Elective PCI Certificate of Need Rulemaking- Planning Area Boundary Revisions, Methodology and General Considerations

Presented on behalf of the
Cardiac Consortium
March 11, 2008

For the Consortium, focus continues to be on improving access while maintaining or improving quality

- Planning Principles:
  - 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 must be redistributed to improve access.

Revised Boundaries

We revised our boundaries in the interest of attempting to reach consensus

- Accepted many of the definitions put forth by several existing providers last week– and considered the request that we aggregate rural Counties to achieve minimum volume levels.

- We have gone from 48 planning areas to 25.

The Planning Areas

1) Clallam, Jefferson, Kitsap

2) Island (less Camano Island), San Juan, Skagit

3) Central Snohomish

4) East Snohomish

5) North Snohomish, plus Camano Island

6) Southwest Snohomish

7) Whatcom

8) North King

The Planning Areas

9) Southwest King

10) Central King

11) East King

12) Southeast King

13) Central Pierce

14) East Pierce

15) West Pierce

16) Mason, Lewis, Thurston

17) Grays Harbor and Pacific

The Planning Areas

18) Wahkiakum and Cowlitz

19) Clark, Skamania and Western Klickitat

20) Chelan, Douglas, Okanogan

21) Benton, Franklin, Grant and Adams

22) Walla Walla, Columbia, Garfield and Asotin

23) Kittitas, Yakima and Eastern Klickitat

24) Ferry, Pend Oreille, Lincoln, Spokane, Stevens and Whitman

25) Gig Harbor Peninsula

Proposed PCI Planning Areas

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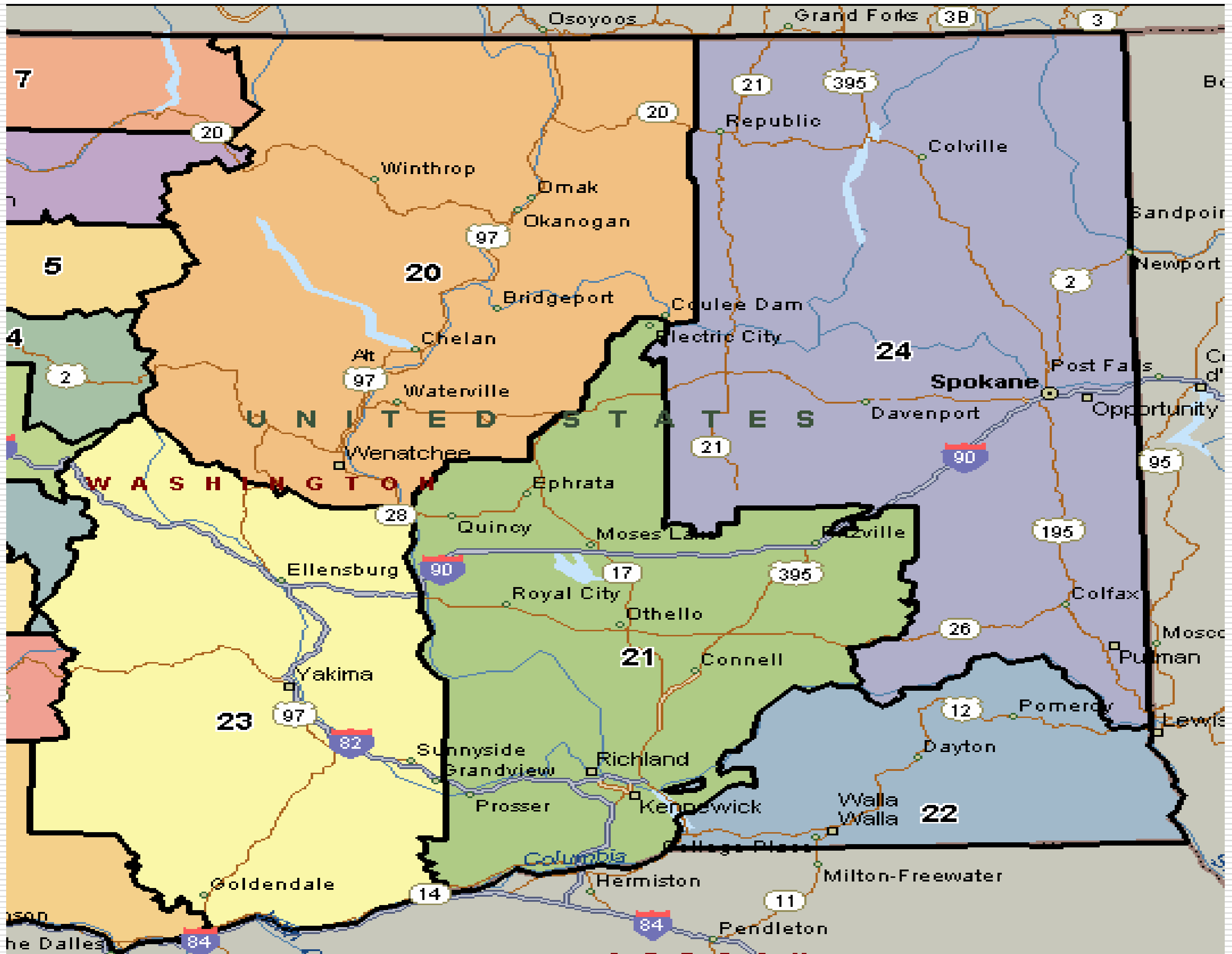
Proposed PCI Planning Areas – EASTERN WA



Proposed PCI Planning Areas – SOUTHWEST WA

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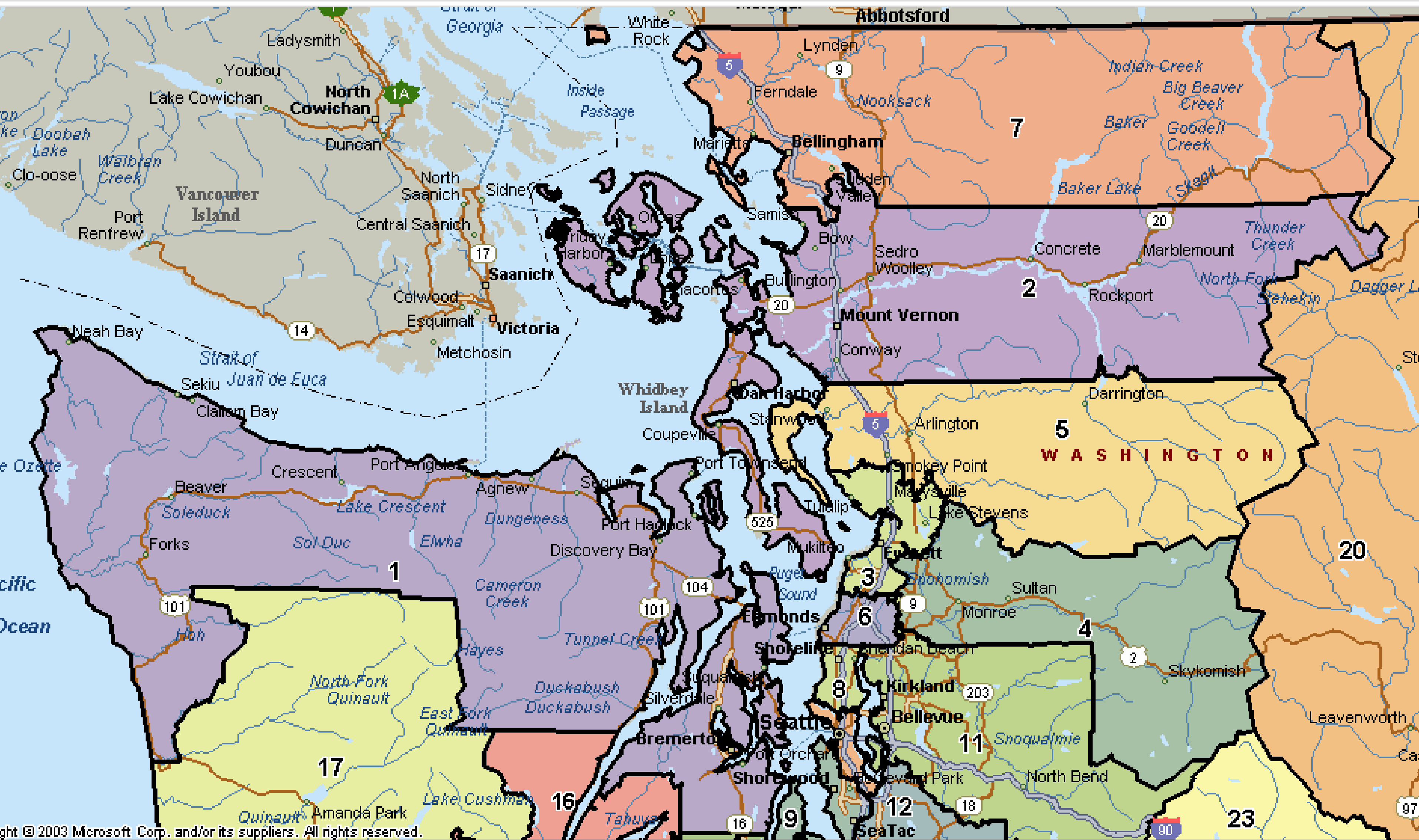
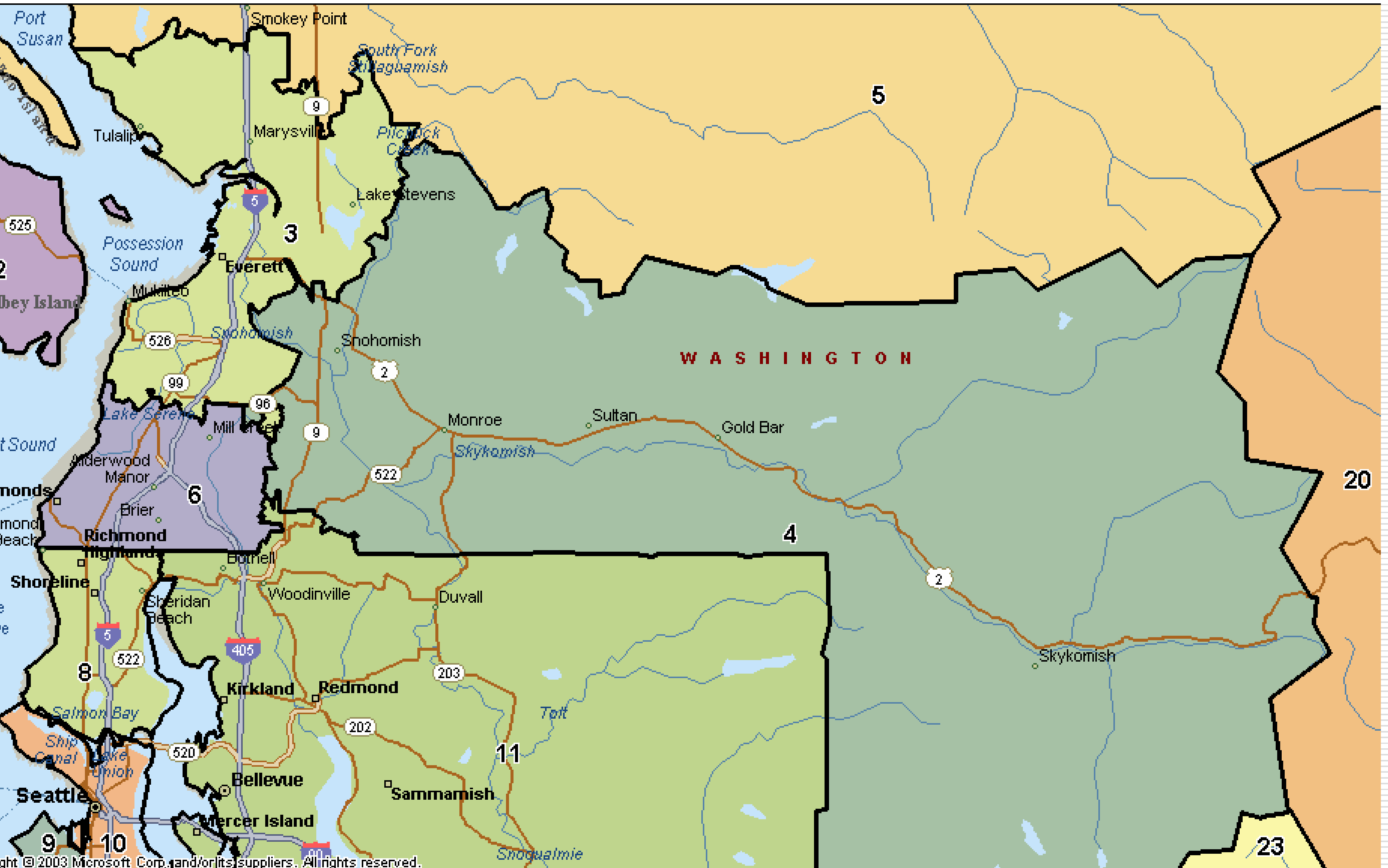
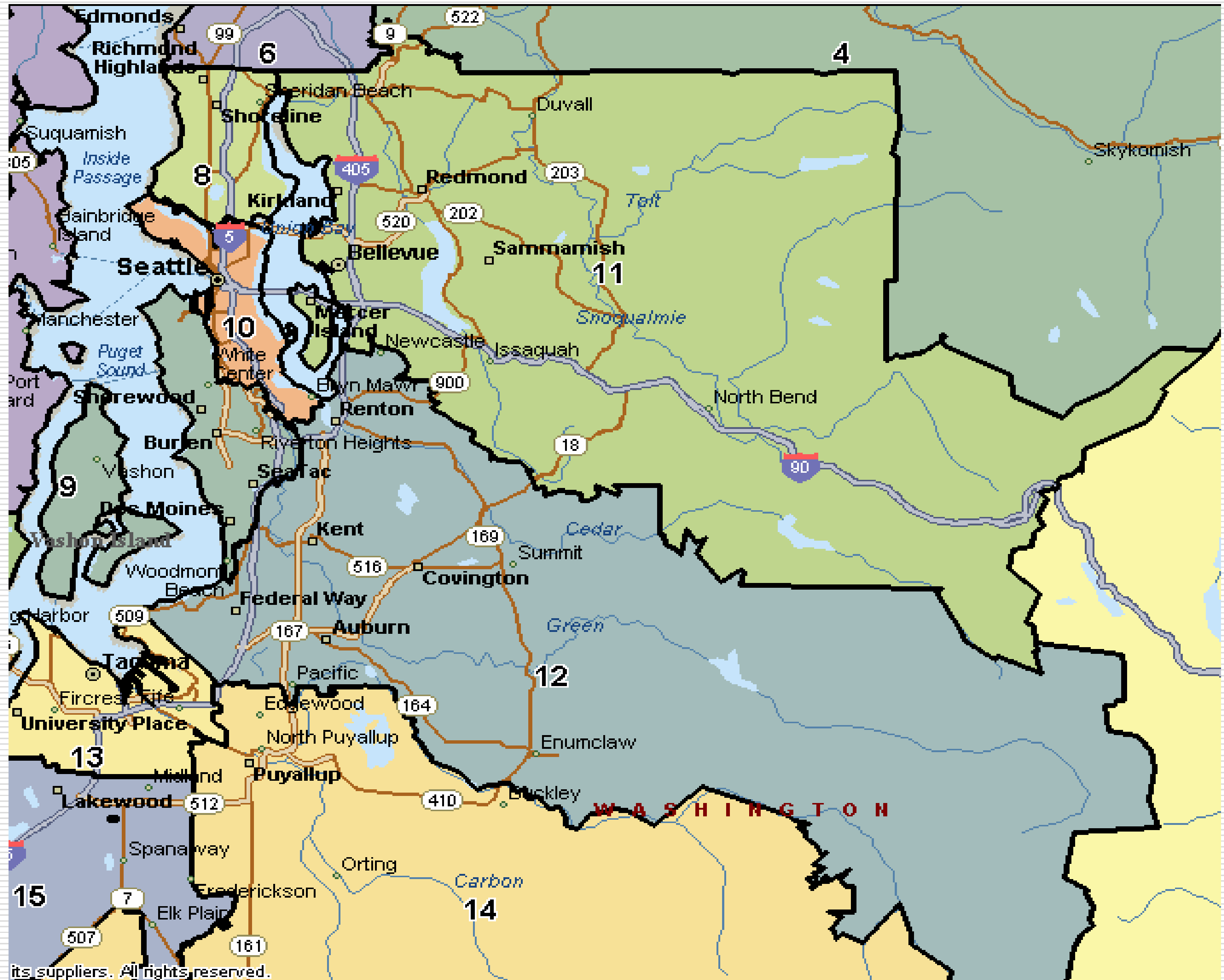
Proposed PCI Planning Areas – NORTHWEST WA



Proposed PCI Planning Areas – SNOHOMISH



Proposed PCI Planning Areas – KING



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Proposed PCI Planning Areas – PIERCE

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Maximum new providers

- The maximum number of non-CAH new providers in 2010 (assuming 200 as entrance level and 200-400 as protection level for existing providers) is likely well under 20.
  - More than half are current emergency-only.

- **However,** it is imperative to note that using our definition – the main "limiters" will be
  - stringent quality standards,
  - **impact on existing providers**, and
  - compliance with all other CN criteria (need, structure and process, financial feasibility and cost containment), and a significantly fewer number of providers would be successful.

Maximum new providers…keep in mind

- There is a big difference between meeting the standards (individually) and the cumulative impact of applications.
- For applicants that are current emergency only providers, many are already performing 100-150+ emergency procedures. They don't need much incremental volume to stabilize/hit evidence-based minimum standard of 200.
- We can't and should not in this process be assuming the role/responsibility of DOH– to determine which and how many will ultimately meet all applicable standards.

Methodology

Key Underlying Assumptions/ Principles—Volume Standards

- A minimum of 200 procedures must be projected to be achieved by the applicant in the third full of operation.
  - Except in rural hospitals located at least 50 miles from the next closest provider-for these hospitals the minimum volume is 150 procedures by the third full year.
  - In calculating need/minimum volume, there is no need to distinguish between emergent and non-emergent cases.
  - No additional programs approved until all CN approved projects are above the minimum standard

Key Underlying Assumptions/ Principles—Prohibitions on New Providers

- No new program can be established in a planning area if there is not a net need for at least 200 (or 150 in the case of certain rural providers) by year 5 of the planning horizon, or
  - If the new program would reduce an existing provider ***in the planning area*** to below the minimum volume standard (200) in the case of hospitals performing less than 400 cases annually, or 400 in the case of hospitals performing more than 400 cases annually, or
  - If the new program would reduce an existing provider ***in a contiguous planning area*** (located within X miles) to less than X% of the minimum volume standard.

Forecasts of future need

- Using Oregon Inpatient data and CHARS or COAP, calculate Planning Area and statewide total use rates for each of the most recent three full years of data.
  - Note: 15+ use rate is 2.4 not 1.9/1,000
- Use the Planning Area use rate, unless it is below the statewide use rate in the last full year of historical data. If it is lower, use the statewide rate.

Forecasts of future resident need

- Trend, average or use the highest annual use rate during the past three year period to project volume five years into the future to estimate total planning area resident need.
  - Note: we need to somehow adjust for missing outpatient data if not using COAP
  - Population should be medium series OFM or other reliable source for partial County planning areas.

Subtract Current Supply

- For planning areas with no existing open heart/elective provider, supply = 0.
- For planning areas with an existing provider, current supply is calculated as:
  - 200 for a provider operating with less than 400 cases annually.
  - 400 for a provider generating more than 400 annual cases.
  - Perhaps some other level for select providers?

Adjusted Net Need

- Calculated as:
  - Total resident planning area need

    Less
  - Planning area provider current supply

    =
  - Net Planning Area Need
    - Reduce this number by 5%+ to account for complex cases.
  - The remaining number of cases needs to be 200 or greater (or 150+).

General Considerations

Other factors that need to be addressed

- If we assume concurrent review- should the cycle be 1 or 2x annually?
  - Should a different cycle be established for the first year or two?
- All data required to estimate need and impact on existing providers needs to be available three months prior to the start of cycle.
  - Can not be modified during the course of review. *Reliability*

Other factors that need to be addressed

- Tiebreakers-could include:

    (i) The most appropriate improvement in geographic access;

    (ii) The most cost efficient service;

    (iii) Minimizing impact on existing programs;

    (iv) Providing the greatest breadth and depth of cardiovascular and support services; and

    (v) Facilitating emergency access to care.

- Process for verifying UW impact.

Special considerations

- Create process to allow hospitals that have more than 40% of their patient days coming from non-Washington, non-Oregon hospitals to demonstrate need.
- Assuming all other standards met- hospitals that can demonstrate lower costs or better quality (outcomes) or patient, provider and payer preference (choice) should be allowed to establish a program.

Other considerations

- Transfer agreements should ideally be with the closest provider, but must be with a hospital wherein D2Surgery time can be met (2 hours).
- Standards should be re-evaluated in 2 years.

Other considerations

- MDs- must be allowed to continue emergency only coverage and procedures.