A meeting regarding the Certificate of Need (CoN) percutaneous coronary intervention (PCI) rules convened on May 11, 2017. The meeting was held at the Department of Health, 111 Israel Road SE, in Town Center 2, Conference Room 145, Tumwater, WA 98501.

PRESENT: Patty Seib, Virginia Mason Memorial - Yakima  
Jonathan Seib, Virginia Mason Memorial - Yakima  
Dennis Hoover, Virginia Mason Memorial - Yakima  
Vicki Eastridge, Legacy Health  
Stephen Pentz, Providence Health & Services  
Chris Thomson, CHI Franciscan (by telephone)  
Diane Buelt, Legacy Health (by telephone)  
Tony McClean, CHI Franciscan  
Tony Saraon, CHI Franciscan  
Ian Worden, CHI Franciscan  
Lisa Grundl, HFP  
Jody Carona, HFP (by telephone)  
Larry Dean, MD, UW Medical (by telephone)  
Greg Eberhart, MD, CHI Franciscan  
Jeff Freimund, CHI Franciscan  
Matt Moe, Providence (by telephone)  
Zosia Stanely, WSHA (by telephone)

STAFF PRESENT: Nancy Tyson, HCF Executive Director  
Andy Fernando, Rules & Legislation Manager, OAS  
Kathy Hoffman, Policy Analyst, OAS  
Jan Sigman, CoN Program Manager

3:00PM – Open Meeting, welcome and introductions – Nancy Tyson

Nancy: (Brief overview of rulemaking activity up to this meeting). CHI requested another presentation, so we’re happy to accommodate that. And so, we did allow an hour for this time period, and if we need to and the group wants to, we can schedule
another session. We can talk about it when this is over and we have a little bit of time for discussion. So, we'll just take it from there and we'll let you go ahead and get started.

**Lisa:** Jody is actually going to start remotely, and she’s going to start with the first slide.

**Jody:** It would be helpful to know, I think I heard everyone on the phone introduce themselves, but…

**Dr. Dean:** This is Larry Dean, I just joined.

**Jody:** Okay, and in the room is…

(In-person attendees introduce themselves)

**Jody:** This is Jody Carona, and I’m just going to kick off to kind of set the stage and then we have some real content experts with us, CHI Franciscan will take over, so if everybody’s got the PowerPoint in front of them, slide 2…well, let me back up a second, I think I want to remind everybody that what the Franciscan’s, CHI Franciscan is requesting, is language that will allow an applicant to submit a certificate of need absent numeric need. That same language would also allow any interested or affected party to comment, and would allow or provide the department with the discretion to deny or approve an application. We’re not asking for a guarantee of approval, we’re asking for an opportunity to submit. Right now it’s (unintelligible). The rule does not allow any latitude for the program to approve an application absent numeric need, and as everybody knows, right now, when the threshold is set at 300, 299 rounds to zero. So, it’s a very high bar and we believe, that that bar right now doesn’t give the department the latitude to account for health disparities or community specific access and availability factors, and that’s what we’re asking for.

So, on slide 2, you can see there are five areas that we’re going to touch today. The first is that exceptions are very common in CN methodologies. The second is that you’ve asked us to put together basically our CN case, so we’re providing in this PowerPoint data that exemplifies community factors in the Highline service area that impact CN access, and those include socioeconomic, it includes cardiac mortality and morbidity data, and it actually includes some cost data, as well. We’re also going to hit on some literature that demonstrates that barriers to access exist for elective PCI, for both low income and high minority communities. We’re going to remind the program is aware of this, we’re going to remind the program of the providers and the community leaders that have weighed in on how important it is for Highline to have elective PCI, and then we’re going to give you some proposed language that I think you’ve been asking for.

So, on slide 3, I’m going to talk a little bit about the CN methodologies. So, you can see on slide 3, virtually every other, actually slides 3 through 11 demonstrate that virtually every other CN methodology has exception language and over 30 years of experience
on my part suggest that that’s likely due to the fact that the methodologies are not precise enough, and data is frequently not publicly available to permit numeric methodology to be the be-all, end-all. And again, in CHI Franciscan and specifically Highline’s experience, numbers alone do not tell the story of the community’s need.

Slide 4 talks about the fact that there are nine tertiary services that are currently regulated by the program, and we’ll go through those. Only one has a prescribed methodology, so a methodology that’s in rule, and that one contains an exception, and that’s open heart surgery. There are six other services, programs, bed-types that are regulated, four of them have a methodology in rule, and each of those allow for an exception. The other one, so the acute beds and the NICU, the methodology is not in rule, but there is an exception in the state health plan, and the department has done an incredible job over employing that when it needs to, to demonstrate need for beds. And then, there is one other – home health – that has no methodology in WAC, and therefore an applicant is given some discretion to demonstrate need. (00:07:05)

The next slide really just provides the data on tertiary services, and I’m not going to go through that in detail, everybody can see that, if you have questions we’re glad to answer them.

And then, slide 6 talks about every other non-tertiary service that’s currently regulated by a certificate of need, and when hospice is finalized, it too will have a methodology in rule and an exception. So, again, we’re not asking for anything, this is the norm, having the latitude, giving the department the discretion is pretty much common place, both for tertiary services and non-tertiary services.

Slides 7 through 11, I’m not going to go into them, they are here if anybody wants to reference them here today in our discussions, in our presentations, but it’s the exception language, slide 7 is the exception language that’s contained in the state health plan, called “Criterion 2” for acute beds, and basically you can see there, that basically that need forecasts by themselves should not be the only criterion used to decide whether a specific group of people or a specific institution should develop additional services.

Ambulatory surgery on slide 8 talks about “should ordinarily not be approved” so that’s the program’s discretion and an applicant’s ability to put forward its case.

Slide 9 is around exceptions for dialysis, and there it’s giving the applicant again the discretion to put forth a rationale and giving the department the latitude to determine whether or not it believes additional stations are needed.

Slide 10 is the hospice rules, and the draft hospice rules, and it just basically says that a specific population is not being served, and again it gives the applicant the opportunity to put forth an application and the program the opportunity to consider that.

Slide 11 are the nursing home bed rules, and again, they give the department the discretion to, absent numeric need, to consider additional nursing home beds.
Any questions on that? If not, I'll just keep going. So, I'm going to talk for a few slides, just putting into context the King West planning area and the CHI Franciscan/Highline actual service area which we refer to as King County. And that's depicted on slide 13. So the grey area, the entire area that's on the map is the area that the rules consider to be the King West planning area for purposes of elective PCI. And Highline is contained in that. The blue area represents Highline's actual service area, that's where 76% of its inpatients come from, and it's called, for most other planning purposes, the Southwest King hospital planning area. Highline is the only hospital located in that planning area.

Slide 14 provides a little bit of context on that planning area, so what we're showing you here in this table is that there is 7 hospitals; 5 of them are allowed to perform elective PCI; has a population of about 1 million people, and what is relatively unique about this planning area is that 50%, nearly 50% of all of the PCI's that are performed by the hospitals located in this planning area, are performed on residents that don’t live in the planning area. And that’s very important because the methodology right now looks at resident need, so it's only looking at the needs of the residents, and it’s subtracting from that all of the capacity done at the hospitals in that planning area (00:11:34), regardless of where those patients live. Which means in an area like King West, with all of the tertiary coronary hospitals in it, and where people come from throughout the state and actually from throughout the (unintelligible) region for services, we're not really taking a look at, we’re not fully accounting for the needs of the residents in this.

In slides 15 and 16, we pulled verbatim Swedish Hospital back in 2012 and 2013 had submitted two certificates of need asking for elective PCI first at its Issaquah hospital and also at its First Hill hospital, and you can see verbatim, these are verbatim comments from their certificate of need, where they’re identifying the problems with the methodology, so they pointed it out very nicely that if you don’t adjust the methodology there will be a shortage of capacity, planning area residents on slide 15, and then slide 16 they talk about the fact that King West is unique among all of the states planning areas because of the scale of in-migration, and if you don’t make adjustments you are going to underestimate need for additional programs. So early on in this process, the reason that we put these slides together, is early on in this process we talked about that fact that the program, the department really didn’t want to be opening up all the rules, tweaking the methodology, tweaking other things, tweaking service areas, and without adjusting for these things, the exception is the best way that we know of to accommodate what’s very unique, and Swedish agrees, in the King West planning area.

And with that, at slide 17, I’m going to turn it over to Tony to focus on the real issues that are going on in the community.

Tony: One of the things that we wanted to do is to give you a sense of the region that we primarily serve at Highline Medical Center, and so we’re going to look at the various socioeconomic factors there that have been shown to be related to healthcare in the community. We also wanted to (unintelligible) morbidity and mortality both globally and well as for cardiac (unintelligible). So if you go to slide 17, this just establishes that it’s
well documented that there are social determinates of health, and it provides a range and location of data in the Southwest King area.

In slide 19, we just want to point out that the Department of Health has documented that there is a notable relationship between health disparities and poverty, there is a strong correlation as evidenced by a number of studies.

On slide 20, this is a visual map that basically looks at that disparity relationship and the thing to point out here is the redder you are on the map, the greater the disparity that is correlated with poverty and health disparities, and as you can see, we are serving the Highline region, Burien and surrounding neighborhoods, we have some of the greatest racial disparity throughout the county.

If you look at slide 21, you get (unintelligible) a more granular level, so basically, the bluer you are on this map, the higher the levels of poverty in the neighborhood. Highline primarily serves, if you look at the number codes here, kind of toward the middle of the page, (00:15:25) 12, 34, 44 and 17. So we’re in the midst of some of the poorest communities in King County.

Next slide really looks at the trend over time for life expectancy, and you know, this is very compelling, it’s well over a ten-year look. What’s notable is that there’s always been disparities. South County has always had the lowest life expectancies. Probably what’s more notable is that over time that gap has not closed at all.

Next slide, when we look at other social determinates of health, like education as a leading indicator towards economic stability, again, same methodology. The bluer your neighborhood, the worse you fare in the state high school graduation rate, and looking at district 34, 12, 44 and 17, the areas Highline serves, we’re the most disadvantaged in the county among the most when it comes to access to education and ultimately economic prosperity in the long run.

If you go to the next slide, this is data attempts to look at, ok, if people have disadvantages in terms of social and economic factors, is there any evidence that they also have a barrier in terms of actually getting access to healthcare. And when you look at unmet healthcare need, go to the right, similar trending on this graph if you look at South County, which is at the top of the unmet healthcare need prevalence performance, a) you’ll see that South County performs worse than any other part of the county, but (b) as we go toward the most recently (available?) data, it’s not improving, you know, the disparity within areas of the county, is similar in some years and growing (unintelligible) more disadvantaged.

The next two slides really are designed to say there is a lot of evidentiary basis for the conclusions we’re demonstrating here. We just meant to pull a few snapshots together for you but these next few pages cite significant evidence that South King County is an area that is poor and fares poorly on just about every (social?) term of health and has
correlated evidence of poor morbidity and mortality, we’ll get in to that specific detail next.

So go to slide 27. One of the (unintelligible) around PCI is that access really depends on the ability to get to a provider. This is a very conservative study that looked at average travel times, its right up on that 30 minute mark. Moreover, it assumes you have a car and that you have reliable transportation and reliable drivers, and those three most of us in this room take for granted, but for a lot of people we serve, each of those is a significant challenge.

Page 28 and 29, let’s (unintelligible) acute myocardial infarction, you know, if you look on the left, it’s our service area, South King county, and if you look on the right, this is the rest of the county, you’ll see that in every year, our (numbers?) are higher and in the most recent year, it’s significantly higher. So, we’re experiencing more morbidity than the rest of the county.

And then if you look at the next slide, really looking more at actual mortality rates, we see a similar trend, again if you look toward the middle of the page, where we’re breaking out the regions of the county, the death rate for South King county is significantly higher than it is for the rest of the county over the four year period where we had the most recently available data. So it’s a big deal.

Next slide, if you get into a more granular look at the heart disease death rates, again, looking at where we serve, it is significantly (blue?). Our immediate area where we draw the most patients is neighborhood 12, that’s Burien, and as you can see, it’s got the highest heart disease death rate in King County. It’s right up there with the other high prevalence neighborhoods.

Next slide we wanted to look at this longitudinally, not just the four year look, but for the last fourteen years. What we see is that we have a higher mortality rate from heart disease, but what’s more troubling with the gap between South County and the rest of the counties is just as big as it was fourteen years ago. And if you really look carefully and granularly and analyze the trend, these other parts of the county are declining slightly. Whereas South King has (collapsed?), so we losing more ground as this current trend continues.

And then finally, slide 33, we wanted to look at similar issues around cardiac mortality but by legislative district, 30th and 33rd are the ones that Highline serves, and basically the higher up you are on the chart, the higher your mortality rate. As you can see, areas that we primarily serve are really in the (unintelligible) of this group. So, for a lot of reasons, we are challenged to serve a very poor community that struggles with socioeconomic barriers. We’ve demonstrated evidence that they don’t have access to healthcare as readily as the rest of the county, and that we’ve correlated poor mortality, poor morbidity both globally and for heart disease. We wanted to have one of our practicing cardiologists, who is actually the chief of cardiology, Dr. Tony Saraon, join us
to really augment some of these statistics with real-life cases, so I’ll hand it over to Dr. Saraon.

**Dr. Saraon:** Thank you. So this slide on page 34, it talks about an article we’ve included to highlight the growth of PCI centers throughout the country. And what we’re seeing is that there is a disproportionate growth and there is a concern of what they call “diluting the pool” of the other cases that each hospital is doing. So what the article really speaks to is that most of these centers are all concentrated in city centers, and that ignores the access patients need to care in the surrounding areas. And, it really highlights that we should really grow the regions that are in areas of need and where patients have a hard time for access. I also kind of want to highlight some cases that we’ve had, kind of give a voice to some of the patients that struggle with access to care.

I was asked to consider whether we had some real-life examples, and then I spoke to my providers, and it took me the whole of one hour to generate 5 cases that are real people that had trouble with access to care. Now we know that elective PCI, there’s no good evidence that it changes mortality but it changes morbidity, it changes quality of life, and patients who are not able to get access to this care, it can significantly impact their long-term ability to function and be productive.

So, the first case that I wanted to talk about is, and I’m going to redact the names, is Mrs. A, she’s an elderly woman who lives alone. She’s deaf, she lives in Des Moines, and she gets her care through Highline because her neighbors are able to bring her to the appointments, and her neighbors are also elderly, and they also have a hard time navigating through cities and in Tacoma. She has a daughter who is supportive but lives outside of the county. So, she had a need for elective PCI. She wanted it done at Highline but could not because there’s not a provision there, and her neighbor could not drive her either to Tacoma or to Seattle because she’s fearful of driving at her age, going on the highway and going to these places. So her procedure was quite delayed, her daughter had to fly in to the country, to then transport her to Tacoma because she wanted to remain with her physician. So our network allows us to go to Tacoma and have her procedure done there. So that’s one example.

The second patient, Mr. B, who was a very (unintelligible) gentleman who lives right next to Highline Medical Center, and he needed elective PCI and he had to be scheduled in Tacoma. He has a sick wife and she’s also very fearful of driving on the highway, but she wanted to be with him because she was very concerned about the procedure, and she wanted to bring him to his appointment and be there and see his face when he came out of the procedure. She wasn’t able to do that. In the end she had to find a friend, who dropped him off at the hospital and the next day he had to take a taxi home but his main disappointment was that he couldn’t have his family there with him, and this is something we ignore when we look at numbers and statistics, we ignore people themselves.

The next patient, Mr. C is an elderly gentleman, he has some (stability?), he lives on his own, he comes to Highline on his own, his son helps him from time to time, his son has
a wife and four children who he supports through his job, his work. And so the patient
wasn’t able to find a ride, and again, we’re going to Tacoma, so his son had to take time
off of work for two days, he needed a ride in, he needed an overnight stay, and then a
ride home. And he basically felt the burden of guilt of having to force his son to take
time off of work to try to transport him to a facility that he could have gone to if it was
Highline on his own. But he felt very blessed that he has a family like this, but he
wonders why this system is in place.

Next is Mr. D. He is a patient who works at Highline, he’s an employee there. He lives
alone and does not have any family in the state, they live outside of the state. The way
he says it, the Highline staff are his family. He has a close connection to everyone
there, and he wanted his procedure also to be done at Highline. And, he needed to be
transported also down to Tacoma, he found someone who could bring him there, he
stayed overnight, but didn’t have a ride to go back. He had to stay overnight in a hotel
and his friend came the next day to bring him back.

And the last case I wanted to highlight was Mr. E. He’s a patient who had acute
intervention done at Highline in the (unintelligible) of a heart attack, and he also had a
secondary artery that was blocked and it was deemed that that could be done at a later
time and became an elective PCI. He continued to have symptoms, and a decision was
made to proceed with the elective PCI. So he was offered to either go to Seattle or to
Tacoma for other facilities, and instead, with his frustrations, he said “I’m not going to do
it” and decided to forego the treatment. And several weeks later he was readmitted with
another acute MI in this other vessel, and he said when we asked him, that he shouldn’t
have waited, that he needed the care, and he said “I didn’t want to change the hospital,
or my doctors, or make another co-pay, and I had no way to go to Seattle or Tacoma
and it’s just too expensive for me to afford.”

So, unfortunately what we face with a lot of the patients in trying to send them to other
centers where there is another cardiologist that they have to meet before elective PCI,
they have to do another copay, that’s another appointment, then they have another
assessment and review of the records before they go to elective PCI. So unfortunately,
for a lot of our patients, who are very low on the socioeconomic status, they don’t have
a lot of money, making more copays and traveling, paying for parking, and trying to find
people to take them is very difficult. We have a very strong program but we also have a
lot of physician turnover because without a good case volume, a cath lab team is not
successful so an interventional cardiologist should do 100 to 150 cases a year and that
includes elective cases and so it’s very hard to retain physicians and again, that’s an
access to care issue because they’re hard to retain, especially interventional physicians,
if they can’t get the procedural volume they need.

The other thing that happens with this is that when you are only taking care of the
sickest patients who walk through the ER, who are all heart attacks, your complication
rates go up and so as physicians we are measured on outcome and complication rates,
whereas all the other hospitals have the ability to do elective PCI which dilutes their
volumes. And also, elective PCI generates more skill for the physicians, and so in the
end, it creates a program which is very unstable. And again, that reduces the ability for them to access care. So these are very kind of important parts deeper in the story that I think I want to highlight.

The other thing I want to highlight is my own experience. When I was growing up, my grandfather, who was 88 and I was 16 at the time, and he needed to have many appointments and many procedures done at this age, and both my parents worked. I had to transport him, I took time off from school because everything is during the daytime, and when you think about going to another facility within 30 minutes, it’s not really 30 minutes. I had to get my grandfather ready, had to get him to the car, go to the site. Once you get there, you have to get a wheelchair, get him in the wheelchair, put him in the lobby, then I had to walk over, look for parking, pay for parking, run back. Then we had to figure out where we are going inside the hospital, which are big mazes, transport him all the way up there, and then the physicians typically are always behind on their appointments so you are there for an hour, and you are waiting, and then they schedule you for a procedure which again, you have to be there two hours ahead of time. So you are transporting back and forth quite a bit. And again, this is about access to care. So my grandfather raised 8 kids, and he came over to this country as an immigrant, and he had to ask his grandson to leave school to bring him to his appointments. This is a huge barrier, he didn’t want to do it, he would minimize his symptoms so he that wouldn’t go to the doctor because he didn’t want to become a burden to the family. And for me, I would miss class. I was a straight-A student, but I would miss classes and I would get detention because I had unexcused absences. And that’s how they (saw this?), I brought a letter saying I was taking my loved one to appointments and they said this is not a reason.

So when you talk about access to care, there is a bigger impact. It affects families, it affects their ability to see their providers, it increases their copays, so it’s a much deeper problem than simply the number of statistics and the number of elective PCI centers we need. It’s about the region, the type of people we have, their ability to access the care.

On the next slide I guess I’ll toss it over back to Jody….

**Lisa:** I think I am…

**Dr. Saraon:** Ok, thank you.

**Lisa:** I have a pretty loud voice. Can you hear me on the phone? (affirmative response) So the next slides are just a lot of documents that the department already has that have been provided over the last several years from people in the community just talking about why they think there (is need?) for a program at Highline. There are some things from SeaMar talking about how the downtown hospitals are not acceptable for people from (north?) service area. There are some things from the City of SeaTac, a past board member from Puget Sound Health Alliance that talks about the health status indicators and the reduced ability to travel, again just confirming a lot of what you’ve just heard, that it’s more than just numbers, there are a lot of issues that impact a community and
whether or not they have access, and so, I won’t read all of these, the department has received letters from people on all of these issues over the years and we just kind of wanted to put those in again. We have a slide on page 38 that is from Senator Keiser that she wrote when Highline was pursuing a Certificate of Need which was denied because of the focus strictly on the numeric methodology, and that is why we really wanted to come and put this forward because right now, if there is no numeric need, that’s the end and I think you’ve heard a lot today that can support that there is much more to King County, South King County in particular, than just the numeric need.

I won’t go over all of these, it sounded like we wanted to give some time for some discussion, so I’ll just skip ahead to that actual language that we’re proposing (slide 41). And I can answer any questions on the other slides, but I thought this is probably the meat of what people want to see so we had presented in our petition some language and we got some good feedback on that back in August and some of the comments were about some of the terms we were using not being very well-defined, we had some language about “catchment area” which was really talking about the Southwest King (unintelligible) Highline and what that means to them, and so we’ve adjusted that language to be clearer, we’re talking about 75% of their inpatients come from this really specific service area, and that’s what we’re talking about when we’re talking about the catchment area for Highline, and we think that, again, this is not just for Highline, this is exception language that other places can apply, and so we really think that’s a pretty standard definition of what it means to be a service area (00:33:30) and so we (unintelligible) if you look at that, that’s very standard (unintelligible) of what you are looking at when you are talking about what a hospital service area is so we thought that dealt with the issue of being a little bit too (vague?) on the catchment area.

And then the other issue that came up at the meeting and that we (support?) is that we hadn’t dealt with the fact that if you were accepted to perform PCI, what standards would you be held to. And so I think that Highline feels very strongly, CHI Franciscan feels very strongly that things (we’re moving to?) and actually probably already do (unintelligible) standards in the rule, and so we’re not asking to be exempted from the quality standards. We’re only asking that if the numeric need does not (unintelligible) for Highline, for an acute care program which I think based on the data it never will, we’re asking, because of what Jody talked about, with the 50% of the patients (unintelligible) planning area, so there will never be a need in West King numerically, and so what they are asking for is the opportunity to just put forth an argument and you’ve seen a lot of what that would look like today, that there is a need so despite that lack of numeric need for a program, but that they understand the quality standards are important and the department put those in place for a reason, and so they would be more than willing to comply with the 200 minimum volume and the staffing requirements, all of the things that are in those quality standards in the rule. So we made that change to make that more clear. And so the rule is very simple, it just allows for an exception, and it just changes the need for (unintelligible) methodology simply to say unless you can show there is a compelling reason in exception language, so that’s it. So it’s very simple, and I think we wanted to provide some closing remarks and then…
Dr. Saraon: I think if you look at the last slide, just in the bold, we have an area which has the highest poverty, lowest socioeconomic status, and one of the highest mortalities. And I think when you read the quote, “The core mission of public health remains the same: the reduction of leading causes of preventable death and disability, with a special emphasis on underserved populations and health disparities. This is our perpetual north star.” This community is, I think, a great opportunity to help, where they have the highest mortality, and have the least access to care. So we have a hospital system which, again, cardiovascular is the greatest leading cause of death in this area, and to create a stable program which has the (ability?) to elective and acute PCI to take care of these patients in a way which is sustainable and long term (unintelligible) all of the providers in the area and not have to pay secondary copays to the other providers, going to other hospitals that may or may not be in network, I think all of these challenges need to be lifted and not apply to the patients that are in the highest need. I think an exemption would be an appropriate way of addressing that, and especially myself, I took time especially to come from clinic to clinic to (make?) clear that this is going beyond numbers and I just hope that the committee here looks beyond the statistics and considers this area for exemption. And I think it is, you know, through the evidence we’re showing pretty transparent that this community really needs this kind of a program.

Lisa/Dr. Saraon: I think that’s it.

Nancy: Questions, comments?

Dennis: I have a question. You indicated that you’ll still adhere to the 200 threshold upon approval of your program, and if I remember your volume data somewhat, I think it was in 2014 you had about 179 cases, and the last two years it has decreased, and I think you’ve alluded to part of that has been (unintelligible) and you haven’t had services available. So you’d still adhere to the 200 upon approval of the application so you’re not really asking for a lower volume.

Lisa: No, and remember this, 179 was just the emergent program. We didn’t have the ability to do elective, so I don’t think they’d have a problem demonstrating that.

Jody: Dennis, this is Jody. The expectation is that all other standards are met, and that includes the volume standard. Highline (Dennis, Jody, Lisa talking at once) giving you a graph where we tied the volume reduction to the retirement of, I think, three of the five long-standing cardiologists in the community. As Tony and others have said, keeping cardiologists has been difficult because they can’t do what they are trained to do.

Lisa: Yes, and I think the way that we had our language worded in the last petition didn’t intentionally do this, but I think there was some language that we had struck out that made it so that wasn’t clear, so I did want to clarify that.

Steve: On behalf of Providence, Providence thinks we should have another meeting to discuss this. We have physicians that we may want to attend and our other hospitals
may want to comment on this. And there is a substantial amount of detail here, and we've only had, this is the third meeting, the first meeting was back in August, and we talked about the reduction in minimum volume standards, and touched on, well, we didn’t touch on, was talked for about fifteen or twenty minutes, we had a meeting on April 11 where, essentially, it was a main presentation by CHI, so, we just think there ought to be more discussion. At the end of the meeting I have a short three-page document that identifies some healthcare policy issues that we think should be considered going forward. I think the department needs to move with deliberation when it comes to, and I understand what CHI’s argument is about, all of the methodology has some sort of exception or exemption process, I might beg to differ with that a little bit legally, which we could get into, not today, though. But, I think when you're talking about tertiary services, the basis of a tertiary service is the legislature in the statute has recognized that there is a direct relationship between patient volume and quality. So I think that the department, and Providence thinks that the department has to move with deliberation when you are crafting some sort of exception for a need methodology within a tertiary service. And we think it should only be done if there is some sort of evidence of a state-wide or system-wide problem with patient access which we’re not seeing. I mean obviously, this whole process has been about Highline, which is fine, and I understand that they feel strongly about this and rightfully so. But, let’s face it. The purpose of CoN law is to allocate resources and there are always going to be people who are unhappy with the outcome. And that's just the way it is. My clients are sometimes happy and they are sometimes unhappy with the outcome. But, especially when you are talking about tertiary services, the whole goal is that there are supposed to be a limited number of providers of tertiary services, that's just the way the regulatory process works.

Now, in addition I think we also need to consider the fact that we have a parallel petition to reduce the minimum volume standards to hospitals to 200. And frankly, Providence has no objection to that. Our concern is, if we, if the department elects to reduce the minimum volume standards to 200, and the physician volume standards to 50, I think the impact of that, we think the impact of that, needs to be assessed before any sort of exception language is adopted because the reduction from 300 to 200 as the minimum volume standard is a substantial reduction and it’s highly likely that there are a number of institutions out there who will now qualify under the 200 standard under the methodology as it’s drafted. So, I think that that’s another thing that needs to be talked about too, that again, moving in a deliberate and measured fashion. So, I'll leave this document for people to pick up and this (will be?) the kind of issues that we’d like to talk about at the next meeting.

**Jody:** So, this is Jody, maybe we could have some time. I’m actually a little floored that Providence now wants to make this a statewide, that the need has to be statewide, that a community can’t take care of itself. We don’t believe that there’s going to be a need for any more than I think one new program by moving the threshold from 300 to 200 so maybe it’s time for Providence to put forth the data that you think needs to be brought to bear on this as opposed to just throwing obstacle after obstacle after obstacle out, and making us jump higher and higher and then changing the place that we’re jumping to.
Look at the data, Steve, I would be embarrassed to just say what you just said, absolutely, totally embarrassed for your system.

Steve: Jody, I’m totally embarrassed.

Jody: You should be embarrassed.

Steve: Let’s behave in a professional manner, okay? All we want….

Jody: I’m behaving in a professional manner. Providence has been blocking this for fifteen years, we now provide data that says people are dying and people’s quality of life is being impacted, and now you are saying it shouldn’t be a community specific issue, it shouldn’t be a planning area specific issue, it should be a state-wide issue. We can see through this.

Steve: Okay, we can…

Jody: It’s about the money that Providence generates by controlling about 50% of all PCIs done statewide. That’s what this is about.

Matt: I’d like to point out that I think Steve’s allowed to (voice?) his opinion without being attacked. This is Matt Moe here, and I definitely appreciate what you just said. I think my only concern is that this really feels like an attempt to change the rules at the program system level just to allow a single exception in the case of Highline. And an additional concern is that the language as it is right now is fairly general, even though it could be health disparities or inequities or lack of access, and it doesn’t necessarily allow the department to have (unintelligible) criteria that could be repeated in the system.

Jody: We don’t think the department should have discretion? And use its expertise? And (allow?) for everybody the opportunity to comment?

Ian: Jody, let me weigh in for a second. On behalf of CHI, we want to thank you all for entertaining. Our interests are simple: We want to take care of patients. This has been nine years where there has been a hole in our community to take care of patients. If the large facilities had wanted to take care of them, it would have been filled by now. And so the question is, are you going to hold up while people are dying, and take it another ten or eleven years? Let me read you something. “We identify our work as a ministry, embracing our responsibility to provide the needs of the communities across Washington.” We believe in that, but it’s not our mission. That’s the Sisters of Providence mission. Okay? Going on to say justice, “We believe everyone has the basic rights to the goods on earth.” That’s not our mission. This is Providences’ mission. If you hold us up, how are you going to plug that hole, how are you going to plug that hole where hundreds of patients are not getting service? You can take the patients with the insurance but you’re leaving everyone else behind. This has been there, nine years, ten years of data that shows that no one has plugged this hole. We’re willing to do it. All
we’re asking you is to change the language consistent with what has actually been done in other services before, not just PCI but other ones. That’s all we’re asking.

Steve: (Exception?) language has never been in tertiary services.

Ian: And so the question is, if you bought this, how are you going to take care of those patients?

Steve: I’m just a little bit bemused at the animus towards Providence. All we’ve said is we want an additional meeting to discuss the issues that have been raised.

Ian: But this is nine years of additional meetings, nine years of discussions on this one topic from my understanding of history, I’ve only been here a year.

Steve: If you are suggesting that Providence has been delaying Highline for nine years that’s absolutely (not true?)…

Ian: I am suggesting that the mission of Providence is to take care of patients or allow us to take care of patients.

Steve: This sort of discussion is extremely unprofessional and I’m not going to participate in it. We’re prepared to talk about technical issues and healthcare policy.

Ian: And we’re here to talk about how do you take care of patients in this state who aren’t receiving care.

Steve: All we’re asking for is an additional meeting to discuss the issues that have been raised by (our issue statement?)

Nancy: I think we’re about out of time. I appreciate the presentation and the discussion, and I think the department has some things to think about and we will certainly take into consideration your request for another meeting and look at our options.

CONCLUSION (00:48:18)