WEBVTT

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00:00:07.630 --> 00:00:08.700
W. Boyd Jackson - OHS: There we are.

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00:00:09.261 --> 00:00:17.930
W. Boyd Jackson - OHS: My name is Boyd Jackson. I'm the director of Legislation and Regulation at the office of Health Strategy. So I manage our legal department.

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00:00:17.950 --> 00:00:41.199
W. Boyd Jackson - OHS: oversee the certificate of need program and manage our legislative and regulatory affairs. So in my con role, this fits under the health systems planning unit that we all come together today to talk about the statewide healthcare facilities and services plan. And I appreciate everyone joining. We have

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00:00:41.330 --> 00:00:50.880
W. Boyd Jackson - OHS: been talking about this with stakeholders for a few weeks now, and I will show where we are with our progress through the the

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00:00:50.970 --> 00:00:52.670
W. Boyd Jackson - OHS: stakeholder engagement.

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00:00:55.130 --> 00:00:57.040
W. Boyd Jackson - OHS: we

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00:00:57.510 --> 00:01:03.791
W. Boyd Jackson - OHS: are at our last advisory group meeting. So we've we've talked through these other

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00:01:04.260 --> 00:01:12.159
W. Boyd Jackson - OHS: category, these, these other topics that are addressed in the plan. And today we'll talk about the acute care and the inpatient bedding methodology.

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00:01:12.461 --> 00:01:16.960
W. Boyd Jackson - OHS: There is still an opportunity. We'll have some. We'll have an opportunity for public comment today.

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00:01:17.020 --> 00:01:39.140
W. Boyd Jackson - OHS: But if you all have anything that you want to add later, or if anyone from your organization would like to add, or any

members of the public would like to add, we'll have a general overview session and opportunity for comment on any aspect of the plan. And we'll welcome those comments on Wednesday afternoon.

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00:01:39.250 --> 00:01:51.700
W. Boyd Jackson - OHS: and of course you will hear me say several times today, this is just the 1st part of our stakeholder engagement. We're doing all of our advisor group meetings and public

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00:01:51.860 --> 00:01:56.900
W. Boyd Jackson - OHS: forums in this 1st month of the comment period.

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00:01:56.970 --> 00:01:58.430
W. Boyd Jackson - OHS: and then

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00:01:58.570 --> 00:02:19.939
W. Boyd Jackson - OHS: we'll have written comment, opportunity through the end of September. We'll then work with altterum, our consultant on this project to review all of the comments, everything said today, everything submitted in written form. We'll review all of that. See what is appropriate to incorporate or to address in another way.

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00:02:20.285 --> 00:02:26.659
W. Boyd Jackson - OHS: And then we'll aim to get out a final version of the report around the end of October.

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00:02:29.730 --> 00:02:33.719
W. Boyd Jackson - OHS: A few things about today. We will.

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00:02:34.910 --> 00:02:49.639
W. Boyd Jackson - OHS: once I finish the logistical overview, I'll turn it over to Corey Ryan from altar to talk a little bit about this section and what we see in it. Some of the changes that have been proposed and where we propose to keep methodologies the same.

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00:02:51.260 --> 00:03:09.210
W. Boyd Jackson - OHS: Then we'll open up the floor for all of the Advisory group members to speak on whichever aspects Corey. We'll have some kind of guiding topics where we are particularly interested in conversation, but you should feel free to talk about any aspect of this section and this topic.

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00:03:09.805 --> 00:03:29.034
W. Boyd Jackson - OHS: After about an hour we'll open it up to public comment to the extent we have any we have. I think this is our most

attended session so far now, so we'll have hopefully, we'll have some members of the public offer some additional feedback, and then we'll come back to the group the Advisory group to offer any

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00:03:30.443 --> 00:03:34.160
W. Boyd Jackson - OHS: response to those public comments or concluding remarks.

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00:03:35.740 --> 00:03:43.880
W. Boyd Jackson - OHS: Any questions about the logistics piece of this? Either the flow of the day or stakeholder engagement and comments.

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00:03:44.258 --> 00:03:53.779
W. Boyd Jackson - OHS: or Corey, anything that I have missed at this point. We've done a few of these, and I want to make sure that I'm I'm getting hitting all of my points for logistics.

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00:03:56.110 --> 00:03:57.039
W. Boyd Jackson - OHS: Nothing from.

24
00:03:57.040 --> 00:03:58.040
Corey Rhyan: Me Boyd.

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00:03:58.290 --> 00:04:04.090
W. Boyd Jackson - OHS: Great, so I will turn it over to Corey to walk us through a brief summary before we open it up for conversation.

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00:04:04.320 --> 00:04:06.488
Corey Rhyan: Fantastic. Can you see my slides

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00:04:07.120 --> 00:04:19.620
Corey Rhyan: awesome? Great! Thank you. I will reiterate what Boyd said, and thanks for all the members of the Advisory Committee for joining us today and looking forward to your comments on these couple sections of the Facility and Services plan.

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00:04:19.866 --> 00:04:39.313
Corey Rhyan: Really looking forward to kind of sharing some of the work that we've done, and and talking with you about the way the calculations and the way the the work has been developed so far. I'm gonna do a really, really high level overview. I'll go through this quickly, cause I know we probably will have lots of comments today. Just generally for folks on the call. We're talking today about the 2024 version of the Connecticut Facility and Services plan.

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00:04:39.822 --> 00:04:56.479
Corey Rhyan: This is a document that we've worked to develop. I'm from alter. I'm sorry I should introduce myself. I am Corey Ryan. I'm a research director with Alterham's health economics and policy team. And we've been contracted by Ohs, to work with them, to develop updates and data analysis relevant to this 2024 plan update.

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00:04:57.005 --> 00:05:16.124
Corey Rhyan: So in working on this new plan, this facility and Services plan is a blueprint document for healthcare delivery in the State of Connecticut. And this is a document that really serves a dual purpose. This is a document that both provides a direct resource for policymakers and those involved in the certificate of need process by providing direct data and also standards and guidelines

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00:05:16.410 --> 00:05:39.770
Corey Rhyan: for how certificate of need applications should be submitted, and also information that details what we know about healthcare within the State of Connecticut, and what we know about the current capacity and need for healthcare services across the State, and so that information is both directly used by certificate of Dean applicants and by ohs and making decisions, and is also a general public knowledge document that helps provide an understanding of the healthcare landscape within the State of Connecticut

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00:05:39.770 --> 00:05:55.079
Corey Rhyan: areas, where there may be particular areas of need for both particular services and among different populations, and it provides a general understanding of the current best known data, as far as the availability, access, affordability and general quality of care available within the State of Connecticut along different service lines.

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00:05:55.900 --> 00:06:16.739
Corey Rhyan: The overall goal of the Facility and Service Plan is to help guide the State of Connecticut in right sizing and understanding the most accessible and pro, providing best access to services within the State. And so what this document does is that it details an understanding of where we know the current capacity and the current need for healthcare services are.

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00:06:16.740 --> 00:06:29.400
Corey Rhyan: and then attempts to understand and detail ways that we can prevent excess, capacity, and duplication of services, and also understand and identify where there may be gaps in services and unmet need across the State.

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00:06:29.400 --> 00:06:47.260

Corey Rhyan: The facility and services. Plan provides guidelines for how those services can be added, and where there may be particular need for those services while promoting fair competition and a level playing field and understanding how, through data and transparency, we can ensure that there's an appropriate geographic distribution and access to all Connecticut residents for different types of healthcare services.

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00:06:48.694 --> 00:06:59.289
Corey Rhyan: The Facility and Services plan is currently written, and what was released as a, as our draft includes 10 different chapters. And you can see here different topic areas that are covered within the current facility and services plan document.

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00:06:59.330 --> 00:07:05.210
Corey Rhyan: You can see here the 1st couple of chapters do detail an introduction and A and an overview to the certificate of need. Process.

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00:07:05.230 --> 00:07:17.600
Corey Rhyan: Chapter 2. Details overarching trends and policy guidelines that we see in going on as far as things that are changing within the state and areas related to policy that impact a broad set of healthcare services across the State of Connecticut

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00:07:17.990 --> 00:07:39.040
Corey Rhyan: chapters 3 through 8. Then detail specific service line categories and detail our understanding of both. Where the existing capacity is for these different service lines across the State of Connecticut. What we see in the utilization of these different services within the State, and then understanding where there may be gaps in access to these different areas, or where we may see differences in the current utilization and supply of these services.

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00:07:39.090 --> 00:08:02.879
Corey Rhyan: So we're gonna talk a lot today about 2 different chapters here, chapter 3, being the acute care. Section and chapter 4 being the outpatient surgery section. There are obviously have been other meetings detailing some of these other chapters, such as imaging behavioral health and primary care, and, as Boyd mentioned, there'll be an opportunity for more comments on those in the general comment. Section advisory committee meeting. That'll happen on Wednesday. But for today, I expect we're just gonna spend most of our time talking about Chapter 3 and Chapter 4,

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00:08:04.260 --> 00:08:22.140
Corey Rhyan: just a high level overview of the relevant chapter sections that have been included in the draft, the section 3.1 through 3.3 being the acute care hospital section. The bed need section and emergency department detailed information that we provided. And then chapter 4,

detailing information about outpatient surgery and ambulatory surgery centers.

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00:08:23.080 --> 00:08:35.630
Corey Rhyan: I'm just gonna do a really high level overview of some of the results that we have in the plan, and some of the things that we've done, as far as Boyd mentioned in changes that have been made, or things that have been maintained from the prior plan that was written in 2,012, and then we'll open it up for public comment after that.

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00:08:36.750 --> 00:08:58.210
Corey Rhyan: So you can see here just a very high level overview of a map of the current hospitals, acute care hospitals that exist within the State of Connecticut, detailing where these hospitals exist within the State, and then breaking the State into these different regions, and these are the healthcare planning regions that are used as far as understanding where these hospitals sit, and tracking utilization within different regions across the State.

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00:08:59.840 --> 00:09:23.919
Corey Rhyan: We also in this work have a list of Connecticut hospitals that exist within different regions across the State, and we detail here a table that, for example, just showing the results of the capital region. How many hospitals exist! The number of licensed beds that exist within those regions, the number of patient days that we saw in the most recent year of data in in 2,022, and then the average occupancy rate of those hospitals based on the comparison of license beds to number of patient days.

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00:09:24.317 --> 00:09:48.319
Corey Rhyan: What is important to note here is that what is currently been shown in the plan that's run been released so far is data through 2022 as we were developing this plan, this data was the most current available. But we know that as we've been in development here that there is now new data available from Ohs. We are working right now to incorporate that. So it wasn't available in that 1st draft. But we are looking to update this particularly important for work, for example, doing from 2022 to 2023.

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00:09:48.320 --> 00:10:05.480
Corey Rhyan: In looking at information on both capacity and also utilization over that time period on the COVID-19 pandemic in 2020 and 2021, and even a little bit into 2022 certainly impacted some of the utilization of different types of care. And so we're looking to get the most current data we can to help project forward the understanding of need

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00:10:05.694 --> 00:10:20.689

Corey Rhyan: using the best available data. And so 2023 data, we're working to update both in what we have from Ohs and the other sources that we have in the report as we go through and develop this. So please note that some of this data looks a little bit old, but we're working to update it over time as as we have a new information provided to us.

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00:10:22.510 --> 00:10:44.419
Corey Rhyan: You can see here an additional set of information that we have coming out of both the Connecticut hospital discharge database and also the all payer claims database in understanding utilization of acute care services within the State of Connecticut, and so we've done a couple of different looks and data analyses to try and understand what types of acute care is being used within the State, and how that care is broken down across different geographic areas

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00:10:44.420 --> 00:11:04.210
Corey Rhyan: broken down across different payer mixes. So where different types of individuals, different insurance coverage are using different types of of hospital care, and also across different race and ethnicity categories as well. So lots of tables included in the report that I'm sure you've seen both in Chapter 3 and also in the appendix of the report. But just highlighting here some of the findings.

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00:11:04.210 --> 00:11:29.809
Corey Rhyan: the general result that we've seen is over this period of time that we've been looking from 2016 through 2021, which we again will be looking to update as well. We've seen a somewhat flat or even slightly declining use of inpatient hospital services over time, and you can see here a a breakout among different categories. Some service lines have seen increases, but in general we're looking at a 6 to 7 decrease on average over over these different types of discharges over time. When you look at discharges.

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00:11:29.810 --> 00:11:50.909
Corey Rhyan: when you look at number of patient days you see about flat or or a slightly less slightly lower amount of a decline. So what that indicates is that well, discharges are going down. Patient severity may be increasing a little bit because we're seeing a somewhat smaller decline in the number of patient days that's occurring over different periods. And again, that varies based on different service lines and different areas of the State. But it's data that's captured in the report.

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00:11:52.730 --> 00:12:15.820
Corey Rhyan: The next section of the port here is then 3.4, and this is the Ohs acute care bed need model. And so this is the information that's used primarily in the certificate of need process to understand the number of beds that are expected to be needed within the State of Connecticut. And this is looking specifically at acute care and patient

hospital beds. I expect we're going to talk a lot about this today, and how these data are developed and how we do these calculations.

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00:12:15.920 --> 00:12:32.460
Corey Rhyan: But to give you a general sense of what's going on in this model. What we're doing is that we're trying to understand a comparison between the number of license beds within a particular region within the State, and we break down those regions. By the different planning regions that are associated. So here is an example for the capital region again.

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00:12:32.808 --> 00:12:54.719
Corey Rhyan: And we're looking to compare the number of license beds to the expected need and the expected need based on the utilization that we observe over the most recent data in the hospital discharge database. And so we're taking in information on the number of patient days over a few years. We're then using a linear linearly weighted moving average to then estimate what we think that those patient needs represent, as far as current utilization

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00:12:54.986 --> 00:13:12.859
Corey Rhyan: in the most recent year, and then looking to then expect going forward. What we think that that need is going to be based on population, change over time and changes and trends in inpatient versus outpatient mix of patients, and then resulting in at the end an estimate of the number of either excess beds or a deficit in beds across different regions of the State.

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00:13:13.010 --> 00:13:22.350
Corey Rhyan: And so this is taking in the best available information that we have trying to understand what we think. The current need is based on the utilization of patient days, and then comparing that to the overall capacity.

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00:13:22.440 --> 00:13:42.250
Corey Rhyan: When we look at the overall utilization, we're trying to do that at the underlying service line level. So you can see here how we break service lines into medical and surgical versus maternity versus psychiatric versus rehab rehabilitation and pediatric. But when we look at the total number of license beds. So far, what we've been able to do is only compare the total number of license beds

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00:13:42.250 --> 00:13:53.470
Corey Rhyan: to the underlying need as developed by the mix and the service lines. We've had some conversations with Ohs to try and better understand what the current number of license beds are, or the current number of beds available are within each of these categories.

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00:13:53.720 --> 00:14:14.989
Corey Rhyan: but based on the understanding that license beds can be moved in some sense from different service categories. We only comparison that we show, as far as generating excess versus deficit need is done at the total level, adding up all the beds within the region. That's a conversation we can have about if that makes sense and how to potentially better understand the need or availability of different beds across different service lines within the state

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00:14:17.520 --> 00:14:29.430
Corey Rhyan: detailing here again, just the data inputs. This is just a reference side for you and understanding what it takes to develop this bed need model. And we can talk more about the data that are used and the calculations that are made when comments and questions that will receive today.

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00:14:31.700 --> 00:14:59.080
Corey Rhyan: The last thing I will note here is that addition to that bed need model that Ohs uses when trying to determine acute care. Bed need. There's a set of other considerations that we know are important to consider, that may not be taken into account in the numbers that are included, but are very important when considering a certificate of need, application. And so we highlight these 4 applicants, and for Ohs to consider as a part of areas where there may be a need for additional beds that may not be called out specifically in the data that are provided in the in the bed need model tables.

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00:14:59.395 --> 00:15:23.809
Corey Rhyan: Examples here are, for example, the number of observation beds or observation days that may be required at a facility. We understand that the beds and the utilization that we see are related to patient days that could occur outside of observation days. And so we may be missing beds that potentially need to be used for observation beds, or need to be used for observation days that are not included in our hospital discharge data. So there's opportunity here for hospitals or applicants and for Ohs to consider those additional needs.

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00:15:24.000 --> 00:15:35.730
Corey Rhyan: There may be differences in the number of license beds versus staff beds, and how workplace shortages may be impacting the number of available beds within a region. This is another consideration. Again, above and beyond the numbers that are provided, that could be considered.

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00:15:35.870 --> 00:15:42.609
Corey Rhyan: There also is a consideration of trends in in use of inpatient versus outpatient settings, and how this may be impacting the need for care within the State.

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00:15:43.600 --> 00:15:56.870
Corey Rhyan: There's a few other other considerations that are included. Here again, all of this is in the report. I just want to highlight. It issues around, discharge delays and impacts on timing changes in the innovations or the way that care is being delivered within different acute care settings.

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00:15:56.870 --> 00:16:21.459
Corey Rhyan: quality or other patient or patient access concerns, and then other Co. N application decisions that may be ongoing at the time of an application is considered. So these are all other things outside of that that need model that can be used in helping Ohs make decisions about acute care. Bed need and as other areas where applicants can potentially demonstrate need outside of those direct numbers, but open to conversation day of what we may be missing, or if there are other things that should be included in these lists of other considerations as well.

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00:16:23.760 --> 00:16:32.740
Corey Rhyan: I'll jump here, then do the supplementary section that then includes information on emergency Departments and emergency department use again another map here that's included in the report.

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00:16:33.200 --> 00:16:39.419
Corey Rhyan: and also a list of Connecticut trauma centers, and where those different levels of care are potentially available within the State.

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00:16:41.030 --> 00:17:04.689
Corey Rhyan: And then some of the data that we include on emergency department use. So a slightly different variant on acute care rather than looking at acute care inpatient beds, but rather looking at emergency department use trends that we're seeing over time is slightly declining use of emergency departments. Again, particular note here for 2020 and 2021 that those data are impacted by the COVID-19. Pandemic and changes in individuals seeking out this type of care and the availability of this care due to the pandemic related concerns.

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00:17:04.918 --> 00:17:15.409
Corey Rhyan: We will attempt to update this as best we can with the newest data we have from Ohs around emergency department use, but noting the trend that we're seeing, and even before the pandemic, a slight decline in emergency departments use within the State over time.

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00:17:17.460 --> 00:17:32.829
Corey Rhyan: You can see here new information that we provided in this report related to emergency department volume and average Wait Times, so particularly trying to use this as a better understanding to understand

where there may be initial need for emergency department capacity within the State and using information that's provided currently by Cms

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00:17:32.830 --> 00:17:59.959
Corey Rhyan: to understand average waiting time within different regions and for a couple of different types of patient patients here as well. I think we've had some conversations in previous advisory committee meetings around potentially gathering even more granular data at the hospital level. And over. A greater period of the year. This is just a Cms survey that's done at a point in time to understand emergency department volume and wait times. But trying again, use this as a better understanding of where there may be need for potentially additional capacity or additional need across the state.

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00:18:02.600 --> 00:18:32.459
Corey Rhyan: Lastly, here we have our sections that include outpatient surgery and ambulatory surgery, surgery center discussions. Some data here, highlighting trends and ambulatory surgery and outpatient surgery occurring between 2,018 and 2020, and some of the details, and again included in the report, breaking out the utilization of this care across different categories of individuals, including where they live in wh. Where they live within the state, different individuals based on race and ethnicity status, and also different individuals based on their healthcare coverage. And what type of health insurance that they have

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00:18:34.000 --> 00:18:52.030
Corey Rhyan: here, for example, is a look, looking at the trends and outpatient surgery, across different insurance coverage status statuses and the trends that we're seeing over time and trends and growth in both total surgeries that are occurring for outpatient surgery, and whether or not those surgeries are occurring in non hospital, outpatient surgery facilities, or hospital outpatient departments.

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00:18:55.370 --> 00:19:13.929
Corey Rhyan: Lastly, here I will note that there are some sections that include our outpatient surgery standards and guidelines. This is what Ohs is using, as far as language that helps assist them in understanding where there may be needs for a potential outpatient surgery, additional outpatient surgery, capacity within the State. And you can see here some of the details that are included in how we understand

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00:19:13.930 --> 00:19:37.070
Corey Rhyan: the utilization that's occurring currently and where there may be additional need based on the current level of utilization we're seeing relative to the capacity that's been given. So this is guidance that both assists certificate and need applicants and providing information to demonstrate need for new capacity within the State, and also assists so Hs. And helping make decisions as far as where there may

be additional need for additional additional outpatient surgery facilities, or additional outpatient surgery beds.

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00:19:40.090 --> 00:20:00.809
Corey Rhyan: These are again, similarly to what I showed in in the section for acute care. Bed need you can see here that some there are some additional standards and guidelines that must be included, and some additional considerations that can be made as far as making decisions around outpatient surgery capacity as well. So, looking forward to conversations with this group of what's been included in these sections, and whether or not this makes sense.

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00:20:00.810 --> 00:20:24.510
Corey Rhyan: as far as the considerations as Ohs is making, or other things outside of the data that have been provided, that could be useful in helping understand an estimate of need for outpatient surgery within the State of Connecticut. One thing that we are particularly interested in. If folks have information on it is trying to move from the current model where what we're doing is we're looking at available capacity and available utilization to Ryan where possible. And we've done this in other sections of the report

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00:20:24.580 --> 00:20:38.430
Corey Rhyan: estimate the kind of independent population level need for outpatient surgery facilities based on both an understanding of the total population within the State of Connecticut, and also the underlying healthcare needs that might drive outpatient surgery, facility, use

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00:20:38.430 --> 00:20:57.369
Corey Rhyan: within within the State, and so trying to generate those independent estimates of what need is for different regions among different populations, outside of the observed utilization is a goal that we have, and I think would be good information to be able to include in this report. So looking forward to conversations with you today of where that type of information might be available, or what potentially could be added to the report in far as

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00:20:57.703 --> 00:21:02.040
Corey Rhyan: new information to help better understand that population level need for care.

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00:21:03.530 --> 00:21:10.479
Corey Rhyan: These are some of those other factors for consideration. Again, these have all been included in the report, so I won't go through these in detail, but we can use them as reference slides for today.

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00:21:10.970 --> 00:21:17.889

Corey Rhyan: and I will lastly, get here to opening up our topics for discussion. And you can see here things I think we're hoping to get feedback on today

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00:21:18.000 --> 00:21:34.130
Corey Rhyan: are 1st and foremost are, both the display of the available data and our demonstration of our current trends and utilization across these different categories of care. So including our look at hospital utilization, acute care and inpatient utilization and emergency department and outpatient surgery utilization

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00:21:34.310 --> 00:21:45.189
Corey Rhyan: details on the types of input data and the sources that we've used to generate our bed need model and the estimates for Ohs and understanding the need for number of acute care beds within different regions across the State.

86
00:21:45.460 --> 00:21:47.249
Corey Rhyan: how those calculations are done.

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00:21:47.360 --> 00:22:05.359
Corey Rhyan: and then other considerations that have been included in the report as far as language that's been provided to detail other things that may be included in the application for a certificate of need, expansion, or or change in the amount of care that's being provided, and and other language that could potentially be included, or other information that may be needed.

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00:22:05.810 --> 00:22:11.199
Corey Rhyan: So, Boyd, I think I will pause there, and I think we can open it up for discussion along these lines.

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00:22:11.200 --> 00:22:13.160
W. Boyd Jackson - OHS: Yeah, thank you. Corey.

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00:22:13.920 --> 00:22:17.720
W. Boyd Jackson - OHS: couple things that I wanted to flag before we open

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00:22:17.780 --> 00:22:20.702
W. Boyd Jackson - OHS: the floor. I know that.

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00:22:22.320 --> 00:22:27.553
W. Boyd Jackson - OHS: there have sometimes been confusions about different parts within a section. So

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00:22:28.100 --> 00:22:33.903
W. Boyd Jackson - OHS: it's it's helpful to think about the the role that this plan plays.

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00:22:34.590 --> 00:22:40.525
W. Boyd Jackson - OHS: generally, you know, it's 258 pages. I think. And

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00:22:41.200 --> 00:22:57.519
W. Boyd Jackson - OHS: it serves a lot of different functions. It has an important role in the certificate of need program for applicants for the agency. But it's also intended to provide information to the public to provide information to policymakers and legislators.

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00:22:57.540 --> 00:23:00.650
W. Boyd Jackson - OHS: So you know, something that sometimes

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00:23:00.680 --> 00:23:12.059
W. Boyd Jackson - OHS: gets confusing is when we talk about planning regions that's to help guide policymakers and the public to understand within a region.

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00:23:12.110 --> 00:23:39.790
W. Boyd Jackson - OHS: what are we generally seeing, as far as utilization. And, for example, bed need goes, but when it comes to the certificate of need assessment under the bed needing methodology, you'd still be using the primary service area which is defined as the area, the towns from which you get 75% of your discharges. And so you wouldn't be looking at needs specifically in that area, specifically under the bedding methodology, looking at the previous 3 years.

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00:23:39.790 --> 00:23:52.089
W. Boyd Jackson - OHS: So you don't just substitute in the planning region for the primary service area. So it's important to remember which part of the section you're talking about when we're looking at how some of these are done

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00:23:52.659 --> 00:24:10.969
W. Boyd Jackson - OHS: so we can get into that as we continue to discuss the only other logistical piece. since there are a lot of folks we won't go around the virtual room and have everyone do introductions. But as you participate, if you could just say your name.

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00:24:10.970 --> 00:24:32.049
W. Boyd Jackson - OHS: your organization that you're from and your role that'll help everyone kind of understand. Where you're coming from with

your comments. I will ask that you please use the zoom, raise hand function to assure that we're not interrupting or speaking over each other, or or going out of turn. So with those

102
00:24:32.260 --> 00:24:34.100
W. Boyd Jackson - OHS: caveats and

103
00:24:34.340 --> 00:24:43.300
W. Boyd Jackson - OHS: additional logistical details. I will now open up the floor to our advisor group members and see who has some opening comments for us.

104
00:24:45.650 --> 00:24:46.719
W. Boyd Jackson - OHS: Go ahead, Chris.

105
00:24:48.050 --> 00:25:02.689
Chris Hyers - UConn Health: Hey, boy, thanks, and I promise not to belabor our recent time together. But just that we on a couple of things around bed. Need I think a lot of people know that? You can. Health has an active and pending certificate of need application around

106
00:25:03.067 --> 00:25:06.880
Chris Hyers - UConn Health: adding some beds, and I just wanted, at a very high level

107
00:25:06.990 --> 00:25:09.820
Chris Hyers - UConn Health: to introduce what we thought.

108
00:25:10.110 --> 00:25:22.869
Chris Hyers - UConn Health: The methodology didn't reflect situation. Be it right or be it wrong, I see that. You know, the 3 year timing is still in there the lag and timing. It was of real concern. Because

109
00:25:22.910 --> 00:25:33.966
Chris Hyers - UConn Health: we're running 85 90% capacity now, but when you use the the old timing it never. It never shows up to say you can actually need beds, even though you can walk the floors and see you do

110
00:25:34.460 --> 00:25:36.290
Chris Hyers - UConn Health: the idea!

111
00:25:36.774 --> 00:26:05.070
Chris Hyers - UConn Health: And I think Corey touched on this, that beds can move before, between categories. At some point. We also need to

consider the fact that when all the beds and all the categories are at the utilization, the dynamic tool doesn't doesn't plan for that that was one of the things we did, and the other thing that was just really interesting. And again, I don't know if that's how we count for policy is while we plan for beds and regions and all that. I I understand all. But it doesn't. It doesn't

112
00:26:05.310 --> 00:26:19.869
Chris Hyers - UConn Health: allow an organization to adapt to changes in consumer pattern, consumer choice and be nimble. And I know we're we're we're unique. And if you put our our volume up over the last couple of years. We look like nobody else

113
00:26:20.050 --> 00:26:48.570
Chris Hyers - UConn Health: but our our learning and experiences. They've showed up at my doors, and I got no place to put them. And so beds available at St. Francis or Central Connecticut or Bristol don't do me a lot of good for the patients who've shown up through the Ed here, or what? That's what that's all things, you know aren't surprised to Boyd, who is our hearing officer, got to hear it all for like 9 glorious hours. But I just kind of wanted to lay out there some of the things that we had found when we were working through this to try to prove why we thought we needed more beds.

114
00:26:51.180 --> 00:26:52.159
W. Boyd Jackson - OHS: Thank you, Chris.

115
00:26:52.682 --> 00:27:10.310
W. Boyd Jackson - OHS: and I. We are taking everything said in that docket as an additional part of your public comments. Which I assume you would echo and continue to adopt. So we are considering all of that in all of this. But some of that will come up in discussion today, I'm sure. So.

116
00:27:10.310 --> 00:27:15.330
Chris Hyers - UConn Health: Right I should have. I should have asked that question if one informed the other. I wanted to make sure it gets a thanks, Boyd.

117
00:27:15.330 --> 00:27:17.220
W. Boyd Jackson - OHS: Yes, Gene.

118
00:27:17.770 --> 00:27:42.510
Jean Ahn: Hi, good afternoon, everybody. So thank you for the time. So Corey and Boyd. One of the questions I had was, I know, starting on page 92 of the document and Corey just touched upon it. There are other considerations. And so, as we're talking about acute care and bed needs,

I think folks are aware that there's a lot of shifts happening outpatient towards ambulatory bed observation, observation, beds, etc.

119
00:27:42.510 --> 00:27:58.410
Jean Ahn: And so the question is, when decisions are being made related to acute care. Bed needs. What level of mapping of other services are coming into the decision. And how are we taking those other considerations into factor.

120
00:27:58.887 --> 00:28:03.890
Jean Ahn: I know that a lot of them were touched on on page 92, and and thereafter. But

121
00:28:03.930 --> 00:28:12.580
Jean Ahn: will there be some flexibility, understanding that there are continuous changes occurring, and so just the purpose of that other consideration and section would be helpful to understand.

122
00:28:16.060 --> 00:28:17.732
W. Boyd Jackson - OHS: Yeah. So I think

123
00:28:18.870 --> 00:28:25.945
W. Boyd Jackson - OHS: different factors will come in in different ways, which I know is not the most helpful start to an answer. So I'll I'll elaborate

124
00:28:26.700 --> 00:28:27.440
W. Boyd Jackson - OHS: earth.

125
00:28:28.370 --> 00:28:36.779
W. Boyd Jackson - OHS: for example, where where some of these other factors have come up in other sections we've discussed have been in imaging. If we're talking about

126
00:28:37.178 --> 00:28:50.781
W. Boyd Jackson - OHS: an interoperative machine that obviously is not going to have the same throughput that a standard machine would. And so it needs to be factored differently. You're not going to impose the same type of

127
00:28:51.200 --> 00:29:03.189
W. Boyd Jackson - OHS: expected capacity as you would for a different machine. So you would take in some of those other factors, and it provides you flexibility within the decision making based on these additional factors.

128
00:29:04.254 --> 00:29:06.999
W. Boyd Jackson - OHS: Here, there's

129
00:29:07.090 --> 00:29:16.169
W. Boyd Jackson - OHS: there's a balance between what is an additional factor that's just atmospherics to consider when making a decision, and what things should be built into the model.

130
00:29:16.240 --> 00:29:17.300
W. Boyd Jackson - OHS: So

131
00:29:17.440 --> 00:29:22.339
W. Boyd Jackson - OHS: something that was brought up in the healthcare Cabinet and has come up

132
00:29:22.699 --> 00:29:24.679
W. Boyd Jackson - OHS: even in some of our other

133
00:29:25.030 --> 00:29:28.254
W. Boyd Jackson - OHS: advisory group meetings has been

134
00:29:29.240 --> 00:29:51.539
W. Boyd Jackson - OHS: Folks have described a change in how observation stays have affected the use of beds even between 2,012, when the plan was 1st done, and 2,024, when we're now revisiting all of our methodologies. And so, you know, that's something that I would definitely want to hear from everyone on the call today, but also in written comments, you know.

135
00:29:51.580 --> 00:29:57.970
W. Boyd Jackson - OHS: is this something that should just be an additional factor to consider? And why, you may say you know

136
00:29:58.750 --> 00:30:06.889
W. Boyd Jackson - OHS: it says that you're right at the correct level of beds. But you have observation. Say so. We're going to allow you to do 2 extra beds.

137
00:30:06.920 --> 00:30:12.969
W. Boyd Jackson - OHS: or is it something that should be built into the calculation and within the model. And if so, how

138
00:30:13.110 --> 00:30:29.240

W. Boyd Jackson - OHS: should those be factored one-to-one for bed use? Should they be factored at some scaled down version. Some conversation around that we've heard from a lot of people about observation stays and recognize that those fit into a general trend.

139
00:30:29.470 --> 00:30:31.176
W. Boyd Jackson - OHS: So any

140
00:30:32.470 --> 00:30:40.306
W. Boyd Jackson - OHS: any description of that, and how it could be factored in the weight that it gets within the model. We

141
00:30:40.820 --> 00:30:44.030
W. Boyd Jackson - OHS: we would appreciate all of those suggestions?

142
00:30:46.100 --> 00:30:49.109
W. Boyd Jackson - OHS: Did that answer any of your question, or do you have

143
00:30:49.230 --> 00:30:50.320
W. Boyd Jackson - OHS: follow ups.

144
00:30:51.020 --> 00:31:00.899
Jean Ahn: I think you know, the observation obviously is one that we're all living with, but just to the degree that there's some flexibility built in such that it's not just a static, non-living

145
00:31:00.910 --> 00:31:02.760
Jean Ahn: role or regulation, if you will.

146
00:31:03.110 --> 00:31:03.860
Jean Ahn: Yeah.

147
00:31:04.542 --> 00:31:09.529
W. Boyd Jackson - OHS: Any other thoughts that you have, Corey, based on the incorporation of those other factors.

148
00:31:09.530 --> 00:31:23.332
Corey Rhyan: No, I I think you've described that. Well, I think the the goal is to use the data that we have to understand the capacity needs based on the data that we have right now, which is looking at the license beds and the relative daily censuses that we've generated, based on the discharges on the patient days.

149
00:31:23.600 --> 00:31:32.739
Corey Rhyan: The observation bets, I understand, are kind of a data world that exists outside of that calculation. And so the reason why the language is written as it is now, is another. Other consideration

150
00:31:32.740 --> 00:31:57.690
Corey Rhyan: is potentially the ability for a hospital to demonstrate that there is that additional need that's not being captured in the quantitative data, as the model is built. Right now, as Boyd said, I need some clarity from you folks as expertise, and how a hospital might demonstrate that. And is there comprehensive data that Ohs could start to incorporate on the use of observation beds and the need for observation beds outside of the current data that's been provided in the model. I think there is a way to.

151
00:31:57.850 --> 00:32:22.899
Corey Rhyan: If there is a way to do it quantitatively, it would be good to be able to include it, otherwise it may be too difficult, and it may just be a reason where, then, it's up to the applicant to be able to demonstrate that within this category of another consideration, demonstrating an additional need above and beyond the calculation that's done in the inpatient model, it really depends on the data availability I built. And we built building on what Ohs has done, based on the available data that we have. We know, observation beds are an issue. Outside of that

152
00:32:23.040 --> 00:32:41.640
Corey Rhyan: I could see some estimate where we start to begin to gather. Ohs! Begins to understand the actual number of observation beds or observation days that are needed at individual facilities. So that's a new data collection activity that could be undertaken, or it could be a world where what we do is we generate some type of like adjustment factor. Right? So you're saying, for the number of acute care beds

153
00:32:41.640 --> 00:32:59.680
Corey Rhyan: we estimate, there's a certain share of observation. Beds and observation dates that exist on top of that as far as need. That's not currently being captured in the model, and could be an additional estimate that could be made really depends on what we can get in data, and I would love to hear from folks of what you think would be useful as data that could be captured, and then could be included in this model going forward.

154
00:33:01.700 --> 00:33:03.679
W. Boyd Jackson - OHS: Thank you, Corey. Lisa.

155
00:33:05.050 --> 00:33:28.970

Lisa Winkler: Hi! Thanks so much. Lisa Winkler, Executive Director of the Connecticut Association of Ambulatory Surgery Centers. Amanda Gunthel is also on on the zoom as well, and and may have additional comments. I don't know if it's the appropriate time void to to move to the section of the report related to ambulatory surgery centers, or, if you prefer to go, sort of point by point under the topics for discussion.

156
00:33:29.230 --> 00:33:34.959
W. Boyd Jackson - OHS: I think we're having a generally a free, flowing conversation. So we're we're fine to bounce around.

157
00:33:34.960 --> 00:33:54.590
Lisa Winkler: Okay, thanks. So thank you. First, st I wanna say, thank you so much for the opportunity, you know, to again participate in this conversation. As as we reviewed the the sections related to ambulatory surgery, center centers and and sort of thinking about our engagement and involvement in the development of past reports. There is

158
00:33:54.850 --> 00:34:07.159
Lisa Winkler: some concern over the terminology that is being used in this section. Things like rep referencing events as opposed to patient encounters.

159
00:34:07.543 --> 00:34:25.950
Lisa Winkler: Certainly some of the definitions. I mean, there is confusion out there about hospital, outpatient departments versus freestanding ambulatory surgery centers, and I think it's further compounded by some of the references in the report that speak to non hospital, outpatient surgical facilities. That's not really a term

160
00:34:26.000 --> 00:34:29.340
Lisa Winkler: that we use in the context of

161
00:34:29.389 --> 00:34:46.069
Lisa Winkler: surgical centers and ambulatory surgery centers, and so certainly we'll provide additional comments. But I I just wanted to flag that as as some concern, and then honestly the also, the reference to Cms guidelines. It's actually from

162
00:34:46.219 --> 00:34:58.280
Lisa Winkler: claims processing information as opposed to conditions of coverage and things like that. So quality and you know, infection control, patient safety, things like that that are very much a part of

163
00:34:58.430 --> 00:35:18.150

Lisa Winkler: the requirements of surgery centers. Under 4.4. So I think that we we could provide some additional clarification and information there. But I do think at the very beginning sort of including some of those specific definitions of the kinds of facilities that we're talking about. Would be helpful. And then

164
00:35:18.640 --> 00:35:20.930
Lisa Winkler: I don't know if I'm going, you know.

165
00:35:21.280 --> 00:35:30.649
Lisa Winkler: too too quickly. But and then in in Table 4, 3. As we look at some of the data, I mean, obviously, we've all been talking about the all pair claims database, and how helpful that is.

166
00:35:30.650 --> 00:35:54.139
Lisa Winkler: But right now, surgery centers also provide patient level data for all of their encounters to the office of health strategy, which I think would be helpful to look at, because, as you look at this data in 4.3 as an example, something that jumped out at me was the discussion of Caesarean sections, and those are not being done in ambulatory surgery centers.

167
00:35:54.370 --> 00:36:02.549
Lisa Winkler: to the best of my knowledge. And so I think, when you look at that data. It sort of raises some concerns

168
00:36:02.650 --> 00:36:18.870
Lisa Winkler: based on maybe the information that's being incorporated, I mean, as you go out and you look across, you know, out to 2021. It talks about 100 being done in non hospital. Oss. I'm not sure where that data is coming from or what

169
00:36:19.280 --> 00:36:34.360
Lisa Winkler: information that is, but as it relates to this section in ambulatory surgery centers, I think it sort of creates confusion, and then I mean some of the other things that we thought would probably be helpful to look at adverse event data that's also shared.

170
00:36:34.761 --> 00:36:49.628
Lisa Winkler: And then, as as there is a discussion about Medicaid, I do think it's really important to talk about the fact that it's not necessarily an apples to apples comparison, because there are simply not codes

171
00:36:50.130 --> 00:37:16.067

Lisa Winkler: for procedures to be done in ambulatory surgery centers under the Medicaid program in some situations. So I think it's important to understand the nuances there and then. Also in some procedures, you know, like in a in a colonoscopy procedure. There is an issue, or even an orthopedics procedure in terms of the devices. There's no coverage under the Medicaid program for for the use of devices. So those were some of the things that

172
00:37:16.920 --> 00:37:22.969
Lisa Winkler: I think we wanted to flag, and we can certainly provide additional

173
00:37:23.342 --> 00:37:41.330
Lisa Winkler: commentary. I think that would be helpful to this discussion, and provide more clarity, as it relates to this report. To paint a a more true picture of what's happening today. In ambulatory surgery centers. And I, I do think that data is an important component of that. Given.

174
00:37:41.610 --> 00:37:45.510
Lisa Winkler: so much is provided on, on, you know every single patient

175
00:37:45.820 --> 00:37:47.969
Lisa Winkler: that's treated in a surgery center.

176
00:37:48.840 --> 00:37:52.600
Lisa Winkler: And Amanda is also on. I don't know if you wanted to echo anything. Amanda.

177
00:37:52.970 --> 00:37:55.469
Amanda Gunthel: I I didn't. I? Just just the

178
00:37:55.500 --> 00:38:19.120
Amanda Gunthel: you really kind of nailed everything that we discussed, Lisa. But just that Medicaid piece, I think, is really important because there are procedures where there just is no established rate for us to be able to perform those in a surgery center, or there may be something where the reimbursement rate, in no way, shape or form can can cover things like that are device or implant, intensive.

179
00:38:21.790 --> 00:38:31.220
Lisa Winkler: And I'm not sure if I mentioned that section 4.5 out. Surger outpatient surgery events, I mean events sort of more aligns with adverse events.

180

00:38:31.220 --> 00:38:31.870
Amanda Gunthel: Yeah.

181
00:38:31.870 --> 00:38:36.770
Lisa Winkler: In our sort of realm. And so, you know, in in the past it's been encounters.

182
00:38:36.770 --> 00:38:37.510
Amanda Gunthel: Counter.

183
00:38:37.510 --> 00:38:40.760
Lisa Winkler: You know, data that's that's more specifically been utilized.

184
00:38:43.040 --> 00:39:04.981
Corey Rhyan: Thank you. That's all very good. Feedback de, definitely, some of those those changes that can be made in language, I think, related to definitions, I would definitely encourage you to submit some feedback to us as well. So we can be both precise and what we're defining, and also make sure that it aligns with the data that we've extracted so far in the all fair claims database. And and if there is additional analysis in that inventory surgery data that's also provided to Ohs, we can figure out how to how to cross that as well.

185
00:39:05.420 --> 00:39:28.259
Corey Rhyan: what I would say with the definitions is a little bit of an issue. And this is, as Boyd has pointed out, this kind of dual purpose of this report in both trying to be a precise document that represents the care that you're providing in the definitions that are technically being used versus the public facing goal of the report which is trying to describe this to a lay public, and what we're seeing in the way care is being provided. So I would really appreciate your feedback. So we can be precise and hopefully be understandable in the in the same way.

186
00:39:28.531 --> 00:39:52.179
Corey Rhyan: Yeah. And we, we have had some discussions about that Caesarean section data. We we can, we can get into a little bit again. This is just the outpatient portion of that. So it's you're missing the whole component of Cesarean sections that are typically always provided in the inpatient setting. And so that's why that number looks a little funny and being 100% there because of the way that we're only capturing that very tiny outpatient piece that is occurring in in those locations

187
00:39:52.200 --> 00:40:14.640
Corey Rhyan: outside of all the other inpatient care that's being provided. So that that's the reason for that. But we again, more, more detail that we can provide, and being precise about those definitions of

the locations, and what we've extracted versus what you determine is is the appropriate way to categorize these different facilities. And then, once we have, we're sure that we're talking, you know, kind of like, for, like in those locations, we can understand what the data is that we've extracted and what we've seen.

188
00:40:14.800 --> 00:40:21.147
Lisa Winkler: And maybe it's like birthing centers or something like that. But that is definitely not in our

189
00:40:21.630 --> 00:40:27.290
Lisa Winkler: section and and certainly not in our purview. And so maybe there needs to be like a separate sort of yeah.

190
00:40:27.290 --> 00:40:51.549
Corey Rhyan: To be a new line right? Exactly. I think we tried to take the facility that we could see within the claims, and in that lumping. My guess is, there's another category that's being included in non hospital osf, that you would not consider to be a non hospital, outpatient surgery center or ambulatory surgery center, if that's the better term. And so I think, yeah, detailing that as an additional line is definitely something that we could do specifically for that category, because it's somewhat unique compared to some of the other service lines.

191
00:40:51.828 --> 00:41:02.699
Amanda Gunthel: Corey, can I ask you a question? If if we have a question about a specific table or a data point, is that something you would want us to put in our in in what we submit, written.

192
00:41:02.700 --> 00:41:03.730
Corey Rhyan: Absolutely. Yep.

193
00:41:03.730 --> 00:41:04.400
Amanda Gunthel: Okay.

194
00:41:04.610 --> 00:41:06.820
Amanda Gunthel: okay. I know we had a few

195
00:41:07.190 --> 00:41:08.030
Amanda Gunthel: perfect.

196
00:41:09.310 --> 00:41:10.270
W. Boyd Jackson - OHS: Thank you.

197

00:41:10.470 --> 00:41:11.660
W. Boyd Jackson - OHS: Liz.

198
00:41:14.850 --> 00:41:19.180
Liz Longmore: Hi, thank you very much. I'm Liz Wilmore. I'm the chief operating officer for Stanford health.

199
00:41:19.190 --> 00:41:28.519
Liz Longmore: I just had a couple of brief comments, so as far as the license bed analysis in relationship to the observation data.

200
00:41:28.520 --> 00:41:51.649
Liz Longmore: both observation days and same day care does impact on the overall bed utilization at hospitals. We do track observation days, and we do also staff our facilities based on both inpatients as well as patients that are in the status of observation or same day care. So that's critical, because

201
00:41:51.650 --> 00:41:53.839
Liz Longmore: those patients are taking up a bed.

202
00:41:53.840 --> 00:42:13.929
Liz Longmore: whether they're an inpatient or they're an outpatient and observation. Patients sometimes have lengths of stay as long as 47 some odd hours. So it is significant in how it is. Each organization utilizes their beds, and that data is traditionally tracked by hospitals, so that would be something that we would be able to make available

203
00:42:13.990 --> 00:42:35.230
Liz Longmore: in addition to that for the table that you showed earlier, which was the roll up of all of the license beds in the State. And it does show that we would be overbedded, based on the 2030 needs. I think it's important for us to be able to discern

204
00:42:35.230 --> 00:42:52.120
Liz Longmore: what types of beds we appear to be over bedded. You know. Yes, you can move licenses around and license beds around. But a bed does not. A bed is not a bed. And I think the other thing that's really important to take into account when looking at. This

205
00:42:52.120 --> 00:43:12.609
Liz Longmore: is how patients access care, and some of the individual demographical needs and the patient population's ability to access care in their communities, and how far they would have to travel if that particular type of care wouldn't be able to be available in their community because license beds were looked at

206
00:43:12.610 --> 00:43:23.700
Liz Longmore: overall as opposed to how it is that patients access care, and what the barriers to that care may be. If they wouldn't be able to, you know, remain in their communities to receive that care.

207
00:43:26.780 --> 00:43:40.730
Corey Rhyan: Is that comment generally incorporated the breakouts in the detail we provided along the service lines? Or is there additional granularity that you think would be useful when we're talking about patient populations or individual types of need that that we should try to consider, to add, in addition to the categories we've already shown.

208
00:43:41.310 --> 00:43:46.129
Liz Longmore: I think you need to have some individual granularity. You know it.

209
00:43:47.170 --> 00:44:16.290
Liz Longmore: It's difficult given what some of the challenges are related to travel and some of the individual communities demographics in the State of Connecticut, and how difficult it may be for patients to be able to access care if that care was only available outside of their community because of the way in which beds were deployed within the State. So I think the individual impacts to particular types of services, and how patients access care need to be taken into consideration.

210
00:44:18.460 --> 00:44:33.891
Corey Rhyan: Okay, i i i think that makes sense. And I think that is, there is some additional data we can show as far as the current available and staffed beds along these different service lines. As the hospitals are reporting. I think the difficulty from Boyd standpoint when their role is at Ohs is determining the appropriate number of total license beds.

211
00:44:34.537 --> 00:44:58.559
Corey Rhyan: That is a determination that's made as as a whole, right? And so into your point. There there should, and hopefully is movement when there is need and new categories. Now, I think there's also been some comments that we've received around. There can be limits and then away beds can potentially be moved from category to category and trying to capture that so I I think that's I'm just more pointing out, is like the tension of the document here, and that we do want to represent where those needs may be in individual categories.

212
00:44:58.560 --> 00:45:26.630
Corey Rhyan: but from a standpoint of Ohs's perspective. Their kind of directive is to look at the total number of beds, which is why we're

showing those totals there. But I agree to give understanding to the state, even if it's not, something, is directly considered and expanding the bed capacity, because the capacities really determine that that total bed level you know, understanding where there may be over under supply, within those individual categories in order to best serve patient needs, is something that we we definitely can add as granularity there, and is something that I think we've received in comments already. So that that's good. Thank you.

213
00:45:27.080 --> 00:45:33.620
Liz Longmore: Yeah. And then, individual, you know, regions and locales as far as how those beds are deployed.

214
00:45:34.280 --> 00:45:50.689
Corey Rhyan: Yeah. And and as Boyd said again, I will just reiterate. You know what we think is a relevant discussion, and what we've shown here is at that planning region level and trying to understand and demonstrate broadly across the State different regions. Obviously, specific applications are going to be made in primary service areas. So just because a region shows

215
00:45:50.950 --> 00:46:12.756
Corey Rhyan: excess capacity either in total or potentially, even, you know, at an at an individual service line level, there may still be need within particular primus primary service areas that could be demonstrated. Or there. You know there, there may be a need again, you know as part of the application process for folks to be able to demonstrate that even within the broader state level data that we're trying to show as far as broader trends. That's just something I want to highlight, too.

216
00:46:13.010 --> 00:46:13.550
Liz Longmore: Thank you.

217
00:46:15.390 --> 00:46:17.404
Corey Rhyan: Boy did anything I missed. There.

218
00:46:17.740 --> 00:46:19.559
W. Boyd Jackson - OHS: Nope sounds good.

219
00:46:21.750 --> 00:46:26.750
W. Boyd Jackson - OHS: Other general opening comments or responses to any

220
00:46:27.420 --> 00:46:29.500
W. Boyd Jackson - OHS: comments that we've had so far.

221
00:46:39.170 --> 00:46:40.100
W. Boyd Jackson - OHS: Kyle.

222
00:46:42.390 --> 00:46:43.747
Kyle Kramer: Good afternoon. Everyone.

223
00:46:44.940 --> 00:46:51.089
Kyle Kramer: number one. I think the the comments made already have been absolutely spot on and important

224
00:46:51.100 --> 00:46:53.690
Kyle Kramer: when we think about bed need.

225
00:46:54.220 --> 00:47:00.310
Kyle Kramer: whether it be acute or otherwise, I think it's impossible to evaluate the

226
00:47:00.690 --> 00:47:08.879
Kyle Kramer: the overall complement of beds and their adequacy without accounting for beds and skilled facilities.

227
00:47:08.930 --> 00:47:15.829
Kyle Kramer: Oftentimes we run into situations with patients being held awaiting placement

228
00:47:16.510 --> 00:47:17.390
Kyle Kramer: which

229
00:47:17.860 --> 00:47:26.090
Kyle Kramer: reduces our capacity and diminishes our ability to accept other patients or puts us in a position of having to hold those patients

230
00:47:26.200 --> 00:47:29.729
Kyle Kramer: in in other units like the emergency department

231
00:47:30.540 --> 00:47:33.379
Kyle Kramer: while we are awaiting simply a placement.

232
00:47:34.040 --> 00:47:46.570
Kyle Kramer: Oftentimes this relates to awaiting title 19. And there are a variety of factors that go into that conundrum, some of which relates to family just simply not engaging

233
00:47:47.090 --> 00:47:49.819
Kyle Kramer: and providing the requisite information. Yet

234
00:47:50.600 --> 00:47:53.799
Kyle Kramer: we get stuck sort of holding the proverbial bag.

235
00:47:54.450 --> 00:48:00.310
Kyle Kramer: and that patient becomes a drain on hospital based resources when they really don't need hospital level care.

236
00:48:01.210 --> 00:48:03.809
Kyle Kramer: So I would. I would ask that we

237
00:48:03.820 --> 00:48:08.049
Kyle Kramer: at least add consideration for post acute beds

238
00:48:08.180 --> 00:48:11.250
Kyle Kramer: beyond what's within our respective hospitals.

239
00:48:14.230 --> 00:48:34.030
Corey Rhyan: Thanks, Kyle, that that's great feedback, I would say I would point you to cause. I think there can potentially be a consideration of new language in those additional considerations. There's number 4, currently, which states impacts of discharge delays, impacting the timing of discharges and average length of hospital stays, including issues around prior authorization as a contributing factor to these timings.

240
00:48:34.340 --> 00:48:47.939
Corey Rhyan: So if there's additional language, and I think you're saying a little bit more than what's already been included in that consideration. There that could us help assist those those concerns. I think we'd be happy to consider, you know, a potential other language in that space. I don't know how well you think

241
00:48:47.940 --> 00:49:11.729
Corey Rhyan: that consideration reflects this. Or if there's more related to the observation beds statement, if there's a more of a quantitative way. To try and treat some of the concerns that you're talking about would be happy to consider that. But I think this one may be a hard area to get exact quantitative data on. So I I just wanna make sure that language in for curious your response. And kinda how well, that reflects that concern, or if there's if there maybe would be proposed changes that would make sense there

242
00:49:11.780 --> 00:49:12.280
Corey Rhyan: any.

243
00:49:12.280 --> 00:49:15.489
Kyle Kramer: I. So I think the language that's included

244
00:49:15.520 --> 00:49:24.625
Kyle Kramer: thus far is a good start. You know. I think there is probably some benefit that would be achieved through additional clarification and specificity.

245
00:49:25.426 --> 00:49:29.009
Kyle Kramer: So would be, and it will certainly highlight that in comments that we submit

246
00:49:29.310 --> 00:49:30.020
Kyle Kramer: great.

247
00:49:30.020 --> 00:49:32.285
Corey Rhyan: We'll keep an eye out. I think that would be helpful. Thank you.

248
00:49:35.770 --> 00:49:36.660
W. Boyd Jackson - OHS: Thank you.

249
00:49:40.790 --> 00:49:52.313
W. Boyd Jackson - OHS: So to build on some of these other considerations and and topics that have been raised. And again, whether it be conversation for right now, or

250
00:49:53.000 --> 00:49:56.020
W. Boyd Jackson - OHS: fodder for written comments.

251
00:49:57.280 --> 00:50:01.709
W. Boyd Jackson - OHS: you know, I think digging into some of the bed need calculation pieces

252
00:50:01.780 --> 00:50:08.950
W. Boyd Jackson - OHS: and and discussion of those. So I know Chris brought up

253

00:50:10.730 --> 00:50:13.020
W. Boyd Jackson - OHS: a question about

254
00:50:13.150 --> 00:50:21.069
W. Boyd Jackson - OHS: the the time, the timing of the weighting of previous years. Average daily census.

255
00:50:21.090 --> 00:50:30.770
W. Boyd Jackson - OHS: So waiting the most recent year by 3, 2 years ago, by 2, 3 years ago, by one the linear waiting, as Corey was describing.

256
00:50:31.169 --> 00:50:34.579
W. Boyd Jackson - OHS: You know the goal there is to kind of

257
00:50:34.730 --> 00:50:36.330
W. Boyd Jackson - OHS: account for

258
00:50:36.480 --> 00:50:37.800
W. Boyd Jackson - OHS: what may be

259
00:50:37.820 --> 00:50:39.253
W. Boyd Jackson - OHS: a momentary

260
00:50:40.260 --> 00:50:51.349
W. Boyd Jackson - OHS: increase or decrease in utilization, to have some smoothing over time to account for that variability is, do do folks have

261
00:50:52.240 --> 00:50:55.000
W. Boyd Jackson - OHS: thoughts or comments around

262
00:50:55.140 --> 00:50:59.340
W. Boyd Jackson - OHS: either? The the use of multiple years of data.

263
00:50:59.410 --> 00:51:01.950
W. Boyd Jackson - OHS: the waiting of those years of data.

264
00:51:02.552 --> 00:51:08.609
W. Boyd Jackson - OHS: And any thoughts on that either for discussion or for written comments. Chris.

265
00:51:08.800 --> 00:51:11.191
Chris Hyers - UConn Health: Yeah. And just to build on that board?

266
00:51:11.510 --> 00:51:13.269
Chris Hyers - UConn Health: I think the question of

267
00:51:13.460 --> 00:51:42.729
Chris Hyers - UConn Health: how long would we consider something to be sustained? Growth, right like you talk about the the tail is is a year pattern enough, is it to kind of that that? What's the what's the method by which we look at our business and say, this isn't going away right, because we've all based other places. But I've looked places with a lot of seasonal residents. We see all sorts of spikes and all over the place. But some kind of understanding of when a trend is a trend, or what are the other things we look at. To say that's gonna last would be

268
00:51:42.810 --> 00:51:45.200
Chris Hyers - UConn Health: be another way to think about the question you're asking.

269
00:51:46.160 --> 00:51:49.230
W. Boyd Jackson - OHS: Yeah, that's that's good additional context.

270
00:51:50.690 --> 00:51:55.280
W. Boyd Jackson - OHS: anyone have thoughts there, or, if not, please

271
00:51:55.290 --> 00:51:58.950
W. Boyd Jackson - OHS: make a note to consider for for written comments. Gene.

272
00:51:59.520 --> 00:52:08.993
Jean Ahn: I do think that we want to emphasize. Probably the later years. I I know, Corey mentioned that we're going to bring in 2023 data, I believe. Chime also now has

273
00:52:09.370 --> 00:52:32.220
Jean Ahn: 2 quarters, or a half year of 2024, but just the pandemic and the and the aftermath of that just make for really strange data trends. So I don't know that we can rely on the whole of the data that's been collected to date with without just really more focusing on the latter years, if you will, 2022, 2023, 2024.

274
00:52:33.600 --> 00:52:58.559
Corey Rhyan: Yeah. And and as we move on and Co, n, considerations are made in future years, obviously, that will continue to move out. So we will move out of that pandemic period, and being in that 3 year, look back, I think there's a discussion now of how much that is a temporary

concern. But to Boyd's point more broadly, I think, you know, is a 3 year. Look back with that linearly weighted, you know, approach taking in the most recent year most heavily in the waiting, you know. Is this the right approach it? Do we think that's the right? Look back, I think comments on that

275
00:52:58.560 --> 00:53:05.720
Corey Rhyan: type of perception. We're doing the best we can. You know the the trade-off here, and the reason why this approach was held from from Prior is, I think

276
00:53:05.720 --> 00:53:35.249
Corey Rhyan: it strikes a good balance between the compromise of understanding that the most recent available data that we have probably best represents the need, but has greater variability because there could be point in time changes that impact one year's worth of data. And so we're trying to take a perspective of taking a look back over a few years to get a broader perspective while still waiting that most recent data as heavily as we can. But there are other approaches that can be taken to potentially do this. We think this is a good one. But certainly open the comments if we think that there are better ways. But to your point. There there is a very unique and kind of acute issue

277
00:53:35.250 --> 00:54:02.760
Corey Rhyan: right now related to the fact that we still have some of those pandemic years included in that 3 year. Look back, that will start to wash out, and so I think those concerns will alleviate a little bit. But you know broader discussion of if this is the right approach to to build forward the projection of what we think the need is going to be over future years. And and how, for example, we've also included population growth trends and train changes in the mix of the population based on different age groups. You know those are all. Again, our best attempt to try and understand what we think that need is going to be going forward.

278
00:54:02.760 --> 00:54:05.750
Corey Rhyan: But open the comments of. You know how that approach is being applied.

279
00:54:05.910 --> 00:54:33.100
Corey Rhyan: Last thing I will know, too, in addition to that, if folks also have comments in the way that we're developing. These estimates include this target occupancy factor. So this is idea. Again, trying to account for those bubbles or spikes that occur at certain points in time to say, we don't want to set everybody at a hundred percent of what the average utilization is right, because we know we're not always going to be at the average utilization. And so what we've used right now in the calculations which is consistent with what we've seen in other States, but is open to discussion

280
00:54:33.100 --> 00:54:55.282
Corey Rhyan: is that assumption that an 80% target occupancy is a good compromise between allowing for some additional capacity without having an oversupply of beds in general, allowing for some of those point in time changes so that 80% level and then 50% from maternity beds was what is included in the model right now. But that's another good option for feedback for folks if they have thoughts, and how we've used those numbers to generate overall need. Chris, I see your hand up.

281
00:54:55.540 --> 00:54:57.939
Chris Hyers - UConn Health: I know. Just to say, I thought the the 80%

282
00:54:58.210 --> 00:55:09.650
Chris Hyers - UConn Health: 50% targets were really actually pretty good ones. They do smooth out some of the the highs, the highs and lows, you know, again, having just played with 3 years, with the data extensively for the last 6 months.

283
00:55:09.650 --> 00:55:37.300
Chris Hyers - UConn Health: I do think a as you see, something begin to trend over 80. Over and over and over again it blinks on the dashboard differently and gives you a almost to the month ability to see what's going on. You know you talk about what's reported and what's not often. There's long lags. If you're looking waiting for Cha data, but at least from a an internal planner perspective, you can dynamically apply yourself against that test and really watch your trend. So just supporting kind of the 80 50 number.

284
00:55:40.760 --> 00:55:41.569
W. Boyd Jackson - OHS: Thank you.

285
00:55:45.280 --> 00:55:46.350
W. Boyd Jackson - OHS: Amanda.

286
00:55:48.860 --> 00:55:49.529
Amanda Gunthel: Hi,

287
00:55:50.330 --> 00:56:05.260
Amanda Gunthel: so a again, this is going to be something that we're gonna clarify when we submit our written commentary. But I just wanna flag. Section 4.6 on page number 127. Regarding trans and utilization and outpatient surgeries.

288
00:56:05.340 --> 00:56:08.254

Amanda Gunthel: There are some inaccuracies here about

289
00:56:09.080 --> 00:56:39.080
Amanda Gunthel: about costs and and pricing related to outpatient surgical facilities versus hopds. And and we can certainly provide clarification regarding the the different pricing indexes, whether it's the consumer pricing index, or the hospital market basket, or and and which services are actually more affordable for for the consumer. But I just wanna flag that section, because that's an important one.

290
00:56:39.598 --> 00:56:51.759
Amanda Gunthel: We sort of, you know it's 1 of our main stays about of of who we are is the lower cost provider for outpatient services. And it's it's in a very important part of of our footprint.

291
00:56:53.090 --> 00:56:54.650
Amanda Gunthel: So I just want to flag that.

292
00:56:54.840 --> 00:56:56.180
Corey Rhyan: Okay. Thank you.

293
00:57:02.800 --> 00:57:03.590
W. Boyd Jackson - OHS: Bliss.

294
00:57:04.680 --> 00:57:32.559
Liz Longmore: So thank you very much. One of the things that we may want to consider also is building in some component of emergency management aspects to our bedding plan and looking at the total number of licensed beds. Considering we did have a pandemic. And then, following the pandemic, we did have some very significant impact in our individual state during the respiratory virus season. The tridemic that we had.

295
00:57:32.560 --> 00:57:41.908
Liz Longmore: you know, one of the things that I had the privilege of doing at Stanford. Was closing our old hospital and moving into our new hospital and decommissioning it.

296
00:57:42.360 --> 00:58:00.729
Liz Longmore: and I never thought I would have to recommission it, and we did as an outflow track during the pandemic. So I think, giving some consideration as to what would be the need in an emergency situation to have some additional capacity. And where does it make sense to build that capability in

297
00:58:01.148 --> 00:58:07.410

Liz Longmore: knowing what we all went through? And then in follow up to that like, I said, experiencing the trend. The trident.

298
00:58:09.420 --> 00:58:14.824
W. Boyd Jackson - OHS: Thank you. And something that that brings to mind as far as

299
00:58:15.340 --> 00:58:17.869
W. Boyd Jackson - OHS: decommissioning and and recommissioning

300
00:58:21.740 --> 00:58:25.470
W. Boyd Jackson - OHS: ohs! Is charged with looking at the licensed beds.

301
00:58:25.520 --> 00:58:46.660
W. Boyd Jackson - OHS: We also have reported to us available beds which are physically existing beds as well as staffed beds. And so I'm interested in any discussion around consideration of those various numbers that are provided. So especially

302
00:58:47.940 --> 00:58:53.280
W. Boyd Jackson - OHS: my understanding is that sometimes, if hospitals merge, for example, and a building is decommissioned.

303
00:58:53.957 --> 00:58:55.749
W. Boyd Jackson - OHS: you may have.

304
00:58:56.353 --> 00:59:01.340
W. Boyd Jackson - OHS: an excess of license beds that still exist, for which there are not.

305
00:59:01.800 --> 00:59:04.819
W. Boyd Jackson - OHS: There's not literal space that exists.

306
00:59:05.299 --> 00:59:13.870
W. Boyd Jackson - OHS: But the license bed still exists. So how? How does that consideration factor in the difference in a licensed bed and a

307
00:59:14.970 --> 00:59:44.420
W. Boyd Jackson - OHS: literal existing bed? And then also, some of I think we've talked a little bit in in some of the slides, maybe about the difference in licensed or available on the one hand, and staffed and staffing constraints, and how that factors in so any discussion about kind of the difference in those numbers as presented, maintaining that ultimately what Ohs is tasked with is looking at the number of licensed

beds. How do we consider these other numbers that hospitals report themselves?

308
00:59:48.330 --> 00:59:49.320
W. Boyd Jackson - OHS: Lisa.

309
00:59:49.650 --> 00:59:52.749
Lisa Winkler: You know, just as you're having. Oh, sorry. I'll come off my

310
00:59:53.090 --> 01:00:06.630
Lisa Winkler: camera. Sorry. Just as we're talking about this in references to Covid. Maybe I mean I it's sort of interwoven through throughout some of the discussion, but I do think it's an important part of this conversation in terms of being

311
01:00:06.630 --> 01:00:23.470
Lisa Winkler: ready and available. To respond in a pandemic situation, or when the flu numbers are high, so both in the sort of discussion of bed capacity, but also, as it relates to surgery centers. And you know there is some discussion about the decline in procedures. But

312
01:00:23.830 --> 01:00:48.570
Lisa Winkler: during the pandemic there were times when you know surgery centers were closed and sharing their ppe and their staff and things like that. So I think it ha! There needs to be sort of a conversation, or maybe some sort of discussion about like being prepared for a pandemic. And I do think that's an important part of the conversation, as it relates to this, whether it's from the Ppe standpoint or the availability of services.

313
01:00:48.720 --> 01:00:55.810
Lisa Winkler: So I do think it's a good point, as it relates to the hospitals, but also sort of in connection to surgery centers. Here.

314
01:00:56.830 --> 01:00:57.569
W. Boyd Jackson - OHS: Thank you.

315
01:01:08.560 --> 01:01:10.600
W. Boyd Jackson - OHS: Anyone have thoughts again.

316
01:01:10.620 --> 01:01:12.650
W. Boyd Jackson - OHS: something that folks can

317

01:01:13.360 --> 01:01:20.239
W. Boyd Jackson - OHS: give some thought and consideration, and include in written comments, as far as how how

318
01:01:20.440 --> 01:01:25.053
W. Boyd Jackson - OHS: available beds and staffed beds might factor into

319
01:01:26.200 --> 01:01:29.710
W. Boyd Jackson - OHS: determinations about the the license bed need.

320
01:01:33.860 --> 01:02:00.626
Corey Rhyan: Yeah. And and I think the goal there would be to potentially provide again, kind of more detailed understanding of the current landscape based on that. You know, demonstration of what we see in the available beds or the staffed beds relevant to what we've shown in the tables so far, which is just the license beds. Even if that is kind of the determination that Ohs must make as far as the number of license bed is, I think, providing understanding to the public would be really useful as far as staffed and available beds. I think, then, addition to that is is, considerations of

321
01:02:00.870 --> 01:02:25.559
Corey Rhyan: how we can ask for potential applicants if they feel there are issues with the difference between the number of license beds and the available beds. If that is influencing capacity within a region or a primary service area of how they can demonstrate that. And so that's in some ways that other consideration section and providing more detail there for Co. Applicants to potentially demonstrate with available beds or staffed beds in a way outside of the language that's already been included.

322
01:02:25.560 --> 01:02:32.280
Corey Rhyan: I think any kind of granularity or guidance we can provide. There only helps the applicants, and only helps ohs! In making those determinations.

323
01:02:41.570 --> 01:02:50.176
W. Boyd Jackson - OHS: So before we move on from some of the bed need calculations. I don't. I'm I wanna make sure, Corey, that I know we? We raised the number of

324
01:02:51.190 --> 01:03:01.090
W. Boyd Jackson - OHS: discussion topics about which people have asked questions in the past. So I want to make sure that we do a full dive there. I know we've talked about

325

01:03:01.280 --> 01:03:04.649
W. Boyd Jackson - OHS: the years at which we look and the weighting of those years.

326
01:03:05.910 --> 01:03:14.119
W. Boyd Jackson - OHS: we've talked about observation stays, and any way to quantify that to bring directly into the assessment

327
01:03:14.420 --> 01:03:16.599
W. Boyd Jackson - OHS: the difference in

328
01:03:17.000 --> 01:03:24.039
W. Boyd Jackson - OHS: licensed and available and staffed beds, and how that might factor in

329
01:03:25.191 --> 01:03:26.998
W. Boyd Jackson - OHS: we've talked about the

330
01:03:28.220 --> 01:03:33.530
W. Boyd Jackson - OHS: target thresholds target capacity, 80% to 50% based on the service line.

331
01:03:36.930 --> 01:03:42.550
W. Boyd Jackson - OHS: any others that we've talked about or other topics that folks want to raise for discussion.

332
01:03:42.940 --> 01:04:07.050
Corey Rhyan: Yeah, I think, specific to that service line. Available beds. Discussion void is, I think, you had received some comments that you relate to me around examples of cases where beds may be exclusively locked to a particular purpose or a particular category, and whether or not those should be considered in the total bed number. I don't know if that's bringing up an example. I'm trying to remember the one that you gave me. But maybe that's a area to discuss.

333
01:04:07.050 --> 01:04:12.080
W. Boyd Jackson - OHS: Yeah. So generally for the bed, need we exclude bassinets?

334
01:04:12.704 --> 01:04:17.245
W. Boyd Jackson - OHS: Are there other bed types that should be

335
01:04:18.330 --> 01:04:21.090
W. Boyd Jackson - OHS: factored differently based on

336
01:04:21.240 --> 01:04:23.000
W. Boyd Jackson - OHS: specific restrictions?

337
01:04:26.070 --> 01:04:26.660
Chris Hyers - UConn Health: Yeah.

338
01:04:26.820 --> 01:04:27.910
Chris Hyers - UConn Health: Yes.

339
01:04:29.590 --> 01:04:30.130
W. Boyd Jackson - OHS: And Chris.

340
01:04:30.130 --> 01:04:45.369
Chris Hyers - UConn Health: Those of us that have lock units for the Department of Corrections think there should be a different count. I don't think any of you want me to float you up to do. C. 5, and I'll lock in with the inmates there. 10 beds on our license. They're in a contract with the Department of Corrections, but they're in our account.

341
01:04:46.995 --> 01:05:05.745
W. Boyd Jackson - OHS: And if they were excluded in the same way as bassinets would it be possible to remove those from the average daily census, and kind of the same way. I think I think that's how it's done for bassinets, is you? Just say let's not count them.

342
01:05:06.120 --> 01:05:17.930
Chris Hyers - UConn Health: Not to get too granular, boy, but when you have the fun of reading my late file, I did it for you. This is still, I just type. We want to illustrate the point. So cause I do. I do think it's important. Nobody here wants to be floated onto those beds.

343
01:05:17.930 --> 01:05:18.560
W. Boyd Jackson - OHS: Yeah.

344
01:05:19.750 --> 01:05:22.665
W. Boyd Jackson - OHS: I think it's several 100 pages. So I.

345
01:05:23.030 --> 01:05:25.830
Chris Hyers - UConn Health: That's what happened. Players get away from me, man.

346
01:05:25.830 --> 01:05:28.434

W. Boyd Jackson - OHS: Have not have not read it in my

347
01:05:29.040 --> 01:05:30.010
W. Boyd Jackson - OHS: 6 h of work.

348
01:05:30.010 --> 01:05:33.589
Chris Hyers - UConn Health: I'm a pictures guy. If you just stick to the graph, show what I thought.

349
01:05:34.630 --> 01:05:35.320
W. Boyd Jackson - OHS: Barbara.

350
01:05:35.320 --> 01:05:53.840
Barbara Durdy: Yes, Hi, thank you. Boyd, Barbara, dirty Hartford healthcare. So I would also add maternity units, maternity beds and behavioral health beds, which are often in locked units, and it's not easy just to switch those beds out for another service.

351
01:05:55.790 --> 01:06:12.279
Barbara Durdy: and if I could just circle back to the bed need conversation just briefly. So I want to echo all of the comments that were made by everyone on this call today, having recent experience working with the model and the 2012 plan.

352
01:06:12.310 --> 01:06:16.959
Barbara Durdy: I think all of the comments were really important and Spot on.

353
01:06:17.000 --> 01:06:46.439
Barbara Durdy: And I, you know I understand the need for Ohs! To have a consistent sort of uniform approach to evaluating bed need. But I also think it's equally important that the plan allows for some flexibility that the plan is adaptable, because there are many, other, many other factors that drive bed need other than you know, changes in population, and I think those factors are equally important to consider.

354
01:06:46.580 --> 01:07:05.070
Barbara Durdy: You know, such as changes in the way services are delivered, changes in the way patients access services, the underlying demographics of the community increasing patient acuity. There are many other factors that you know we need to give weight to when doing this analysis.

355
01:07:06.410 --> 01:07:30.560

Corey Rhyan: Yeah, thank you. I I agree, that's really important. So what I, what I would key us to is some of those factors are going to show up in the data, right? So changes in demographics and the way patients are demanding services are going to show up in increases in patient days and increases in that average daily census that then, should drive that number that demonstrates that need. If there are examples of that that fall kind of outside that we think are going to generate need that doesn't show up in the model itself.

356
01:07:30.680 --> 01:07:54.240
Corey Rhyan: That's then where I think that space for those other considerations, observation beds are like a good example right now, right? But I understand that there's probably more so encourage today. Could discussion now, or in written comments, of what are those other considerations that don't drive the increase in the numbers that we can actually observe? And how can? Oh, you, as an applicant, potentially represent that, or or an applicant. Can they represent that? And

357
01:07:54.240 --> 01:08:04.600
Corey Rhyan: how can? Ohs take those into consideration? Cause? I I think there are some times where you're right, like the demographics and the State will shift over time, we may see an increase in the use and utilization as a result of that.

358
01:08:04.600 --> 01:08:34.109
Corey Rhyan: Ohs can track that. And so I think that I'm less concerned about those factors. I'm more concerned about the factors that might drive an increase need that doesn't get represented in the data, such that there is a disconnect between what Ohs sees in the data as what the actual need is versus what the underlying need is so I think other areas like that. And then how do we develop language that can go into those other considerations, such that we don't miss that underlying need that that's my biggest concern. As we generate those numbers. So I would key us, you know, in written comments and discussion today to to look towards those other areas.

359
01:08:44.850 --> 01:08:56.270
W. Boyd Jackson - OHS: And would definitely welcome additional written comments on on the points you made about behavioral health beds and maternity beds, and kind of how those factor in and and

360
01:08:57.180 --> 01:09:01.489
W. Boyd Jackson - OHS: why they may not be able to be, why you may not be able to shift

361
01:09:01.790 --> 01:09:16.379
W. Boyd Jackson - OHS: beds around within your license limit across those service lines, and how that factors in and changes that we see over time,

and any kind of information that can provide additional context to the limitations of swapping out those beds.

362
01:09:19.060 --> 01:09:24.069
W. Boyd Jackson - OHS: Any other comments at this point about the bedding methodology?

363
01:09:24.790 --> 01:09:26.109
W. Boyd Jackson - OHS: otherwise.

364
01:09:27.740 --> 01:09:43.100
W. Boyd Jackson - OHS: Well, I guess. We are coming up on the 2 h, or the 1 h and 15 min mark, which is where we're supposed to open up for public comment. I think if my, if I still have my numbers memorized?

365
01:09:43.493 --> 01:09:50.396
W. Boyd Jackson - OHS: So I will go ahead and open the floor. If there's anyone on the call who would like to

366
01:09:50.899 --> 01:09:54.569
W. Boyd Jackson - OHS: share a comment, ask a question, raise a topic for discussion.

367
01:09:55.162 --> 01:10:02.340
W. Boyd Jackson - OHS: We will allow for public comment at this point, and then kind of ongoing for the next

368
01:10:02.820 --> 01:10:09.280
W. Boyd Jackson - OHS: little while. We don't have to stop our conversation, but since we're at a breaking point, I just wanted to

369
01:10:09.920 --> 01:10:11.879
W. Boyd Jackson - OHS: see if there was anyone

370
01:10:21.310 --> 01:10:23.889
W. Boyd Jackson - OHS: all right. Oh, yes, Gerald.

371
01:10:25.630 --> 01:10:40.770
Jeryl Topalian: Hi, thanks again for hosting these meetings. I just do have one question. And I I didn't see it addressed in the chapter. And that's just the emerging models, such as hospital at home.

372
01:10:41.791 --> 01:10:54.789

Jeryl Topalian: You know. How is oh, just going to consider those in terms of reporting census. If a program is started. You know, and does the limit.

373
01:10:55.230 --> 01:11:02.909
Jeryl Topalian: you know, on your license bed preclude you from being able to try to innovate with

374
01:11:03.070 --> 01:11:08.999
Jeryl Topalian: new programs such as that. If you have to include them within your existing license beds.

375
01:11:18.890 --> 01:11:23.470
W. Boyd Jackson - OHS: I don't know, Corey, is that something that came up in your work? If not, I'll take

376
01:11:24.760 --> 01:11:25.630
W. Boyd Jackson - OHS: stab.

377
01:11:26.030 --> 01:11:49.540
Corey Rhyan: I think. I I it's not something that came up in my research. It was not something that I had seen in in other examples, but I think it very much is an emerging discussion. And so I I, curious of what I and this may need something where we need to go back and and look at the legal definitions right? And what potentially gets included, or would be a restriction versus. Not so. I don't really want to speak to that without exact knowledge. But if you want to take a stab, and then I think that is a good point for us to take back to look at.

378
01:11:49.960 --> 01:11:52.843
W. Boyd Jackson - OHS: Yeah. So to echo

379
01:11:53.510 --> 01:11:57.909
W. Boyd Jackson - OHS: definitely something that we can look at. And I would

380
01:11:58.140 --> 01:12:04.869
W. Boyd Jackson - OHS: request in your written comments that you provide any additional information, especially

381
01:12:05.470 --> 01:12:13.090
W. Boyd Jackson - OHS: how those will be counted as far as licenses with Dph, go and the interaction there.

382

01:12:14.950 --> 01:12:22.399
W. Boyd Jackson - OHS: They're the ones actually licensing the beds. And our role is just to say whether you can apply to

383
01:12:22.490 --> 01:12:34.923
W. Boyd Jackson - OHS: increase that number. So, understanding how they're counted there will help us understand our role but definitely, something that we can take back and put a little additional thought in. Perhaps that's

384
01:12:35.830 --> 01:12:38.410
W. Boyd Jackson - OHS: something to be included in the

385
01:12:38.900 --> 01:12:43.877
W. Boyd Jackson - OHS: additional factors for consideration. And some of these innovative models and

386
01:12:44.500 --> 01:12:45.610
W. Boyd Jackson - OHS: types of

387
01:12:46.800 --> 01:12:49.080
W. Boyd Jackson - OHS: types of use of the license bed

388
01:12:49.090 --> 01:12:52.799
W. Boyd Jackson - OHS: definition that fall outside of the standard

389
01:12:54.020 --> 01:12:55.920
W. Boyd Jackson - OHS: beds within the hospital.

390
01:12:59.770 --> 01:13:06.560
W. Boyd Jackson - OHS: so yes. Any any additional information on that will help guide our follow-up research, but definitely something we can take back.

391
01:13:12.350 --> 01:13:16.609
W. Boyd Jackson - OHS: and that that highlights, the importance of

392
01:13:16.740 --> 01:13:24.460
W. Boyd Jackson - OHS: a robust and ongoing update process to the facilities and services plan as

393
01:13:24.480 --> 01:13:26.000
W. Boyd Jackson - OHS: as these

394
01:13:27.850 --> 01:13:33.059
W. Boyd Jackson - OHS: as new methods and services and technologies emerge.

395
01:13:33.458 --> 01:13:39.720
W. Boyd Jackson - OHS: It's important that that we be able to incorporate those in updated plans, and that is certainly

396
01:13:39.730 --> 01:13:44.250
W. Boyd Jackson - OHS: our goal and vision. Moving forward is to not have

397
01:13:44.830 --> 01:13:45.510
W. Boyd Jackson - OHS: a

398
01:13:46.460 --> 01:13:50.620
W. Boyd Jackson - OHS: not have long, long waits between such robust

399
01:13:51.890 --> 01:13:53.550
W. Boyd Jackson - OHS: revisions of the plan.

400
01:13:53.570 --> 01:13:58.599
W. Boyd Jackson - OHS: So we hope that we'll be able to incorporate things like that on a more timely basis going forward.

401
01:13:59.030 --> 01:14:00.519
W. Boyd Jackson - OHS: So thank you for flagging.

402
01:14:02.001 --> 01:14:10.928
W. Boyd Jackson - OHS: If anyone else has public comment, we'll take that now. Otherwise. We can move on to some of our other discussion points. And

403
01:14:11.860 --> 01:14:17.519
W. Boyd Jackson - OHS: we can circle back to anyone who needs wants to raise a hand and provide a comment. Later.

404
01:14:17.840 --> 01:14:21.860
W. Boyd Jackson - OHS: So, Corey, I'll turn back to you to move through the next

405
01:14:21.910 --> 01:14:24.340

W. Boyd Jackson - OHS: section of discussion topics.

406
01:14:24.480 --> 01:14:49.280
Corey Rhyan: Yeah, I think I'd like to go next to the emergency department section asking for folks if they have comments on both. The way that we've represented trends and emergency department use within the State. And and I guess, particularly the way that we've tried to start to develop a better understanding of underlying need for emergency department capacity within the State of Connecticut, and then starting to do that by looking at average wait times as an example data point that we've tried to pull in

407
01:14:49.552 --> 01:14:59.347
Corey Rhyan: under the understanding that if we're seeing larger, wait times in particular regions of the State or at particular hospitals for your emergency department care that that is an indication of a capacity constraint

408
01:14:59.957 --> 01:15:18.262
Corey Rhyan: for that that type of care, but curious of folks of what they think and what we've presented so far and potentially other information that could be provided to again provide, and that kind of independent look of an understanding of emergency department need. So curious of other data, other things that could be included there, or the way we presented those insights so far.

409
01:15:20.140 --> 01:15:24.350
Chris Hyers - UConn Health: Would it be possible to put that summary slide back up just to refresh our memory? After that.

410
01:15:24.350 --> 01:15:25.319
Corey Rhyan: Absolutely. I can.

411
01:15:25.320 --> 01:15:26.319
Chris Hyers - UConn Health: But need, yeah.

412
01:15:28.890 --> 01:15:52.200
Corey Rhyan: I am here and what we've shown so far. And so this is again coming from Cms data. I think we had had a conversation with the healthcare cabinet potentially around looking for this data being accessible directly from hospitals, because I think they are tracking it rather than kind of through the Cms pipeline, which is where I pulled this information from for the report. So far. Curious thoughts in in the accessibility of that data. And you know how, oh, just could incorporate that into this work.

413

01:15:52.200 --> 01:15:54.630
Chris Hyers - UConn Health: I'd be curious what other people think about the

414
01:15:54.880 --> 01:16:23.039
Chris Hyers - UConn Health: the the idea that wait times left without being seen is is an indicator or becomes a factor, because it could also just be a factor of an inefficient operation or understaffed operation that you might fact not need. And I don't know that right? I'm just then I run up. It's been a lot of different hospitals, run a lot different places, and sometimes you do a lot, and sometimes you don't do much, so I don't know how would all begin to factor together.

415
01:16:23.140 --> 01:16:27.800
Chris Hyers - UConn Health: Right? If it's what? What's your underlying test, is it?

416
01:16:27.930 --> 01:16:37.970
Chris Hyers - UConn Health: You know, rooms per visit, is it visits per day? Is that kind of what's the what's what's just like you laid out the 80 50 test before? What's the test here.

417
01:16:40.900 --> 01:17:03.869
Corey Rhyan: Yeah. And and you know, we've we've tried to look in, you know, in the literature and the way that some of this has been represented. You know, I think wait. Times are are a data point that a lot of folks have. So it's a data point that gets talked about a lot. But to to your point, you're right. It it may not be the best metric that we can look at, and looking at overall capacity or need so you know, curious of other experts on the on the call here, of of what might be other ways to represent this or or other things that should be considered.

418
01:17:13.890 --> 01:17:14.840
W. Boyd Jackson - OHS: Lisa.

419
01:17:14.840 --> 01:17:26.519
Lisa Winkler: Sorry related to that. I do think and and correct me if I'm wrong. There was legislation that passed. I thought this session that created sort of a data gathering effort on emergency department

420
01:17:27.310 --> 01:17:42.249
Lisa Winkler: issues in terms of wait times and and boarding and things, or overcrowding and things like that. So there may be at some point date, additionally, additional data available relative to that. And you just may want to reference that in the report as well as

421

01:17:42.320 --> 01:17:45.330
Lisa Winkler: data that's being collected in Connecticut.

422
01:17:47.370 --> 01:17:59.480
Corey Rhyan: Thank you. We will look that up. And would. That definitely is something we want to capture in the policy and trend section, and maybe can set that up as a as a section of this report that could begin to be included in a quantitative way if that data become publicly available and gathered systematically.

423
01:18:00.630 --> 01:18:01.450
Corey Rhyan: Thank you.

424
01:18:04.640 --> 01:18:05.370
W. Boyd Jackson - OHS: Jean.

425
01:18:06.120 --> 01:18:14.839
Jean Ahn: I in response to Corey's question, you know one of the things that the State of Massachusetts in the Health Policy Commission takes a look at in terms of ed utilization, which

426
01:18:14.910 --> 01:18:19.492
Jean Ahn: for a statewide health plan, we may also want to start tracking. Not that

427
01:18:20.200 --> 01:18:42.529
Jean Ahn: any certain decisions will be made is just ambulatory, sensitive conditions and emergency departments. So I I didn't see that in this particular plan. But that is something helpful to know. Are, you know the appropriate types. There's a whole host of considerations, but for the most part are the appropriate patients being seen in the emergency departments which then affects

428
01:18:43.156 --> 01:18:46.590
Jean Ahn: percentage left without being seen, and all those other factors, as well.

429
01:18:47.960 --> 01:19:11.300
Corey Rhyan: Yeah, thank you. We we can look at that specific example from the Health Policy Commission. I, I will note 3.6 figures 3.6. We do use a definition of a potentially avoidable emergency department visits that's trying to look at some of those those types of examples. There was an independent study that Ohs got some claims identifiers from, and then ran that on their emergency department data in order to observe those potentially avoidable visits, I think, open to a conversation of

430
01:19:11.553 --> 01:19:21.379
Corey Rhyan: you know. Is there an additional definition, or or slightly different way to look at that? But I would agree. That is something we're we're thinking about, and is something that you know is important to highlight as far as trends of use in the State.

431
01:19:23.510 --> 01:19:25.069
W. Boyd Jackson - OHS: Thank you. Liz.

432
01:19:27.830 --> 01:19:44.169
Liz Longmore: Thank you. So, looking at emergency department use and overall emergency department like this day, I always joke that this is a mosaic because it ties back to things like staffed beds. It ties back to overall bed utilization, bed availability.

433
01:19:44.210 --> 01:20:12.919
Liz Longmore: And I think that, like some of my other colleagues, have spoken about looking at Emergency Department utilization, and how the Ed is utilized, and then tying that back to how it is that your beds are staffed incorporating the observation data, which is an important component of understanding your overall bed use, and then tying that back regionally to the licensed beds and staff beds, will give you a much better perspective

434
01:20:12.920 --> 01:20:34.410
Liz Longmore: on what it is that that emergency department is experiencing it. You know there are going to be individual situations around efficiency of operations. But there's so many of those other things that tie into how the emergency department is deployed, how it's utilized and what your overall emergency department length of stay and what you're left without being seen.

435
01:20:34.480 --> 01:20:36.240
Liz Longmore: Percentages look like.

436
01:20:38.710 --> 01:20:56.970
Corey Rhyan: Yeah, thank you. That's that's good comments. And so I think what we try and do in the in this report is where we have those individual components. We try and lay out the trends that we're seeing and those individual components along the different lines that we have to your point trying to tie those together, and a thread we can do a little bit in narrative, but is is difficult because we want to try and develop a standardized process to represent

437
01:20:56.970 --> 01:21:10.260

Corey Rhyan: some of this. So if if folks have additional thoughts, and either quantitatively, or models that exist, to try and understand the way to incorporate those components into a need or a capacity constraint, estimate, you know. Happy to consider them otherwise. I think our goal in this report is

438
01:21:10.260 --> 01:21:30.349
Corey Rhyan: to lay the data out that Ohs and the State have to understand those needs. And and then it's kind of, you know, up to Ohs, to kind of read into that, and the applicants to read into that as far as where need is, across the state based on those those flags. But if there are kind of thresholds or or levels of concern that gets set among different statistics. Or, again, different relationships between different things, such as

439
01:21:30.585 --> 01:21:50.400
Corey Rhyan: observation, bed use, and capacity and types of use, you know altogether what would certainly welcome written comments or comments here of you know what? What would be some ideas and how to do that more systematically, cause that that is the role of this document to kind of systematically represent the data as best we can. And we can do that individually, and if there's ways to tie pieces together, would would love feedback on that in ways we haven't done so far.

440
01:22:01.190 --> 01:22:03.419
W. Boyd Jackson - OHS: Any other comments on the

441
01:22:03.800 --> 01:22:05.300
W. Boyd Jackson - OHS: Ed use.

442
01:22:12.430 --> 01:22:13.450
W. Boyd Jackson - OHS: Lisa.

443
01:22:29.870 --> 01:22:31.973
W. Boyd Jackson - OHS: and went down. So

444
01:22:35.160 --> 01:22:37.600
W. Boyd Jackson - OHS: Lisa Freeman, if you were trying to.

445
01:22:37.600 --> 01:22:40.110
Lisa Freeman, CTCPS: Yeah, just realized I'm I was muted. I apologize.

446
01:22:40.110 --> 01:22:41.130
W. Boyd Jackson - OHS: There we go!

447
01:22:41.130 --> 01:22:48.422
Lisa Freeman, CTCPS: I. I also was having difficulty, so I haven't heard the last like few minutes of the conversation in the meeting.

448
01:22:48.880 --> 01:22:56.850
Lisa Freeman, CTCPS: but I do wanna say that in terms of the emergency department overcrowding and

449
01:22:59.010 --> 01:23:15.000
Lisa Freeman, CTCPS: overcrowding and the length of time that patients have to stay there? It's a huge problem. And I think that there must be more information that we can gain for that as a representative of patients in Connecticut.

450
01:23:15.604 --> 01:23:18.705
Lisa Freeman, CTCPS: I think it creates a real patient safety issue

451
01:23:19.120 --> 01:23:36.379
Lisa Freeman, CTCPS: it has to do with. Where do the patients need to go afterwards? I mean, I heard one reference earlier, and I don't. This is not the only reason, but it referred to the family of patients on title 19, and the discharge delays having to do with

452
01:23:36.440 --> 01:23:41.490
Lisa Freeman, CTCPS: family involvement and engagement, and getting information and things of that nature.

453
01:23:42.390 --> 01:23:47.457
Lisa Freeman, CTCPS: Perhaps the patients need to be better educated about what's really needed.

454
01:23:47.900 --> 01:23:51.130
Lisa Freeman, CTCPS: I think a lot of times they don't understand

455
01:23:51.390 --> 01:23:54.890
Lisa Freeman, CTCPS: what the purpose of the emergency department is.

456
01:23:55.740 --> 01:23:57.640
Lisa Freeman, CTCPS: But it's not a clinic

457
01:23:58.367 --> 01:24:03.820
Lisa Freeman, CTCPS: and that's just a small portion. By the way, I don't want to like paint. Broad brush strokes here.

458
01:24:03.840 --> 01:24:12.760
Lisa Freeman, CTCPS: but I think patients in general do not understand. Patients who don't have insurance are even more confused, and I think it would behoove

459
01:24:13.348 --> 01:24:20.151
Lisa Freeman, CTCPS: the people who are in positions of authority, who are writing documents to help stem these problems.

460
01:24:20.560 --> 01:24:26.349
Lisa Freeman, CTCPS: to include a a degree of patient education so that

461
01:24:26.510 --> 01:24:35.659
Lisa Freeman, CTCPS: we can support them in the emergency department. Are there people just there to assist patients who don't quite understand what's going on?

462
01:24:36.362 --> 01:24:45.397
Lisa Freeman, CTCPS: Or what's needed, or where they can get more appropriate care or things of that nature. And I think that the wait times

463
01:24:46.050 --> 01:24:52.406
Lisa Freeman, CTCPS: are are much longer, both to my personal experience, and from what I hear you know of people

464
01:24:53.702 --> 01:24:55.569
Lisa Freeman, CTCPS: from people that

465
01:24:55.770 --> 01:25:03.180
Lisa Freeman, CTCPS: the the wait time sometimes can be hours and hours. I mean I I personally, I went there with a concussion. At 1 point.

466
01:25:03.300 --> 01:25:06.499
Lisa Freeman, CTCPS: somehow I got discharged while I was waiting.

467
01:25:06.970 --> 01:25:10.139
Lisa Freeman, CTCPS: and I didn't ultimately get taken care of

468
01:25:10.210 --> 01:25:18.759
Lisa Freeman, CTCPS: if we could call what a treatment I got taken care of, but it took 8 h for me to go from getting there to being released.

469
01:25:19.180 --> 01:25:19.780
Lisa Freeman, CTCPS: and

470
01:25:20.450 --> 01:25:22.540
Lisa Freeman, CTCPS: it should never have taken that long.

471
01:25:22.970 --> 01:25:28.809
Lisa Freeman, CTCPS: So I I think that we need to look at what the patient's actual experiences are.

472
01:25:29.460 --> 01:25:34.129
Lisa Freeman, CTCPS: and find a way to analyze it and find a way to assess. Wait times.

473
01:25:34.774 --> 01:25:42.059
Lisa Freeman, CTCPS: and make sure that we're responding to it and make sure that we're providing the most appropriate care.

474
01:25:43.440 --> 01:25:44.670
Lisa Freeman, CTCPS: That's needed.

475
01:25:47.300 --> 01:25:48.450
Corey Rhyan: Yeah, I I think.

476
01:25:48.480 --> 01:25:50.049
Corey Rhyan: taking available of all

477
01:25:50.090 --> 01:26:05.789
Corey Rhyan: I'll take make making available all the available data that we have on examples such as Ed overcrowding and and wait times is definitely something we want to do in this report and represent that where it's potentially impacting need and and patient access related to your comments around resources for patients. I I think

478
01:26:05.800 --> 01:26:17.769
Corey Rhyan: this is probably a difficult document to to provide some of that information in, but we can think about. If there are ways to kind of link to other Connecticut resources that are available to try and do that work again. This is a difficult document, and that it serves a dual purpose, and both

479
01:26:17.770 --> 01:26:35.959

Corey Rhyan: being a public document and for patients, but also a pretty technical document that contains a lot of information that's needed. For you know, regulators and and for facilities, you know, within the State. So we can think about how to how to provide that. You know, in a way, when maybe showing where available resources are. You know, for for a public use as well.

480
01:26:36.170 --> 01:26:36.650
Lisa Freeman, CTCPS: Thank you.

481
01:26:46.270 --> 01:26:49.199
W. Boyd Jackson - OHS: Anyone else on emergency department use

482
01:26:49.890 --> 01:26:51.679
W. Boyd Jackson - OHS: and the accompanying

483
01:26:52.790 --> 01:26:54.640
W. Boyd Jackson - OHS: data questions.

484
01:26:56.520 --> 01:27:21.767
Corey Rhyan: And and some of the comments we've gotten here are are very relevant around the types of care that's being provided in emergency departments. And whether or not some of that care could be provided in better settings, or in better ways to you know, serve the the needs of the Connecticut population, and I will point folks, if if they're interested in that topic, to also look at our primary care section of this report, and we do talk about some of the issues related to availability and access to primary care providers, and that way

485
01:27:24.320 --> 01:27:38.009
Corey Rhyan: under supply and primary care, currently within the State where that exists, could potentially drive additional emergency department demand in a way that potentially could be avoided. So that is another section of the report. Curious of folks that have expertise on the emergency department side to take a look at that that section as well in the way we reference. Some of those topics.

486
01:27:44.440 --> 01:27:45.120
W. Boyd Jackson - OHS: Great

487
01:27:45.941 --> 01:27:48.888
W. Boyd Jackson - OHS: so we wanna move on to

488
01:27:49.930 --> 01:27:57.499

W. Boyd Jackson - OHS: 5, 6 and 7 outpatient surgery. Obviously, we've had a little bit of discussion on these topics.

489
01:27:57.570 --> 01:28:02.493
W. Boyd Jackson - OHS: especially as it relates to ambulatory, surgery centers, facilities.

490
01:28:03.220 --> 01:28:04.606
W. Boyd Jackson - OHS: any other

491
01:28:06.150 --> 01:28:11.059
W. Boyd Jackson - OHS: thoughts about the data and how it's presented, or estimates of need.

492
01:28:17.600 --> 01:28:19.450
Lisa Winkler: One other. Oh, sorry! I'll raise.

493
01:28:19.450 --> 01:28:21.600
W. Boyd Jackson - OHS: Go go ahead! Go ahead! Lisa.

494
01:28:21.600 --> 01:28:27.579
Lisa Winkler: Sorry. I'm so bad that way. One other thing that I wanted to mention, too, was just in terms of

495
01:28:27.740 --> 01:28:35.309
Lisa Winkler: workforce and ability, and I'm wondering if it makes sense to include some discussion as we think about need.

496
01:28:35.693 --> 01:28:58.730
Lisa Winkler: You know the ability to recruit physicians to Connecticut. I I think the availability and inclusion and ambulatory surgery center is an important component of of our abilities to recruit workforce. And I do think that's an important conversation to have in this document. You know, regardless of the the provider, but certainly, as it relates to surgery centers.

497
01:29:00.720 --> 01:29:05.259
Lisa Winkler: and we'd be happy to maybe submit. Submit some comments or information on that, as well.

498
01:29:06.370 --> 01:29:19.399
Corey Rhyan: We certainly do have some provider sections of the report. And and I think you're right. There could be a role for that directly in the outpatient surgery section, but also in the in the provider supply

and capacity sections as well. So yeah, I think that would be great if you have suggested language or or thoughts.

499
01:29:19.620 --> 01:29:20.310
Lisa Winkler: Thank you.

500
01:29:20.750 --> 01:29:39.422
W. Boyd Jackson - OHS: Yeah, I think that there's some discussion around workforce and staffing in this document. But I think we also anticipate addressing it in what will essentially be phase 2 of this overall project, the State Health Improvement plan. I think that there will be

501
01:29:39.890 --> 01:29:47.880
W. Boyd Jackson - OHS: more conversation and discussion around workforce challenges and staffing issues that folks have experienced.

502
01:29:48.470 --> 01:29:56.079
W. Boyd Jackson - OHS: So it's that that kind of touches both of these documents, but just flagging that there will be additional

503
01:29:56.090 --> 01:29:59.119
W. Boyd Jackson - OHS: coverage of those topics in in that document.

504
01:30:07.940 --> 01:30:11.500
W. Boyd Jackson - OHS: Anyone else on the outpatient piece, Corey? I don't know if you have

505
01:30:12.330 --> 01:30:14.969
W. Boyd Jackson - OHS: specific callouts and questions.

506
01:30:15.630 --> 01:30:28.769
Corey Rhyan: I I think. I, we got some great comments already, and some of the data that we've shown, I think we will definitely take back some of those definitional issues and look forward to the written comments there. So we can be more precise on that. I think. My thoughts. Here were Boyd, as I know you've mentioned in a couple of these other meetings.

507
01:30:29.100 --> 01:30:51.520
Corey Rhyan: Trying to do the best we can and estimate based on the population level estimates of need. What we think the need is for outpatient surgery capacity within the State, and how we are currently doing, as far as meeting that need based on what we have. And so a lot of what I've shown in the report folks will note is estimates of utilization right where I'm looking at the actual number of cases, number encounters that are incurring

508
01:30:51.520 --> 01:31:06.900
Corey Rhyan: and what is going on and trends in those over time. What's kind of left out of that. Look at just utilization is what we think independently. The level of need is, and then the and the actual capacity that it exists within the State, and I think that's useful for Ohs to understand if there are

509
01:31:06.910 --> 01:31:28.330
Corey Rhyan: other pieces of data or other methodologies that folks are aware of that have been used to estimate what the essential capacity is, and particularly what the essential capacity is within a region, or for particular types of care, or for particular types of patients, and and how we can better represent if we're meeting that need in the State of Connecticut, or what might be needed as far as understanding where those gaps may exist.

510
01:31:28.565 --> 01:31:39.549
Corey Rhyan: So I think that's like an open question that would love to have folks think about if they're aware of additional data that could be brought in, or additional methodologies that could be used to represent that from a population level understanding what the need is for these types of services.

511
01:31:40.940 --> 01:31:41.790
W. Boyd Jackson - OHS: Lisa.

512
01:31:42.620 --> 01:31:47.939
Lisa Winkler: Sorry. So a a as you just mentioned that, Corey, the one thing that I was thinking about is sort of

513
01:31:48.290 --> 01:31:49.320
Lisa Winkler: you know, that

514
01:31:49.450 --> 01:32:06.704
Lisa Winkler: maybe including some sort of conversation that not every patient is appropriate for care in a surgery center, and some of it is based on the anesthesia guidelines. And I I think it's important for people to maybe to have an you know, including some conversation about that as well.

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01:32:07.200 --> 01:32:13.750
Lisa Winkler: as we think about this. Obviously we mentioned cost and things like that as a comparison.

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01:32:14.140 --> 01:32:19.250
Lisa Winkler: But I think that certainly the discussion of the appropriate patient is important to that conversation.

517
01:32:19.530 --> 01:32:36.929
Corey Rhyan: Yeah, thank you. I think that's potential good inclusion. I'm I'm thinking I'm I'm the reason why, I'm thinking, is, I'm thinking, where what section that might fit in, and it could be in, in the discussion of the utilization, potentially or even just in the introduction to the chapter. But a few recommendations of where that may fit. I think you're welcome to submit that written comments, but I will take that back and think about that, too, because that's a great comment.

518
01:32:37.150 --> 01:32:42.189
Lisa Winkler: And certainly patient selection. I mean, I think, making sure that patients have the choices is important, too.

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01:32:42.800 --> 01:32:59.911
Corey Rhyan: Right, and and that, of course, is the, you know, at the crux of the issue, and understanding. What we see in the utilization may not represent the optimal amount of utilization where patients are forced to make choices because there is lack of capacity or or mismatch capacity in different areas. You know as best we can, we wanna try and represent what that underlying patient need is

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01:33:00.160 --> 01:33:18.520
Corey Rhyan: along those different lines. And so again, any data or information we have. We know this is a hard question, but we don't want to miss anything that potentially might be available and trying to identify underlying at that population level. What we think that need is, and how well our utilization statistics are capturing where that actual need is and where there may be gaps and access occurring as a result.

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01:33:30.670 --> 01:33:54.010
Corey Rhyan: And then my last one here Boyd, is is related to just those standards and and guidelines that we included, and I think there is a small quantitative component related to to outpatient surgery in that section in 4.6 point 2, and then, you know, similar to the discussion we've had around the acute care bed need of those those other factors for consideration, and how well those capture additional needs that potentially might be, need need to be considered or you know things that would occur outside of

522
01:33:54.010 --> 01:34:08.360
Corey Rhyan: applications that would just include the quantitative understanding and the amount of care that would be provided. You know, we're trying to capture E examples of issues related to particular

populations, particular changes and trends, and the types of care that's being provided, or how care is being provided.

523
01:34:08.655 --> 01:34:22.560
Corey Rhyan: Lisa you mentioned. You know, the discussions around cost and quality, and those have been included. But curious thoughts. In that section. If there are additional considerations or changes in the language that should be considered within the outpatient surgery certificate of need, applications.

524
01:34:36.220 --> 01:34:46.670
Lisa Winkler: I I think we'll certainly have some comments on that, as it relates to the average time. You know the times of procedures and things and things like that. And again, that delivery rooms for Caesarean sections.

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01:34:47.250 --> 01:34:55.659
Lisa Winkler: I don't know if it's from birthing centers, but it's we are not doing that in our surgery centers. So just something to to think about, too.

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01:35:04.260 --> 01:35:06.549
W. Boyd Jackson - OHS: Great. We'll take a look at that.

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01:35:08.570 --> 01:35:11.520
W. Boyd Jackson - OHS: Does anyone have any

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01:35:11.840 --> 01:35:13.900
W. Boyd Jackson - OHS: other general comments?

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01:35:14.340 --> 01:35:17.270
W. Boyd Jackson - OHS: Conclusion remarks, yes, Jean.

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01:35:18.250 --> 01:35:28.649
Jean Ahn: So one of the things that the report did point out is that the number of Medicaid Enrollees at non hospital outpatient surgical facilities are lower.

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01:35:28.790 --> 01:35:45.710
Jean Ahn: And so, you know, one of the general just observations and questions is as we move forward? Is there going to be more of a leveling of the playing field, you know, if you want to. If you want to provide services in the State, you really should be providing services to all people at levels equivalent to what

532
01:35:45.880 --> 01:36:02.300
Jean Ahn: hospitals or others in that region or area provide. So that's just a general question and observation, because otherwise more and more of the Medicaid population comes to the hospitals, and more of the commercial goes to the non-hospital facilities. And so I do think

533
01:36:02.390 --> 01:36:08.530
Jean Ahn: that's just. Whether it's inpatient rehab, rehab facilities, the for-profits that come in?

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01:36:09.219 --> 01:36:17.250
Jean Ahn: And then the non hospital facilities. What are they doing to help share in the burden of Medicaid utilization and services provided.

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01:36:19.240 --> 01:36:20.273
W. Boyd Jackson - OHS: Thank you.

536
01:36:20.820 --> 01:36:21.770
W. Boyd Jackson - OHS: certainly.

537
01:36:23.490 --> 01:36:31.330
W. Boyd Jackson - OHS: Access for Medicaid patients is sprinkled throughout our coin. Criteria. So any suggestions for

538
01:36:32.340 --> 01:36:42.689
W. Boyd Jackson - OHS: you know, additional guidance or explanation of interpretation that you think should be included in this document that would help

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01:36:42.840 --> 01:36:48.770
W. Boyd Jackson - OHS: explain any of that welcome comment on that as well, and where

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01:36:49.020 --> 01:36:55.570
W. Boyd Jackson - OHS: where the consideration fits. Within this document versus, just as a general note you make about

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01:36:56.010 --> 01:36:57.370
W. Boyd Jackson - OHS: the criteria

542
01:36:57.610 --> 01:37:00.439
W. Boyd Jackson - OHS: so definitely welcome any thoughts there.

543
01:37:01.290 --> 01:37:02.260
W. Boyd Jackson - OHS: Lisa.

544
01:37:03.380 --> 01:37:07.400
Lisa Winkler: Thanks. I just as a follow up to that that comment. I just wanted to

545
01:37:07.900 --> 01:37:11.510
Lisa Winkler: sort of reiterate our comments about the lack of

546
01:37:11.530 --> 01:37:34.690
Lisa Winkler: reimbursement under the Medicaid program for some of the things that we talked about in terms of implants, or or, you know, umbrella clips in a colonoscopy, or things like that, which oftentimes, you know, are more expensive than the reimbursement for the procedure themselves, and so that is an obstacle and a barrier to providing care in some cases. I know that there is a provision about.

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01:37:34.690 --> 01:37:42.879
Lisa Winkler: you know, Medicaid services as a as a pro, as a requirement of the Co. N review process, and then

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01:37:43.580 --> 01:38:00.200
Lisa Winkler: There certainly was an issue for many years for surgery centers, as it related to the Ambulatory Surgery Center tax which removed so much of of the revenue out of surgery centers that would have allowed many of them to sort of increase access. So I think maybe some of

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01:38:00.230 --> 01:38:13.669
Lisa Winkler: the discussion about those issues would be helpful, but certainly as part of the adverse event data that's collected, that the pay or mix is included, and I would say most, if not all, centers, are providing care to to Medicaid patients.

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01:38:14.000 --> 01:38:28.480
Amanda Gunthel: Lisa. I just wanna further on that, and that it's there's there's 2 pieces to this, and part of it is reimbursement. But part of it is also not having an established rate or coverage to perform those cases. In an Asa

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01:38:28.500 --> 01:38:44.170
Amanda Gunthel: where, you know, for example, there is a there is a rate and an established fee to perform this in an Hpd. But there is not one that exists in an Asc. Even though we could absolutely do that case, and we provide those services to all kinds of payers.

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01:38:44.850 --> 01:38:52.360
Amanda Gunthel: It's it's simply not covered. And that's a rate limiting step for us. And I think that's an important part of the information, and we're happy to provide that.

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01:38:57.260 --> 01:38:58.080
W. Boyd Jackson - OHS: Thank you

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01:39:02.620 --> 01:39:12.199
W. Boyd Jackson - OHS: anyone else. General comments, comments about the plan as a whole, questions or any

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01:39:13.680 --> 01:39:16.799
W. Boyd Jackson - OHS: conclusion. Statements from anyone.

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01:39:18.240 --> 01:39:23.579
W. Boyd Jackson - OHS: or public public comments. I think we're still technically still in the

557
01:39:24.140 --> 01:39:26.249
W. Boyd Jackson - OHS: public comment portion.

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01:39:26.805 --> 01:39:29.650
W. Boyd Jackson - OHS: But if not, I can wrap us up.

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01:39:30.405 --> 01:39:40.200
W. Boyd Jackson - OHS: I just want to say thank you again to everyone who participated and did so in a in a fulsome manner. Here.

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01:39:41.230 --> 01:39:42.209
W. Boyd Jackson - OHS: we

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01:39:42.470 --> 01:39:48.809
W. Boyd Jackson - OHS: very much appreciate you reviewing the the plan, contributing your comments.

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01:39:49.324 --> 01:39:54.009
W. Boyd Jackson - OHS: Engaging with us as we posed a lot of questions to you all today.

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01:39:55.250 --> 01:40:05.100

W. Boyd Jackson - OHS: do please continue to review and think and reflect on our conversation, and we welcome any

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01:40:05.290 --> 01:40:12.050
W. Boyd Jackson - OHS: additional comments and feedback in your written comments. Especially, you know.

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01:40:13.070 --> 01:40:19.140
W. Boyd Jackson - OHS: if we think about certain of these areas that we've highlighted. We're really looking for solutions

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01:40:19.190 --> 01:40:39.430
W. Boyd Jackson - OHS: in the data. And we're looking for where we can specify things in the the kind of methodologies themselves. So whether it be any guidelines for figuring out the population level need for outpatient surgical facilities and their operating rooms.

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01:40:39.480 --> 01:40:48.289
W. Boyd Jackson - OHS: or whether it is determining how to wait. The years of average daily census, how to consider

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01:40:48.300 --> 01:41:06.060
W. Boyd Jackson - OHS: observation stays. You know all these points that we've highlighted. Any additional information and suggestions you can give for how to handle all of that effectively is what's really useful to moving this plan forward and making sure that it is a useful document for both

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01:41:06.060 --> 01:41:30.990
W. Boyd Jackson - OHS: the agency. As we are applying these methodologies to the, to the applications, and also to the applicants themselves, so that folks understand what the agency is looking for and how they're going to determine the need. And you know, for the, for example, the the Medicaid access and things like that. So any additional guidance and suggestions that you all have

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01:41:30.990 --> 01:41:38.280
W. Boyd Jackson - OHS: can provide in written comments is very welcome. And we will consider that along with everything we heard today. We've been taking

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01:41:38.561 --> 01:41:48.969
W. Boyd Jackson - OHS: detailed notes. So thank you all very, very much for spending your afternoon with us. It has been very useful for all of us. And I hope you have a great rest of your afternoon.