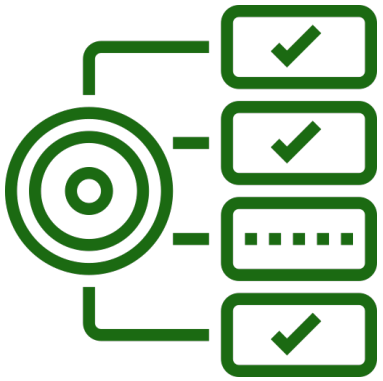
PCI Rulemaking
External Group Collaboration

Participants To-Date:

- Alex Burton, Virginia Mason Franciscan Health
- Jody Corona, Health Facilities Planning
- Lisa Crockett, Providence
- Erin Kobberstad, MultiCare
- Frank Fox, Health Trends
- Jon Fox, Health Trends
- Matt Moe, Providence
- Hunter Plumer, Health Trends

Please note that this remains an open offer for anyone who would like to partner between the Department's PCI Workgroup meetings to discuss key topics and offer questions and/or recommendations. We are glad to invite others into these optional touch-base meetings.

Overview of Topics



- ✓ **Data Sources.** Review questions and topics for discussion about COAP as a primary data source
- ✓ **Need Methodology.** Review questions and scenarios for the PCI need methodology, including exploring the pros & cons of need model options

COAP: Key Issues & Discussion Points

COAP – Key Issues & Discussion Points

Participation in COAP

- What steps need to be taken to make participation in COAP mandatory?
- Does COAP need to take any actions with its leadership and/or members?
- Similarly, is it necessary to codify in WAC (or elsewhere) that hospital facilities must participate in COAP reporting?

Costs to Access COAP Data

- What are the additional costs or resources required for either data access or participation in COAP for both facilities and other parties (i.e consultants/analysts)?
- Are there any additional licensing fees?
- If the frequency of COAP data availability was increased (e.g. monthly or quarterly, as opposed to annually for CN), what would be the associated costs and/or resource implications?

COAP – Key Issues & Discussion Points

COAP Data for Full Spectrum of CN Needs

- Can COAP data be used for full CN requirements and usage, including enforcement requirements?
- When the Department approves a new elective PCI program, will it start adding a CN condition requiring ongoing participation in COAP reporting?
- If COAP data is chosen as the primary data source for the DOH need methodology, will COAP be able to share summary procedure count data to other entities in addition to the CN program?
  - To be able to validate the DOH need methodology, CN stakeholders would need access to PCI procedure volume data, including facility name, date (e.g. year at a minimum but may also include month or quarter), patient age group (e.g. 15-64 years old, 65+), and patient zip code.
  - The CN stakeholder community would need access to all PCI procedure volume counts; PCIs could not be 'suppressed' (i.e. If a particular zip-code/facility/age/date combination had a PCI procedure count between 1-10, then the actual number will need to be shown to allow aggregation).

COAP – Key Issues & Discussion Points

COAP vs CHARS Volume Analysis

- When comparing CHARS/survey and COAP volumes, there are differences in the volume counts between these models.
- Before endorsing a shift to COAP data, some members of the CN Community would be served by comparing CHARS/Survey to COAP to understand the implications of shifting to a single data source.

PCI Data Sources – A Comparison of COAP vs CHARS/Survey

2023-2024 Percutaneous Coronary Intervention Numeric Need Methodology											
	Using CHARS and CN Survey Data					Using COAP Data					Difference: (COAP - CHARS/Survey)
Planning Area	Total PSA PCIs	2022 Use Rate	2027 Projected Net Need	Projected Need/200	# of New Programs	Total PSA PCIs	2022 Use Rate	2027 Projected Net Need	Projected Need/200	# of New Programs	Total PSA PCIs
PSA 1	1420	2.12	28	0.14	0	898	1.36	-633	-3.16	0	-522
PSA 2	580	1.94	95	0.48	0	624	2.09	77	0.38	0	44
PSA 3	441	3.26	-75	-0.37	0	336	2.48	-29	-0.15	0	-105
PSA 4	532	2.17	159	0.79	0	565	2.30	177	0.89	0	33
PSA 5	957	1.77	9	0.04	0	813	1.52	-8	-0.04	0	-144
PSA 6	1366	2.98	342	1.71	1	1431	3.12	234	1.17	1	65
PSA 7	796	2.35	485	2.43	2	802	2.37	455	2.27	2	6
PSA 8	904	2.20	-553	-2.76	0	761	1.86	-543	-2.72	0	-143
PSA 9	1685	1.60	-35	-0.18	0	1617	1.54	83	0.42	0	-68
PSA 10	1148	1.27	-771	-3.85	0	1170	1.30	-975	-4.87	0	22
PSA 11	1515	2.19	408	2.04	2	1656	2.40	420	2.10	2	12
PSA 12	589	2.95	431	2.15	2	598	2.99	344	1.72	1	9
PSA 13	1279	3.87	207	1.04	1	963	2.92	175	0.88	0	-316
PSA 14	793	4.07	-253	-1.26	0	560	2.87	-122	-6.12	0	-233

Need Methodology: Key Issues & Discussion Points

Need Methodology – Key Issues & Discussion Points

Use Rates

- What are the implications of using a statewide use rate rather than a planning area use rate?
- Similarly, should the model include age group use rates to create more precision for populations with higher use rates?
- How might a model factor in differential use rates by race/ethnicity (this is leaning towards a qualitative argument)?
- Will statewide use rates solve for the issue of in- and outmigration between planning areas?

Concurrent Review Cycle

- Should we consider eliminating the elective PCI concurrent application cycle and allow applicants to apply at any time?

Need Methodology – Key Issues & Discussion Points

Alternative Methodology

- Are there alternative methodologies we need to consider? (e.g. counting programs as part of the supply factor).
- Are there sound alternative qualitative methods?

State Health Plan

- Due diligence is required around ensuring that no PCI remnants remain in the SHP.
- All SHP must be migrated to the WAC.

Methodology Next Steps

- Continue to evaluate current state vs. alternate numeric need methodologies. Also explore any other methodology options that others are considering, including the pros and cons of each alternative
  - Proposed Alternative #1: Effectively Elective Only
  - Proposed Alternative #2: Acute Care Style
  - Proposed Alternative #3: Constrained Supply Style
  - Proposed Alternative #4: Benchmark Supply Model
  - Proposed Alternative #5: Statewide Use Rate

- Evaluate non-numeric need alternatives (e.g. qualitative approach) and complete additional work to understand the metrics and data that could be utilized to make this type of case for a CN