Objective #2 – Health Care Facilities and Services Plan

Purpose and Scope

RCW 43.370.030(3)(b)(i–iv) requires that the State Health Plan and Resource Strategy include a **health care facilities and services component** that:

1. Provides an inventory of existing health care facilities and services in each geographic region of the state.
2. Projects the future need for different types of health care facilities and services, including those subject to certificate of need (CON) review.
3. Identifies policies to guide the addition or expansion of health care facilities and services to promote high-quality, evidence-based, and cost-effective health care delivery.
4. Assesses the availability of the infrastructure needed to support health care facilities and services in each region, including health care providers, public health resources, transportation systems, and other supporting resources.

I. Inventory of Existing Health Care Facilities and Services

RCW 43.370.030(3)(b)(i)

The first component of the health care facilities and services plan is a comprehensive inventory of the existing health care infrastructure across Washington. This inventory provides a baseline understanding of the current supply of health care facilities and services within each Accountable Community of Health (ACH).

How to Read the Inventory Tables

The inventory of existing health care facilities and services is organized into several tables that reflect different components of the health care delivery system. Each table focuses on a specific category of facilities or services and is structured to support later analysis of health system capacity and access across Accountable Communities of Health (ACHs).

The tables are organized as follows:

Table	Content	Purpose
Table 1	Institutional / bed-based licensed facilities	Identifies freestanding inpatient facilities that provide acute, behavioral health, rehabilitation, or end-of-life care.
Table 2	Community-based / outpatient licensed entities	Describes the outpatient clinical infrastructure that supports primary care, specialty care, behavioral health treatment, and other ambulatory services.
Table 3	Residential care and long-term care capacity	Captures residential care settings that provide ongoing support services for aging populations, individuals with disabilities, and people with behavioral health needs.
Table 4	Bed-based hospital service lines	Describes inpatient service capacity embedded within hospitals, including medical/surgical beds and specialized inpatient units.
Table 5	Hospital-based clinical specialty service lines	Identifies high-intensity specialty services such as cardiac procedures, oncology treatment, and transplant programs.
Table 6	Hospital designations and classifications	Lists hospitals with specialized designations that support regional emergency, trauma, maternal, and specialty care systems.

Together, these tables provide a comprehensive overview of the facilities and services currently available in each region. By examining both facility counts and operational capacity (such as staffed beds and service volume), the inventory helps identify areas where the health system may be experiencing capacity constraints, geographic access challenges, or reliance on a limited number of providers.

The inventory also distinguishes between facilities that are subject to CON review and those that are not. This distinction is important for understanding where the state has regulatory oversight of capacity expansion and where capacity is largely determined by market conditions.

A. Institutional/Bed-Based Licensed Facilities

Institutional inpatient facilities represent the core clinical infrastructure of the health care system. These facilities provide acute, behavioral health, rehabilitation, and other inpatient services that support patients requiring hospital-level or residential medical care. Assessing the number, capacity, and geographic distribution of these facilities helps determine whether regions have sufficient inpatient infrastructure to meet current demand and respond to fluctuations in utilization.

Table 1. Institutional/bed-based licensed facilities by ACH
(License-based — freestanding institutions only; exclude hospital service lines or designations)

ACH	Licensed Institutional Facility Type	Facility Count	Licensed Beds[1]	Staffed Beds[2]	Avg Daily Census (ADC)[3]	Available Beds[4]	Occupancy %[5]	CON-Subject (Y/N)	Notes
	Acute Care Hospitals							Y	
	Alcohol & Chemical Dependency Hospitals							Y	
	Freestanding Inpatient Rehabilitation Hospitals							Y	
	Private Psychiatric Hospitals							Y	

ACH	Licensed Institutional Facility Type	Facility Count	Licensed Beds[1]	Staffed Beds[2]	Avg Daily Census (ADC)[3]	Available Beds[4]	Occupancy %[5]	CON-Subject (Y/N)	Notes
	Residential Hospice Facilities							Y	
	Residential Treatment Facilities (RTF)							Y	

Definitions:

1. **Licensed Beds:** Maximum number of beds authorized under state facility licensing.
2. **Staffed Beds:** Beds that are operational and available for patient care based on staffing levels and operational decisions.
3. **Average Daily Census (ADC):** Average number of patients occupying licensed inpatient beds during the reporting period.
4. **Available Beds (Staffed Beds – ADC):** Staffed beds that are not occupied.
5. **Occupancy (%) (ADC÷Staffed Beds):** Utilization of staffed beds during the reporting period.

Key questions for Table 1:

1. What is the current level of institutional inpatient capacity in each ACH when considering facility counts, licensed beds, staffed beds, and utilization levels (ADC)?
2. How large is the gap between licensed beds and staffed beds, and how much capacity is unavailable due to staffing limitations?
3. How much staffed capacity remains available after accounting for current utilization (available beds)?
4. Are occupancy rates persistently above typical operating ranges (e.g., 85–90 percent), indicating limited surge capacity?
5. Are certain institutional facility types—such as psychiatric, rehabilitation, or behavioral health facilities—operating near or at capacity?
6. How are institutional facilities distributed geographically across each ACH?
7. Are there significant rural or underserved areas with limited access to inpatient services?
8. What behavioral health inpatient infrastructure exists within each region?
9. Is residential hospice capacity sufficient relative to end-of-life care needs, including inpatient hospital deaths?

10. Are there trends indicating declining staffed capacity at existing facilities?
11. Have any facilities experienced closures, service suspensions, or reductions in inpatient services?

B. Community-Based and Outpatient Licensed Entities

Community-based and outpatient providers support preventive care, chronic disease management, behavioral health treatment, and other services that can reduce the need for hospitalization. Assessing the availability and distribution of these facilities helps identify whether outpatient care infrastructure is sufficient to support population health and prevent avoidable inpatient utilization.

Table 2. Community-based / outpatient licensed entities by ACH

ACH	Licensed Entity Type	Facility Count	Core Capacity Measure #1	Core Capacity Measure #2	# Tribal / IHS Sites	# School-Based Sites	# FQHC / RHC Sites	CON-Subject (Y/N)	Notes
	Ambulatory Surgical Centers		OR / Procedure Rooms	Annual Cases					
	Behavioral Health Agencies (BHA)		Clinic Sites / Programs	Clinician FTE					
	Birthing Centers		Delivery Rooms	Annual Births					
	Blood Establishments		Units Collected	Storage Capacity					
	Diagnostic Imaging Centers		MRI / CT Units	Annual Scans					
	Freestanding Primary Care Clinics		Clinic Sites	PCP FTE					
	Freestanding Specialty Clinics		Clinic Sites	Specialist FTE					
	Home Care Agencies		Clients Served	Caregiver FTE					

ACH	Licensed Entity Type	Facility Count	Core Capacity Measure #1	Core Capacity Measure #2	# Tribal / IHS Sites	# School-Based Sites	# FQHC / RHC Sites	CON-Subject (Y/N)	Notes
	Home Health Agencies		Patients Served	RN/Therapy FTE					
	Medical Laboratories		Test Volume	Specialty Capability					
	Medical Test Sites		Test Volume	Service Type					
	Non-Residential Hospice Agencies		Patients Served	% Home Deaths					
	Nursing Pools / Staffing Agencies		Agencies	Clinicians Supplied					
	Opioid Treatment Programs		Programs	Daily Patient Capacity					
	Outpatient Rehabilitation Practices (PT / OT / SLP)		Clinic Sites	Therapist FTE					
	Pharmacies		Pharmacy Count	Hours per Week					
	Renal Dialysis / ESRD Centers		Stations / Chairs	Shifts per Day					
	Stand-Alone Emergency Departments		Treatment Bays	Annual Visits					
	Urgent Care Centers		Treatment Bays	Annual Visits					

Key questions for Table 2:

1. What types and how many community-based and outpatient licensed entities operate within each ACH?
2. What is the relative supply of different outpatient service types (e.g., primary care clinics, specialty clinics, behavioral health agencies, dialysis centers, and ambulatory surgical facilities)?
3. What do capacity indicators (such as clinic sites, provider FTE, treatment stations, or procedure rooms) suggest about the scale of outpatient services available in each region?
4. What behavioral health outpatient infrastructure exists within each ACH (e.g., behavioral health agencies and opioid treatment programs)?
5. What safety-net outpatient infrastructure exists within each region based on the number of Tribal/IHS sites and FQHC/RHC sites?
6. What school-based health service infrastructure exists within each region?
7. How much of the outpatient system falls under certificate of need (CON) review?
8. Are certain outpatient service types represented by only a small number of facilities within an ACH?

C. Residential Care and Long-Term Care Capacity

Residential care settings provide housing and supportive services for individuals who require assistance with daily living or long-term care. These settings play an important role in the health care continuum by providing alternatives to hospital-based care and supporting aging populations and individuals with complex needs.

Table 3 Residential care and long-term care capacity by ACH

ACH	Residential Care Facility Type	Facility Count	Licensed Beds / Units	Staffed Beds / Units	Avg Daily Census (ADC)	Occupancy %	CON-Subject (Y/N)	Notes
	Adult Family Homes							
	Assisted Living Facilities							
	Enhanced Services Facilities							
	Nursing Homes (Skilled Nursing Facilities / Long-Term Care Centers)							
	Supported Living / Developmental Disabilities Residential Programs							

Key questions for Table 3:

1. What types and how many residential care facilities operate within each ACH?
2. What is the total licensed and staffed capacity of residential care facilities within each region?
3. What does average daily census (ADC) indicate about the current utilization of residential care capacity?
4. Are occupancy levels within residential care facilities persistently high, suggesting limited available capacity?
5. How does capacity vary across different residential care facility types (e.g., adult family homes, assisted living facilities, nursing homes, and enhanced services facilities)?
6. What proportion of residential care capacity is subject to certificate of need (CON) review?
7. Are certain residential care facility types represented by only a small number of facilities within an ACH?
8. Are there indications that residential care capacity is declining due to reductions in staffed beds or facility closures?

D. Bed-Based Hospital Service Lines

In addition to freestanding inpatient facilities, hospitals provide several bed-based service lines that contribute to regional inpatient capacity. These services, including medical-surgical beds, psychiatric units, rehabilitation units, and obstetric services, play a critical role in supporting patient care and managing hospital throughput.

Table 4. Bed-based hospital service lines by ACH

ACH	Hospital Service Line	# Hospitals Offering	Licensed Beds / Units	Staffed Beds / Units	Avg Daily Census	Occupancy %	CON-Subject (Y/N)	Notes
	Acute / Med-Surg Beds							
	Inpatient Psychiatric Unit		Psych Beds					
	Inpatient Rehabilitation Unit		Rehab Beds					
	OB / Labor & Delivery Unit		L&D Rooms	—	Annual Births	—		

Note: Inpatient Rehabilitation Units (IRUs) represent hospital-based rehabilitation beds. Some IRUs may also be designated as Medicare-certified Inpatient Rehabilitation Facilities (IRFs) or Washington Level I Rehabilitation Programs, which are identified separately in Table 5.

Key questions for Table 4:

1. Which inpatient service lines are available within hospitals in each ACH (e.g., medical/surgical beds, inpatient psychiatric units, inpatient rehabilitation units, and obstetric services)?
2. What is the total licensed and staffed capacity for each hospital service line within each region?
3. What does average daily census (ADC) indicate about current utilization of hospital inpatient service lines?
4. Are occupancy levels persistently high for certain inpatient service lines, suggesting limited available capacity?
5. Are certain inpatient service lines offered by only a small number of hospitals within an ACH?

6. Are there indications that hospital service line capacity is declining due to reductions in staffed beds or service closures?

E. Hospital-Based Clinical Specialty Service Lines

Some hospital-based services require highly specialized equipment, workforce expertise, and infrastructure. These services often serve patients across multiple regions and may be concentrated in a limited number of hospitals. Understanding their availability helps identify potential access gaps and regional dependencies.

Table 5. Hospital-Based Clinical Specialty Service Lines by ACH

ACH	Service Line	# Hospitals Offering	Core Capacity Measure	Annual Volume	Workforce Dependency	CON-Subject (Y/N)	Notes
	Cardiac Catheterization		Cath Labs	Annual Procedures	Interventional Cardiology		
	Level I Rehabilitation Programs (Hospital-Based)		Rehab Beds	Admissions	PM&R Specialists		Designation layered on IRU
	Oncology Chemotherapy / Infusion Services		Infusion Chairs	Annual Infusion Visits	Oncology		
	Open Heart Surgery		Hospitals Offering	Annual Cases	Cardiothoracic Surgery		
	Organ Transplant Programs		Hospitals Offering	Transplant Volume	Multidisciplinary Teams		
	Radiation Oncology Services		Linear Accelerators	Annual Treatment Courses	Radiation Oncology		

ACH	Service Line	# Hospitals Offering	Core Capacity Measure	Annual Volume	Workforce Dependency	CON-Subject (Y/N)	Notes
	Specialty Burn Services		Burn Beds / ICU Beds	Annual Burn Cases	Burn / ICU Teams		
	Therapeutic Cardiac Catheterization (PCI)		Labs Capable	Annual PCI Cases	Interventional Cardiology		

Key questions for Table 5:

1. Which specialized clinical service lines are available within hospitals in each ACH (e.g., cardiac procedures, oncology treatment, transplant programs, and burn care)?
2. How many hospitals offer each specialty service line within a region?
3. What do available capacity measures (e.g., infusion chairs, catheterization labs, or radiation therapy equipment) indicate about the scale of specialty services available?
4. What does annual service volume indicate about the utilization of these specialty services?
5. Are certain specialty services offered by only a small number of hospitals within an ACH, indicating potential concentration of specialized care?

F. Hospital Designations and Classifications

Hospital designations and classifications identify facilities that play specialized roles within the health care system. Some designations indicate advanced clinical capabilities, such as trauma care, stroke care, or maternal and neonatal levels of care. Other classifications, such as Critical Access Hospitals and Disproportionate Share Hospitals, reflect policy mechanisms that support rural access to care or hospitals serving high numbers of low-income patients. Examining the distribution of these designations helps illustrate how specialized clinical capabilities and safety-net responsibilities are structured across regions.

Table 6. Hospital designations and classifications by ACH

ACH	Designation	# Facilities	Level / Type	System Role/Policy Significance	Regional Concentration Risk	Notes
	Critical Access Hospital (CAH)		Yes/No	Rural access hospital designation		
	Disproportionate Share Hospital (DSH)		Yes/No	Safety-net hospital service high Medicaid/uninsured populations		
	Inpatient Rehabilitation Facility (IRF)*		Yes/No	Post-acute rehabilitation system role		Medicare-certified
	Level I Rehabilitation Program*		Level I	Washington CON-designated rehabilitation capacity		
	Maternal Level of Care		Level I–IV	Obstetric and maternal care capability		
	Neonatal Intensive Care Unit (NICU) Level		Level I–IV	Neonatal intensive care capability		
	Organ Transplant Center		Organ Type	Advanced tertiary care capability		
	Specialty Burn Center		Verified / Non-verified	Regional burn care capability		
	STEMI / PCI-Capable Hospital		Yes/No	Emergency cardiac intervention capability		

ACH	Designation	# Facilities	Level / Type	System Role/Policy Significance	Regional Concentration Risk	Notes
	Stroke Center		Primary / Comprehensive	Time-sensitive neurological care		
	Trauma Center		Level I–IV	Regional trauma system capability		

*Some hospitals may hold both a Medicare-certified Inpatient Rehabilitation Facility (IRF) designation and a Washington Level I Rehabilitation Program designation.

Key questions for Table 6:

1. What hospital designations exist within each ACH (e.g., trauma centers, stroke centers, STEMI-capable hospitals, maternal levels of care)?
2. How many hospitals hold each designation within the region?
3. What levels of specialized care are available for designated services (e.g., trauma level, maternal level of care, NICU level)?
4. Are certain designations held by only a small number of hospitals within an ACH?
5. Which designations indicate hospitals serving specialized regional or statewide roles?

The inventory of existing facilities and services provides the foundation for assessing whether Washington's health care infrastructure is aligned with the needs of its population. The next section builds on this baseline by projecting future demand for health care facilities and services and identifying areas where additional capacity may be needed.

II. Approach to Projections of Need

RCW 43.370.030(3)(b)(ii)

The second component of the health care facilities and services plan is to project need for each category of health care facility and service included in the inventory from the first component.

Projections of need estimate the level of service capacity required to meet projected population health needs under cost-effective, evidence-based delivery models. Analyses will be conducted at the Accountable Community of Health (ACH) level and incorporate population trends, historical utilization, access to care, and evolving models of service delivery.

Key analytical questions include:

- What population is driving demand?
- What health needs and disease prevalence influence utilization?
- What is current level of capacity?
- What are utilization trends?
- What gap exists between projected need and capacity?

A. Guiding principles:

Projections are intended to inform planning and policy decisions and should not simply extend existing supply. Analyses should:

- Use **population projections** that reflect demographic drivers of health care utilization.
- Identify **demand drivers** for each facility and service category.
- Account for **changes in care delivery**, including shifts toward outpatient, telehealth, and home-based services.
- Evaluate whether capacity is **insufficient, adequate, potentially excessive, or geographically concentrated**.

B. Types of projections

Two complementary projection approaches are used.

1. **Capacity-based projections** estimate the number of physical or programmatic resources required to meet demand (e.g., beds, sites, programs)

2. **Volume-based projections** estimate service utilization levels that inform capacity planning (e.g., surgical procedures, ICU days, dialysis sessions, psychiatric admissions)

C. Standardized Methodology for ACH Projections:

The following steps are used to project need across facility and service categories.

1. Define the Unit of Analysis

Determine the facility or service category being evaluated and the planning horizon. Units of analysis may include beds, facilities, service lines, procedure volumes, or designation levels.

2. Establish Effective Capacity

Assess operational capacity rather than licensed maximums. Indicators may include staffed beds, active service lines, operating hours, and recent service volumes.

3. Population and Demographic Adjustment

Anchor projections in population trends by applying age-stratified population forecasts and growth in demographic groups associated with higher utilization.

4. Utilization Trend Analysis

Examine historical utilization patterns over a three-to-five-year period, including admissions, procedures, visits, length of stay, and emergency department use. Analyses may account for policy changes or temporary disruptions such as COVID-19.

5. Delivery Model Adjustment

Consider anticipated changes in care delivery that may influence demand, including shifts from inpatient to outpatient services, telehealth expansion, home-based care, and community-based behavioral health services.

6. Access Performance Indicators

Evaluate whether patients experience barriers to obtaining care. Indicators may include travel time to services, transportation infrastructure, appointment wait times, Medicaid acceptance, and patient-reported experience.

7. Translate Demand into Capacity Units

Convert projected service volume into the capacity required to meet demand at sustainable utilization levels, using factors such as projected admissions, length of stay, occupancy targets, or evidence-based volume standards.

8. Gap Assessment

Compare projected demand with effective capacity to determine whether a region experiences:

- A capacity deficit
- Adequate capacity
- Potential excess capacity
- Geographic concentration or maldistribution

Interpretation should consider both quantitative indicators and stakeholder input.

D. Data inputs:

Projections analyses may incorporate multiple data sources, including:

- Population forecasts and demographics trends
- Admissions, procedure counts, visit volumes, and length-of-stay trends
- Utilization of outpatient and community-based services
- Workforce supply and service growth trends
- Expansion of behavioral health service models
- Access indicators – drive times/travel distance, wait times, emergency department boarding (behavioral health focus), provider participation, appointment availability, patient experience

E. Output

Projection analyses produce three primary outputs:

1. **Population demand** for services
2. **Effective capacity** available within each region
3. **Access indicators** reflecting the population's ability to obtain care

Together, these outputs support identification of capacity gaps, geographic disparities, and potential areas of excess supply and inform subsequent policy guidance and regional support assessments.

III. Planning Framework for the Addition or Expansion of Health Care Facilities and Services

RCW 43.370.030(3)(b)(iii-iv)

The third and fourth components of the health care facilities and services plan interpret the potential service gaps identified by the projections of need. Projections of need described in Section II incorporate population trends and service utilization patterns over time. Identification of projected need does not necessarily imply that new facilities or services should be developed. Additional analysis is required to determine whether service expansion is appropriate and feasible.

The planning framework described in this section incorporates two related components:

- **Policy considerations** used to evaluate whether expansion of services aligns with quality, evidence-based, and cost-effective health care delivery; and
- **Regional resource assessments** used to determine whether the workforce, public health systems, transportation infrastructure, and other regional resources necessary to support proposed services are available.

Together, these components help ensure that decisions regarding the addition or expansion of health care facilities and services promote:

- timely and equitable access to care
- high-quality health outcomes
- efficient and cost-effective use of health system resources

A. Policies to Guide the Addition of New or Expanded Health Care Facilities and Services

RCW 43.370.030(3)(b)(iii)

Policy considerations are used to evaluate whether expansion of health care facilities or services supports statewide health system objectives related to access, quality, health outcomes, and cost-effectiveness.

These considerations may include factors such as timely access to care, health equity, evidence-based delivery models, quality of care, cost-effectiveness, financial sustainability, duplication of services, and the potential impact of provider market structure.

Table 7 summarizes the policy and planning considerations and potential indicators or data sources that can be used to assess these measures.

Table 7. Policy considerations to guide the addition or expansion of health care facilities and services

Policy Consideration	Planning Consideration	Why It Matters	Potential Indicators / Data Sources	Analytic Method
Timely Access to Care	Evidence of delays obtaining care, such as long appointment wait times, emergency department boarding, or limited service availability	Indicates potential service capacity gaps		
Health Equity	Whether expansion would reduce disparities in access or health outcomes among geographic, racial, or socioeconomic populations	Supports equitable access to care		
Evidence-Based Delivery Models	Whether needs could be addressed through outpatient, telehealth, home-based, or community-based care models	Encourages efficient care delivery		
Quality of Care	Whether sufficient patient volume and clinical expertise exist to maintain high-quality outcomes	Protects quality and safety		
System Cost Impact	Whether expansion supports efficient use of health system resources	Supports sustainable health system spending		
Financial Sustainability	Whether projected patient volume and payer mix are sufficient to sustain services over time	Supports long-term service stability		
Duplication of Services	Whether expansion would create excess capacity without improving access or outcomes	Avoids unnecessary duplication		

Policy Consideration	Planning Consideration	Why It Matters	Potential Indicators / Data Sources	Analytic Method
Market Structure and Competition	Whether provider consolidation or service concentration may limit access or patient choice	Considers market impacts on service availability		

B. Assessment of Regional Resources and Infrastructure Supporting Health Care Facilities and Services

RCW 43.370.030(3)(b)(iv)

In addition to policy considerations, evaluation of potential service expansion must include an assessment of regional resources and infrastructure necessary to support health care facilities and services.

These resources may include the availability of health care providers, public health capacity, transportation infrastructure, emergency medical services, clinical support infrastructure, community-based care services, referral networks, and residential or long-term care capacity.

Tables 8-10 summarize the regional resources and infrastructure factors considered in assessing the feasibility of service expansion.

Regional resources and infrastructure supporting health care facilities and services

Table 8. Workforce and Public Health Capacity

Infrastructure Area	Planning Consideration	Why It Matters	Potential Indicators / Data Sources	Analytic Method
Health Workforce	Availability of clinicians and support staff needed to operate the service	Workforce shortages may limit feasibility		
Public Health Resources	Capacity of local public health systems to support prevention, coordination, and population health needs	Supports continuity of care and population health		

Table 9. Physical and Transportation Infrastructure

Infrastructure Area	Planning Consideration	Why It Matters	Potential Indicators / Data Sources	Analytic Method
Geographic Access	Whether services are located within a reasonable travel distance for the population served	Distance may create access barriers		
Transportation Infrastructure	Availability of transportation systems enabling patients to reach services	Important for rural and underserved populations		
Emergency Medical Services (EMS)	Capacity of emergency transport systems to support timely patient transport and emergency care	Critical for trauma, emergency care, and rural access		

Table 10. Health System Support Services

Infrastructure Area	Planning Consideration	Why It Matters	Potential Indicators / Data Sources	Analytic Method
Clinical Support Infrastructure	Availability of diagnostic and clinical support services such as imaging, laboratories, pharmacies, and specialty referral services	Enables safe and effective care delivery		
Community Care Systems	Availability of behavioral health, home health, and other community-based services supporting care transitions	Supports patient flow and continuity of care		
Residential and Long-Term Care Capacity	Availability of assisted living, adult family homes, and skilled nursing facilities (see Table 3)	Affects discharge capacity and care coordination		

Infrastructure Area	Planning Consideration	Why It Matters	Potential Indicators / Data Sources	Analytic Method
Referral Networks	Presence of referral relationships and care coordination systems	Supports effective use of services		

Application of Policy and Regional Support Considerations

The planning considerations described in **Tables 7 through 10** outline the approach that may be used to interpret projections of need when evaluating potential additions or expansions of health care facilities and services. When projections identify potential gaps in service capacity or access, the policy considerations in **Table 7** provide a framework for evaluating whether service expansion would align with quality, evidence-based, and cost-effective health care delivery. The regional resource factors in **Tables 8 through 10** provide a complementary framework for assessing whether the workforce, infrastructure, and community resources necessary to support the proposed service are available within the region.

This approach is intended to support a more comprehensive evaluation of potential service expansion by considering both policy objectives and regional capacity. In circumstances where policy considerations suggest a potential benefit to service expansion but regional infrastructure or workforce capacity may be limited, the analysis may also identify strategies that could strengthen regional capacity, such as workforce development, transportation improvements, or enhancements to community-based services. Feedback from stakeholders may inform further refinement of how these considerations are applied in future analyses.

Relationship to Certificate of Need Review Criteria

Certificate of need (CON) applications are evaluated using statutory criteria that consider population need, availability of alternative delivery models, financial feasibility, accessibility of services, efficient use of existing resources, quality of care, and the potential impact of proposed services on health system costs and community access.

The planning considerations and regional resource factors described in **Tables 7 through 10** are intended to support and complement these statutory review criteria. By identifying policy and infrastructure factors that may influence the availability and sustainability of services, this framework provides an analytical approach that may help inform the interpretation of need and system capacity in future CON reviews. Feedback received

through the development of the State Health Plan may also inform how this framework is applied in practice.

Conclusion of Health Care Facilities and Services Plan

The health care facilities and services plan described here outlines an approach for evaluating the availability of health care services and identifying potential future needs across regions of the state. The inventory of existing facilities and services provides a baseline understanding of current system capacity and the regional distribution of health care resources. Projections of need incorporate demographic trends and service utilization patterns to identify areas where future demand for services may change. The planning framework builds on these analyses by outlining policy considerations and regional resource factors that may be used to interpret projected needs and evaluate potential service expansion.