WEBVTT

1
00:00:00.200 --> 00:00:01.180
CT-N 1B: July.

2
00:00:03.250 --> 00:00:05.390
CT-N 1B: where members of the public

3
00:00:05.840 --> 00:00:09.620
CT-N 1B: and we'll have an opportunity to provide their feedback

4
00:00:09.870 --> 00:00:14.709
CT-N 1B: to Ohs in writing, which we obviously encourage everyone to do.

5
00:00:14.900 --> 00:00:24.639
CT-N 1B: And as I mentioned the topic, specific meetings over the 90 day period where people can comment in verbally as well.

6
00:00:25.410 --> 00:00:34.119
CT-N 1B: So lots of opportunity between now and the finalization of the report later on this year to get feedback from the public.

7
00:00:34.200 --> 00:00:48.569
CT-N 1B: And we look forward to hearing from you. And today is that first such opportunity? So I'm going to turn the any questions from committee members. First of all, on the either the report itself

8
00:00:48.670 --> 00:00:49.590
CT-N 1B: or

9
00:00:50.000 --> 00:00:51.800
CT-N 1B: process for public engagement.

10
00:00:54.240 --> 00:00:55.190
CT-N 1B: Okay.

11
00:00:55.310 --> 00:00:58.447
CT-N 1B: I'm gonna turn the meeting over now to

12
00:01:00.254 --> 00:01:00.910
CT-N 1B: To

13
00:01:01.530 --> 00:01:12.669
CT-N 1B: Corey Ryan, who is Director of Research at Altarim, and the vendor that has been working very closely with Ahs on this version of the report.

14
00:01:12.930 --> 00:01:13.960
CT-N 1B: and

15
00:01:15.950 --> 00:01:18.969
CT-N 1B: just to let everyone know that this is a draft

16
00:01:18.990 --> 00:01:31.220
CT-N 1B: of the report and the decisions or options that may be discussed today are for discussion purposes, and we very much look forward to hearing from you. But

17
00:01:31.543 --> 00:01:40.030
CT-N 1B: if something is presented in Cory's overview today. It does not mean that. Well, it will appear either in the draft or the final version of the report.

18
00:01:41.420 --> 00:01:45.890
CT-N 1B: So with that, Corey. Thank you very much, and I will turn it over to you.

19
00:01:46.550 --> 00:02:09.219
Corey Rhyan (Altarum): Wonderful thanks. So much for the opportunity to present to this group today, and thanks for all the attendees for taking the time to be able to share their feedback on the work of what we've done so far, and I will echo what you said, Dr. Gifford, in the stage that we're at here. It which is looking at receiving feedback on an initial draft of the report that's been completed and submitted with Ohs! Right now, this is the first opportunity for both the healthcare cabinet and the public to see some of the initial findings of that work.

20
00:02:09.685 --> 00:02:30.290
Corey Rhyan (Altarum): I'm certainly not gonna be able to present the entire document to you today. This is a over 200 page document. And we'll do the best I can to highlight some of the key areas where I think we wanna start the discussion of public feedback and feedback with you as experts from the healthcare cabinet around important issues that could potentially change, or or certainly warrant deep consideration from the experts within the State and within the different fields.

21
00:02:30.510 --> 00:02:35.569

Corey Rhyan (Altarum): In order to make sure that we're making the right decisions and including the right language and the right recommendations within the plan.

22
00:02:36.618 --> 00:03:02.420
Corey Rhyan (Altarum): So what I'm gonna do today is I'm gonna do a quick overview of the current chapters. The way the plan is laid out. Just so you have a general scope of what's going to be included and the work that's been done so far, I'm gonna include a discussion of some of the expanded analyses, new data work that we've included in the plan and some of the approaches that we've taken, and trying to provide more detail to the State of Connecticut. Through this plan in the overall utilization of healthcare services, availability of healthcare services and potential gaps and unmet needs and care.

23
00:03:02.580 --> 00:03:19.710
Corey Rhyan (Altarum): I'm gonna do a deep dive into some of the equity and utilization results that we included in some of the sections, and perhaps most importantly, and where I really would like folks on the call today to be able to pay attention is, doing a detailed review of some of the certificate of need standards and guidance sections within the plan for those that are familiar with the 2012 plan.

24
00:03:19.710 --> 00:03:37.329
Corey Rhyan (Altarum): There are specific sections for particular categories of care where there are language and guidance that's provided for both those that are submitting certificate of need applications, and also ohs, as they review those applications that must be considered as a part of making those determinations, and

25
00:03:37.330 --> 00:03:54.249
Corey Rhyan (Altarum): some of those sections that we're gonna talk through where language is currently included in the 2012 plan is around acute care bed need for inpatient beds around outpatient surgery facilities and the potential expansion or initiation of new facilities within the State, around the expansion of cardiac care services within hospitals and outpatient settings

26
00:03:54.280 --> 00:04:22.110
Corey Rhyan (Altarum): and around imaging equipment, both the purchase and expansion of imaging equipment and new technologies within the State. So these are really important sections that are critical to get feedback from the larger group. And as Dr. Gifford said, we have proposed some changes, and to the to these sections so far based on both data analysis that we've done based on other research that we've done and based on updates in foundational documents that are included. In in developing these guidelines and standard sections.

27

00:04:22.338 --> 00:04:39.240
Corey Rhyan (Altarum): But these are by no means final. And and I'm gonna have some specific questions today for folks that are both in the room and on the call to be able to get to give some feedback. I expect we will not get through all the sections of the plan. Certainly. And and so it. We will certainly have other opportunities for more feedback to be given in the future.

28
00:04:40.080 --> 00:04:42.759
Corey Rhyan (Altarum): I know folks on the call are generally familiar, but just for.

29
00:04:42.760 --> 00:04:43.190
CT-N 1B: Right.

30
00:04:43.190 --> 00:04:44.150
Corey Rhyan (Altarum): So upset it's got.

31
00:04:44.150 --> 00:04:51.459
CT-N 1B: Interrupting. I just if members of the Cabinet have a question while you're presenting, do you want them to go ahead and

32
00:04:51.480 --> 00:04:57.229
CT-N 1B: interrupt you with their question, or do you want to save questions till the end? How do you want to handle that.

33
00:04:57.230 --> 00:05:11.209
Corey Rhyan (Altarum): So I've got this broken into 3 or 4 different sections. If you don't mind, I will pause for particular sections for feedback and and then we'll solicit it then. But folks should feel free to put questions in the chat. So you don't forget them or or raise a hand, and I will. I will just get to them in certain sections. If that's okay.

34
00:05:11.210 --> 00:05:27.380
CT-N 1B: Thank you, Corey, and then for members of the public who are listening in that are not Cabinet members. Again, you will have an opportunity for comment at at towards the end of the meeting. We're hoping for around 3 o'clock to be able to open up for public comment. Thanks, Corey.

35
00:05:28.260 --> 00:05:40.530
Corey Rhyan (Altarum): So here's just a quick picture of the 2,012 Facility and Services plan. This is a blueprint document, as Dr. Gifford mentioned for healthcare delivery within the State, and serves as a

critical resource for both policy makers and those involved in the certificate of need process.

36
00:05:41.410 --> 00:05:54.010
Corey Rhyan (Altarum): The goal of this plan is to lay out an understanding of the availability of specific healthcare services with the State, and also considering the availability of capacity and potential unmet need for those services across different parts of the State.

37
00:05:54.362 --> 00:06:04.979
Corey Rhyan (Altarum): The plan provides clear guidelines for adding services, taking away services, modifying services for particular categories of care. And it's used to help foster fair competition, a level playing field.

38
00:06:04.980 --> 00:06:24.140
Corey Rhyan (Altarum): and better access to services for all Connecticut residents. And we do that through providing transparency and data on geographic distribution of care. And and we've expanded a lot in the proposed new 2,024 plan with additional data, both in a better understanding of where care is being received and provided across the State of Connecticut, and different populations that are receiving care over time.

39
00:06:25.290 --> 00:06:48.100
Corey Rhyan (Altarum): I'll note that this plan has received supplemental updates over a period of time since 2,012. But those are primarily data focused updates that provided new information on utilization and trends going on within the State. But this is the first time since 2,012 that the State and Ohs is taking the opportunity to go back and potentially revise specific language within the plan, and a lot of the language around certificate of need standards and guidelines.

40
00:06:48.100 --> 00:07:02.649
Corey Rhyan (Altarum): And so a lot of what we've done is gone and looked at reference materials to understand where potential underlying sources have been updated, where data has changed, and where we've taken an opportunity to better understand what might make sense, as far as certificate needs a language and guidelines to be included.

41
00:07:02.848 --> 00:07:17.119
Corey Rhyan (Altarum): So that's that's the main focus of what we want to talk about today is some of the language components that have been updated. There's going to be lots of additional data in this plan that I won't have time to share with you today, but certainly will be shared. Once the plan is made public the draft is made public in at the end of June.

42
00:07:19.520 --> 00:07:40.880
Corey Rhyan (Altarum): just a quick reminder of where this plan sits within the larger certificate of need. Process. I see you. I apologize. The text is small, but the the flag number 2 here is that based on the Connecticut statute for certificate going to need guidelines and principles. The the relationship of the proposed project must be considered in context with the statewide healthcare facility and services plan.

43
00:07:40.880 --> 00:07:52.030
Corey Rhyan (Altarum): and so that both relates to the data that are included in the plan. The general understanding of healthcare needs across the State, and then also specific language and guidance that's provided in some of the certificate needs sections in the plan as well.

44
00:07:53.800 --> 00:08:07.620
Corey Rhyan (Altarum): Here's a general structure of the plan as it's been submitted to. Ohs! So far in the draft that's been developed. You can see we have up to 12 chapters. The first couple of chapters providing both an introduction to the plan and an overview of the certificate of neat process within the State of Connecticut.

45
00:08:07.630 --> 00:08:24.820
Corey Rhyan (Altarum): Chapter 2. Providing details on overarching trends and policy trends that are going on within the state, around issues of affordability, of care, workforce and within the healthcare sector, innovation and changes and practice trends and overall oversight and and impact on healthcare providers and healthcare facilities. As a result of those policy changes.

46
00:08:25.070 --> 00:08:46.089
Corey Rhyan (Altarum): Chapter 3 is where we start to get into the meat of the plan, and we look at the acute care sector, particularly looking at inpatient beds. Emergency department beds cardiac services and cancer. Care. Chapter 4. Looks at outpatient surgery facilities. Chapter 5. Looks at imaging and new technologies. Chapter 6, looks at long term services and supports and post acute care and availability of those services.

47
00:08:46.180 --> 00:08:58.519
Corey Rhyan (Altarum): Chapter 7. Looks specifically at unmet needs and vulnerable populations across the State. So not focusing on a particular type of service, but intend focusing on vulnerable populations across the State, and where unmet need might exist across all categories of care.

48
00:08:58.700 --> 00:09:01.760

Corey Rhyan (Altarum): Chapter 8. Looking at primary care and maternity, care.

49
00:09:01.830 --> 00:09:12.630
Corey Rhyan (Altarum): Chapter 9, looking at behavioral healthcare facilities and services, and then chapters 1011, and 12, looking at impacts of healthcare consolidation more broadly across the State, and some recommendations next steps and data limitations.

50
00:09:13.020 --> 00:09:39.639
Corey Rhyan (Altarum): So what we're gonna do today is I'm gonna drill down into 4 of these chapters and some specific sections of these chapters, as I mentioned, where specific language on certificate of needs, standards and guidelines have been reviewed and updated by our team and begin to get feedback from the experts on this call and their understanding of both the changes that we've made in the plan or the proposed changes that we've made so far and potential feedback in how we could either improve, or or change, or modify or validate some of those decisions that have been made so far.

51
00:09:42.120 --> 00:09:58.510
Corey Rhyan (Altarum): I'll note that. The facility and services plan standard and guidelines. Typically, in the 2012 plan. And we're carrying this through in the 2024 plan contain about 5 different types of components. The first is typically a set of definitions so important to understand, for example, what is the definition of an outpatient surgery, facility.

52
00:09:58.510 --> 00:10:14.740
Corey Rhyan (Altarum): How is that defined? And then how do you define the associated geographies, types of care that are provided, and different categorizations of of again, definitions of care in order to understand the scope of where the language is applicable for the different categories of care has been defined.

53
00:10:15.305 --> 00:10:24.169
Corey Rhyan (Altarum): The second component is then looking at numerical guidelines of needs. So really understanding detailed data of the availability of different services.

54
00:10:24.440 --> 00:10:30.839
Corey Rhyan (Altarum): The third component that's included in Sarah and guidelines is then measures of utilization, and how to measure utilization and how to measure capacity.

55
00:10:30.940 --> 00:10:55.449

Corey Rhyan (Altarum): And then the fourth component is looking at other types of guidelines that are set in the for certificate and need standard and guidelines. So these are often quality suggestions, ownership limitations, financial components that must be considered or safety patient safety components that must be considered. And then, lastly, there's usually a catch, all of additional considerations that are included in these standards and guidelines as well across different categories of care. And these vary across the 4 different areas that I'm going to talk about today. But generally include all these different components.

56
00:10:56.290 --> 00:11:09.699
Corey Rhyan (Altarum): Here's a quick summary. I'm not gonna linger on this slide too long, but just noting that what was done in the 2,012 plan had a mixture of different well, all of these components here, these acute care bed need, emergency department, cardiac surgery, outpatient surgery.

57
00:11:09.750 --> 00:11:31.869
Corey Rhyan (Altarum): and other categories of care were all included in the 2012 fine. There was a variance in the utilization of whether or not quantitative need was defined, and whether or not qualitative factors were also included in the definitions and the standards and guidelines for care. What we're trying to do in this plan is we're trying to be as quantitative and data focused as possible to bring more clarity to understanding what the levels of need are. For different types of care are within the state

58
00:11:32.149 --> 00:11:47.499
Corey Rhyan (Altarum): and using the kind of approaches that have been defined in the 2012 plan while updating based on data that we have and then also based on updated guidelines and language that we can provide that provide more clarity for the both certificate of need applicants and also for Ohs to understand

59
00:11:47.500 --> 00:11:52.719
Corey Rhyan (Altarum): when and where there is additional need for services across different populations and across different parts of the State as well.

60
00:11:52.750 --> 00:12:02.420
Corey Rhyan (Altarum): So we're gonna talk about some of the details, and some of these components, for example, occupancy thresholds that have been defined and utilization limits that have been detailed. Across these different categories of care.

61
00:12:04.790 --> 00:12:32.129

Corey Rhyan (Altarum): here is just a general list of the steps of the certificate. Need standards and guidelines. I'm actually gonna breeze past this cause I would like to get to the actual first step here. And but just before I get to the acute care inpatient bed need modeling and approach. I first wanna briefly talk about just this additional section that we've included in the plan so far, which is around the discussion of how we develop the certificate of need standards and guidelines, and how we're going about evaluating the capacity and need for services across the State.

62
00:12:32.433 --> 00:12:47.760
Corey Rhyan (Altarum): And so what we've done is that we've tried to consider what we think is an ideal way to measure the need for healthcare services and contrast the underlying need for care across these different categories of care with the actual observed utilization and the actual demand for care that is associated with it.

63
00:12:47.800 --> 00:13:11.649
Corey Rhyan (Altarum): I'll note that what often what we're doing is that we're looking at utilization statistics, either coming from the hospital discharge database or coming from reported utilization of imaging services within the State or looking at the all pay or claims database to look at the utilization of certain types of healthcare services within the State, to understand where there might be gaps in access, or where we might be close to capacity based on the current capacity. That is, that is available.

64
00:13:11.790 --> 00:13:27.800
Corey Rhyan (Altarum): I'm just highlighting here that there is a risk in that approach in both underestimating and overestimating current capacity, depending on how those data are considered, and we do our best to compensate for that. But I think it's an important thing to highlight when you're looking at using utilization data to understand the need and capacity for healthcare services.

65
00:13:27.800 --> 00:13:45.919
Corey Rhyan (Altarum): For example, if you look at utilization data and you see low utilization of certain services that could be interpreted as a saying, well, we have sufficient capacity. There's low utilization. I'm noting here that, for example, there could be other barriers to access to care that are leading to low utilization that need to be considered. In addition to the fact of the actual utilization that's being reported.

66
00:13:46.280 --> 00:14:11.020
Corey Rhyan (Altarum): Conversely, high rates of utilization may not necessarily mean that we need additional capacity. There could be instances where services are just being used in addition, and up to their full capacity, approaches of defensive medicine and and kind of high utilization of existing services, because those services are available

that could lead to overestimating the overall need and underestimating the current capacity as well. And so we try and compensate for this as best we can in the data that have been provided in the sections.

67
00:14:11.080 --> 00:14:14.739
Corey Rhyan (Altarum): I think this is kind of an important caveat to note in the data that we're using in this process.

68
00:14:15.320 --> 00:14:25.739
Corey Rhyan (Altarum): I'll pause there just for a sec. Any questions on kind of the overall things that I'm going to talk about today and the categories that we're looking at, and otherwise I'll jump into the queue. Care inpatient Petney. But I'll pause for questions real quick.

69
00:14:33.540 --> 00:14:35.829
Corey Rhyan (Altarum): cool hearing. None. I will

70
00:14:35.950 --> 00:14:56.110
Corey Rhyan (Altarum): begin to talk about what we've done in the inpatient bed. Need section of the report. Here's just a quick map that we show of the existence of general acute care hospitals across the State. And just highlighting here. That one change you'll notice in the plan this year relative to the 2022 plan is the new geographic definitions that are going to be used in this plan, and these are looking at the Connecticut planning regions.

71
00:14:56.396 --> 00:15:12.990
Corey Rhyan (Altarum): That are slightly different from what was the old version of Connecticut counties that were being used? And so when we aggregate services to look at utilization across different regions within the State. We are now using the Connecticut planning regions. As these are now the the current definitions of of subdividing the State into different regions.

72
00:15:13.400 --> 00:15:21.980
Corey Rhyan (Altarum): But just note that that some of those statistics, some of the numbers, and some of the groupings of different facilities will look different in the spine compared to 2,012. As a result of these different definitions.

73
00:15:23.800 --> 00:15:36.999
Corey Rhyan (Altarum): here's just a quick set of some examples of of data that are included in this acute care. Inpatient bed need component. We're looking at the number of hospitals that exist in the different regions across the State. We have information on the number of licensed beds available at each of those hospitals.

74
00:15:37.000 --> 00:15:54.220
Corey Rhyan (Altarum): the number of patient days that were served within those hospitals, and an average occupancy rate based on the comparison of the number of license beds and the patient days that we're seeing across different areas. And I'm not showing the whole table here. But what we're showing in this report gives you an understanding of average patient utilization and occupancy across different parts of the State.

75
00:15:54.270 --> 00:16:14.030
Corey Rhyan (Altarum): We also then break down hospital discharges across different service lines within the State, to get a better understanding of both. Whether or not there are greater increasing or decreasing hospital discharges over this time period with the most recent data that we have, and then also looking at where different types of services are driving either greater use or few less use of hospital inpatient need need across the State.

76
00:16:15.480 --> 00:16:37.729
Corey Rhyan (Altarum): Lastly, we also, which is new in this report, include a bunch of data around, looking at discharges across different populations and across different insurance coverage statuses. And so this is incorporating race and ethnicity data that we have in both a hospital discharge database and another sources and geographic data to better understand where there might be disparities in access and disparities and utilization across different populations across the State.

77
00:16:38.023 --> 00:16:56.520
Corey Rhyan (Altarum): So this is a a new addition to the plan, and and hopefully, something that will be considered mean better understanding the over underlying need and not just looking at average need across all populations. But now, further, drilling down and looking at detail above need, across specific race and ethnicity populations and also insurance cover populations across the State.

78
00:16:56.784 --> 00:17:03.039
Corey Rhyan (Altarum): I know I'm just looking past the data here. This is more just to give you a sense of what's in the plan? Not necessarily to go about any specific results at this time.

79
00:17:04.790 --> 00:17:23.400
Corey Rhyan (Altarum): So where I wanna go to now is and for folks that are familiar with the 2012 plan. This language is coming from the 2012. Plan is the acute care bed need methodology. So this is the approach that's used to understand and provide information to Ohs! Of whether or not there is a need for additional inpatient beds at

80
00:17:23.715 --> 00:17:46.439

Corey Rhyan (Altarum): individual hospitals and at individual facilities across the State. And so the approach that's taken to do this is to look at the available number of beds that are available within each different region. Looking at utilization of those beds across different age groups and different categories of care, and then creating an estimate of the average daily census of patient days across different areas over the previous 3 years.

81
00:17:46.760 --> 00:18:05.159
Corey Rhyan (Altarum): and then compare that average daily census to the current capacity as listed by the license number of license fed within each hospital and then rolled up to the Connecticut planning region within each State. So this is the same approach that was used in 2,012. We have not modified it because it works for Ohs, and we think it still makes sense, and it's very consistent with what is being done in other States.

82
00:18:05.160 --> 00:18:19.420
Corey Rhyan (Altarum): But this is again an area where there would be an opportunity if there would be recommendations from the public, or from a healthcare Cabinet Committee members to make modifications to this approach, and how we're determining overall need for acute care beds for inpatient beds across the State.

83
00:18:20.136 --> 00:18:46.550
Corey Rhyan (Altarum): Noting here just in how this work is done, and that the number of total beds is determined, and then that total number of beds is compared against the need. That's developed over time. The last thing I will note is this is a forward looking projection, so that what Ohs is doing when they're doing their bedding. Methodology is they're taking the average utilization today. And in fact, over the past 3 years projecting what need is today. And then further projecting, going forward. What need is going to be in 2025 and 2030.

84
00:18:46.560 --> 00:19:09.130
Corey Rhyan (Altarum): And so what that work does is it looks at taking population projections that are provided by the State of Connecticut, the Population Health Office, I think, and trying to estimate, based on how utilization is broken out across different age groups and different regions of the State, and where population growth is occurring across those age groups across the state of how there might be changes in need for different inpatient bed categories across the State.

85
00:19:10.888 --> 00:19:29.000
Corey Rhyan (Altarum): And so what is being done here is that there? I think I've said a lot of this. There's use of historical data and use of population growth to then project future needs going out to 2030 and then an estimate of total bed needs is made across different service lines.

And what I'll note here in Number 4, and this is potentially an area for conversation today

86
00:19:29.000 --> 00:19:46.639
Corey Rhyan (Altarum): is that what has been done in the, in the facility and services plan in the past is that there is not a distinction made by individual service lines for inpatient hospital beds. So we categorize and we look at the utilization of hospital beds across different service lines. I'll show that in just a sec. But when we look at the overall need.

87
00:19:46.640 --> 00:20:13.020
Corey Rhyan (Altarum): the assumption is made that a hospital and individual facility can shift a bed from being used, for example, from a psychiatric bed to a surgical bed, or from a general medicine bed to to a maternity bed. And so what is being done right now is that we're just looking at total counts of total beds in in assessing whether or not we are hitting the correct level of need, and then comparing that to what the projected need is based on those population projections from the past.

88
00:20:13.130 --> 00:20:16.249
Corey Rhyan (Altarum): the last component here that I will note, and I'll show it in the next slide

89
00:20:16.550 --> 00:20:34.960
Corey Rhyan (Altarum): is that there is a use of what's known as a target occupancy. So when we're comparing the total need with the total capacity. What we're saying is that what we want? The total need is to hit a threshold that is somewhat below the total capacity. It's often 80% is the number that's used for maternity beds is 50 and so this helps

90
00:20:34.980 --> 00:21:04.010
Corey Rhyan (Altarum): create a buffer in order to to not over subscribe and availability of care given that there's going to be variability throughout the year over time. So another place of feedback that we could potentially receive from this group is whether or not this current approach, this target occupancy of 80 and 50. For some categories of care makes sense is still relevant and is still something that should be kept within the plan. We do see this. Another certificate of need approaches that are done across the country. It is a typical standardized approach. But I think it's an area of discussion that we can potentially have.

91
00:21:04.430 --> 00:21:32.940
Corey Rhyan (Altarum): The option we can have today is around some of these additional considerations. We have proposed to not potentially include these in the updated plan, although they were included in the 2012 plan. That allows the consideration of some of these other pieces of

information during the application for the stricter need process might not include in this language. We don't think that we're precluding this information from being propriet prescribed by applicants. But not specifically calling out in this work. And so this would be another area. We where we could potentially get feedback from you at at the healthcare cabinet.

92
00:21:33.250 --> 00:21:35.570
Corey Rhyan (Altarum): I'll just give a quick review here of like

93
00:21:35.610 --> 00:21:58.059
Corey Rhyan (Altarum): what the overall tables look like within the facility and services plan, and how the number of patient days and the average capacity is compared over time. And if you can see my mouse, you can see in like the fourth to last column. There you can see that target occupancy number that gets applied, and looking at the different expectations of how to compare the overall utilization today in the average daily census

94
00:21:58.060 --> 00:22:16.020
Corey Rhyan (Altarum): based on a projection, and then comparing that to the overall number of beds. And you can see. As I mentioned, there is not a list of the number of license beds across the different categories. There's just one total at the bottom, and then what you see is then on the bottom right is that last, the projected excess or deficit of inpatient hospital beds, and this is, for example, in the metropolitan region within the State.

95
00:22:16.020 --> 00:22:32.959
Corey Rhyan (Altarum): What we found in doing this work is that most regions actually do seem to have sufficient inpatient hospital beds currently not extremely strong growth in the use of inpatient services over this time. Period. Moderate population growth, and and showing that actually there is sufficient capacity across many, many regions within the State.

96
00:22:34.140 --> 00:22:48.970
Corey Rhyan (Altarum): So this is where I will pause. I know I gave a lot there. I think I saw one chat come up? So I can. Happy to take that question and then open for feedback in general, things that I've talked about in the way that this process works and in the way that the current structure of the Q care bed need model has been designed. So far.

97
00:22:49.090 --> 00:22:54.436
Corey Rhyan (Altarum): So Danielle asked. I have a question about the calculation of bed. Need no rush. I can wait. Okay, Danielle, go ahead.

98

00:22:54.680 --> 00:23:07.629
Danielle Morgan: Hi, thanks, Corey. Your your discussion is incredibly informative and and very comprehensive. So I am a behavioral health. Provider. So I'm very intrigued by that and and I think

99
00:23:07.630 --> 00:23:31.710
Danielle Morgan: it, it seems to be pre. It may be problematic that the service lines aren't broken out in sort of defining those definitions. And I'm wondering how we sort of assume for or calculate for missing this data. So you know, it's interesting to me that there's like an appropriateness assumption around. You know, accessing behavioral health beds. Because while I certainly haven't gathered that data.

100
00:23:31.710 --> 00:23:54.438
Danielle Morgan: I can say as someone who's been practicing in this State for upwards of 30 years. There's a paucity of inpatient bed availability in the psychiatric service line. So I wouldn't. I would sort of challenge that data. And in defining it, you know, I I'm not sure how we capture the folks that seek those beds that can't find those beds that are turned away sent back to community

101
00:23:54.750 --> 00:24:17.570
Danielle Morgan: and it may be different than perhaps the Maternity service line or the surgical service line or or whatnot. So you know I I would be happy to be part of that discussion and and participate in those efforts. But I think it's super important to capture that data because it I don't think it's reflective so far in our definitions. But it's it's so incredibly important in the middle of

102
00:24:17.630 --> 00:24:20.270
Danielle Morgan: certainly a mental health crisis.

103
00:24:21.490 --> 00:24:22.110
Danielle Morgan: Well.

104
00:24:22.110 --> 00:24:47.010
Corey Rhyan (Altarum): Great comments. Thank you. And we will definitely take that back and happy to include you in both the inpatient side and also in the behavioral health sections as we go forward in in doing this work. That would be great. Yeah. So I I I agree with that. And I agree certainly, with a lot of the data that's been shown both nationally and the State of Connecticut. Of the need for psychiatric beds. More broadly, I think the challenges. Is that what I understand is the way that the beds are currently licensed? Give hospitals, the flexibility to allocate those beds across service lines as they see fit. Now, maybe that's wrong. Maybe

105

00:24:47.010 --> 00:24:54.459
Corey Rhyan (Altarum): that's outdated. So we need to check that. But the argument would be if there's a shorter psychiatric beds, it's not that we need to license more beds. It's that hospitals need to allocate those beds

106
00:24:54.460 --> 00:25:05.185
Corey Rhyan (Altarum): to that service line. And so I think we need to investigate this more. This is a great example of an area that I think deserves more discussion, more understanding from experts in the room. But that that would. I think that's a process we can take on later on.

107
00:25:05.400 --> 00:25:06.669
Danielle Morgan: Thank you for that. Education.

108
00:25:06.870 --> 00:25:07.510
Corey Rhyan (Altarum): It?

109
00:25:08.060 --> 00:25:09.883
Corey Rhyan (Altarum): Other questions, other comments.

110
00:25:11.420 --> 00:25:40.009
CT-N 1B: Alright. Yeah. So I I agree with what Danielle said, and ensuring Dr. Yoder, do you mind just identifying yourself? Alright. So, Dr. Anthony Yoder. I agree with what Danielle said as far as the ensuring the availability of behavior health beds, because that's certainly a separate category. I'm just wondering, can you elaborate a little bit more on why you excluded the observation beds? That. I mean, there's still something they're going to take up resources and potentially lead to backlogs and just wondering how you came to that.

111
00:25:40.610 --> 00:26:05.268
Corey Rhyan (Altarum): Yeah, yeah. The the thinking was just without having the data to be able to understand the the overall availability of those beds. It was not included as an additional component to be included in the bed. Need calculations. I I think it's an open discussion of whether or not that's a useful piece of information that applicants are using when they're considering this approach. And whether or not Ohs is con, including those so I think that's very much a topic for for further discussion. But the thinking was that without the underlying data like we have

112
00:26:05.510 --> 00:26:14.616
Corey Rhyan (Altarum): in the in the actual license bed and utilization. That that was excluded at in at this point. But I think that's open to discussion.

113
00:26:14.930 --> 00:26:24.130
CT-N 1B: I just, I think, as particularly as payers push towards observation status versus inpatient. It's something to consider, because it certainly goes to to the need.

114
00:26:25.620 --> 00:26:26.270
CT-N 1B: Thank you.

115
00:26:26.631 --> 00:26:29.158
Corey Rhyan (Altarum): 1 point while I can thank you.

116
00:26:30.160 --> 00:26:36.650
CT-N 1B: Corey. I'll just cause I can see the people in the room. Maybe I'll if I see hands here, I'll call on them. Does that work for you?

117
00:26:37.090 --> 00:26:37.880
Corey Rhyan (Altarum): Perfect.

118
00:26:37.880 --> 00:26:51.674
CT-N 1B: Okay, Commissioner Gutani. Thank you. Manisha Gutani from Tph. I think the issue of behavioral health beds particularly for children's behavioral health is definitely a very important one, and one where we've seen

119
00:26:52.410 --> 00:26:57.600
CT-N 1B: time periods of stress and pressure in terms of availability. So

120
00:26:57.960 --> 00:27:08.860
CT-N 1B: my understanding is that you know, we've had various different systems, bring additional beds online for this purpose, but that it is part of the overall count number.

121
00:27:09.010 --> 00:27:11.919
CT-N 1B: And so I think, to the degree that we

122
00:27:11.940 --> 00:27:26.419
CT-N 1B: know how many a system is planning to use for behavioral health and ensure that they continue using them for that purpose is important to make sure that there's enough capacity and bandwidth within the system to be able to meet

123
00:27:26.500 --> 00:27:28.790
CT-N 1B: the behavioral health needs for children.

124
00:27:29.700 --> 00:27:33.499
CT-N 1B: And and just to confirm what Corey said.

125
00:27:34.575 --> 00:27:38.539
CT-N 1B: Department of Public health does not license specific

126
00:27:38.600 --> 00:27:51.839
CT-N 1B: bed. So you have a number of licensed inpatient beds, and they're they're fungible to use the term that core used correct? So you could. That is correct track to maternity and add to psych, or vice versa without seeking additional

127
00:27:52.359 --> 00:28:02.060
CT-N 1B: license. Your authority from Dph, that's correct. And it's also true that certificate of need is not required to make that kind of swap between bed types

128
00:28:02.130 --> 00:28:06.390
CT-N 1B: and and the other thing I'll just note for background is that

129
00:28:06.600 --> 00:28:30.970
CT-N 1B: most of our hospitals, not all of them, but most of our hospitals are staffing beneath their licensed bed capacity, so they they don't necessarily staff all of their licensed beds. Most of them did during the pandemic. But at this point in time our data suggests that there are a number of hospitals that are staffing beneath their licensed capacity.

130
00:28:34.230 --> 00:28:41.279
David Whitehead: Commissioner if I could. It's Dave Whitehead. Going back to this issue of fungibility of license beds.

131
00:28:41.550 --> 00:28:44.770
David Whitehead: while the number itself may be fungible.

132
00:28:44.830 --> 00:28:46.569
David Whitehead: the requirements

133
00:28:47.150 --> 00:28:50.400
David Whitehead: between behavioral bed, behavioral health

134
00:28:50.730 --> 00:28:57.010

David Whitehead: beds and the equipment, and others that are included in that room versus an inpatient

135
00:28:57.330 --> 00:28:58.200
David Whitehead: dead

136
00:28:58.845 --> 00:29:02.750
David Whitehead: very widely. So I just wanna make sure that we're aware

137
00:29:02.980 --> 00:29:04.739
David Whitehead: that the requirements

138
00:29:04.780 --> 00:29:08.690
David Whitehead: are not fungible. The number of licensed beds may be.

139
00:29:10.750 --> 00:29:11.449
CT-N 1B: Thank you.

140
00:29:16.220 --> 00:29:25.909
CT-N 1B: Just to follow up from Dph again, that is definitely correct. So that assessment is accurate, that what is evaluated in terms of the physical space of what

141
00:29:25.970 --> 00:29:29.390
CT-N 1B: qualifies as a behavioral health bed versus not.

142
00:29:29.500 --> 00:29:31.920
CT-N 1B: does need to meet a different standard

143
00:29:38.000 --> 00:29:40.929
CT-N 1B: like there's no other hands up in the room here. Corey.

144
00:29:41.650 --> 00:29:42.420
Corey Rhyan (Altarum): Wonderful.

145
00:29:43.370 --> 00:30:05.319
Corey Rhyan (Altarum): I will move on to the next section that we have here, which is looking at specifically the still within the acute care section. But now, looking at emergency departments, and you can see here a separate map that we have of looking at acute care, hospital and satellite emergency departments the majority of emergency departments across the State being housed within the existing hospital facilities.

Although there are a few satellite emergency departments within some of the regions across the State.

146
00:30:06.160 --> 00:30:23.600
Corey Rhyan (Altarum): just noting some some of the data that we include in the report. I think this was in the the prior 2012. Report as well. But we've updated we're relevant is additionally looking at different categories of of emergency department care and looking at trauma centers across the State, and how that might impact the different types of of emergency care that can be provided to patients.

147
00:30:24.160 --> 00:30:40.120
Corey Rhyan (Altarum): And also some updated data with the most recent statistics, looking at the current utilization of emergency departments based on emergency department visits, and how those visits are leading to either admissions, inpatient admissions or discharges across different groups.

148
00:30:40.130 --> 00:30:55.560
Corey Rhyan (Altarum): and then oops. I apologize and then, also looking at the use of emergency department care across different populations. So looking at different categories of care that are being provided, different populations that are receiving care and different insurance coverage statuses of those that are using emergency departments within the State.

149
00:30:56.180 --> 00:31:13.319
Corey Rhyan (Altarum): The other thing that we've included in this report. Which is new this year, which is trying to get a better understanding of need for emergency departments across the State. Is data that we've collected from Cms in looking at emergency department volume and average wait times. So this is data that is new to the report in 2,012.

150
00:31:13.320 --> 00:31:40.185
Corey Rhyan (Altarum): I I'm sorry in 2024, and differs from what was done in the 2012 plan, adding additional information. Again, this is just a snapshot in time. That's been provided by Cms. But gives an understanding of across different hospitals within the and emergency departments within different regions of where there might be regions on average, that have higher Median wait times and and higher times for particular patients, noting here psychiatric patients in particular, and where there might be higher rates of patients that are leaving before they've been seen

151
00:31:40.726 --> 00:31:47.920

Corey Rhyan (Altarum): and the overall average Gd volume across different areas within the State. So not comprehensive here on this table again, as I apologize, is clipped off.

152
00:31:48.242 --> 00:31:56.310
Corey Rhyan (Altarum): But this detail will be provided in the draft plan, and is up additional piece of information that could be considered as a result of being included in the plan.

153
00:31:57.200 --> 00:32:21.050
Corey Rhyan (Altarum): So here is the language that's included. And I apologize. I know this is a little bit small, but I tried to get as much on these slides as I could. And I wanna note here how the standards and guidelines language differs in. For example, in the emergency departments here, compared to the acute care bed need well the acute care bed need was very rooted in the understanding of looking at the comparison between capacity of available beds and utilization of those beds.

154
00:32:21.356 --> 00:32:36.693
Corey Rhyan (Altarum): The emergency department planning language is much more flexible and and primarily relies on this American college's emergency physicians policy statement. This was updated in 2021. So we're now incorporating the newest version of this policy statement. That gives recommendations on emergency department planning and resource guidelines.

155
00:32:37.303 --> 00:33:01.546
Corey Rhyan (Altarum): It notes some characteristics of emergency departments and notes, some both quality recommendations, operational recommendations, and other policy recommendations that are made for those that are establishing emergency departments within the State. So the way that Ohs would use this guidance in making their certificate any processes in addition to all the other components that they would consider in whether or not to pro to permit the expansion or development of a new emergency department within the State

156
00:33:02.116 --> 00:33:24.740
Corey Rhyan (Altarum): would be to also consider these these quality guidelines and these policy statements as made by the American College of Emergency Physicians. As far as we can tell that this is the the best and most relevant document based on the professional society. Here, in guiding the determination of the availability, quality and and access to emergency departments within the State. But open to other conversations with other groups to make sure that this is the most relevant language that could be included.

157
00:33:25.554 --> 00:33:37.369
Corey Rhyan (Altarum): So any comments or questions on on this here I I'm you'll note there's there's there's a big difference in. And this is

consistent with what was done in 2,012 in that. Some of these recommendations are very prescriptive

158
00:33:37.370 --> 00:33:58.400
Corey Rhyan (Altarum): in the language and the guidance around. How you determine capacity, how you determine utilization, and how you make determinations of whether or not there is need for different types of care, and some of these that are more flexible in the language that's being provided in the standards and guidelines. And this is definitely one of the more flexible versions again, rooted mostly in statements around this this Asap policy statement that was that was published in 2,021.

159
00:33:58.630 --> 00:34:00.429
Corey Rhyan (Altarum): Alan, I see a hand up.

160
00:34:02.810 --> 00:34:08.344
Alan Kaye: Yeah, I noticed that the data for for 2,020 or 21, the most

161
00:34:08.719 --> 00:34:10.679
Alan Kaye: recent utilization data

162
00:34:11.147 --> 00:34:16.162
Alan Kaye: and was that also the same database that was used for the

163
00:34:17.442 --> 00:34:19.010
Alan Kaye: walk out great

164
00:34:19.530 --> 00:34:20.300
Alan Kaye: rates of the.

165
00:34:20.596 --> 00:34:28.887
Corey Rhyan (Altarum): No, that is, that is, this is different. This is directly coming from Cms. This is coming from their their quality. Metrics that are reported for facilities

166
00:34:30.050 --> 00:34:31.190
Alan Kaye: Okay. Yeah.

167
00:34:31.190 --> 00:34:37.249
Corey Rhyan (Altarum): Yup, that's 2022. And then this is the most recent data that we had at the time that we were putting these data together of the actual utilization.

168
00:34:37.570 --> 00:34:57.539
Corey Rhyan (Altarum): Coming from State of Connecticut. This is coming from Ohs's tracking. And and there's actually a lot more. I'm only showing a couple of charts. I think there's 8 to 10 charts detailing different types of Ed use. different categories of patients that are receiving care across the State. And a little bit of information around preventable hospitalizations and frequent flyers as well. That's included in the in the plan.

169
00:34:57.540 --> 00:34:58.269
Alan Kaye: Thank you.

170
00:35:00.250 --> 00:35:21.279
Corey Rhyan (Altarum): It. It's a good general question. In general. Our approach is to use the most recent data that are available, depending on the sources that were required for these different sections. So occasionally, it's 2021, 2022 data a couple of times. Sometimes it's only back to 2019, but we, we're we're just trying to. We're not really trying to be consistent. Year over year. We're just trying to use the whatever the most relevant and most current snapshot is of need across the State.

171
00:35:21.955 --> 00:35:22.969
Alan Kaye: I do know

172
00:35:23.240 --> 00:35:38.219
Alan Kaye: the the the changes we've had between Covid and Post Covid and things like that. It's important. And the 2022 is that the is that the hospital fiscal year, which generally 2022, ends in September or August of 2021.

173
00:35:40.152 --> 00:35:41.960
Corey Rhyan (Altarum): Yes, that's correct. That's.

174
00:35:41.960 --> 00:35:48.122
Alan Kaye: Okay, so this is really out of date information. Is there no way to get anything more more current cause? Things have changed.

175
00:35:48.740 --> 00:36:10.909
Corey Rhyan (Altarum): We can, we can confirm with OS. If there's one more vintage and some of this has suffered from the fact that this data has been with us for analysis for a while, so we can confirm with OS. And they may have independent statistics. We can certainly see to include, as you know, these data are rolling out and getting updated over time. So we, we can confirm one more time. You're right. These are fiscal years in the way that these years are defined. So that's an important point. And I do note this caveat in

176
00:36:10.910 --> 00:36:33.997
Corey Rhyan (Altarum): a bunch of sections of the facility and services plan around the issues around Covid, the impact that has on utilizations of particular types of care potential caveats, and where it makes sense. Sometimes we go back to 2019 data to kind of reference the trend Pre covid pandemic. And as soon as possible, you know, Ohs will continue to update these data with data that are post pandemic. To get a better understanding of kind of that return to util standard utilization or more normal utilization.

177
00:36:34.260 --> 00:36:37.710
Alan Kaye: So you know, hospitals publish these data internally

178
00:36:37.850 --> 00:36:39.210
Alan Kaye: every month

179
00:36:39.630 --> 00:36:51.065
Alan Kaye: for for utilization of the Ed, and walk out rates and things like that. And so it might be. We might require or want an alternate alternative

180
00:36:51.840 --> 00:36:54.280
Alan Kaye: source. If we're gonna really be

181
00:36:54.350 --> 00:36:55.950
Alan Kaye: comprehensive and accurate.

182
00:36:55.950 --> 00:37:12.339
Corey Rhyan (Altarum): Happy to have that conversation with experts, and and oh, trust as well of what data they collect, currently collect, how it could potentially be modified, or what could be collected independently for this report. Happy to have those conversations, and I think that could be a great opportunity to bring the experts in the room during some, our advisory committee meetings of what could potentially be added to the data that we have in the plan already.

183
00:37:23.560 --> 00:37:25.290
Corey Rhyan (Altarum): Other questions or comments in the room.

184
00:37:25.440 --> 00:37:27.150
CT-N 1B: No hands up here, Corey.

185
00:37:29.890 --> 00:37:48.183

Corey Rhyan (Altarum): Great. Okay, I'm gonna move to the cardiac services. And I'm gonna detail a little bit of what's included in those definitions. So here's section 3.4 point 1 of the current plan, and noting that a certificate of need is required for the establishment of cardiac services, including inpatient and outpatient cardiac catheterization.

186
00:37:48.510 --> 00:38:08.339
Corey Rhyan (Altarum): interventional cardiology, and cardiovascular surgery. Can I get hospitals seeking authorization to establish a cardiac program or required to demonstrate that they meet clear public need, as well as other criteria, set forth in the following section. And then there's additional language that's going to be included in the plan around guidance and standards for establishing new cardiac services within the State.

187
00:38:08.650 --> 00:38:17.089
Corey Rhyan (Altarum): So the first thing we do in the section is highlight, where different categories of cardiac services are available across different hospital facilities within the State.

188
00:38:17.469 --> 00:38:24.729
Corey Rhyan (Altarum): And this is again done in an Ohs inventory. This is looking at. I don't sorry. Don't have a year here. But it's this is for 2022

189
00:38:25.088 --> 00:38:31.519
Corey Rhyan (Altarum): in looking at the current utilization and availability of different cardiac services across different hospitals within the State.

190
00:38:32.260 --> 00:38:53.679
Corey Rhyan (Altarum): We then provide some data on trends in discharges for cardiac care. Both at the inpatient level, more broadly. Looking at the differentiation between cardiac medical versus surgical discharges, and then also looking at discharges across different populations, adding, at this year, in the new plan, in in trying to get a better understanding of the utilization of these different types of services across different populations.

191
00:38:53.958 --> 00:39:06.219
Corey Rhyan (Altarum): Noting, for example, differences in the mix of race and ethnicities that tend to use cardiac care for for medical versus surgical interventions talk a little bit about that of, and some of the interpretations of that in the, in the document itself.

192
00:39:06.220 --> 00:39:18.680

Corey Rhyan (Altarum): and giving a better understanding of both what the broader utilization is of these services across the State. But also, again, how different populations. Different geographic regions of the State are using these types of care and different insurance coverage statuses are using this care as well.

193
00:39:19.870 --> 00:39:47.940
Corey Rhyan (Altarum): So we are proposing right now, and this is just a proposal. Pretty significant changes to the cardiac services standards and guidance as written in the plan, and the primary reason for that is that the main reference document that was used in making the recommendations in the 2012 plan was a 2011 combination of a bunch of cardiology, professional societies, practice guidelines for Pci, and and other cardiac interventions.

194
00:39:47.940 --> 00:39:56.279
Corey Rhyan (Altarum): And this 2,011 document has now been deprecated by a 2021 document that's been released by a similar group of professional societies.

195
00:39:56.280 --> 00:40:23.799
Corey Rhyan (Altarum): And so there was a lot of recommendations that were included in this 2011 document that no longer exist in the 2021 document or have been kind of supplemented with some other documents from these professional societies as well. And and so there there are, gonna be some changes. I'm gonna try and walk through as best I can the detail here. But th, this is almost something that's gonna need review of individuals with experts. In in to look at specific language as we've as we've written it. But I wanna highlight some of the major changes that we've made to the the cardiac care recommendations.

196
00:40:23.850 --> 00:40:51.210
Corey Rhyan (Altarum): The first noting that there was a lot of text and guidance in the prior plan around Pci in locations without surgical backup. It was a period of time where there's still a lot of research being done, of whether or not these types of procedures could be done in facilities without surgical backup. And what standards and what kind of procedural and operational requirements would be needed for facilities that wanted to provide Pci where they didn't have the surgical backup facilities available at the same location.

197
00:40:51.740 --> 00:40:59.920
Corey Rhyan (Altarum): What we have seen in the evidence is that, there seems to be a trend based on the recommendations that have been written by some of these same professional societies that

198
00:40:59.920 --> 00:41:14.069

Corey Rhyan (Altarum): the this is an overall safe approach, and then it appears, and again, I'm not a medical doctor, so I would encourage us to all talk to, to kind of medical professionals in this space. But my interpretation of the literature is that it is generally been

199
00:41:14.330 --> 00:41:37.740
Corey Rhyan (Altarum): more accepted to allow and permit these types of interventions to take place in facilities that don't have the surgical backup in place, and a lot fewer restrictions have been recommended by these professional societies for facilities that want to provide these types of of considerations. So we've removed a lot of language from the current plan that had a lot of guidance, of whether or not these types of interventions could be done, and whether or not these programs could be established in facilities without that surgical backup.

200
00:41:38.290 --> 00:42:06.580
Corey Rhyan (Altarum): There was also an additional section in the 2,012 fund that included a lot of information around recommendations of minimum volumes and ideal volumes, and really looking at only doing these procedures, or highly recommending that these procedures are only done in facilities that do a certain number of these procedures within a year or within a certain time period, and do a certain number of categories of different types of procedures within a certain time period, under the idea that larger facilities that do more of this are going to be of higher quality, and therefore they should be doing more of these procedures.

201
00:42:06.760 --> 00:42:28.079
Corey Rhyan (Altarum): We do not see a lot of those recommendations carried through into this new 2021 update of these clinical Practice guidelines. So we've removed a lot of that language right now, or proposed to remove a lot of that language from the certificate of need, guidance, and standards in the 2024 plan. This is very much something that I think we want to continue to talk through with experts. But again, I'm just flagging here. Our proposed changes so far based on our rate of the of the literature.

202
00:42:28.940 --> 00:42:39.580
Corey Rhyan (Altarum): I'm just highlighting here some of the new primary documents that we're referencing in this section. This includes this 2021 broader guidelines for a coronary artery, rebascarization among these 3 professional societies.

203
00:42:40.116 --> 00:42:49.210
Corey Rhyan (Altarum): And then also an additional statement around Pci without on surgical backup, and some some recommendations that are still made in this 2023 recommendation document.

204

00:42:49.740 --> 00:43:13.720
Corey Rhyan (Altarum): and then also some additional language that we've pulled in from a 2017 document. Again, all 3 of these documents were not available in 2,012, when the prior language was written around the appropriate use for a coronary vascularization in patients, and particularly those that have a stable stable of scheme at heart disease. As a result of, I think, some concerns around overuse of these procedures. In cases where, while they may not necessarily be dangerous, they may provide minimal benefit to patients.

205
00:43:14.031 --> 00:43:30.859
Corey Rhyan (Altarum): And so some recommendations and guidance has been I provided to physicians. And and what we're proposing is that some of this language is carried through in the standard and guidelines to ensure that sites that want to initiate a a cardiac services that they're following. These recommended guidelines by these professional societies.

206
00:43:31.189 --> 00:43:45.880
Corey Rhyan (Altarum): And then, lastly, here I'll note there we are still relying on, because it has not. As far as we can tell, it has not been updated a 1,996 document specifically around open heart surgery and cardio thoracic surgery. As was noted by the American college Surgeon Boards of Regents in in 1,996.

207
00:43:45.900 --> 00:43:49.879
Corey Rhyan (Altarum): So those are the. Those are the primary documents that we're using in these updates.

208
00:43:50.280 --> 00:44:10.369
Corey Rhyan (Altarum): I have a bunch of language here that's gonna be hard for us to go through without me reading it. So I think maybe what I will do is I will kind of skip to the end, and then, if folks have specific questions around some of the changes that we propose to the language that we've included right now. We can talk through that in more detail. But this is probably a section that's gonna make more sense to do in a small group with a with specific experts. But those are the broader changes that we've tried to make here.

209
00:44:11.215 --> 00:44:11.810
Corey Rhyan (Altarum): So

210
00:44:11.860 --> 00:44:15.040
Corey Rhyan (Altarum): broader questions for the group, for folks that would like to give feedback.

211
00:44:15.339 --> 00:44:31.529

Corey Rhyan (Altarum): Firstly, about the appropriateness of where we have seen documents get updated from these professional societies of, if it makes sense for us to only reference those replacement documents, and and kind of replace the reference to the older documents of those that are presumably out of date. Now that new guidelines have been written.

212
00:44:31.867 --> 00:44:45.450
Corey Rhyan (Altarum): This proposal to take a revised focus away from focusing on guidelines for Pci without surgical backup. Given that more and more evidence seems to be pointing, based on our interpretation of the literature. The that is generally a safe approach. That doesn't require as many restrictions.

213
00:44:45.590 --> 00:44:54.849
Corey Rhyan (Altarum): a new revised focus on these 2021 guidelines and also revised focus on this appropriate use. Criteria that was not available in the when the 2,02012 plan was published

214
00:44:54.860 --> 00:45:08.140
Corey Rhyan (Altarum): around use of coronary revascularization for particular patients. And then anything else that should be considered for the facility and services plan. So that's the cardiac section and and open conversation that we can have around these these topics.

215
00:45:19.500 --> 00:45:20.010
CT-N 1B: Or y-.

216
00:45:20.010 --> 00:45:21.083
Corey Rhyan (Altarum): Thank you.

217
00:45:22.173 --> 00:45:33.519
CT-N 1B: It's Dj, Gifford. I will just say that. We know that this is an area of intense interest in the healthcare industry. Understandably. So it's an important healthcare service and service line.

218
00:45:33.800 --> 00:45:41.240
CT-N 1B: So we look forward to engaging subject subject matter. Experts here. Ohs has had

219
00:45:41.678 --> 00:45:47.109
CT-N 1B: as an advisory body around these issues in the past. So we intend to

220
00:45:47.170 --> 00:46:00.099

CT-N 1B: reconvene. A diverse group of of experts on this issue, but really welcome the feedback of this group? As well, because it it is a very important set of considerations.

221
00:46:03.500 --> 00:46:04.840
Corey Rhyan (Altarum): Alan, I see your hand up. Go ahead!

222
00:46:04.840 --> 00:46:21.150
Alan Kaye: Yeah. So I'm not. I'm not a cardiologist. But I am a radiologist. That does interventional procedures or did intervention procedures. Is it safe to assume that the number 3 there, that they, the guideline, includes guidelines for the facilities offering it.

223
00:46:21.830 --> 00:46:46.360
Corey Rhyan (Altarum): In in in many cases it does. Yes, it's both guidelines for the care being provided, and then also facilities providing as well a as I noted in Number 2 here. There's less guidance in this new 2021 plan around the facilities than there was in the prior version. My interpretation of that is that because they are kind of relaxing some of those needs around guidance around operational and facility requirements. But where those facility requirements were specifically mentioned where we found them in the 2020

224
00:46:46.460 --> 00:46:55.169
Corey Rhyan (Altarum): one version of these guidelines, we did incorporate them into the language as best we could into the plan, but I think that's open for further discussion with experts.

225
00:46:55.470 --> 00:46:58.190
Alan Kaye: That's probably pretty good pretty good

226
00:46:58.300 --> 00:47:00.299
Alan Kaye: source, I think.

227
00:47:00.940 --> 00:47:01.760
Alan Kaye: Good.

228
00:47:01.760 --> 00:47:08.998
Corey Rhyan (Altarum): That's that's a great start. I'm glad to hear that. There's not something drastic that I've missed so far, but if if there is, we will work to incorporate it, as we have more time.

229
00:47:15.270 --> 00:47:16.739
CT-N 1B: No hands up here, Corey.

230
00:47:18.010 --> 00:47:18.790
CT-N 1B: Great.

231
00:47:20.840 --> 00:47:40.840
Corey Rhyan (Altarum): Okay, I will go to Chapter 4. And this is around outpatient surgery facilities. Just highlighting some of the new data that we're including in this section. This is looking specifically at some of, for example, the most commonly performed outpatient surgeries. At outpatient surgery facilities within the State. And looking at the breakout of where those surgeries are being provided

232
00:47:40.840 --> 00:47:51.790
Corey Rhyan (Altarum): and trends in the use of those surgeries over time. Looking at a period of 2016 through 2021. Again, as far as I'm aware, 2021 is the most recent data that is available for this outpatient surgery data set

233
00:47:52.042 --> 00:48:00.130
Corey Rhyan (Altarum): and also the most recent of the Apcd year that we had when we did some of these analyses. But we can certainly double check on that as well.

234
00:48:00.768 --> 00:48:10.079
Corey Rhyan (Altarum): And just noticing, you know again, this is just a snapshot of some of the most common surgeries, outpatient surgeries that are provided in in these outpatient settings, and trends and use of that care.

235
00:48:10.747 --> 00:48:27.622
Corey Rhyan (Altarum): Noting here again that we also in the in the report, now break out the use of those different surgeries across the different regions. This is aggregated up to the planning regions. And looking at trends in the total number of those surgeries that are being provided. And again, where those surgeries are being provided at different types of locations.

236
00:48:27.910 --> 00:48:29.010
Corey Rhyan (Altarum): within the state.

237
00:48:30.050 --> 00:48:55.730
Corey Rhyan (Altarum): And then, lastly, also breaking out as we've done for some of these other sections. And this is new. In the 2024 report. The utilization of these types of care across different types of patients. For example, those with different types of insurance coverage and different race and ethnicities and different patient populations, as well across the State, to get an understanding of where these services

are being used by different populations, and where there might be gaps in access or unmet need.

238
00:48:55.730 --> 00:49:16.440
Corey Rhyan (Altarum): Even if there's not unmet need in a total state level or aggregate level, there could be unmet need for particular populations or for particular groups due to barriers to access. And so that's something that we really felt was important to highlight in this report. And and so we we tried as best as possible to break down and understand where utilization was different, across different groups and across different regions and across different populations of the State.

239
00:49:18.040 --> 00:49:38.009
Corey Rhyan (Altarum): Here, again is a definition that is not very prescriptive. In the certificate of need standards and guidelines based on the 2012 plan, and we kept much of this language. We made very minimal changes to this. There were not kind of new reference documents that we found based on these recommendations. And in general, these recommendations seem consistent with other certificate of need guidelines that have been made

240
00:49:38.010 --> 00:49:54.030
Corey Rhyan (Altarum): across different States. And so we we in general have not proposed major changes to this, but open to conversations. With folks that use these definitions and use these standards and guidelines in their day to day work both with ohs, and also in considering certificate into applications more broadly.

241
00:49:54.443 --> 00:50:12.049
Corey Rhyan (Altarum): So you note here just definitions around primary service area and around capacity. I also cut out Number one here. Number one was a broad definition of what is defined as an outpatient surgery facility. I don't believe, apart from maybe changing a brief Cms definition, that anything changed in those in those definitions in the new plan.

242
00:50:12.230 --> 00:50:35.762
Corey Rhyan (Altarum): And then looking at the standards and guidelines for outpatient surgeries. Looking at what it would mean for an established for an applicant to propose a new facility. And then how they would go about determining the overall capacity that what that facility would be, and noting then what an optimal utilization level would be for that outpatient surgery facility. And then recommendations are within. These guidelines are not prescriptive, like depending

243
00:50:36.703 --> 00:50:51.126
Corey Rhyan (Altarum): kind of comparison of overall utilization compared to license beds, but basically just noting what an optimal utilization

rate would be. And then, noting that applicants should show that they believe that the utilization of their new facility would meet these would meet these measures.

244
00:50:52.403 --> 00:51:02.930
Corey Rhyan (Altarum): Here's some just some additional factors that can potentially can be included in the outpatient surgery facility guidelines. But again, we're not. We haven't so far in what ways and what we're proposing, making many significant changes to this language, based on what's been written.

245
00:51:03.450 --> 00:51:11.050
Corey Rhyan (Altarum): And then just some other factors that could be considered for for consideration. When making these outpatient surgery certificate of need determinations.

246
00:51:11.210 --> 00:51:33.940
Corey Rhyan (Altarum): So not as much to talk about here, but would be curious for folks if there are folks in the room that have used these guidelines before, or more more familiar with this language as it was written in the 2012 Plan. If there would be recommendations for changes given that we're not proposing anything so far, could be discussions to be had of whether or not that language is still appropriate, and whether or not is still working in current based on the on the state of knowledge within the State, and and more broadly

247
00:51:34.360 --> 00:51:36.560
Corey Rhyan (Altarum): so I'll pause for questions on outpatient surgery.

248
00:51:47.030 --> 00:51:52.819
CT-N 1B: Corey. This is Dre Gifford. I think one area that Ohs would be interested in hearing from

249
00:51:53.580 --> 00:51:55.350
CT-N 1B: the community is

250
00:51:55.430 --> 00:52:06.940
CT-N 1B: the interplay between the growth in ambulatory, surgery and hospital inpatient need. So I think you mentioned in

251
00:52:07.010 --> 00:52:08.280
CT-N 1B: your

252
00:52:09.527 --> 00:52:11.980
CT-N 1B: bed need methodology.

253
00:52:12.180 --> 00:52:15.060
CT-N 1B: You know that we we we look at

254
00:52:15.646 --> 00:52:31.499
CT-N 1B: existing occupancy, and use that as a a basis for projections. But as we see, an expansion of the types of procedures that are being performed in outpatient settings.

255
00:52:31.730 --> 00:52:36.819
CT-N 1B: Is there anything that oh, Hs should be considering

256
00:52:37.296 --> 00:52:51.489
CT-N 1B: with respect to that, whether it's observation days or something else. With respect to that, as we think about the inpatient bed need methodology, and we don't need to discuss it today. But I will just say that as that's a

257
00:52:51.790 --> 00:52:55.640
CT-N 1B: question that I think we would appreciate getting feedback on.

258
00:53:08.210 --> 00:53:09.730
Corey Rhyan (Altarum): Anything further in the room.

259
00:53:12.460 --> 00:53:13.320
CT-N 1B: Nothing here.

260
00:53:14.280 --> 00:53:15.110
Corey Rhyan (Altarum): Wonderful.

261
00:53:15.930 --> 00:53:36.170
Corey Rhyan (Altarum): I agree with that comment and definitely would take back some of the thinking that we could do around, you know, doing more robust kind of capacity estimates and then projecting some of that need forward. We certainly note a lot of those broader trends. Dr. Gifford, in the, in the discussion of the report and some of the policy trends and some of the trends that we're seeing in the data where we report on the data and use of outpatient surgery facilities.

262
00:53:36.436 --> 00:53:45.929
Corey Rhyan (Altarum): But I think making that more robust in in, in adding additional guidance where that language might make sense for Ohs, or might be helpful, and where that data are available certainly would be something that could be considered to be included.

263
00:53:49.800 --> 00:54:15.600
Corey Rhyan (Altarum): Okay, chapter 5. Here. And this is one of the recommendations. That is a little bit more prescriptive. So it is a little bit more well defined. In the 2012 plan. And and we're we are proposing again a couple of quantifications based on what we've seen in the data. And some of the language around the certificate of need, guidelines and standards. And this is for specifically for imaging around 3 different categories of imaging machines. Ct scans, MRI scans and pet Cp scans.

264
00:54:15.992 --> 00:54:30.389
Corey Rhyan (Altarum): So the first thing that we do in in this section is that we highlight the inventory data that's been collected by Ohs! Of the number of machines that are available most across the State more broadly, and then regionally where those machines are located. Looking at the number of scans that are done per machine

265
00:54:30.470 --> 00:54:48.259
Corey Rhyan (Altarum): where this data has been provided. I think. Oh, we just request this from all owners of these. these machines across the State. I would say the data are about 70% complete depending on the year that we looked at in the inventory data of whether or not a number of scans were reported

266
00:54:48.527 --> 00:55:06.449
Corey Rhyan (Altarum): but what we try and do is that we try and estimate the overall capacity based on the average number of scans that are being provided per machine. Across these different categories of scanners, both across the different typo scanners, ct versus MRI versus Pet. Ct. And then based on the location of those scanners as well. So whether or not those scanners are hospital based.

267
00:55:06.450 --> 00:55:19.009
Corey Rhyan (Altarum): whether or not they're at a satellite hospital location, or whether they're not associated with a hospital, but at a satellite location as well. So what you'll see here is that and this is new to the report this year is that we we generated statistics both on

268
00:55:19.230 --> 00:55:31.829
Corey Rhyan (Altarum): the Median scans per machine that were were reported. The 70 fifth percentile scans per machine that were reported, and then the the largest number of scans per machine that were reported among these different categories of of imaging equipment across the state.

269
00:55:33.340 --> 00:55:54.060

Corey Rhyan (Altarum): So what we do is that we are then looking to try and use this information to get a better understanding of what the actual capacity is for imaging across different areas of the State. What was done in the past is that there were based on kind of per machine counts. There was an estimate of the total capacity for Mris, for Ct's, for pet Ct's

270
00:55:54.060 --> 00:56:05.025
Corey Rhyan (Altarum): across the State and across different regions. But we wanted to try and do our best to update those numbers, as there has been evidence that's been shown that the efficiency of imaging the scans per per day per minute

271
00:56:05.280 --> 00:56:24.159
Corey Rhyan (Altarum): have increased over time. And so the 2012 kind of thresholds that have been set for how many scans an MRI can complete within a day within a year may have increased over time as a result of machines becoming more modern and also just because of practices that have improved the the efficiency with what these machines are able to be used. And so, as a result of that

272
00:56:24.816 --> 00:56:49.989
Corey Rhyan (Altarum): we we took the information that we collected in this report in the review of the inventory data and specifically looked at this, 70 fifth percentile number of scans made per machine across different category and then use that to potentially update or propose an update. And this is something that we would like to talk with experts in the field and and and would welcome your feedback as the healthcare cabinet, and potentially proposing some new thresholds, some new capacity thresholds

273
00:56:50.020 --> 00:57:03.060
Corey Rhyan (Altarum): based on individual scanners across these different categories. And you can see most of these we are. We are proposing a potential increase in the proposed new capacity. For these, for these scanners based on what we're observing in the 70 fifth percentile. And then all based on

274
00:57:03.353 --> 00:57:20.666
Corey Rhyan (Altarum): what we've seen across other certificate of need recommendations that have been made in other States across the country. So this is a very common approach that's used in certificate of need language across other states. And so setting and observing what the kind of proposed capacity thresholds are. The availability of these machines are across the State.

275
00:57:21.280 --> 00:57:33.829

Corey Rhyan (Altarum): yeah, sorry across the country is also useful in considering what we think the capacity is within Connecticut. So I'm just highlighting these here. And and I think this is an open area of discussion. But we at least attempted to make a proposal based on the data that we've collected so far.

276
00:57:34.300 --> 00:57:55.240
Corey Rhyan (Altarum): and then based on what those potential new thresholds would be. We then are now reporting across the different regions, and we do this for each of the different types of imaging machines. The number of scanners that would be available. The total capacity based on that estimated capacity per machine based on where those machines are located and the ownership of those of those machines, and then also again.

277
00:57:55.510 --> 00:58:13.349
Corey Rhyan (Altarum): the estimated Ca, number of of scans that they could do within within a year. And then what the observed utilization is based on the use of those of that equipment right now and then looking at the total population, and then the number of scans that are being provided per that population with within the region, to give not only a comparison

278
00:58:13.350 --> 00:58:25.410
Corey Rhyan (Altarum): of what the capacity is, and what the utilization is, but then also looking at the rate of utilization across different regions. And we do these scans for population, both looking at where the region defined as where the imaging equipment exists.

279
00:58:25.410 --> 00:58:27.990
Corey Rhyan (Altarum): and also where the population is coming from.

280
00:58:27.990 --> 00:58:42.650
Corey Rhyan (Altarum): And so what that does for us is that gives us a sense of where there are more scans being done in different areas across the State, and then, where different populations, depending on where they are coming from across the State are receiving more scans, and we did that because, for example, you'll notice something like the south central region within the State

281
00:58:42.650 --> 00:59:02.200
Corey Rhyan (Altarum): where you have a more populated area. You have more intensive services being provided, and larger facilities are getting more scans per population based on the region of where that scanner is being offered, but may not indicate that that population is getting more scans. It's just that people are more likely to be traveling for intensive services that are requiring greater use of imaging equipment within that region.

282
00:59:02.330 --> 00:59:08.929
Corey Rhyan (Altarum): So we try and show both. We show both a regional definition based on where the scanner is located and also based on where the population is coming from.

283
00:59:09.880 --> 00:59:36.730
Corey Rhyan (Altarum): Here's the subsequent information for Ct. Scans again doing the same thing, looking at the counts of scanners and the estimated capacity and the overall utilization. And this is just an estimate. You'll note, for example, even some of these are estimated at being utilized above their current capacity, and that would be because we're estimating the capacity based on a small set of scanners across the State. And and some of these may be above that 70 fifth percentile level above our proposed threshold. And so there's actually very high rates of utilization. But what that I think would indicate is that

284
00:59:36.730 --> 00:59:46.550
Corey Rhyan (Altarum): in areas that have higher rates of utilization that would potentially pretend that you have a greater need for greater imaging. When a numbers of imaging equipment within within these regions that have high rates of utilization right now

285
00:59:47.300 --> 00:59:51.900
Corey Rhyan (Altarum): and then looking separately at the scans for population within those regions as well.

286
00:59:52.200 --> 01:00:01.139
Corey Rhyan (Altarum): Lastly, here's pet ct, these scans are are, have much lower capacities, and are much fewer across the state. But again showing some more statistics here.

287
01:00:02.730 --> 01:00:16.079
Corey Rhyan (Altarum): We also then include some data. I think I mentioned this on population utilization by different insurance coverage components and across different regions within the State to get a better sense of utilization of these machines, and of of imaging more broadly across different populations.

288
01:00:16.170 --> 01:00:41.890
Corey Rhyan (Altarum): And then, lastly, that leads us to a couple of proposed changes that we're making to the language around certificate and need standards and guidelines. I'm just gonna show the MRI example. Here within the report. There is separate language for Ct scans and for pet Ct's hands as well. But I'm just gonna show you the example for MRI and and these are pretty prescriptive in the language that's been provided

than what Ohs considers when they're considering an application for new imaging equipment across the State.

289
01:00:42.180 --> 01:01:00.769
Corey Rhyan (Altarum): And and one of the changes that we were proposed making here is around this definition of current estimated capacity. I showed that in the table earlier, where we're proposing a potential bump up in the estimated capacity per machines when individuals applicants are, you know, considering whether or not a region or their primary service area has a need for additional capacity.

290
01:01:01.590 --> 01:01:27.409
Corey Rhyan (Altarum): And then what we're also then doing is also considering, then, a potential change around some of the language that's been defined around. Considering whether or not the capacity is needed at the regional level or whether it's needed at the individual hospital level. So I'm gonna skip ahead a little bit here, and then I'll jump back. So what I will note is in the prior facility and Services plan language. You can see here. This is the gray box indicates the prior language that was included.

291
01:01:27.919 --> 01:01:38.449
Corey Rhyan (Altarum): An applicant was able to demonstrate a need for a new imaging equipment for a proposed scanner based on the fact that the primary service area had a utilization rate above 85,

292
01:01:38.840 --> 01:01:55.579
Corey Rhyan (Altarum): or if the applicant had one of its own scanners in the primary service area that was individually being used greater than 85%. So it gave an applicant, and either, or option based on the conversations that we've had in looking at the way that these certificate of need languages are written across other states.

293
01:01:55.580 --> 01:02:09.109
Corey Rhyan (Altarum): This second piece is a little bit more unusual, and I think we are potentially proposing that what we do is that we move this recommendation rather than being from a very prescriptive. You could meet this need by the 85 region, regionally or individually.

294
01:02:09.250 --> 01:02:18.979
Corey Rhyan (Altarum): solely going to looking at the regional need for these, this imaging equipment, but then adding a section in kind of other things that could be considered

295
01:02:19.050 --> 01:02:44.740
Corey Rhyan (Altarum): in which is a later section of the language here around the applicants current percent utilization of any of its own

scanners operating within the primary service area of the proposed scanner. So we're adding a, we're keeping the flexibility and being able to consider the consideration of the percent utilization without specifically including it in the need methodology section of the language. So be a little bit more clear when folks have time to actually kind of sit down with the entire section, but wanted to flag that. That is one of the changes that we're proposing to make.

296
01:02:44.970 --> 01:02:47.449
Corey Rhyan (Altarum): And I'm just going to jump back here. I apologize for flipping

297
01:02:47.797 --> 01:03:05.929
Corey Rhyan (Altarum): just again, noting that, you know, one really key component of this need. Methodology is this percent utilization of current capacity based on the way that it's being calculated. So that's influenced, based on not only looking at the estimated number of scans that each machine can perform. But then the number of observe scans that is occurring within specific regions.

298
01:03:05.930 --> 01:03:32.800
Corey Rhyan (Altarum): and then using this 85% threshold. So kind of like that 80% threshold that we talked about with inpatient beds. Here's an example where there's an 85% threshold. This again, seems relatively consistent with other certificate of need states in the way that their imaging guidelines are written. But this is something that could consider to be updated. If we think that this is still the best appropriate number to look at setting a threshold of when we think a region might need additional imaging capacity across these different these different equipment needs. Hmm.

299
01:03:35.000 --> 01:03:41.199
Corey Rhyan (Altarum): I think I flag that there. So yeah, just highlighting here again, just summarizing for feedback. And I'll give folks a chance to to. To comment

300
01:03:41.647 --> 01:03:58.189
Corey Rhyan (Altarum): one is, is that looking at these revisions of how we're estimating capacity per machine and the data that we provided on the 70 fifth percentiles of utilization in the in the Ohs inventory. I don't believe that that imaging inventory, although somebody at Ohs can correct me

301
01:03:58.190 --> 01:04:12.649
Corey Rhyan (Altarum): was actually available in 2,012. I think that process had just started. So this is new data that are technically available. Now, as we're developing the language here, which is why we

considered, including the data that hadn't been included before into. For in determining that machine capacity.

302
01:04:12.910 --> 01:04:41.140
Corey Rhyan (Altarum): Then also proposing revisions to the based on separating machines based on location and ownership. So in the previous language, it was just an MRI machine could do 4,000 scans per per year I think that's the right one you know. Could do a set number of scans per year, regardless of where that machine was operated, and who the owner of that machine was, we've noticed, is that there's pretty distinct differences in the utilization of machines that occur in hospital settings and hospital owned settings versus satellite settings.

303
01:04:41.470 --> 01:04:48.009
Corey Rhyan (Altarum): And so we're proposing using that additional information to change the estimated capacity per machine based on where that machine is located.

304
01:04:48.414 --> 01:04:50.530
Corey Rhyan (Altarum): And what the ownership of that machine is

305
01:04:50.850 --> 01:04:58.199
Corey Rhyan (Altarum): we're proposing updating to the regional definitions as I've talked about in other sections of this report going to the planning regions as the definition to estimate capacity and need

306
01:04:58.539 --> 01:05:10.740
Corey Rhyan (Altarum): and then this, this other consideration around applicants, current scanner utilization, and where that language is actually included in the section, whether or not it's included in the need, methodology, or whether or not it's included in kind of the other considerations component of the imaging section.

307
01:05:11.360 --> 01:05:26.740
Corey Rhyan (Altarum): So that's kind of the major changes that we've talked about to the imaging section so kind of moderate changes that that we're potentially proposing again open for feedback from the the expert advisory committees and and also from experts on the cabin here, but any any comments questions from from groups or folks in the room.

308
01:05:27.480 --> 01:05:29.275
Corey Rhyan (Altarum): Alan, I see your hand again. Go ahead.

309
01:05:29.500 --> 01:05:30.029
Alan Kaye: Sorry

310
01:05:30.560 --> 01:05:31.109
Corey Rhyan (Altarum): And oh, you good.

311
01:05:31.110 --> 01:05:37.810
Alan Kaye: First part was, actually, I thought of it to let. I'm in the discussion on the cardiac, but it applies actually to this as well.

312
01:05:38.400 --> 01:05:42.519
Alan Kaye: one of the things that you didn't discuss was the effect of

313
01:05:43.512 --> 01:05:47.120
Alan Kaye: of availability of personnel

314
01:05:47.680 --> 01:06:04.010
Alan Kaye: to provide the services. As you probably are aware, there's a major workforce issue in in radiology and in in nursing staff, at hospitals and things like that. So in radiology, technologists

315
01:06:05.490 --> 01:06:22.090
Alan Kaye: real adding additional services to to other, to new places might create a a more difficult situation for the others, for for those existing providers has, that is, that something that we should consider in a Co. In process.

316
01:06:24.860 --> 01:06:26.360
Alan Kaye: Did you consider it.

317
01:06:26.360 --> 01:06:40.089
Corey Rhyan (Altarum): It. It's it's an excellent question. So what I will say is, we do have a workforce section of this report, but it is, as far as I can tell, was never something that was included in the 2012 report in the specific guidelines for these particular facilities. But I think it's something we very much could consider.

318
01:06:40.815 --> 01:06:41.120
Alan Kaye: I.

319
01:06:41.120 --> 01:06:56.268
Corey Rhyan (Altarum): I believe we could get data on that I I wholly. I definitely agree with you that that oftentimes the restrictions, particularly over the past couple of years, given the staffing charges across healthcare more broadly, have been around staffing, not around physical availability of beds or machines.

320
01:06:56.900 --> 01:06:58.290
Alan Kaye: This would be the time to definitely.

321
01:06:58.290 --> 01:06:59.150
Corey Rhyan (Altarum): Include that we just.

322
01:06:59.150 --> 01:06:59.760
Alan Kaye: Don't!

323
01:06:59.760 --> 01:07:12.169
Corey Rhyan (Altarum): Come up with a process, come up with the data to be able to support that, and then work with Ohs! To make sure that, you know, they can replicate that over time as the in their evaluation of potential. You know, additional new capacity. But I agree, very, very important thing to consider.

324
01:07:12.170 --> 01:07:12.960
Alan Kaye: Yeah, just not something.

325
01:07:12.960 --> 01:07:34.697
Corey Rhyan (Altarum): I mean, that was in the prior plan. So we we kind of consider. We we included it where we had information more broadly on workforce constraints, but not specifically to this section. And I would need to do some research of what's availability of you know how we can understand where staffing constraints might be, and and how we can determine where utilization might be affected by staffing versus based on physical availability of machines.

326
01:07:35.340 --> 01:07:39.249
Corey Rhyan (Altarum): that sounds tricky. But I would be excited to think about it. If we can find that data and find that.

327
01:07:39.250 --> 01:07:55.161
Alan Kaye: Yeah. And second second thing, before before I go before you go on. You know this very provocative presentation on the imaging stuff of which I'm very interested no longer have a stake in this anymore just other than doing the right thing. So

328
01:07:56.184 --> 01:08:08.460
Alan Kaye: so I'd like to. I had been thinking about how we might change the the utilization capacity data the guidelines for that. I'm I'd

329
01:08:08.580 --> 01:08:15.569

Alan Kaye: can't really make a comment on on yours without good doing a deeper dive in it. But clearly machines are more efficient.

330
01:08:15.710 --> 01:08:38.339
Alan Kaye: but also reimbursement parameters. Cpt codes have changed. So you might get 3 exams where you got one in the same amount of time, and those sorts of considerations, things we considered when we did the original guidelines. I think we were the first ones in the country to come up with a state mandated utilization factor. It was largely based on information from

331
01:08:38.500 --> 01:08:40.380
Alan Kaye: the scanner industry.

332
01:08:40.450 --> 01:08:45.239
Alan Kaye: and that might have been a little bit liberal, but clearly time to redo that.

333
01:08:45.310 --> 01:08:48.449
Alan Kaye: and I also would say that it does matter who owns it

334
01:08:48.550 --> 01:08:52.939
Alan Kaye: in a major way. I'm not talking about just hospital versus

335
01:08:53.646 --> 01:09:04.570
Alan Kaye: entrepreneur versus official versus private equity versus physician owned the utilization rates change and are controlled.

336
01:09:04.740 --> 01:09:22.519
Alan Kaye: and sometimes by the ownership structure of the of the entity. So I think that's something that if we're really gonna make a meaningful change here, or meaningful contribution we should look into mostly on the basis of whether the person who owns the scanner is also in a position to refer to that scanner

337
01:09:23.117 --> 01:09:30.979
Alan Kaye: and to then impute 85%. It. It's a self fulfilling prophecy. If that's what's required. That's what it will take.

338
01:09:31.029 --> 01:09:37.209
Alan Kaye: So I really look forward to this process. Thank you. A a deeper dive. I'm looking forward to

339
01:09:38.439 --> 01:09:39.340

Alan Kaye: thank you.

340
01:09:41.750 --> 01:09:43.100
Corey Rhyan (Altarum): Danielle, is your hand up.

341
01:09:43.590 --> 01:09:48.220
CT-N 1B: It. Just I just wanna say it's it's 3 21

342
01:09:48.685 --> 01:10:11.130
CT-N 1B: we are scheduled to go until 3 30. I think Corey is near the end of his presentation, but I want members of the public to know we we at Ohs will stay on to hear your comments. Members of the Cabinet may need to leave at 3, 30, and we certainly understand if you do need to sign off or leave the room.

343
01:10:11.210 --> 01:10:27.479
CT-N 1B: But we wanna make sure that the public has an opportunity to comment. So when Corey is done with his presentation, we'll open it up for public comments, and we'll stay past the 3 30 time the Ohs staff will to to get your comments. Thanks, Corey.

344
01:10:32.600 --> 01:10:33.540
Corey Rhyan (Altarum): Danielle. Go ahead.

345
01:10:34.800 --> 01:10:53.479
Danielle Morgan: Thanks. So the science is part of me, too, thinking a little bit about both your cardiac talk, and that the imaging talk and a little bit about what Alan was saying. This may be meaningless, but but the contribution of the prior authorization process as well, and how that may have shifted or put off.

346
01:10:53.897 --> 01:11:18.120
Danielle Morgan: The use or the access to what has been needed, as determined by the medical provider. But not having been accessed by the patient. So another significant barrier that may contribute to a large volume of missing this data. In again both the cardiac and the the imaging data set. So

347
01:11:18.280 --> 01:11:26.390
Danielle Morgan: I don't know how much of that is even meaningful to this compilation of data, but it is intriguing in the back of my head that

348
01:11:26.980 --> 01:11:31.180
Danielle Morgan: that that section of folks may not be represented here.

349
01:11:33.020 --> 01:11:45.835
Corey Rhyan (Altarum): Thank you. Good comment. I believe. In our broader trend section we have a discussion of prior authorization. In the in Chapter 2 of the report. But nothing specifically that I've mentioned in either the cardiac or the or the imaging sections.

350
01:11:46.120 --> 01:12:07.340
Corey Rhyan (Altarum): would be open to considering if that might make sense, or at least I think it's at least an important piece of information to understand as the trends in the industry have changed around the use of prior authorization and how that potentially impacts the utilization data that we're observing to my point all the way back around in Chapter one around issues of, you know, barriers to care and how that might potentially impact to the observed utilization that we see in the data that have been provided.

351
01:12:07.340 --> 01:12:14.299
Danielle Morgan: Yeah, I think it. It provides a barrier to just about every aspect of care that we see. In all the service lines.

352
01:12:18.190 --> 01:12:29.200
Corey Rhyan (Altarum): Reminds me, I will go back to our chapter 2 discussion and make sure that's robustly addressed in in what we've included, and then would welcome your feedback on on that kind of broader policy. Shift in the way we describe it in Chapter 2, as well.

353
01:12:36.430 --> 01:12:38.139
CT-N 1B: No other hands up here, Corey.

354
01:12:38.520 --> 01:13:05.790
Corey Rhyan (Altarum): Great Dr. Gifford, you were correct. I believe I have one slide left. And that is just next steps. And I think you actually did a good job already describing. What some of our next steps were. I'll just detail a couple as us coming from the contractor side. We're working with Ohs! Based on the draft that we've submitted so far to get their feedback and then welcome the plan that Dr. Gifford laid out to get broader community feedback, both in the upcoming meeting. And also in some of these direct advisory committee meetings as well.

355
01:13:06.233 --> 01:13:21.080
Corey Rhyan (Altarum): to the section specific sections of the report and then working on finalization of the draft. And then the last thing I wanna note we are working with, though. Hs as well. To define what we're calling an addendum to this resilient services plan. So we're very focused right now on the Facility and Services Plan, as written in the chapters that I detailed.

356
01:13:21.374 --> 01:13:40.170
Corey Rhyan (Altarum): But there's been a desire from Ohs and the Department of Public health in Connecticut as well. To work to better incorporate considerations of social, economic, and public health needs and public health factors in the way that they contribute to overall healthcare needs in particular, the way they can. They impact vulnerable populations and particular populations of need across the State of Connecticut.

357
01:13:40.402 --> 01:14:03.209
Corey Rhyan (Altarum): So there's a whole. Another line of work that's gonna happen beyond the facility and Services plan. That's gonna be included into an addendum of this report that does a much better job in trying to detail how those other factors might contribute to overall healthcare need and other considerations that should be made, and considering unmet need for care, due to barriers, to access due to social determinants of health and other social and economic needs across the State as well. So keep an eye out for that. That's likely later into 2024, and

358
01:14:03.210 --> 01:14:13.359
Corey Rhyan (Altarum): and maybe even into early 2025, as as that document will be worked on. But our priority right now is certainly based on the guidelines and need for this final draft. Is based on the language and the sections that we've laid out so far.

359
01:14:13.690 --> 01:14:26.570
Corey Rhyan (Altarum): And, Dr. Gifford, I think that that's all I have. Would encourage folks based on today's conversation to reach out to Ohs, and and I'm sure we will be scheduling lots of meetings with experts that are in the room here around these specific sections. So thanks for all your feedback today.

360
01:14:27.540 --> 01:14:34.680
CT-N 1B: Corey. Thank you. Could you? Could I ask you to just go back to? I think it was Slide 3. But it was the slide that listed the

361
01:14:36.470 --> 01:14:41.699
CT-N 1B: advisory committees that we are contemplating. I just wanted to get feedback.

362
01:14:41.870 --> 01:14:44.310
CT-N 1B: See if there's any feedback from the cabinet.

363
01:14:45.020 --> 01:14:53.299

CT-N 1B: So now you've heard a flyover of the report. These are. This is a list of the

364
01:14:53.620 --> 01:14:58.750
CT-N 1B: content-specific advisory bodies that we are contemplating. They in some ways

365
01:14:58.850 --> 01:15:05.250
CT-N 1B: mirror a set of committees that have been convened in the past by Ohs! But they're reflective of

366
01:15:05.260 --> 01:15:13.040
CT-N 1B: the volume of CON. Applications that we see the the places where we are providing guidance in the facilities and services, plan and

367
01:15:13.736 --> 01:15:31.960
CT-N 1B: and, as I said, past practice, so we were contemplating behavioral health, acute care which would include the bed need methodology for inpatient hospitals, cardiac imaging physician practice, and reproductive health. Labor and delivery!

368
01:15:32.080 --> 01:15:36.729
CT-N 1B: Are there any other areas where you think. Oh, hs, I'm speaking to the

369
01:15:36.950 --> 01:15:40.189
CT-N 1B: to the Cabinet members now, are there any other areas

370
01:15:40.310 --> 01:15:43.279
CT-N 1B: that you think? Hs should consider

371
01:15:43.600 --> 01:15:47.330
CT-N 1B: a content-specific advisory body?

372
01:15:47.410 --> 01:15:49.520
CT-N 1B: Or does this? Is this a good list?

373
01:15:54.750 --> 01:16:10.049
CT-N 1B: Audio? Yep, Commissioner Gifford, one thought. And this may be a component of all those advisory boards, but trying to look intentionally at equity. So some of our partners on a cross-cutting theme about how equity impacts access and affordability and overall system planning.

374

01:16:10.960 --> 01:16:14.250
CT-N 1B: Thank you. So that's a excellent suggestion.

375
01:16:16.020 --> 01:16:17.180
CT-N 1B: Anybody else?

376
01:16:18.630 --> 01:16:19.490
CT-N 1B: Okay.

377
01:16:20.130 --> 01:16:21.403
CT-N 1B: thanks everyone.

378
01:16:22.230 --> 01:16:47.700
CT-N 1B: Corey, thank you so much. And thanks to you and your colleagues at Altarim for this work, it's obviously a very large undertaking. We are fortunate to have the partnership of Altarim this time around, thanks to the Legislature and the Governor and Opm, who appropriated the funding for us to engage a partner in this work.

379
01:16:47.850 --> 01:16:56.079
CT-N 1B: It's a very important, as I said, foundational document for Ohs in the State. So thanks, Corey, for all your work

380
01:16:56.810 --> 01:17:20.880
CT-N 1B: all right. With that we will go to public comments. If you could raise your virtual hand, Abby will call on you and unmute you, and if you could, please, identify yourself, and then keep your comments as close to 3 min as possible. We would appreciate it, thanks to all of you for your patience in waiting to make your comments until the presentation was concluded.

381
01:17:21.240 --> 01:17:24.179
CT-N 1B: Are there any members of the public that would like to comment?

382
01:17:38.640 --> 01:17:41.600
CT-N 1B: I have my timer set at 3 min. So we

383
01:17:45.220 --> 01:17:46.100
CT-N 1B: nobody.

384
01:17:46.510 --> 01:17:47.350
CT-N 1B: Okay.

385

01:17:47.830 --> 01:17:50.319
CT-N 1B: all right. Well, then, our timing was perfect.

386
01:17:50.845 --> 01:18:11.099
CT-N 1B: Thank you again to those of you in the Cabinet who came today. We sincerely mean it when we say we would really like your input on this plan. It's a little hefty. So I when it's released, you know, if you can. Give it at least

387
01:18:12.170 --> 01:18:15.120
CT-N 1B: glance, and tell us whether you think we have all the

388
01:18:15.160 --> 01:18:32.779
CT-N 1B: appropriate chapters. We welcome the participation of healthcare Cabinet members on our advisory committees that are going to be convening after the report is released. So if you have an interest in one of those, please let us know. Otherwise we will be back together again. Probably in July

389
01:18:34.120 --> 01:18:35.370
CT-N 1B: July 20. Third.

390
01:18:35.840 --> 01:18:37.610
CT-N 1B: Do I have a motion to adjourn.

391
01:18:39.010 --> 01:18:40.609
CT-N 1B: Moved by Dr. Yoder.

392
01:18:41.700 --> 01:18:43.290
CT-N 1B: seconded by.

393
01:18:43.290 --> 01:18:44.120
Alan Kaye: Clicking.

394
01:18:45.830 --> 01:18:47.217
CT-N 1B: And Dr. K.

395
01:18:48.000 --> 01:18:51.500
CT-N 1B: All right. Anybody opposed to adjournment.

396
01:18:52.590 --> 01:18:54.690
CT-N 1B: Great! Thank you very much. Everyone.