WEBVTT

1
00:00:25.010 --> 00:00:26.500
Also recording.

2
00:00:33.290 --> 00:00:34.789
Aby Cotto, OHS (she/her): Can you guys hear me?

3
00:00:37.370 --> 00:00:38.110
Steven Lazarus-OHS: Yes.

4
00:00:38.310 --> 00:00:38.730
Aby Cotto, OHS (she/her): Okay.

5
00:00:38.730 --> 00:00:39.180
Cindy Dubuque-Gallo (OHS): Yes.

6
00:00:39.400 --> 00:00:42.990
Aby Cotto, OHS (she/her): Alright! I have a whole brand new laptop.

7
00:00:43.060 --> 00:00:45.680
Aby Cotto, OHS (she/her): so everything is downloading.

8
00:00:46.990 --> 00:00:52.399
Steven Lazarus-OHS: We. I went through that end last week. Then I hit up with Blisberg 24 h later.

9
00:00:52.810 --> 00:01:01.199
Aby Cotto, OHS (she/her): Alright. And now my zoom, I guess, is the most updated version. So it looks a little bit different. So I'm trying to pause, the Oh! Here we go!

10
00:01:01.200 --> 00:01:01.890
W. Boyd Jackson, OHS: Good.

11
00:01:03.860 --> 00:01:19.391
W. Boyd Jackson, OHS: Alright my name is Boyd Jackson. I am the director of Legislation and Regulation at the office of Health Strategy. So I oversee our legal department, our certificate of need program and our legislative and regulatory affairs. Team

12
00:01:20.304 --> 00:01:23.034

W. Boyd Jackson, OHS: I'm joined by a number of

13
00:01:23.810 --> 00:01:45.119
W. Boyd Jackson, OHS: Ohs staff and I know our staff person on point, for this has been Cindy Dubut Gallo, our legislative liaison, so I know many of you heard from her in this process, and she'll be tracking all of our conversations today to make sure that we're able to incorporate thoughts and respond accordingly.

14
00:01:45.676 --> 00:02:03.990
W. Boyd Jackson, OHS: I'm also joined by Corey Ryan from altar, and they were our consultant on this project, and really helped review all the literature review. What other States have done and and try to help us think through the way we draft our

15
00:02:03.990 --> 00:02:26.590
W. Boyd Jackson, OHS: cardiac services chapter in the Facilities and Services plan. A. As many of you all will be very familiar. This is an extremely important document to a lot of different constituencies, one being our certificate of need program and the applicants under that program. It really lays out how the agency is thinking about. Some of these

16
00:02:26.590 --> 00:02:40.150
W. Boyd Jackson, OHS: criteria. This chapter especially has a big section on quality. And we're also trying to understand the need for these services and and the distribution of those across the State.

17
00:02:40.270 --> 00:02:48.170
W. Boyd Jackson, OHS: It also helps guide policy makers, legislators, and it's an important resource for the public. So

18
00:02:48.310 --> 00:02:59.990
W. Boyd Jackson, OHS: you know, we we think about this stuff every day. We know you all live it every day. So we really appreciate you all coming and sharing the insight that you have from your everyday experience

19
00:03:01.080 --> 00:03:04.470
W. Boyd Jackson, OHS: just a little bit about the flow of this conversation.

20
00:03:04.820 --> 00:03:21.609
W. Boyd Jackson, OHS: We'll have a little bit of an introduction from Corey on the the chapter highlight. Some key points and key updates. We'll have about an hour for the Advisory group to discuss. That can be

free flowing. We have some. We have identified some key concepts that we would like to discuss.

21
00:03:21.920 --> 00:03:34.660
W. Boyd Jackson, OHS: but you should feel free to comment on any part of that. Then we'll pause for about 30 min to take any public comments that we have. We have a number of members of the public who are not

22
00:03:34.660 --> 00:03:43.880
W. Boyd Jackson, OHS: formal advisory group members. And then we'll take a little extra time just for advisory group reflection on comments and

23
00:03:44.400 --> 00:04:03.850
W. Boyd Jackson, OHS: conclusions. I want to remind everyone to. We'll have our full discussion today. Everything you say today is recorded. We're taking notes. We will incorporate all your thoughts today. But please do consider submitting written comments as well, with

24
00:04:03.870 --> 00:04:13.709
W. Boyd Jackson, OHS: accompanying resources, literature, anything like that that you might want us to consider as we move from a preliminary draft to a final draft.

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00:04:15.170 --> 00:04:22.919
W. Boyd Jackson, OHS: we oh, this is this product lives with Ohs! And it is Ohs's responsibility to put out every 2 years.

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00:04:23.449 --> 00:04:30.460
W. Boyd Jackson, OHS: So we will be taking all of these comments and considering them to the extent possible, we will

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00:04:30.630 --> 00:04:46.279
W. Boyd Jackson, OHS: kind of put those comments into buckets and respond accordingly. Whether we say this has been incorporated into the draft, or whether we lay out the rationale for why something was done a certain way, or why something was not incorporated.

28
00:04:46.300 --> 00:04:52.989
W. Boyd Jackson, OHS: So with that backdrop on kind of the logistics of the day. The logistics of this process

29
00:04:53.080 --> 00:05:15.569
W. Boyd Jackson, OHS: written comments are due by the end of September, and then we're looking to get out our final draft by the end of October. So that's the general framework. If anyone has questions about that. I'm

happy to address those as well, but otherwise I will turn it over to Corey for a little introduction and and highlights from this. Oh, thanks, Corey! From this

30
00:05:16.030 --> 00:05:16.960
W. Boyd Jackson, OHS: chapter.

31
00:05:19.370 --> 00:05:43.600
Corey Rhyan: Wonderful. Thank you. Boyd. Yeah. Just as an introduction. I'm a research director with Alterham's health economics and policy team, and we've been partnered with ohs! Over the last 2 years to work on updating this facility and Services plan document. So thanks for the opportunity today to present some of the work in the current draft that we have released, and they'll give a couple of highlights here, and then open up the opportunity from some discussion with the group, and we look forward to all your feedback and the notes you guys can send us today.

32
00:05:44.160 --> 00:05:47.389
Corey Rhyan: I will see if I can figure how to share my screen here.

33
00:05:48.810 --> 00:05:50.099
Corey Rhyan: Can you see that boy.

34
00:05:52.680 --> 00:05:54.720
Cindy Dubuque-Gallo (OHS): Anything yet that's coming, though.

35
00:05:55.070 --> 00:05:56.590
Corey Rhyan: Havana. Okay.

36
00:05:56.590 --> 00:05:57.660
W. Boyd Jackson, OHS: There we go!

37
00:05:57.660 --> 00:05:59.470
Corey Rhyan: Perfect. Thank you very much.

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00:06:00.130 --> 00:06:19.399
Corey Rhyan: Okay, so just a really, really high level overview for folks on the call. I know everybody's probably familiar with the Facility and Services plan. But we're talking here about the 2024 version and the current draft that was released as of June and the general overview of what the facility and services plan is is the plan is a blueprint for healthcare delivery in the State of Connecticut.

39
00:06:19.400 --> 00:06:33.990

Corey Rhyan: and it's a dual purpose document. It's a documents that serves both as a resource for policymakers and those involved in the Co. N process to make decisions around con applications and the consideration of the expansion of services under particular categories within the State of Connecticut.

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00:06:34.110 --> 00:06:58.189
Corey Rhyan: And it's also a general public facing document that also provides broad information and about current policies that are impacting healthcare delivery within the State of Connecticut, the projections of need for particular services and an understanding of utilization of existing services within the State of Connecticut, and also then details of how those policies and current policies are impacting the expected future need for care within the state.

41
00:06:59.860 --> 00:07:09.829
Corey Rhyan: The overall goal of the Facility and Services plan document is to 1st and foremost understand the current utilization of care and then project how that care

42
00:07:10.120 --> 00:07:33.360
Corey Rhyan: lines up with the existing capacity to provide healthcare services. And so what the goal of this is is both to prevent excess, capacity, prevent the ex, the the excess and duplication of of services across the State at particular medical facilities and for particular types of care, but also identify gaps in in services, and where there are underlying areas of need and which populations within the State of Connecticut have the greatest need for particular types of care.

43
00:07:34.160 --> 00:07:58.190
Corey Rhyan: The Facility and services plan helps provide some guidelines for adding services. This is a document that's very critical for the Ohs staff in making certificate and need determinations. There's a long list of considerations that need to be made when making these decisions. But one of the things that need to be considered are the data and underlying guidelines that have been laid out in the facility and services plan. And so we're going to talk today about the cardiac

44
00:07:58.190 --> 00:08:04.469
Corey Rhyan: sections of this report and the overall guidelines and standards that have been that have been included in the in the draft. So far

45
00:08:05.390 --> 00:08:33.509
Corey Rhyan: the goals of the facility and Services plan are also to foster fair competition and a level playing field for entry into the healthcare market, and to ensure that access to services are balanced across the State, and that there's an adequate geographic distribution of

available services, making sure that where services are available in the State aligns with where need is, and allowing Ohs to better understand what trends in change in those use of services over time might look like in order to ensure that all Connecticut residents have access to affordable and accessible healthcare services.

46
00:08:35.539 --> 00:08:47.019
Corey Rhyan: The current report has 10 chapters included in it, running from an introduction and an overview of the Co. N. Process, then highlighting some overarching policy trends and trends that have been observed within the State of Connecticut.

47
00:08:47.180 --> 00:09:06.370
Corey Rhyan: and then a few chapters that look at particular service categories and particular types of care and the underlying recommendations for the expansion of those particular service types. You'll see their chapter 3 includes acute care included in acute care a couple of sub population categories and and sub services. One of those is cardiac care that we'll be talking about today.

48
00:09:06.480 --> 00:09:11.359
Corey Rhyan: Then we also have some sections on outpatient surgery facilities, imaging and new technology

49
00:09:11.460 --> 00:09:13.290
Corey Rhyan: behavior, healthcare services.

50
00:09:13.500 --> 00:09:15.069
Corey Rhyan: primary care services.

51
00:09:15.490 --> 00:09:24.869
Corey Rhyan: long term care services and supports and post acute care, and then chapters 9 and 10 includes some recommendations, next steps and acknowledgement of data limitations in the report as written so far.

52
00:09:24.930 --> 00:09:27.850
Corey Rhyan: So we're going to talk today primarily about this acute care. Chapter

53
00:09:28.070 --> 00:09:36.599
Corey Rhyan: and in in particular. Section 3.4, which details our our standards, guidelines, and information on current utilization of cardiac services within the State.

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00:09:36.878 --> 00:09:54.490

Corey Rhyan: There are lots of other advisory meetings as Void has mentioned, that are talking about other topics within this report. So we're gonna try and focus our attention today on these cardiac services categories. Although if folks have have comments that relate kind of more broadly to the report, we're happy to take those as well in in further in further advisory committee meetings.

55
00:09:55.280 --> 00:10:07.580
Corey Rhyan: the cardiac Services section includes some 1st and foremost, some definitions of cardiac services and what falls underneath the purview of the cardiac services certificate of need process, and how those services are defined.

56
00:10:07.890 --> 00:10:21.680
Corey Rhyan: It then includes some information on the current utilization of cardiac services within the State. What has been observed in looking at both the all pair claims database. What has been observed in the hospital discharge database and other measures of current utilization of cardiac services.

57
00:10:21.860 --> 00:10:30.900
Corey Rhyan: It includes a section on the locations of where those cardiac services currently are offered, and where the facilities that can offer those services that currently exist within the State of Connecticut.

58
00:10:31.020 --> 00:10:47.809
Corey Rhyan: and then some recommendations on standards and guidelines for the certificate of need process around what should be considered what quality guidelines, what other standards should be included when thinking about considering a certificate or need application specific to some of these cardiac services components

59
00:10:49.800 --> 00:11:09.790
Corey Rhyan: just detailing here, right off the top what falls underneath the purview for the certificate of a need process as as currently defined by the Connecticut general statutes. We see here that a certificate need is required for the establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery.

60
00:11:09.880 --> 00:11:18.810
Corey Rhyan: So Connecticut hospitals seeking authorization to establish a cardiac program are required to demonstrate they meet a clear public need, as well as other criteria set forth in that section.

61
00:11:21.560 --> 00:11:41.499

Corey Rhyan: I'm just gonna give a quick highlight here of some of the findings that we have out of the report in identifying where cardiac services currently are available within the State of Connecticut. What we see as current utilization of those cardiac services and trends in those services, and then we'll very quickly here jump to our discussion, and the particular questions and feedback we'd like to receive from folks. Related to this section today.

62
00:11:42.000 --> 00:11:47.330
Corey Rhyan: You can see here just a detail of the current Connecticut hospitals that offer one of these cardiac services.

63
00:11:47.380 --> 00:11:52.390
Corey Rhyan: and which which particular service is offered at at particular locations.

64
00:11:53.890 --> 00:12:13.449
Corey Rhyan: You can then see here, this is another table coming from the current report. That details the current utilization of cardiac services, and you can see trends over time. Looking from fiscal year 2016, through 2021, in the use of cardiac care. Both related to inpatient discharge trends, and then the second table there being inpatient, patient days over time.

65
00:12:13.520 --> 00:12:24.580
Corey Rhyan: So you can see small small declines between 2,016 and 2021, in the number of discharges that occurred, or inpatient discharges that occurred for cardiac services within the State of Connecticut.

66
00:12:24.610 --> 00:12:39.929
Corey Rhyan: but an increase in the number of patient days. And so what this may indicate is that while there may be a slightly smaller number of individuals that are receiving treatment over this period. What we are seeing is we're seeing a greater intensity of care being provided, and that the number of inpatient days is increasing over time.

67
00:12:40.340 --> 00:13:04.900
Corey Rhyan: Also important to note here that you see that the final 2 years of this table, or fiscal year 2020 and 2021. These are both periods that were heavily impacted by the COVID-19 pandemic therefore some of these volumes may change over time. We are currently working with OS right now actually to extend the days the years that are included in this in this report, as data became available as we were producing this document. So we're looking to supplement and add the new data for 22

68
00:13:04.900 --> 00:13:13.879

Corey Rhyan: 22 onto this table as well, which should give us a better perspective of closer to a post period after the pandemic. And what cardiac utilization trends look like over time.

69
00:13:16.270 --> 00:13:45.880
Corey Rhyan: Also, in the report included our a couple of tables that look at not only just the total counts of utilization of cardiac services, but also the rate of cardiac services that were received by different populations. So, looking here across different regions within the State of Connecticut, across different race and ethnicity categories that are tracked within the hospital, discharge database, and looking at the underlying rate of care that was received for different types of cardiac services. You can see here the split among medical versus surgical cardiac care services received over time.

70
00:13:45.910 --> 00:13:48.040
Corey Rhyan: and looking at the comparison

71
00:13:48.430 --> 00:14:10.949
Corey Rhyan: of how the utilization rates differ among different groups, and you can see pretty large disparities across different race and ethnicity groups, and we also see similar disparities in the use of cardiac services across those with different types of insurance. We attempt, we attempt for possible to control for age and underlying differences among these these groups when we do this in in the report. But there are some remaining differences that occur there as well, so important to know when you look at these data. But

72
00:14:11.241 --> 00:14:20.569
Corey Rhyan: some of these differences are driven by differences in the race. Ethnicity or insurance definition categories. Some of these differences may be driven by underlying differences in the populations as well.

73
00:14:22.150 --> 00:14:48.089
Corey Rhyan: but hopefully, that information provides a better understanding of the overall use of cardiac services, and how the rate of cardiac services compares in Connecticut to other parts of the country. One of the things we do want to talk about is in this in this section, and and would look for feedback from this group is is how we can do a better job and in identifying the underlying need for cardiac care within the State. What we have currently in the data that we have available to us as we have the observed utilization of different types of cardiac services.

74
00:14:48.090 --> 00:15:02.398
Corey Rhyan: understanding what the underlying need is, and how that compares to the utilization, and how that compares to the current

capacity is something that Ohs is very interested in doing. But it's a difficult task to do, and that there needs to be an understanding of what the current capacity is for current services in different regions.

75
00:15:02.650 --> 00:15:22.539
Corey Rhyan: and how that capacity compares to what the potential underlying need might be if that capacity was different. So that's something we've tried to do in a couple of different ways. In the report we look forward to talking about that today, but also receiving feedback from folks, and how we could better, under understand and detail the underlying differences between utilization and current capacity for these services across the State.

76
00:15:23.980 --> 00:15:50.609
Corey Rhyan: The last thing I want to point out here is some updated documentation that was referenced within the current report, looking at the current guidelines and recommendations made by professional societies and other experts in the field to help guide. How we describe the current recommendations for how a certificate of need application should be considered. We can talk about some comparisons between how this was done in the 2012 Facility and Services plan language compared to how it was done today.

77
00:15:50.610 --> 00:16:14.879
Corey Rhyan: But in general. What we've tried to do is we've tried to take the documentation that was written by the Acc. A a other other expert professional societies within the field and update the language within the report to be consistent with the guidelines as written by these professional societies. So hopefully, that's captured. Well in the report, and we look forward to your feedback, both on the individual documents that were used to generate the guidelines as written.

78
00:16:14.880 --> 00:16:24.119
Corey Rhyan: and also if there were any other documents or any other professional recommendations that should be included when assisting Ohs and making the determinations about the expansion of care.

79
00:16:25.950 --> 00:16:39.100
Corey Rhyan: So I've got some specific topics for discussion today. We can get to these if if we need kind of additional categories to talk about. But I think I will open the floor, boy, with you to let folks begin providing feedback.

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00:16:39.920 --> 00:17:02.047
W. Boyd Jackson, OHS: Thank you, Corey. And just a couple of more logistical pieces. To the extent possible. Please use the raise hand function in zoom so that we can try to prevent accidental interruptions

and talking over and rather than do a round of introductions, if, when you when you speak.

81
00:17:02.450 --> 00:17:15.549
W. Boyd Jackson, OHS: if you could just briefly say who you are, where what entity you're representing and what your role is there? That'll help everyone get to know each other as we go along.

82
00:17:16.810 --> 00:17:28.029
W. Boyd Jackson, OHS: So with that I will open it up for any opening thoughts based on what you've seen in the report, and what you've seen in the presentation.

83
00:17:53.790 --> 00:17:59.668
W. Boyd Jackson, OHS: I did not expect the Cardiac Services group to be the shy one to

84
00:18:00.440 --> 00:18:09.499
W. Boyd Jackson, OHS: to to start out. I've I've heard from many, many folks, specifically on this section. Over the last

85
00:18:09.730 --> 00:18:12.230
W. Boyd Jackson, OHS: 6 or 7 months that I've been here. So

86
00:18:12.730 --> 00:18:14.790
W. Boyd Jackson, OHS: I guess one

87
00:18:14.920 --> 00:18:19.360
W. Boyd Jackson, OHS: piece that Corey just brought up that is an update

88
00:18:19.912 --> 00:18:37.880
W. Boyd Jackson, OHS: is regarding the guidelines around quality. And specifically one of the pieces that was kind of perennially a challenge for applicants in the certificate of need program. We're we're challenges demonstrating the the quantity threshold.

89
00:18:38.337 --> 00:18:46.879
W. Boyd Jackson, OHS: So the the best measure of quality that they used was whether you were doing 200 Pci's.

90
00:18:47.010 --> 00:19:00.299
W. Boyd Jackson, OHS: And they basically said, If you're not doing 200, you should not be doing elective Pci's, and so they you are all. You should only be approved for emergency. I know that that has been a big

91
00:19:00.870 --> 00:19:03.847
W. Boyd Jackson, OHS: factor for a lot of folks over time.

92
00:19:04.260 --> 00:19:21.930
W. Boyd Jackson, OHS: I think that's been updated now, the the quantity threshold for quality has been removed. Is that something that that the folks in this group generally agree with. Are there any concerns about removing that language? Any additional thoughts

93
00:19:22.160 --> 00:19:26.590
W. Boyd Jackson, OHS: on using quantity as a metric for quality.

94
00:19:32.040 --> 00:19:33.789
W. Boyd Jackson, OHS: All right, Mark, go ahead.

95
00:19:35.920 --> 00:19:36.850
W. Boyd Jackson, OHS: You're on mute.

96
00:19:40.490 --> 00:19:46.889
Mark Warshofsky: Mark Washovsky in advance. Health. I'll break the ice here. I do think that

97
00:19:47.680 --> 00:19:48.720
Mark Warshofsky: omitting

98
00:19:48.880 --> 00:19:51.149
Mark Warshofsky: that 200 number is

99
00:19:52.570 --> 00:19:57.249
Mark Warshofsky: wise. Given some of the new guidance given

100
00:19:57.630 --> 00:19:59.880
Mark Warshofsky: that, we've got programs doing

101
00:20:00.800 --> 00:20:03.230
Mark Warshofsky: primary angioplasty.

102
00:20:04.960 --> 00:20:10.479
Mark Warshofsky: And it's a bit of a chicken and the egg, you know, to get to that 200

103
00:20:11.570 --> 00:20:15.529
Mark Warshofsky: you've got to open up the ability to do the

104
00:20:17.350 --> 00:20:20.469
Mark Warshofsky: the the quote unquote elective pci.

105
00:20:20.850 --> 00:20:23.781
Mark Warshofsky: So I'm glad that was removed.

106
00:20:24.610 --> 00:20:27.310
Mark Warshofsky: There was still a reference in there to

107
00:20:28.128 --> 00:20:30.241
Mark Warshofsky: looking back to that

108
00:20:30.840 --> 00:20:32.010
Mark Warshofsky: 2020

109
00:20:32.500 --> 00:20:35.220
Mark Warshofsky: 3 scai

110
00:20:35.420 --> 00:20:38.380
Mark Warshofsky: document in terms of

111
00:20:39.670 --> 00:20:45.080
Mark Warshofsky: individual operator experience and numbers, and I think that's

112
00:20:45.410 --> 00:20:46.450
Mark Warshofsky: appropriate.

113
00:20:56.610 --> 00:20:57.310
W. Boyd Jackson, OHS: Scott.

114
00:21:02.340 --> 00:21:03.310
Scott Martin, Stamford Health: Yeah, I

115
00:21:03.790 --> 00:21:06.559
Scott Martin, Stamford Health: I think the the guidelines are

116

00:21:06.990 --> 00:21:11.443
Scott Martin, Stamford Health: respond to reality, and that there are a lot of places in the country where

117
00:21:11.870 --> 00:21:12.350
Scott Martin, Stamford Health: the

118
00:21:13.170 --> 00:21:17.979
Scott Martin, Stamford Health: Provider and Center volume has dropped below that and and to

119
00:21:18.680 --> 00:21:19.510
Scott Martin, Stamford Health: I've

120
00:21:19.690 --> 00:21:22.559
Scott Martin, Stamford Health: decide that you know, half the programs are

121
00:21:23.800 --> 00:21:33.439
Scott Martin, Stamford Health: out of compliance would would not be acceptable. I think everyone would agree that, you know, in Cardia Cath as in anything. I'm sorry. I'm Scott Martin Stanford, Health Director of Interventional cardiology.

122
00:21:33.610 --> 00:21:44.789
Scott Martin, Stamford Health: you know, as with anything you'd rather have a provider who's and and a center who's doing a decent number of procedures. I think we should be cautious about, you know, diluting care too much.

123
00:21:45.305 --> 00:21:52.459
Scott Martin, Stamford Health: But but I you know I do agree that incorporating these guidelines and you know that hard and fast numbers are

124
00:21:53.650 --> 00:21:55.840
Scott Martin, Stamford Health: confirmed by the wayside in our guidelines.

125
00:22:02.240 --> 00:22:03.060
Scott Martin, Stamford Health: There's.

126
00:22:03.220 --> 00:22:06.485
W. Boyd Jackson, OHS: And an accompanying piece of this

127
00:22:07.440 --> 00:22:08.590
W. Boyd Jackson, OHS: is

128
00:22:08.600 --> 00:22:20.722
W. Boyd Jackson, OHS: the determination of need which I think Corey just mentioned. It's mentioned in the report. It was highlighted. In some of the accompanying documentation of a particular area of interest for conversation.

129
00:22:22.860 --> 00:22:29.489
W. Boyd Jackson, OHS: Does this? Is this group aware of any kind of guidelines that exist, for

130
00:22:30.559 --> 00:22:41.430
W. Boyd Jackson, OHS: you know the number of facilities providing Pci per population, or the the recommended distance to

131
00:22:42.200 --> 00:22:50.673
W. Boyd Jackson, OHS: cardiac services of various types. Or you know, I know. Often we hear about door to balloon times.

132
00:22:51.630 --> 00:22:52.880
W. Boyd Jackson, OHS: versus.

133
00:22:52.920 --> 00:23:13.460
W. Boyd Jackson, OHS: You know what that means in relation to showing up at a hospital that has the services available or being transferred. Of course it's different for primary and secondary Pci. So when we just think about you know, this map is where they're currently located.

134
00:23:13.800 --> 00:23:23.330
W. Boyd Jackson, OHS: You know, how do we think about the need for additional or the lack of need or quantifying that need? And any guidelines on those?

135
00:23:26.820 --> 00:23:27.880
W. Boyd Jackson, OHS: Yeah, mark.

136
00:23:31.780 --> 00:23:32.900
Mark Warshofsky: So I

137
00:23:33.420 --> 00:23:34.840

Mark Warshofsky: you know, I think

138
00:23:34.910 --> 00:23:40.939
Mark Warshofsky: distance in and of itself, can be somewhat misleading. Right? If we're talking about.

139
00:23:41.340 --> 00:23:45.039
Mark Warshofsky: you know, 15 miles as the crow flies or

140
00:23:46.230 --> 00:23:51.040
Mark Warshofsky: 15 mile drive in a rural area that's very different than

141
00:23:51.280 --> 00:23:53.639
Mark Warshofsky: trying to get somewhere in.

142
00:23:54.300 --> 00:23:55.609
Mark Warshofsky: You know, a more

143
00:23:55.840 --> 00:23:58.789
Mark Warshofsky: dense area during rush hour

144
00:23:59.390 --> 00:24:01.410
Mark Warshofsky: so, or during

145
00:24:01.790 --> 00:24:05.180
Mark Warshofsky: snowstorm or or other bad weather. So I think.

146
00:24:06.030 --> 00:24:07.809
Mark Warshofsky: you know it's it's

147
00:24:08.870 --> 00:24:15.559
Mark Warshofsky: I don't see that as a hard and fast determination, or determinant of whether you've got

148
00:24:16.050 --> 00:24:16.995
Mark Warshofsky: adequate

149
00:24:19.330 --> 00:24:20.889
Mark Warshofsky: access to care

150
00:24:22.760 --> 00:24:25.710

Mark Warshofsky: And then I think we also have to think about

151
00:24:26.210 --> 00:24:28.210
Mark Warshofsky: communities where

152
00:24:29.150 --> 00:24:31.290
Mark Warshofsky: there are, there's

153
00:24:31.530 --> 00:24:32.980
Mark Warshofsky: access to care

154
00:24:34.154 --> 00:24:36.929
Mark Warshofsky: for primary Pci, but

155
00:24:37.140 --> 00:24:37.980
Mark Warshofsky: you know

156
00:24:38.550 --> 00:24:41.269
Mark Warshofsky: and quote elective Pci. We've got to get

157
00:24:41.300 --> 00:24:44.490
Mark Warshofsky: transferred out of the hospital that we're in

158
00:24:44.710 --> 00:24:46.800
Mark Warshofsky: and go to a different hospital.

159
00:24:47.340 --> 00:24:49.590
Mark Warshofsky: You know that to me

160
00:24:49.920 --> 00:24:50.900
Mark Warshofsky: is not

161
00:24:52.210 --> 00:24:57.569
Mark Warshofsky: really fair or equitable in terms of some communities having access to this care

162
00:24:57.990 --> 00:24:59.350
Mark Warshofsky: and others not

163
00:24:59.430 --> 00:25:02.440
Mark Warshofsky: so I think you know, the physicians

164
00:25:02.640 --> 00:25:07.659
Mark Warshofsky: move around a lot. But to ask the patients to move around a lot I don't think is

165
00:25:07.850 --> 00:25:09.110
Mark Warshofsky: is appropriate.

166
00:25:20.050 --> 00:25:20.800
W. Boyd Jackson, OHS: Scott.

167
00:25:21.770 --> 00:25:28.109
Scott Martin, Stamford Health: Yeah. J, just to the question you asked. i i i don't know of any guidelines related to you know it.

168
00:25:28.240 --> 00:25:29.105
Scott Martin, Stamford Health: What

169
00:25:30.599 --> 00:25:36.190
Scott Martin, Stamford Health: what population density is appropriate to having a cath lab, or you know what

170
00:25:37.340 --> 00:25:40.680
Scott Martin, Stamford Health: You know what kind of distance is is is required.

171
00:25:40.690 --> 00:25:42.130
Scott Martin, Stamford Health: But I I

172
00:25:42.420 --> 00:25:43.250
Scott Martin, Stamford Health: I would

173
00:25:43.640 --> 00:25:45.890
Scott Martin, Stamford Health: add that you know I don't think anyone would.

174
00:25:46.628 --> 00:25:51.110
Scott Martin, Stamford Health: you know, raise an objection if someone was gonna open a cath lab in in the upper right

175
00:25:51.410 --> 00:25:55.689

Scott Martin, Stamford Health: quadrant of your map there, where there is no need, but in instead, you know.

176
00:25:56.250 --> 00:26:06.650
Scott Martin, Stamford Health: there's no push to open a cath lab there, you know, the push is going to be where the money is right. So where there are already a bunch of centers, and there's already, you know, a lot of access to care.

177
00:26:07.158 --> 00:26:08.350
Scott Martin, Stamford Health: You know. And I,

178
00:26:09.550 --> 00:26:10.860
Scott Martin, Stamford Health: you know the

179
00:26:11.380 --> 00:26:13.230
Scott Martin, Stamford Health: concern that the you know the

180
00:26:13.290 --> 00:26:20.229
Scott Martin, Stamford Health: the motive isn't optimizing access, you know, when when you want to add another center in in the bottom left of this map.

181
00:26:20.320 --> 00:26:23.090
Scott Martin, Stamford Health: but but rather, you know, for profit.

182
00:26:27.410 --> 00:26:29.370
W. Boyd Jackson, OHS: Thank you. Dave.

183
00:26:30.370 --> 00:26:37.323
Dave S: Good morning, Dave Shipley, nor walk Surgery Center. Forgive me for my voice. It's kind of broken up today. But

184
00:26:38.990 --> 00:26:44.630
Dave S: I'm thinking about access across different sites of services.

185
00:26:44.850 --> 00:26:46.559
Dave S: And how does

186
00:26:47.490 --> 00:26:49.439
Dave S: the way just determine?

187

00:26:50.592 --> 00:26:59.469
Dave S: Who's going to be performing what types of services? Obviously, Cms, several years ago came out with

188
00:27:01.080 --> 00:27:05.639
Dave S: their new approved procedure list, which includes multiple

189
00:27:05.780 --> 00:27:09.499
Dave S: Pci codes to be performed at surgery centers across the country.

190
00:27:09.700 --> 00:27:11.410
Dave S: And so, if we're looking at

191
00:27:11.640 --> 00:27:14.400
Dave S: long term, the cost of healthcare.

192
00:27:14.690 --> 00:27:18.020
Dave S: the sites of service that were performing specific

193
00:27:19.002 --> 00:27:20.420
Dave S: types of procedures.

194
00:27:21.020 --> 00:27:23.800
Dave S: increased complexity going out of

195
00:27:24.070 --> 00:27:30.010
Dave S: the acute care hospitals and into outpatient facilities and and and ambulatory surgery centers.

196
00:27:30.110 --> 00:27:36.329
Dave S: So I may be early in the discussion here, but I I think it's something that we need to consider

197
00:27:36.930 --> 00:27:38.010
Dave S: long term.

198
00:27:41.730 --> 00:27:44.610
W. Boyd Jackson, OHS: Yeah, that's a great point. When

199
00:27:44.640 --> 00:27:55.690

W. Boyd Jackson, OHS: when these guidelines were initially developed in our facilities and services plan, the guidelines generally were that these procedures, the Pci should all be done in the

200
00:27:56.790 --> 00:28:00.579
W. Boyd Jackson, OHS: General Hospital with that, and I think with access to

201
00:28:01.130 --> 00:28:12.380
W. Boyd Jackson, OHS: broader cardiac services, and obviously some of those guidelines have changed which interact in different ways with our certificate of need. Program. You know.

202
00:28:13.260 --> 00:28:22.300
W. Boyd Jackson, OHS: So it it creates some some interesting points there as far as when Ohs is involved with expansions or contractions of service.

203
00:28:23.465 --> 00:28:23.950
W. Boyd Jackson, OHS: I'm

204
00:28:24.280 --> 00:28:27.819
W. Boyd Jackson, OHS: Jeptha, and apologies if I mispronounced.

205
00:28:29.382 --> 00:28:35.837
Jeptha Curtis: No, you got the right thanks. So I'm the director of corner interventions for Young and health system.

206
00:28:36.678 --> 00:28:41.560
Jeptha Curtis: And just a couple of comments that have been loading up here. I think

207
00:28:41.610 --> 00:28:42.449
Jeptha Curtis: one

208
00:28:43.310 --> 00:29:08.029
Jeptha Curtis: I think it's hard to have this conversation without having some sense of of where you all are with regards to ambulatory surgical centers, because I think that is in my mind a very different kettle of fish than expanding pci and cardiac services within hospitals. I think the Sky document kind of conflated them or made them more or less equal. But I I think that that is a

209
00:29:08.100 --> 00:29:27.860

Jeptha Curtis: they're 2 different extreme, or they're very different in terms of how extreme a movement it would be for the care with of cardiac patients in Connecticut. So that would be helpful, I think, to sort of boost this conversation to know what where you guys are thinking about that upfront. Number 2. I I totally agree that that volume

210
00:29:27.860 --> 00:29:45.167
Jeptha Curtis: is a very poor surrogate of quality, and totally wholeheartedly endorse the removal of of most volume requirements. As long as it is accompanied by other mechanisms for better defining quality. And we certainly have lots of data registries within

211
00:29:45.580 --> 00:30:03.049
Jeptha Curtis: the cardiac space that allow us to assess quality and appropriateness of care. Very well. So I think any expansion obviously would have to be coupled with participation or ideally coupled with participation in those registries in a robust and complete fashion.

212
00:30:03.190 --> 00:30:25.810
Jeptha Curtis: And I think the other thing. And again, this is my 1st time on one of these calls so apologies if I'm going out of scope here. But I think the other factor that really is relevant for this conversation is what's going on in adjacent states, and I think for a long time new England, by and large, has always been very conservative in terms of its expansion of states, and I think that's done

213
00:30:26.220 --> 00:30:45.829
Jeptha Curtis: well, by our patience for the most part. But it is hard to be out of out of step with adjacent states, and I think New York. I'm not so familiar with what's going on in Massachusetts, and and no surgery on site. Pci! But certainly New York seems to have thrown in the tell for its certificate of need program and is opening them up rapidly.

214
00:30:46.110 --> 00:30:58.069
Jeptha Curtis: And while that doesn't necessarily impact our patients in detrimental fashion. It does impact the bottom line of our hospitals economics. So I don't know if that's in or out of scope, but that'd be helpful to know.

215
00:31:01.180 --> 00:31:05.121
W. Boyd Jackson, OHS: Yes, I think that all of that is in scope.

216
00:31:06.250 --> 00:31:07.360
W. Boyd Jackson, OHS: and

217
00:31:07.610 --> 00:31:18.429

W. Boyd Jackson, OHS: you know, under under the coin program, you have Connectic Connecticut general statutes. 19. A dash 638, which lays out

218
00:31:18.520 --> 00:31:41.759
W. Boyd Jackson, OHS: who requires a certificate of need. Under that number 9 is the establishment of cardiac services, including inpatient, outpatient cardiac catheterization, interventional, cardiology and cardiovascular surgery. So it's a specifically called out piece that's applied broadly. It doesn't limit it to within a hospital so if

219
00:31:42.720 --> 00:31:51.369
W. Boyd Jackson, OHS: ambulatory surgical center decided they wanted to start providing these kinds of services that would fall under that category. So

220
00:31:51.800 --> 00:32:08.210
W. Boyd Jackson, OHS: that's part of this conversation as well, you know which guidelines should we be looking at, the whose recommendations do folks feel confident that an ambulatory surgery center is capable of doing this type of procedure.

221
00:32:08.210 --> 00:32:29.799
W. Boyd Jackson, OHS: Certain of them might be. You know what are the quality measures? That we should be looking at under that so all of the quality where it should be done is one piece, and then what is the need for these services is kind of the other big piece that comes into play. When these applications come in. Scott.

222
00:32:32.160 --> 00:32:41.729
Scott Martin, Stamford Health: Yeah, just with regards to the ambulatory surgical center, you know. My, my, take on it is, you know, I'm I'm an interventional cardiologist. I think I would be

223
00:32:41.850 --> 00:32:46.810
Scott Martin, Stamford Health: very competent to do these procedures as an outpatient in the ambulatory surgery kill center.

224
00:32:46.940 --> 00:32:50.590
Scott Martin, Stamford Health: you know, from so in in terms of safety. I think that that's

225
00:32:50.610 --> 00:32:55.279
Scott Martin, Stamford Health: would would be fine, you know. I, you know, follow the guidelines and and such

226

00:32:55.769 --> 00:33:02.360
Scott Martin, Stamford Health: my concern would be, you know, with if a certificate of need were eliminated. You just give you a hypothetical.

227
00:33:02.500 --> 00:33:10.720
Scott Martin, Stamford Health: if you know. Private equity approached me, and I was going to team up with the Vasco surgeon and open an office-based lab in town

228
00:33:11.070 --> 00:33:15.305
Scott Martin, Stamford Health: and no longer work with the hospital.

229
00:33:16.090 --> 00:33:25.619
Scott Martin, Stamford Health: you know I could probably cut costs from those patients, because, you know, I wouldn't have to provide, you know, emergency services and intensive care unit 24, 7 coverage.

230
00:33:26.028 --> 00:33:31.719
Scott Martin, Stamford Health: You know, I could poach a lot of patients who had, you know, who had good pay or mix and well insured.

231
00:33:32.285 --> 00:33:45.554
Scott Martin, Stamford Health: You know, and I I think for me and for my patients. That might be a good solution. But I think if we look statewide or Stanford wide, or you know, I I think that that really puts, you know the the

232
00:33:45.890 --> 00:33:52.860
Scott Martin, Stamford Health: emergency services, you know, at risk. If we divert off, you know the the good pair mix to to to

233
00:33:53.130 --> 00:34:01.490
Scott Martin, Stamford Health: to facilities that don't require. You know they don't. Don't have to have 24, 7 care that could call 911 if something goes wrong instead of you know, taking care of the patient.

234
00:34:04.590 --> 00:34:05.420
W. Boyd Jackson, OHS: Thank you

235
00:34:13.949 --> 00:34:32.959
W. Boyd Jackson, OHS: and Corey. I want to check in with you to see if any of these conversations have brought up any thoughts or questions from you. I know there was especially reference to what other States are doing, and I know that that's part of what Altarum did in in looking at

all of this. So just wondering if you have any, follow up questions based on the conversation so far.

236
00:34:33.750 --> 00:34:59.169
Corey Rhyan: No, i i i don't think so. I I think that's all relevant. And and I agree, looking at what neighboring states are doing does make sense in at least considering how to align as best as possible, or considering the implications of that, as far as services offered within Connecticut, and I know that there are a couple of sections of the the guidelines that I think, allow Ohs to consider at least the provision of services and other states when making these decisions. So I think it is something that, based on the the guidelines is is allowed right now.

237
00:34:59.697 --> 00:35:21.079
Corey Rhyan: Yeah, I I'm knowing here on on this current slide. Some of the other kind of quality or standards that have been set. And this is specific to a a document that looks at pci without on-site surgical backup. I think this is related to some of the conversations we've been having around. How do I identify some of those other quality measures in a case where, as as we found, I think, the the

238
00:35:21.352 --> 00:35:32.900
Corey Rhyan: professional societies are moving away from a strict number of of quantity limits as an ability to look at at quality. But what those other data might be, you know, I think there was a reference to to registries that might be available.

239
00:35:32.900 --> 00:35:56.680
Corey Rhyan: I think it's a it's a opportunity here for us to learn what those things might be, and and how Ohs can take advantage of that, or how Ohs can provide guidance to submitters in the Co. And process, as far as what data they would like to see, as far as establishing the the potential quality or the existing quality of the services that they're offering. I think we don't have a lot of detail in there right now about that guidance for submitters or for H. Ohs, and

240
00:35:56.780 --> 00:36:08.300
Corey Rhyan: there would be an opportunity to add that if folks are are aware of kind of some, some either industry, standard or or, you know, kind of other other high quality measures of quality that we can use in this, in this process.

241
00:36:10.370 --> 00:36:10.990
W. Boyd Jackson, OHS: Dave.

242
00:36:12.761 --> 00:36:17.096
Dave S: Yeah, I thinking about the surrounding states.

243
00:36:18.660 --> 00:36:21.480
Dave S: and I'm not sure if if Corey mentioned it or not, but

244
00:36:21.510 --> 00:36:25.890
Dave S: would think Ohs would would wanna identify the Cms data?

245
00:36:26.377 --> 00:36:28.249
Dave S: Not just not just

246
00:36:28.680 --> 00:36:35.690
Dave S: in states that are border states. But you know also the national data that Cms has with regards to

247
00:36:35.720 --> 00:36:38.360
Dave S: to cardiac care in surgery centers.

248
00:36:39.780 --> 00:36:41.680
Corey Rhyan: Can you be a little bit more specific, Dave.

249
00:36:43.160 --> 00:36:44.776
Corey Rhyan: when you say Cms data.

250
00:36:45.100 --> 00:36:50.172
Dave S: Well, when Cms put out there. I guess it was 2019, or 2020

251
00:36:50.530 --> 00:36:52.625
Dave S: when they approve basically

252
00:36:54.350 --> 00:36:59.070
Dave S: the Pci's procedures to be performed in in ambulatory surgery centers.

253
00:37:00.610 --> 00:37:07.680
Dave S: It was an it was. It was national, right? So it was. It was broad, based in, in, in bringing those approved procedures across

254
00:37:07.750 --> 00:37:11.504
Dave S: surgery centers that are Cms certified. So I would think.

255
00:37:12.330 --> 00:37:17.710

Dave S: somewhere along the line in the past 4 years they have to have some type of of data as to

256
00:37:18.646 --> 00:37:20.593
Dave S: the performance of these

257
00:37:21.490 --> 00:37:34.659
Dave S: procedures in ambulatory surgery centers it. It really doesn't matter what state it is, you know at the end of the day it's a matter of do you got a competent team? In these outpatient facilities that can perform the procedures, and

258
00:37:34.820 --> 00:37:39.910
Dave S: you know, have great patient experiences and and great quality outcomes. So

259
00:37:41.270 --> 00:37:44.260
Dave S: hopefully, that's helps Corey a little bit. So.

260
00:37:44.260 --> 00:38:09.340
Corey Rhyan: Okay, yeah, that's something we can look at. Thank you. And you know. And then I will note, you know, I think also important is, you know, included in, you know, some of these recommendations here have been, you know, very specific and detailed transfer agreements that ensure that there's an ability to take a patient to a a site that can provide higher acuity care if it's required. So I think that is something that's built into the way the current documentation is written, and what what Ohs would want to consider as far as making these approvals. But that's that's just one other thing to know.

261
00:38:11.110 --> 00:38:12.520
W. Boyd Jackson, OHS: Thank you. Mark.

262
00:38:13.480 --> 00:38:17.500
Mark Warshofsky: Yeah, I I do. Wanna reiterate. I think it's important for

263
00:38:17.710 --> 00:38:21.060
Mark Warshofsky: the State to really distinguish between

264
00:38:21.970 --> 00:38:23.460
Mark Warshofsky: in hospital

265
00:38:23.630 --> 00:38:28.609

Mark Warshofsky: Pci without cardiac surgical backup versus

266
00:38:28.680 --> 00:38:31.479
Mark Warshofsky: in an ambulatory surgical center.

267
00:38:32.790 --> 00:38:36.780
Mark Warshofsky: Because in large part you're talking about serving

268
00:38:36.840 --> 00:38:38.899
Mark Warshofsky: different patient populations.

269
00:38:39.160 --> 00:38:43.430
Mark Warshofsky: you know, somebody admitted to the hospital with an unstable

270
00:38:43.830 --> 00:38:45.280
Mark Warshofsky: coronary syndrome

271
00:38:46.290 --> 00:38:51.450
Mark Warshofsky: is going to get their care in the hospital, and that's a population where

272
00:38:51.520 --> 00:38:53.200
Mark Warshofsky: we know Pci

273
00:38:53.810 --> 00:38:55.030
Mark Warshofsky: impacts

274
00:38:55.430 --> 00:38:57.389
Mark Warshofsky: morbidity and mortality

275
00:38:57.800 --> 00:39:03.530
Mark Warshofsky: in the ambulatory setting, somebody with chronic stable disease. For instance.

276
00:39:04.070 --> 00:39:06.911
Mark Warshofsky: they may get symptomatic relief

277
00:39:07.880 --> 00:39:10.220
Mark Warshofsky: from their Pci, but in large part

278

00:39:10.530 --> 00:39:13.379
Mark Warshofsky: it it does nothing for their

279
00:39:14.570 --> 00:39:16.920
Mark Warshofsky: mortality, improvement.

280
00:39:17.710 --> 00:39:19.759
Mark Warshofsky: and and so, you know.

281
00:39:20.650 --> 00:39:21.979
Mark Warshofsky: I think that

282
00:39:23.230 --> 00:39:26.000
Mark Warshofsky: that's an important distinction. And

283
00:39:26.280 --> 00:39:29.210
Mark Warshofsky: to the point that was made earlier about diluting

284
00:39:31.100 --> 00:39:33.210
Mark Warshofsky: the the hospital program.

285
00:39:34.455 --> 00:39:35.050
Mark Warshofsky: For

286
00:39:35.310 --> 00:39:41.090
Mark Warshofsky: the sake of having this available in an ambulatory surgical center, I think, requires

287
00:39:41.360 --> 00:39:43.050
Mark Warshofsky: fair amount of consideration

288
00:39:45.460 --> 00:39:48.130
Mark Warshofsky: and thought before before that's done.

289
00:40:22.750 --> 00:40:24.160
W. Boyd Jackson, OHS: Anyone

290
00:40:24.180 --> 00:40:27.392
W. Boyd Jackson, OHS: else have thoughts on that piece, and I think

291
00:40:28.070 --> 00:40:30.870

W. Boyd Jackson, OHS: as far as the Cms

292
00:40:30.930 --> 00:40:33.121
W. Boyd Jackson, OHS: guidance goes, I think it's

293
00:40:35.170 --> 00:40:40.984
W. Boyd Jackson, OHS: I think there are local coverage determinations that were adopted by all of the

294
00:40:41.980 --> 00:40:53.209
W. Boyd Jackson, OHS: all of the different contractors. So it does there. There is a local coverage of termination l. 34, 7, 61, which

295
00:40:54.640 --> 00:40:56.670
W. Boyd Jackson, OHS: covers Connecticut.

296
00:40:56.780 --> 00:41:02.559
W. Boyd Jackson, OHS: and and lays out the Pci guidance from Cms on coverage and reimbursement.

297
00:41:21.990 --> 00:41:50.759
Corey Rhyan: So, Boyd, I I think the the point was well received around the current report, and the way that we've tried to define the current locations of these facilities. And potentially doing a better job and trying to capture you know, a a time to location rather than a raw distance location, then limitations there, I think that's something we can take into consideration. I think you also had a separate question around trying to identify underlying population need for these services, even in areas, maybe where there are multiple existing facilities

298
00:41:50.760 --> 00:41:53.200
Corey Rhyan: where there could be capacity limitations.

299
00:41:53.551 --> 00:42:20.049
Corey Rhyan: Curious, we we obviously have shown some data so far, and looking at trends in broad use of cardiac services over time within the State. That's what's Ohs is currently capturing thoughts on the way that that data are currently being displayed, or what other more detailed data might be useful to try and understand and generate a population level need for these these services, and whether or not different regions of the State or particular narrow areas are, you know, primary service areas of the State

300
00:42:20.050 --> 00:42:24.279

Corey Rhyan: have sufficient capacity in order to provide these these services.

301
00:43:03.550 --> 00:43:08.146
Corey Rhyan: Okay? Something for folks to take back, perhaps. Oh, go ahead.

302
00:43:08.530 --> 00:43:12.553
Jeptha Curtis: Oh, so no! So tang! Tangential topic. But.

303
00:43:13.000 --> 00:43:13.660
Corey Rhyan: Go, far.

304
00:43:13.660 --> 00:43:32.399
Jeptha Curtis: Question earlier. I I think you mentioned, or or we're wondering to identify or wanted to identify appropriate registries or or quality assessment tools. So 1st is a disclaimer is that I I do work a lot with the American College of Cardiology and Cdr, right? So they that's probably the dominant

305
00:43:32.967 --> 00:43:48.364
Jeptha Curtis: group in the measurement space for cardiac disease and specifically for for cats. And Pci. So I would argue that that's a really good place to start. There are other registries that are being

306
00:43:49.814 --> 00:44:04.725
Jeptha Curtis: brought out for particularly, and focused on ambulatory surgical centers that are a little bit smaller and and more streamlined in terms of the resources required. You do lose some of the ability to measure or assess appropriateness if you do streamline like that.

307
00:44:05.140 --> 00:44:07.712
Jeptha Curtis: And then, you know, I think the

308
00:44:10.510 --> 00:44:34.630
Jeptha Curtis: the the the economics of this are are gonna be tough. And and I again, I wanna come? I don't wanna harp too much on ambulatory surgical centers, but I think that is sort of the the elephant in the room here is that there are consequences. There's reason. Been venture. Capital is going into ambulatory surgical centers because you can, as noted, create a profit from it. I think we

309
00:44:35.130 --> 00:44:52.890
Jeptha Curtis: all hospitals in Connecticut, regardless of the presence or absence of Pci services, need to understand rapidly where the State is

going to fall on this specific topic, because it has, I think, far reaching implications for heart and vascular centers across the State.

310
00:45:05.440 --> 00:45:10.350
Corey Rhyan: Thanks. That's that's good insight on the on the registries currently or wondering from folks

311
00:45:10.490 --> 00:45:12.930
Corey Rhyan: as part of this committee of

312
00:45:12.940 --> 00:45:34.409
Corey Rhyan: if those registries can or should be used to set specific thresholds for either quality or outcomes that should be required, and should, ohs be considering something like that, or should, Ohs be considering general recommendations of the types of quality measures that could be extracted and included from those registries. What is the best way for Ohs! To utilize that data.

313
00:45:38.010 --> 00:45:53.320
Jeptha Curtis: So I'll I'll just speak on that. So I think it's very hard particularly to get to low volume centers, which I think most of the centers would be to sort of set an absolute threshold, I think what's better or what needs to happen is a periodic review process by which

314
00:45:53.360 --> 00:46:04.529
Jeptha Curtis: anytime you're you know there's a threshold above which a larger review is performed, and I think that's something that's been done at Lawrence and Memorial hospital with the State to success.

315
00:46:04.967 --> 00:46:10.680
Jeptha Curtis: And I think that would be something that should be baked into any expansion of programs going forward.

316
00:46:11.290 --> 00:46:31.810
Jeptha Curtis: I think the other piece, and I forgot to mention this before. So I apologize is we. We do focus a lot on percutaneous corner interventions. And I think that's sort of a a historical artifact of where we were back in the nineties. But the provision of cardiac care in the in the State has expanded dramatically since that time.

317
00:46:32.332 --> 00:46:53.307
Jeptha Curtis: Such. That interventional cardiology is defined, I think, in your document is like all electrophysiology procedures. All structural procedures and all those things. So you know, we we spend a lot of time thinking about this, but I do wonder if if we need, or about Pci, which

is appropriate. But to what extent, over the next few years would you anticipate

318
00:46:54.090 --> 00:47:01.720
Jeptha Curtis: addressing outpatient tavers, or outpatient ablations, or or things like that, specifically calling that out in the Fsp.

319
00:47:16.510 --> 00:47:19.910
W. Boyd Jackson, OHS: Go ahead, Scott, and I'll continue thinking on that. That question.

320
00:47:21.100 --> 00:47:31.249
Scott Martin, Stamford Health: Yeah, I would agree with those comments. You, you know, I think, in terms of incorporating Ncdr, data into evaluating cath labs.

321
00:47:31.260 --> 00:47:33.291
Scott Martin, Stamford Health: It's a challenge, because

322
00:47:33.880 --> 00:47:39.394
Scott Martin, Stamford Health: you know a couple of things. One is that you know, as you mentioned earlier, you know, the the volume

323
00:47:40.230 --> 00:47:47.899
Scott Martin, Stamford Health: Numbers have been removed from some of the documents because the procedures become so safe. It's actually hard to, to.

324
00:47:48.530 --> 00:47:52.999
Scott Martin, Stamford Health: you know. Assess, you know, to compare programs or compare operators, even

325
00:47:53.317 --> 00:48:07.690
Scott Martin, Stamford Health: with regards to quality, just because the numbers are so good, you know. And you know nearly every eventual cardiologist will, will, you know, report a 99% success rate. And you know less than 1% mortality rate. And and so it's hard to to come with those

326
00:48:07.750 --> 00:48:11.359
Scott Martin, Stamford Health: those numbers. And you know, in New York they do public reporting.

327
00:48:11.400 --> 00:48:26.289

Scott Martin, Stamford Health: and they found that you know the operators who get asterisk for a you know. Poor quality of care care, you know. It doesn't tend to repeat year to year. It's not generally a consistent, you know, finding where you know the the. It's a bad operator. It tends to be more related to chance.

328
00:48:26.790 --> 00:48:36.720
Scott Martin, Stamford Health: So I think you know, quality measures are are good in in theory, but in in practice it's it's a challenge to distinguish between operators and programs based on that.

329
00:48:44.630 --> 00:48:45.020
W. Boyd Jackson, OHS: So

330
00:48:45.390 --> 00:48:52.050
W. Boyd Jackson, OHS: to the point about kind of the focus on Pci, which

331
00:48:52.250 --> 00:49:00.330
W. Boyd Jackson, OHS: is a historical you know it. It is placed in the historical context of the 2,012 plan.

332
00:49:01.062 --> 00:49:08.149
W. Boyd Jackson, OHS: It is specifically called out in the statute, via inpatient, outpatient cardiac catheterization.

333
00:49:10.660 --> 00:49:13.910
W. Boyd Jackson, OHS: W. Are there other specific

334
00:49:14.240 --> 00:49:16.709
W. Boyd Jackson, OHS: cardiac services that

335
00:49:17.169 --> 00:49:31.189
W. Boyd Jackson, OHS: the Fsp. Should take a closer look at as far as whether it be utilization or whether it be need for other services. I do think that there is some discussion of the fact

336
00:49:31.230 --> 00:49:36.252
W. Boyd Jackson, OHS: that generally Pci's have decreased over time.

337
00:49:37.160 --> 00:49:38.260
W. Boyd Jackson, OHS: But

338
00:49:38.910 --> 00:49:42.680

W. Boyd Jackson, OHS: you know, what? What are those other services? That

339
00:49:43.236 --> 00:49:58.499
W. Boyd Jackson, OHS: we should. That Ohs should really be thinking about the Fsp. You know. Not just today, not just over the last 12 years. But really, as we're looking forward to the trajectory of cardiac services, what are those that we need to have

340
00:49:58.520 --> 00:49:59.749
W. Boyd Jackson, OHS: an eye on?

341
00:50:01.820 --> 00:50:04.650
W. Boyd Jackson, OHS: And yes, go ahead, I will.

342
00:50:05.690 --> 00:50:10.699
rsoucier: Yeah. Hi, Hi, this is Rick Sousier. I'm a cardiologist. I've spent some time

343
00:50:10.970 --> 00:50:12.720
rsoucier: at Trinity. Health

344
00:50:12.950 --> 00:50:15.889
rsoucier: spent some time at Yale, and now I'm

345
00:50:15.950 --> 00:50:20.560
rsoucier: working up in Putnam, Connecticut, and I just want to sort of make a comment about.

346
00:50:20.670 --> 00:50:24.359
rsoucier: you know, as all these procedures have become more

347
00:50:25.030 --> 00:50:39.790
rsoucier: safe, it's not the way it was when I was 1st starting out in practice where it was a big deal to do, Pci, before we had stents, and you had to do it in the. You know the setting of a surgical backup. I think that that's much less relevant now, and it really now becomes

348
00:50:39.970 --> 00:50:43.499
rsoucier: a. The. The issue that I see is

349
00:50:43.600 --> 00:50:55.749

rsoucier: is access, patient access. And that graph, or that map that you showed really kind of brings out a very important point about where patients, you know what part of the State patients

350
00:50:56.020 --> 00:51:03.830
rsoucier: are, probably not getting the access that they need to. Procedures that I think are relatively simple. And again, I'm I'm less.

351
00:51:04.060 --> 00:51:09.429
rsoucier: I'm less focused on, you know the acute myocardial infarction that comes in at 2 in the morning

352
00:51:09.440 --> 00:51:13.480
rsoucier: cause that needs a critical mass. But I think that there's a way that we could.

353
00:51:13.900 --> 00:51:21.540
rsoucier: You know that we could expand access across the State. It has become difficult, especially in the setting of Covid.

354
00:51:21.860 --> 00:51:24.980
rsoucier: where the bigger hospitals are full

355
00:51:25.180 --> 00:51:26.150
rsoucier: always

356
00:51:26.360 --> 00:51:32.739
rsoucier: with patients that don't have cardiac disease. This is one of the frustrations I had at St. Francis when I was there.

357
00:51:33.100 --> 00:51:36.439
rsoucier: Full, always hard. It's hard to get people from

358
00:51:36.480 --> 00:51:39.170
rsoucier: point A to point B sometimes. And

359
00:51:39.400 --> 00:51:44.889
rsoucier: you know, I I just, I think if we focus more on where the access is and what the needs are.

360
00:51:44.930 --> 00:51:53.529

rsoucier: that's probably best. And and I'm talking about that, you know, peripheral vascular a lot of the ep procedures, a lot of the things that I think you know.

361
00:51:53.670 --> 00:51:57.380
rsoucier: high quality programs can sort of develop across the State.

362
00:51:57.400 --> 00:51:59.069
rsoucier: So thanks for let me comment.

363
00:52:01.400 --> 00:52:03.160
W. Boyd Jackson, OHS: Thank you. Kyle.

364
00:52:03.770 --> 00:52:12.950
Kyle Kramer: I'll echo Dr. Sousie's comments with regards to to access and distances. I've had the privilege of working with

365
00:52:13.279 --> 00:52:30.600
Kyle Kramer: Dr. Curtis when I I was part of the executive team with Yale to haven health, have worked in cardiovascular services for the better part of my 34 year career. And you know, as Dr. Sushi said, you know, in the early nineties this was, you know, a major event in 2,024.

366
00:52:30.600 --> 00:52:46.050
Kyle Kramer: The Pci is, is relatively straightforward, and you know I qualify my statement by noting that I am not a physician, you know, while I have stated a few holiday and expresses. You know I am not, capable of performing any of these procedures, but it's become more routine.

367
00:52:46.890 --> 00:52:56.359
Kyle Kramer: I still think that there is value in having the scale associated with the likes of the teams at Yale Haven, or Stanford, or Hartford.

368
00:52:56.440 --> 00:53:10.050
Kyle Kramer: or any of the other major leading cardiac enterprises. Throughout the country. However, there are real geography matters at hand here, and it doesn't matter how you slice it or dice it. To get from Putnam to Hartford

369
00:53:10.060 --> 00:53:11.940
Kyle Kramer: is an hour drive.

370
00:53:12.200 --> 00:53:20.859

Kyle Kramer: and whether it's elective or urgent time matters, and you've also got to factor in the realities of the population being served.

371
00:53:21.120 --> 00:53:27.180
Kyle Kramer: it is not easy for an elderly individual who lives in the north east corner

372
00:53:27.250 --> 00:53:30.719
Kyle Kramer: to get to Hartford. There is a hardship element of this.

373
00:53:31.110 --> 00:53:37.689
Kyle Kramer: Certainly there are criteria and qualifications that should go into any contemplation of expansion

374
00:53:37.770 --> 00:53:46.549
Kyle Kramer: to other hospitals or to ambulatory surgical centers. I certainly don't think the State should embrace a willy-nilly expansion

375
00:53:46.610 --> 00:53:54.260
Kyle Kramer: of services. But there are geographic realities that I think have to come into play with the modern realities of the fact that

376
00:53:54.270 --> 00:53:59.889
Kyle Kramer: we're talking about things that are now performed commonly with consistently high quality outcomes.

377
00:54:00.210 --> 00:54:10.990
Kyle Kramer: The trained individuals that are performing these procedures have been expertly educated and and are reproducing results that are high quality.

378
00:54:11.300 --> 00:54:15.360
Kyle Kramer: And if, in fact, there are those situations where you have

379
00:54:15.630 --> 00:54:24.899
Kyle Kramer: teams of providers that are not producing those outcomes, then there should be, you know, intervention associated with that, and perhaps the program should be closed. But

380
00:54:24.970 --> 00:54:41.899
Kyle Kramer: you know, I do think that we are at a time in 2,024, and going forward where we have to look at distribution on a reasonable level. Don't think there should be a Surgi center that does coronary intervention on every corner. But there are opportunities.

381
00:54:41.930 --> 00:54:47.890
Kyle Kramer: If we're talking about meaningful health planning for the State of Connecticut, where it might make sense

382
00:54:47.900 --> 00:55:01.670
Kyle Kramer: to contemplate some programmatic expansion for cardiac access, and geographies like the northeast corner, where you have a population of 125,000, plus individuals. Large portion of them are 55 and older.

383
00:55:01.680 --> 00:55:07.580
Kyle Kramer: who are cardiac eligible where that would be a meaningful improvement to health outcomes for the State.

384
00:55:08.280 --> 00:55:09.190
Kyle Kramer: Thank you.

385
00:55:12.450 --> 00:55:13.736
W. Boyd Jackson, OHS: Thank you.

386
00:55:38.700 --> 00:55:45.310
W. Boyd Jackson, OHS: Does anyone else have thoughts on the geographic Distribution point? That has come up

387
00:55:45.470 --> 00:55:49.629
W. Boyd Jackson, OHS: from several comments, especially in this last one.

388
00:55:50.800 --> 00:55:54.288
W. Boyd Jackson, OHS: you know, that's obviously intertwined with

389
00:55:56.320 --> 00:55:59.336
W. Boyd Jackson, OHS: determining need for these services.

390
00:56:00.000 --> 00:56:03.010
W. Boyd Jackson, OHS: access to these services.

391
00:56:04.800 --> 00:56:15.011
W. Boyd Jackson, OHS: How how do you as practitioners? How would you want? Ohs! To be thinking about what is reasonable, sufficient access? What is

392

00:56:16.050 --> 00:56:28.442
W. Boyd Jackson, OHS: What's kind of a clear lack of access, you know. We just heard comments about taking an hour to get from the northeast corner into Hartford for these services.

393
00:56:30.790 --> 00:56:31.910
W. Boyd Jackson, OHS: What a

394
00:56:32.300 --> 00:56:35.409
W. Boyd Jackson, OHS: how! How would you like? Ohs! To be thinking about

395
00:56:36.040 --> 00:56:39.109
W. Boyd Jackson, OHS: the need for services and access to services

396
00:56:39.510 --> 00:56:45.486
W. Boyd Jackson, OHS: broadly and then kind of throughout some of these areas that do have a more concentrated

397
00:56:46.110 --> 00:56:49.599
W. Boyd Jackson, OHS: more concentrated providers in that area. Mark.

398
00:56:50.760 --> 00:56:56.480
Mark Warshofsky: Yeah, I mean, I I think thinking about this from the patients. And the patient's family

399
00:56:57.180 --> 00:57:03.120
Mark Warshofsky: point of view is is the way to go. So you know whether you're talking about

400
00:57:03.470 --> 00:57:05.919
Mark Warshofsky: the northeast corner? Are you talking about

401
00:57:06.270 --> 00:57:08.040
Mark Warshofsky: the southwest corner?

402
00:57:08.690 --> 00:57:10.430
Mark Warshofsky: If a patient's

403
00:57:11.530 --> 00:57:12.960
Mark Warshofsky: gotta travel

404
00:57:15.300 --> 00:57:17.369

Mark Warshofsky: how difficult is that travel.

405
00:57:17.750 --> 00:57:20.599
Mark Warshofsky: What burden does it put on them and their family?

406
00:57:21.160 --> 00:57:22.220
Mark Warshofsky: And

407
00:57:22.990 --> 00:57:26.229
Mark Warshofsky: again, I'll go back to the example of a patient who is

408
00:57:26.910 --> 00:57:29.860
Mark Warshofsky: in a hospital. Maybe they came in for their

409
00:57:30.180 --> 00:57:32.930
Mark Warshofsky: heart attack. They were treated for the Stemi.

410
00:57:33.400 --> 00:57:35.500
Mark Warshofsky: They've got residual disease.

411
00:57:36.770 --> 00:57:38.869
Mark Warshofsky: The physicians want to take care of that.

412
00:57:39.080 --> 00:57:41.609
Mark Warshofsky: That patient now has to get transferred out.

413
00:57:42.746 --> 00:57:44.780
Mark Warshofsky: So I think you know.

414
00:57:44.850 --> 00:57:47.220
Mark Warshofsky: with the knowledge that we have today

415
00:57:47.740 --> 00:57:48.630
Mark Warshofsky: to

416
00:57:50.630 --> 00:57:52.769
Mark Warshofsky: have to subject that patient

417
00:57:53.610 --> 00:57:55.119
Mark Warshofsky: to be transferred.

418
00:57:55.870 --> 00:57:59.340
Mark Warshofsky: increasing the costs increasing the burden on the family.

419
00:58:01.110 --> 00:58:04.240
Mark Warshofsky: you know, if we're looking at that from a patient standpoint.

420
00:58:05.080 --> 00:58:07.530
Mark Warshofsky: we would say it would be preferable for them

421
00:58:07.670 --> 00:58:09.319
Mark Warshofsky: not to have to

422
00:58:10.100 --> 00:58:12.320
Mark Warshofsky: get into an ambulance.

423
00:58:12.650 --> 00:58:14.890
Mark Warshofsky: have the next hospital, work them up.

424
00:58:15.110 --> 00:58:19.259
Mark Warshofsky: and then have their procedure at that next hospital. So again, I think

425
00:58:19.950 --> 00:58:22.810
Mark Warshofsky: all of this needs to be looked at

426
00:58:22.980 --> 00:58:24.750
Mark Warshofsky: through the lens of the patients.

427
00:58:52.710 --> 00:58:53.510
W. Boyd Jackson, OHS: Dave.

428
00:58:54.586 --> 00:58:55.536
Dave S: Yeah, I think,

429
00:58:56.460 --> 00:58:58.419
Dave S: Mark made some great points

430
00:58:58.670 --> 00:59:00.290
Dave S: there. I think

431
00:59:01.020 --> 00:59:02.820
Dave S: not only

432
00:59:03.740 --> 00:59:05.940
Dave S: travel logistics for

433
00:59:05.960 --> 00:59:09.210
Dave S: for the patients, but I think I think cost is a huge.

434
00:59:09.520 --> 00:59:13.799
Dave S: huge driver. It it just really is around healthcare at this point. In time.

435
00:59:13.920 --> 00:59:17.520
Dave S: I guess. I guess my question may be back to

436
00:59:17.910 --> 00:59:19.356
Dave S: to Boyd,

437
00:59:21.260 --> 00:59:22.490
Dave S: is.

438
00:59:22.610 --> 00:59:30.149
Dave S: how does? How has Ohs made determinations? Historically, with regards to Co. N,

439
00:59:32.020 --> 00:59:35.469
Dave S: What I've seen over time is

440
00:59:37.880 --> 00:59:42.510
Dave S: giving out. CO ends not necessarily based on

441
00:59:44.020 --> 00:59:46.980
Dave S: any specific factors other than.

442
00:59:48.390 --> 00:59:57.563
Dave S: And forgive me for saying this plopping, plopping a healthcare facility in a specific area. So there's there's oftentimes

443
00:59:59.720 --> 01:00:03.660

Dave S: increased healthcare services and specific parts

444
01:00:04.150 --> 01:00:07.430
Dave S: of the State that don't necessarily need to be there.

445
01:00:07.910 --> 01:00:10.570
Dave S: and I'm not sure that

446
01:00:11.750 --> 01:00:13.100
Dave S: oh, hs!

447
01:00:14.990 --> 01:00:19.870
Dave S: All of the time looks at the right data, and that's all. And so

448
01:00:20.470 --> 01:00:25.429
Dave S: I think the question is is, how do you? How historically have you determined?

449
01:00:26.216 --> 01:00:29.619
Dave S: Giving out CO. Ends to specific

450
01:00:29.820 --> 01:00:32.439
Dave S: health systems and or

451
01:00:33.397 --> 01:00:36.140
Dave S: Llcs, or whatever they may be.

452
01:00:38.310 --> 01:00:44.499
W. Boyd Jackson, OHS: Sure. So the the certificate of need criteria are laid out. In 19. A

453
01:00:44.750 --> 01:00:47.040
W. Boyd Jackson, OHS: dash, 6, 39

454
01:00:49.160 --> 01:01:02.660
W. Boyd Jackson, OHS: I will not pretend to be able to recite them from memory. But some of the key factors, are access to care, a clear public need for the services or facility

455
01:01:03.717 --> 01:01:06.590
W. Boyd Jackson, OHS: cost effectiveness, quality

456
01:01:07.480 --> 01:01:12.040
W. Boyd Jackson, OHS: on avoiding unnecessary duplication of services.

457
01:01:13.030 --> 01:01:15.839
W. Boyd Jackson, OHS: access for medicaid patients.

458
01:01:16.440 --> 01:01:18.750
W. Boyd Jackson, OHS: Diversity of providers.

459
01:01:19.420 --> 01:01:28.419
W. Boyd Jackson, OHS: So there's a whole list. Spelled out this document is really intended to help folks

460
01:01:30.160 --> 01:01:36.549
W. Boyd Jackson, OHS: understand some of that, and to provide context and guidance for

461
01:01:37.230 --> 01:01:44.740
W. Boyd Jackson, OHS: ohs, as we're reviewing and for applicants as folks are preparing an application. So

462
01:01:45.160 --> 01:02:05.620
W. Boyd Jackson, OHS: that's precisely the goal for today is to talk about and make sure that when we're talking about the need for a service that we're looking at the right data, and that we have the right guidelines and right guidance. Excuse me for thinking about what's the need for a service.

463
01:02:06.127 --> 01:02:13.600
W. Boyd Jackson, OHS: We've heard some conversation around cost, and that factors into cost effectiveness. We've heard about

464
01:02:13.940 --> 01:02:35.500
W. Boyd Jackson, OHS: access generally. We also heard some discussion about perhaps differential access for different types of payers, which is a a criterion that we consider. So all of these are factors. And that's what we're trying to make sure we discuss clearly in this plan

465
01:02:35.610 --> 01:02:38.710
W. Boyd Jackson, OHS: is what are the things we should be looking at?

466
01:02:39.307 --> 01:02:42.410
W. Boyd Jackson, OHS: When we're determining that there's need.

467
01:02:42.830 --> 01:03:02.709
W. Boyd Jackson, OHS: what should Ohs consider, and what should an applicant provide? Should an applicant be providing currently in our service area? You know, it takes people 45 min to get to the nearest place for cardiac services in an emergency. And that's not right. So we should be able to do cardiac services, is it?

468
01:03:02.780 --> 01:03:06.299
W. Boyd Jackson, OHS: We can provide cardiac services at

469
01:03:06.480 --> 01:03:12.658
W. Boyd Jackson, OHS: 20% less than the neighboring facility. So we're more cost effective care, you know.

470
01:03:13.669 --> 01:03:19.930
W. Boyd Jackson, OHS: Given the criteria, and I think Cindy put them in the chat. A link to the statutory criteria.

471
01:03:20.870 --> 01:03:21.310
W. Boyd Jackson, OHS: I'm

472
01:03:21.780 --> 01:03:33.500
W. Boyd Jackson, OHS: given these broad categories. We've tried to lay out kind of how Ohs is thinking about it. The data underlying these decisions and whatnot. But are there any kind of

473
01:03:34.070 --> 01:03:39.940
W. Boyd Jackson, OHS: data sources that are missing any guidelines that you would point us to in thinking about

474
01:03:39.980 --> 01:03:42.340
W. Boyd Jackson, OHS: need, quality.

475
01:03:42.390 --> 01:03:44.169
W. Boyd Jackson, OHS: access to care.

476
01:03:44.420 --> 01:03:46.399
W. Boyd Jackson, OHS: cost, effectiveness of care.

477
01:03:46.963 --> 01:03:49.330
W. Boyd Jackson, OHS: Any of those key criteria.

478
01:03:54.010 --> 01:04:01.317
W. Boyd Jackson, OHS: And I saw hand. I think it was from Jepsa. I don't know if you lowered it, or if it timed out because I was rambling for too long.

479
01:04:02.070 --> 01:04:03.816
Jeptha Curtis: No, I didn't. Wanna

480
01:04:05.616 --> 01:04:22.710
Jeptha Curtis: get out of the way of that conversation, which is important. But I didn't have anything to add to that specific point. Like, I think you guys have done a very comprehensive job of identifying the correct sources of guidance and appreciate your guys reaching out to clinicians to try and provide additional

481
01:04:22.820 --> 01:04:48.889
Jeptha Curtis: opinions as to what should be done here. So I think there's no magical data set that says what should be done, or where, and getting back to that geographical question which is where my point was is, there's lots and lots of maps that are published in the cardiac literature that show where new angioplasty sites have evolved or come into being in the last 20 years. And the same thing is happening for structural heart interventions.

482
01:04:49.160 --> 01:05:02.710
Jeptha Curtis: And none of them have an a, an actual guidance. They they. They point out that there's a lot of potential duplication of service, but nobody says that it's necessarily bad duplication of service right? And I think it all depends on the perspective that you're bringing to bear. So

483
01:05:03.165 --> 01:05:18.209
Jeptha Curtis: I think geograph geography is but one of many factors that should be considered by your committee and making these determinations. I think the patient experience is probably increasing in importance.

484
01:05:18.626 --> 01:05:46.020
Jeptha Curtis: Because the risk of the procedure is going down right. And I think that there is very little risk in Connecticut of creating a perverse incentives for doing too many procedures right? We probably do too few procedures as opposed to too many procedures. So I I think that we're not gonna turn out as other states that have operated without certificate of needs for decades, and how they've evolved. I just don't see that happening here.

485
01:05:46.340 --> 01:06:00.579

Jeptha Curtis: I will note, and again, I will also know that this is self serving comment. But for my system there are in that list of hospitals a couple of hospitals that are doing primary pci without electives. And then there's some that are doing no surgery on site

486
01:06:01.148 --> 01:06:18.340
Jeptha Curtis: procedures with electives, and so that that differential probably should be considered as as you go forward. Because it it doesn't make a whole lot of sense to me as to how you can care for the sickest of the sick patients with acute myocardial infarction.

487
01:06:18.340 --> 01:06:30.959
Jeptha Curtis: but not take care of elected Pci with the the data that we've discussed as to how safe those procedures can be when appropriate quality assessments and case selection are are put into play.

488
01:06:42.860 --> 01:06:44.313
W. Boyd Jackson, OHS: Yeah. So

489
01:06:45.370 --> 01:06:52.776
W. Boyd Jackson, OHS: the the split between primary and effective sorry primary and secondary or elective is

490
01:06:54.170 --> 01:06:59.255
W. Boyd Jackson, OHS: as we've discussed a remnant of prior guidance where?

491
01:07:00.480 --> 01:07:02.890
W. Boyd Jackson, OHS: they basically the the

492
01:07:02.970 --> 01:07:19.099
W. Boyd Jackson, OHS: specialty societies basically said, everyone should be able to do primary emergencies. Because it's it's worth it to save a a life, but for the secondary elective procedures. That's where they have the the quality quantity thresholds.

493
01:07:19.210 --> 01:07:25.729
W. Boyd Jackson, OHS: So that's what yielded some of those splits, and it's helpful to have some conversation around

494
01:07:27.430 --> 01:07:29.200
W. Boyd Jackson, OHS: that piece, and

495
01:07:29.440 --> 01:07:30.720

W. Boyd Jackson, OHS: whether

496
01:07:31.300 --> 01:07:33.580
W. Boyd Jackson, OHS: whether there's a need to expand

497
01:07:33.630 --> 01:07:40.950
W. Boyd Jackson, OHS: the elective procedures to additional places that have been able to do primary, whether we have about the right

498
01:07:41.010 --> 01:07:46.840
W. Boyd Jackson, OHS: number of providers. Currently, is there an unmet need for

499
01:07:47.850 --> 01:07:49.530
W. Boyd Jackson, OHS: elective pci

500
01:07:49.680 --> 01:07:52.015
W. Boyd Jackson, OHS: or other cardiac services.

501
01:07:53.300 --> 01:07:57.440
W. Boyd Jackson, OHS: that's 1 of the things that we're really trying to take a hard look at in this plan.

502
01:07:58.450 --> 01:07:59.320
W. Boyd Jackson, OHS: Yes.

503
01:07:59.480 --> 01:08:00.320
W. Boyd Jackson, OHS: Tau.

504
01:08:00.780 --> 01:08:05.495
Tal Azemi: Yeah. Hi, thank you. I'm one of the individual cardiologists here at Hartford healthcare.

505
01:08:06.050 --> 01:08:15.299
Tal Azemi: I think that's I think an important point and to Drowski's point. You have someone who goes to one of our satellite hospitals

506
01:08:15.360 --> 01:08:17.109
Tal Azemi: with an acute Stemi

507
01:08:17.270 --> 01:08:34.980

Tal Azemi: and they have, you know, they have primary abilities. They have elective abilities in terms of diagnostic abilities, but they can't do elective pci. I'm not sure that's the best way of resource utilization to now transfer that patient

508
01:08:35.220 --> 01:08:58.700
Tal Azemi: from someone who just saved their, you know life doing a primary Pci, and now shipping them up to Hartford Hospital to do you know, an elective Pci on 2 sort of other vessels. I think that's where you know expansion of, you know, Pci. Capabilities and existing you know, facilities would be a a sort of a good start there.

509
01:09:00.500 --> 01:09:03.309
Tal Azemi: because, as of now, a lot of our patients

510
01:09:03.430 --> 01:09:18.499
Tal Azemi: where or they can get a diagnostic path, they come in with a an acute corner syndrome, and they see ruptured plaque, but because it's not quote unquote a stemi. They now have to get shipped, you know, via an ambulance.

511
01:09:18.670 --> 01:09:29.650
Tal Azemi: you know. Take their family now. They have to come up to Hartford Hospital to now fix an 80 ruptured plaque. I I think that that's a waste of resource utilization.

512
01:09:37.500 --> 01:09:39.930
W. Boyd Jackson, OHS: Thank you, just taking some notes. So

513
01:09:40.120 --> 01:09:43.150
W. Boyd Jackson, OHS: if anyone has another comment, I'll I'll look to

514
01:09:44.220 --> 01:09:45.990
W. Boyd Jackson, OHS: someone else to call on a hand.

515
01:10:05.350 --> 01:10:10.840
W. Boyd Jackson, OHS: So we're coming up on time for any public comments.

516
01:10:12.000 --> 01:10:22.569
W. Boyd Jackson, OHS: We don't have to pause this conversation, but I do want to make sure that if anyone from the public who is not a member of the Advisory group.

517
01:10:23.900 --> 01:10:31.269

W. Boyd Jackson, OHS: If anyone has a comment, you're more than welcome to raise your hand and contribute to this conversation as well, whether it be

518
01:10:31.930 --> 01:10:41.070
W. Boyd Jackson, OHS: a specific comment or a question to raise for this group for discussion? We welcome any contributions from those who are on the call at this point.

519
01:10:51.650 --> 01:10:55.060
W. Boyd Jackson, OHS: and I'm just checking the chat. But it looks like

520
01:10:56.620 --> 01:10:58.209
W. Boyd Jackson, OHS: those are just

521
01:10:59.080 --> 01:11:03.580
W. Boyd Jackson, OHS: Ohs! Comments so, Corey. I don't know if you had additional

522
01:11:04.970 --> 01:11:09.599
W. Boyd Jackson, OHS: areas for discussion based on either what you've heard or what's in the report.

523
01:11:12.260 --> 01:11:16.136
Corey Rhyan: I might have one other boy. I'll try and find it here.

524
01:11:16.510 --> 01:11:35.289
Corey Rhyan: Again. Getting back to some of the reference documentation in the 2024 report was the inclusion of this 2017 document, asking Ohs to take into consideration the appropriate use criteria for coronary revascularization, particularly in patients with a stable heart disease.

525
01:11:35.460 --> 01:11:43.193
Corey Rhyan: Is that a document that is the most current document of art in this in this space? And and does it make sense when we're trying to have ohs,

526
01:11:43.470 --> 01:11:47.750
Corey Rhyan: consider quality guidelines that we ask that providers

527
01:11:48.087 --> 01:12:13.919
Corey Rhyan: follow those appropriate use criteria when making decisions around cardiac services. I think it's something that we included in this report that was not included in a previous report. That's why I'm

highlighting it here. I I think we feel and alongside. Ohs! That this is one of the ways that Ohs can help take into account quality in that making sure that the right services are offered to the right patients. But wanna make sure this is the right document and the right approach for Ohs to consider in that.

528
01:12:19.470 --> 01:12:20.330
W. Boyd Jackson, OHS: Chopped up.

529
01:12:20.330 --> 01:12:25.669
Jeptha Curtis: Corey, so I think it is the most up to date document. I think it is appropriate for this to be

530
01:12:25.760 --> 01:12:42.730
Jeptha Curtis: presented is something that should be followed pretty closely, because I think they're reasonably fair. I believe that this document is scheduled to be updated at the end of this year or early in 2023. So it's not. It's still embargoed, but but you should keep an eye out for it.

531
01:12:44.420 --> 01:12:46.395
Corey Rhyan: Thank you. That's very helpful.

532
01:13:01.660 --> 01:13:13.349
Corey Rhyan: Yeah, boy, I'm still just thinking to myself about, you know, some of the issues around trying to identifying underlying need and and helping you with Ohs! Have more guidance of you know how to understand where areas of the State

533
01:13:13.610 --> 01:13:20.169
Corey Rhyan: have a need for more services, or where there are current capacity constraints that that might be something that we can identify in the data.

534
01:13:20.683 --> 01:13:22.450
Corey Rhyan: I'm thinking through maybe some

535
01:13:22.530 --> 01:13:24.800
Corey Rhyan: analyses that can be done in in

536
01:13:24.860 --> 01:13:28.090
Corey Rhyan: the discharge data or in the in. The all payer claims data.

537
01:13:30.320 --> 01:13:45.289

Corey Rhyan: whether or not it's you know. Again, we've tried to do work in the report so far to identify population based rates. You know, the idea is that looking at not only the rate of the number of procedures that's occurring at specific facilities. But looking at the rates of care that are being provided for particular populations across the State.

538
01:13:45.680 --> 01:14:07.919
Corey Rhyan: I think that's the right way to to try and identify potential gaps and looking at areas where there might be less utilization than we would expect. I think the difficulty in that process is trying to understand what the underlying need is. Outside of the observed utilization. There could be differences in need across different areas of the State that are driving those differences in utilization. We've tried to capture where patients are flowing between different areas of the State. But

539
01:14:08.202 --> 01:14:13.717
Corey Rhyan: I I guess that's an ongoing question that we're just gonna have to keep grappling with and try and provide you the best information you can.

540
01:14:18.500 --> 01:14:40.259
W. Boyd Jackson, OHS: Yeah, I think you know the the challenge that comes up here is the the burden is on the applicant to demonstrate that they meet the criteria, and part of that is demonstrating that there's a need for your proposal. And so that's why we've been kind of beating that drum today.

541
01:14:40.260 --> 01:14:59.880
W. Boyd Jackson, OHS: we want to ensure that we know what to be looking for from the Ohs perspective, and that applicants when they come in and say we need to be able to expand whatever type of cardiac service it is that they know how they need to be demonstrating that there's a need for those services. So

542
01:14:59.920 --> 01:15:00.800
W. Boyd Jackson, OHS: you know.

543
01:15:01.590 --> 01:15:02.610
W. Boyd Jackson, OHS: I

544
01:15:02.780 --> 01:15:14.859
W. Boyd Jackson, OHS: invite everyone to to continue to think on that over the next couple of weeks. You have some time before commas, or do if you have any thoughts about.

545

01:15:15.360 --> 01:15:18.479
W. Boyd Jackson, OHS: you know, if you were, if you were proposing

546
01:15:19.180 --> 01:15:21.669
W. Boyd Jackson, OHS: an expansion of cardiac services.

547
01:15:22.230 --> 01:15:27.569
W. Boyd Jackson, OHS: how would you tell Ohs, that there was a need. Aside from

548
01:15:28.450 --> 01:15:37.880
W. Boyd Jackson, OHS: I have some patients, and I want to be able to provide this service to them. You know. How would you demonstrate that need to? Ohs! Whether it be.

549
01:15:37.900 --> 01:15:42.329
W. Boyd Jackson, OHS: you know, some large data set or distance to the next

550
01:15:42.946 --> 01:15:48.753
W. Boyd Jackson, OHS: provider of that service, or a lack of those services in the area.

551
01:15:49.580 --> 01:15:54.040
W. Boyd Jackson, OHS: I think that would be that. That's really within the cardiac

552
01:15:54.240 --> 01:16:07.039
W. Boyd Jackson, OHS: chapter. What we're trying to make sure we capture. How should Ohs be looking at need? How should applicants be trying to demonstrate need? What are the key? Indicators? There?

553
01:16:13.260 --> 01:16:15.372
W. Boyd Jackson, OHS: And again we are

554
01:16:16.610 --> 01:16:23.434
W. Boyd Jackson, OHS: in the public comment section. So if anyone on the call we haven't had anyone join since my last announcement. But

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01:16:24.020 --> 01:16:25.710
W. Boyd Jackson, OHS: I do invite

556
01:16:25.970 --> 01:16:27.400

W. Boyd Jackson, OHS: public comment.

557
01:16:28.190 --> 01:16:29.110
W. Boyd Jackson, OHS: I think

558
01:16:29.710 --> 01:16:43.282
W. Boyd Jackson, OHS: cardiac services is the the section of the facilities and Services plan that Cindy and I heard about at the Capitol nearly every day during the last legislative session. So

559
01:16:45.010 --> 01:16:57.140
W. Boyd Jackson, OHS: If folks don't have additional comments, I am going to internalize that this revision of the plan really addressed a lot of those concerns, because that was a hot topic.

560
01:16:57.250 --> 01:17:05.412
W. Boyd Jackson, OHS: So if you have any other thoughts, we welcome them here. Otherwise.

561
01:17:06.230 --> 01:17:14.290
W. Boyd Jackson, OHS: we can adjourn early, and we can eagerly await any written comments or supplements that folks have.

562
01:17:14.440 --> 01:17:20.189
W. Boyd Jackson, OHS: But I want to give folks a last opportunity either to raise a new

563
01:17:20.870 --> 01:17:27.630
W. Boyd Jackson, OHS: topic for discussion, or any concluding remarks based on what we've heard or key takeaways.

564
01:17:41.340 --> 01:17:44.581
W. Boyd Jackson, OHS: Alright. Well, seeing no hands.

565
01:17:45.340 --> 01:17:58.181
W. Boyd Jackson, OHS: I just want to give my personal appreciation as well as my appreciation on behalf of Ohs for everyone. Taking the time to come and engage on these issues.

566
01:17:58.610 --> 01:18:16.857
W. Boyd Jackson, OHS: your thoughts as practitioners in this area is is incredibly helpful. If you have any other thoughts, please. Don't hesitate to reach out you. All, I think, have received correspondence

from Cindy, so you can reach out through her. You can reach out through me, boy Jackson.

567
01:18:17.230 --> 01:18:32.269
W. Boyd Jackson, OHS: Or you can follow the the typical comment submission process that's laid out. In the report and accompanying materials. So thank you to Corey for walking us through that. And thank you all for taking the time to spend with us today.

568
01:18:34.180 --> 01:18:35.130
Cindy Dubuque-Gallo (OHS): Thank you. Everyone.