

Planning Area Boundaries – Elective PCI Certificate of Need Rulemaking

Presented on behalf of the
Cardiac Consortium
March 5, 2008

Setting the Stage – The bottom line is improving access while maintaining or improving quality.

- ❑ Standards focus on *minimum* standards to ensure safety and quality – based on evidence.
 - ❑ Planning area boundaries recognize importance of timely, local access to PCI and the inextricable link between emergent and elective.
 - ❑ Recognition that some existing volumes will be redistributed to improve access.
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Our exhaustive evaluation of potential boundaries considered/reviewed...

- ❑ All current CN Planning Area definitions.
 - ❑ Definitions contained in SHP documents.
 - ❑ Logical healthcare delivery patterns.
 - ❑ Geographical access barriers and travel times.
 - ❑ Variation in historical age-adjusted use rates.
 - ❑ In addition, we looked for guidance from AHPA.
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Selected boundaries modeled after newest CN methodology which addressed similar access issues and made calculation of need within PA “black and white”.

- The planning areas are:
 - 1) pre-defined – either by County boundary or zip code with no modifications permitted.
 - 2) acknowledge traffic issues unique to Puget Sound area.
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Selected boundaries modeled after newest CN methodology which addressed similar access issues and made calculation of need within PA “black and white”.

3) promote rural service development by allowing applicant to claim resident activity in adjacent planning area if no existing provider exists.

4) allow easy and regular access to historical volume and net need calculations.

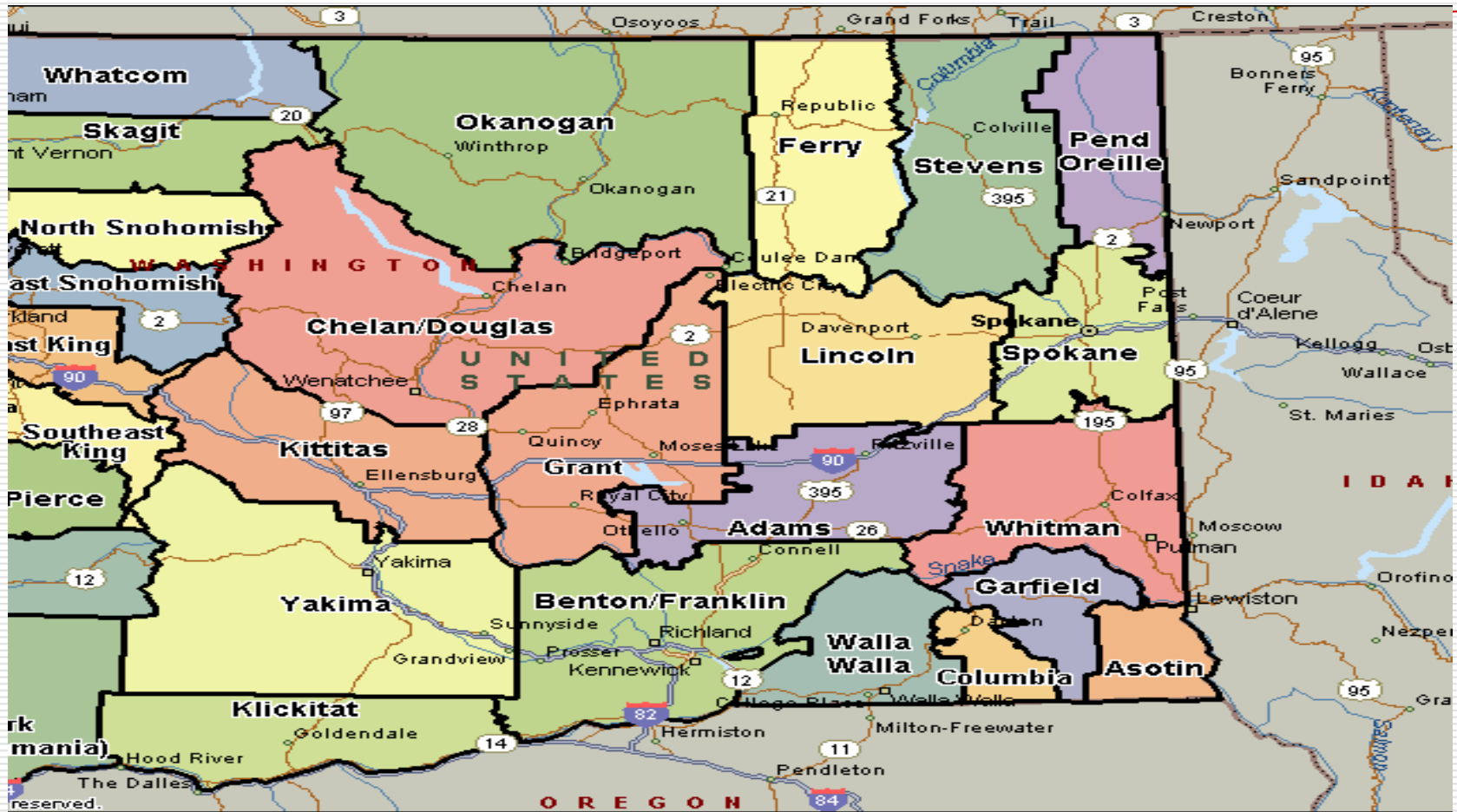
5) ensure that everyone “gets the same answer”—they are reliable and predictable.

Based on all of the above, we recommend the following planning areas:

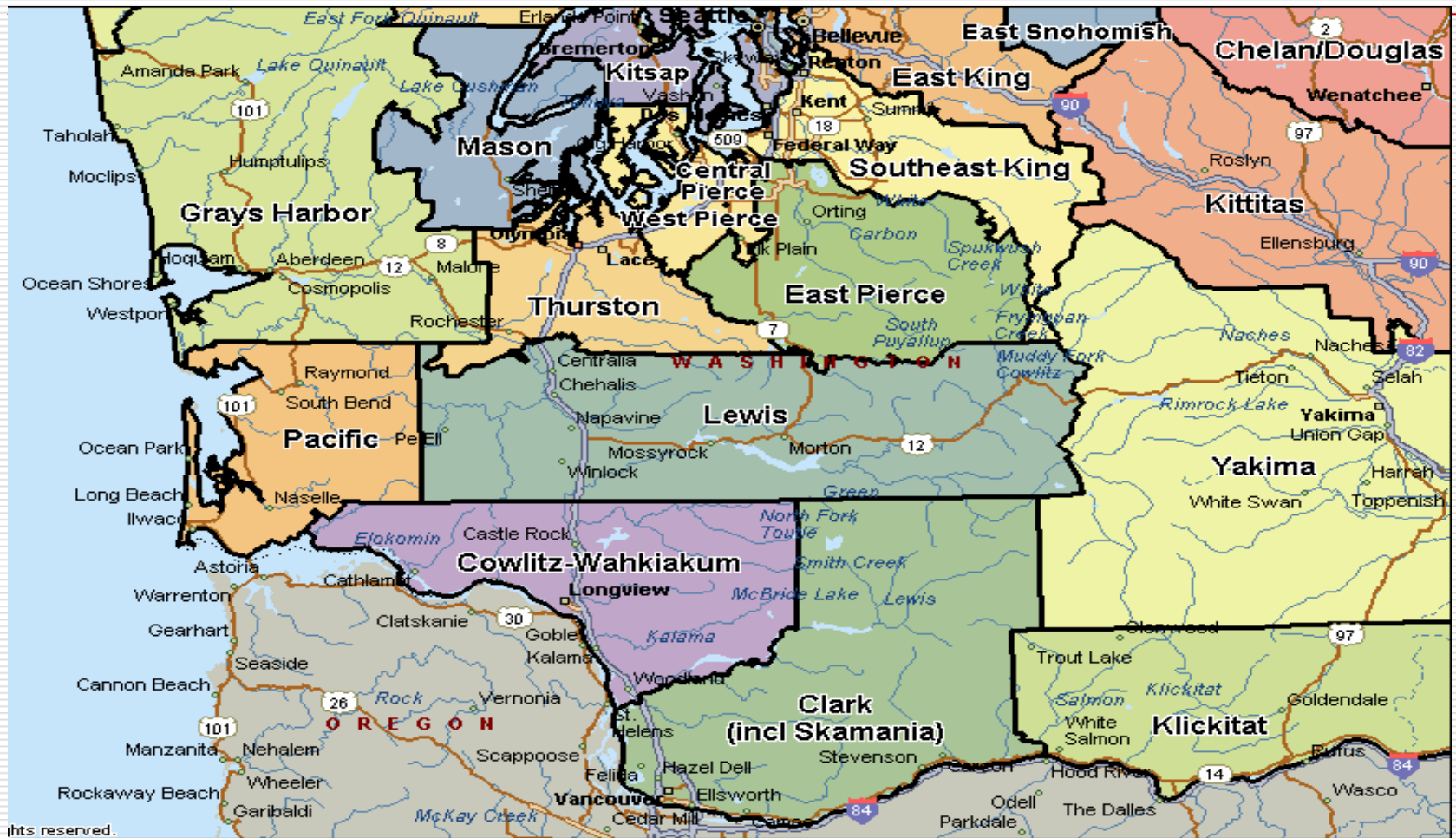
- The historical, well-established planning area hospital boundaries be used in King (5), Pierce (3 – or maybe 4 to adjust for reality of Gig Harbor Peninsula) and Snohomish (4) be used.
- All others be either the County or in the case of:
 - Benton/Franklin
 - Clark/Skamania
 - Cowlitz/Wahkiakum
 - Chelan/Douglas

be the health district boundaries.

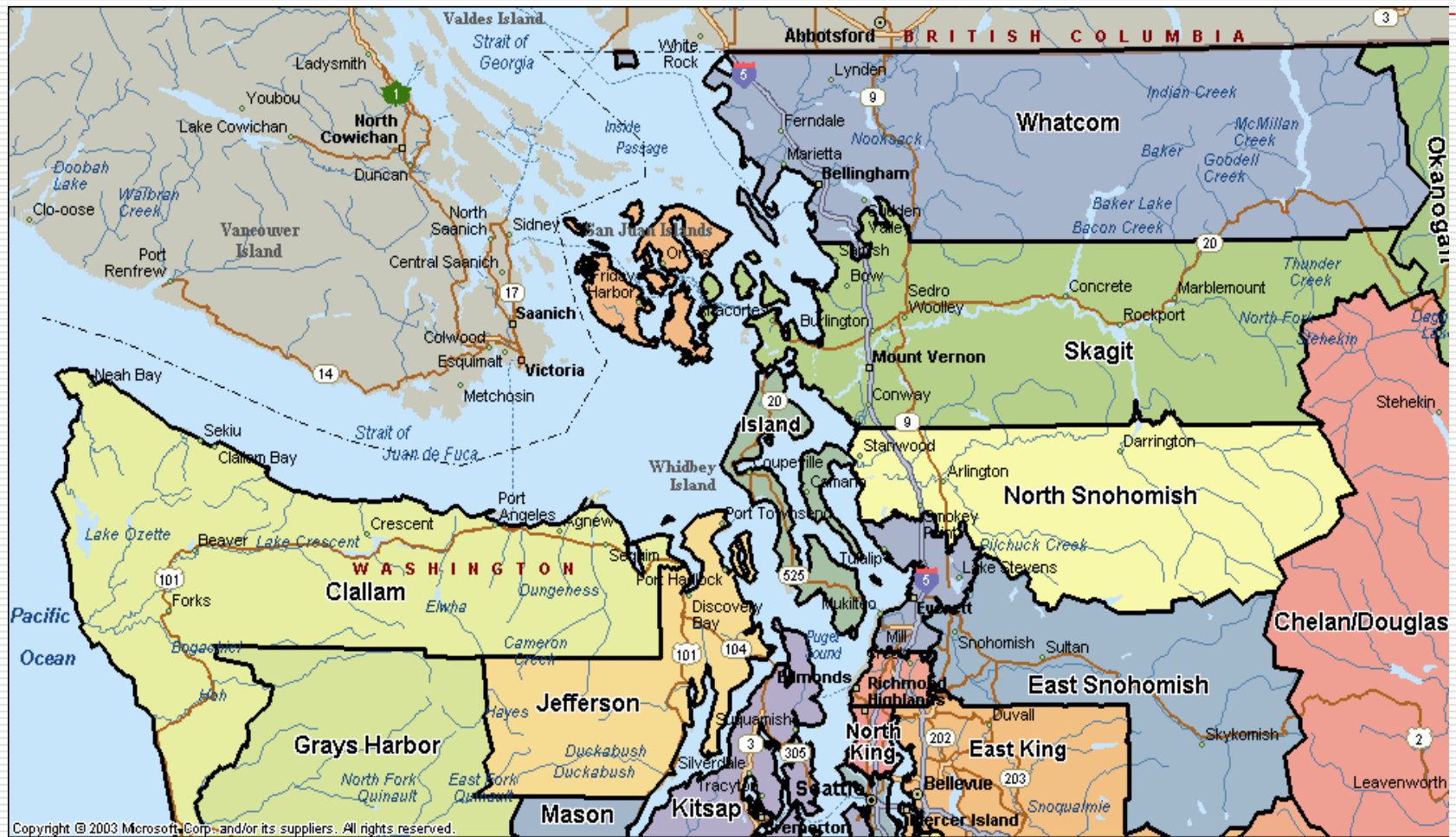
Proposed PCI Planning Areas – Eastern WA



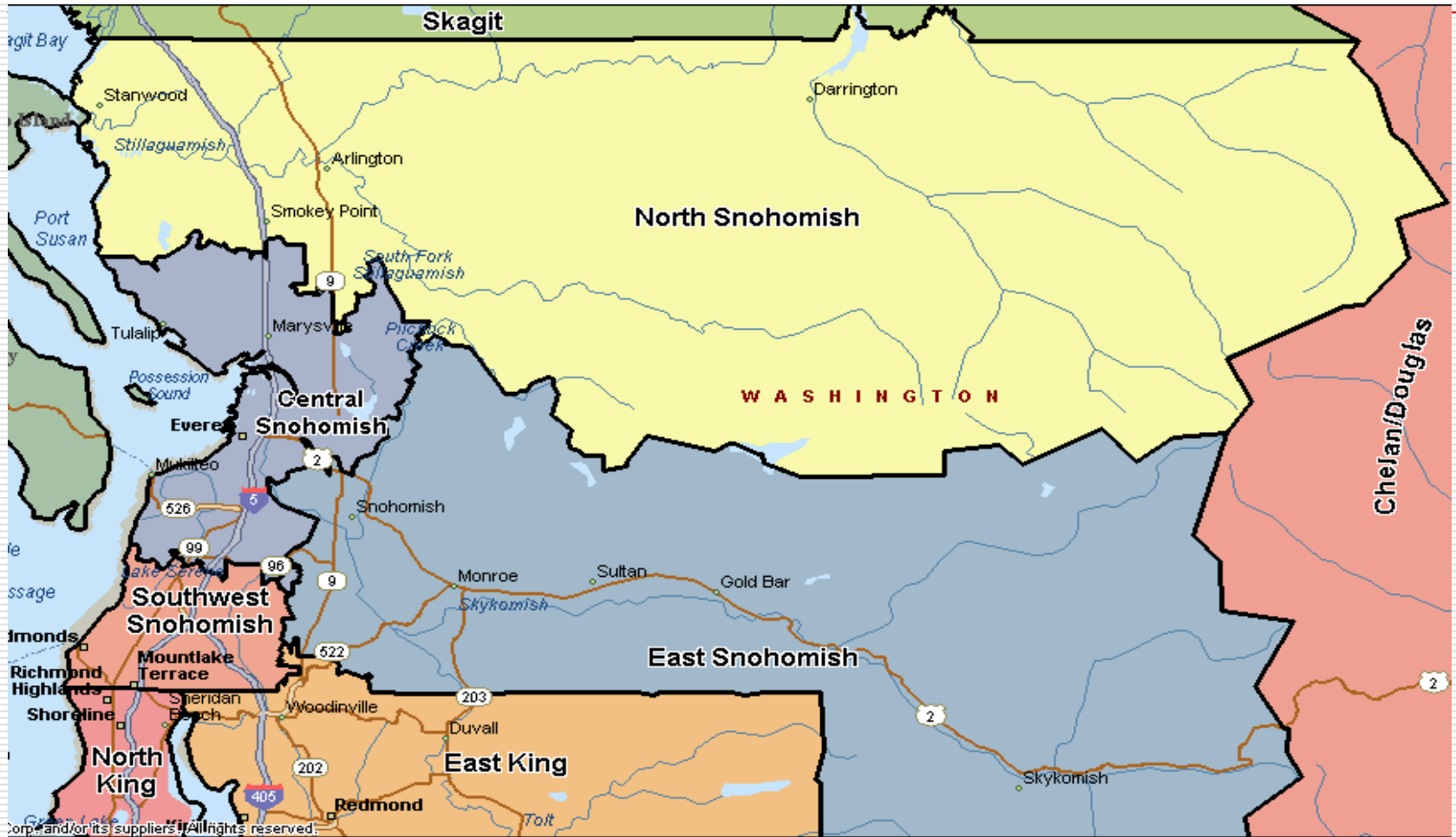
Proposed PCI Planning Areas – Southwest WA



Proposed PCI Planning Areas – Northwest WA



Proposed PCI Planning Areas – Snohomish



Proposed PCI Planning Areas – King



Proposed PCI Planning Areas – Pierce



Maximum new providers allowed

- It is unreasonable to estimate maximum new providers until the boundaries are finalized, the methodology established and new provider entry and existing provider “protection” levels established.
 - However, it is fair to say that using our definition – the main “limiters” will be
 - minimum volumes,
 - stringent quality standards,
 - impact on existing providers, and
 - compliance with all CN criteria (need, structure and process, financial feasibility and cost containment),not planning area boundaries.
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Other issues needing to be addressed

- Our analysis to date suggests that CHARS currently understates by PCI by probably 15 – 20%--and for some providers it could understate by almost 100%. So flattening of volumes is directly attributable to movement to outpatient setting.
 - Industry experts is telling us that this trend is expected to accelerate.
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Per Health Care Advisory Board (February 2008)

- HCAB projects by 2011, a 7% decline in inpatient PCI and a 93% increase in outpatient.
 - InterQual now classifies elective PCI as outpatient – not appropriate for inpatient.
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Per Health Care Advisory Board (February 2008)

- “In response to Masspro’s request for supporting evidence related to the change in setting, InterQual® provided the following:
‘An urgent PCI is appropriate for inpatient admission as this procedure is being performed urgently due to the patient’s symptoms. While the procedure is the same for inpatient and outpatient, the patient appropriate for an inpatient stay is symptomatic and potentially unstable, for example, they may have unstable angina or an evolving MI.

Percutaneous Coronary Interventions (PCI) considered outpatient procedures when scheduled electively. Patients who are undergoing a PCI as an outpatient are clinically stable. It is understood that patients who have elective PCI’s require post-procedure monitoring which may or may not require an overnight stay. If complications occur, the Severity of Illness Criteria will dictate the need for admission.

NOTE: An elective cardiac catheterization, with possible ad hoc stent insertion based on the cath results, is not considered an urgent procedure.’”
