ National Cancer Institute (2007-2011). Common types of cancer affecting AYAs, ages 15-39. Retrieved from: https://www.cancer.gov/PublishedContent/Images/images/snapshots/2014/english/2014_AYA_BAR_v6-side.png.

¹²¹ Washington State Department of Health (2016). Washington state cancer registry. Retrieved from <https://fortress.wa.gov/doh/wscr/Query.mvc/SubmitToCHATQueryService>.

¹²² Centers for Disease Control and Prevention (2013). Cancer rates by U.S. states. Retrieved from <http://www.cdc.gov/cancer/dcpc/data/state.htm>.

¹²³ Washington State Department of Health (2015). Leading causes of death by age group and sex for residents. Retrieved from <http://www.doh.wa.gov/portals/1/Documents/5400/DeathC32015.xls>.

Age Group	Average Annual Population	Average Annual Observations	Age-Spec. Rate per 100,000	95% CI
15-19	455682	107	23.4	[21.5, 25.5]
20-24	467660	215	46	[43.3, 48.8]
25-29	477620	366	76.5	[73.1, 80.1]
30-34	461542	521	112.8	[108.5, 117.2]
35-39	443680	717	161.6	[156.4, 167.0]

Table 4. Washington State Cancer Incidence Data 2009-13¹²⁴

Transplant

More than 121,000 people in the U.S. are waiting for a life-saving organ transplant.¹²⁵ An average of 21 people, children and adults, die each day from the lack of available transplant organs.¹²⁶ All patients waiting for a deceased-donor transplant in the U.S. have equal access to donated organs. Potential recipients waiting for a deceased-donor organ are listed with the United Network for Organ Sharing (UNOS). More than 3,400 people in the Northwest (UNOS region 6: Washington, Alaska, Idaho, Montana, Oregon and Hawaii) are currently in need of life-saving organ transplants.¹²⁷ UNOS, however, gives special allowances for children in certain circumstances. For example, pediatric liver transplant candidates need smaller organs so they receive priority if the donor is younger than 18.

YEARS	< 1	1-5	6-10	11-17
All organs	3	14	12	16
Kidney	0	10	3	12
Liver	1	2	2	3
Pancreas	0	0	0	0
Kidney/ Pancreas	0	0	0	0
Heart	2	1	1	0
Lung	0	0	0	0
Heart/ Lung	0	0	0	0
Intestine	0	1	6	1

Table 5. Children and Youth on Waitlist for Organ Transplant in Washington State as of 02/26/2016¹²⁸

¹²⁴ Washington State Department of Health, Washington State Cancer Registry (January 2016). Washington state cancer incidence. Results generated: Nov. 28, 2016 from <https://fortress.wa.gov/wscr>.

¹²⁵ HRSA Organ Procurement and Transplantation Network. (2016). Retrieved from <http://optn.transplant.hrsa.gov>.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ Ibid.

Heart Disease

Congenital heart disease (CHD) is the most common birth defect in the United States. Individuals with this chronic disorder have a high risk of developing additional problems and require lifelong monitoring.¹²⁹ The majority of children born with a congenital heart defect survive into adulthood, yet many require specialized and ongoing medical treatment.¹³⁰ The cause of most congenital heart diseases is still unknown and can be genetic,¹³¹ but some congenital heart defects can be prevented. Being obese, having diabetes, and smoking during pregnancy increase the chances of having a baby born with a heart defect.¹³² In the United States, about 40,000 infants are born with a heart defect each year.¹³³ While Washington State does not have a comprehensive birth defects registry thus making it difficult to find specific birth defect rate information, the Collaborative on Health and the Environment – Washington (CHE-WA) “estimates that about 800 babies are born with heart defects or congenital heart disease every year in Washington State.”¹³⁴

¹²⁹ The Children's Heart Foundation. (2016). Transition and lifelong care goals. Retrieved from <http://www.childrensheartfoundation.org/advocacy/transition-and-lifelong-care>.

¹³⁰ American Heart Association. (2011, February 28). Adult care for congenital heart disease patients should begin in adolescence. Retrieved from <http://newsroom.heart.org/pr/aha/1278.aspx>.

¹³¹ Centers for Disease Control and Prevention (2015). Five facts about congenital heart defects. Retrieved from <http://www.cdc.gov/features/heartdefects>.

¹³² Ibid.

¹³³ Centers for Disease Control and Prevention (2016). Congenital heart defects. Retrieved from <http://www.cdc.gov/ncbddd/heartdefects/data.html#References>.

¹³⁴ The Collaborative on Health and the Environment – Washington (2016). Birth defects. Retrieved from http://washington.chenw.org/Rlgroup/birth_defects.html.

Community Assets and Resources

Care Coordination

- The benefits for care coordination are well documented. There are nationally recognized curricula, such as Boston's Children's Hospital Curriculum for Pediatric Care Coordination.¹³⁵ The Center for Medicare and Medicaid Services (CMS) has endorsed this in the 2014 publication "Making Connections: Strategies for Strengthening Care Coordination in the Medicaid Benefit for Children and Adolescents."¹³⁶ Further, care coordination is called out as a strategy in the national "Standards for Systems of Care for Children and Youth with Special Health Care Needs"¹³⁷ which has outlined evidence based strategies on many key domains to support optimal outcomes for this population. Seattle Children's Pediatric Partners in Care (PPIC) program is improving outcomes and reducing the total cost of care for children with special health care needs. Launched with a federal grant, PPIC strives to keep children out of the hospital, reduce the use of emergency services for non-emergent care, and prevent unplanned inpatient returns.

Chronic Conditions

- The Stanley Stamm Camp provides a medically supported one-week overnight camp experience in an outdoor wilderness setting for children ages 6 to 14 with terminal or chronic medical illnesses. The camp is free to all who attend.
- The Center for Children with Special Needs at Seattle Children's has developed a directory with an additional 68 camps for children with special needs in Washington state.

¹³⁵ Pediatric Care Coordination Curriculum. <http://www.childrenshospital.org/care-coordination-curriculum>.

¹³⁶ Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children & Adolescents. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSTD-Care-Coordination-Strategy-Guide.pdf>.

¹³⁷ Standards for Systems of Care for Children and Youth with Special Health Care Needs. <http://www.ipfch.org/publication/standards-systems-care-children-and-youth-special-health-care-needs>.

Cancer

- The Seattle Cancer Care Alliance (SCCA) brings together Seattle's top cancer research organizations: Fred Hutchinson Cancer Research Center, University of Washington Medicine and Seattle Children's. Through the SCCA partnership, Seattle Children's cares for hundreds of new pediatric cancer patients each year. Research has found that teenagers with cancer do better if they are given treatment plans designed for children. Through the SCCA, teenagers can continue to be treated on pediatric protocols as they enter adulthood.
- The Fred Hutchinson Cancer Research Center conducts research to improve prevention and treatment of cancer and related diseases. The center pioneered bone marrow transplantation procedures.
- The Adolescent and Young Adults With Cancer (AYA) Program at Seattle Children's provides expert medical care and support for teens and young adults with most forms of cancer into their late 20s. The program offers a weekly "Teen Hangout" staffed by a hematology/oncology social worker where young people with cancer can meet peers and address their psychosocial needs. The AYA is open to anyone in the community. The group partners with other community organizations that provide support for young adult patients and survivors.
- Seattle Children's Cancer Survivor Program is a follow-up program for childhood cancer survivors, whether they were treated at Seattle Children's or elsewhere. It aims to keep survivors healthy throughout their lives by providing care and education about their health risks. The Cancer Survivor Program was designed to meet the unique needs of survivors treated during childhood. The program serves survivors who are still children, as well as adults who were treated for cancer during childhood. It also gives survivors the chance to take part in research

studies so we can learn more about the best ways to keep survivors well.

- Seattle Children's is a regional and national leader in fertility preservation services and education. Children who have had cancer may experience decreased fertility as a result of their treatment. We lack resources, treatment guidelines and systems for treating pediatric cancer patients' reproductive issues. Data shows that fertility preservation improves hope and resilience among cancer therapy patients. In response to patient/family requests and community needs, Seattle Children's Cancer Center developed the fertility preservation program, providing fertility counseling and reproductive services for cancer patients. Seattle Children's offers a standard process for sperm banking to all at-risk boys over age 12.
- Through Seattle Children's Cancer and Blood Disorders Center, the multidisciplinary team of pediatric cancer experts treats about 250 children newly diagnosed with cancer every year — more than any other institution in the region — and provides follow-up care to more than 12,700 children and adolescents. In outpatient clinics and in the 48-bed inpatient unit, children receive advanced diagnoses and treatments, participate in state-of-the-art research studies and get specialized care.
- Seattle Children's is specifically:
 - Implementing health awareness efforts targeting secondary cancer prevention (testicular, breast and skin cancers).
 - Working to increase awareness and health promotion for the Gardasil vaccine (for boys and girls).
 - Promoting community education regarding the Gardasil vaccine and skin cancer.
 - Addressing myths associated with sperm banking.
 - Providing web-based education to any cancer patient with materials such as "Having a Life With Cancer" and

"Fertility and Cancer," which is a fertility preservation informational video for girls.

- Using social media for patient education and support.
- Seattle Children's providers:
 - Share practice guidelines, resources and systems with other healthcare institutions regarding fertility preservation and reproductive services for cancer patients.
 - Provide consultation and share expertise, resources and guidelines through Continuing Medical Education to community practitioners about adolescent and young adult oncology, fertility preservation and other topics.

Adolescent Transition

- A new clinical intervention, called the "Six Core Elements of Health Care Transition," was published in 2014 for widespread implementation to address the adolescent transition gap within the medical home.¹³⁸ This tested transition model¹³⁹ – available for use in pediatric and adult care settings – is aligned with the AAP/AAFP/ACP Clinical Report on Transition.¹⁴⁰ The Six Core Elements, a multi-team transition model for youth and young adults between the ages of 12 and 26, is different from the plethora of transition care coordination efforts designed to improve transfer from one setting to the next. It extends over a longer time and includes a broader set of services. For pediatric practices, the core elements include a transition policy, transition tracking, transition readiness assessment, transition planning, transfer of care, and transfer completion. For adult practices, the core elements include a young adult transition and care

¹³⁸ Six Core Elements of Health Care Transition 2.0. Available at www.gotttransition.org. Accessed on June 5, 2015.

¹³⁹ McManus MM, White P, Barbour A, Downing B, Hawkins K, Quion N, Tuchman L, Cooley WC, McAllister JW. Pediatric to adult transition: a quality improvement model for primary care. *Journal of Adolescent Health*.2014; 1-6.

¹⁴⁰ American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, Transitions Clinical Report Authoring Group. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*.2011; 128:182-202.

policy, tracking of new young adult patients, orientation to adult practice, integration into adult practice, initial visit, and ongoing care. The Six Core elements include sample tools for each transition element along with measurement and consumer feedback forms.

- Seattle Children's new multidisciplinary Adolescent Health Transition Committee and Family Task Force have formed to develop an infrastructure for adolescent health transition at the hospital. Ten clinics, centers and departments have offerings in place to support families with adolescent health transition. We have updated our patient and family education resources and have made them more accessible to both families and healthcare providers.
- The Center for Children with Special Needs Website's Teens and Young Adult section has many materials for teens and young adults who have special needs and are transitioning to adult care.
- The University of Washington Medicine's Transition Care Program works with young adult patients who are between 18 and 24 years old and have complex medical needs as they transition from to adult healthcare.

Transplant

- The Washington State Medical Association offers information to inspire and facilitate organ donation.
- LifeCenter Northwest is the organ and tissue program that services the WAMI region.
- Seattle Children's Transplant Center is the largest and only pediatric transplant center serving UNOS Region 6 (Washington, Alaska, Idaho, Montana, Oregon and Hawaii). Seattle Children's delivers world-class care to patients with end-stage diseases of the kidneys, heart, liver and intestine, and has been transplanting organs for more than 25 years. The center focuses on patient care, provider education, community partnerships and advocacy.

Heart Disease

- The American Heart Association's mission is to build healthier lives free of cardiovascular diseases and stroke through advocacy, research and educational resources for healthcare providers, patients, families and the community. In Washington state, the American Heart Association's branches in Seattle, Tacoma and Spokane organize awareness events and campaigns, offer online resources and fund state-specific research. Seattle Children's Heart Center is working on the following goals to improve heart health in the community:
 - Create a Heart Center family advisory group
 - Build a stronger relationship with the Heart-to-Heart Congenital Heart Defects group
 - Address the need for heart services for Latino families from Central Washington
 - Provide community education on heart-healthy behaviors for children, teens and young adults.

Additionally, the Heart Center promotes education through several programs, including:

- Heart-to-Heart, a monthly support group for families who are dealing with CHD, illness-related heart conditions or heart transplant
- An adolescent transplant support group where teens can share concerns and providers can address noncompliance issues
- Free, in-school cardiovascular screenings and electrocardiograms (ECGs) for student athletes. These screenings are offered in partnership with the Nick of Time Foundation and are conducted every two months during the school year by volunteer physicians, ECG technicians and echocardiographers, with cardiologist referrals provided as needed.

The Heart Center also promotes provider education, such as conferences for primary

care providers about new developments in diagnosis.

- The Sudden Cardiac Arrest (SCA) Awareness Act went into effect in 2015 to make youth athletes, their families and coaches aware of sudden cardiac arrest.

Opportunities

Via community input focus groups and listening sessions, many strategies for addressing the needs of CSHCN were brainstormed. These include promoting adequate reimbursement, working with families to assure insurance coverage, training providers in how to care for patients with special needs and encouraging medical homes.

CSHCN Overall

Overall, children with special health care needs have concerns above and beyond the healthy population. CSHCN are more likely to have difficulty meeting the criteria for care for a medical home and obtaining needed referrals than children without special needs. They are also less likely to have adequate insurance to meet their healthcare needs. (See the Access to Care for Children With Special Health Care Needs/Chronic Conditions section on page 39.)

Opportunities to address these issues include:

- Improving data systems used to identify clients needing care coordination;
- Supporting comprehensive systems of care with fiscally sustainable reimbursement;
- Ensuring that there is a viable system of CSHCN Coordinators to serve children with special health care needs and that managed care organizations need to reimburse appropriately for care coordination;
- Addressing the safety net for undocumented children with special health care needs. Currently, children who are “undocumented” remain in fee-for-service Medicaid and children in foster care have the option of either fee-for-service or managed care;

- Identifying opportunities to incorporate the nationally developed Standards of Care for Children and Youth with Special Health Care Needs into systems development and improvements.

Cancer

Several public health strategies have been recommended by the Centers for Disease Control and Prevention (CDC) to improve Cancer Survivorship:¹⁴¹

- Ensure all cancer survivors have adequate access to high-quality treatment and other post-treatment services.
- Establish or maintain training for healthcare professionals to improve delivery of services and increase awareness of issues faced by cancer survivors.
- Identify appropriate mechanisms and resources for ongoing surveillance of people living with, through and beyond cancer.
- Increase awareness among the general public, policymakers, survivors, providers and others of cancer survivorship and its impact.

Transplant

- Continue to raise awareness about organ donation and encourage people to become donors because the recipient need is larger than the number of available organs.
- Seattle Children’s must continue to act as a regional expert and partner resource for pediatric transplants.

Heart Disease¹⁴²

- Increase cardiovascular screening in athletes.¹⁴³ The goal of performing cardiovascular screening of young athletes

141 Centers for Disease Control and Prevention. (2004). A national action plan for cancer survivorship: Advancing public health strategies. Retrieved from <http://www.cdc.gov/cancer/survivorship/pdf/plan.pdf>.

142 Nick of Time Foundation. (2016). Home. Retrieved from <http://www.nickoftimefoundation.org>.

143 Nick of Time Foundation. (2010). Cardiovascular screening program in children and young adults. Retrieved from <http://www.nickoftimefoundation.org>.

is to reduce sudden cardiac death through early detection and appropriate medical interventions, activity modification or withdrawal from athletic participation.

- In early adolescence, CHD survivors needing lifelong congenital heart care should begin to transition to appropriate adult congenital heart disease care. CHD survivors should be educated on how to choose adult congenital heart care and be made aware of care guidelines and the benefits of cardiac heart surveillance. A successful transition will include:

- Obtaining health insurance
- Selecting an adult care physician to provide and coordinate comprehensive care
- Receiving reproductive, genetic and career counseling
- Educating adult healthcare providers about the patient's congenital heart disease
- Maintaining communication between patients, families and healthcare providers¹⁴⁴

Access to Care, Use of Clinical Preventive Services and Oral Health

Access to comprehensive, high-quality healthcare facilitates prevention and early detection of disease and varies by type of insurance and geographic location. Health insurance reduces the out-of-pocket costs of health care and has been shown to be the single most important predictor of healthcare utilization. Without health insurance coverage, many people find health care unaffordable and forgo care even when they think they need it, thus disparities in insurance coverage perpetuate disparities in health and quality of life.

Access to health insurance has improved with the expansion of Medicaid eligibility and implementation of health insurance marketplaces for Qualified Health Plans. However, there are still children in King County without health insurance, especially among American Indian/Alaska Native children, low-income households, and children living in South King County. In part due to inadequate insurance coverage, too many adults and children in King County do not receive recommended clinical preventive services or regular oral healthcare services.

Access to Care

Insurance Coverage

While the Affordable Care Act (ACA) was primarily designed to address uninsured adults, its implementation, coupled with the expansion of Medicaid and the transition of Medicaid clients into managed care, benefitted children, as well.

For children who are United States citizens and meet financial eligibility standards, including those in foster care and adoption support, the ACA implementation means they are now part of the Medicaid managed care plan (versus fee-for-service). Children who are in an undocumented status are in Fee-For-Service (FFS). Tribal members can choose FFS or MC.

¹⁴⁴ American Heart Association. (2011, February 28). Adult care for congenital heart disease patients should begin in adolescence. Retrieved from <http://newsroom.heart.org/pr/aha/1278.aspx>.

In 2015, 4% (or 77,200) of Washington state children had no health insurance coverage.¹⁴⁵ After the Medicaid expansion and the launch of the WA Healthplanfinder health exchange, uninsurance rates drop significantly. The percent of children without health insurance fell to 1.6%.¹⁴⁶

The ACA implementation had other immediate benefits for children, including no denials for pre-existing conditions, no cap on lifetime benefits, no out-of-pocket costs for preventive care, and allowances for young adults to stay on their parent's policy up to age 26. The uninsurance rate for young adults between 19 and 25 years old dropped from 31.9% in 2008 to 9.3% in 2015.¹⁴⁷

American Indian/Alaska Native children were five times more likely than non-Hispanic, white children to be uninsured. Children in low-income households (less than 200% of the federal poverty level) were five times more likely than those in the highest income households to be uninsured. Children living in the South Region were more than twice as likely to be uninsured than children living in the East Region.

However, the implementation of the ACA also required families to apply or renew their Medicaid coverage through the Washington Healthplanfinder. This process has been challenging for many, including those with limited English skills and families who have the additional responsibilities of caring for a child with special health care needs.

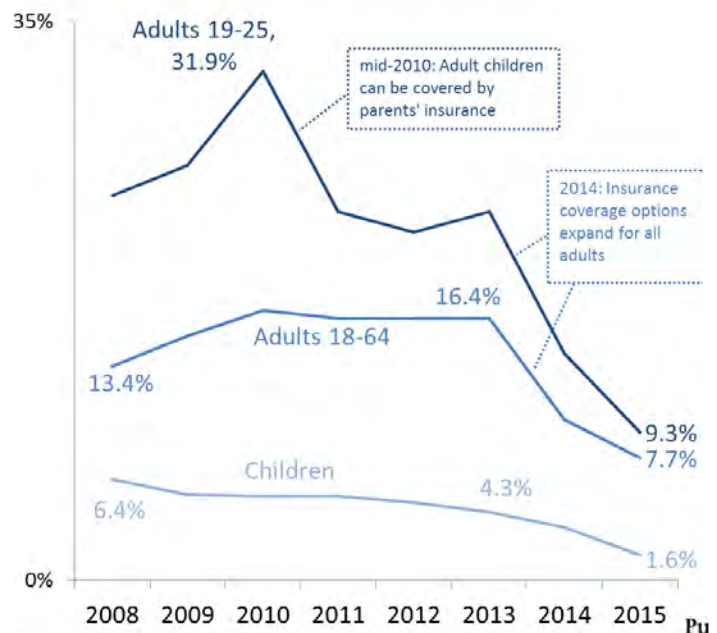


Figure 24: Percentage of Young Adults and Children Without Health Insurance, 2008-2015 Average¹⁴⁸

Many families live in areas with limited internet access and have long wait times when calling a call center, which may use up their cellphone minutes. Additional supports such as health navigators who have an additional set of challenges, as they must work with up to five different Medicaid managed care plans, each with different sets of rules, processes, and reimbursement rates.

States administer their Medicaid managed care programs within general federal rules. States must identify individuals with special health care needs to managed care organizations (MCOs), to identify any ongoing conditions that require treatment or monitoring.¹⁴⁹

Care coordinators for children with special health care needs and chronic conditions (CSHCN) have been put in place at the local health jurisdictions to assist this vulnerable population. These providers have knowledge of and connections with community resources.

¹⁴⁵ Kaiser Family Foundation (2016) Health insurance coverage of children 0-18. Retrieved from <http://kff.org/other/state-indicator/children-0-18/?dataView=1¤tTimeframe=0&selectedRows=%7B%22nested%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22coll%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹⁴⁶ Public Health – Seattle & King County (2016) Affordable Care Act Enrollment in King County: Increases in Health Insurance Coverage. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/affordable-care-act-increases-in-coverage-sept-2016.ashx>.

¹⁴⁷ Ibid.

¹⁴⁸ Ibid.

¹⁴⁹ Washington Healthplanfinder Open Enrollment Closes with 146,000 Enrolled in Qualified Health Plans. <http://wahbexchange.org/news-resources/press-room/press-releases/april-1-enrollment-report/>. Retrieved 07/15/2014 and v American Community Survey (ACS) Retrieved 02/24/2014. <http://kff.org/other/state-indicator/children-0-18>.

However, care coordinator also face challenges due to budget cuts and changes to local public health delivery system.

Children who are non-U.S. citizens and undocumented are not in managed care. As of February 2014, there were over 17,000 children in this group. Undocumented children with special health care needs will age out of Medicaid coverage at age 18, even though their medical needs will not go away. There are extremely limited options for coverage after age 18.¹⁵⁰

Incomplete Vaccinations

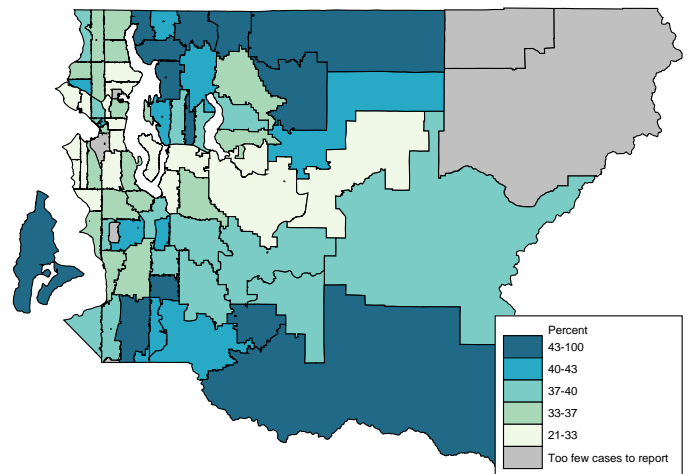
In 2014, 45.9% of children ages 19 to 35 months in Washington state and 38% of those in King County had not completed the recommended series of immunizations for young children (4:3:1:3:3:1:4 series).¹⁵¹ These estimates are based on vaccination records submitted by healthcare providers to the Washington State Immunization Information System (WSIIS). According to past statewide assessments, WSIIS estimates of vaccination coverage underestimate true coverage due to incomplete submission of vaccine records and retention of vaccine records of children after they have moved to another area.

According to these same statewide assessments, children do not receive vaccines for a variety of reasons, including barriers to accessing clinical preventive services and family choices to not have children vaccinated. Completion rates are lowest in the South and North regions, representing both low-income and high-income areas of King County, respectively.¹⁵²

¹⁵⁰ WAC 182-507-0125 Alien Nursing Facility Program - Must meet all other eligibility factors for nursing home placement and have prior approval authorization by Aging and Disability Services Administration. This program is subject to caseload limits. Retrieved 04/22/2014. <http://www.hca.wa.gov/medicaid/aem/pages/index.aspx>.

¹⁵¹ Public Health-Seattle & King County. (2014). Incomplete vaccination coverage, age 19-35 months, King County, 2014. Retrieved from <http://www.kingcounty.gov/healthservices/health/data/%7e/media/health/publichealth/documents/indicators/AccessToCare/IncompleteChildVaccinationSeries19-35mo.ashx>.

¹⁵² Ibid.



Source: Source: WA State Immunization Information System. Prepared by Public Health - Seattle & King County, APDE on 11/8/14.

Figure 25: Percentage of Children Age 19-35 Months with Incomplete Vaccine Series by King County Zip Code¹⁵³

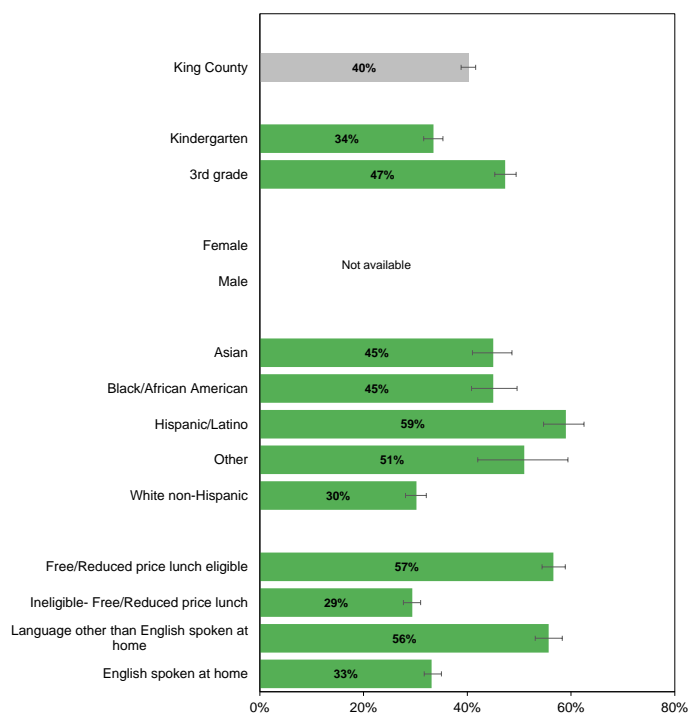
Oral Healthcare

Tooth decay in children leads to an increase in missed school, pain, discomfort and difficulty with daily activities.¹⁵⁴ Rates of tooth decay in Washington state children are higher today than in 2000. Significant oral health disparities exist for minority, low-income, non-English-speaking children, and children with special healthcare needs. These groups have the highest levels of dental disease and the lowest levels of access to preventive and restorative services.

In 2010, 40.2% of kindergarten and third-grade children in King County had treated or untreated cavities. Children eligible for free or reduced-price school meals were almost two times more likely than those from higher-income families to have untreated dental disease. Untreated dental disease was also more likely among children of color (compared to white, non-Hispanic children) and children whose family spoke a language other than English at home.

¹⁵³ <https://data.kingcounty.gov/dataset/King-County-Vaccination-Rates/j49t-d3p7/alt>.

¹⁵⁴ Washington State Department of Health. (April, 2011). Smile survey (2010): The oral health of Washington's children. Retrieved from http://www.doh.wa.gov/Portals/1/Documents/Pubs/160-099_SmileSurvey2010.pdf.



Source: 2010 King County Smile Survey

Prepared by: Public Health Seattle & King County, Assessment, Policy Development, & Evaluation, 1/2015

-----: Confidence interval shows range that includes true value 95% of the time

* Too few cases to protect confidentiality and/or report reliable rates

§ Too few cases to meet precision standard, interpret with caution

Figure 26: Percentage of Kindergarten and 3rd Grade Students with Cavities, King County, 2010

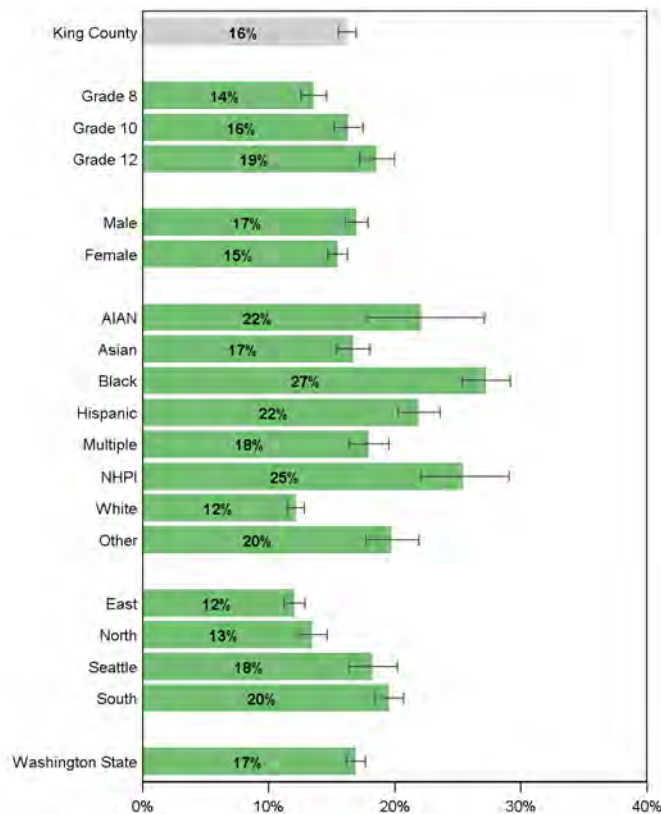
Healthy People 2020's goal is to ensure 51% of children, adolescents and adults use the oral healthcare system within the past year.¹⁵⁵ In Washington state, 17% of children had not seen a dentist in the last year, which is far better than the national average.¹⁵⁶ In King County, 18% of school-age youth in eighth, 10th and 12th grades had not had a dental check-up, exam, teeth cleaning or other dental work in the last year.¹⁵⁷ From 2008 to 2012, 30% of Native Hawaiian/Pacific Islander, 28% of black, 25% of American Indian/Alaska Native and 24% of Hispanic school-age children had not seen a dentist in the last year compared to 13% of white children.¹⁵⁸

155 Healthy People 2020. (2016). Oral health of children and adolescents. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health/objectives>.

156 Public Health-Seattle & King County. (2012). No dental checkup in the last year (school-age), King County, 2010 and 2012. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/access/dental-checkup-in-last-year-children.ashxx>.

157 Ibid.

158 Ibid.



Source: Healthy Youth Survey.

Prepared by Public Health - Seattle & King County, APDE, 08/2016.

-----: Confidence interval shows range that includes true value 95% of the time.

* Too few cases to protect confidentiality and/or report reliable rates.

§ Too few cases to meet precision standard, interpret with caution.

Data by income or poverty level not available

Figure 27: Percentage of King County School-age Children Who Did Not Have a Dental Checkup in the Last Year by Subgroup

Community Input

Access to Care

While many residents have found coverage since the implementation of the Affordable Care Act, some are not eligible for subsidies or Medicaid, choose not to enroll, or struggle to afford premiums. Community members stressed that the healthcare system should continue to provide charity care for people who fall through the cracks.

For those with coverage, ongoing challenges include access to specialty care, adult dental care and behavioral health services. Even

159 Public Health-Seattle & King County. (2012). No dental checkup in the last year (school-age), King County, 2010 and 2012. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/access/dental-checkup-in-last-year-children.ashxx>.

with increased health insurance coverage, high deductibles and co-pays may deter an individual from seeking care when faced with the challenges of meeting basic needs, like food and housing.

The potential loss health insurance means loss of services, such as case management, integrated mental health, nutrition counseling and other nonclinical services, presents another challenge to maintaining good health.

Workforce Capacity

Community health centers report severe shortages of primary care providers. Community members stress the importance of a workforce that reflects our communities' diversity. In focus groups and listening sessions with community health center providers, they explain that their primary care providers are considered safety net providers because they deliver health care to uninsured patients and Medicaid patients. Safety net providers work in community health centers, federally qualified health centers, public hospitals, school-based clinics, and community and teaching hospitals. Without these safety net providers, many communities would have little or no contact with the health care system. Therefore a further (or ongoing) shortage of providers reflects a challenge in caring for this population. In order to ensure that our workforce is able to meet the demands of delivering primary care or specialty care to patients many challenges were mentioned: Program funding, financing mechanisms and incentives, and implementing infrastructure changes are all needed to ensure that clinicians are attracted to primary care, faculty are in place to educate health care professionals, and health care delivery is efficient and effective. Ameliorating the problems presently impeding primary care delivery involves more than just training additional doctors to become primary care physicians. Drs. Sherman and Moscou explain that at the core of the debate are several issues: (1) how to address the financial reimbursement

inequities seen in primary care and specialty care; (2) how health care will be delivered; (3) which professionals will provide primary care, oral health care, and behavioral health care; and (4) how emerging technologies will be used.¹⁶⁰

Incomplete Vaccinations

In focus groups and listening sessions, parents expressed that incomplete vaccinations remain a concern. King County does not meet the Healthy People 2020 objective of reducing incomplete vaccination coverage to 20% of children ages 19 to 35 months.

Community Assets and Resources

Access to Care

- The first open enrollment period for new health insurance options took place in 2013 and 2014. Organizations in King County partnered in the "Coverage Is Here King County" campaign and through their collective efforts enrolled 165,000 residents, 1,454 of whom were children with new coverage. Seattle Children's played a role in helping families access new free and low-cost health insurance options. From 2013 to 2015, 12 Seattle Children's staff members were trained and certified as in-person assisters to help families with enrollment in Medicaid, Apple Health for Kids, or a Qualified Health Plan through Washington Healthplanfinder. Countywide, hospital staff helped enrolled more than 3,557 individuals. For enrollment data, visit <http://www.kingcounty.gov/healthservices/health/partnerships/HealthReform.aspx>.
- In 2014, several hospitals provided funds to assist low-income households with the payment of insurance premiums. To qualify, household income needed to be less than 200% of the federal poverty level (in 2014,

¹⁶⁰ Journal of Health Care for the Poor and Underserved. Archived: http://www.clinicians.org/images/upload/Primary_Care_Crisis.pdf.

that was about \$47,700 a year for a family of four, which includes two children), and had to be enrolled through Washington Healthplanfinder, the state's health benefit exchange. Project Access Northwest manages this ongoing program.

- In Washington, the DOH has a CSHCN Program within the Healthy Starts and Transitions unit in the Office of Healthy Communities. The CSHCN Program is primarily funded through the federal Maternal and Child Health Block Grant (Title V). The CSHCN program promotes an integrated system of services for infants, children and youth up to age 18 years who are defined as having or are at risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond what is generally needed. DOH has strong ties with the Health Care Authority-Medicaid program (HCA) (now known as Apple Health) aimed at identifying children with special health care needs through a data sharing process and providing coordination and liaison activities for this population. This relationship has been beneficial to children and families as this population migrates into managed care.
- Historically, CSHCN coordinators have assisted with accessing eligibility for the CSHCN program, but are currently experiencing issues with timely enrollment of hospitalized newborns with complex medical needs. In order to better support these families, the state's Health Care Authority has hired staff at the local level to assist families.
- Best practices outline strategies for medical care and care planning for child to adolescent to adult transitions and are posted on sites such as <http://www.gotttransition.org/>. Local healthcare systems are using this website as a resource for best practices in helping children who are transitioning to adult care.
- Recently, the Association of Maternal and Child Health Programs (AMCHP) released

Standards of Care for Children and Youth with Special Health Care Needs with the goal of influencing health policy across the nation. It is anticipated that these standards will help guide wise decisions by policymakers and payers to improve systems of care for children with special needs and their families. Having evidence-based guidelines for optimal care and support for CSHCN is essential to ensure that their care isn't compromised. Sharing these with the HCA and the managed care plans and incorporating these standards, where appropriate, into contract language, should assist in the planning of care for children with special health care needs.

- The Health Coalition for Children and Youth (HCCY) is a coalition of organizations in Washington state that work to meet the full spectrum of health needs of children, including medical, dental and mental healthcare.
- Community health centers continue to serve all residents, regardless of their ability to pay. Public health centers, tribal clinics and school-based health centers also serve the health needs of the community.
- Seattle Children's is committed to providing charity care to low-income individuals and enrolling residents in health insurance. In 2015, Seattle Children's provided more than \$111 million in uncompensated care.
- Project Access Northwest connects low-income and uninsured patients with specialty care and provides health literacy education.
- The Pacific Hospital Preservation and Development Authority provides funding for programs that address access to care issues.
- The First Friday Forum is a coalition of community health centers, social service organizations, government agencies and hospitals that share information related to publicly sponsored healthcare program eligibility, enrollment and best practices.

- WithinReach connects families to whatever resources they may need (e.g. healthcare enrollment, food, etc.) online, in person and through a telephone hotline.
- The Medical Legal Partnership for Children (MLPC) is a collaboration of pediatric clinicians, social workers and attorneys who address the unmet legal needs of patients and families. While this program model has been used in more than 30 states and 160 hospitals and clinics, MLPC is the first partnership of its kind in the Pacific Northwest. The program, which began in 2008, serves children and families from Odessa Brown Children's Clinic (OBCC) and the Harborview Children and Teens' Clinic. The organization addresses unmet legal needs by training healthcare workers and other stakeholders to handle advocacy issues affecting vulnerable families; enabling constituents to identify potential legal issues and offering referrals; providing case consultation to providers and direct legal services to pediatric patient families (up to and including full-court representation, when indicated); and participating in systemic advocacy efforts that promote child health and well-being.
- Odessa Brown Community Clinic (OBCC), a Seattle Children's community clinic located in Seattle's Central District, was established in 1970 and had 23,751 patient visits in 2015. Serving an urban, predominantly African-American population insured primarily by Apple Health for Kids, OBCC's staff members are strong advocates for multicultural families.
- Seattle Children's provides school-based care at Garfield, Madrona and Beacon Hill schools. The school-based and school-linked health center model is nationally recognized as one of the best ways to provide effective, efficient and appropriate healthcare services to adolescents. School-based and school-linked health centers are comprehensive primary care clinics that provide medical and mental

health screening and treatment for young people on or near school grounds. The center targets adolescents who are uninsured and underinsured, and serve youth with health insurance who desire confidential care and advice.¹⁶¹

- In 2014, several hospitals provided funds to assist low-income households with the payment of insurance premiums. To qualify, household income needed to be less than 200% of the federal poverty level (in 2014, that was about \$47,700 a year for a family of four, which includes two children), and had to be enrolled through Washington Healthplanfinder, the state's health benefit exchange. Project Access Northwest manages this ongoing program.

Workforce Capacity

- Seattle Jobs Initiative's Healthcare Career Pathway program trains diverse, low-income residents in healthcare careers.
- As part of its healthcare workforce strategic plan, Seattle Central Community College expanded its nursing and allied health programs by opening the Seattle Central Health Education Center at the Pacific Tower in January 2016. The new satellite location offers additional training opportunities and programs for students pursuing careers in healthcare. A consortium of local colleges is also creating a program for community healthcare workers/patient care navigators.
- The University of Washington School of Medicine is investing in the next generation of physicians by offering the only pediatric residency program in the WAMI region. Resident programs include:
 - **WAMI rotation:** Pediatric residents spend two months of their training in a rural primary care setting.
 - **Pathway program:** Eight residents per year participate in the Community Health

¹⁶¹ King County Public Health. What is a school-based or linked teen health center? Retrieved from <http://www.kingcounty.gov/healthservices/health/child/yhs/thc.aspx>.

and Global Health Pathways, which provide public health, clinical and research experience to understand and influence determinants of child health and health disparities at the community level.

- **Alaska track:** Four residents per year focused on primary care spend one-third of their training in Alaska.
- During the 2015 to 2016 school year, 877 residents and fellows completed rotations and 132 physicians participated in a pediatric subspecialty residency or fellowship at Seattle Children's, which offers fellowships in more than 30 specialty areas. More than half of all Seattle Children's-affiliated graduates practice in the Pacific Northwest after completing their training.

Incomplete Vaccinations

- The VAX Northwest Immunity Community program trains parents to be immunization advocates in child care settings, preschools and elementary schools and aims to ensure that everyone can find accurate information about the value of vaccines.
- Almost all pediatric providers (around 340) are enrolled in the Vaccines for Children Program, a federal program that provides vaccines at no cost to children who otherwise may not be vaccinated.
- Each year, Public Health – Seattle & King County's Immunization Program and the Washington State Department of Health visit 50% of clinics enrolled in the Vaccines for Children Program. They assess clinics for best immunization practices and provide education and recommendations to healthcare providers. Additionally, 25% of these clinics receive a site visit from the CDC's Assessment, Feedback, Incentives and eXchanges (AFIX) quality improvement program to increase immunization coverage.
- The WithinReach Immunization Program promotes immunization coverage through a variety of programs, including

the Immunization Action Coalition of Washington, which raises public awareness and provides education to groups ranging from healthcare providers to parents.

- The Washington State Department of Health's Child Profile Health Promotion System helps ensure that Washington's kids get the preventive healthcare they need, provides free educational resources to families, and tracks individual and population-level immunization coverage. The Child Profile Health Promotion System sends child health and safety information to all families with young children in Washington State by mail and email. Each mailing has age-specific reminders about well-child checkups and immunizations. They also give up-to-date information on growth and development, nutrition, safety, and many other health topics.
- A grassroots campaign led by Vashon Island resident Celina Yarkin has been lauded for working to improve vaccination coverage among the island's children.

Oral Healthcare

- Several community health centers opened new dental clinics in 2014 and 2015 to make dental care accessible on-site with medical care. Seattle Children's provides dental services at OBCC for children ages 1 to 15, and The Dental Clinic at Seattle Children's Hospital sees patients on the main hospital campus by referral.
- The Seattle and King County Access to Baby and Child Dentistry program connects low-income children from birth through age 5 with private dentists. The Seattle-King County Dental Society provides donated dental services for low-income residents who do not qualify for Medicaid.
- The SmileMobile is a mobile dental office offering oral health services to low-income children who have limited access to a dentist. Services range from examinations and preventive care to fillings and minor

oral surgery. Seattle Children's is a partner in operating the SmileMobile. Since 1995, the mobile clinic has treated more than 25,000 children throughout Washington — that's an average of 60 children per week. In 2013, 38 volunteer dentists served 1,776 children.

Opportunities

Access to Care

- For the last few years, Seattle Children's has worked with the Children's Hospital Association on federal legislation called the Advancing Care for Exceptional (ACE) Kids Act of 2015. The proposed legislation focuses on creating networks to better manage the care for medically complex children insured by Medicaid in all states. The network would provide appropriate care close to a child's home, thus decreasing the need for emergency room visits and hospital stays.¹⁶² If passed, the legislation will:¹⁶³
 - Address problems with fragmented care across state lines.
 - Improve coordination of care for children to reduce the burden on families.
 - Possibly save around \$13 billion during its first 10 years.
 - Gather national data on complex conditions to help researchers improve treatments for rare diseases.
- Of those surveyed in Washington, 68.2%¹⁶⁴ of families with CSHCN reported that they have adequate private or public insurance to pay for the services they need. What is not widely known is that families with a private insurance plan can also apply for Medicaid as a secondary insurance for their children. This is a crucial piece of information for families who may incur high additional medical expenditures (co-pays, deductibles,

benefits and limits to services not present in Medicaid). Having Medicaid as a secondary insurance may mitigate the additional expenditures for this special population. There is an opportunity to include this information in navigator or in-person assistor training.

Incomplete Vaccinations

- Working with healthcare providers to improve vaccination coverage is extremely important. Since patients trust their healthcare providers, recommendations from their providers can shape a caregiver's decision to vaccinate a child.
- Improving vaccination coverage data would help public health practitioners identify patient populations in particular need.
- Working with alternative as well as allopathic healthcare providers to improve vaccination coverage is also important and will help improve data on vaccination coverage.

Oral Healthcare

- Increasing reimbursement rates could provide incentive for dentists to accept patients with Medicaid.

Mental and Behavioral Health

Behavioral health refers to mental and emotional well-being and/or actions that affect wellness.¹⁶⁵ Behavioral health conditions encompass both mental health and substance use disorders, and are related to physical health and wellness. Mental illness is the second leading cause of disability and premature mortality, and accounts for more than 15% of the burden of all diseases in the United States.¹⁶⁶

¹⁶⁵ Substance Abuse and Mental Health Services Administration. (2016). National Behavioral Health Quality Framework (Overview). Retrieved from <http://www.samhsa.gov/data/national-behavioral-health-quality-framework#overview>.

¹⁶⁶ Murray, C.L. and Lopez, A.D. (Eds.) (1996) The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge MA: Harvard University. As quoted in Mental Health: A Report of the Surgeon General.

¹⁶² Ibid.

¹⁶³ Speak Now for Kids. (2016). ACE Kids Act. Retrieved from http://www.speaknowforkids.org/ace_kids_act.

¹⁶⁴ National Survey of Children with Special Health Care Needs. <http://www.childhealthdata.org> Retrieved 8/2016.

Health problems associated with substance abuse include psychosis, depression, drug overdose, skin and lung infections, HIV/AIDS, motor vehicle injuries and other injuries.

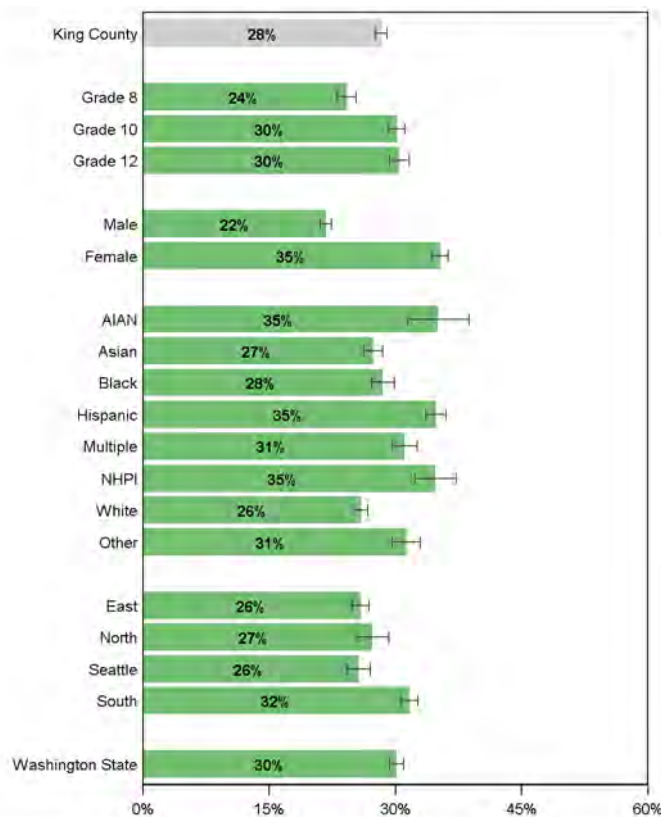
Early mental health interventions and support mechanisms are critical for our youth, as symptoms of mental illness can be obscured by the behavioral changes typical of puberty and adolescence. One in five children in the United States suffers from a mental disorder such as anxiety, depression or a behavior disorder, but only 20 percent of these children receive needed services. Half of adult mental disorders have their onset during childhood. According to Parity or Disparity: The State of Mental Health in America 2015, prepared by Mental Health America, Washington state ranked 47th in the country regarding youth behavioral health service needs and access to care.

Depression

Depression is a problem faced by many children and teens. At any given point in time, about 1 to 8% of children and teens are struggling with depression. By the age of 18, 1 in 5 youth have had a depressive episode and over half have had some depressive symptoms. During childhood, about the same amount of boys and girls have depression. Between the ages of 13 and 15, slightly more girls than boys are depressed. By middle to late adolescence, girls are twice as likely to be depressed. Children and teens become depressed for many reasons. There isn't one single cause but stress plays a key role in the start of depression.

In 2014, about one in four (27%) of Washington state eighth graders and about one in three (35%) of 10th graders experienced depressive feelings.

- Students were considered to have had depressive feelings if, during the past year, they reported feeling so sad/hopeless almost every day for two or more consecutive weeks that they stopped doing some usual activities.
- Females were 1.5 times more likely than males to report depressive feelings.



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 08/2016.
[-----] Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

Figure 28: King County Youth With Depressive Feelings by Subgroup, 2008-2012 Average

- Hispanic, Native Hawaiian/Pacific Islander and American Indian/Alaska Native youth were more likely than black and white youth to report depressive feelings.
- From 2004 to 2012, youth rates of depressive feelings decreased for King County overall and for Seattle and the North Region of the county.

In 2015-2016, the number one Seattle Children's outpatient service by volume was psychiatry with 45,019 visits. In our clinics, we provide short-term individual and group treatment using methods that have been shown to help.

Children with complex mental health problems may need to stay in the hospital at times. When this happens, we have the 41 bed Psychiatry and Behavioral Medicine Unit (PBMU), the focus of which is to help children during a mental

health crisis and ensure their immediate safety. The PBMU works to resolve the crisis and to teach the child and family skills that can help after the child leaves the hospital. Most stays in the PBMU are seven to eight days. In 2015, Seattle Children's Hospital treated approximately 1,000 youth as inpatients for various depressive episodes. In many stakeholder interviews, it was reiterated that the front line for identifying and coordinating treatment for these disorders is primary pediatric care — the medical home. The American Academy of Pediatrics recommends annual screening for depression and substance use starting at age 11. Screening would allow us to address many problems early, before children reach a crisis state. Unfortunately, Washington's Medicaid program does not reimburse physicians for performing these screens or coordinating services when a child is in need of help.

Substance Abuse and Chemical Dependency

Youth Binge Drinking

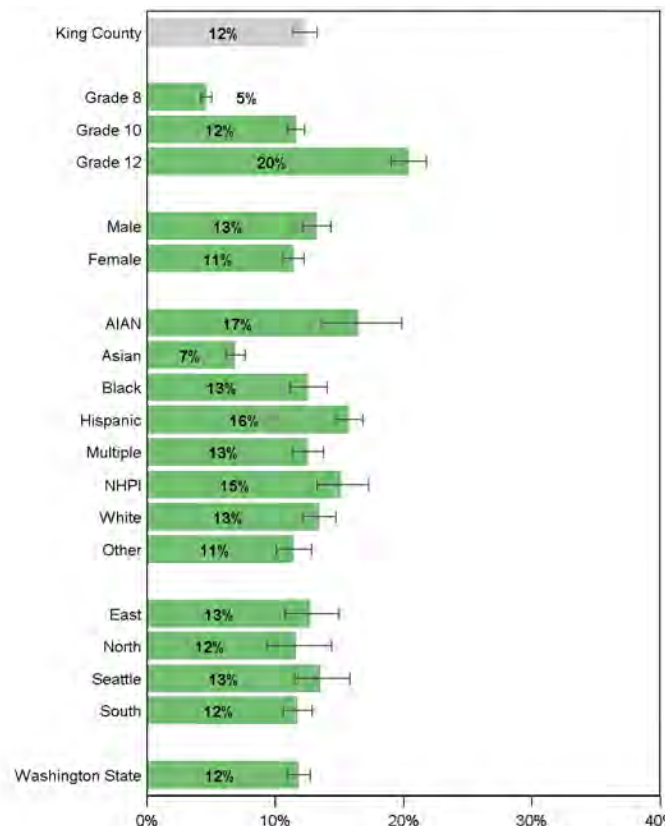
From 2008 to 2012, 15% of King County students in eighth, 10th and 12th grades engaged in binge drinking, which is defined as having five or more alcoholic drinks in a row in the past 14 days.

- The binge drinking rate for American Indian/Alaska Native youth was 2.5 times that of the lowest King County rates.
- The binge drinking rate for 12th graders was 1.5 times the county average for students of all grades.
- From 2004 to 2012, binge drinking rates among youth declined for the county overall and for all regions except the East Region.

Substance Abuse¹⁶⁷

In 2014, an average of 25% of school-age youth in eighth, 10th and 12th grades in King County reported using alcohol, marijuana, painkillers

or other illegal drugs during the past 30 days. The 2012 and 2014 average rates were highest among 12th graders, and American Indian/Alaska Native and Hispanic students. About 18% of Asian students reported using alcohol or drugs during the past 30 days, which was significantly less than the average.¹⁶⁸



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 08/2016.
|-----| Confidence interval shows range that includes true value 95% of the time.
† Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

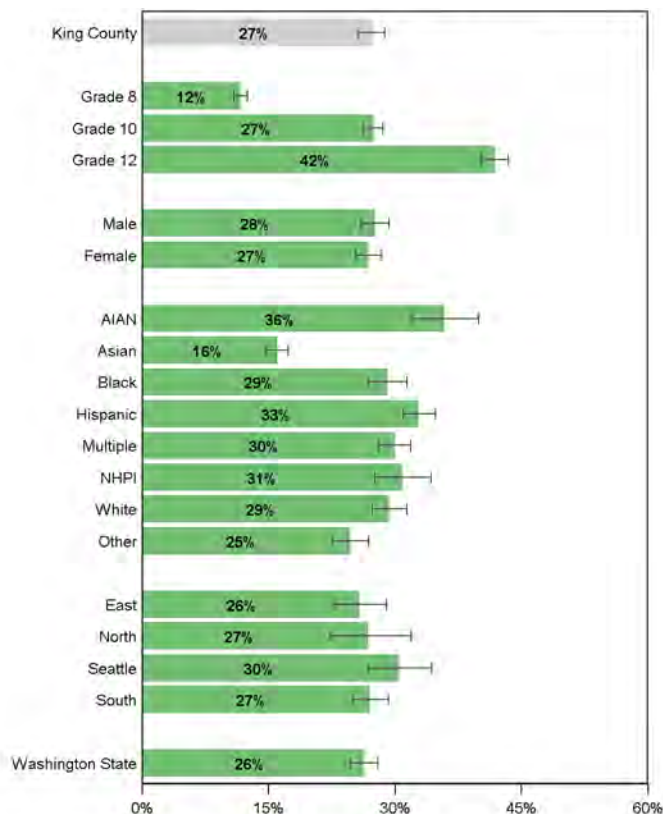
Figure 29: King County Binge Drinking Rates Among School-age Children by Subgroup, 2012-2014 Average

The average rate of alcohol-induced deaths in King County from 2010 to 2014 among all ages was 9.7 per 100,000 population. No cases were reported in youth under age 25 because there were too few cases to protect confidentiality and/or report reliable rates. Alcohol-induced deaths were highest in men, high-poverty neighborhoods and among American Indian/

¹⁶⁷ Public Health-Seattle & King County. (2016). King County community health indicators. Retrieved from <http://www.kingcounty.gov/healthservices/health/data/indicators.aspx>

¹⁶⁸ Public Health-Seattle & King County. (2016). Illegal drug use (school-age), King County, 2012 & 2014 average. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/behavior/illicit-drug-use-past-30-days-children.ashx>

Alaska Native populations.¹⁶⁹ In 2013, the rate of fatal crashes in King County involving a driver with a blood alcohol content of 0.08 or above was 1.0 per 100,000, which was down from 1.4 per 100,000 in 2012.¹⁷⁰



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 07/2016.
[-----] Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

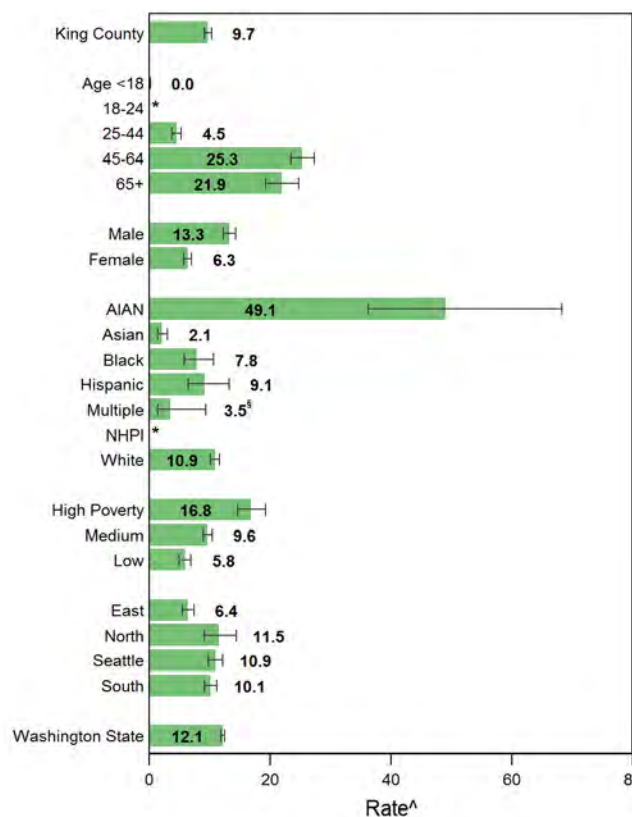
Figure 30: King County Youth Illegal Drug Use by Subgroup, 2012 & 2014

Also from 2010 to 2014 in King County, the drug-induced death rate was 14.1 per 100,000 population for all age groups. The drug-induced death rate for young adults ages 18 to 24 was 11 per 100,000 population. Drug-induced deaths included deaths from poisoning, drug dependence and conditions resulting from acute or chronic exposure to drugs. Drug-induced deaths were higher than average

169 Public Health-Seattle & King County. (2012). Alcohol-induced deaths. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/injury-prevention/motor-vehicle-deaths.ashx>.

170 <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/injury-prevention/motor-vehicle-deaths.ashx>.

in high-poverty neighborhoods and among American Indian/Alaska Native (32.4 per 100,000), Black (20.2 per 100,000) and white (14.2 per 100,000) populations.¹⁷¹



Source: WA State DOH, Center for Health Statistics, Death Certificates.
Prepared by Public Health - Seattle & King County, APDE, 08/2016.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.
[-----] Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Persons of Hispanic ethnicity can be of any race and are included in the racial categories.
Poverty = Neighborhood poverty levels defined by median household income.

Figure 31: King County Youth Alcohol-induced Deaths by Subgroup, 2008-2012 Average

171 Public Health-Seattle & King County. (2012). Drug-induced deaths, King County, 2008-2012 average. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/behavior/drug-induced-deaths.ashx>.

172 According to report, age <18=0, 18-24=too few cases to report reliable rates. See: <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/behavior/alcohol-induced-deaths.ashx>.

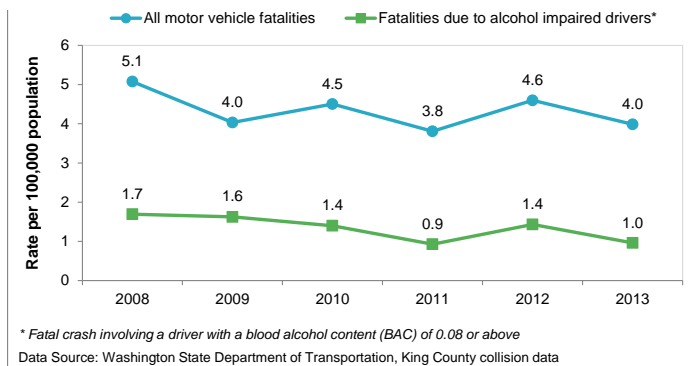
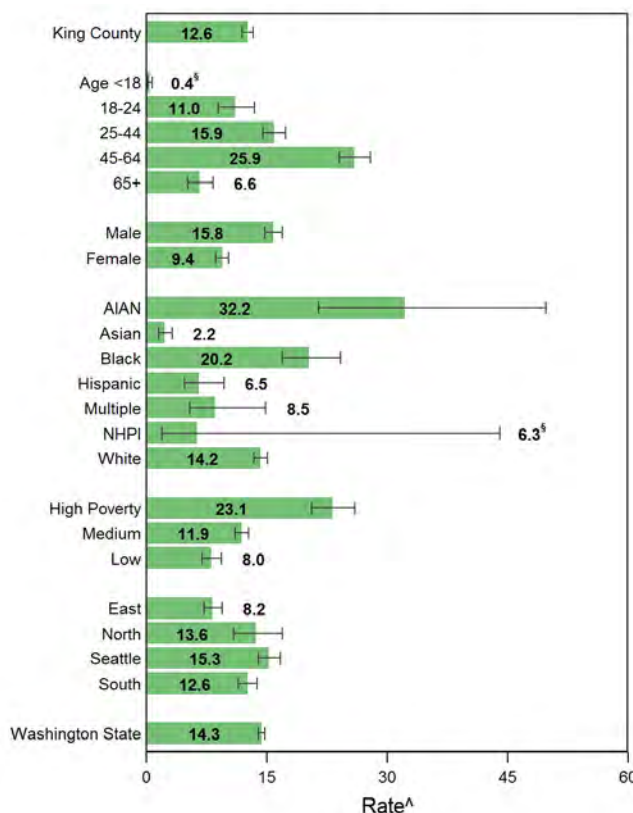


Figure 32: Rate of All Motor Vehicle Fatalities and Motor Vehicle Fatalities Due to Alcohol-impaired Drivers in King County, 2008-2013



Source: WA State DOH, Center for Health Statistics, Death Certificates.
Prepared by Public Health - Seattle & King County, APDE, 08/2016.
^aRate = cases per 100,000 population, age-adjusted to the 2000 US population.
[-----] Confidence interval shows range that includes true value 95% of the time.
† Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Persons of Hispanic ethnicity can be of any race and are included in the racial categories.
Poverty = Neighborhood poverty levels defined by median household income.

Figure 33: King County Youth Drug-induced Deaths by Subgroup, 2008-2012 Average

Autism

Autism is a complex neurological disorder that impacts brain development in social interaction, communication and repetitive behaviors. The definition of autism has broadened to be defined as a spectrum disorder that includes the disorders of autism, Asperger syndrome and pervasive developmental disorder—not otherwise specified. According to the Centers for Disease Control and Prevention, one in 68 children in the United States has an autism spectrum disorder (ASD).¹⁷⁴ The Washington State Department of Health estimates that ASDs affect 8,000 to 12,000 children and youth in the state. In some school districts in the Puget Sound area, autism rates are estimated as high as one in 50.¹⁷⁵

The National Survey of Children with Special Healthcare Needs found that, compared with all families of children with special healthcare needs, ASD families were less likely to participate in decision-making with their providers and be satisfied with the services they receive; less likely to have a medical home; and less likely to find it easy to use community-based service systems.¹⁷⁶

Community Input

Interviews with members of community coalitions and organizations identified three key issues related to behavioral health: (1) access to behavioral healthcare; (2) integration of human services and behavioral and physical healthcare; and (3) boarding of mental health patients.

Access to Behavioral Healthcare

Those who are seriously mentally ill often face difficulty accessing behavioral healthcare in a primary care setting. Insurers' regulatory barriers can also limit the range of needed services that are covered. Members of

¹⁷⁴ Centers for Disease Control and Prevention. (2016). Autism spectrum disorders. Retrieved from <http://www.cdc.gov/ncbddd/autism/data.html>.

¹⁷⁵ Seattle Children's. Autism case for support.

¹⁷⁶ Washington State Department of Health. (2009, January). Autism awareness fact sheet.

¹⁷³ <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/behavior/alcohol-impaired-driving-fatalities.ashx>.

vulnerable populations struggle to access care and need a high level of assertive engagement. Families and children with mental health issues often face challenges related to access to care in moments of crisis and great need.

Integration of Human Services and Behavioral and Physical Healthcare

Community members strongly support hospitals' efforts to integrate systems of human services and behavioral and physical healthcare. Serious mental illness is often associated with chronic disease and homelessness, so it is critical to cross-train staff to address physical health and human services, as well as behavioral health issues.

Boarding of Mental Health Patients

Community members identified the practice of psychiatric boarding — involuntarily placing mentally ill patients in emergency rooms without treatment — as a serious problem. Individuals who are in danger of hurting themselves or others should not be “warehoused.” Instead, they should receive appropriate treatment in a therapeutic setting.

Community Assets and Resources

Access to Behavioral Healthcare

- In 2015, Seattle Children's grew its inpatient mental health services by expanding its Psychiatric and Behavioral Medicine Unit from 20 beds to 41 beds. The unit works to diagnose, treat and prevent problems with emotions and behavior in patients ages 3 to 18 through a hospital stay, which averages about six days. The unit offers five dedicated beds for patients with severe autism spectrum disorders. The PBMU will work closely with each child's community providers to support the return home.

- Odessa Brown Children's Clinic (OBCC) provides mental health services, along with primary care and care coordination in multiple elementary, middle and high public schools, and Wellspring, which serves homeless children. This outreach allows OBCC to reach children who may not have other opportunities to receive primary and mental healthcare.
- OBCC also offers family-focused, evidence-based programs, such as the Promoting First Relationships program, which focuses on parents of children up to age 3, and Parent-Child Interactive Therapy for children who have difficulties with emotional regulation from ages 3 to 8. Seattle Children's has experts who are involved in mental health-related prevention efforts, including violence prevention in collaboration with schools and community organizations.
- Seattle Children's Autism Center and the Alyssa Burnett Adult Life Center provide specialized care and therapy to children and special programs for adults with autism spectrum disorders.
- Seattle Children's publishes the Autism Blog and Teenology 101, which frequently addresses mental health in teens, in order to reach children and families beyond those who actually receive care at Seattle Children's.
- Seattle Children's offers support groups for deaf and hard-of-hearing teens and preteens who have mental illness, and meal support classes for parents of children or teens with eating disorders.
- The Partnership Access Line (PAL) is a state-funded, telephone-based child mental health consultation service in Washington that is administered by child psychiatrists at Seattle Children's.
- Telemental Health through Seattle Children's allows children with mental healthcare needs in certain underserved communities in the WAMI region to speak with a psychiatrist in a distant center through videoconferencing.

- The Middle School Support Project (MSSP) is a partnership with Nesholm Family Foundation and Sound Mental Health. The program provides full-time mental health professionals in schools with high levels of poverty and low student performance. The goal is to develop a school-based initiative to support students' academic success by integrating behavioral health services into the schools' existing student support systems.
- Children's Crisis Outreach Response System (CCORS) provides mobile crisis outreach and crisis stabilization services for children and youth up to age 18.
- Culturally specific providers, including the Seattle Indian Health Board, the Muckleshoot Clinic, the Snoqualmie Nation Clinic, Sea Mar, Consejo, Seattle Counseling Service, and the Asian Counseling and Referral Service.
- A progressive and supportive community; specific communities like the lesbian, gay, bisexual, transgender and questioning (LGBTQ) community provides private funds to cover services.
- The Mental Illness and Drug Dependency (MIDD) funds through King County provide additional services for individuals who do not qualify for Medicaid. The MIDD program helps stabilize youth and adults suffering from chemical dependency and mental illness so they can receive the mental healthcare services they need to avoid an emergency room visit or jail stay.¹⁷⁷
- Specialty courts (e.g. domestic violence court, drug court, mental health court and family treatment court) also address mental health.
- The Washington Council for Behavioral Health (formerly the Washington Community Mental Health Council) advocates for community behavioral health agencies so they can improve the lives of individuals in Washington state who have mental illness or a substance use disorder.¹⁷⁸
- The Developmental Pathways Research Program with Seattle Public Schools provides training and consultation for 17 school-based mental healthcare providers in assessing and managing mental health concerns.
- Seattle Children's Autism Center provides assessment, diagnosis, treatment and support for autism spectrum disorders. Its clinicians provide medical, psychiatric, behavioral and speech services for babies, children and young adults. Approximately 45% of families seeking autism services at Seattle Children's lack adequate insurance coverage for their child's care. The Autism Center offers provider and community education, as well as individual patient and family education. The center offers monthly support groups and community classes for parents and caregivers of children with autism on a variety of topics. Classes are available statewide through Seattle Children's video and teleconferencing outreach program.

Integration of Human Services and Behavioral and Physical Healthcare

- OBCC provides pediatric mental healthcare in the same facility as primary care and also trains pediatricians to integrate mental health into primary care visits. OBCC has a Birth to 5 program (provided with financial support from Seattle Children's Guild Association) embedded into the primary care setting in which families who have challenging situations are referred to a staff member who can support them. Tackling mental health in the medical environment reduces stigma and affirms that mental health is part of being healthy. The Birth to 5 Team (a mental health expert, a social worker and two community care coordinators) helps families focus on what they are doing well. By looking at positives, parents open their eyes to their own success and encourage them wherever they are.

¹⁷⁷ Public Health-Seattle & King County. (2016). Mental illness and drug dependency (MIDD) action plan. Retrieved from <http://www.kingcounty.gov/healthservices/MHSA/MIDDPlan.aspx>.

¹⁷⁸ Washington Council for Behavioral Health. (2016). Retrieved from <http://www.thewashingtoncouncil.org>.

- OBCC is partnering with Nowland Premier Soccer Academy Foundation to provide soccer training at the Rainier Vista Boys & Girls Club. The program is an example of using sports to help teach social and emotional skills. It is a high-level, year-round, free soccer training that aims to prepare teams in Rainier Valley to compete in Seattle leagues.
- The Partnership Group, consisting of community behavioral health providers, collaborates on policies and practices to promote integration and quality care.
- School-based integrated health centers provide behavioral and physical healthcare.
- Plymouth Housing Group and the Downtown Emergency Services Center (DESC) provide permanent, supportive housing to homeless people with chronic mental illness.
- Seattle Children's Alyssa Burnett Adult Life Center offers classes and activities for adults with ASD and other developmental disabilities as they transition out of the education system and into adulthood. The Alyssa Burnett Adult Life Center hosts year-round classes and activities for adults ages 18 and older that promote lifelong learning and independence, enhance quality of life and provide meaningful ways to take part in the community.

Boarding of Mental Health Patients

- A new mobile crisis team and additional Program for Assertive Community Treatment (PACT) team will soon be available to help divert people from hospitals.
- A new transition program helps hospitals find placement solutions for psychiatric patients.
- The Crisis Solutions Center, operated by DESC, offers an alternative to hospitalization for adults.

Opportunities

Access to Behavioral Healthcare

- Our current mental health system is inadequate to handle the volume of patients who need care. To address this, the state's Managed Care Organizations should be held accountable for providing timely access to mental health care, and we need to invest in increased hospital capacity for inpatient and outpatient care. Creative use of telemedicine, like Seattle Children's Hospital's Physician Access Line, can help bridge gaps where there are too few providers in a region to care for all the kids who need services.
- Standardized referral guidelines for behavioral health treatment, created in coordination with behavioral healthcare providers, could streamline the process and improve access for patients.
- Providing additional outreach services in places where vulnerable children and families live through partnerships with community centers, schools and organizations could improve access to behavioral healthcare services.
- Providing support and educational opportunities to parents will reinforce their parenting skills and help them develop additional skills and obtain new knowledge about child health and development.
- Seattle Children's and OBCC have expertise in pediatric mental healthcare with psychologists, psychiatrists and counselors who see patients and do groundbreaking research to improve care. These experts could potentially engage in efforts to build capacity among primary care providers to screen for mental health and manage treatment for some conditions.
- Public health messaging about mental health could inform and educate children and families.

- Integration of Human Services and Behavioral and Physical Healthcare Coordination related to discharge planning (including notification of behavioral healthcare providers and communication of prescriptions to all relevant providers) could create efficiencies and reduce unnecessary emergency department use.
- Clinicians in primary care and emergency departments can use the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process to identify individuals at risk for substance abuse disorders.
- Many healthcare organizations are increasing their capacity for integrated behavioral healthcare.
- Continued advocacy for improved coordination between mental and physical health services can highlight the importance of this issue.
- Boarding of Mental Health Patients:
 - Seattle Children's opened 21 additional psychiatric treatment beds (41 total beds), including beds for adolescents and individuals with severe autism spectrum disorders.
 - Medicaid will cover psychiatric services within freestanding psychiatric hospitals for the next two years.
 - A new 16-bed evaluation and treatment center recently opened in King County.
- The Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) educates families and those who routinely interact with youth — teachers, mental health professionals and doctors — about key signs to look for in young people to identify and prevent psychosis.
- Applying trauma-informed care principles within healthcare facilities can reduce unnecessary trauma for people living with a mental illness or trauma impacts.

Maternal and Child Health

Healthy pregnancies, healthy babies and healthy mothers are important goals for all communities. Mothers' mental, physical, emotional and socioeconomic well-being — before, during and after pregnancy — can affect outcomes in infancy, childhood and adulthood. Maternal and child health outcomes are also markers of overall community health; a healthy community is one that ensures all children thrive and reach their full potential.

While King County has made progress in decreasing rates of poor birth outcomes, it does not meet the Healthy People 2020 objective for prenatal care. Disparities in birth outcomes persist, particularly among black/African American and American Indian/Alaska Native populations.

Infant Mortality

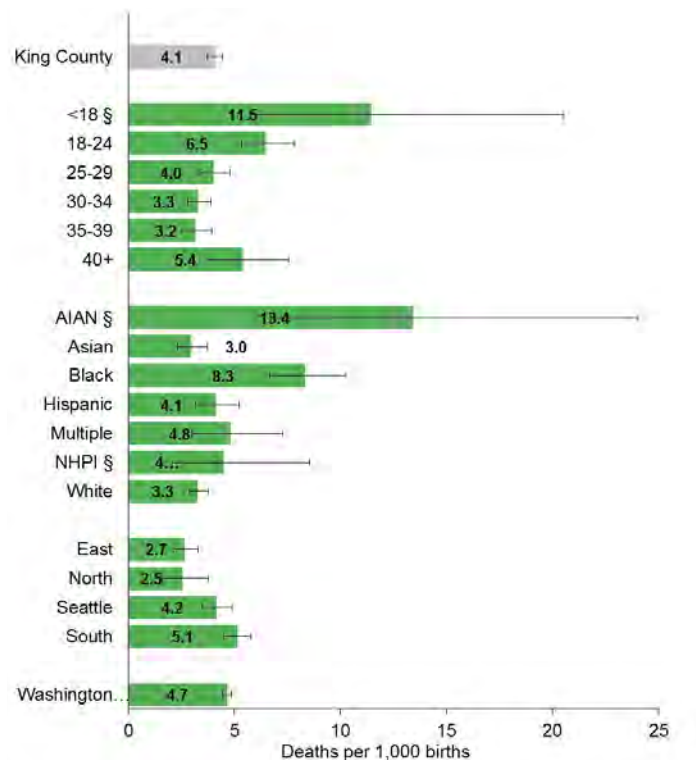
The infant mortality rate is the number of babies who die before their first birthday per 1,000 live births in a given year. Two-thirds of infant deaths are associated with labor and delivery-related conditions, birth defects and prematurity. Because many of these deaths are preventable, infant mortality is a measure of the overall health of a population.

The Healthy People 2020 goal for infant mortality is 6.0 per 1,000 live births.¹⁷⁹ In 2015, the infant mortality rate in Washington state was 4.8 deaths per 1,000 live births.¹⁸⁰ From 2011 to 2015, King County's average infant mortality rate was 4.1 deaths per 1,000 live births.

¹⁷⁹ Public Health-Seattle & King County. (2012). Infant mortality, King County, 2008-2012 average. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/maternal/infant-mortality.ashx>.

¹⁸⁰ Washington State Department of Health (2016) All Infant Death Tables By Year. Retrieved from <http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/InfantDeath/InfantDeathTablesbyYear>.

- Infants born to American Indian/Alaska Native and Black mothers were more likely than those born to white or Asian mothers to die before their first birthday.
- In King County, infant mortality has declined since 2000.



Source: Linked Birth-Death Certificate Data, Washington State Department of Health, Center for Health Statistics; § Too few cases to meet precision standard, interpret with caution

Figure 34: King County Infant Mortality Rates by Subgroup, 2011-2015 Average

Early and Adequate Prenatal Care

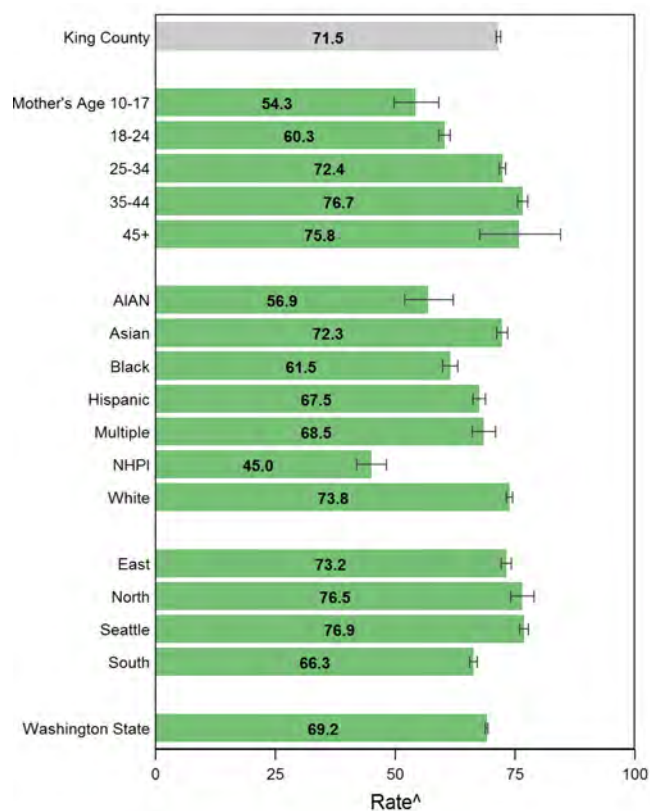
Starting prenatal care early in pregnancy and having regular visits improves the chances of a healthy pregnancy. The indicator of adequate prenatal care is the number of births for which prenatal care started before the end of the fourth month and 80% or more of the recommended number of visits occurred.

From 2010 to 2014, 69.2% of expectant mothers in Washington and 71.5% of expectant mothers in King County received early prenatal care. This is compared to 73.5% of expectant mothers in

the United States, which still falls short of the Healthy People 2020 goal of 77.6%.¹⁸¹

In King County:

- Only about half of teen mothers (54.3%) received early and adequate prenatal care.
- American Indian/Alaska Native, black, Hispanic Native Hawaiian/Pacific Islander and multiracial mothers were less likely than Asian and white mothers to receive early and adequate prenatal care.
- Early and adequate prenatal care increased recently in the South Region and Seattle, but declined in the East Region.



Source: WA State DOH, Center for Health Statistics, Birth Certificates. Prepared by Public Health - Seattle & King County, APDE, 11/2016.
 ^Rate = per 100 live births.
 [-----] Confidence interval shows range that includes true value 95% of the time.
 * Too few cases to protect confidentiality and/or report reliable rates.
 § Too few cases to meet precision standard, interpret with caution.
 Persons of Hispanic ethnicity can be of any race and are included in the racial categories.

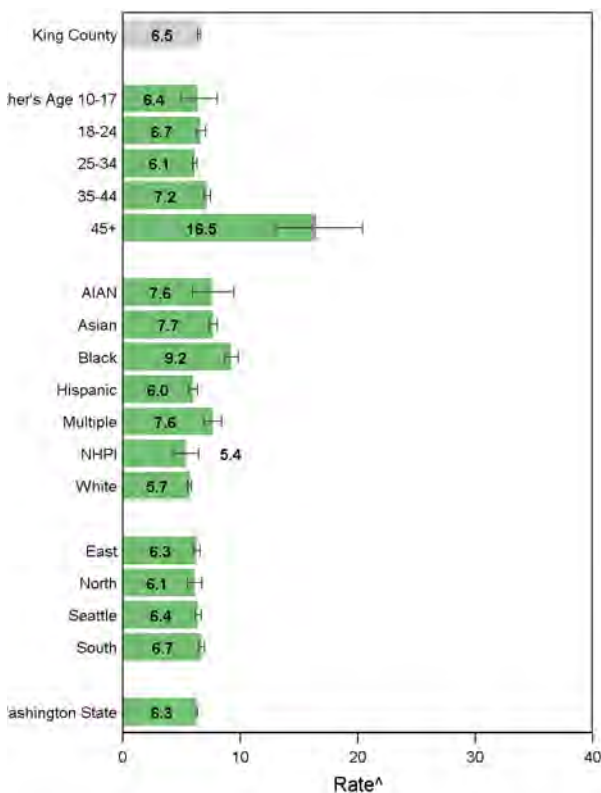
Figure 35: King County Rates of Early and Adequate Prenatal Care by Subgroup, 2010-2014 Average

181 Public Health-Seattle & King County. (2012). Early and adequate prenatal care, King County, 2008-2012 average. Retrieved from <http://kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/maternal/early-adequate-prenatal-care.ashx>.

Low Birth Weight

Any infant born weighing less than 2,500 grams (about 5.5 pounds) is considered low birth weight. Low birth weight infants are at higher risk of infant mortality, respiratory disorders and neurodevelopmental disabilities.

From 2010 to 2014, 6.5% of infants born in King County were low birth weight. That is compared to 6.3% in Washington state in 2010-2014 and 8.2% in the United States in 2010.¹⁸² Although King County meets the Healthy People 2020 objective of 7.8% or fewer infants born at low weight, 1,727 low birth weight babies were born in King County in 2014.



Source: WA State DOH, Center for Health Statistics, Birth Certificates.
 Prepared by Public Health - Seattle & King County, APDE, 08/2016.
^aRate = per 100 live births.
^bConfidence interval shows range that includes true value 95% of the time.
^cToo few cases to meet precision standard, interpret with caution.
^dPersons of Hispanic ethnicity can be of any race and are included in the racial categories.

Figure 36: King County Low Birth Weight Rates, 2010-2014 Average

¹⁸² Public Health-Seattle & King County. (2012). Low birth weight (all births), King County, 2010-2014 average. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/healthhttp://kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/maternal/low-birthweight-all-births.ashx>.

- Infants born to Black mothers were more likely to be low birth weight than infants born to mothers of any other race.
- After increasing in the early 2000s, rates of low birth weight have recently leveled out in King County, Seattle, North King County and Washington State. The increase has continued in the East and South Regions.

Community Input

A community needs assessment produced by United Indians of All Tribes Foundation cited the high rates of poverty among American Indian/Alaska Native families and inadequate support for these families to promote the healthy development of their infants.

Community groups stressed the importance of providing adequate opportunities for pregnant women to receive culturally competent care and social support. Without this, they may resort to using the emergency department or other hospital-based care.

Community members also emphasized the importance of recognizing how adverse childhood experiences can lead to chronic disease in adulthood and poor birth outcomes for the next generation.

Community Assets and Resources

- The Global Alliance to Prevent Prematurity and Stillbirth (GAPPS) — an initiative of Seattle Children's — is dedicated to improving understanding of the causes of prematurity and stillbirth as a foundation for developing successful prevention and treatment strategies.¹⁸³ GAPPS is home to a large repository of specimens collected from a large and diverse group of pregnant women. These specimens are available to investigators worldwide who aim to understand the biological mechanisms of prematurity and stillbirth.¹⁸⁴ GAPPS stewards

¹⁸³ Global Alliance to Prevent Prematurity and Stillbirth. (2016). Retrieved from http://gapps.org/index.php/research/our_approach.

¹⁸⁴ Ibid.

the Preventing Preterm Birth initiative, a Grand Challenge in Global Health from the Bill & Melinda Gates Foundation, designed to unite the scientific community to combat and prevent prematurity. The Perinatal Interventions Program (PIP) will improve survival and reduce disability of newborns and mothers by standardizing the care of preterm infants and improving maternal conditions that lead to preterm birth, stillbirth and other life-threatening and disabling conditions.

- The Equal Start Community Coalition brings together leaders of nearly 30 organizations to promote healthy mothers, families and communities, and seeks to reduce infant mortality.
- The Native American Women's Dialogue on Infant Mortality is a native-led collective whose members are concerned about high rates of infant mortality in their communities.
- Governor Jay Inslee's statewide "Results Washington" framework calls for reducing birth outcome disparities.
- An objective of the Public Health Improvement Partnership — convened by the Washington State Department of Health — is to prevent or reduce the impact of adverse childhood experiences, such as abuse and neglect.
- Nurse Family Partnership and other home-visiting and prenatal-support programs, including MOMs Plus, offers support for high-risk pregnant and parenting women. Providers remain concerned that there is not sufficient capacity within these programs.
- The Period of PURPLE Crying curriculum is a way to help parents understand this time in their baby's life and is a promising strategy to reduce the risk of child abuse. Seattle Children's Protection Program promotes the Period of PURPLE Crying Approach to Shaken Baby Prevention and hosts a statewide taskforce to disseminate

The time to prevent chronic disease is during pregnancy and early childhood.

this information through state hospitals, clinics and agencies that have contact with pregnant women and their partners, as well as to parents and caregivers of newborns.

Opportunities

- The Baby-Friendly Hospital Initiative encourages and recognizes hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding.
- Adverse Childhood Experiences (ACEs) are common and increasingly recognized as significant risk factors for poor child and adult health outcomes. The ACEs Collaborative, an informal work group of providers through Public Health-Seattle & King County, is developing a common framework of trauma-informed care and the life-course model (a strengths-based framework grounded in understanding and responding to the impact of trauma across the lifespan). The group's goals are to offer technical guidance and support and to promote existing and emerging data and research on the life-course model.
- Prenatal care can offer an opportunity to address lifelong health issues with women.
- Many strong community-based organizations offer home visits and provide other support to pregnant and parenting women and are strong partners to healthcare systems.

Preventable Causes of Death

Every day, more than two dozen children die from an injury that was not intended. The number of potentially preventable deaths – premature deaths that could have been avoided – has been declining in Washington state overall.

Obesity, Physical Activity and Nutrition

Children who are overweight or obese often have worse health, limited ability to move and be active,¹⁸⁵ lower self-esteem¹⁸⁶ and increased risk for type 2 diabetes.¹⁸⁷ Children and adolescents who are overweight or obese have a higher risk of being obese as adults.¹⁸⁸ Many different factors are related to overweight and obesity, including characteristics of the child, and the child's home and community environments.¹⁸⁹ To be successful, efforts to prevent and reduce childhood obesity and overweight must consider these different factors.

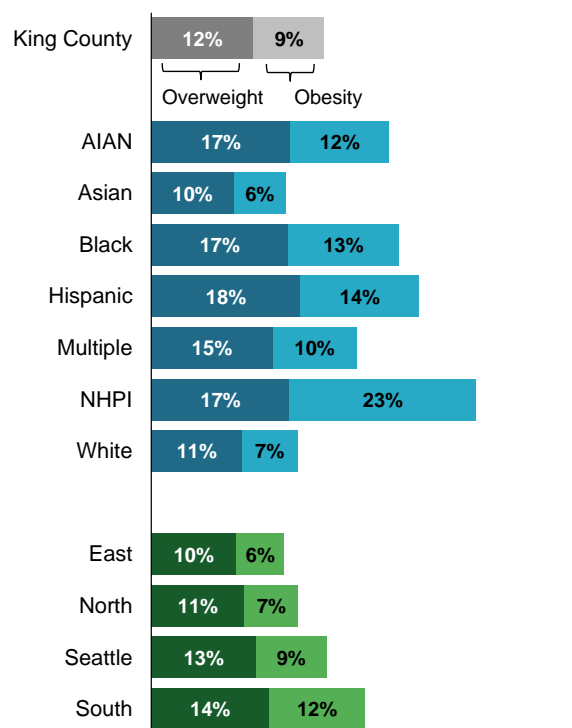
Obesity and Overweight Prevalence

Children and adolescents are considered obese if their body mass index (BMI) is in the top 5% for their age and gender. They are considered overweight or obese if their BMI is in the top 15%.

In Washington state in 2014, 11% of students in 10th grade were obese, and 14% were overweight based on the statewide Healthy Youth Survey.¹⁹⁰ These levels have held constant since 2002.¹⁹⁰ In 2014, 8% of King County students in grades 8, 10 and 12 were obese, and 20% were overweight or obese.¹⁹¹

In Washington state:¹⁹²

- Native Hawaiian/Pacific Islander students in 12th grade were about 2.7 times more likely to be obese than white students in the same grade.¹⁹³
- American Indian/Alaska Native, Black/African American, Native Hawaiian/Pacific Islander and Hispanic students were more likely than Asian or white students to be overweight.¹⁹⁴
- The South King County region had a significantly lower percent of students at a healthy weight than any other region.¹⁹⁵



Sources: Healthy Youth Survey.

Figure 37: King County Youth Obesity and Overweight Rates by Subgroups, 2008-2012 Average

¹⁸⁵ Wallen, K.C., Reither, E.N., Haas, S.A., Meier, A.M. (2005). Overweight, obesity, and health-related quality of life among adolescents: The national longitudinal study of adolescent health.

¹⁸⁶ Strauss, R.S. Childhood obesity and self-esteem. *Pediatrics*. 200; 105(1)

¹⁸⁷ Biro, F.M., Wien, M. (2010). Childhood obesity and adult morbidities. *American Journal of Clinical Nutrition*. 91(5):1499S-1505S.

¹⁸⁸ Guo, S.S., Chumlea, W.C. (1999). Tracking of body mass index in children in relation to overweight in adulthood. *American Journal of Clinical Nutrition*. 70:145S-8S.

¹⁸⁹ Davison, K.K., Birch, L.L. (2001, August). Childhood overweight: a contextual model and recommendations for future research. *Obesity Review*. 2(3): 159-171.

¹⁹⁰ Washington State Department of Health. (2015, December). Health of Washington state. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/5500/RPF-Obs2015-DU.pdf>.

¹⁹¹ Washington State Department of Health. (2014, January). Washington state healthy youth survey factsheet analytic report. Retrieved from <http://www.askhys.net/FactSheets>.

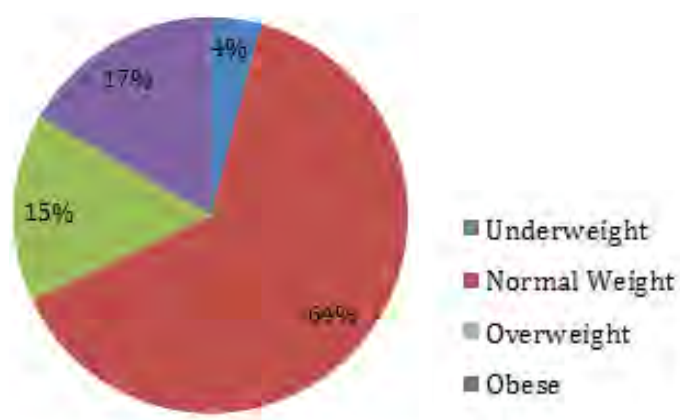
¹⁹² Washington State Department of Health. (2014, January). Washington state healthy youth survey 2012 analytic report. Retrieved from <http://www.doh.wa.gov/DataandStatisticalReports/DataSystems/HealthyYouthSurvey/Reports>.

¹⁹³ Washington State Department of Health. (2015, April). Healthy <http://www.askhys.net/Reports>.

¹⁹⁴ Ibid.

¹⁹⁵ Public Health – Seattle & King County. (2016, September). Health of children and youth in King county. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/health-of-children-youth-king-county-2016.ashx>.

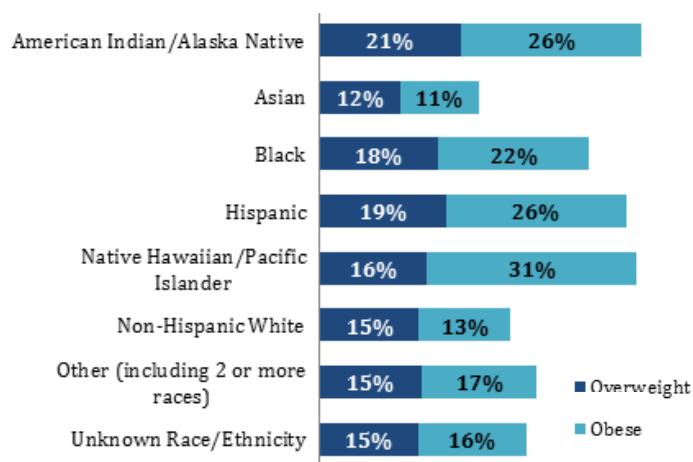
In 2015-2016 for patients ages 2 to 18 at Seattle Children's, 64% of patients were normal weight, 4% were underweight, 15% were overweight and 17% were obese. Native Hawaiian/Pacific Islander, American Indian/Alaska Native, Hispanic and black populations were more likely to be overweight or obese compared to white and Asian youth. Children on Medicaid were more likely to be overweight or obese than children with any other form of insurance.



N=60,862 patients

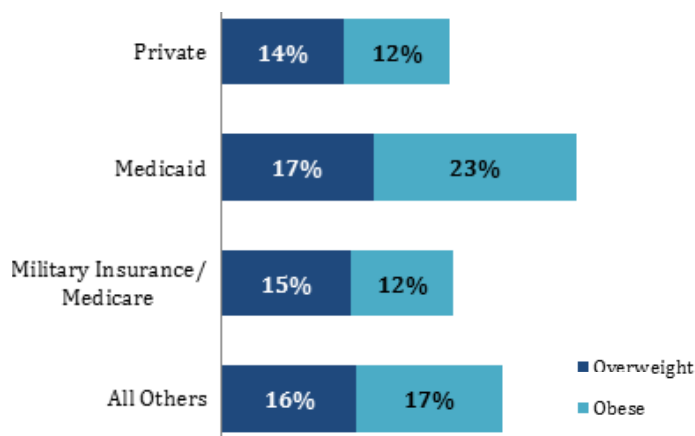
Figure 38: Seattle Children's Patient Weight Breakdown for Ages 2 to 18

Note: Data were available for 62% of all patients (n=60,862) seen as inpatients or outpatients at all Seattle Children's locations, including regional clinics and Odessa Brown Children's Clinic (primary care).



N=60,862 patients

Figure 39: Seattle Children's Patient Weight Categories by Race/Ethnicity



N=60,862 patients

Figure 40: Seattle Children's Patient Weight Categories by Insurance Type

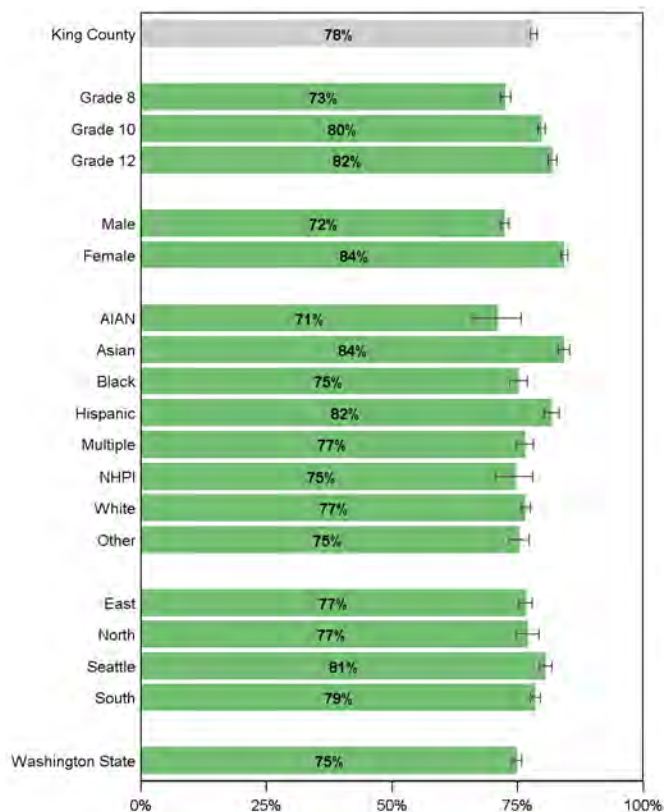
Physical Activity

About 75% of school-age children in Washington state do not meet the recommendation of participating in at least 60 minutes of physical activity on seven of the past seven days, compared to 76% of school-age children in King County in 2012.¹⁹⁶

In King County:

- Of all race/ethnicity groups, Asians were least likely to meet recommendations of physical activity in 2012-2014.
- As grade level increased, student participation in physical activity declined, with 12th graders 0.8 times as likely as 6th graders to meet recommendations.
- Rates of not meeting physical activity recommendations among youth decreased between 2006 and 2012 for the county and in all four regions.

¹⁹⁶ Public Health-Seattle & King County. (2012). Physical activity recommendation not met (school-age), King County, 2010 and 2012. <http://www.kingcounty.gov/healthservices/health/data/%7e/media/health/publichealth/documents/indicators/prevention/PhysActivityRecNotMetSchAgeYth.aspx>.



Source: Healthy Youth Survey.
 Prepared by Public Health - Seattle & King County, APDE, 08/2016.
 [-----] Confidence interval shows range that includes true value 95% of the time.
 * Too few cases to protect confidentiality and/or report reliable rates.
 § Too few cases to meet precision standard, interpret with caution.
 Data by income or poverty level not available.

Figure 41: King County Youth Physical Activity Recommendation Not Met by Subgroup, 2012 and 2014

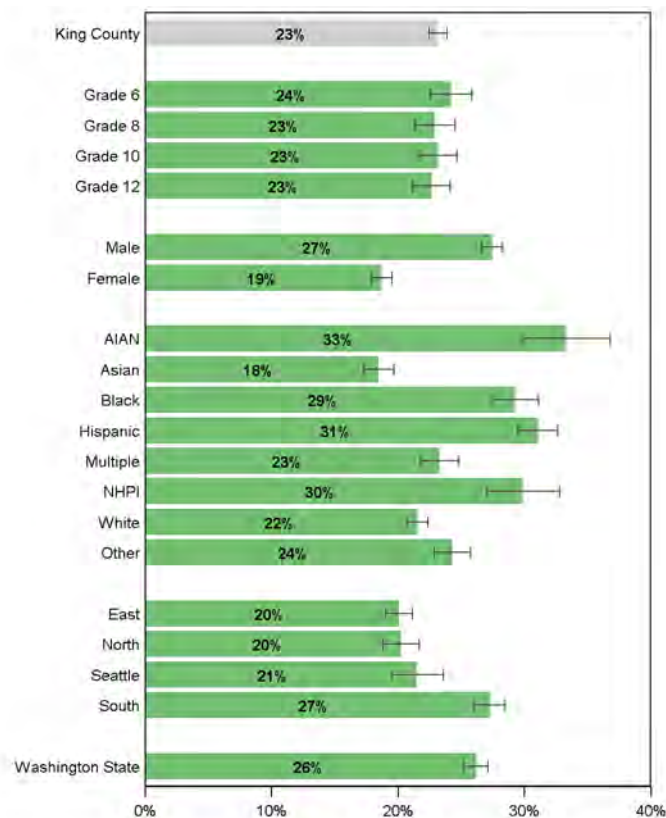
Youth Soda Consumption

Sugary drink consumption is associated with obesity, diabetes, and diseases of the heart, kidneys and liver. In Washington state in 2014, 5% of 8th graders, 4% of 10th graders and 4% of 12th graders reported drinking sweetened drinks daily at school.¹⁹⁷ In King County, the proportion of 6th, 8th, 10th and 12th graders drinking sugar-sweetened drinks or soda daily decreased significantly from 2004 to 2014.

- Males were more likely than females to drink sugary drinks daily.
- Hispanics, Native Hawaiians/Pacific Islanders, Blacks and American Indians/Alaska Natives were more likely than Asians and whites to

drink soda or sweetened beverages every day.

- South Region students were more likely to consume sugary beverages daily than were students in the other three regions.
- From 2004 to 2014, rates of daily sugary drink consumption decreased for students in the county overall and in all four regions.



Source: Healthy Youth Survey.
 Prepared by Public Health - Seattle & King County, APDE, 08/2016.
 [-----] Confidence interval shows range that includes true value 95% of the time.
 * Too few cases to protect confidentiality and/or report reliable rates.
 § Too few cases to meet precision standard, interpret with caution.
 Data by income or poverty level not available.

Figure 42: King County Youth Daily Soda or Sugar-Sweetened Beverage Consumption Rates by Subgroups, 2012 & 2014

Fruit and Vegetable Consumption

Eating fruits and vegetables lowers the risk of developing many chronic diseases and can support weight management.

Eating fruits and vegetables lowers the risk of developing many chronic diseases and can support weight management. In 2014 in Washington State, 24% of 8th graders and

¹⁹⁷ Washington State Department of Health. (2016). Washington state healthy youth survey 2014. Retrieved from <https://www.askhys.net/FactSheets>. King County data are from new CHI not yet on line.

22% of 10th and 12th graders ate five or more servings of fruit and vegetables per day over the past seven days.¹⁹⁸

In King County, 27% of King County 8th, 10th and 12th graders ate five or more servings of fruits and vegetables per day during the past seven days. These rates are similar for children of all ages, race/ethnicity categories and residential location.¹⁹⁹

Food Insecurity

Food insecurity, referring to the inability to provide adequate food for one or more household members due to a lack of resources,²⁰⁰ is at its lowest level since before the Great Recession.²⁰¹ In 2015, 12.7% of U.S. households experienced food insecurity compared to 14% in 2014, continuing the downward trend from a high of 14.9% in 2011.²⁰² However, despite the significant progress, food insecurity remains a concern across the country. For years, food insecurity has been harming the health and well-being of millions in the United States.²⁰³ Furthermore, the United States Department of Agriculture (USDA) reports that food insecurity rates are higher for Hispanics and Blacks or African Americans than for their white counterparts.²⁰⁴

In Washington state, one in five kids live in a household that struggles to put food on the table and one in seven Washingtonians relies on food stamps known as SNAP (Supplemental

“I don’t think any family prefers to eat processed foods; but at certain times of the month, it’s what’s consumed because there’s not the funds to buy the fresh produce.”

– King County mother

Nutrition Assistance Program).²⁰⁵ Half of all people on SNAP are kids.²⁰⁶ Although food insecurity is harmful to any individual, it can be particularly devastating among children due to their increased vulnerability and the potential for long-term consequences.

According to the Healthy Youth Survey (HYS) Analytic Report, compared to children from families who are food secure, children from families with food insecurity are more likely to have behavior problems, do poorly in school, need medical care and hospitalization, and develop chronic diseases.²⁰⁷ Food insecurity is also associated with poor-quality diet and obesity.²⁰⁸ Many overweight or obese children lack access to high quality nutritious foods at affordable prices. Hunger induces irregular eating patterns which can lead to being overweight and obese, reflecting the strong link between health and hunger.

In addition to contributing to the development and effects of certain chronic diseases, food insecurity causes people to adjust their health behaviors, causing further problems to their health and ability to manage chronic health conditions. Some living with food insecurity will reduce, skip, delay or use lower-cost medications as a result of using what little resource they have to purchase

198 Washington State Department of Health. (2014, January). Washington state healthy youth survey factsheet analytic report. Retrieved from <http://www.askhys.net/FactSheets>.

199 Public Health-Seattle & King County. (2012). Less than five fruits and vegetables daily (school-age), King County, 2008 and 2012 average. Retrieved from <http://www.kingcounty.gov/healthservices/health/data/%7e/media/health/publichealth/documents/indicators/Prevention/LessThanFiveFruitsVegDailySchAgeYth.ashx>.

200 USDA Economic Research Service. (2016). Characteristics of the food insecure in the U.S. Retrieved from <http://www.ers.usda.gov/data-products/food-security-in-the-united-states/interactive-chart-food-security-characteristics.aspx>.

201 NPR. Number Of Hungry U.S. Kids Drops To Lowest Level Since Before Great Recession. (2016). Retrieved from <http://www.npr.org/sections/thesalt/2016/09/07/493010010/number-of-hungry-u-s-kids-drops-to-lowest-level-since-great-recession>.

202 USDA Economic Research Service. (2016). Household Food Security in the United States in 2015. Retrieved from <http://www.ers.usda.gov/publications/err-economic-research-report/err215.aspx>.

203 Journal of the American Medical Association. 298:1851-1853.

204 USDA Economic Research Service. (2016). Trends in U.S. food security. Retrieved from <http://www.ers.usda.gov/data-products/food-security-in-the-united-states/interactive-chart-food-security-trends.aspx>.

205 Northwest Harvest. (2016). Focus on Food Security: Connecting the Dots. Retrieved from http://www.northwestharvest.org/stuff/contentmgr/files/0/a3b2de7ff8400bb855ba9abf50fff559/pdf/fgr_15_16_webfinal.pdf.

206 Ibid.

207 Center on Hunger and Poverty. (2002). The consequences of hunger and food insecurity for children: Evidence from recent scientific studies. Waltham, MA: Center on Hunger and Poverty, Heller School for Social Policy and Management, Brandeis University.

208 Townsend, M.S., Peerson, J., Love, B., Achterberg, C., Murphy, S.P. (2001). Food insecurity is positively related to overweight in women. *Journal of Nutrition*. 131:1738-1745.

food.^{209 210} Additionally, independent of other social determinants of health, household food insecurity strongly correlates with healthcare utilization and costs.^{211 212}

The Hungry in Washington report, based on USDA data, found that 12.9% of Washington residents were food insecure in 2016 compared to 13.7% the year before.²¹³ Despite improvements seen in food security across the state, more people are struggling now than before the recession, indicating the need to continue efforts to curb food insecurity experienced by those in Washington and throughout the U.S.

In Washington, access to healthy foods may be determined by where residents live. The USDA's 2015 Household Food Security report indicates that the prevalence of food insecurity in the U.S. is higher in rural areas than urban areas.²¹⁴ Additionally, some residents in rural areas live in food deserts where they are 10 miles or more from a large supermarket. (See Rural Washington section on page 22.)

Across the country, households with children are more likely to be food insecure than households without children. The State of Washington's Kids report states that 13.2% of 10th graders were food insecure in 2014.²¹⁵ In 2015, 16.6% of all U.S. households with children experienced food insecurity, down significantly from 19.2% in 2014.²¹⁶ In about half of these households, food insecurity only affected the adults, as many parents would sacrifice their own meals so their children wouldn't have to go hungry. However, in 7.8% of these households, both the children and adults were food insecure.²¹⁷

"Hunger is a health issue and food is the best medicine."

**- Jason Gromley,
The Root Cause Coalition**

Public Health – Seattle & King County's Health Behaviors and Academic Risk report highlights the relationship between failing academically and 23 specific health-risk behaviors. Of King County students in grades 8, 10 and 12, 12.6% reported being food insecure in 2012 and 2014.²¹⁸ Academic risk, defined as receiving grades of mostly C's, D's or F's in school, nearly doubled for students who were food insecure compared to those who were not food insecure. In 2012 and 2014, 39.1% of King County students who reported being food insecure were at academic risk, compared to 19.4% at academic risk among food secure students.²¹⁹

Certain groups in King County are more affected by food insecurity than others. Between 2010 and 2013, food insecurity increased significantly for low-income households and residents who were unemployed.²²⁰

209 <http://www.ncbi.nlm.nih.gov/pubmed/24440543>.

210 <http://www.ncbi.nlm.nih.gov/pubmed/17000938>.

211 <http://www.ncbi.nlm.nih.gov/pubmed/26261199>.

212 <http://www.ncbi.nlm.nih.gov/pubmed/25960393>.

213 Anti Hunger & Nutrition Coalition. (2016). Hungry in Washington. Retrieved from <http://files.constantcontact.com/7dc0cad5401/3b474660-6c8d-4b83-b892-de69e6a4e891.pdf>.

214 USDA Economic Research Service. (2016). Household Food Security in the United States in 2015. Retrieved from <http://www.ers.usda.gov/publications/err-economic-research-report/err215.aspx>.

215 State of Washington's Kids. (2016). Retrieved from <http://budgetandpolicy.org/SWC%202016%20annual%20report%20Final.pdf>.

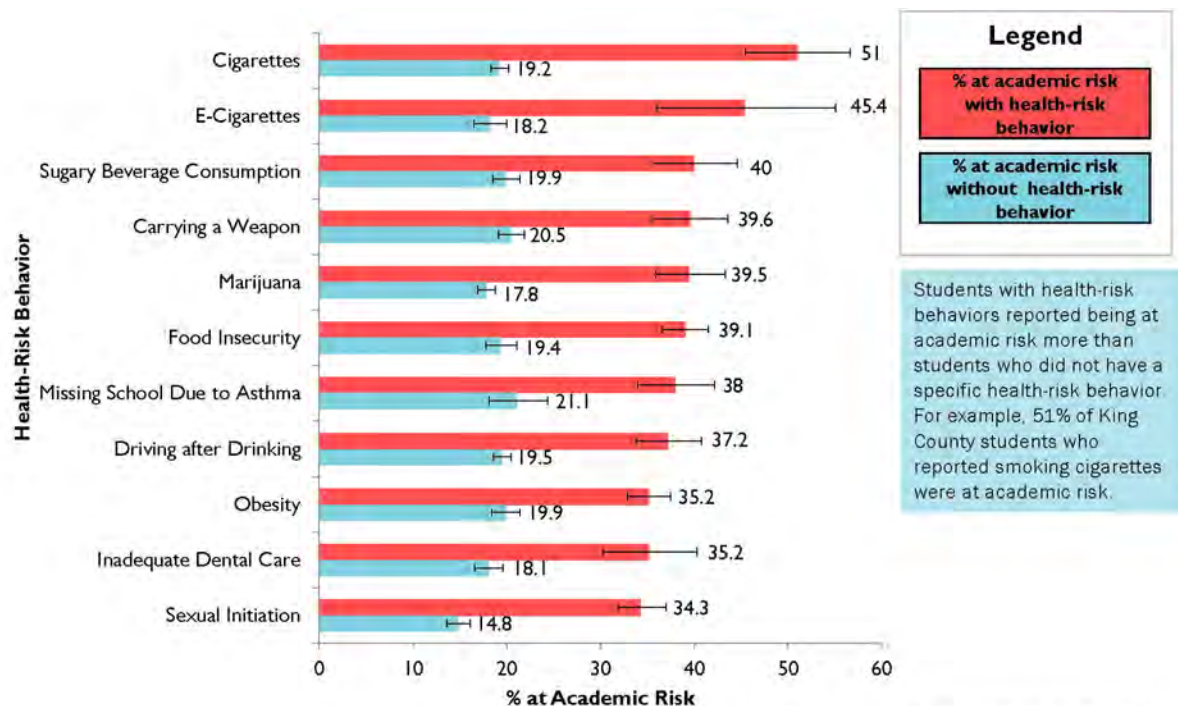
216 Anti Hunger & Nutrition Coalition. (2016). Hungry in Washington. Retrieved from <http://files.constantcontact.com/7dc0cad5401/3b474660-6c8d-4b83-b892-de69e6a4e891.pdf>.

217 Ibid.

218 Public Health – Seattle & King County. (2016). Health Behaviors and Academic Risk: Examining the Healthy Youth Survey in King County Students. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/Health-Behaviors-and-Academic-Risk.ashx>.

219 Ibid.

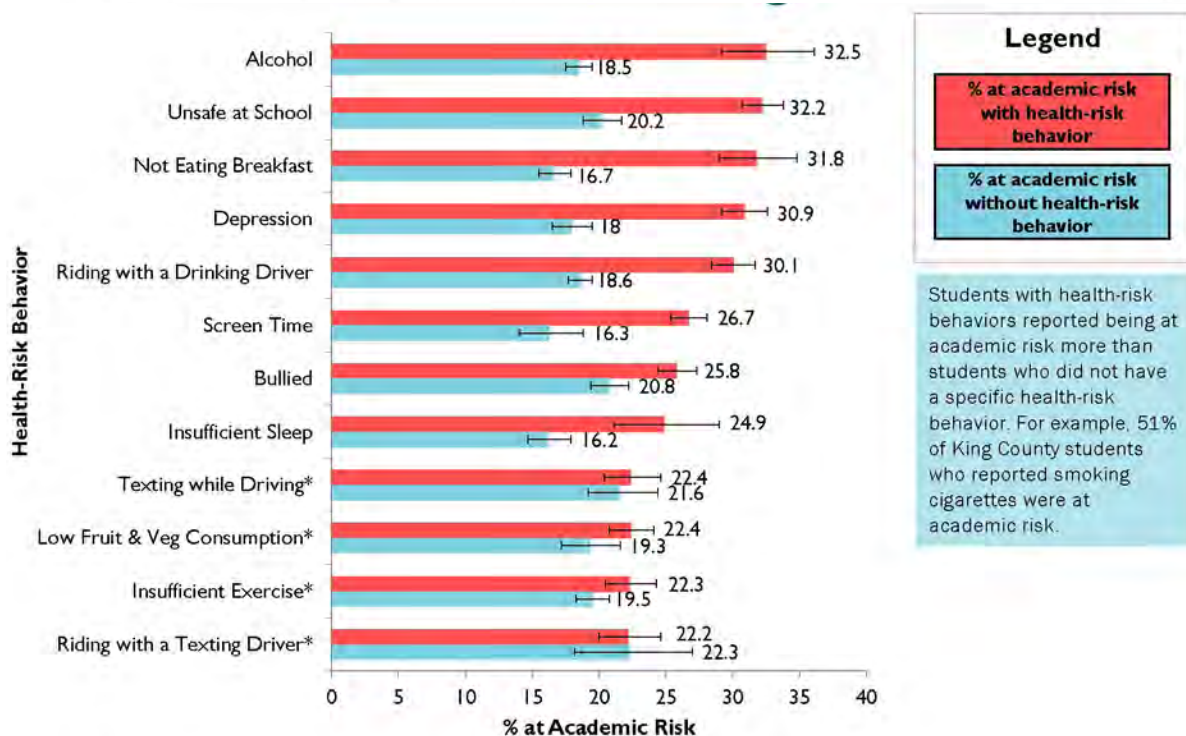
220 Communities Count. (2016). Food Hardship Trends in King County. Retrieved from <http://www.communitiescount.org/index.php?page=trends-by-age-education-employment-income-race-ethnicity-region>.



Continued on next page

—: Confidence interval shows range that includes the true value 95% of the time.

15



*No significant difference between percentages at academic risk with and without health-risk behavior.

—: Confidence interval shows range that includes the true value 95% of the time.

15

Figure 43: King County students at academic risk with and without health-risk behavior, 2012 & 2014 average

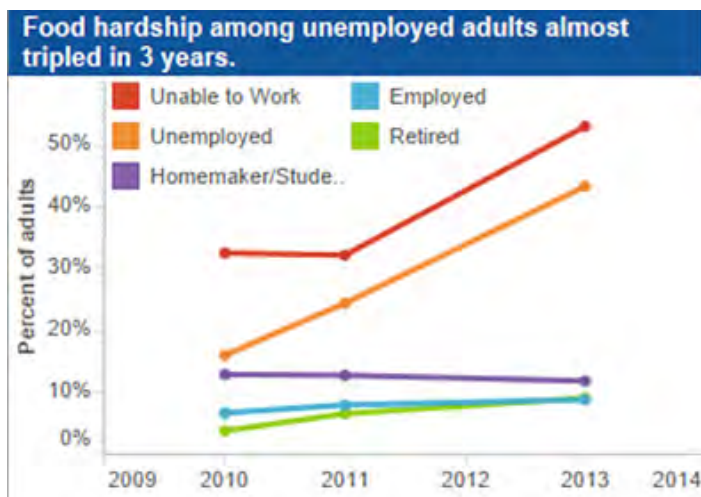


Figure 44: Food hardship by employment status in King County²²²

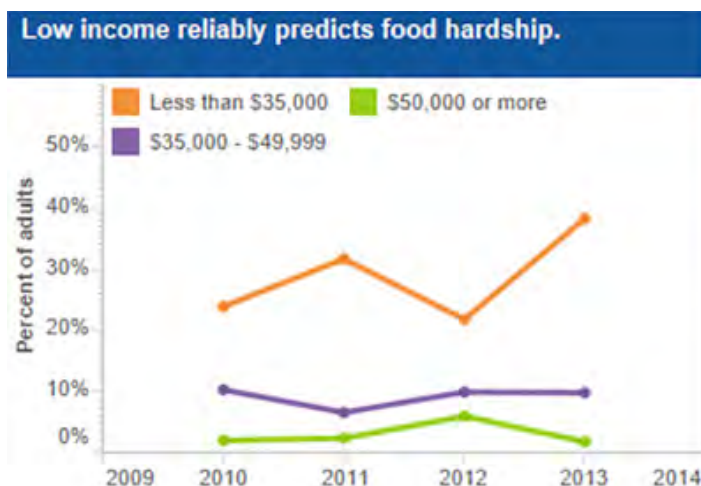


Figure 45: Income level and food hardship in King County²²³

In western Washington state, there are approximately 673,000 food insecure people; one in seven are hungry, half of whom are children and seniors.²²⁴ In 2014, 13.3% of King County residents were food insecure; 18% were children.²²⁵

Of King County's food insecure children, 53% were income-eligible for nutrition programs.²²⁶

In King County, 36% of students received free or reduced-price meals in 2014, compared to 46% in Washington State and 50% throughout the United States. The rate varies from 4% of students receiving free or reduced-price meals in Mercer Island to 79% in Tukwila.²²⁷



Figure 46: Child Food Insecurity in King County, 2014²²⁸

²²² Communities Count. (2016). Food Hardship Trends in King County. Retrieved from <http://www.communitiescount.org/index.php?page=trends-by-age-education-employment-income-race-ethnicity-region>.

²²³ Communities Count. (2016). Food Hardship Trends in King County. Retrieved from <http://www.communitiescount.org/index.php?page=trends-by-age-education-employment-income-race-ethnicity-region>.

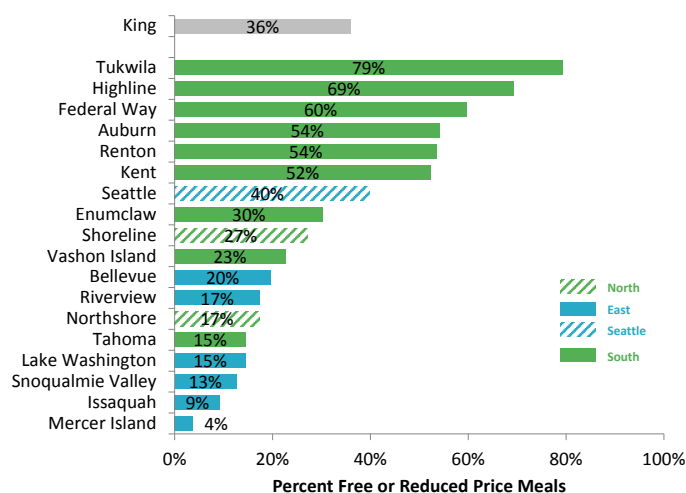
²²⁴ 2014 Missing Meals Report, Food Lifeline: www.foodlifeline.org/missingmeals.

²²⁵ Feeding America. (2014). Child Food Insecurity in King County. Retrieved from <http://map.feedingamerica.org/county/2014/child/washington/county/king>.

²²⁶ Ibid.

²²⁷ Public Health-Seattle & King County. (2014). Free or reduced-price meals, 2013-2014 school year, King County. Retrieved from <http://www.kingcounty.gov/healthservices/health/data/%7e/media/health/publichealth/documents/indicators/Demographics/FreeReducedLunch.ashx>.

²²⁸ Feeding America. (2014). Child Food Insecurity in King County. Retrieved from <http://map.feedingamerica.org/county/2014/child/washington/county/king>.



Data Source: Washington State Office of Superintendent of Public Instruction
Prepared by: Public Health - Seattle & King County; Assessment, Policy Development & Evaluation Unit; 11/2014.

Figure 47: Percent of King County Public School Students with Free or Reduced Price Meals by School District, 2013-2014 School Year

Mental Health and Obesity

In addition to physical activity and nutrition challenges, poor mental health is often linked to overweight and obesity. Physicians and dietitians at Seattle Children's and OBCC have noticed this connection between mental health and the tendency to be overweight or obese. The following are key takeaways:

- It is difficult to determine whether poor mental health can lead to overweight and obesity, or if overweight and obesity can lead to poor mental health, but it is clear they are related.
- Research on low-income adults shows that adults who have depression have a higher risk of overweight and obesity.²²⁹
- Overweight and obesity can also have an impact on mental health. Youth who are overweight or obese are more likely to have depression, low self-esteem, social or school difficulties, and lower quality of life compared

229 Flórez, K.R., Dubowitz, T., Ghosh-Dastidar, M.B., Beckman, R., Collins, R.L. (2015, July). Associations between depressive symptomatology, diet and body mass index among participants in the Supplemental Nutrition Assistance Program. *Journal of the Academy of Nutrition and Dietetics*. 115(7):1102-8.

to healthy children.^{230 231 232} In fact, based on research with children who are obese, their health-related quality of life is similar to the health-related quality of life of children with cancer.²³³

Families' stress and mental health issues can also impact a child's health and weight, so it is important to consider the child's family situation when determining how to support children dealing with obesity and overweight, and how to help prevent obesity and overweight.

- Adolescent girls who experience financial strain, family disruption and conflict are more likely to be overweight and obese.²³⁴
- Adolescent boys who are exposed to maternal risky health behaviors have a trend toward having a higher weight status.²³⁵
- Maternal depression is an important risk factor for child overweight and obesity because it affects mother-child relationships. Researchers have found that mothers with depression pay less attention to children about food and allow their children less independence in making decisions about eating, which can set the stage for obesity. Mothers who have symptoms of depression say they pressure their children to eat more frequently and tend to be more demanding about eating. They are also more likely to have the television on during meals and less likely to eat with their children.²³⁶
- Children whose parents over control how they eat are more likely to overeat when

230 Swallen, K.C., Reither, E.N., Haas, S.A., Meier, A.M. (2005). Overweight, obesity, and health-related quality of life among adolescents: The national longitudinal study of adolescent health. *Pediatrics*. 115:340-347.

231 Greenleaf, C., Petrie, T.A., Martin, S.B. (2014, January). Relationship of weight-based teasing and adolescents' psychological well-being and physical health. *Journal of School Health*. 84(1):49-55.

232 Schwimmer, J.B., Burwinkle, T.M., Varni, J.W. (2003, April). Health-related quality of life of severely obese children and adolescents. *Journal of the American Medical Association*. 289(14):1813-1819.

233 Ibid.

234 Hernandez (2015).

235 Ibid.

236 Goulding, A.N., Rosenblum, K.L., Miller, A.L., Peterson, K.E., Chen, Y., Kaciroti, N., Lumeng, J.C. (2014). Associations between maternal depressive symptoms and child feeding practices in a cross-sectional study of low-income mothers and their young children. *International Journal of Behavioral Nutrition and Physical Activity*. 11(75). Retrieved from <http://www.ijbnpa.org/content/11/1/75>.

they are stressed than children of parents who do not.²³⁷

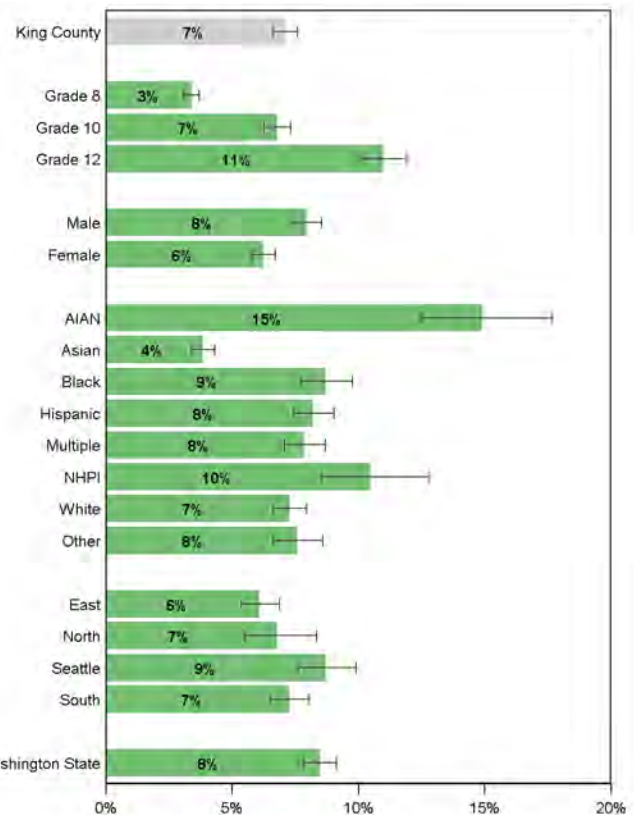
- When mothers use food as a way to deal with their feelings instead of to satisfy hunger, their children seem to imitate that behavior.²³⁸

Youth Tobacco Use²³⁹

In 2014 in King County, 21% of students in 8th, 10th and 12th grades were current cigarette smokers, compared to 25% in Washington state²⁴⁰ and 11.3% in the United States.²⁴¹ Both cigarette smoking and use of smokeless tobacco have decreased from 2010 to 2014 in King County and Washington state. Use of electronic cigarettes and vapor products is on the rise among youth in King County, Washington state and in the U.S.²⁴²

In King County:

- Native Hawaiians/Pacific Islanders and American Indians/Alaska Natives were about three times more likely than Asian students to be current smokers.
- From 2004 to 2014, rates of youth cigarette smoking declined for King County and all four of the county's regions.



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 08/2016.
[-----] Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

Figure 48: King County Youth Smoking Rates, 2012 and 2014

Community Input

Physical activity

- Many low-income families and listening group participants report difficulty being physically active because of public safety issues, lack of exercise-related information in their own language, body image stigma, cost and lack of time.
- Listening group participants report other barriers, such as transportation issues, winter weather conditions and a lack of opportunities in rural locations.
- Participants also share challenges engaging in physical activity if the parents have more than one job, which limits their time and

237 Farrow, C.V., Haycraft, E., Blissett, J.M. (2015). Teaching our children when to eat: how parental feeding practices inform the development of emotional eating – a longitudinal experimental design. *American Journal of Clinical Nutrition*. 101:908-13.

238 Kroller, K., Jahnke, D., Warschburger, P. (2013). Are maternal weight, eating and feeding practices associated with emotional eating in childhood? *Appetite*. 65:25-30.

239 Public Health-Seattle & King County. (2012). Cigarette smoking (school-age), King County, 2010 and 2012. Retrieved from <http://www.kingcounty.gov/healthservices/health/data/%7e/media/health/publichealth/documents/indicators/prevention/CigaretteSmokingSchAgeYth.ashx>.

240 Washington Department of Health (2016) Healthy Youth Survey Fact Sheet 2014. Retrieved from <https://www.askhys.net/FactSheets>.

241 U.S. Department of Health & Human Services (2016) Trends in Adolescent Tobacco Use. Retrieved from <http://www.hhs.gov/ash/oah/adolescent-health-topics/substance-abuse/tobacco/trends.html#>.

242 Ibid.

results in children spending unsupervised time indoors, usually watching television or playing video games.

Nutrition

- Recent community-based surveys of low-income women and women of color reported on the difficulty of purchasing healthy food with limited food assistance and/or limited income.²⁴³ In addition, low-income families often depend on public transportation when purchasing food, which can make grocery shopping a lengthy and difficult endeavor. Recent Metro bus service reductions may exacerbate this problem. There are fewer transportation options in suburban cities.
- Listening group participants shared concerns about the quality of school food (including breakfast and lunch) and appropriateness for their culture due to differences in the food they eat compared to U.S. food.
- Teen and adult participants have some knowledge about nutrition, such as the importance of eating fruits and vegetables and limiting soda consumption, but adults mention challenges finding time to cook, particularly if they have more than one job.
- Participants say they are not always sure if their child is a healthy weight. In some immigrant communities, this may be partly because of cultural perceptions that heavier weight in children is desirable or the perception that heavier weight shows success and prosperity.

Youth Tobacco Use

Community members working to reduce tobacco use report an overall decline in resources for prevention and cessation, and a corresponding leveling off of previous declines in smoking rates. Disparities persist among black and American Indian/Alaska

Native communities. Stakeholders also report an increase in use of tobacco alternatives (including e-cigarettes and hookahs) by youth. According to Public Health-Seattle & King County compliance checks, tobacco retailers are illegally selling e-cigarettes to minors at more than twice the rate (16%) of cigarettes.²⁴⁴

Community Assets and Resources

Nutrition

- As of this year, organizations in Washington have grouped together to propose a fruit and vegetable prescription program supported by the Food Insecurity Nutrition Incentive (FINI) Program. The idea is for healthcare providers and supportive housing sites to screen individuals for food insecurity, provide the food insecure with Fruit and Vegetable Prescriptions to use at participating retailers for fresh produce, and track their health outcomes. Such a program, mirrored after the Wholesome Wave's Fruit and Vegetable Prescription Program (FVRx),²⁴⁵ would bring greater food security to food insecure households, reduce healthcare costs, support the local economy and help prevent diet-related chronic diseases.
- Community gardens and farmers' markets provide the opportunity to learn about and access fruits and vegetables.
- The Fresh Bucks program enables shoppers who receive basic food assistance to double their money at farmers' markets.
- The Women, Infants and Children Special Supplemental Nutrition program helps pregnant women, new mothers and young children eat well, learn about nutrition and stay healthy.

244 Personal communication, Scott Neal, Tobacco Program Manager, Public Health-Seattle & King County, (2014, July 25).

245 Wholesome Wave. (2015). Fruit and Vegetable Prescription Program Factsheet. Retrieved from <http://www.wholesomewave.org/wp-content/uploads/2015/09/FVRx-Factsheet.pdf>.

243 Seattle Women and Food Access: Learning from Women in Delridge, 2014. Building a Healthier Tomorrow: Health Equity and Access in Auburn, 2014.

- Food banks and other feeding programs sponsored by faith-based organizations are working to provide healthier options to customers.
- Seattle Children's participates in several nutrition initiatives that benefit the community:

The nutrition team offers healthier options on menus and provide nutrition education to employees, patients and visitors.

Seattle Children's contributes to local and regional initiatives to improve access to fruits and vegetables, such as Fresh Bucks, grocery store vouchers for produce, and free or low-cost food bags.

Seattle Children's has organic gardens and offers classes to patients and families about gardening and nutrition.

Healthy Eating and Active Living

- Local parks, community centers and pools offer public places for physical activities; some offer programs, such as single-gender swim times and scholarships for children.
- The Healthy King County Coalition aims to reduce health inequities by improving nutrition, increasing physical activity, and decreasing smoking rates and other tobacco use.
- The CDC-funded Partnership to Improve Community Health (PICH) will build on efforts to increase access to healthy foods and physical activity, and reduce exposure to unhealthy foods, beverages and tobacco products. ACT!, a YMCA-based healthy lifestyles program, provides support and education to overweight and obese youth (ages 8 to 14) who have a body mass index (BMI) greater than the 85th percentile, along with their families.
- OBCC promotes healthy lifestyles during well-child visits and offers follow-up visits for children who are overweight or obese.

Families can learn about healthy eating and attend nutrition and cooking classes.

- Childhood Obesity Prevention Coalition, a coalition of 52 organizations, engages in legislative advocacy.

Youth Tobacco Use

- Strong partners committed to reducing the prevalence of Tobacco, Marijuana and Other Drugs (TMOD). These members are part of the Healthy King County Coalition TMOD committee and include the Center for Multicultural Health, Asian Pacific Islander Coalition Against Tobacco, Entre Hermanos, Neighborhood House, Gay City and the Seattle Indian Health Board.
- The Washington State Quitline provides telephone support, self-help materials and medications (when appropriate) for individuals wanting to quit tobacco.
- Cessation medication combined with counseling is the most effective cessation method. Behavioral health providers are increasingly addressing tobacco cessation with patients who have some of the highest smoking rates.

Opportunities

At Seattle Children's

- Seattle Children's has adopted the "Healthy Food in Healthcare" pledge and enrolled in the Healthier Hospitals Initiative Healthy Beverages Challenge, which calls on institutions to increase healthy beverage purchases by 20%. In 2012, Seattle Children's removed all sugar-sweetened beverages from cafeterias, vending machines and gift shops. More than 57% of beverages purchased for the cafeteria, patient menus and vending machines are now healthy.
- Seattle Children's is also working to increase the purchase of local and sustainable food by 15% each year.

- In fall 2016, Seattle Children's opened a larger, better-equipped kitchen that has enabled staff to prepare made-to-order meals using fresh ingredients for hospitalized patients. The kitchen was designed with the goal of creating tasty, healthy, fresh whole foods, including locally sourced foods from the Pacific Northwest, more gluten-free and organic products, and antibiotic-free meats. Kitchen staff will also prepare food for the cafeteria and catering requests.
- Brief tobacco screening and interventions in emergency departments, primary care, dental and other healthcare settings can improve smoking-cessation rates. This is an evidence-based practice.

In Communities at High Risk

- Communities should offer free or low-cost education on cooking and grocery shopping for adults and children through fun, interactive activities that the whole family can enjoy together in settings that are convenient for community members. Educational opportunities and information should also be available online or through social media for families who are not able to attend in person. Opportunities should be culturally relevant and accessible to families who speak different languages. Immigrant families have different needs compared to U.S.-born families because they are exposed to and interested in both U.S. foods and familiar foods from their countries of origin.
- Increase access to affordable and healthy foods and beverages in low-income communities, including at retailers and farmers' markets.
- Work with schools and childcare centers to increase consumption of healthier foods and improve physical activity offerings, including outdoor activities.
- Provide training and capacity-building around healthy eating and active living to teachers, administrators, school nurses, primary care providers and others who work with children.
- Improve access to physical activity in collaboration with employers, coalitions, agencies and communities. These groups are creating walking trails, building new exercise facilities, providing access to existing nearby facilities, reducing the cost of opportunities for physical activity and providing activities for the whole family. It is important to provide opportunities for physical activity that are inclusive and non-competitive.
- Provide culturally relevant education about positive parenting and incorporate content related to healthy eating and active living. Participants in listening groups representing different cultures and communities expressed their commitment to their children's health, and several mentioned an interest in parenting education and support. For recent immigrants, this could include parenting in a new country and balancing U.S. culture with the preservation of original culture and traditions, potentially incorporating information related to eating and nutrition using both traditional and U.S. foods.
- Work with communities to improve community safety, increase active commuting to school and ensure access to safe places for physical activity and recreation. Communities with high rates of obesity and overweight frequently also have high rates of crime, and many listening group participants mentioned concerns that their neighborhood was not a safe place for children to play outside.
- Promote safe transportation options, including walking, riding a school bus and bicycling.
- Advocate for policies to support food security, healthy eating and active living at the local, state and federal levels.
- Help residents increase their earning capacity (and their ability to buy healthy food) by

supporting job training programs, community economic development and living wage ordinances.

- Tobacco-cessation coverage varies by health plan. No mandated coverage standard exists in King County. Continuing tobacco prevention and cessation messaging to the

public and to patients, and implementing evidence-based brief tobacco screenings may decrease rates of tobacco use among children and adolescents.

Violence and Injury Prevention

This section reports on hospitalizations and deaths from both intentional and unintentional injuries. However, hospitalization numbers underestimate injury rates. For each case that results in hospitalization, many more injuries are never reported, and hospitalization data exclude cases where emergency department treatment was received but the patient was not admitted to the hospital.

While some types of injuries have declined since the 1990s, recent increases in deaths due to suicide and poisoning raise new concerns. Among all age groups, falls are a leading cause of emergency department visits and hospital readmissions. Intentional injuries and deaths (assaults, homicides and suicide) remain problematic for regional communities. Although motor vehicle fatalities have decreased sharply, distracted and impaired driving continue to endanger drivers, passengers, bicyclists and pedestrians.

Intentional Injuries

Suicide

Suicide is the second leading cause of death in Washington state and the third leading cause of death in the United States among children and young adults ages 10 to 24, with highest rates among white and American Indian youth.²⁴⁶ In 2014 in Washington state, 135 suicide deaths

occurred among youth ages 5 to 24.²⁴⁷ This includes:

- 10 suicide deaths among children ages 5 to 14 (a rate of 1.1 per 100,000 population)²⁴⁸
- 43 suicide deaths among teenagers ages 15 to 19 (a rate of 9.7 per 100,000 population)²⁴⁹
- 82 suicide deaths among young adults ages 20 to 24 (a rate of 17.1 per 100,000 population)²⁵⁰

The use of a firearm is the most lethal method of suicide²⁵¹ and was the leading method of youth suicide in Washington state in 2014.²⁵² The presence of a household firearm in the home is linked with an increased risk of adolescents using a firearm to attempt suicide.²⁵³ Moreover, risk of completed firearm suicides among King County children (<18 years) is 9.2 times greater when firearms in or around the home are stored unlocked compared to when firearms are stored locked.²⁵⁴ Securing or removing a firearm from the home reduces the opportunity that youth

247 Washington State Department of Health. (2014). Leading causes of death by age group and sex for residents, 2014. Retrieved from <http://www.doh.wa.gov/portals/1/Documents/5400/DeathC32014.xls>.

248 Ibid.

249 Ibid.

250 Ibid.

251 Washington State Department of Health: Death Certificate Data; Hospital Discharge Data; Comprehensive Hospitalization Abstract Reporting System (CHARS) data. Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Washington, 2014. HHS Publication No. SMA-15-4895WA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Looking Glass Analytics (2015). Healthy Youth Survey 2014 Report of Results: Statewide Results, Grade 10.

252 <http://www.askhys.net/library/2014/StateGr10.pdf>.

253 Grossman, D.C., Mueller, B. A., Riedy, C., Dowd, M. D., Villaveces, A., Prodzinski, J. & et al. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. Journal of the American Medical Association, 293(6), 707-714.

254 <http://www.doh.wa.gov/Portals/1/Documents/5500/IV-SUI2015-DU.pdf>.

246 Washington State Department of Health. Retrieved from <http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/YouthSuicidePrevention/YouthSuicideFacts>.

and adults at risk for suicide will use it to harm themselves.

In Washington state in 2014, 9% of eighth graders, 10% of 10th graders, and 8% of 12th graders attempted suicide in the past year.²⁵⁵ The Healthy People 2020 goal is to reduce the percentage of youth in ninth through 12th grades who attempt suicide to 1.7%.²⁵⁶ In Washington state in 2014:

- Girls in grades 8, 10 and 12 were more likely than boys to attempt suicide.²⁵⁷
- 10% of 10th graders reported they had attempted suicide in the past year. This is a significant increase from 2012, when 8% said they had attempted suicide. Prior to this increase, results had been consistent since 2002.²⁵⁸

From 2004 to 2013, an average of 820 non-fatal suicide hospitalizations occurred in King County each year among all ages, with an average rate of 43.3 per 100,000 population. The suicide hospitalization rate for young adults ages 18 to 24 was 1.7 times the county average.²⁵⁹

Over the same period, however, rates increased in the East Region and decreased in the South Region. The suicide hospitalization rate for young adults ages 18 to 24 was 1.7 times the county average.

Homicide Deaths

From 2009 to 2013, 302 homicide deaths among youth ages birth to 24 occurred in Washington state, which is an average of about 60 per year.²⁶⁰ Women in violent relationships, young men, American Indians/Alaska Natives

Violence and injuries are preventable. They are also the leading causes of death for people between the ages of 1 and 44.

and black people of all ages are most likely to be homicide victims.²⁶¹

During that same period, in King County there were 77 homicides, an average of 15 deaths per year.²⁶² Homicide deaths for individuals ages 18 to 24 were 2.5 times the county average, and the rate of homicide deaths among black people was 4.4 times the county average from 2008 to 2012.

Washington State ²⁶³			King County ²⁶⁴	
Age	Total number of homicides, average per year	Rate per 100,000 population	Total number of homicides, average per year	Rate per 100,000 population
0-4 years	47, >9	6 for ages less than 1 year, 1.9 for 1-4 year-olds	8, 2	1.6 for 1-4 year olds
5-9 years	13, 2	0.6	0	
10-14 years	10, 2	0.5	3, <1	
15-19 years	86, 17	2.9 for 15-17 year olds, 5 for 18-19 year olds	21, 4	2.6 for 15-17 year-olds, 5 for 18-19 year-olds
20-24 years	146, >29	6.2	45, 9	7.1

Table 6. Homicides among children and young adults from 2009 to 2013

255 Washington State Department of Health. (2014, January). Washington state healthy youth survey: 2014 fact sheet. Retrieved from <http://www.askhys.net/FactSheets>.

256 Ibid.

257 Ibid.

258 Washington State Department of Health. (2015, June). 2014 Washington State Healthy Youth Survey Facts about Depressive Feelings and Suicide. Retrieved from: <https://www.askhys.net/Docs/HYS%202014%20Fact%20Sheet-%20Youth%20Depression%20and%20Suicide%206.18.15.pdf>.

259 Washington State Department of Health. (2013). Washington state injury data tables. Retrieved from: <http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/Data/WashingtonStateInjuryDataTables>.

260 Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

261 Ibid.

262 Washington State Department of Health. (2013). Washington state fatal injuries by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689146.pdf>.

263 Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

264 Washington State Department of Health. (2013). Washington state fatal injuries by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689146.pdf>.

Nonfatal Assault-related Hospitalizations

From 2009 to 2013, there were an average of 2,252 nonfatal assault-related hospitalizations that occurred among youth ages birth to 24 in Washington state, which is an average of 450 per year.²⁶⁵ In King County over the same period, there were 660 nonfatal assault-related hospitalizations of youth ages birth to 24, which is an average of 132 per year.²⁶⁶ From 2000 to 2012, assault hospitalization rates decreased in King County, the North Region and Seattle.

Washington State ²⁶⁷			King County ²⁶⁸	
Age	Total number, average per year	Rate per 100,000 population	Total number, average per year	Rate per 100,000 population
0-4 years	391, 78	81.4 for ages less than 1 year, 7.6 for 1-4 year-olds	77, 15	51.3 for ages less than 1 year, 6.4 for 1-4 year olds
5-9 years	32, 6	1.5	7, 1	1.2
10-14 years	91, 18	4.2	18, 3	3.2
15-19 years	642, 128	21.5 for 15-17 year olds, 37.8 for 18-19 year olds	216, 43	25.5 for 15-17 year-olds, 53.4 for 18-19 year-olds
20-24 years	1096, 219	46.9	342, 68	53.7

Table 7. Nonfatal assault-related hospitalizations among children and young adults from 2009 to 2013

Child Maltreatment

In the United States, child protective services estimates that about 686,000 children were victims of child maltreatment, which is a rate of 9.2 per 1,000.²⁶⁹ As the affected child grows older, child abuse and neglect increase the risk

of delinquency, substance abuse, adolescent pregnancy, adverse health behaviors, suicide attempts and HIV-risk behaviors.²⁷⁰ In 2011, 46,636 children were referred to Washington State Child Protective Services (CPS), which is rate of 30 per 1,000 children under age 18.²⁷¹ Across the state, children ages 0 to 3 are at the greatest risk of any abuse. They have the highest abuse and neglect rates, and they are the most likely to experience recurrence of abuse and to die from abuse and neglect.²⁷² Neglect is defined as “a failure to provide the basic needs required to sustain and promote a child’s health, safety and well-being.”²⁷³

Neglect accounts for 70% of validated child maltreatment cases in the state.

Unintentional Injuries

Unintentional injuries are the leading cause of death for children and youth ages 1 to 24. Unintentional injuries include those due to motor vehicle collisions, poisoning, fire, firearms, drowning and suffocation. Most of these injuries, and the deaths they cause, are preventable. The sections below summarize data on deaths and hospitalizations from all types of unintentional injuries. Falls accounted for the highest rate of unintentional injuries among children and young adults ages birth to 24, with more than 315 per year from 2009 to 2013 in King County²⁷⁴ and more than 1,161 per year in Washington state.²⁷⁵

There are significant disparities in unintentional injury rates among racial and ethnic population subgroups. In Washington state and nationally, injury death rates increase as poverty increases

265 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

266 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

267 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

268 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

269 Centers for Disease Control and Prevention. (2014). Child maltreatment. Retrieved from <http://www.cdc.gov/violenceprevention/pdf/childmaltreatment-facts-at-a-glance.pdf>.

270 Washington State Department of Health. (2013, January). Washington state injury and violence prevention guide. Retrieved from www.doh.wa.gov/Portals/1/Documents/2900/InjuryReportFinal.pdf.

271 Ibid.

272 Ibid.

273 Rivara, F., McCormick, E., Jenkins, C., and Christakis, D. (2010). The potential role of Seattle Children’s in preventing child maltreatment and optimizing parenting in Washington state. Report presented at the Advocacy Advisory Council, Seattle Children’s Hospital.

274 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

275 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

Washington State²⁷⁶

Age	Total number, average per year	Rate per 100,000 population	Leading cause	Total number, average per year	Rate per 100,000 population	Leading cause
0-4 years	204, 40	28.3 for ages less than 1 year, 7.5 for 1-4 year-olds	Suffocation and drowning	19, 4	6.8 for ages less than 1 year, 3.2 for 1-4 year olds	Suffocation
5-9 years	62, 12	2.9	Motor vehicle accidents	16, 3	2.8	Fire and motor vehicle accidents
10-14 years	76, 15	3.5	Drowning, motor vehicle accidents	12, 2	2.2	Motor vehicle accidents
15-19 years	383, 76	12.1 for 15-17 year olds, 23.6 for 18-19 year olds	Motor vehicle accidents, poisoning	76, 15	8.1 for 15-17 year-olds, 20 for 18-19 year-olds	Motor vehicle accidents, poisoning
20-24 years	716, 143	30.6	Motor vehicle accidents, poisoning	163, 32	25.6	Motor vehicle accidents, poisoning

King County²⁷⁷

Table 8. Unintentional injury deaths among children and young adults from 2009 to 2013

Unintentional Injury Deaths

From 2009 to 2013 in Washington state, 1,441 unintentional injury deaths occurred among youth ages birth to 24, which is an average of 288 unintentional injury deaths per year. In King County over that same time period among youth ages birth to 24, 286 unintentional injury deaths occurred, which is an average of 57 unintentional injury deaths per year.

Unintentional Injury Hospitalizations

From 2009 to 2013 in Washington state, 22,065 unintentional injury hospitalizations occurred among youth ages birth to 24, which is an average of 4,413 unintentional injury hospitalizations per year. In King County over that same time period among youth ages birth to 24, 5,313 unintentional injury hospitalizations occurred, which is an average of 1,062 unintentional injury hospitalizations per year.

Washington State²⁷⁸

Age	Total number, average per year	Rate per 100,000 population	Total number, average per year	Rate per 100,000 population
0-4 years	4276, 855	326.5 for ages less than 1 year, 223.9 for 1-4 year-olds	1179, 235	318.2 for ages less than 1 year, 226.2 for 1-4 year olds
5-9 years	2290, 458	105.8	553, 110	96.3
10-14 years	3048, 609	139.5	665, 133	119.6
15-19 years	5712, 1142	240.9 for 15-17 year olds, 264.7 for 18-19 year olds	1261, 252	204.1 for 15-17 year-olds, 232.2 for 18-19 year-olds
20-24 years	6739, 1347	288.2	1655, 331	259.9

King County²⁷⁹

Table 9. Unintentional injury hospitalizations among children and young adults from 2009 to 2013

276 Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

277 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

278 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

279 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

Poisoning

From 2009 to 2013, an average of 16 King County youth ages birth to 24 and an average of 65 youth ages birth to 24 in Washington state died from unintentional poisonings each year. From 2008 to 2012 in King County, the unintentional poisoning death rate for American Indians/Alaska Natives was 17.4 times the rate for Asian residents. From 2000 to 2006, death rates from poisoning increased in King County overall, but have flattened out since then. The rate in the South Region began to plateau in 2008, but the rate continues to increase in the East Region. In addition, an average of 98 King County youth ages birth to 24 and 77 youth ages birth to 24 in Washington state were admitted to hospitals for unintentional, nonfatal poisonings each year.

Motor Vehicle Deaths

Motor vehicle deaths result from motor vehicle collision (MVC) and include deaths of vehicle occupants, motorcyclists, bicyclists and pedestrians. From 2009 to 2013, an average of 22 King County youth ages birth to 24 and 117 Washington state youth ages birth to 24 died from motor vehicle collisions each year.²⁸⁰

²⁸¹ From 2008 to 2012 in King County, the MVC death rate for American Indians/Alaska Natives was three times the county average. Between 2000 and 2012, MVC death rates declined in King County, Seattle, the North Region and the South Region. The rate in the East Region began its decline in 2005.

²⁸⁰ Washington State Department of Health. (2013). Washington state fatal injuries by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689146.pdf>.

²⁸¹ Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

Washington State ²⁸²			King County ²⁸³	
Age	Total number	Average per year	Total number	Average per year
0-4 years	26	5	3	<1
5-9 years	27	5	6	1
10-14 years	27	5	5	1
15-19 years	195	39	34	7
20-24 years	304	60	66	13

Table 10. Motor vehicle deaths among children and young adults from 2009 to 2013

Motor Vehicle Injury Hospitalizations

From 2009 to 2013, an average of 328 King County youth ages birth to 24 and 777 Washington state youth ages birth to 24 were hospitalized for nonfatal MVCs each year. In 2008 to 2012, the rate of MVC hospitalization for adults ages 18 to 24 was 1.6 times the county average. The rates of nonfatal MVC hospitalizations have been decreasing for all ages in King County overall and Seattle since 2006, and in the other three regions since 2000.

Washington State ²⁸⁴			King County ²⁸⁵	
Age	Total number	Average per year	Total number	Average per year
0-4 years	168	33	49	10
5-9 years	226	45	53	10
10-14 years	361	72	87	17
15-19 years	1,414	282	285	57
20-24 years	1,711	342	387	77

Table 11. Motor vehicle injury hospitalizations among children and young adults from 2009 to 2013

²⁸² Ibid.

²⁸³ Washington State Department of Health. (2013). Washington state fatal injuries by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689146.pdf>.

²⁸⁴ Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

²⁸⁵ Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

Child Passenger Safety

Nationally, 43% of children ages 4 to 7 are restrained in booster seats.²⁸⁶ Child safety seats reduce the risk of death in passenger cars by 71% for infants and by 54% for children ages 1 to 4.²⁸⁷ For children ages 4 to 7, booster seats reduce injury risk by 59% compared to seatbelts alone.²⁸⁸ Child-restraint systems are often used incorrectly. One study found that 72% of nearly 3,500 observed car and booster seats were misused in a way that could increase a child's risk of injury during a crash.²⁸⁹

Motor vehicle crashes remain the leading cause of injury and death for children and young adults in Washington state.²⁹⁰ A risk factor for most causes of injury is drug or alcohol impairment in supervising adults and older children. More than two-thirds of fatally injured children were killed while riding with a drinking driver.²⁹¹ About 45% of children and teens in Washington who died in crashes were unrestrained by a child safety seat or seatbelt.²⁹² Of those children ages 4 to 8 who died in car crashes, only one (5%) was in a booster seat.²⁹³

The Healthy People 2020 initiative aims to:²⁹⁴

- Reduce motor vehicle crash-related deaths.
- Reduce nonfatal motor vehicle crash-related injuries.

286 U.S. Department of Health and Human Services. (2010). Healthy people 2020. Injury and violence prevention. Retrieved from <http://www.healthypeople.gov/2020/default.aspx>.

287 Harborview Medical Center, Seattle Children's Hospital, Public Health Seattle & King County. (2004-2006). Injury Free Coalition for Kids Seattle. Report to the Community.

288 Durbin, D.R., Elliott, M.R., & Winston, F.K. (2003). Belt-positioning booster seats and reduction in risk of injury among children in vehicle crashes. *Journal of the American Medical Association*. 289(14):2835-40.

289 National Highway Traffic Safety Administration. (2006). Department of Transportation (U.S.), National Highway Traffic Safety Administration (NHTSA), Traffic Safety Facts Research Note 2005: Misuse of Child Restraints: Results of a Workshop to Review Field Data Results. Washington (DC). Retrieved from http://www.nhtsa.dot.gov/people/injury/research/TSF_MisuseChildRestraints/images/809851.pdf.

290 Washington State Department of Health Injury Prevention Program. (2004). Washington state childhood injury report (DOH Publication No. 341-012). Olympia, WA.

291 Shults, R.A. (2004). Child passenger deaths involving drinking drivers—United States, 1997–2002. *Morbidity and Mortality Weekly Report*. 53(4):77–9.

292 Ibid.

293 Ibid.

294 U.S. Department of Health and Human Services. (2010). Healthy People 2020: Injury and violence prevention. Retrieved from <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=24>.

- Increase age-appropriate vehicle restraint system use in children where 95% of children ages 0 to 1 are restrained in a rear-facing child safety seat (baseline was 86% in 2008); 79% of children ages 1 to 3 are restrained in a front-facing child safety seat (baseline was 72% in 2008); 47% of children ages 4 to 7 are restrained in a booster seat (baseline was 43% in 2008); and 86% of children ages 8 to 12 use safety belts (baseline was 78% in 2008).

In Washington state:

- Teens ages 15 to 17 have the highest rate of motor vehicle occupant deaths and hospitalizations among youth ages 0 to 17.²⁹⁵
- Compared to 10th grade youth without disabilities, Washington state 10th graders with disabilities are more likely to never or rarely wear seatbelts and to drive after drinking alcohol. Similar results were found for eighth and 12th graders.²⁹⁶

Drowning

Unintentional drowning is the second leading cause of injury death for Washington children ages 1 to 14.²⁹⁷ From 2009 to 2013, unintentional drowning among Washington state youth ages birth to 17 accounted for an average of about 16 deaths and about 20 nonfatal hospitalizations per year.^{298 299} Drowning death rates are highest in children ages 1 to 4 and in adolescents ages 15 to 17.³⁰⁰

295 Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

296 Washington State Department of Health. (2013). Retrieved from http://www.doh.wa.gov/Portals/1/Documents/Pubs/910-907_CFHNeedsAssessInjuryViol.pdf.

297 Washington State Department of Health. (2016). Pool safety. Retrieved from <http://www.doh.wa.gov/CommunityandEnvironment/WaterRecreation/PoolSafety>.

298 Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

299 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

300 Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

In Washington state:³⁰¹

- Infants are most likely to drown in a bathtub.
- Children ages 1 to 4 most often drown in open water and most of the swimming pool-related deaths occurred in this age group.
- None of the pools or hot tubs involved in a child drowning had a locked gate.
- A lifeguard was present in only three of the 58 drowning deaths that occurred in open water or in a pool.
- About 89% of children birth to age 5, 80% of children ages 6 to 12, and 50% of youth ages 13 to 17 wear life jackets in boats.³⁰²
- The risk for drowning increases among individuals with less formal education and higher poverty rates and disproportionately affects minorities.^{303 304}
- Compared to 10th graders without disabilities, Washington state 10th graders with disabilities are less likely to use a life vest when in a small boat.³⁰⁵
- People with a seizure disorder have a higher risk of drowning. Children and adolescents with a history of seizure disorder are at particular risk and need close monitoring and supervision when bathing and when in or near water. Of the child drowning deaths reviewed, 10% either had a history of seizure disorder or seizure was listed on the death certificate.³⁰⁶

Pedestrian Injuries

Pedestrian injuries are one of the leading causes of injury death for Washington children ages 1 to 9. Statewide from 2009 to 2013, pedestrian injuries in children ages 0 to 17 accounted for an average of nine deaths and 79 hospitalizations each year.^{307 308} Pedestrian death rates were highest in children ages 0 to 4 and 15 to 17. The majority of these deaths occurred on a driveway or city street and involved motor vehicles.

Bicycle Injuries

Head injury is the most common cause of death and serious disability in bicycle crashes. A correctly worn bicycle helmet reduces the risk of a head injury by nearly 85%.³⁰⁹ In a national study by Safe Kids, 41% of children observed were wearing a helmet while participating in wheeled sports. More than one-third of child riders wearing helmets wore them improperly.³¹⁰

There is a need for adolescent helmet education and awareness programs. In 2012, 31% of eighth graders, 27% of 10th graders and 26% of 12th graders who rode a bicycle in the past year wore a helmet most of the time or always.³¹¹

Bicycle injuries among Washington children ages 0 to 17 accounted for an average of two deaths and 134 nonfatal injury hospitalizations per year between 2009 and 2013. Bicycle hospitalization rates were highest in the 10 to 14 age group. Bicycle injuries are the third leading cause of injury hospitalization for Washington children ages 5 to 14.

301 Washington State Department of Health, Maternal and Child Health Assessment. (2006, June). Washington State child death review database.

302 Seattle Children's Hospital and Harborview Injury Prevention and Research Center. (2011). Washington state boating personal flotation device (PDF) use report, 2011. Retrieved from www.seattlechildrens.org/dp.

303 Ibid.

304 Washington State Department of Health. (2004). The health of Washington state 2004 supplement: A statewide assessment addressing health disparities by race, ethnic group, poverty and education. Retrieved from <http://www.doh.wa.gov/HWS/doc/HWS2004Supp.pdf>.

305 Washington State Department of Health, Office of Maternal and Child Health. (2009, October). Youth with disabilities risk factors for injury data monograph. Retrieved from <http://www.doh.wa.gov/cfh/mch/documents/Injymonograph09.pdf>.

306 Washington State Department of Health. (2004, June). Child death review state committee recommendations on child drowning prevention. Retrieved from http://www.doh.wa.gov/cfh/mch/documents/Child_Drowning_Prevention.pdf.

307 Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

308 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

309 Centers for Disease Control and Prevention. (1995). Injury-control recommendations: bicycle helmets. *Morbidity and Mortality Weekly Report*. 44:RR-1.

310 Cody, B.E., Quraishi, A.Y., Mickalide, A.D. (2004). Headed for injury: An observational survey of helmet use among children ages 5 to 14 participating in wheeled sports. Washington DC: National SAFE KIDS Campaign.

311 Washington State Department of Health. (2012). Washington state healthy youth survey. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/160-193-HYS-AnalyticReport2012.pdf>.

Though law in Seattle and King County requires bike helmets, many children do not wear helmets when they ride. Many families cannot afford bike helmets and are unaware of the importance of wearing them. On average, a \$12 bike helmet for children ages 3 to 14 generates \$580 in benefits to society.³¹²

Sports Injuries

Nationally, about 38 million children and adolescents participate in organized sports, and about one in three children involved in a team sport sustain an injury that causes them to miss games or practices.³¹³ Half of the injuries sustained by youth while playing sports are likely preventable.³¹⁴ Each year, emergency departments in the United States treat an estimated 173,000 traumatic brain injuries (TBIs) related to sports and recreational activities among children ages 5 to 18, which includes concussions.³¹⁵

Increased awareness of TBI risks, prevention strategies, and the importance of timely identification and management are essential for reducing the incidence, severity and long-term negative health effects of this type of injury.³¹⁶ Athletes who have had a concussion are at increased risk for another concussion, and children and teens are more likely to get a concussion and take longer to recover than adults.³¹⁷ Parents, players and coaches lack training, skills and knowledge in sports injury and concussion prevention.

312 Health Resources and Services Administration's Maternal and Child Health Bureau-Children's Safety Network. (2010). Injury prevention: what works? A summary of cost-outcome analysis for injury prevention programs.

313 Safe Kids Worldwide. (2016). We work to prevent sports injuries. Retrieved from <http://www.safekids.org/we-work-prevent-sports-injuries>.

314 The prevention of sport injuries of children and adolescents. (1993, August). *Medicine & Science in Sports & Exercise*. 25(8 Suppl): 1-7.

315 Centers for Disease Control and Prevention. (2011, October). Nonfatal Traumatic Brain Injuries Related to Sports and Recreation Activities Among Persons Aged ≤19 Years — United States, 2001–2009. *Morbidity and Mortality Weekly Report*. 60(39): 1.

316 Ibid.

317 Centers for Disease Control and Prevention. (n.d.). Injury prevention and control-Traumatic brain injury. Recommendations for preventing concussions in sports. Retrieved from <http://www.cdc.gov/headsup/index.html>.

Community Input

Community members expressed the need for increased regional coordination and standard implementation of best practices in violence and injury prevention.

Intentional Injuries

Strong community support was expressed for training all community providers — including social workers, medical providers and mental health providers — in suicide assessment and treatment interventions.

Unintentional Injuries

- Law enforcement officials and community members said they were increasingly concerned about texting, talking and other uses of mobile devices while driving.
- Law enforcement officials expressed concern about a possible rise in impaired driving related to the legalization of marijuana. They also said that quickly testing the blood of drivers arrested for suspicion of DUI is critical to accurately assessing the level of impairment.
- Individuals with few economic resources or little formal education are less likely to use safety devices due to lack of money. They are more likely to lack transportation to a store where they could purchase safety devices, to lack control over housing conditions, and to believe that injuries are preventable.^{318 319}

Community Assets and Resources

Intentional Injuries

- The Central EMS and Trauma Care Council, which promotes and supports a system of emergency, medical and trauma services in King County.

318 National SAFE KIDS Campaign (NSKC). (2004). Children at risk fact sheet. Washington (DC): NSKC.

319 Cubbin, C., Smith, G.S. (2002). Socioeconomic inequalities in injury: critical issues in design and analysis. *Annual Review of Public Health*, 23:349-75.

- Forefront, a research organization based at the University of Washington, is training health professionals to develop and sharpen their skills in the assessment, management and treatment of suicide risk.
 - House Bill 2315 and other bills passed over the past several years in Washington state require school staff, behavioral health providers and other healthcare providers to participate in suicide prevention training as part of their licensure.
 - The Youth Suicide Prevention Program provides training for students and educators.
 - Children's Crisis Outreach Response System provides mobile crisis outreach and crisis stabilization services for children and youth up to age 18.
 - The Crisis Solutions Center offers a therapeutic option when police and medics are called to intervene in a behavioral healthcare crisis. The program minimizes inappropriate use of jails and hospitals, and provides rapid stabilization, treatment and referrals for up to 46 patients.
 - Strengthening Families Washington (formerly Council for Children & Families), an initiative of the Department of Early Learning, focuses on helping families strengthen family bonds, understand child development and develop positive parenting skills.
 - Parent Trust for Washington Children promotes health and safety in families and communities by offering free or low-cost classes, workshops, educational campaigns and coaching for families.
 - Safe Firearm Storage such as those promoted by LOK-IT-UP and the Washington State Firearm Tragedy Prevention Network as coordinated by Seattle Children's are also community assets.
- Mobile Impaired Driving Unit (MIDU), a self-contained mobile DUI processing center and incident command post. Employers are also creating policies related to the use of cell phones by drivers.
- The Target Zero Task Force, which focuses on reducing traffic crashes and traffic-related injuries to zero by the year 2030.
 - The Safety Restraint Coalition collaborates with families, law enforcement, healthcare providers, government agencies and advocates to promote the use of seatbelts and car seats.
 - In Washington state, several strong laws support child passenger safety, including the child passenger restraint law and the seat belt law. Seattle Children's provides free, on-site car seat checks to the public each quarter to review individual car seats for proper installation and to educate parents.
 - Safe Kids Washington, which includes Safe Kids Eastside and Safe Kids Seattle/South King County, implements evidence-based programs, such as car seat checks and safety workshops, to help prevent childhood injuries.
 - To reduce drowning rates, local parks departments, YMCAs and other organizations provide swimming lessons and lifeguarded pools and beaches. The Washington State Parks Boating Program and Safe Kids Washington State also help coordinate and set up life jacket loaner programs.
 - Several local organizations, including Feet First, advocate for safe walking in neighborhoods and cities, raise concerns of pedestrians in conversations with government agencies and community groups, and encourage Washingtonians to make alternate transportation choices, like taking a bus or train, riding a bike or walking. Seattle Children's has made a strong commitment to promote alternate transportation options, improve pedestrian

Unintentional Injuries

- To address impaired driving, law enforcement conducts high-visibility patrols and uses the

safety, and link the hospital and surrounding community to larger walking and biking networks.

- Seattle Children's promotes helmet safety by offering free helmet fittings in the community and offering low-cost helmet sales.
- To address sports injuries, several organizations work to prevent brain injury and support individuals and their families impacted by traumatic brain injury. Seattle Children's offers several programs in the community, including youth sports participation exams and presentations on injury prevention. Seattle Children's has also helped develop concussion care and treatment guidelines to determine if the patient is able to return to play.

Opportunities

Intentional Injuries

- Provide coordination between emergency department staff and law enforcement/first responders, including meetings to discuss challenges and opportunities of working with people who are homeless and/or have serious mental illnesses.
- Share emergency department data with the Washington State Department of Health to provide a more complete understanding of the impact of violence and injuries on youth.
- Utilize existing suicide-prevention tools and strategies, and offer low-barrier mental health and substance-abuse screenings at health fairs to help identify more people at risk for suicide.
- Continue research efforts, like the Collaborative Adolescent Research on Emotion and Suicide (CARES) study through the University of Washington and Seattle Children's, which evaluates the effectiveness of dialectical behavior therapy among suicidal adolescents.

- Opportunities to tackle child maltreatment include more public education about what abuse is, how to recognize it and how to report it; and education to parents on positive, safe and nurturing strategies to raise children.

Unintentional Injuries

- Offer prevention-related primary care assessments/screenings, including intake assessments that include questions about the use of cell phones while driving, seatbelt use and driving while impaired.
- To promote child passenger safety, it is important to increase the availability of car seats by offering low-cost car seats or booster seats, and to promote car seat education by offering car seat checks to families in English and Spanish.
- To address drowning, community partners should offer education and awareness programs around drowning for children and adults; increase the use of life jackets through education and offering free or low-cost life jackets for all ages; increase access to swim lessons for low-income and culturally diverse children; develop a culturally competent water safety education campaign; and increase the number of lifeguarded swim beaches.
- Improvements in the community infrastructure to create safer walking environments (e.g. more pedestrian bridges, streetlights, playgrounds, sidewalks, paths and trails) will improve pedestrian safety.
- To improve bicycle safety, community organizations should increase the accessibility of bicycle helmets, especially to low-income families; boost education about bike safety; and offer additional helmet fittings in the community.
- To address sports injuries, players, parents and coaches need to learn the signs and symptoms of traumatic brain injuries, including concussions, and take appropriate action when they suspect such an injury.

Appendix A: Methods

Methods for this 2016 Pediatric Community Health Assessment and the Jointly Authored 2015 King County Hospital's Community Health Needs Assessment (CHNA) are summarized in the introduction and explained in detail below.

Identification of Health Needs and Selection of Indicators

A committee of representatives from King County Hospitals for a Healthier Community (HHC), facilitated by Public Health-Seattle & King County staff, used a community health framework and population-based approach for the CHNA to identify health needs and develop criteria for indicators used to measure health needs. The Pediatric Community Health Assessment (CHA) team also had sector representatives and the two groups finalized the selection of indicators with feedback from public health and hospital staff.

For each assessment, representatives planned a succinct report focused on key indicators that relate to the hospitals' and communities' assets and resources and inform future collective strategies. These indicators were to be focused on population-based preventive strategies and promote policy/systems/environmental change for maximum population health impact. It was also recognized that partnerships between hospitals, public health, community organizations and communities are key to successful strategies to address common health needs.

Representatives were subject matter experts who helped identify population-level health needs. The groups reached consensus to focus particularly on access to care, preventable causes of death, maternal and child health, behavioral health, and violence and injury prevention. Each hospital could also gather additional data and community input to address more specific service areas, such as cancer care, pediatrics and rural health.

Representatives for both assessments developed criteria to select indicators for the King County CHNA and the Pediatric Health Assessment recognizing that each assessment is not intended to provide all of the data necessary for each specialized topic. All topic areas were previously identified as areas of concern in other assessments. We used the criteria below to identify indicators other than those specified in the mandated topic areas.

1. Ability to address **health equity**, particularly by age, gender, race/ethnicity, geography, socioeconomic status, although not all demographic breakdowns may be available for all indicators.
2. **Availability of high-quality data** that are population-based (where possible), measurable, accurate, reliable and regularly updated. Data should focus on rates rather than counts.
3. Ability to make valid **comparisons** to a baseline or benchmark.
4. **Prevention orientation** with clear sense of direction for **action by hospitals** for individual, community, system, health service, or policy interventions that will lead to community health improvement.
5. Ability to **measure progress** of a condition or process that can be improved by intervention/policy/ system change, and there exists a capacity to affect change.
6. Alignment with local and national **healthcare reform** efforts, including the triple aim, which involves enhancing the patient experience of care, improving the health of populations and reducing the per capita cost of healthcare.

Beyond the stakeholder interviews conducted with the CHNA, the pediatric assessment's community input included meetings with over 10 coalitions; listening groups with 51 children and youth, over 84 parents and caregivers, and 17 providers and caregivers; feedback from 59 community organizations; two statewide

surveys with parents and caregivers as well as input from 65 Seattle Children's leaders, faculty and staff.

Description of the Data

Quantitative data used in the CHNA/CHA and cited in this report are high-quality, population-based data sources and were analyzed by the PHSKC Assessment, Policy Development & Evaluation Unit. Data come from local, state and national sources, such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Washington State Department of Health, King County and Public Health-Seattle & King County. Data sources for each indicator are shown in the each figure in each section and full details for each indicator are online. Some data, such as births, deaths and hospitalizations, are based on information for each event in King County.

Other data sources based on surveys follow rigorous sample design and complex survey analysis in order to present population-based percentages. In order to assess reliability of rates, 95% confidence intervals were calculated.

Community Input

As mentioned in the methodology section, community input included meetings with 10 coalitions; listening groups with 51 children and youth, 84 parents and caregivers, 17 providers and caregivers, feedback from 59 community organizations, two statewide surveys with parents and caregivers as well as input from 65 Seattle Children's leaders, faculty and staff. The 2015 CHNA and 2016 Pediatric CHA took into account input from people who represent the broad interests of the communities served by hospitals and health systems. Three methods of gathering information from community members about identified health needs and assets were used.

1. In both the King County CHNA and Pediatric CHA between January and July 2014 conducted interviews with stakeholder coalitions with broad representation. This method maximized the number and diversity of stakeholders who could provide input. Coalitions were identified that have expertise on health needs identified through quantitative data, have diverse membership, and have a regional or subregional focus. Stakeholders included those who represent the broad interests of the community; representatives of medically underserved, low-income and minority populations, and populations with chronic disease needs; and representatives from the local health department. Stakeholder groups included human service providers; community health centers; behavioral health providers; state, county and local government staff; fire departments; law enforcement; advocacy organizations; hospital staff; groups focused on health disparities in communities of color; faith communities; labor organizations; and managed care organizations. A total of 10 coalitions and 276 individual organizations or key informants provided information.
2. An online survey was also available for those who were unable to attend the respective coalition meeting and wished to provide input in writing. Thirty-one individuals responded to the survey.
3. Recent reports on health needs were also reviewed for themes and relevant assets and resources.

The following interview questions were used for the in-person interviews and online survey:

1. What are the main concerns you or your organization have about (topic) right now?
2. What are the people, places, and things that make your community healthy, safe, and strong and tell us why these people, places, and things are important? These could include organizations, leaders, coalitions,

initiatives, policies, or physical/environmental attributes.

3. What programs or projects are happening or planned that are most relevant to the identified needs?
4. How can hospitals and health systems be involved in addressing the issues you have identified?
5. What are the most significant gaps in resources, coordination, etc. in this area?
6. Is there anything else you would like to add?

The information collected through these methods was analyzed for themes about key issues, available assets and resources, and opportunities. The findings were included in this report.

Interviews were conducted with individuals belonging to the following coalitions, agencies and organizations:

Those who represent the broad interests of the community:

- Eastside Human Services Forum
- Aging & Disability Services
- The Arc of King County
- City of Bellevue
- City of Kirkland
- City of Redmond
- Friends of Youth
- Hopelink
- Issaquah Human Services Commission
- Issaquah Sammamish Interfaith Coalition
- King County Council
- Kirkland City Council
- Overlake Medical Center
- Redmond City Council
- Youth Eastside Services
- YWCA Seattle-King-Snohomish
- North Urban Human Services Alliance

- Center for Human Services
- City of Lake Forest Park
- City of Shoreline Human Services
- Hopelink
- Northshore/Shoreline Community Network
- Shoreline Community College
- Seattle Human Services Coalition
- South King Council of Human Services
- King County Traffic Safety Task Force
- Burien Police Department
- Kent Police Department
- Kirkland Police Department
- Issaquah Police Department
- Maple Valley Police Department
- Newcastle Police Department
- Redmond Police Department
- Renton Police Department
- Seatac Police Department
- King County Emergency Medical Services
- Safe Kids Seattle/South King County
- Feet First Pedestrian Safety Coalition
- Harborview Spine Center and Concussion Program
- Safe Kids Eastside
- Brain Injury Alliance
- CarSafe Kids
- Duvall Fire Department
- Eastside Aid Community
- EvergreenHealth
- Nick of Time Foundation
- Olympic Physical Therapy
- Central Region EMS & Trauma Care Council
- EvergreenHealth Emergency Department
- Group Health Emergency Department
- Harborview Medical Center Emergency Department

- Highline Medical Center Emergency Department
- Multicare Auburn Emergency Department
- Northwest Hospital Emergency Department
- Overlake Medical Center Emergency Department
- Seattle Children's Hospital Emergency Department
- Snoqualmie Valley Hospital Emergency Department
- St. Elizabeth Hospital Emergency Department
- St. Francis Emergency Department
- Valley Medical Center Emergency Department
- Airlift Northwest
- AMR Ambulance
- Falck Northwest Emergency Medical Services
- Tri-Med Ambulance
- Washington Ambulance Association
- Public Health-Seattle & King County Emergency
- Medical Services
- Washington State Department of Health

Representatives of medically underserved, low-income and minority populations, and populations with chronic disease needs assisted in the assessment, including:

- Carol Allen, coordinator, Access to Baby and Child Dentistry Program, Public Health-Seattle & King County
- Behavioral Health Partnership Group
- Asian Counseling and Referral Services
- Catholic Community Services
- Community House Mental Health
- Community Psychiatric Clinic
- Consejo Counseling

- DESC
- EvergreenHealth
- Harborview Mental Health
- NAVOS
- Seattle Counseling Service
- Sound Mental Health
- Valley Cities Counseling
- YMCA
- King County Mental Health Chemical Abuse and Dependency Services
- Country Doctor Community Health Center
- SeaMar Community Health Center
- Forefront
- Equal Start Community Coalition
- Children's Alliance
- Local Hazardous Waste Management
- Open Arms Perinatal Services
- Native American Women's Dialogue on Infant Mortality
- Center for Multicultural Health
- YWCA
- Odessa Brown Children's Clinic
- Health Coalition for Children and Youth
- Cedar River Group
- Childhood Obesity Prevention Coalition
- Children's Alliance
- Community Health Network of Washington
- Molina Healthcare
- Neighborhood House
- Northwest Health Law Advocates
- Odessa Brown Children's Clinic
- Partners for our Children
- Seattle Children's Hospital
- Service Employees International Union Healthcare

- 1199NW
- Washington Chapter, American Academy of Pediatrics
- Washington Dental Service Foundation
- Washington State Hospital Association
- WithinReach
- Sallie Neillie, Executive Director, Project Access Northwest

Individuals with expertise in public health and representatives from the local health department also assisted, including:

- **Alan Abe**, program manager, Injury Prevention, King County Emergency Medical Services
- **Jennifer DeYoung**, health reform analyst, Public Health-Seattle & King County
- **Tony Gomez**, RS, manager, Violence and Injury Prevention, Public Health-Seattle & King County
- **Scott Neal**, tobacco program manager, Public Health-Seattle & King County
- **Lisa Podell**, interim health reform analyst, Public Health-Seattle & King County
- **Whitney Taylor**, program manager, Firearm Violence Prevention/Child Fatality Review Program, Public Health-Seattle & King County
- **Crystal Tetrick**, manager, Parent Child Health, Public Health-Seattle & King County
- **Sharon Toquinto**, prevention and treatment manager, Mental Health Chemical Abuse & Dependency Services Division, King County
- **Jim Vollendroff**, division director, Mental Health Chemical Abuse & Dependency Services Division, King County

Review of Existing Reports

Recent reports including broad community needs assessments, strategic plans, or reports on specific health needs were reviewed for context and relevant assets, resources, and opportunities. The following reports were reviewed:

1. Preliminary information from the King County Accountable Community of Health (ACH) exploration
2. Delridge Women's Food Access report, 2014
3. Duwamish Valley Cumulative Health Impacts Analysis, 2013
4. Distracted driving report card, 2013
5. Got Green Food Access report, 2014
6. High School Outcomes for DSHS involved youth, 2012
7. Ina Maka Family Program Community Needs Assessment 2012
8. King County Equity and Social Justice Report, 2013
9. King County Strategic Plan community adults report, 2014
10. Puget Sound Educational Service District Early Head Start, Head Start, and ECEAP Programs Community Assessment, 2014
11. Regional Equity Network Grantee Recommendations, 2013
12. Seattle Healthy Living Assessment Pilot Implementation Report, 2011
13. Seattle Racial Equity Community Survey, 2013
14. State Policy Action Plan to Eliminate Health Disparities, 2012
15. United Way of King County Investment Plan, 2013
16. Trans* Resource and Referral Guide, 2014
17. Vietnamese Community Assessment Report, 2011
18. Washington State Department of Health Strategic Plan, 2014

19. Washington CAN Health Equity and Access in Auburn, 2014
20. Group Health Community Health Needs Assessment, 2013
21. Franciscan St. Elizabeth Community Health Needs Assessment, 2013
22. Highline Medical Center Community Health Needs Assessment, 2013
23. Multicare Auburn Community Health Needs Assessment, 2013
24. Navos Community Health Needs Assessment, 2013
25. Northwest Hospital Community Health Needs Assessment, 2013
26. Overlake Community Health Needs Assessment, 2011
27. Seattle Children's Hospital Community Health Needs Assessment, 2013
28. Seattle Cancer Care Alliance Community Health Needs Assessment, 2013
29. Snoqualmie Valley Hospital District Community Health Needs Assessment, 2013
30. Swedish Hospital Community Health Needs Assessments, 2013
31. Virginia Mason Community Health Needs Assessment, 2013

Evidence-based Practices

Additional information on evidence-based practices is available from the following sources. Hospitals should consult these guides when planning interventions.

1. The Robert Wood Johnson Foundation's What Works for Health
2. The Centers for Disease Control and Prevention's Community Guide to Preventive Services
3. Blueprints for Healthy Youth Development
4. The Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Registry of Evidence-based Programs and Practices

Limitations

Key limitations of this report include incomplete or inadequate quantitative data on some topics of interest and our inability to summarize every asset and opportunity in King County. For example, although we report data on fruit/vegetable consumption, comprehensive population-based data on healthy eating are simply not available. In addition, resource limitations prevent us from mentioning all of the valuable organizations and assets in our communities. We collected data from agencies that use varying data sets. A particular challenge was inconsistent age groupings in epidemiological and outcome data. Data were also inconsistent in defining life-stage categories, such as when a child is considered an adult.

Inconsistencies in terminology and definitions made it difficult to make side-by-side comparisons. For example, the definition of "Hispanic" varies from one community to another. The definition of "community" also varies. Individuals participating in a CHNA and CHA likely define their community differently; a community can be a geographic area, a racial group, a school or a religious affiliation. This poses problems when analyzing interview and survey results.

We had fewer connections to community leaders in other areas of Washington state, so most of our respondents were from King County. While we gathered a great deal of community input from a wide range of stakeholders, limited resources made it impossible to reach all of our constituents. While we were able to conduct listening groups with multiple communities and interview several community members, these qualitative results should be interpreted as the perspective of the people who participated. While they are intended to provide insight into the assets, needs and ideas of the communities, they should not be interpreted as representing the whole community. These limitations may inadvertently reinforce health inequalities.

Appendix B: Report Structure

For each indicator, this report includes the following (if available):

- A description of the indicator
- Overall estimate for King County and/or Washington state (if available)
- Multiple-year averaged estimates for select subpopulations (e.g. race/ethnicity and region) in either a bar chart or map
- A list of sub-populations that have a statistically significant higher burden of risk, disease or injury than the overall King County or Washington state population.

Appendix C includes more complete information for each indicator, including tables, charts, figures and other data sources.

Confidence interval (also known as error bar) is the range of values that includes the true value 95% of the time. If the confidence intervals of two groups do not overlap, the difference between groups is considered statistically significant (meaning that the chance or random variation is unlikely to explain the difference). For some indicators, results are reported with a 90% confidence interval, showing the range that includes the true value 90% of the time.

Crude, age-specific and age-adjusted rates

- Rates are usually expressed as the number of events per 100,000 population per year. When this applies to the total population (all ages), the rate is called the crude rate. When the rate applies to a specific age group (e.g., ages 15 to 24), it is called the age-specific rate.
- The crude and age-specific rates present the actual magnitude of an event within a population or age group.
- When comparing rates between populations, it is useful to calculate a rate that is not affected by differences in the age composition of the populations. This is the **age-adjusted rate**. For example, if a neighborhood with a high proportion of

older people also has a higher-than-average death rate, it will be difficult to determine if that neighborhood's death rate is higher than average for residents of all ages or if it simply reflects the higher death rate that naturally occurs among older people. The age-adjusted rate mathematically removes the effect of the population's age distribution on the indicator.

- Some graphs have a * or § symbol. A * means that there are too few cases to protect confidentiality and/ or report reliable rates. A § denotes that while rates are presented, there are too few cases to meet a precision standard, and results should be interpreted with caution.

Geographies

Whenever possible, indicators are reported for King County as a whole and for four regions within the county. If enough data are available for a valid analysis, they may also be reported by smaller geographic areas (cities, neighborhoods within large cities, and groups of smaller cities and unincorporated areas). Education data are reported by school district.

Federal poverty guidelines, issued by the U.S. Department of Health and Human Services, are a simplified version of the federal poverty thresholds. The guidelines are used to determine financial eligibility for various federal, state and local assistance programs. For a family of four, the federal poverty guideline was \$22,050 in 2010; in 2013 it was \$23,550 and in 2015 it was \$24,250.

Neighborhood poverty levels are based on the proportion of households in a census tract in which annual household income (as reported in the U.S. Census Bureau's American Community Survey) falls below the federal poverty threshold.

- High poverty: 20% or more households in the neighborhood fall below poverty threshold.
- Medium poverty: 5% to 19% of households fall below poverty threshold.

- Low poverty: fewer than 5% of households fall below poverty threshold.

Race/ethnicity and discrimination

Race and ethnicity are markers for complex social, economic and political factors that can influence community and individual health in important ways. Many communities of color have experienced social and economic discrimination and other forms of racism that can negatively affect the health and well-being of these communities. We continue to analyze and present data by race/ethnicity because we believe it is important to be aware of racial and ethnic group disparities in these indicators.

Race/ethnicity terms

Federal standards mandate that race and ethnicity (Hispanic origin) are distinct concepts requiring two separate questions when collecting data from an individual. “Hispanic origin” is meant to capture the heritage, nationality group, lineage or country of birth of an individual (or his/her parents) before arriving in the United States. Persons of Hispanic ethnicity can be of any race. The 2010 U.S. Census Bureau terms include: Hispanic or Latino; Not Hispanic or Latino; White alone (Not Hispanic or Latino); Black or African American; American Indian or Alaska Native; Asian; Native Hawaiian or Other Pacific Islander; White; Some Other Race; and Two or More Races. Persons of Hispanic ethnicity can be of any race and are included in other racial categories. Racial/ethnic groups are sometimes combined when sample sizes are too small for valid statistical comparisons of more discrete groups.

Some surveys collect race/ethnicity information using only one question on race. These terms are: Hispanic, non-Hispanic, white non-Hispanic, black, American Indian/Alaska Native (AIAN), Asian, Native Hawaiian/Pacific Islander (NHPI), white and multiple race (multiple).

Rolling averages

When the frequency of an event varies widely from year to year, rates are sometimes

aggregated into averages – often in three-year intervals – to smooth out the peaks and valleys of the yearly data in order to view the trend. For example, for events occurring from 2001 to 2010, rates may be graphed as three-year rolling averages: 2001-2003, 2002-2004, 2005-2007 or 2008-2010. In this report, data is often used over five-year intervals, from 2008-2012 and from 2009-2013. Adjacent data points will contain overlapping years of data. Statistical tests comparing data points with overlapping times are not appropriate.

Statistical significance

Differences between sub-population groups and the overall county are examined for each indicator. Unless otherwise noted, all differences mentioned in the text are statistically significant (unlikely to have occurred by chance). The potential to detect differences and relationships (termed the statistical power of the analysis) is dependent, in part, on the number of events and size of the population, or, for surveys, the number of respondents or sample size. Differences that do not appear to be significant might reach significance with a large enough population or sample size.

Appendix C: Data for Report Indicators

Additional indicators are available online at www.kingcounty.gov/health/indicators.

Figures by Section

Introduction

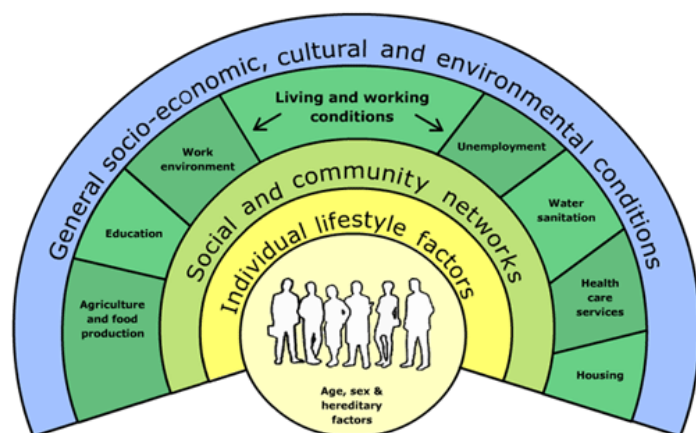


Figure 1: General Socioeconomic, Cultural and Environmental Conditions that Impact Health ³²⁰

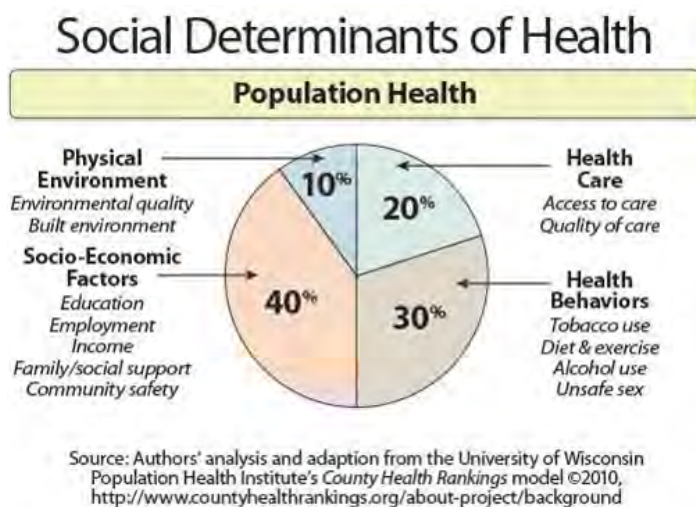


Figure 2: Impact on Population Health ³²¹

³²⁰ Dahlgren, Göran and Whitehead, Margaret, (1991), Policies and strategies to promote social equity in health. Background document to WHO - Strategy paper for Europe, No 2007:14, Arbetsrapport, Institute for Futures Studies.

³²¹ Source: Adapted from County Health Rankings, University of Wisconsin Public Health Institute.

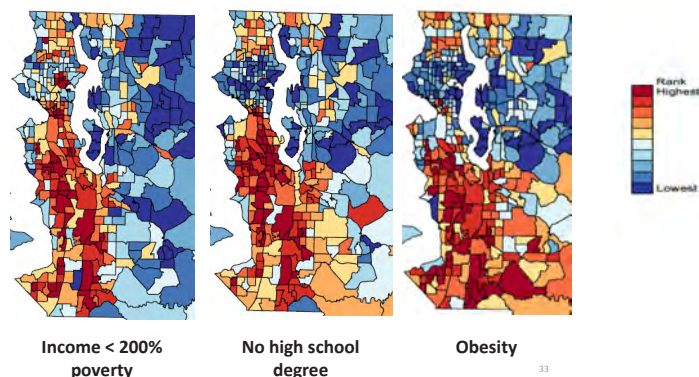


Figure 3: King County Poverty, Education and Obesity Map by Area ³²²



Figure 4: Community Health Assessment Focus Area

Community Social and Economic Context

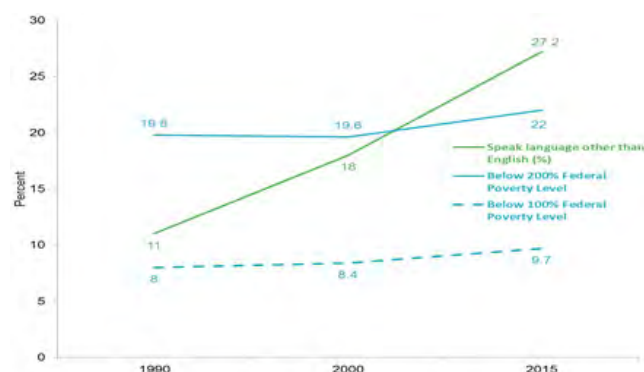


Figure 5: Demographic Trends in King County ³²³

³²² U.S. Census Bureau, BRFSS, CHARS, data, map produced by Public Health - Seattle & King County.

³²³ American Community Survey, US Census (2016). Prepared by Public Health - Seattle & King County Assessment, Policy Development & Evaluation. Retrieved from: <http://kingcounty.gov/depts/health/data/community-health-indicators.aspx>.

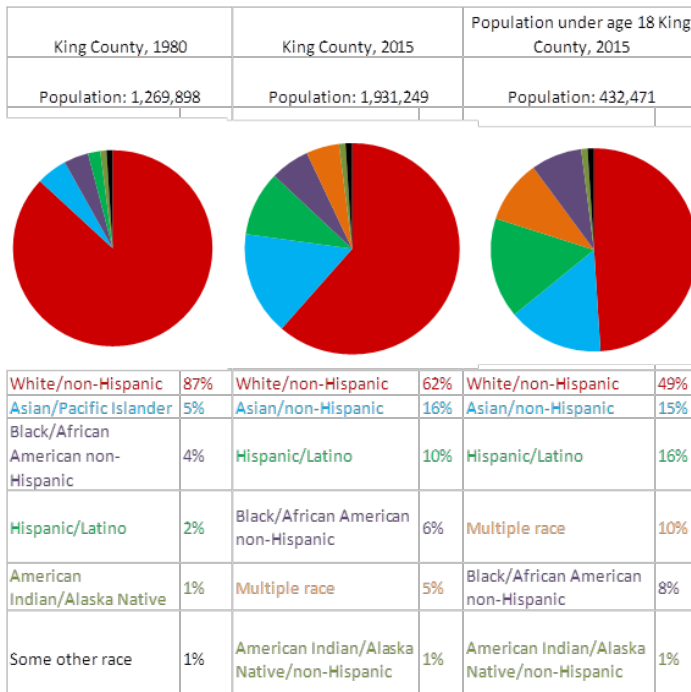


Figure 6: King County Population Breakdown Overall (1980 vs. 2015) and Population of Children Under Age 18 in 2015

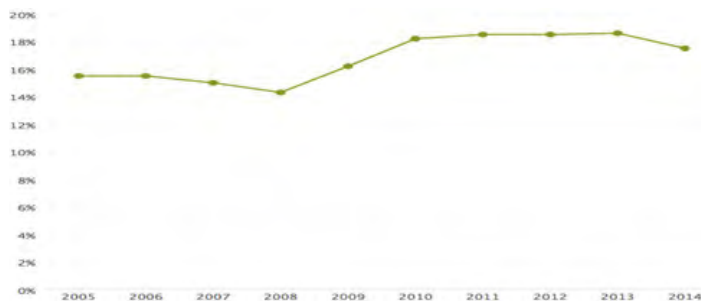


Figure 7: Percentage of Children Under 18 in Poverty in Washington State (2005-2014)

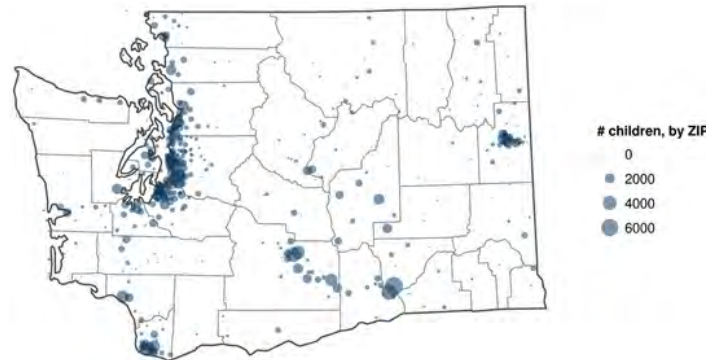
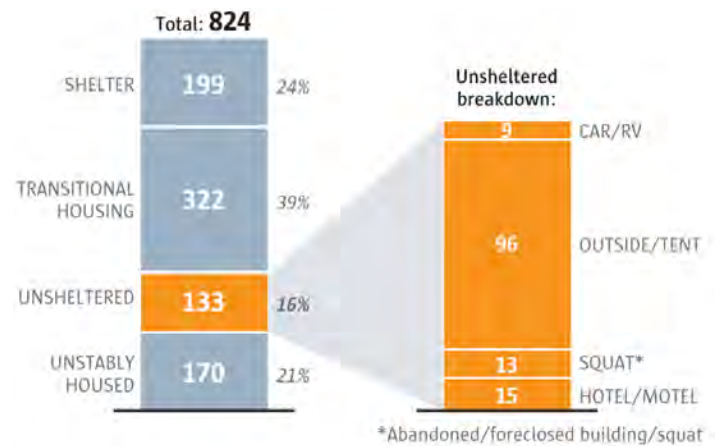


Figure 8: Density of Children Living in Poverty by Washington State Zip Code



Source: King County's Point-in-Time Count, 2015 report

THE SEATTLE TIMES

Figure 9: Housing Status of Homeless Youth in King County, 2015

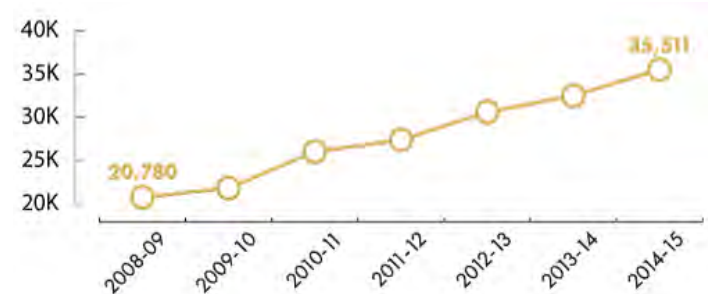


Figure 10: Number of Homeless Children in Public Schools, Washington State, 2008 to 2014

³²⁴ US Census Bureau, Census 1980; WA Office of Financial Management 2015. Percentages may not add up to 100% due to rounding.

³²⁵ Kids Count Data Center: A Project of the Annie E. Casey Foundation. (2013). Children under 18 in poverty. Retrieved from <http://datacenter.kidscount.org/data/line/3298-children-under-18-in-poverty?loc=49&loc=2#2/any/false/869,36,868,867,133,38,35,18,17,16/asc/any/6800>.

³²⁶ Seattle Children's with 2013 5-year ACS data. (2015). Children Living in Poverty: Washington. This graph was created by Dr. John Mosser in r-studio using 2013 5-year ACS data, and represents the location of children living in poverty in Washington (absolute numbers). Each point represents a zip code, and the # of children living in poverty is concordant with the size of the circle.

³²⁷ Seattle Times. (2015). Children on the street slip through the cracks; state has misplaced priorities. Retrieved from <http://www.seattletimes.com/opinion/editorials/editorial-homeless-youth-children-seattle-king-county-dshs>.

³²⁸ State of Washington's Kids. (2016). Retrieved from kidscountwa.org/wp-content/uploads/2016/06/State-of-Washingtons-Kids-2016.pdf.

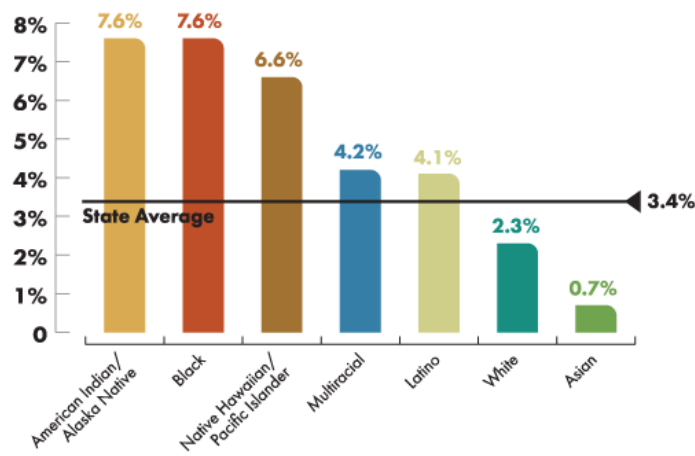


Figure 11: Percentage of Students who are Homeless by Race and Ethnicity, Washington State, 2008 to 2014

	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/Alaska Native	Asian/Pacific Islander	State Total	Healthy People 2020 National Target	State Rank
Population (2014) (all ages)	72.5	4.4	11.7	2.2	9.2	7,061,530		
Major causes of death (rate per 100,000)*								
All cause	703.2	746.1	441.1	926.6	415.5	681.5	+	11
Heart disease	144.1	151.6	84.0	187.4	73.4	139.3	+	9
Coronary heart disease	99.5	99.4	61.7	135.1	52.0	96.3	100.4	17
Total cancer	186.1	189.2	96.6	151.7	118.2	161.4	181.4	20
Colon cancer	13.7	15.2	+	+	9.5	13.2	14.5	7
Lung cancer	44.1	56.7	21.7	36.5	30.0	42.3	45.5	19
Stroke	34.4	31.2	32.2	32.5	27.7	34.3	34.8	18
Chronic obstructive pulmonary disease (age 45 & over)	121.6	61.0	48.6	127.9	31.6	113.2	102.6	21
Diabetes-related	74.8	125.4	87.4	129.0	58.9	76.2	66.6	36
Influenza and pneumonia	9.3	+	8.9	+	9.1	9.8	+	5
Unintentional injuries	40.7	30.9	25.2	70.3	19.3	38.3	36.9	16
Suicide	16.5	8.7	6.9	15.3	6.2	14.6	10.2	32
Health risk factors (percent) ‡								
Diagnosed high blood pressure (2013)	29.8	41.1	33.7	39.2	23.9	30.2	26.9	22
Obesity (2014) (age 20 & over)	27.9	33.5	35.0	43.6	10.7	27.4	30.5	14
No leisure-time physical activity (2014)	15.9	27.8	23.6	31.8	18.0	17.9	32.6	4
Smoking currently (2014)	15.7	27.7	13.8	21.4	9.7	15.0	12	10
Eats 5+ fruits and vegetables a day (2009)	24.9	26.0	20.4	24.7	31.7	25.0	+	18
Preventive care (percent) §								
Cholesterol screening in past 5 yrs. (2013)	73.0	77.1	58.5	73.7	78.7	72.9	82.1	25
Relative check-up in past 2 yrs. (2014)	78.7	84.1	73.5	81.5	82.1	78.0	+	26
Dental visit within the past year (2014)	65.7	61.9	52.5	53.8	64.7	66.5	+	21
Health insurance coverage (percent)								
Health insurance coverage (2014) (age 15-64)	90.9	87.9	61.3	81.6	98.9	86.0	100	19

Figure 12: King County Health Disparities Profile, All Ages, 2014

POPULATION MEASURES

Life expectancy

Health, broadly defined

Adverse childhood experiences	20%
Frequent mental distress	14%
Smoking	20%
Obesity	33%
Diabetes	13%
Preventable hospitalizations	1.0%

Housing

Poor housing condition	8%
------------------------	----

Economic opportunity

Low-income, below 200% poverty	54%
Unemployment	13%

RANKING
Census Tracts ranked by an index of health, housing and economic opportunity measures.
Data Sources: U.S. Census Bureau, BRFSS, CHASS. Produced by: Public Health - Seattle & King County

Freeway

Dark red areas
populations most impacted
74 years

Dark blue areas
populations least impacted
87 years

Lowest Ranked

Highest Ranked

Figure 13: King County Population Measures

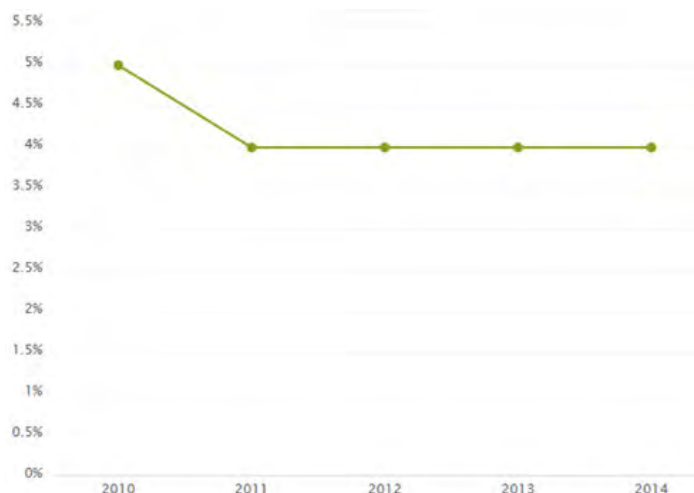


Figure 14: Percent of Washington State Children Living in Low-Income Households without a Working Adult, 2010-2014

329 Ibid.

330 The Office on Women's Health. (2014). Health disparities profiles: Washington state. Retrieved from http://www.healthstatus2020.com/disparities/ChartBookData_list.asp & http://52.207.219.3/qhdo/disparities/ChartBookData_search.asp.

331 Kids Count Data Center. (2016, March). Washington indicators. Retrieved from <http://datacenter.kidscount.org/data#WA/2/0/char/0>.

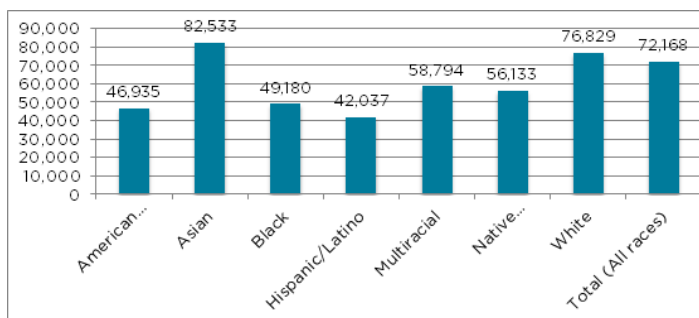
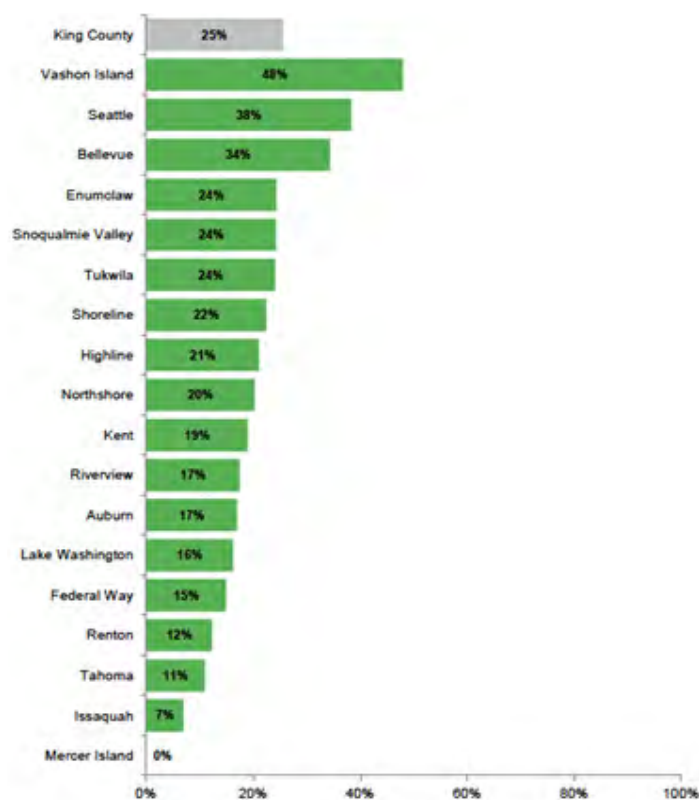


Figure 15: Median Income by Race/Ethnicity in King County, 2009-2013



Source: Puget Sound Educational Service District, Office of the Superintendent of Public Instruction, Dept Early Learning

Figure 16: Estimated Percent of Children Eligible for Head Start and ECEAP Served in King County, 2014

332 Kids Count Data Center. (2013). Median family income by race and ethnicity (5-year average). Retrieved from <http://datacenter.kidscount.org/data/Tables/4682-median-family-income-by-race-and-ethnicity-5-year-average?loc=49&loc=2#detailed/2/any/false/1376/437,172,133,12,4100,826,816,13/10944>.

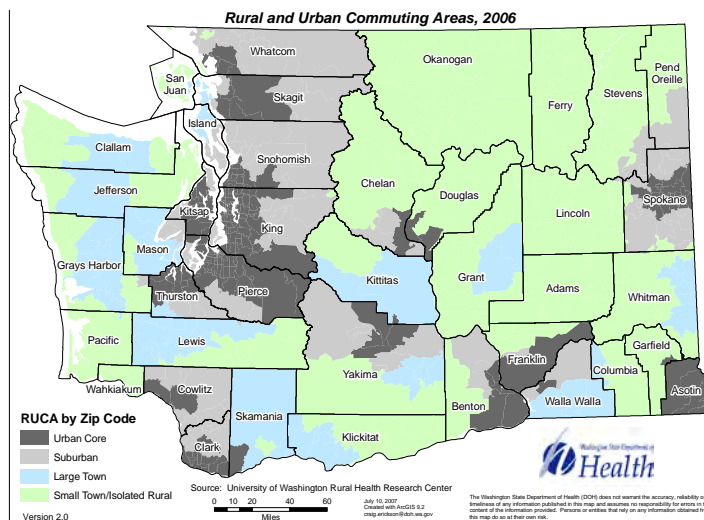


Figure 17: Urbanicity of Washington State According to the U.S. Census

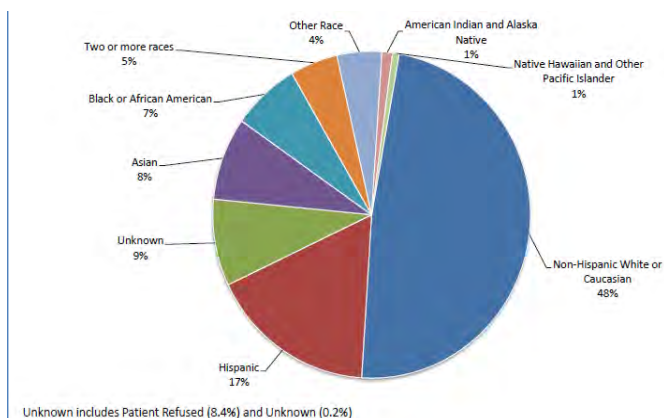


Figure 18: Race/Ethnicity of Seattle Children's Patients, 2015-2016

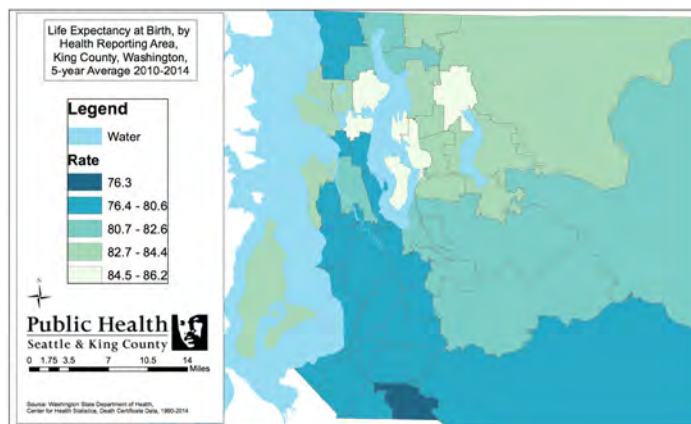
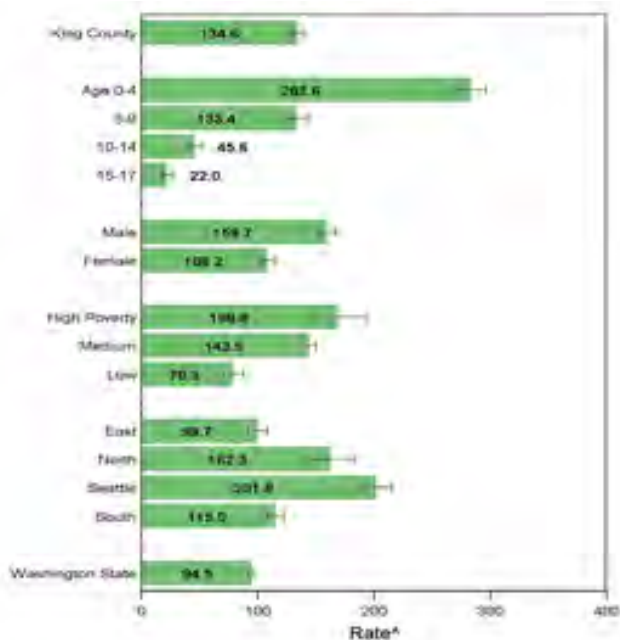


Figure 19: Life Expectancy at Birth by Health Reporting Areas, King County, 2009-2014

333 Washington State Department of Health. Retrieved from ftp://ftp.doh.wa.gov/geodata/layers/maps/ruca_zip_06.pdf.

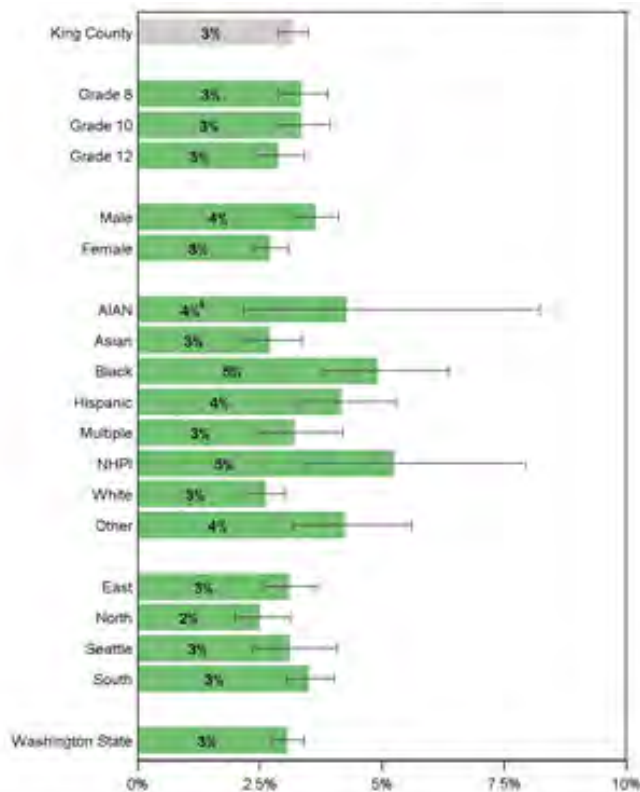
334 <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/population-maps/life-expectancy-at-birth-HRA.ashx>.

Children and Youth with Special Health Care Needs and Chronic Conditions



Source: WA State DOH, Office of Hospital and Patient Data Systems.
Prepared by Public Health - Seattle & King County, APDE, 07/2015.
^aRate = cases per 100,000 population, age-adjusted to the 2000 U.S. population.
[---] Confidence interval shows range that includes true value 95% of the time.
^b Too few cases to protect confidentiality and/or report reliable rates.
^c Too few cases to meet precision standard, interpret with caution.
Data by race/ethnicity not available.
Poverty = Neighborhood poverty levels defined by median household income.

Figure 21: Asthma Hospitalizations Rates Among Subgroups of Children in King County



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 06/2016.
[---] Confidence interval shows range that includes true value 95% of the time.
^a Too few cases to protect confidentiality and/or report reliable rates.
^b Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

Figure 22: Rates of Diabetes Among Subgroups of School-age Children in King County, 2014 Average

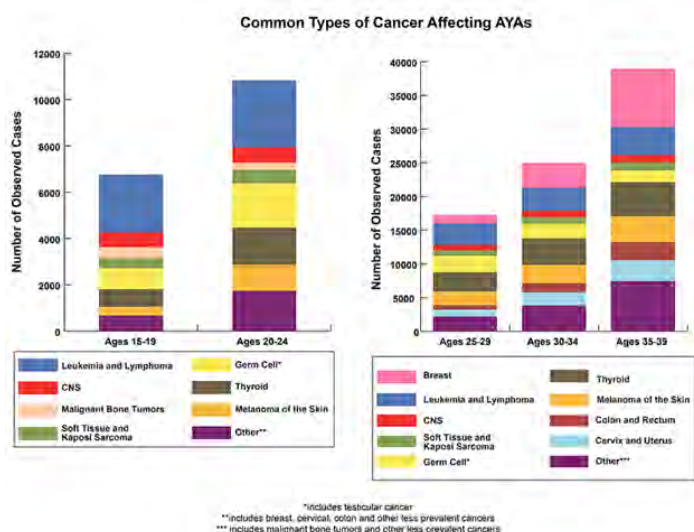


Figure 23: Common Types of Cancer Affecting AYAs

335 Public Health-Seattle & King County. (2012). Child asthma hospitalizations (age 0-17). Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/chronic-illness/asthma-prevalence-children.ashx><http://www.kingcounty.gov/depts/health/data/community-health-indicators.aspx>.

336 National Cancer Institute (2007-2011). Common types of cancer affecting AYAs, ages 15-39. Retrieved from: https://www.cancer.gov/PublishedContent/Images/images/snapshots/2014/english/2014_AYA_BAR_v6-side.png.

Access to Care, Use of Clinical Preventive Services and Oral Health

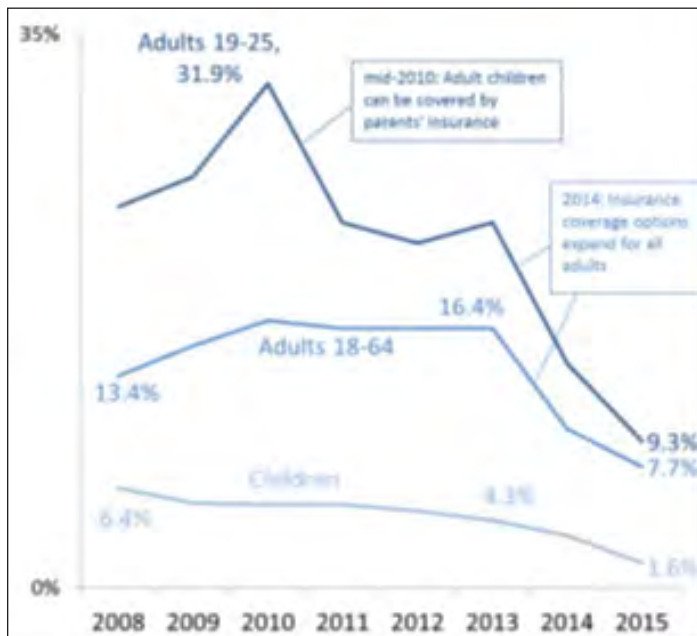


Figure 24: Percentage of Young Adults and Children Without Health Insurance, 2008-2015 Average

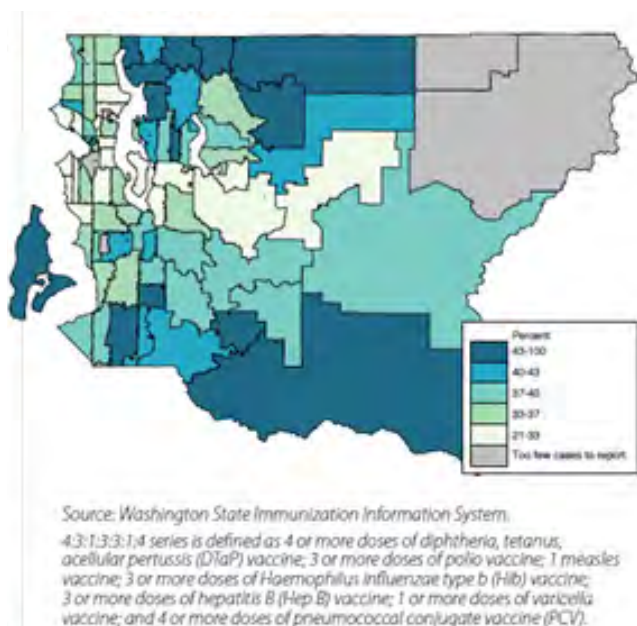
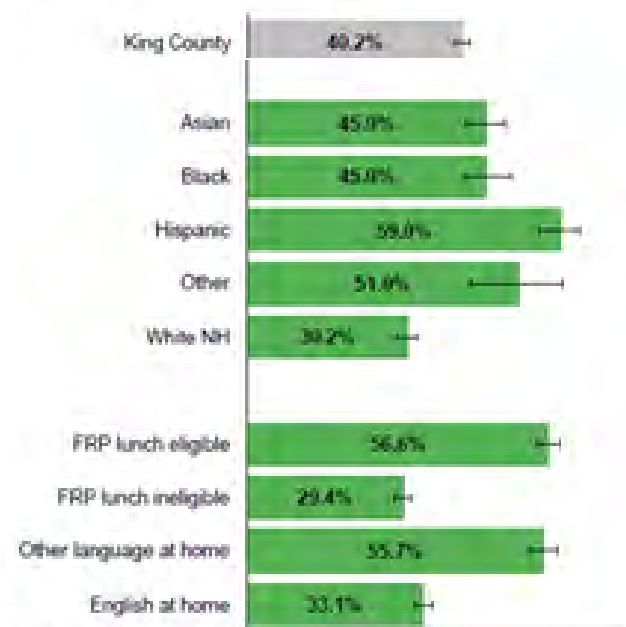


Figure 25: Percentage of Children Age 19-35 Months with Incomplete Vaccine Series by King County Zip Code in 2014

337 Public Health – Seattle & King County (2016) Affordable Care Act Enrollment in King County: Increases in Health Insurance Coverage. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/affordable-care-act-increases-in-coverage-sept-2016.ashx>.

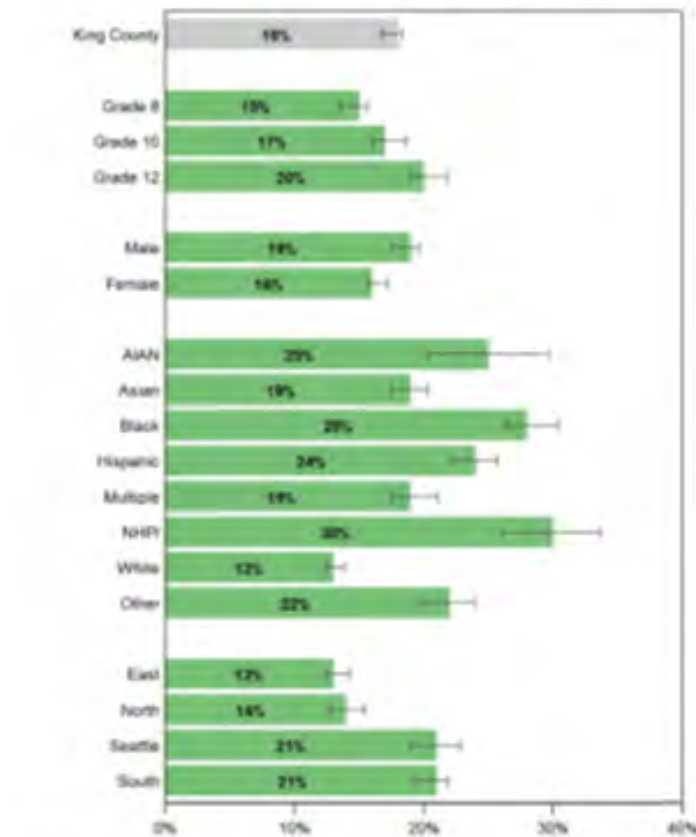
338 <https://data.kingcounty.gov/dataset/King-County-Vaccination-Rates/j49t-d3p7/alt>.



Source: 2010 King County Smile Survey
 FRP, Free/Reduced Price
 Other language: language other than English spoken at home
 English: English spoken at home

Figure 26: Percentage of Kindergarten and 3rd Grade Students with Cavities, King County, 2010

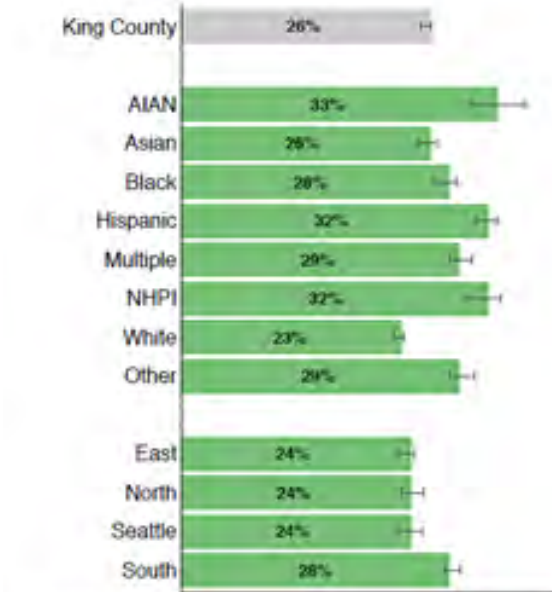
Mental and Behavioral Health



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 12/2014.
— Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
† Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

Figure 27: Percentage of King County School-age Children Who Did Not Have a Dental Checkup in the Last Year by Subgroup

339 Public Health-Seattle & King County. (2012). No dental checkup in the last year (school-age), King County, 2010 and 2012. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/access/dental-checkup-in-last-year-children.ashxx>.



Source: Healthy Youth Survey.

Figure 28: King County Youth With Depressive Feelings by Subgroup, 2008-2012 Average

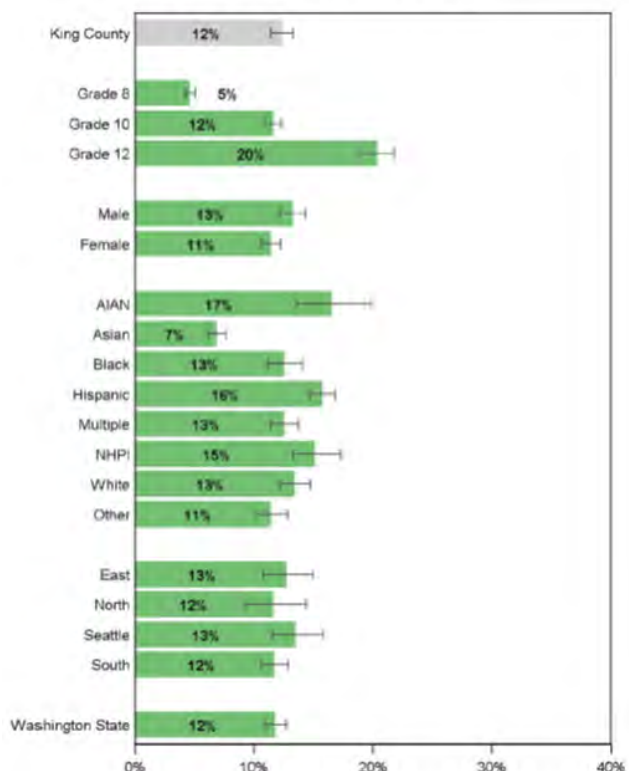
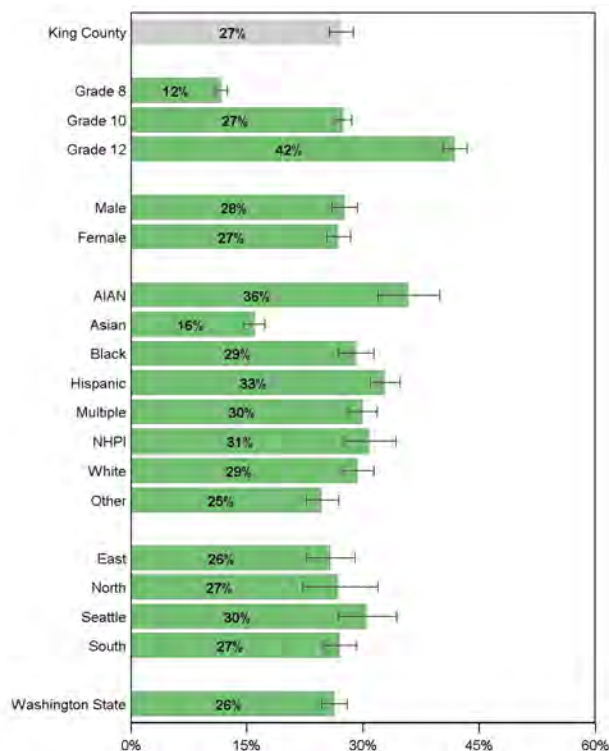


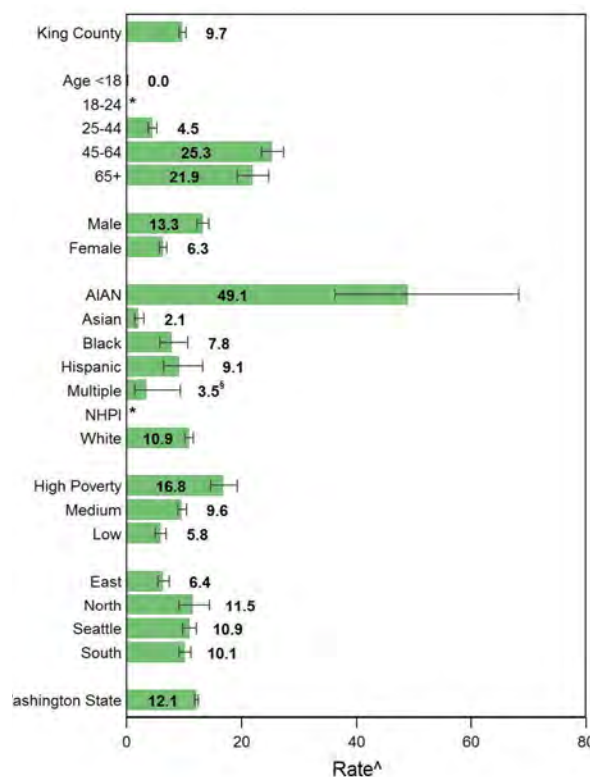
Figure 29: King County Binge Drinking Rates Among School-age Children by Subgroup, 2012-2014 Average

340 <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/behavior/binge-drinking-children.ashx>.



Source: Healthy Youth Survey.
 Prepared by Public Health - Seattle & King County, APDE, 07/2016.
 [---] Confidence interval shows range that includes true value 95% of the time.
 * Too few cases to protect confidentiality and/or report reliable rates.
 § Too few cases to meet precision standard, interpret with caution.
 Data by income or poverty level not available.

Figure 30: King County Youth Illegal Drug Use by Subgroup, 2012 & 2014



Source: State DOH, Center for Health Statistics, Death Certificates.
 Prepared by Public Health - Seattle & King County, APDE, 08/2016.
 Rates per 100,000 population, age-adjusted to the 2000 US population.
 [---] Confidence interval shows range that includes true value 95% of the time.
 * Too few cases to protect confidentiality and/or report reliable rates.
 § Too few cases to meet precision standard, interpret with caution.
 Data by income or poverty level not available.
 Hispanic ethnicity can be of any race and are included in the racial categories.
 Neighborhood poverty levels defined by median household income.

Figure 31: King County Youth Alcohol-induced Deaths by Subgroup, 2008-2012 Average



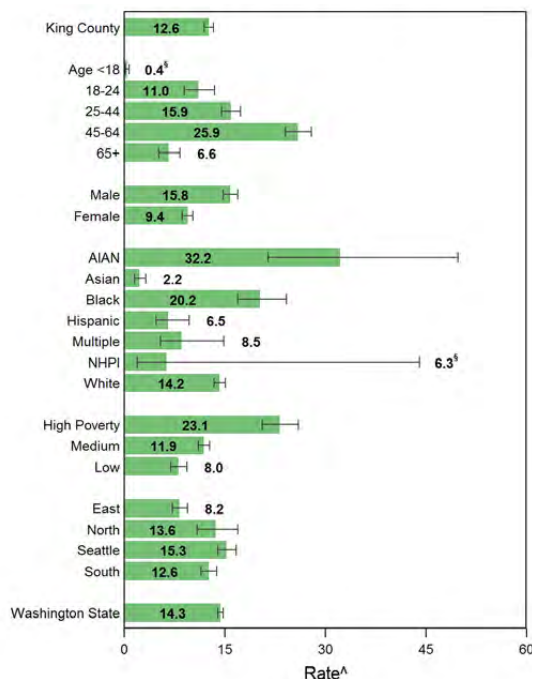
* Fatal crash involving a driver with a blood alcohol content (BAC) of 0.08 or above
 Data Source: Washington State Department of Transportation, King County collision data

Figure 32: Rate of All Motor Vehicle Fatalities and Motor Vehicle Fatalities Due to Alcohol-impaired Drivers in King County, 2008-2013

341 <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/behavior/illicit-drug-use-past-30-days-children.ashx>.

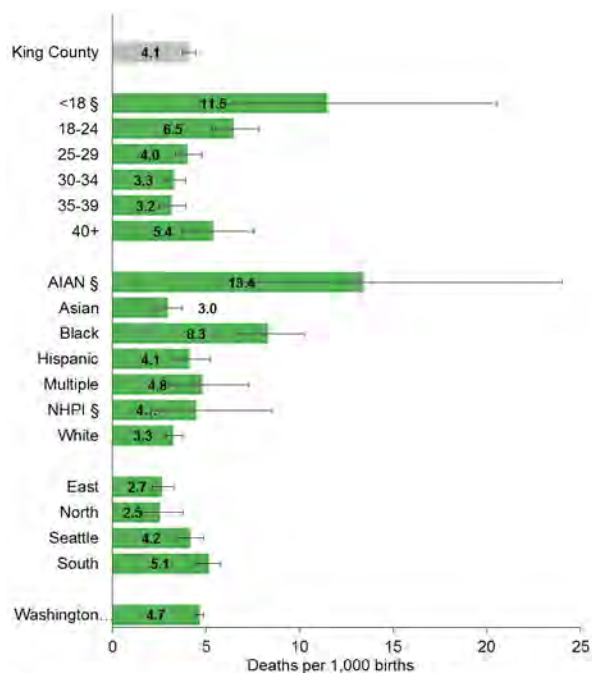
342 According to report, age <18=0, 18-24=too few cases to report reliable rates. See: <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/behavior/alcohol-induced-deaths.ashx>.

343 <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/behavior/alcohol-impaired-driving-fatalities.ashx>.



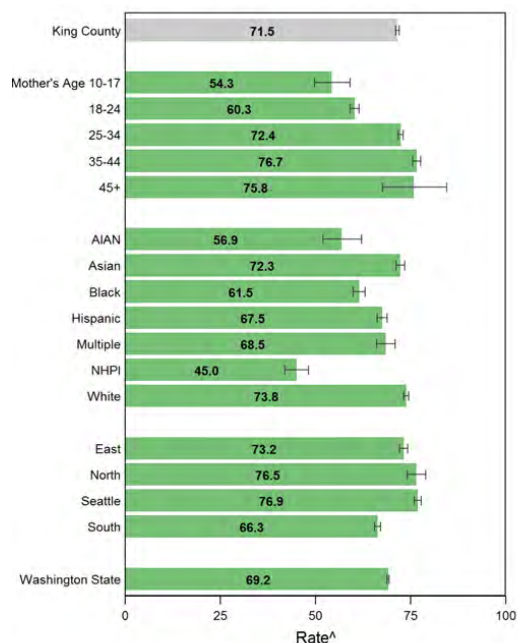
Source: WA State DOH, Center for Health Statistics, Death Certificates.
 Prepared by Public Health - Seattle & King County, APDE, 08/2016.
^ARate = cases per 100,000 population, age-adjusted to the 2000 US population.
 [-----] Confidence interval shows range that includes true value 95% of the time.
 § Too few cases to protect confidentiality and/or report reliable rates.
 ¶ Too few cases to meet precision standard, interpret with caution.
 Persons of Hispanic ethnicity can be of any race and are included in the racial categories.
 Poverty = Neighborhood poverty levels defined by median household income.

Figure 33: King County Youth Drug-induced Deaths by Subgroup, 2008-2012 Average



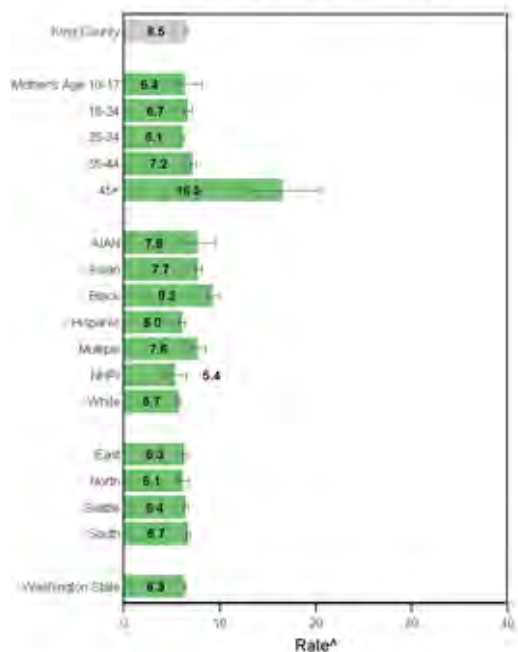
Source: Linked Birth-Death Certificate Data, Washington State Department of Health, Center for Health Statistics; § Too few cases to meet precision standard, interpret with caution

Figure 34: King County Infant Mortality Rates by Subgroup, 2011-2015 Average



Source: WA State DOH, Center for Health Statistics, Birth Certificates.
 Prepared by Public Health - Seattle & King County, APDE, 11/2016.
^ARate = per 100 live births.
 [-----] Confidence interval shows range that includes true value 95% of the time.
 § Too few cases to protect confidentiality and/or report reliable rates.
 ¶ Too few cases to meet precision standard, interpret with caution.
 Persons of Hispanic ethnicity can be of any race and are included in the racial categories.

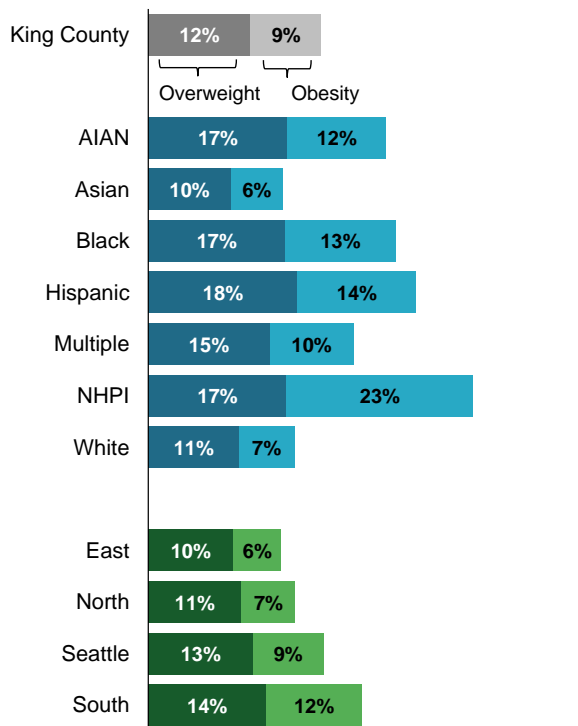
Figure 35: King County Rates of Early and Adequate Prenatal Care by Subgroup, 2010-2014 Average



Source: WA State DOH, Center for Health Statistics, Birth Certificates.
 Prepared by Public Health - Seattle & King County, APDE, 08/2016.
^ARate = per 100 live births.
 [-----] Confidence interval shows range that includes true value 95% of the time.
 § Too few cases to protect confidentiality and/or report reliable rates.
 ¶ Too few cases to meet precision standard, interpret with caution.
 Persons of Hispanic ethnicity can be of any race and are included in the racial categories.

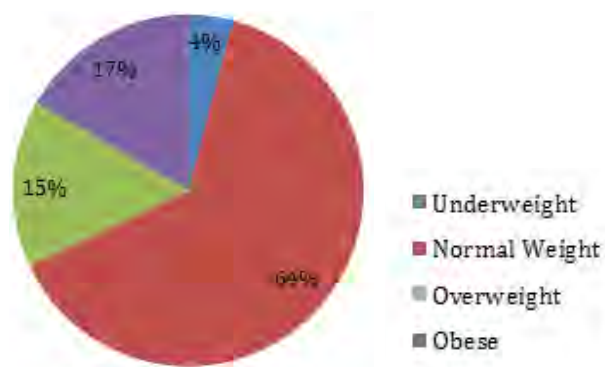
Figure 36: King County Low Birth Weight Rates, 2010-2014 Average

Preventable Causes of Death



Sources: Healthy Youth Survey.

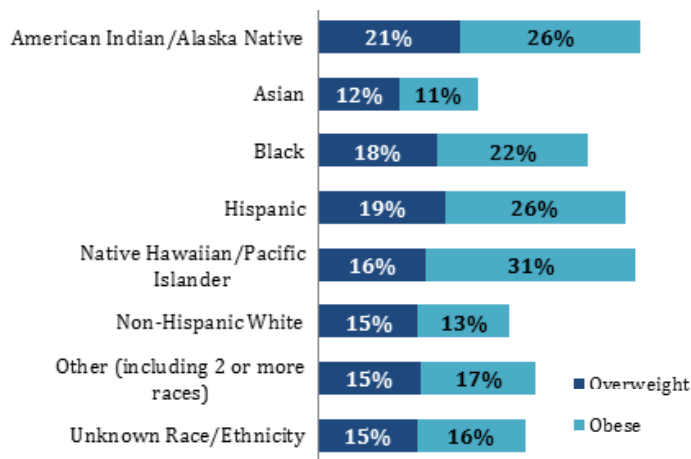
Figure 37: King County Youth Obesity and Overweight Rates by Subgroups, 2008-2012 Average



N=60,862 patients

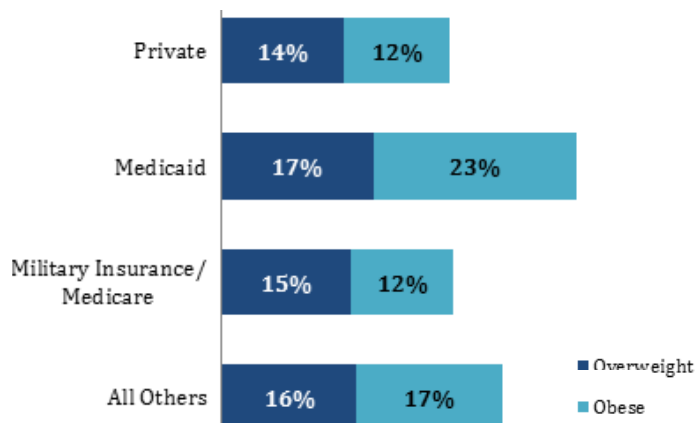
Figure 38: Seattle Children's Patient Weight Breakdown for Ages 2 to 18

Note: Data were available for 62% of all patients (n=60,862) seen as inpatients or outpatients at all Seattle Children's locations, including regional clinics and Odessa Brown Children's Clinic (primary care).



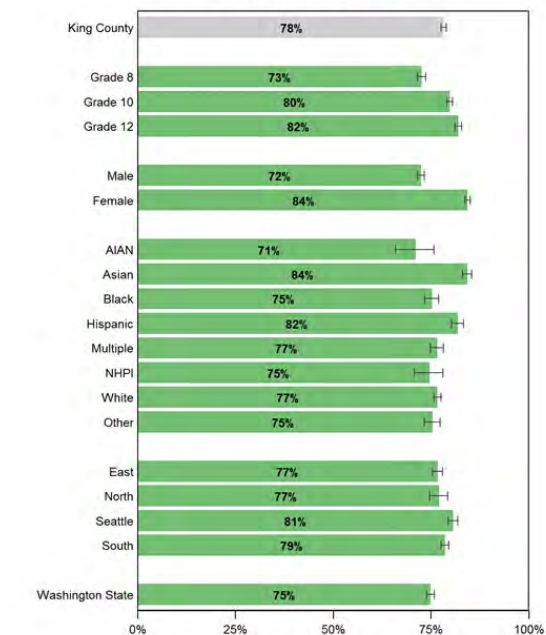
N=60,862 patients

Figure 39: Seattle Children's Patient Weight Categories by Race/Ethnicity



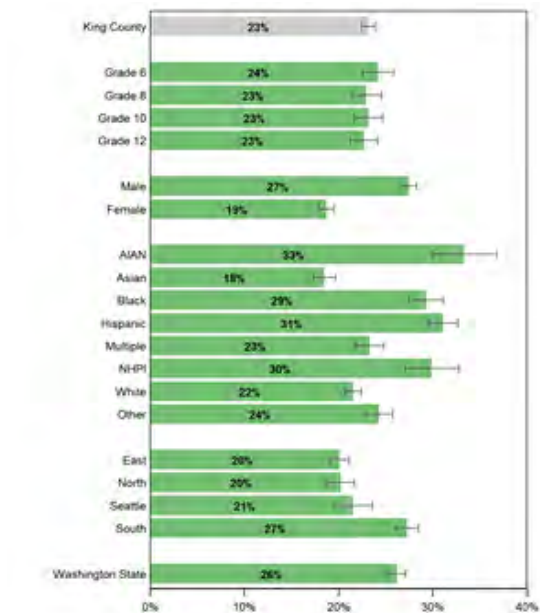
N=60,862 patients

Figure 40: Seattle Children's Patient Weight Categories by Insurance Type



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 07/2016.
— Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

Figure 41: King County Youth Physical Activity Recommendation Not Met by Subgroup, 2012 and 2014



Source: Healthy Youth Survey.
Prepared by Public Health - Seattle & King County, APDE, 07/2016.
— Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

Figure 42: King County Youth Daily Soda or Sugar Sweetened Beverage Consumption Rates by Subgroups, 2012 & 2014

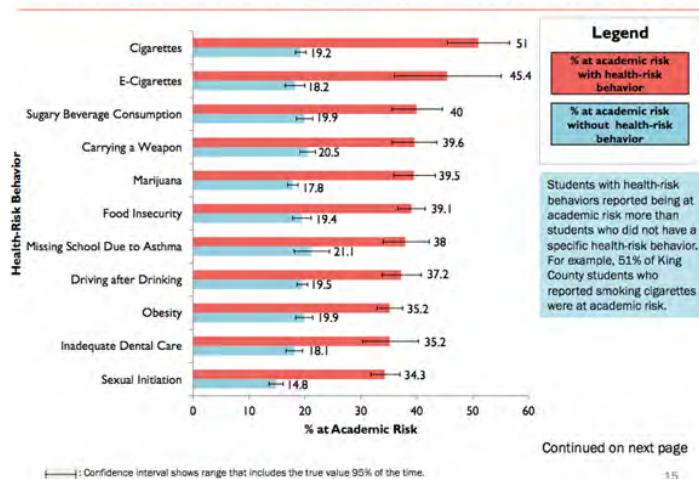


Figure 43: King County Students at Academic Risk with and without Health-risk Behavior, 2012 & 2014 Average

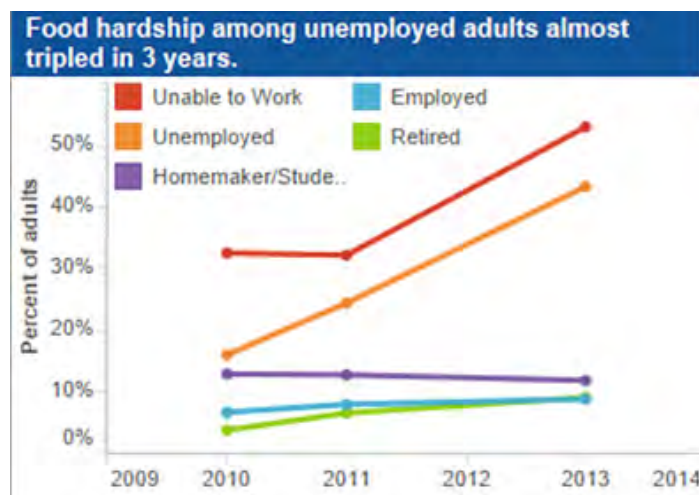


Figure 44: Food Hardship by Employment Status in King County

344 Public Health - Seattle & King County. (2016). Health Behaviors and Academic Risk: Examining the Healthy Youth Survey in King County Students. Retrieved from <http://www.kingcounty.gov/depts/health/data/-/media/depts/health/data/documents/Health-Behaviors-and-Academic-Risk.ashx>.

345 Communities Count. (2016). Food Hardship Trends in King County. Retrieved from <http://www.communitiescount.org/index.php?page=trends-by-age-education-employment-income-race-ethnicity-region>.

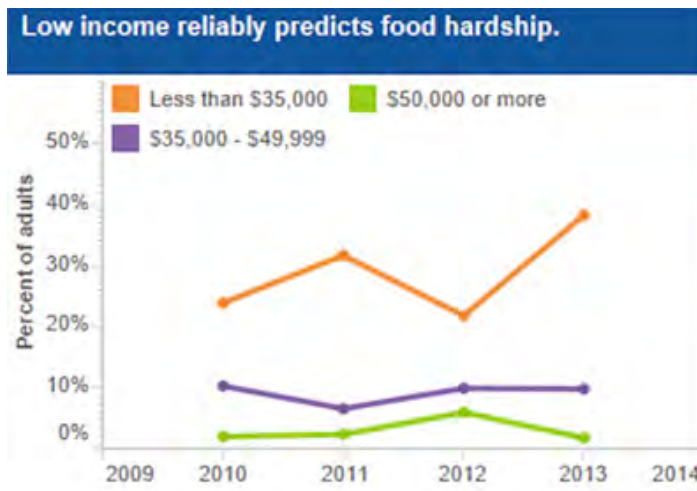
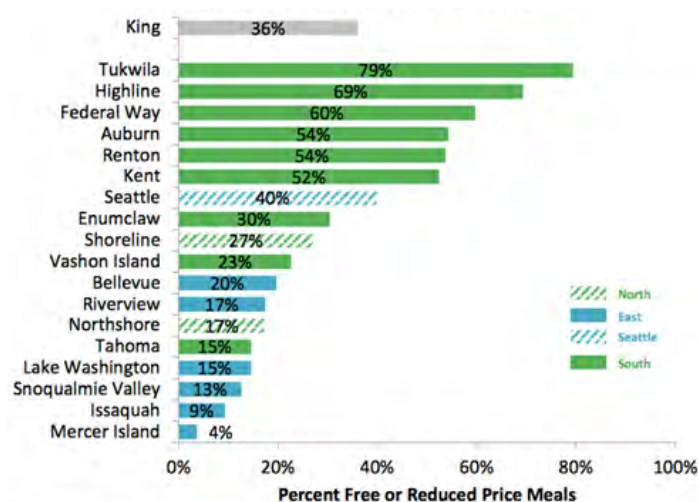


Figure 45: Income Level and Food Hardship in King County

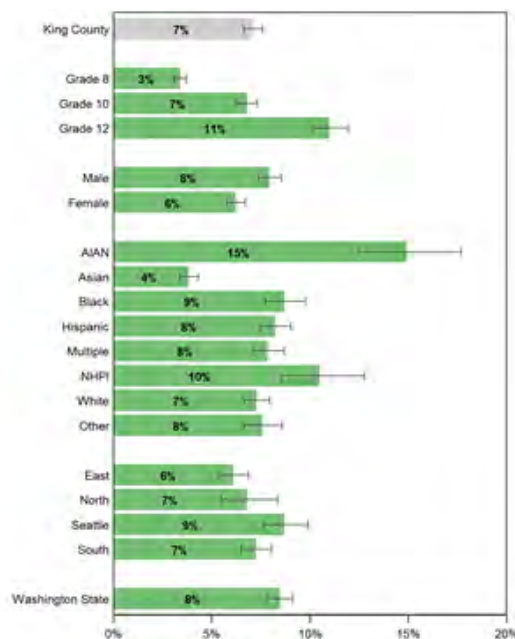


Figure 46: Child Food Insecurity in King County, 2014



Data Source: Washington State Office of Superintendent of Public Instruction
Prepared by: Public Health - Seattle & King County; Assessment, Policy Development & Evaluation Unit; 11/2014.

Figure 47: Percent of King County Public School Students with Free or Reduced Price Meals by School District, 2013-2014 School Year



Source: Healthy Youth Survey
Prepared by Public Health - Seattle & King County; APDE, 07/2016.
— Confidence interval shows range that includes true value 95% of the time.
* Too few cases to protect confidentiality and/or report reliable rates.
§ Too few cases to meet precision standard, interpret with caution.
Data by income or poverty level not available.

Figure 48: King County Youth Smoking Rates, 2012 and 2014

346 Communities Count. (2016). Food Hardship Trends in King County. Retrieved from <http://www.communitiescount.org/index.php?page=trends-by-age-education-employment-income-race-ethnicity-region>.

347 Feeding America. (2014). Child Food Insecurity in King County. Retrieved from <http://map.feedingamerica.org/county/2014/child/washington/county/king>.

Tables by Section

Employment and Income

	Median Income in Dollars	90% Margin of Error
King County	\$73,035	+/-697
Seattle	\$67,365	+/-1,101
Auburn	\$57,635	+/-2,066
Burien	\$52,140	+/-2,586
Des Moines	\$58,308	+/-3,420
Federal Way	\$54,186	+/-2,378
Kent	\$57,490	+/-2,551
Renton	\$62,949	+/-2,763
SeaTac	\$46,595	+/-4,153

Table 1. Median Household Income in King County Region, 2010-2014³⁴⁸

Leading Causes of Death

Rank	Age Groups				
	<1	1-4	5-9	10-14	15-19
1	Congenital Anomalies 94	Unintentional Injury 20	Unintentional Injury 14	Malignant Neoplasms 13	Unintentional Injury 79
2	Short Gestation 53	Congenital Anomalies 11	Malignant Neoplasms ---	Suicide 10	Suicide 57
3	SIDS 47	Malignant Neoplasms ---	Congenital Anomalies ---	Unintentional Injury ---	Homicide 12
4	Maternal Pregnancy Comp. 30	Homicide ---	Perinatal Period ---	Congenital Anomalies ---	Malignant Neoplasms ---
5	Placenta Cord Membranes 23	Influenza & Pneumonia ---	Anemias ---	Cerebrovascular ---	Heart Disease ---
6	Unintentional Injury 20	Perinatal Period ---	Chronic Lower Respiratory Disease ---		Meningitis ---
7	Necrotizing Enterocolitis ---	Heart Disease ---	Meningitis ---		Cerebrovascular ---
8	Respiratory Distress ---	Acute Bronchitis ---			Congenital Anomalies
9	Intrauterine ---	Chronic Lower Respiratory Disease			Influenza ---
10	Atelectasis & Circulatory System Disease (tie) ---	Diseases of Appendix ---			Pneumonitis ---

Note: counts less than 10 are suppressed as --- to prevent identification of individual cases.

Table 2. 10 Leading causes of death in Washington state by youth age, 2013³⁴⁹

348 U.S. Census Bureau. (2014). 2010-2014 American Community Survey 5-Year Estimates. Retrieved from <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>.

349 Centers for Disease Control and Prevention. (2016). Injury prevention and control. Retrieved from http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_lcd.html.

Leading Causes of Hospitalization

Rank	Infants (<1 year)			Age 1-14			Age 15-24		
		Rate (per 100,000)	Count (per year)		Rate (per 100,000)	Count (per year)		Rate (per 100,000)	Count (per year)
	<i>All causes</i>	102635.5	25502	<i>All causes</i>	1396.4	4563	<i>All causes</i>	3862.8	9469
1	Newborn delivery	97142.8	24137	Asthma	163.2	533	Pregnancy / childbirth complications	1609.6	3946
2	Respiratory infections	1514.8	376	Respiratory infections	158.7	519	Mental illness	717.0	1758
3	Jaundice	1332.1	331	Unintentional injuries	119.4	390	Unintentional injuries	222.3	545
4	Congenital anomalies	982.8	244	Lower gastrointestinal disorders	93.2	305	Lower gastrointestinal disorders	166.1	407
5	Urinary tract infections	317.1	79	Mental illness	92.4	301	Cancer and benign tumors	93.9	230
6	Unintentional injuries	257.6	64	Cancer and benign tumors	77.8	254	Infectious and parasitic diseases	79.1	194
7	Infectious and parasitic diseases	182.7	45	Epilepsy, convulsions	69.2	226	Self-inflicted injuries	74.0	181
8	Short gestation & low birth weight	165.8	41	Congenital anomalies	63.5	208	Diabetes with complications	66.2	162
9	Upper gastrointestinal disorders	137.6	34	Skin infections	36.4	115	Normal pregnancy & delivery	55.2	135
10	Fever of unknown origin	124.0	31	Infectious and parasitic diseases	29.4	96	Skin infections	51.6	127

Source: Washington State Department of Health, Office of Hospital and Patient Data Systems, Hospital Discharge Data. Data Prepared By: Public Health - Seattle & King County; Assessment, Policy Development, & Evaluation, 11/2016

Table 3. Leading Causes of Hospitalization by Age, King County, 2010-14 average³⁵⁰

Age Group	Average Annual Population	Average Annual Observations	Age-Spec. Rate per 100,000	95% CI
15-19	455682	107	23.4	[21.5, 25.5]
20-24	467660	215	46	[43.3, 48.8]
25-29	477620	366	76.5	[73.1, 80.1]
30-34	461542	521	112.8	[108.5, 117.2]
35-39	443680	717	161.6	[156.4, 167.0]

Table 4. Washington State Cancer Incidence Data 2009-13³⁵¹

³⁵⁰ Public Health-Seattle & King County. (2016). Leading causes of hospitalization by age, King County, 2010-2014 average.

³⁵¹ Washington State Department of Health, Washington State Cancer Registry (January 2016). Washington state cancer incidence. Results generated: Nov. 28, 2016 from <https://fortress.wa.gov/wscr>.

YEARS	< 1	1-5	6-10	11-17
All organs	3	14	12	16
Kidney	0	10	3	12
Liver	1	2	2	3
Pancreas	0	0	0	0
Kidney/ Pancreas	0	0	0	0
Heart	2	1	1	0
Lung	0	0	0	0
Heart/ Lung	0	0	0	0
Intestine	0	1	6	1

Table 5. Children and Youth on Waitlist for Organ Transplant in Washington State as of 02/26/2016³⁵²

Violence and Injury Prevention

Washington State ³⁵³		King County ³⁵⁴		
Age	Total number of homicides, average per year	Rate per 100,000 population	Total number of homicides, average per year	Rate per 100,000 population
0-4 years	47, >9	6 for ages less than 1 year, 1.9 for 1-4 year-olds	8, 2	1.6 for 1-4 year olds
5-9 years	13, 2	0.6	0	
10-14 years	10, 2	0.5	3, <1	
15-19 years	86, 17	2.9 for 15-17 year olds, 5 for 18-19 year olds	21, 4	2.6 for 15-17 year-olds, 5 for 18-19 year-olds
20-24 years	146, >29	6.2	45, 9	7.1

Table 6. Homicides among children and young adults from 2009 to 2013

³⁵² HRSA Organ Procurement and Transplantation Network. (2016). Retrieved from <http://optn.transplant.hrsa.gov/>

³⁵³ Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>

³⁵⁴ Washington State Department of Health. (2013). Washington state fatal injuries by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689146.pdf>

Washington State ³⁵⁵			King County ³⁵⁶	
Age	Total number, average per year	Rate per 100,000 population	Total number, average per year	Rate per 100,000 population
0-4 years	391, 78	81.4 for ages less than 1 year, 7.6 for 1-4 year-olds	77, 15	51.3 for ages less than 1 year, 6.4 for 1-4 year olds
5-9 years	32, 6	1.5	7, 1	1.2
10-14 years	91, 18	4.2	18, 3	3.2
15-19 years	642, 128	21.5 for 15-17 year olds, 37.8 for 18-19 year olds	216, 43	25.5 for 15-17 year-olds, 53.4 for 18-19 year-olds
20-24 years	1096, 219	46.9	342, 68	53.7

Table 7. Nonfatal assault-related hospitalizations among children and young adults from 2009 to 2013

³⁵⁵ Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>

³⁵⁶ Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>

Washington State³⁵⁷ King County³⁵⁸

Age	Total number, average per year	Rate per 100,000 population	Leading cause	Total number, average per year	Rate per 100,000 population	Leading cause
0-4 years	204, 40	28.3 for ages less than 1 year, 7.5 for 1-4 year-olds	Suffocation and drowning	19, 4	6.8 for ages less than 1 year, 3.2 for 1-4 year olds	Suffocation
5-9 years	62, 12	2.9	Motor vehicle accidents	16, 3	2.8	Fire and motor vehicle accidents
10-14 years	76, 15	3.5	Drowning, motor vehicle accidents	12, 2	2.2	Motor vehicle accidents
15-19 years	383, 76	12.1 for 15-17 year olds, 23.6 for 18-19 year olds	Motor vehicle accidents, poisoning	76, 15	8.1 for 15-17 year-olds, 20 for 18-19 year-olds	Motor vehicle accidents, poisoning
20-24 years	716, 143	30.6	Motor vehicle accidents, poisoning	163, 32	25.6	Motor vehicle accidents, poisoning

Table 8. Unintentional injury deaths among children and young adults from 2009 to 2013

Washington State³⁵⁹ King County³⁶⁰

Age	Total number, average per year	Rate per 100,000 population	Total number, average per year	Rate per 100,000 population
0-4 years	4276, 855	326.5 for ages less than 1 year, 223.9 for 1-4 year-olds	1179, 235	318.2 for ages less than 1 year, 226.2 for 1-4 year olds
5-9 years	2290, 458	105.8	553, 110	96.3
10-14 years	3048, 609	139.5	665, 133	119.6
15-19 years	5712, 1142	240.9 for 15-17 year olds, 264.7 for 18-19 year olds	1261, 252	204.1 for 15-17 year-olds, 232.2 for 18-19 year-olds
20-24 years	6739, 1347	288.2	1655, 331	259.9

Table 9. Unintentional injury hospitalizations among children and young adults from 2009 to 2013

Washington State³⁶¹ King County³⁶²

Age	Total number	Average per year	Total number	Average per year
0-4 years	26	5	3	<1
5-9 years	27	5	6	1
10-14 years	27	5	5	1
15-19 years	195	39	34	7
20-24 years	304	60	66	13

Table 10. Motor vehicle deaths among children and young adults from 2009 to 2013

Washington State ³⁶³			King County ³⁶⁴	
Age	Total number	Average per year	Total number	Average per year
0-4 years	168	33	49	10
5-9 years	226	45	53	10
10-14 years	361	72	87	17
15-19 years	1,414	282	285	57
20-24 years	1,711	342	387	77

Table 11. Motor vehicle injury hospitalizations among children and young adults from 2009 to 2013

357 Washington State Department of Health. (2013). Washington state fatal injuries. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689152.pdf>.

358 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

359 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

360 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

361 Ibid.

362 Washington State Department of Health. (2013). Washington state fatal injuries by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689146.pdf>.

363 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689155.pdf>.

364 Washington State Department of Health. (2013). Washington state nonfatal injury hospitalizations by county. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/689145.pdf>.

Appendix D: Evaluation of Our Community Benefit Implementation Plan

Background

The federal government updated the community benefit requirements for tax exempt hospitals, starting in 2019, to include evaluating the impact of the actions taken to address the significant health needs identified in their prior community health assessment. While we realize that we are not mandated to evaluate our 2013-2016 community benefit initiatives, we do so in advance of being required to in large part because of our vision to be an innovative leader in pediatric health and wellness through our unsurpassed quality, clinical care, relentless spirit of inquiry, and compassion for children and their families.

Together with our partners in the community, we made significant progress in each of the five priority areas of our 2013-2016 Community Benefit Plan, developed in response to the most urgent health and safety needs of the children, teens and families in Washington state and King County identified through our first Community Health Assessment (2013). In this report we aim to document results of our priority area strategies implemented over the past three years.

Summary

5 Community Benefit Priorities/ 15 Strategies/47 Projects

- 9 Closed successfully
- 21 On target/ongoing
- 4 Some issues
- 3 On hold
- 0 Critical issues

Results

1. Access to High-Quality Healthcare

Highlights:

- Dollars provided in uncompensated care from 2013 to 2016: \$349.5 million
- Contributions to community organizations in 2013-2016: \$2.6 million
- Number of staff certified to be Washington Health Benefit Exchange Navigators: 9

1.1: Keep our promise to provide healthcare to all children in the WAMI region regardless of ability to pay.

- We educated families on how to obtain the insurance coverage they needed for their children's healthcare. We informed patients 18 to 21 years old about their insurance options as young adults, established a dedicated phone line to answer questions from families and shared information online. We also educated state and federal decision makers about the importance of ensuring that all insurance plans in the Exchange offer all pediatric specialty services within their provider networks.

1.2: Increase access to mental and behavioral healthcare.

- The Health Coalition for Children and Youth - a statewide advocacy group chaired by Seattle Children's that works to promote policies to improve child health - helped pass legislation to improve the state's child mental health system during the 2015 legislative session.

2. Coordinated Care for Children and Teens with Chronic Conditions

Highlights:

- Number of patients participating in the Pediatric Partners in Care program: 4,200

- Number of organizations using the Pediatric Medical Complexity Algorithm: +20

2.1: Enhance care coordination.

- In 2014, Seattle Children's won a \$5.56 million innovation grant from the Centers for Medicare and Medicaid Services to create Pediatric Partners in Care (PPIC). This pilot program aims to improve outcomes and reduce the cost of caring for 3,000 disabled children in King and Snohomish counties who receive Supplemental Security Income benefits from Medicaid. We do a good job at caring for patients who have complex healthcare needs such as those enrolled in PPIC. We can do a better job at keeping track of them when they're not in the hospital and consistently coordinate care with their other providers. PPIC helps us improve coordination and communication with patients' families, providers, specialists and other hospitals involved in caring for these patients.

2.2: Develop a method to identify and track children and teens with chronic conditions.

- We developed the Pediatric Medical Complexity Algorithm, which distinguishes patients who are medically complex from those who are not in order to optimize the allocation of limited resources. The algorithm is publically available and being used by many organizations nationwide, as well as at Seattle Children's.

2.3: Develop an adolescent health transition structure and process.

- Ten clinics, centers and departments at Seattle Children's have structures in place to support families with adolescent health transition. Also, we now work closely with and refer patients to the Transition Clinic at the University of Washington.

3. Equity and Access in South King County

Highlights:

- Number of people who provided input about the health of South King County communities: 211 children and youth, parents and caregivers, and community organization staff
- Number of cities benefitting from Partners in Community Health (PICH): 39 out of 39 cities in King County

3.1: Learn about the interests, strengths and needs of South King County residents and communities.

- We used a variety of strategies to learn about the health of South King County communities, including review of existing assessments and city plans, a tour of South King, interviews, and listening groups with children, teens, parents/caregivers, and community leaders. Also, two dozen youth described health in their communities through photos.

3.2: From a place of learning and humility, connect with businesses, government, healthcare providers and communities to help link economic vibrancy and health.

- We opened Seattle Children's South Clinic in Federal Way to expand pediatric specialty care for families in south King and north Pierce counties. The clinic offers 15 specialty clinics, an urgent care clinic, imaging center, laboratory and infusion center.
- We increased the number of collaborations and partnerships with organizations that serve the South King County communities. Before 2013, our involvement in the area was limited to participating in a couple of community events. Now we have trusted relationships with organizations such as the Healthy King County Coalition, International Community Health Services, International Rescue Committee, South King County Council of Human Services, WA-CAN, and many others.

3.3: Work with communities on their goal for culturally respectful, educational and positive media stories.

- Media highlights about the many successes of joint efforts between Seattle Children's and partners such as Public Health – Seattle & King County, the Healthy King County Coalition and community organizations contributed to efforts to change how South Seattle and South King County are depicted in the local news.

4. Obesity

Highlights:

- Number of Washington state counties represented in meetings to promote the use of a common healthy eating and active lifestyle message: 22
- External funding received and dedicated to obesity prevention: over \$10 million
- Number of Healthier Hospital Initiative challenges that Seattle Children's is pursuing: 6 of 6

4.1: Educate caregivers, providers and community leaders to be wellness advocates and promote policy change.

- Clinicians and community partners agreed on an evidence-based message to promote healthy eating and active lifestyles: 7-5-2-1-0. We conducted trainings, created healthcare provider packets, developed a toolkit with activities to teach children about healthy choices, and promoted 75210 through media, social media outlets and community events. In partnership with many partners, we hosted meetings attended by 79 representatives from 22 counties to build a collective movement to use the messages. We distributed and taught 75210 messages/materials to over 4,671 youth and their families in 2016 at 9 events in King County.
- Everyone Swims brought together over 20 community clinics, pools and water recreation programs to improve access to

swimming and water recreation among low income and racially/ethnically diverse communities. Thanks to this program, applying for swim class scholarships is easier and available in multiple languages; clinic screening for swim ability is embedded in electronic medical records or well child checklists; single gender swims are allowed as part of public swim programs; and pool swim lesson registration increased.

4.2: Partner with community organizations for obesity prevention programs.

- In Washington state, 43 hospitals are participating in the Healthier Hospitals Initiative. Seattle Children's is one of only four hospitals that have committed to all six challenges, which include purchasing and serving healthier foods and beverages to patients, employees, visitors and the communities we serve.
- Actively Changing Together! (ACT!), a Seattle Children's and YMCA program to help children who are obese and overweight and their families lead healthier lifestyles, has grown from four Seattle-area YMCAs when it started to 17 locations statewide.
- The Community Transformation Grant (CTG), co-led by Seattle Children's, Public Health – Seattle & King County and the Healthy King County Coalition, provided over \$2 million to 19 organizations in South Seattle and South King County to develop, implement or support policies related to healthy eating and physical activity. As a result, two school districts implemented new physical activity curricula, and access to healthy beverages like water and availability of healthy foods in school cafeterias and hospitals increased.
- Partners in Community Health (PICH) has continued and expanded the work of CTG with an investment of \$8 million over 3 years into partnerships and projects to foster communities that support health. PICH's 29 different projects in King County build

healthy and affordable food systems, create physically active communities, and reduce tobacco use/exposure among families and youth.

4.3: Advocate for stronger insurance coverage for obesity.

- In 2013, we assessed the state of insurance coverage for obesity by interviewing insurance and medical experts, surveying health insurance companies and employee benefits staff of children's hospitals across the nation, and reviewing published insurance policies and billing data from Seattle Children's. Half of the insurers surveyed do not cover any services to treat obesity in youth.
- More patients and families have obesity reimbursement coverage because obesity reimbursement has improved over time. We are part of a broader advocacy effort to address this issue, for example serving on the Executive Committee of the American Academy of Pediatrics Section on Obesity, which is interested in obesity reimbursement.

5. Mental and Behavioral Health

Highlights:

- Increase of number of inpatient beds for children and teens needing psychiatric care: from 20 to 41
- Percentage of patients seeking mental health services in the Emergency Department who have care plans: 100%
- Centers of Excellence with ongoing research studies: 4 of 4

5.1: Increase number of inpatient beds for children and teens needing psychiatric care.

- We have doubled our previous bed capacity so we can better meet the community's pressing need for greater mental health services. Our Psychiatry and Behavioral Medicine Unit has 41 single-patient rooms plus a family reception area, a classroom,

a comfort room, a dining area, an exercise/recreation area and a designated space for the Autism Spectrum Disorders Program.

5.2: Sustain mental health care support in the Emergency Department as a safety net.

- Every patient who seeks mental health services in the Emergency Department and is waiting for admission receives a care plan. Those patients discharged from the ED receive a crisis plan.

5.3: Develop research portfolios in four Centers of Excellence (Disruptive Behavior Disorders, Mood Disorders, Pediatric Psychology and Autism) to improve outcomes and better serve healthcare providers and patients with complex behavioral health conditions.

- Researchers at Seattle Children's studied an intervention that integrates mental health treatment into primary care by having teens diagnosed with depression meet with a care manager in the primary care clinic. In a study comparing two groups, we found 86% of the intervention group received evidence-based treatment for their depression versus only 27% of those whose primary care doctor refers them to mental health specialists. In addition, 67% of the first group had at least a 50% reduction in depression symptoms compared to 39% of the second.
- OwlOutcomes, a program developed by researchers from Seattle Children's and the University of Washington, monitors mental health treatment objectively. The program uses computerized surveys to track progress between each therapy session. Parents and patients (if they're old enough) respond to statements in the surveys about the severity of their symptoms. The responses are plotted on graphs that show how the severity changes over time. All of the providers in our Psychiatry and Behavioral Medicine Clinic were trained to use the program.

5.4: Foster and sustain collaborations for mental and behavioral health continuum of care.

- Our Partnership Access Line (PAL) offers mental and behavioral health telephone consultation to primary care providers when they need help caring for patients showing symptoms of mental health issues. Child psychiatrists from Seattle Children's and the University of Washington School of Medicine help providers across Washington and Wyoming diagnose conditions, prescribe treatment, make referrals and guide families to resources in their home community.
- Seattle Children's opened the Alyssa Burnett Adult Life Center to help young adults with developmental disabilities and their families find resources in the community to meet many of their unique educational and social needs. It offers classes ranging from music to fitness to cooking and provides a gathering place for young adults with developmental disabilities of all kinds.

Looking Forward

Our community benefit evaluation is an ongoing process of asking and answering questions about the quality and effectiveness of our strategies to address identified pediatric health and safety needs. We endeavor to collect information about our hospital's activities and the impact of programs we offer on community health. We attempt to use this information to make informed decisions about the program, including how to address future health needs.

During 2013 to 2016 we sought to make a positive impact in five priority areas by embarking on 15 strategies and 47 projects. In total, we proudly accomplished 19, are continuing the good work of 21, are reevaluating the impact of 4 and are pausing 3; all in all a successful three year effort. To learn more about our Community Benefit work, please visit: www.seattlechildrens.org/communitybenefit

Seattle Children's Community Benefit Implementation Plan 2013-2016 Progress Report

Last updated September 2018

CB Priority	Anticipated Impact	Project/Tactic	Status
Access to High Quality Healthcare	Access to high quality care for every child.	Advocacy for Medicaid & Apple Health for Kids	▲
		Enrollment of youth in Apple Health for Kids	▲
		Utilizing Emergency & Urgent Care: the right care at the right time	▲
		Partnerships to improve access including Health Coalition for Children and Youth, Pediatric Partners in Care and CIN	▲
		Family education about accessing health care	▲●
		Financial assistance up to 400% Federal Poverty Line	▲●
		Exchange promotion with King County Hospitals for a Healthier Community (KCHHC)	▲●
		Monitoring and advocating for changes in new health care environment focusing on network adequacy	▲
	Increased access to Mental and Behavioral Health.	Legislative policy priorities	▲
		Coalition participation	▲●
		Expansion of Partnership Access Line	○
Coordinated Care for Children with Chronic Conditions	Greater understanding of needs/assets, new models, improved government policies.	Assessment	▲
		Education to policymakers	▲
		Cost effective sites of care partnerships including Pediatric Partners in Care CMS grant	▲
	Successful method(s) identified, researched and analyzed.	Parameters to identify patients who would benefit most from care coordination	▲
		Review of other registries	▲
		Dissemination of Pediatric Medical Complexity Algorithm	▲●
	Shared care plan across providers and caregivers developed and piloted.	Shared care plan assessment	▶
		Shared care plan process, system at Seattle Children's	▶
		Exploration of care management models	▶
	Adolescent and Young Adult health transition system developed.	Health transition assessment	▲●
		Health transition toolkit	▲●
Measures to identify which patients are meeting transition goals		○	
Health Equity and Access in South King County (SKC)	Better understand interests, strengths and needs of South King County.	SKC needs, strengths assessments review	▲●
		Inclusion of assets on King County Hospitals CHNA	▲●
		SKC asset mapping	▲●
	Partnerships with South King County organizations to help link economic. vibrancy & health	Community interests via comm. cafés, focus groups, photo voice	▲●
		Partnerships with community, health care organizations & others	▲
		Implementation of new collaborations & partnerships	▲
	Support respectful, educational & positive media.	Media assessment	▲
		Communication plan to promote positive media agenda	▲
Obesity	Caregivers, providers & community leaders deliver consistent health eating active living (HEAL) messages, understand impact of policy change and are empowered to promote it.	Development of common HEAL messaging	▲●
		Implementation action for each of the #s within 75210	▶
		Common obesity message education	▲●
		HEAL policy promotion	▲
		Hospital food and beverage improvements	▲
		Active in KCHHC obesity initiative	▲●
	Children's & partners obtain funding to develop campaign to prevent & eliminate childhood obesity.	Assessment of obesity priorities by local funders	▲
		Community capacity HEAL policy through Community Transformation Grant	▲
	Experts agree on obesity benefit for staff & dependents, partner with Human Resources. Children's creates obesity benefit, discuss a pilot program with state.	Obesity coverage assessment	▲●
Staff & dependents obesity coverage exploration		▲●	
Mental and Behavioral Health	Inpatient psychiatric beds are available when needed.	Psychiatric inpatient bed increase	▲●
	Patients/families have access to emergent mental health evaluations. Patients going to ED are referred to appropriate resources for treatment.	24/7 mental and behavioral services in the Emergency Department	▲
		Mental/behavioral health care plan in the Emergency Department	▲●
	Increased knowledge of evidence-based treatments among mental health providers.	Research on mental and behavioral health treatments, including improved outcomes for patients in treatment	▲●
	Care is coordinated and consistent. Improved access to consultation services.	Clinical pathways across continuum of mental health services established	▲
		Mental health consult expansion	○

Project Status Legend:

▲ On Target/Ongoing ▶ Some Issues ▼ Critical Issues ○ Proposed/On Hold ● Closed



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