Kathy: Good morning everyone. Today’s meeting is a Certificate of Need PCI Rules. Today is July 19 and we’re convening today to allow Providence to make their presentation with respect to their position and then have some additional dialogue about CHI presentation and I think Dennis Hoover wanted to present a letter as well and then have any other conversation that we – that is appropriate for today’s meeting. So before we get started let’s go ahead and start with introductions. Can people on the phone hear me okay?

Matt Moe: Yes I can hear you, Kathy.

Kathy: Great. That must be Matt Moe.

Matt Moe: Yes, this is Matt Moe.

[indiscernible]


Lisa: From a logistics standpoint are we going to use – I had brought a flash drive – do we not – we thought the presentation we gave you back in June – how are we doing that today?

Kathy: We can put it up on the overhead of you want to. Please put that up for us real quick. I wasn't expecting a presentation. But that's okay, we have help.

Lisa: OK we can talk if everybody has copies of what we sent –

Kathy: Does everybody have copies of the CHI presentation? Okay. So I guess we can work with IT folks to get that –

Man: There is the one that said response to –


Kathy: Okay anyway if we could continue with introductions. Go ahead, Jody.

Jody Carona: Jody Carona, Health Facilities Planning.

Greg Eberhart: Greg Eberhart, CHI.

Tony Saraon: Tony Saraon, CHI.

Tony McLean: Tony McLean, CHI.

Chris Thomson: Chris Thomson, CHI.

Vicki Eastridge: Vicki Eastridge, Legacy Health.
Ian Worden: Good morning. My name is Ian Worden. I am the chief operating officer of CHI Franciscan Healthcare.

Stephan Pentz: Steve Pentz, Providence.

Frank Fox: Frank Fox, Providence.

Jonathan Seib: Jonathan Seib, YMMH

Dennis Hoover: Dennis Hoover, VMM.

Patty Seib: Patty Seib, VMMH.

Nathan Ward: Nathan Ward, MHS.

Nancy Tyson: Nancy Tyson, Department of Health.

Kathy: Jenny Kido, administrative assistant. She’s here to assist today which is nice. The purpose of this meeting today is to provide a forum for the exchange of information, engage in dialogue regarding both the CHI Franciscan and Providence presentations. We want to allow professional expression of multiple positions on these issues related to elective PCI in Washington. And so along those lines, we expect a professional, respectful, high level exchange today -- and an additionally robust discussion. So, my role is as the facilitator. I’m with the office of the assistant secretary. And I just want to remind everyone of the overarching goal of RCW 70.38 – that’s the Certificate of Need program - and that's cost containment, quality and access to care. So with that – anything anybody wants to add before we get going?

Matt: Kathy, we just [indiscernible} on the phone. I know that Lisa –

Kathy: Oh I’m sorry. Totally forgot. [indiscernible]People on the phone we’ve got Lisa Grundl, I know Matt Moe – anyone else? And I heard from Larry Dean and he’s going to come in about an hour into the meeting. Jan Sigman was called out of town on a family emergency so she won’t be here today. So Steve you have the floor.

Steve: Thank you. Providence Health and Services has set forth our position on CHI [indiscernible] –

Lisa: We can’t hear you Steve there’s noise above you.

Steve: We’ve set forth our position in the documents that were submitted on May 11. June 12th. And we’re not going to go through those documents page by page. However we would like to highlight what we consider to be important points. The first point which I will speak to is defining characteristics of a tertiary health service – which is, there’s a volume quality relationship to the service. The second issue as Frank Fox will address is the importance of recognizing that we’re here to talk about the elective PCI – the emergent PCI is subject to CON review. I think that’s important because of the volumes associated with each of those types of procedures. The third item, which Frank will also discuss, is the exception language that’s being proposed by CHI. We believe that it’s overly broad and vague. Fourth, Frank will finally address the issue that there is no evidence of any lack of access to either elective or emergent PCI services in southwest [indiscernible] county. Or for that matter anywhere else in the state. And that’s one of the points we’ve made from the outset – that if the department is considering adopting an exception provision given the nature of a tertiary health service that should only be done if there is some sort of
evidence of a state-wide or system-wide issue that people are experiencing around the state for that particular service for which an exception is being requested. Finally, and this is extremely important, CHI has failed to show that there is any relationship between the inability of Highline Medicine or to provide elective PCI services. In the incidence of what CHI refers to in its proposed regulation as “health disparities or inequities” I think we all agree – everybody that’s involved in this process – that we’re all concerned about health disparities and inequities and socioeconomic factors. There’s no dispute on that. But the key issue here – the issue frankly that CHI has failed to show us – that there is any relationship whatsoever between Highline’s ability to do elective PCI services and addressing the “health disparities” or inequities that may be present in southwest [indiscernible] county.

Those are the 5 issues that we are going to discuss during our presentation. As I said I’ll start out by talking about the defining characteristics of a tertiary health service. This is made very clear in the statutory provision because it’s [indiscernible]. A tertiary health service is “a specialized service that meets complicated medical needs of people and requires sufficient patient volume to optimize provider effectiveness, quality of service and improved outcomes of care.” So what’s important there is the nexus between volume and quality.” That’s the essence of a tertiary service. As we all know elective PCI has long been identified as a tertiary health service. And in fact 2 years ago in 2015 the department revisited whether elective PCIU should remain a tertiary health service. And the decision that they issues in August of that year the department concluded that in accordance with the legislative intent of the Certificate of Need Statute elective PCI should remain designated a tertiary health service. So there’s been a recent affirmation by the department that there is a volume quality relationship with respect to elective PCI services.

As a result, given the fact that there’s a volume quality relationship, it’s a truism that there’s going to be a limited number of providers of tertiary health services. That’s simply how it works out. That’s how CN works in general but it’s particularly true with respect to tertiary health services. Inevitably that leads to some people being disappointed with the outcome. But that’s why there’s review for tertiary health services. You need to have a limited number of providers in order to maintain the volume quality relationship.

The clinical literature is also very clear on this. And the clinical literature by the way was discussed and evaluated at length by the department in its 2015 Tertiary Health Services Review. The key document with respect to volume quality relationships in the clinic literature is the 2014 consensus document. That consensus document establishes that there is a volume quality in relationships with respect to PCI services. Now as we know, given the Yakima valley’s petition to reduce the minimum volume standard from 300 to 200 there has been discussion about that and I’m not going to get into that today but [indiscernible] has stated before that we have no objection to an accordance with the clinical literature moving to a minimum volume standard of 200. That’s what’s reflected in the 2014 consensus document.

And it’s important to recognize that the department in this regulation recognizes that volume quality relationship. Right now as I just mentioned the Yakima valley would like to reduce the minimum from 300 to 200, which again reflects the 2014 consensus document. And as far as I know there has been no consensus document since then that would alter that.

With respect to the volume quality relationship, CHI in its proposal and in its presentations it has made – including the presentation that we’ll make today – takes the position that we’re not proposing to go around the minimum volume standard. We’re going require that if someone qualifies for this exception we’re proposing they also have to meet the minimum volume standards. The problem with that approach is that even if Highline – to use the example that has been before since the start of this process – even if
Highline is able to show that it can either do 200 or 300 cases per year. 200 if we assume we go down to 200 for minimum volume standards – that’s not the issue.

The issue is that, as Dr. Larry Dean of University of Washington Medical Center has pointed out in the past, the volume of PCI’s has been on the decline over the past 10 years or so. And it’s continuing to decline. In fact, in 2015 the most recent data – which Mr. Fox has provided to me – there was a continuing decline from 2014. In 2014 there was 11,674 inpatient and outpatient PCI procedures in Washington. In 2015 there 11,291. That’s down from a peak of 14,473 in 2008. So what’s happening here, as Dr. Dean has pointed out, is that we essentially have static or declining volume. So to the extent that you add additional providers to the mix you’re simply dividing up that pie so to speak among additional higher volume of providers. So even though Highline may be able to come in and say “we’re going to do 200 procedures a year” the fact is those 200 procedures have to come from somewhere. And as the department knows well there’s the number of hospitals that have PCI programs that are either right on the edge of 300 or 200 in terms of the number of procedures they provide per year. So what happens is that yeah, sure, Highline or whoever qualifies for an exemption may be able to show that we’re gonna do 200 or 300 procedures per year. But those procedures are going to be coming from other providers – which either will move a provider below the minimum volume standard or for someone who is a newer provider of PCI services will prevent that new provider from reaching the minimum volume standard – whether it will be 200 or 300.

What’s interesting about that and which CHI has not recognized in any of its presentation materials but which we have is that the literature – the clinical literature – recognizes this problem of declining PCI volumes and points out very clearly that this is not good either for patient access or for the health care system as a whole. And I’ve quoted this before but I think it’s helpful to quote it again. It’s a short quote. This also comes from the 2014 consensus document which established or suggested a 200 per year minimum volume standard for institutions. This is a quote from the 2014 document:

Hospitals justify the creation of new PCI centers without onsite surgery by stating that they improve access for geographically underserved populations and allow patients to be cared for in close geographic proximity to their own families and physicians. However, multiple low volume and partial service PCI centers within geographic area diffuse PCI expertise, increase costs for the overall health system, and have not been shown to improve the [indiscernible].

The consensus document goes on to state: “the development of PCI facilities within a 30-minute emergency transfer time is therefore strongly discouraged.”

This is not Providence saying this. This is not a provider saying this. This is the consensus document for 2014 upon which we are basing our potential move to 200 per year minimum volume standard. But this is not the sole document or sole piece of clinical literature which takes this view. There’s another important study from 2013 entitled Evidence of Systematic Duplication by New Percutaneous Intervention Programs. This study was authored by Canon, et al. The summary of the abstract of this article is “Our data show new PCI programs were systematically [indiscernible] of existing programs and did not help patients gain access to timely PCI. The total cost of recent U.S. investments in new PCI programs is large and of questionable value to patients.” And that’s from a study in 2013.

Finally, and by the way all these studies are referenced on pages 7 and 8 of our June 12 document. There’s a 2014 article written by Barron et al titled The Challenges of Success – Maintaining Access to High Quality Coronary Intervention in the Face of Declining Procedural Volumes – that article states “unfortunately the reality is that most new catheterization laboratories in the united States have opened
in areas that already have established PCI programs and therefore do not increase access in any meaningful way. Without improving access to PCI there really is no discernible benefit to society to continue to develop PCI centers. In fact, there is likely substantial societal cost both monetarily – by duplication of services and increased capital expenditures – and clinically if patient outcomes are compromised by diluting operator and hospital procedural volumes.”

So there is clinical consensus. There’s clinical consensus that would probably be appropriate to move to a 200 PCI procedure volume per year standard. There’s also clinical consensus that the proliferation of elective PCI programs – PCI programs in general – does not improve patient access. In fact it dilutes provider and operator capabilities and costs society more money. That’s why we think the department should take a long and hard look on whether it should start banning the exception of the list along the lines of that suggested by CHI.

I will now turn the floor over to Mr. Fox and he will address issues 2-4.

Frank Fox: Thank you. The first issue is elective vs. emergent PCI’s. The CHI request concerns an elective PCI program. Highline provides emergent PCI [indiscernible]. The CHI Power Point presentation that we saw recently at a prior meeting frequently comingles the provisional PCI’s with the general and the provision of elective PCI’s specifically. It may well be the same procedure but the difference is that PCI’s broadly defined include both the emergent and elective PCI’s. Highline provides a large number of PCI’s. Currently based on their own figures they provided 228 PCI’s in 2015. This reflects [indiscernible] emergent PCI which are not subject to significant [indiscernible] review approval. Highline can and does provide PCI’s today. Plus the CHI’s statements about PCI’s and access the issue is much narrower. Highline can not provide elective PCI’s which are defined to include PCI’s performed on a patient with cardiac function that’s been stable in the days or week prior to the procedure. Elective cases are usually scheduled at least 1 day prior to the surgical procedure. That is quoted right out of the [indiscernible].

This contrast to the department’s definition of emergent PCI’s – which means a patient needs immediate PCI because in the eyes of the treating physician’s best clinical judgment delay would cause – delay would result in undue harm or risk to the patient. This fundamental difference between emergent and elective PCI’s recognizes emergent PCI’s are intended to save lives which logically should have different standards than PCI’s performed on an elective basis.

The next issue that I would like to discuss is CHI’s proposed exception language that in our opinion is flawed [indiscernible]. CHI’s criteria to justify the use of exception permission includes demonstration 1 – health disparities, 2 – inequities, or 3 – lack of access. There are no clear definitions attached to any of these terms nor are there any measures that could be used consistently and accurately using publicly available statistics to demonstrate them. In the case of health disparities, inequities or lack of access there are numerous PCI programs in King West and King East, in relatively short distances of Highline. And also, most importantly, there is no demonstration of a link between health disparities or inequities to increase provision of elective PCI services. There are simply no languages provided.

Furthermore, the department would need to determine what health disparities, inequities, or lack of access actually mean. As I mentioned, they’re not defined. Nor are they measured. The problem we also need to understand how these measures would or could be measured on a consistent revocable basis. And third, when any of these conditions exist, and if they exist, whether they’re present should trigger an
exception to the numeric need methodology. None of this is discussed or demonstrated by CHI in its request for exception provision.

There are also flaws within the zip code analysis that CHI proposes as the applicant service area. Most importantly the zip code definitions are totally silent regarding unique distance factors in time to care standards such as those included in the open heart surgery exception that CHI quotes as another tertiary service where there is an exception provision. But the exception provision for open-heart surgery as we discussed in our paper is fundamentally different and much more well-defined and bounded than is the CHI provision which is just the opposite. Such time and distance metrics would be essential since we know the Valley Medical Center, for example, which is the nearest location of an elective PCI program to Highline, is less than 6 miles away from Highline.

The third point that I’d like to discuss is the issue of lack of access. In all of its materials CHI has provided no evidence that there is a system-wide patient access problem with respect to elective PCI’s – as Steve has discussed. Instead, CHI has based its argument on the adoption of the exception provisions based on only what it perceives to be unique in its Highline Medical Center – one of ten hospitals operated by CHI Franciscan in western Washington. Under the elective PCI need methodology, King County is divided into 2 distinct PCI planning areas – King East and King West. Highline is part of the King West PCI planning area. In one of these presentations CHI presented travel times, intended to demonstrate lack of access we will presume. But they are misleading and are inaccurate. In its Power point presentation CHI included travel times to the closest PCI provider from Highline, including times to [indiscernible] Virginia Mason and St. Francis. CHI intimates that in that tangle the travel time to Valley is the shortest – which CHI states on average is 22 miles. Oh no excuse me CHI states on average it’s 22 minutes. However we know from the department’s own evaluation that the Highline’s 2013 Certificate of Need application for PCI services at Highline – which was not approved – that Valley is only 5.9 miles away from Highline and Swedish Cherry Hill and Virginia Mason are 10 ½ miles from Highline. Further, these times obviously ignore emergency transport times which would be much shorter.

We appreciate that there may be issues regarding residents’ ability to travel – including lack of access to personal vehicles and travel costs. Though elective PCI’s are by definition are a tertiary service in our state which will not and should not be available in every community. The issue is access to elective PCI programs which can be scheduled in advance or travel can be coordinated. CHI comments might have some validity if CHI were referring to travel time of greater than 30 minutes for emergent PCI’s. It’s not discussing that. That would be a positional [indiscernible] clinical literature as Steve quoted from. However, this isn’t the case. Providers such as Highline are able to perform the emergent PCI’s now without significantly [indiscernible] factor provided as of 2015 of over 120 PCI’s. [indiscernible] scheduled in advance and the travel time suggested by CHI are far more appropriate than would be expected. Simple maps that show hospitals that provide PCI’s in King West and King East planning areas demonstrate that a simple 15 mile ring of Highline that of course lowers travel time but within a simple 15 mile ring there are 3 King West hospitals – Swedish Cherry Hill, The University of Washington Medical Center, and Virginia Mason – and 4 additional hospitals in King East – Overlake, Maui Medical Center, St. Francis, and multi-care Auburn Center of King East. All 7 of these hospitals provide PCI procedures on an elective basis. In our opinion this demonstrates not lack of access but in fact access to elective PCI’s to residents in the Highline service area.

Steve: Thank you Frank. The final point we’d like to talk about is one that I referenced in my introduction which is whether the fact that CHI has failed to show that there is any direct relationship between provision of elective PCI services at Highline and addressing the socioeconomic conditions in Southwest King County. And before I get to that further, I think we can all agree everybody who is participating in
this process is concerned about, is aware of, and has a passion for health care disparities in the [indiscernible].

No one who is involved in this process – person or institution – has a monopoly on concern or compassion for those issues. Any suggestion to the contrary is simply unfair and inappropriate. I’d like to preface my remarks on this issue with that thought.

And again the point is that if you are going to grant an exception based on the existence of “health care disparities and inequities” in a particular area of zip codes which is what CHI is proposing you have to be able – for that exception to make any sense whatsoever there has to be a linkage—there has to be a relationship between granting an exception to provide elective PCI services and addressing or – the CHI suggesting resolving the healthcare disparities and inequities in that particular area. CHI has produced absolutely no documentation showing that there is a direct relationship between the provision of elective PCI procedures at Highline and the resolution of those issues – which we are all concerned about. We are talking about a very small number of procedures.

I went back and looked at the evaluation of Highline’s 2013 application to establish an elective PCI program. First of all in 2014 based upon the data that I have Highline performed 134 PCI’s. I’m presuming those are all emergent because Highline [indiscernible]. In their [indiscernible] application in 2013, they were proposing to do a total of 180 PCI procedures in 2014, 250 PCI procedures in 2015, and 305 PCI procedures in 2016. So we’re talking about them roughly moving from 134 emergent PCI’s to 300 total PCI’s. We’re talking about an increase of 170 elective PCI procedures. There’s 2 points here. The first point, as I noted before, is those are simply coming from other providers, which is a key point. The second point is – is the provision of 170 elective PCI procedures going to address the [indiscernible] socioeconomic and health issues that CHI has presented to the department? No. It isn’t.

And there’s no evidence. They’ve made no attempt whatsoever to show that that’s the case. And by the way, because this essentially has been a de facto certificate need application by CHI at Highline – all we’ve heard from is them. Nobody else from around the state has come in and said “Oh yeah, we’ve got the same problem here. We’ve got the same problem in Spokane. We’ve got the same problem in Southeastern Washington. We’ve got the same problem in Central Washington. We’ve got the same problem in Northwestern Washington.” This is – despite CHI’s protestations to the contrary – this has been a single provider [indiscernible] petition for ruling. Again it’s a de facto certificate review. Let’s not lose sight of the fact we all want to see these issues addressed. But CHI has not shown that adding elective PCI at Highline is going to address these issues.

Just one brief follow up note and this goes to Frank’s comment to driving distance between Highline Community Hospital and the general Southwest King area that Highline serves – I will echo his comments that there’s a large number – several PCI programs within that area. I would also point out that, speaking of consensus documents, I refer to the 2014 consensus document – they also make a statement about travel times. Again, quoting form the 2014 consensus document:

If the transfer time is less than or equal to 30 minutes it is reasonable to assume that transfer to the nearest PCI center will provide reperfusion as rapidly as if it were available at the first hospital. For transport times longer than 30 minutes performing PCI onsite is likely to be quicker than a transport.

By Highline and CHI’s own admission, there are several PCI programs within less than 30 minutes driving distance using the Google driving distance application. The consensus talks about emergency drive times so if the times are less than 30 minutes to all these PCI programs for Google driving time which is normal traffic quote unquote at various times of the day, then emergency transfer time certainly is well below 30
minutes. Again, and this is by way of segue into comment by Mr. Moe which will follow next – and I appreciate your comments at the beginning of this meeting. I think we all need to approach this in a professional way. And we all need to recognize everyone in this room, everyone on the phone, everybody who has been involved in this in any fashion is concerned about socioeconomic factors, is concerned about healthcare disparities and inequities. The question here is whether from a societal standpoint, from the standpoint of the application of [indiscernible] under preservation of the volume quality relationship of tertiary health services we’re going to start allowing exceptions.

At that I would turn it over to Mr. Moe who would like to speak a little bit about Providence’s role in this process.

Matt Moe: I just want to thank [indiscernible]. I just want to take a couple minutes to conclude with a few words on the path of Providence. But first I want to make sure – am I coming through clearly?

People: Yes. Yes.

Matt Moe: If that’s not the case, let me know. So I just want to reiterate that Providence comes to the process with a genuine intention to help shape the rule making in a positive way and we’ve had [indiscernible] ensuring the impact of any rule making result imposed with outcome to the community and the individual level. Our passion during this process is a way to [indiscernible] and land on outcomes and improve quality and patient safety along with helping shape reliable [indiscernible] that work for the participants. Our joint work with the committee on the Yakima petition demonstrates that commitment by digging into the facts, examining the data and using the clinical research literature guide we as a group have shown that the Yakima petition to reduce provider and institutional PCI volume is a sound position. Most importantly that decision to reduce the volume – or the pending decision is supported by the compendium of literature and in fact the data we examined.

In the case of the CHI petition that we’re discussing today -- for the reason just stated by my colleagues we strongly believe that creating vague exception language is not the way to proceed. We feel that the department would be well advised to not adopt the CHI exceptions language. In fact, our position is that before adopting any further changes we would be best served by deferring any further exception provision until the impact of the reduction of the minimum volume standard can be adequately assessed.

Finally, as we step into the next portion of the meeting I want to be clear that the focus of this [indiscernible] making is on the CHI proposal. This meeting is not about Providence. We are a participant here but it is not about us. And we ask that the participants focus on the CHI proposal and the merits on that proposal and we look forward to having a constructive conversation along these lines. Thanks. I’ll pass it back over to you, Steve.

Steve: Thank you, Matt. That concludes our presentation. I just have one housekeeping matter to refer to. On June 5 Legacy Health submitted a letter to the department in which it suggested additional modifications to 2 of the PCI [indiscernible] relations. As the department knows, the scope of this particular rule making process is limited to the subject matter of first the Yakima Valley petition for the [indiscernible] which is the minimum volumes [indiscernible]. And second, to CHI’s petition for rule making, which is the exception language, the “modifications” proposed by Legacy have nothing to do with the subject matter of those two petitions. Moreover, the modifications proposed by Legacy go beyond the scope of the rule making process as described by the department in this CR 101 that was issued on July 6 of 2014. We’ve prepared a letter addressing that issue. I close the letter by saying that we presume that the department is not going to consider Legacy’s modifications given that Legacy does not appear on
today's agenda. And we presume – perhaps I'm overly presumptuous – and you will agree with us, that you're not going to consider those modifications. However, if the department should decide to consider those modifications we believe that all affected parties including Providence have been given an opportunity to respond in writing to those applications and that there be an additional meeting or meetings held to discuss those modifications in [indiscernible]. And I'll give you a letter at the close of the meeting.

Kathy: Okay.

Steve: Thank you. That concludes our presentation.

Kathy: Just to be clear. We are going to encourage discussion, including from Legacy with respect to the contents of your letter. Whether or not the modifications – you know, it's proposed language. We're just going leave it at that. Okay. Thank you. So I think we wanted to just open up discussion now with respect to the CHI presentation and position. Or do you want to take a few minutes and do your presentation, Jody?

Jody Carona: What we'd like to do. I think what we were prepared to do – what we thought we were supposed to do was prepare a response to the Providence document. I think they expanded the record today so we'll want an opportunity to respond to that. But there are a few items from our Power Point that I think would be useful to set the stage. So if that's possible that would be great. Just a couple of things as well then I want to turn it over to the folks with the clinical expertise. But I think I would disagree this is not a de facto Certificate in Need. This is simply a petition asking for the department to create an exception such that these kinds of robust conversations can happen appropriately in a Certificate in Need process. Had this been a de facto CN I think on the way out we would have been issued the CN frankly – the case is compelling, the data is compelling. But this is not specific to Highline. This is an issue that probably exists in several communities in the state. And it's about underserved communities, health disparities. The Secretary of the Department of Health has an incredible definition of disparity. You might want to look on his website. It's an issue that I think the Department of Health exists to try and remedy. And we are here asking for that consideration.

So if I can just go through a couple of slides and then turn it over to the key folks here. The other thing that I would add in response to what Providence said is we agree with the volume quality relationship. Highline today is on track in 2017 to do 180 emergent PCI's. The reasons Highline's volumes were down in the last few years – you're asking for the correlation between addressing health disparities and having the ability to do an elective PCI program – that relationship was taught to me about 8 years ago by MultiCare’s Good Samaritan program. We were the consultants that worked with MultiCare, with Good Samaritan, to help them establish a program. And their cardiologist provided an incredible amount of evidence that we can pull out of the record from that period of time that says if you do not have the ability to also perform elective PCI's you can not sustain an emergency program because conventionally trained cardiologists will not, do not need to, can go other places, staff a program 24/7 where they can not do what they are trained and equipped to do. The Franciscans have by any mean since it acquired Highline put together – right now I believe it's backed to I believe a 24/7 staffed program. You can see that the volumes went from 130 cases in 2014 to 180 cases today. But those cardiologists will not stay in this community if they do not have the ability to do what they are trained to do and what they think is in the best interests of patients. And what we will add to the record today is a letter from Seattle King County signed by the Medical Services Administrator for King County Medic One, the Program Director for King County Medic One, and for the Medical Program Director for King County EMS basically indicating that the system does not work. The quote here is “King county Medic One is challenged to and cannot
guarantee to respond to a given hospital to transport to alternative facilities when a hospital is unable to
deliver a standard intervention such as a catheterization to a patient already in house. From an EMS
perspective additional travel away from the assigned paramedic service area – which is what happens
when Highline is on divert – leads to subsequent delays and gaps in EMS response throughout the
regional emergency system. From an operational clinical perspective the ideal system would have each
hospital providing high quality reliable coronary catheterization services. This is from King County Medic
One. And we also have a letter from Highline’s emergency physicians talking about the number of hours
on divert due to lack of cardiology coverage in the past year.

I will also add to the record that I live in Normandy Park – so I live in Highline service area – I had the
opportunity to go to a meeting yesterday at Valley Medical Center at 3 pm. I think it’s 9 miles. It took me
an hour and 10 minutes to traverse Hwy 518, to get on 405, to get on 167, to get there. There was a car on
fire close to South Center. I5 and 405 were shut down completely. If anybody tries that commute in the
morning or in the afternoon it is not a 6-mile jaunt. It is a long excruciatingly painful time in the car trying
to get those 6 miles.

So with that I just want to respond to a couple of other comments and then again turn it over to the
clinicians. If we can – do I drive – or how are we going to do this?

Jeni: You can take it wherever you like it or just scroll down it’s –

Jody Carona You feel free. I just want to move to slide 5 right now. Everybody has this, everybody’s had
an opportunity to look at it. So I think Providence is arguing that we have to be very careful about tertiary
-- that they should be regional, that there should not be many and that the bar should be set pretty high –
Highline, CHI Franciscan and any other subsequent application applicant is glad to have that bar set high.
I want to show you what’s going on for the services that are defined as tertiary in Washington state in the
last few years.

So Level 3 and now Level 4 NICU. Neonatal intensive care. There’s no methodology in rule. And in King
County over the past 8 or 9 years there’s been 6 neonatal intensive care units approved. University in
Seattle Children’s 1.6 miles apart, Overlake in Evergreen – they both had about 10 years ago CN’s to
establish neonatal intensive care units. They’re 7.6 miles apart. Try that commute someday. That’s a
terrible commute as well. This one sticks out specifically to me – the solid organ transplant. So about 7
years ago – no methodology in rule – Providence’s Swedish hospital put forth a CN application. There
were 110 cases statewide. 110 liver transplants statewide. They put forth the case that they wanted the
only program in the state at that time was at the University of Washington Medical Center. They sought
and secured CN approval asking for an exception basically because they wanted to try a new kind of
transplant service. They are 4.7 miles from the University of Washington. 4.7 miles and that project was
approved.

Level One rehab again you can see just recently – that’s a tertiary service. About 6 months ago the
department approved expansions – a brand new one for the Franciscan and an expansion to the
MultiCare Good Sam Level One rehab 14 miles apart. You can see the same thing for Level 20V. Nothing
has happened in this inpatient pediatric services area and then in 2008 when the department changed
the rules around elective PCI what we found in the King East planning area – there were 4 hospitals
approved to provide elective PCI all within 10 miles of each other. So to say that the bar needs to be so
high and so careful is really not the practice of the program. They are looking at internal need. Again,
what we are asking for is the opportunity to put forth an application to demonstrate that.
I think that there’s one other slide that I’d like to show you here. And that slide is on page 11. What we’re showing you here is that Highline has a – right now today – a 33% market share of all PCI’s done [indiscernible. So these are both elective – any elective that would be admitted and then emergent. But we have a 55% market share of Medicaid. So we are the sole provider in Southwest King planning area and we disproportionately serve the Medicaid population in that area. When Providence suggests that maybe we transfer our patients in a 15 mile radius to Overlake or to Evergreen or to some of these other locations this is not the payer mix these hospitals are necessarily interested in serving. And Highline does have difficulty at times identifying hospitals that will accept its patients when it’s on divert.

I just want to end it with that piece of information. Again, the stage here is – this is not a de facto CN. This is an opportunity to ask that the rules be modified. And I’d like to turn it over to Dr. Saraon.

Dr. Saraon: That’s a really key point. This meeting is about creating an exemption to the current CoN. I think the idea that a single policy would serve the entire state and to think that it wouldn’t adversely affect some communities is not wise. That’s why we have exemption – because certain communities are not being benefited or adversely affected. And that’s why exemptions exist. Also, we are basing this kind of push on the fact that this community is underserved. It has a health disparity. It has the highest mortality in the region – which is due to cardiovascular death. So the idea of how do we connect these things – well we know through training in medicine that prevention, prevention, prevention is the key -- modifying risk factors, being a part of the community education, doing public lectures and talks – which we do at Highline. Providing these kinds of services, talking to the community is what makes the biggest difference. But to have stable groups of cardiologists, primary providers, and an ER which can staff emergencies is what you need.

So then the question becomes well how does an elective PCI fit into all this? And I want to go through a few of these points that Steve was mentioning. He kept talking about PCI and volumes and volumes and PCI. What he’s not telling you – which is misleading – is what the rest of the data he presented suggests – is that above 200 cases there’s not any further benefit. So as you go to 300, 400, 500, 600 PCI’s it’s not like your getting more and more benefit. That’s why the line on 200 seems to be the critical line. And it’s not that every program under 200 is going to be terrible but it’s just that you put your population – the entire 200 – at an increased risk for adverse outcome. So that is how elective PCI does modify the mortality of a particular server. So if Highline is able to exceed with an elective PCI program the branch of 200 – even the current people we’re serving – will be at less risk of increased mortality and bad outcomes. So as you pass that 200 mark – and that PCI volume is for the entire cohort, whether it’s elective or it’s emergency. The entire group benefits because the operators are more skilled, the staff can be appropriately – the service can be appropriately staffed because there’s enough cases going on that the providers will stay present. Those providers that stay present over time get invested into the community and do other things that local providers or people that are just there temporarily don’t do. People get into the community – they become part of the region. They go out and do talks and they get involved with the community. They donate back to the community. This is how this process evolves. So trying to create a stable group in this region, which has the highest mortality again in the region due to cardiovascular health is the key premise. And having elective PCI part of that is what’s important.

So if we get above that 200 number I guess the next question is do we adversely affect the other community hospitals. And that’s also been brought up – that we’re going to somehow adversely affect Providence or Overlake or Valley or these other hospitals. The reality is if they’re not falling under the 200 mark all the data suggests that you do not adversely affect them. So you can provide that locally.
The quotes that we’re getting directly from that data is about establishing new PCI programs. New PCI programs should not be started up in territories where there is within 30 minutes of other programs emergent. That’s the point. And that was said repeatedly. And quoted. But it has nothing to do with existing programs that want to do elective PCI. So that doesn’t even apply to what we’re talking about. So it’s distracting and it kind of irritates me that we’re quoting from data which is not applicable to the current statements. That is talking again and again about new programs. And I can understand why we’re doing that – because we can’t find this data out there. This is a very unique situation in which you have an existing PCI program expanding into an elective program to benefit this program over all. You’re not going to find much data on this because this is kind of a unique situation. It doesn’t get analyzed like this.

And again, people will separate these two services: this is elective and this is emergent. But the reality is this is a service provided to a community which is essentially benefitting that whole patient pool if you can get your population above 200 cases. If you stabilize the cardiology group you can have less adverse outcomes for that group that’s in that cohort including the emergency and you can benefit the community as a whole. And that’s kind of the global thinking. Again that was brought up – how do you connect all of this? It’s all connected. It’s not a straight line how it gets connected. But it’s all connected and it creates this kind of atmosphere where you can improve the community. I think we talk about dividing up this pie of procedures and procedure volume going down. The reason the procedures are going down from 2008 to now is – and there’s a lot of debate around this – is because we were performing a lot more PCI’s when they probably weren’t necessary. So when we really look at the data why the PCI volume is going down is we’re being closer to appropriate use criteria for appropriately treating these patients. We’re providing PCI in the right settings. So the volumes going down – and I agree they are going down but probably for the right reasons. But the second thing to know is that they are not going down in a substantial fashion. Even numbers that are quoted the difference was 500 or 600 across the state. And again just to reiterate the PCI volume at Swedish is 480, at UW is above 400, Virginia Mason is above 400. Allowing elective PCI at Highline will improve the mortality, stabilize the group and not adversely affect the surrounding community because their numbers are greatly above the 200 anyway.

And talking about these transport times and how long does it take to get somewhere – let me tell you about the reality. The reality is if I have to send my patient – which I do – for elective PCI to another hospital. First we have to call to send over all the notes, because I don’t go to those hospitals. Ask for a new cardiologist. They have to drive over for an appointment which takes 3 weeks – that’s the average wait time for a cardiologist in our area. Then they’ll meet this doctor, make a new copay and try to establish trust. Because we’ve already had a doctor that took care of you, now you’re going to a new doctor who is going to open your heart and do something else – so it doesn’t always gel. So now they have to either stick with this provider or find another provider because they’re not sure they agree with this provider. Then let’s say they do agree with this provider, they want the elective PCI. Sometimes this new provider, which is common, will perform more tests. New stress tests, new procedures, new ECHOs because they don’t have these things readily on hand. So they go through more procedures, more testing. And that’s why there’s this process of duplicative testing – which is a reality. Then they’ll be scheduled for elective PCI. Probably from the start to the end you’re looking at least to a minimum of 5 weeks before they are able to get this procedure.

Just to highlight a recent patient: he came to our facility. He had a bypass done. And now one of his bypass grafts closed. He is a laborer working person. So he has refractory angina and I have been struggling to get him into appointments to other providers because I can’t do the elective PCI. And the interesting part is I have to keep writing these disability letters for him for work. He’s missing out on work. He’s not being paid. He’s being adversely affected. And this is being repeated and repeated.
When I have to face my patients and try to explain to them why can’t you do this well you have to go to this new provider because of the Certificate of Need blah blah blah. Yeah but we don’t – this area has the lowest income, the highest health disparity and yet these patients have to be shipped to another site to then meet with a new doctor, pay another co-pay, if their insurance is accepted, possibly go through more testing and then finally get their procedure.

So it’s a bizarre situation and if you ask cardiologists throughout the country like my colleagues I tried to explain this to them their first question is oh that’s interesting but why. Why does this exist? And when you look at these kinds of things before – especially [indiscernible] – the data is pretty clear. Once you’re over 200 the mortality doesn’t change and all the data talks about new PCI programs. We’re an existing PCI program and that is a totally different story.

Finally, the idea that this patient can simply be shipped to another provider and get this elective PCI is not a reality. This community just doesn’t go. And that’s another reason why our volumes are going up. They don’t go. It’s too difficult for them. They can’t get the appointment. And they end up getting readmitted with a myocardial infarction instead of an elective PCI. So we end up seeing the same patients back again in the hospital now with a heart attack rather than getting an elective PCI. Because of some of the barriers they had to getting these appointments. So it’s not as simple as yes it’s a 30 minute drive time and they can go get this procedure, walk in and get it done. It’s quite complicated. It’s a complicated procedure. As simple as it is to find tertiary service requires a lot of explanation. A lot of testing to show – establishing relationships. So this is where the story that this is just a procedure that can be shipped to another facility is not a reality. These are not inpatients. There are not patients you can ship within 30 minute drive times emergently. These are outpatients that need to establish this kind of relationship and for me I think the key thing about the language being vague is – it’s not vague. It’s very specific – it’s an underserved population with the health disparity and the facility can do greater than 200 cases. That is very narrow. You’re not going to find too many places that can suffice those needs in this state. And again I think – just to reframe why we’re here. We’re here to discuss whether there should be an exemption clause like there is for other things so that we can submit this information for review, so it can be discussed in an open forum, we can debate these things. We’re pre-debating just to show that there is a need. But we’re really asking for this exemption clause and I think that by looking at the precedent set through other areas it’s appropriate. And it’s appropriate to be able to discuss these things. There shouldn’t be a closed door where you cannot provide even future facilities who end up with problems an avenue to present their case why this community would benefit from and elective PCI program.

Jody: Can I just show 2 more slides and then I think we’ll be done with our piece if that’s okay? So slide 12 would be the next one. I wish I had put on this slide the volume of all the King West providers. This volume is basically intended – this is COPE data. What we’re showing is every Providence hospital’s volume. Providence statewide has about a 40% market share of all PCI’s. A pretty significant market share.

Steve: that’s totally irrelevant. What does that have to do with your proposal?

Jody: Do I get to make –

Steve: I don’t care. We said at the beginning – Matt said at the beginning this is not about Providence. Don’t try and make it about Providence.

Dr. Saraon: Steve, you had mentioned that PCI volume is tied and if it adversely affects other topics –
Steve: Okay then why don’t we have all hospitals in the state of Washington up there?

Man: I thought you said we wanted to be professional?

Steve: I am being professional. She’s being unprofessional. We’re objecting to –

Jody: Are you guys going to let this conversation go on? Because I can interject if you like.

Kathy: Let’s let Jody finish and then we’ll open it up to –

Steve: Okay I would just like to state for the record that this proceeding is not about Providence.

Dr. Saraon: but Steve you opened up –

[crosstalk]

Kathy: Time out for a second. This is not – everybody keeps calling this a proceeding and on the record. This is a meeting. We’ve opened a CR101 on 2 rules petitions. So this is not a formal proceeding. We’re trying to have a professional discussion about the issues at hand. So yes, we’re recording it because we’re going to make a transcript of what we’ve said here so I have it if anyone asks. This is not a formal hearing. I just want to say that one more time.

Jody: So thank you and my point is very simple. In retrospect I probably should have added all the hospitals on here but we were responding to Providence’s public comment. The one facility of Providence that is located in the same service area is Swedish Cherry Hill and that facility did almost 1200 PCI’s last year so I don’t think we have to worry about that facility dropping below 200 and in fact no facility in King West would be anywhere near 200 if Highline was able to establish its program.

The next slide I want to show, if we can just move to the last –

Dennis: If it would help, just for completeness I have, based on COAP the University of Washington submitted 728 cases. Virginia Mason Seattle submitted 402. [indiscernible] they did 227. So I think those are all the King West [indiscernible] just so you have all of them available.

Jody: Thank you. The last slide I want is a slide that reiterates a legal case that both the department and Providence Swedish have made. And this is a case that basically – oh you went 1 too far. This is an excerpt – the Department itself has argued for exceptions in legal appeals. This is the quote from a recent court filing of the Department of Health. And if everybody can’t see it or for those of you on the phone it says “Indeed the department would be acting arbitrarily and contrary to the public interest if it denied a CN application solely because numeric need methodology showed no net need in the planning area.”

So again asking for an exception is very consistent with what the department itself is arguing in court. The department cited several cases in that court ruling from other jurisdictions. And the court of appeals affirmed the department’s use of an exception to find need even though numeric need didn’t exist. If you want the court citation, glad to give it to you. But what we also want you to be aware of is that Providence itself – Swedish – argued to the court of appeals in 2015 that there should be an exception to the PCI rules allowing a finding of need for an elective program in King county. There were arguing for King East even thought 2 [indiscernible] providers were not meeting the minimum volume standard. And they took that to court. And they argued for the exception. So this is pretty consistent. We are not asking for something
that is not an argument that has been raised before. And I just want the department staff to be aware that the department AG's are arguing for exceptions. Thank you.

Lisa Grundl: This is Lisa from Health Facilities Planning. I just want to support that again we're not asking for a decision today as to whether Highline should get a program. That's not what this meeting is about and I think that we keep talking about what the impact to providers will be, whether this is a new or existing program. All these things are all part of what will come up during a CN process. What we're asking for is simply that we have the opportunity in community – and Highline's a great example because they will never show numeric need based on the way the methodology is currently written – to just recognize that there might be some community specific issues and during that process the same data, the same clinical data that we've talked about today can be evaluated. So I just want to please encourage the department and the others in the room we don't have to decide who is right or wrong on the clinical data today or decide whether there will be impact on other providers in Highline's district today. We don't need to decide if Highline can make it to 200 today. We just need to decide do we as a group or does the department agree that sometimes a numeric need – a statewide numeric need – can't possibly address every community specific issue and is there reason to have language that allows someone to make the argument in a CN [indiscernible]. We don't need to make decisions on who's right or wrong or what data is relevant or irrelevant today. We have to say there's data out there and let's have a chance to show for a specific community that wants to perform a CN that there might be some community specific issues that are adversely impacting cardiac health in their community. Period. That's all that needs to be decided. Not anything else about the rest of this. I think it's been great presentations, I appreciate it. But I just don't want to get caught up in people feeling like there has to be a final answer today about whether or not there's a program at Highline or anywhere else in the state. Just whether or not we want people to feel that they can make an argument for that recognizing that a statewide numeric methodology can't possibly address every community in the state.

Kathy: Thanks Lisa. I'm wondering – anybody need to take a 5-minute breather?

Nancy: I do.

Dr. Dean: This is Larry Dean. I'm sorry to join late.

Kathy: Hi Larry. I think we're going to take a 5-minute break real quick. So let's just break for 5 minutes and then come back. Thank you.

[break]

Kathy: Okay, we turned the recorder back on again. I think we've – Nancy did you want to say something?

Nancy: 2 things: first of all I had hip replacement surgery 2 weeks ago so if I get up and leave it's just because I need to get up and leave it has nothing to do with conversation or anything and I don't want anyone to take offense. But it's only been 2 weeks and so I am still struggling with sitting for long periods of time so – so just wanted to be aware of that so I don't mean to offend anybody by squirming or getting up and leaving. And the other thing is – are we back on – is to thank Lisa for her comments that yes, absolutely there is no decision that’s going to be made today. And then also that the decisions by the department will not be made on a Providence or a Highline issue. This is a statewide issue. It's a [indiscernible] change that will affect every single participant in the state so we will be looking at it from that angle. I just wanted to piggyback on to what Lisa said and appreciate that very much. Thank you.
Kathy: Thanks Nancy. So I think now we’ve heard from Providence. We’ve heard from CHI. Anyone else want to comment on what’s been presented today? Or what we’ve worked on up to now? Steve, go ahead.

Steve: I’ll [indiscernible] but I want to comment on what CHI said.

Kathy: Okay and one more thing. I didn’t have time to adjust the agenda to actually add Dennis’ letter or the Legacy letter so we’re just going to add them in so you can discuss what you’ve provided in the way of –

Dennis: Are you asking for that now, then?

[crosstalk]

Kathy: We’re open for comments from anyone right now.

Steve: Why don’t I finish my comments so Dennis can have a clean space?

[laughter, crosstalk]

Steve: I just want to make a few comments. First of all – a few of which are just housekeeping – [indiscernible. First of all we did not “expand the record.” As you may have noticed Frank and I pretty much were reading from documents that we previously submitted. The only “expansion of the record” I saw was on mentioning that the volume [indiscernible] go down. Mr. Fox handed Kathy a copy of the data that I based that statement on. If anybody wants an opportunity to respond to those we welcome them too.

On the other hand CHI by its own admission has expanded the record. They have quoted – Jody quoted at length from a letter from Seattle [indiscernible] Medic One/EMS and also mentioned a letter from the Highline emergency physicians. We would like to receive copies of those and we intend to respond to them and would like an opportunity to respond to them because they are not part of the record.

To address some of the substantive issues – and I’ll try to keep this short – Jody made the comment that – I hope I’m quoting her right here – that these sort of problems probably exist in several communities in the state. Again, perhaps that’s the case but CHI filed as a petition for rule making on June 1, 2016 – 13 months later I haven’t seen anybody come forward from any part of the state expressing that there’s some sort of linkage between the ability to perform elective PCI and addressing healthcare disparities and inequities. So there’s no evidence that this problem does exist in any part of the state. Doctor, with all due respect, you say that we’ve injected this issue of travel distances and times into this discussion. In fact, we didn’t. CHI introduced it in their May 11, 2017 Power Point on page 27 where they pointed out the travel distances between Highline and other providers. So we’re just responding to what you said.

Doctor, you also mention that the language is not broad and that exception language exists in other need methodologies. As you know, it only exists in one other need methodology which is open heart methodology. As Mr. Fox suggested that exception language is very specific. And I’m quoting from 246-310-261(4)(g) – “the OHS, the open heart surgery exception applies only if 1) the applying hospital can meet all the other CoN review criteria for an open heart surgery program including [indiscernible] and 2)n there is documented evidence that at least 80% of the patients referred for open heart surgery by the medical staff of the applying hospital are referred to institutions more than 75 miles away.”
Very specific language. With all due respect, as Frank pointed out in his presentation, health disparities or inequities is a completely undefined and open-ended term. If the department were to define, were to adopt an exception provision based on that sort of language it would be incumbent upon them given that this is a significant legislative rule to have a very detailed definition as to what health disparities or inequities are. Otherwise, the department’s going to be dealing with the likes of me for years to come as we battle over what health disparities or inequities mean.

Referring to page 13 which I believe we’re still on of CHI’s most recent filing with respect to the first quote. Having been involved in that case – and correct me if I’m wrong, Jody – that was an acute care bed case. It has nothing to do with tertiary services. With respect to the final quote -- yes, Swedish made that argument. Fact is, Swedish lost. Neither the department accepted that in this evaluation of the application nor did the court of appeals accept it. So the fact that people argue for exceptions means nothing. The issue here is whether the department as a matter of policy in accordance with the legislative intent of the CoN program should adopt an open-ended and vague exception rule.

Finally and could we go back to slide 12 please? Thank you. I’m doing my best to not be argumentative but when we saw this slide in CHI’s most recent submission imagine our surprise and imagine our surprise at the title “Providence’s volumes and market share continue to grow.” What does that have to do with an exception request. So Jody's representation that the only reason the slide is here is to show the volumes at Swedish Cherry Hill – with all due respect is completely utterly disingenuous. This slide was put here to show that Providence is purportedly trying to muscle itself into the PCI business and that is totally false. So that’s all I have to say on this point. And it’s totally inappropriate to say it’s anything but that.

Jody: It’s totally inappropriate to say disingenuous.

Steve: It’s totally disingenuous.

Dr. Saraon: Well that’s your perception so it’s up to every person to take their own perception of the slide.

[crosstalk]

Jody: That slide was originally put in simply because Providence argued that the volumes were decreasing statewide and this slide shows that that’s not the case for Providence.

Steve: Thank you. It’s all about Providence. Thank you.

Jody: It was a response to Providence –

Kathy: Thank you. All right.

Frank: I don’t have any more comments other than the fact that my data indicates that volumes are not growing. They’re not even close – in effect they’re declining so it’s a shrinking pie and whatever is decided here with exceptions language is going to be a zero sum gain. And that’s what’s going to occur. And there’s a number of provider in King East that are below the threshold volumes right now and they may even be below the volume threshold of 200 cases if in fact the department moves to 200 cases. I don’t believe that can be ignored.
Dr. Saraon: So again that’s entirely inaccurate. The fact is that the majority of the patients that we see in our community that has a health disparity problem don’t go to other places. So it’s not that we take away volume from other places. It’s that these patients simply aren’t being served. And that’s what an underserved population means. The population doesn’t have enough money, enough resources to get to these sites if they [indiscernible]. So this is not a lawyer game about numbers. This is a physician talking to you about reality on behalf of our patients. This is the reality on the floor. So I know the arguments are being made about numbers and numbers are distracting from the reality. Why is there a high mortality in this community? Why do they have this problem? And that’s the heart of the matter. It’s not about understanding the volumes of 500 declined over whatever time is going to adversely affect programs. That’s just an empty kind of supposition that we don’t even have the data for. So the reality is we’re making assumptions based on nothing. And we know that [indiscernible] 200 there’s no change in mortality. So I really don’t agree with you there. I think that’s just looking hard at numbers and not looking at real people. I think that’s the mistake here.

Frank: Yes, and I appreciate that. I don’t agree with the Highline presentation or the CHI Franciscan presentation of showing health disparities or inequities and their linkage to elective PCI’s. Again we’re talking about PCI’s in general. You’re doing a lot of PCI’s at Highline currently. There’s nothing in the rules that says you can’t. But we’re talking about elective PCI’s and in that case they’re fundamentally different. And you’ve shown – well not you but CHI Franciscan representation has shown no linkage basically between health disparities or inequities and lack of access to elective PCI’s.

Jody: I would argue that we did. There’s a slide in one of the presentations where we showed higher use rates. We have got higher PCI use rates for emergency PCI than elsewhere and we have higher rates of cardiac morbidity attributable to exactly what Dr. Saraon is saying – patients will not leave the community. They don’t have the ability to leave the community. They don’t trust leaving the community. There are concerns about leaving the community all across the spectrum for them. They wait –

Lisa: I can’t hear people anymore. I don’t know what happened. I don’t know if anyone else that is on the phone is having the same problem?

Matt: I’m having the same problem as well.

[crosstalk]

Jody: But the data shows that people are having heart attacks at higher rates attributable in large part because they do not get the elective intervention and they come back with an acute MI and that’s what’s treated. There’s a higher cost. There’s higher complication rates. It’s not the way health care should be delivered. We want to focus on prevention and those kind of services. Not treating acute MI’s.

Frank: And just a reminder. We’re not talking about all sorts of morbidity. We’re talking about acute MI which is pretty tightly related to [indiscernible]. For the rest of the county we look at .653 acute MI rate per 1,000 and for the Southwest King area we’re talking about 1.14. That is not an insignificant difference. If that’s not a disparity I’m not sure what is.

Man: And again you have the complete ability to provide emergent PCI’s and you do. You’re one of the largest providers of emergent PCI’s in the state.
Jody: We don’t want to wait for people to have heart attacks. That’s my community. I don’t want to have my neighbor collapse on their lawn because they didn’t travel for care. And then get picked up in an ambulance –

Dr. Saraon: I mean fundamentally this work group has come together with the Department of Health to work on public health and to do so in a cost effective way and the reality of it is that acute MI’s are sometimes not preventable. And many MI’s are preventable. What we have in Highline right now is the ability to wait until people at their sickest because of either poor self-care or lack of ability to access services on an elective basis and then we’ll treat them at the highest cost to the state and to the providers. And they are less likely to have a better outcome. Okay? And we can only do that intermittently because we can’t have a stable cardiology service if we can only treat them when they’re at their sickest. We usually don’t have enough volume to keep that program going. So this false separation of elective PCI or emergent PCI may work on a county spreadsheet or in a policy framework but it doesn’t work clinically when you’re trying to amass a program that is of high quality, that is safely staffed by a cardiology team and that gets people in who are sick at the earliest point in the process. That is fundamentally what we need to do and we don’t see other providers taking patients from our community and caring for them early -- including providing elective PCI – so this acute MI rate will go down. We’re trying to do that. That’s not vague. That’s been proven data, it’s been evidence based. You need to go to do that in the future [indiscernible].

Steve: Well with all due respect using your own document on page 27 of your May 11, 2017 presentation -- CHI has a hospital – according to your own data, Google travel time – 28 minutes away. St. Francis hospital. St, Francis hospital has a PCI program. I think one option here for Highline – I know we’ve not made this about Highline but after all CHI has a facility that’s very close. So I would suggest that there’s ways of addressing this issue.

Lisa: I think again we’re just focusing so much on all these details. I think that the CHI cardiologist made an excellent presentation today about the reality of his patients and the reality of what it takes to deal with people that are of lower income and have higher health disparities and lack of transportation. It’s a comprehensive program. I think the state has been [indiscernible] on that – talking about integration of services and care coordination and client care management, building trust in providers and all the things that can make a difference in patients that suffer from health disparities, suffer from low economic status, struggle with a lot of the socioeconomic determinants of health. And so I think they’ve made a great argument today that there may be a case at least in one community in the state where underserved people are being left behind because of a state methodology that has eliminated a program from entering their community. I think they’ve made a great argument to the department today that let’s consider having an exception.

Getting too detailed in exactly what exception would be given would be exactly what Providence said we don’t want to do which is carving out a program for one community. What we want to say is the statewide methodology may not apply to all communities. Let’s put these arguments forth in a CN process that deals with all of these issues: cost containment, quality, financial viability, protection of other providers, minimum standards. Do that in the CN process. Not in a CR101 meeting today. The arguments are strong. I think CHI’s cardiologist today did a phenomenal job of saying here’s the reality. Here’s real patients -- not numbers, not page 12, not [indiscernible] – real things happening to real patients. Let’s give them an opportunity to make that argument in a CN. And then everyone that’s concerned about that – the existing providers in that community can put their arguments forth and the department can have an opportunity to look and see if these underserved people are actually suffering from the statement that [indiscernible] is eliminating care. I think we can keep talking about the specifics but I think that’s the
point. I think the case was made very well today that there can be some very specific community issues that are being impacted. And I think the rest of that can be discussed in the CN process.

Frank: Lisa, I appreciate your comments but in fact from the outset as we had thought when CSI presented this petition back in 2016 we would be looking at broader issues – more regional and statewide issues. In fact, every thing that’s being brought forward in this petition is all about Highline and Southwest King. So in fact that

Lisa: I’m giving you an example of how the state methodology has impacted their community because it has impacted their community. I think the point is that no specific exception criteria that’s carved out a specific definition or any statewide methodology can address every specific community and that’s why. And I know you said there’s only one exception specifically in open heart -- but there’s exceptions allowed in a lot of these other methodologies where they don’t exist in rule. This department has made many exceptions to things because there are a lot of these methodologies that aren’t even in rule so there is – has been the ability to look at community’s specific issues and that is all that CHI is asking for and the reason they are making this presentation specific to the community is because it has had adverse effects on their community.

Frank: But again, with respect to tertiary services using CHI’s own presentation data there’s only one other tertiary service that has defined methodology and rule and has exception provisions and that’s open heart. And the exception provision that CHI has presented for elective PCI’s is fundamentally different – significantly more broad, more vague, ill defined. It’s not at all similar to open heart.

Nancy: I’m going to suggest – the parties are not going agree on this. I suggest we allow Memorial and Legacy to make their comments. It’s 10:35. We could banter back and forth on these issues all day. It’s not going to make a difference at this point in time. I’d really like to hear Memorial’s and Legacy’s comments. Unless – I’m sorry [indiscernible] I didn’t meant to cut you –

Frank: I agree. That’s what I was going to say actually. Let’s move on.

Kathy: I agree. So who would like to – Dennis or Vicki?

Vicki Eastridge: So I’m Vicki Eastridge. I know that there’s a lot of faces here that I haven’t seen before so I am the – I’m a nurse. And I’m the Director of Surgical and Interventional Services at Legacy Salmon Creek. But my comments today have been approved by everybody at Legacy so I’m representing Legacy.

We have been very carefully following the 2 petitions that were submitted for the last 2 years. And we’d like to weigh in on these things at this time. Both the Virginia Mason Memorial and the CHI Franciscan – based on the documents that have been presented, the discussions that we’ve heard, and the data that we previewed carefully we find very strong merit to both petitions. Furthermore, over the past 5 years Legacy has been in touch with the department, with the Secretary of State, with the Secretary of Health, with the delegation about access issues within our own community. And because of some of these access issues that we actually attribute to what we consider to be a challenging and ill-defined planning area within our service area. We are very interested in this opportunity for the communities to submit for an exception. Now I know that they’ve added some suggested changes to the current capacity ruling. Part of that is that as we looked at our need to possibly – if the rule has changed – our need to ask for an exception or pursue an exception we identified actually there are some maybe changes, some fairly simple changes to how we measure current capacity within a service area that might keep us within the current framework and not require us to have an exception but just to reiterate we believe that the
Department of Health and all of us at the table here have a responsibility to look at improving public health in the state for our residents and we believe that an exception clause within this rule is an important thing for the state to consider.

I am going to talk just very briefly about our concerns with the current capacity ruling.

9 years ago when the ruling was set, Legacy elective not to submit a Certificate of Need – partly because 35 miles north of us in Cowlitz County St. John Hospital was submitting for a Certificate of Need. We recognized that based on the rule they would be considered a priority because they were farther away than the current program – which is also in Vancouver at [indiscernible] Southwest. We did not oppose their application. 8 years later they have a very high quality program that we believe serves well the residents of Cowlitz County and residents west of Cowlitz County in very small counties all the way out to the coast. So they provide life saving PCI and elective cardiology care for those patients. However, because only 2/3’s of the population in our service area is actually served by that hospital. Of the 600,000 residents of the – of the population, 600,000 of the residents live in Clark County. So the Certificate of Need in Cowlitz County does not serve those patients. And it’s left us with access issues. And in fact because of our access issues we’re seeing increasing drift of our patients having to go into Oregon and to get elective PCI care which could actually be leaving somewhat to our data – the state of Washington’s data numbers – because we’re losing patients out of our state.

So again I want to reiterate that we believe that the program in Cowlitz County – even they’ve never met the 300 threshold and in fact have never met a 200 threshold and because of their population we do not expect them to be able to even reach the new threshold should it be approved. Their quality is very good. We do not – we would prefer to leave their program intact. It serves their community well. However, we have some suggestions that could address that in the rule. We’re asking that the definition of current capacity would count all cases – inpatient, observation and outpatient. And that it count cases occurring in our planning area residents that occur in Oregon. So right now those are not counted. So when we consider the need within our service area we lose sight of those patients.

Secondly, we believe the programs that have been in existence for greater than 3 years and are not meeting the threshold currently the wording in the rule counts them at their actual volume or the threshold, whichever is greater. So even though St. Johns is only doing 150 cases a year, they’re getting counted at 300. So we would propose that for programs that are beyond their 3rd year and they’ve stabilized their volume that they would be counted at their existing volume and not at the minimum threshold.

And finally we would like to see the definition of PCI be updated to include most current notes.

So that was the letter that we sent on June 5th. Again, we believe that with those simple changes our service area may not need to ask for an exception. We still believe that should be an opportunity for every community that has disparities and have lack of access.

So finally – I’ll finish on this – in terms of this CHI petition we have reviewed data for the state of Washington extensively. We do believe that even in healthy communities such as King County pockets of disparity exist. And we believe that it’s all of our responsibility to figure out how to provide the care for those patients in the most cost-effective way that provides them the best outcomes.
We also note that virtually every other CN rule contains the opportunity for an exception and elective PCI should be no different. So we support the rule change. And thank you for allowing us to participate in this – all of this at this table – it is a privilege.


Steve: I’ll just – again we have [indiscernible] I think this would be a marvelous petition [indiscernible] but it’s a little bit late in the game.


Dennis: Where do I start? I’ve said much of this content in our previous 3 meetings but in March of last year Memorial submitted a petition of which that department opened this year a 101 Process and that petition we believed stood on its own. As the department knows, over the last 10 years our hospital has been working on this initiative in a variety of ways and we have chosen to specifically focus our approach on really what is in the existing regulation that indicate that these standards shall be updated every 3 years. Since 2008 [indiscernible] or maybe it was even 2007 there has not been an update in that period of time. In 2013 and 2014 the [indiscernible] and ACC Foundation came out with new consensus documents indicating volume standards as we have discussed are appropriate.

In the 3 meetings to date and in fact again today there has been a general agreement – although we’ve not had a vote, there’s been no opposition expressed to our petition. Furthermore, not reflected in the letter but of the 8 programs that were approved back in 2008, 5 of them would meet the volume threshold of 200 or greater. One of them is on the bubble and 2 of them are below that long-term. At a minimum it brings the compliance to the requirements for volume into greater compliance and they exist now where nearly all programs except for Good Samaritan had 300 last year so they hit that target. All the other programs are below the current volume threshold.

So while we have enjoyed the discussion on the 2nd petition and have elective deliberately to stay neutral on that petition our focus is on having the regulations comply with the consensus documents as it relates to volume standards. So we respectfully request after this meeting that the department do 1 of 2 things potentially: decouple the 2 petitions. Have separate processes for those in that there continues as we have seen today a variety of news. The only other option is to make a decision on the 2 petitions and move forward. I won’t tell you what choice I would make I would just respectfully say I think those are largely the 2 options that are before the department. The importance of this is there is a window of time to submit a Certificate of Need in the regulations and that’s during the month of January. Without the rules being updated with the volume threshold between now and December 31st there’s an inability to apply for a Certificate of Need until January of 2019, which will be almost 3 years from the time we submitted our petition. It’s already going to be almost 2 years if the department is able to move from our CR101 to the CR102 phase. I don’t have personal experience of how long that lasts but perhaps it is really fast.

So we would ask that. The second point brought up in our letter is that the forecast methodology has not been updates for – I’m not sure if the 2012 – 2013 – which year that represents. But the bottom line is that needs methodology has not been updated. It is a challenging process as indicated by Legacy’s petition. I believe the department in our application for Certificate of Need 2010 indicated “you’re going to do your best to count all the PCI’s. And whether it’s DRG’s or ICD9 codes which are surveyed and sent out to the hospital – the last time it was sent out asked for ICD9 code 0.66 which is the procedure code here at PCI and at ICD10 there are about 12 procedure codes for a PCI that you have recognized and you
have updated your goal of counting all the PCI’s. Whether it’s CoAP data which actually are addressed in the regulations – and it says that they’re not zip code content in that now. Because it follows the PCI national registry. It does have some patient zip codes. There are 2. I will just parenthetically say there are 2 hospitals who don’t submit their zip codes to the Cope registry. But nevertheless there’s a robust amount of data and so I would respectfully ask also that that need methodology begin and the actual population being the denominator dividing by 200 to determine once the regulations or rules have been updated. Most of the county stuff because it does take several months for that to happen and a survey historically when they did come out came out usually in the June or July time frame -- because I’d receive them and fill them out. It would be timely to move forward with that. So I think those are our 2 points: move forward at a minimum with our CR101, petition for volume thresholds and then again the needs forecast methodology.

Kathy: Okay, thank you Dennis. Any comments for Dennis? Ian?

Ian: You don’t mind a wrap up comment from CHI – I don’t know if there’s any [indiscernible]

Kathy: No I just want to see if anyone had a –yes we’re going to do a roundtable. Absolutely.

Woman: Can I say one thing first before you wrap up? I’m not speaking for CSI Franciscan but I agree with the Legacy comments. If you look at some of the data the Franciscans put into the record on health disparities – surprise me but the other red portion of the state was your service area and I found that very intriguing. I was not expecting that.

Vicki: We call it heart attack alley.

Jody: It’s pretty interesting and Dennis – you and I have spent a lot of time trying to count cases. So the – requesting that the rules reflect how to now count cases – if you look in the [indiscernible] observation data there’s a lot of cases that have not been being counted. Memorial knows very well that you can look at a patient discharge but that patient might have had 2 different PCI’s during a single stay based on needs. And so right now those kinds of cases are not being counted and I’m well aware what happens. The state tries to get the Oregon inpatient database but it does not even attempt to survey the hospitals down there any longer for outpatient. And I know when I talked to you folks a year or so ago you had literally 100’s of cases going to your own hospitals in Oregon that are not being kept in the data.

Dennis, I think we could have 15 more meetings and the parties are not going to agree. I think the information is in front of the program and it would be nice to see the program make a decision about what it’s going to do here. And move forward with the votes. I agree about the January days.

Dennis: I appreciate that. I’m just going to make one more comparison. Since many of you don’t spend much time in the east side of the state – there is one elective PCI program in Wenatchee and Tri-Cities. That’s equivalent to 1 program between Everett and Vancouver, WA. Granted their populations are a little bit different but their geography – Everett to Vancouver, Wenatchee to Kennewick – or actually it’s Richland – 1 elective PCI program.

And so

Jody: You might get there faster than from Highline to downtown Seattle.

[crosstalk]

Nancy: We’ve got 8 minutes. No.

Kathy: Any final comments?

Nathan: I just agree with [indiscernible] that [indiscernible]. I don’t think there’s a lot of disagreement with that.

Woman: I would agree. There has been no one that’s come forward to disagree on the volume standards and we would hope that the department would move forward and act in a timely manner.

Jody: So my – I just want to clarify – what I’m saying is move forward on everything. You’ve got the information in front of you around the disparities. There’s no more information I don’t think that can be brought to bare and I don’t know that it does us a lot of good to continue sparring across the table.

Kathy: Okay.

Man: Just to clarify: we have asked for an opportunity to review and comment on the new information that was submitted today. And we’ve also said that if the department is going to consider the Legacy application with all due respect these are not simple changes. The department does not have enough information to issue a decision on which the modification [indiscernible] to Legacy.

Kathy: Okay. Dennis, anything else you want to –

Dennis: No.

Kathy: Jonathan –

Jonathan: No I’m good.


Ian: All right, thank you. Well first of all I want from CHI Franciscans I just want to say how much we appreciate the time to allow us to make our case. I know this [indiscernible] folks spent a lot of time on this and we want to say how much we appreciate [indiscernible]. Lots of our colleagues – the providers – have listened to us over the last several months and we appreciate your patience, your support and input. But I think it’s important to know that when you’re a provider you work with patients on the day to day and realize that while the Certificate of Need program intent was to insure the residents of Washington have access to high quality care on a daily basis we realize that those rules sometimes fall short because of things that are out of your control and our control. They have unintended consequences and those consequences are that there are areas where patients don’t have access to care for a number of different reasons. It could be that there’s no service, the providers are not stable – but whatever reason there are groups of patients that are really underserved and really we just want the opportunity to discuss one area that we are very well aware of that we believe is underserved.

Those that have had the ability and quite frankly the obligation have been unable to serve as well in those areas for a different variety of reasons. It could be just the patients can’t get to where those programs are.
But whatever reasons – our focus, our goal will always be on trying to provide high quality patient care to those patients that are within our geographic area in our community. So our goal will always focus on them. We understand this is a difficult decision. If it was easy it would have been made a number of years ago. But we do believe that part of the rule of [indiscernible] need is not [indiscernible] understand pure numbers. But also understand that you have to balance both the numbers, the ability to provide quality and the access. Those things are really difficult. And quite frankly as you can tell from our discussions there's various [indiscernible].

But I think it's going to take wisdom on your part to figure out how to appropriately balance those 3 links now. It's been an honor to provide you with the data. It's not just our data but it is data from different state agencies and [indiscernible]. But we do believe that we have provided sufficient enough data to consider the ability – our ability to [indiscernible]. We also support Virginia Mason Memorial’s application of moving to 200 and I do believe that in the future you are going to have look at other areas that might have disparities. CHI will always follow the regulations but our default position is always about taking care of patients within our geographic areas and our communities.

Therefore this is why we are before you. We do believe a number of our community members are just not getting the appropriate access. We just ask for your consideration. Again, thank my colleagues, Providence Virginia Mason Memorial, as well as Legacy and others that may have been in this process. We appreciate their input and counsel [indiscernible].

Kathy: Thank you.

Vicki: My only comment is – this is my first time through this process – is that it seems clear based on the data that we evaluated that there’s been a problem identified. And I applaud Highline for coming forward and saying “We see a problem. We have what we believe is the solution that we can bring to the table to solve this problem.” This is not Highline’s problem to solve. It is the Department of Health. It is the state of Washington. It is all of our responsibility to ensure that our residents receive care and to say that we’re linking just elective PCI to outcomes -- a cardiology program is a program. It is necessary to have all aspects of that in order for the community to rely on for their care. And so my only comment is when a problem’s been identified to come to a table and come to a table and just say “No that’s not the right answer” and then walk away – that doesn’t feel right. It feels like there should be at least an alternative solution. So.

Man: Well thanks for hearing us out. I’ll look forward to [indiscernible].

Man: I think there’s been enough discussion. I think we need to make a decision, move forward. There’s always going to be people asking for more time and more meetings, and more meetings. The data’s there. It’s just a question of what the solution – the state department thinks – I would just advocate pushing forward because these patients are for a year and a half even two years even how many years going back they’ve been trying to establish this kind of program. [indiscernible]

Kathy: Okay on the phone – how about Lisa?

Lisa: I have not been able to hear for a while so I’m not sure why my name came up.

Kathy: Oh I’m so sorry. I’m not sure what happened with -- We’re doing roundtable. Any last comments?
Lisa: Final comments? I haven’t heard what everyone else said but I just wanted to thank the Department of Health. You’ve been incredibly gracious and I really appreciate your communication and the way that you have just kept bringing us back to the table and I really appreciate it. I can’t say that enough. And I don’t know if someone already said this but in response to the [indiscernible] letter I just want to say that I think we can move forward with everything now. I think the data’s been presented and I think that we don’t need to hold up. I feel like the CHI and [indiscernible] and Providence and everyone has been given plenty of opportunity to get their data now and I will just trust the department to move forward.

Kathy: Okay. Thank you. Matt are you still on the phone?

Matt: Yes I am. I [indiscernible]. I appreciate all the work the department has done in this process and I think we’ve stated our position here quite clearly and I don’t think there’s anything else at this point that we need to say but I will defer to Steve and Frank now to see if they have any last comments.

Kathy: Okay. And Dr. Dean. Any last comments from you.

Dr. Dean: Yeah I think [indiscernible] again what Lisa said. I appreciate the Department of Health’s involvement in this discussion. It’s been a great discussion. Unfortunately as I mentioned a moment ago I couldn’t make the beginning of this meeting but look forward to reviewing the transcripts when they’re available.

Kathy: Thank you. All right with that I think we’ll conclude the meeting. Next step for us is to meet internally. Discuss what was presented here and then we’ll be in touch with you in the next few weeks about any decision we’ve reached on that. Okay? Thank you.

[end of file]