CERTIFICATE OF NEED

HOSPITAL BEDS PUBLIC HEARING
February 3, 2004

Lake Ontario Room – Michigan Library & Historical Center
702 W. Kalamazoo Street
Lansing, Michigan

ORAL TESTIMONY

(Proceedings scheduled to start at 10:00 a.m.; actual start time was 10:21 a.m.)

MS. ROGERS: Good morning. My name is Brenda Rogers; I am Special Assistant to the Certificate of Need Commission from the Department of Community Health. Chairperson, Renee Turner-Bailey, has asked the Department to conduct today's hearing.

We are here today to take testimony concerning proposed revisions to the review standards for hospital beds. The proposed Certificate of Need Review Standards for Hospital Beds are being reviewed to update the subarea and bed need methodologies and add the Medicaid participation requirements and rural county definition update, pursuant to PA 619 of 2002. Please be sure that you have signed the sign-in log. Packets and cards can be found on the table. A card is to be completed if you wish to provide testimony. Please hand your card to me if you wish to speak. Additionally, if you have written testimony, please provide a copy as well.

As indicated on the Notice of Public Hearing, written testimony may be provided to the Department through February 10th, 2004, at 5:00 p.m. We will begin the hearing by taking testimony from those of you who wish to speak. The hearing will continue until all testimony has been given, at which time we will adjourn. Today is Tuesday, February 3rd, 2004, and we are now taking testimony. Jim Budzinski, Sparrow Hospital. And I also ask, as you come up to speak, would you please print your name on the sheet at the podium? Thank you.

MR. BUDZINSKI: Good morning. Jim Budzinski from Sparrow Hospital. I am going to be very brief today. We have previously mailed in comments to the chairperson of the CON Commission on these proposed standards. I will provide Brenda a copy of that letter that was sent in on January 23rd.

Our comments remain consistent with those comments provided to the CON Commission at its last meeting. We continue to believe that the subarea redefinition is essentially getting the cart before the horse. We continue to believe that HSA should be reevaluated to reflect current state of affairs with respect to the delivery of care in the state. We would propose, for example, that the emergency preparedness regions be used as a starting point for an updated HSA model and, from that point in time, subareas could then further be reviewed but, at this point in time, no such review of HSA's has been performed. And we would recommend that that occur before any subarea activity for reconfiguration occurs.

On a side note, we do also provide comments on the rural county definition; that is, the changes to reflect metropolitan and micropolitan concepts. We have previously commented in a letter to the chairperson of the Commission, as well, regarding another hearing, that we believe that the continued use of metropolitan and micropolitan frameworks and definitions is inconsistent with the federal government's desire regarding the use of those definitions for such things as hospital planning. In fact, we issued a separate comment paper on that, and suggested that the rural

county definition just simply needs to be a population-based methodology. As it currently stands, the proposal for micropolitan and metropolitan uses would have some rural counties, substantially less in population, being defined as a metropolitan area and some counties with substantially more population being designated as rural. It really is inconsistent. With that, I submit a copy of our letter we previously sent in, and would be glad to take any questions.

MS. ROGERS: Thank you. James Falahee, Bronson Health Care.

MR. FALAHEE. Thank you. James Falahee, otherwise known as Chip Falahee, here to speak on behalf of the proposed standards. I'm wearing two hats today. First is either a current or former member of the hospital bed ad hoc, I'm not sure which. But, in any event, as a member of that ad hoc, first, I was not a member of what was -- it's been called the TAC, the Technical Advisory Committee, that spent many, many hours on the subarea designations, and some of those people are in this room. I was a member of the ad hoc, itself. We heard the reports from the TAC members.

I would say, as someone who up 'til then wasn't familiar with subareas too much, I was impressed with the quantity and quality of the work that was done by the TAC. There is no question in my mind that the work was done thoroughly, and without any favoritism being played, and I think the members of that TAC did an exceptional job. For that reason I supported, when I voted on the ad hoc, for the TAC report to go through, and I still strongly support the work that the members of the TAC did, and the recommendations that they came out with.

I would also like to now switch hats to wear my Bronson hat as well. Bronson, as a hospital in Kalamazoo, strongly supports these standards, especially, and specifically to Bronson, the standards that impact the subarea that is Kalamazoo. There is a proposed subarea for Kalamazoo, proposed subarea 3A. We strongly support the hospitals that are proposed to be included in that hospital subarea 3A. The reason, those hospitals all serve the same common market, and when you boil it all down, that's the goal of what the subareas are supposed to be about. When you serve a common market, you're in the same subarea.

There have been questions raised about whether a hospital in Sturgis, Michigan, which is right on the border, should or should not be included in that proposed subarea. Bronson strongly supports the inclusion of Sturgis in that proposed subarea 3A.

I also have in front of me a letter that was sent to Commissioner Bailey -- to Chairman Bailey, from the CEO of Sturgis Hospital, dated January 7. I will not read the entire letter. I'm sure it's in the file. But let me point out -- here's the CEO of Sturgis. Who better knows what the Sturgis patients want and the area wants? And here are some comments from his letter, quote: "I believe both the qualitative and quantitative data support the fact that St. Joe County and Kalamazoo County function as one market for health care services. For the first six months of 2003, 1,801 patients that live in Sturgis zip codes were admitted to either Sturgis, Three Rivers Hospital, Borgess Medical Center or Bronson Methodist Hospital. These patients accounted for 86 percent of all the residents from Sturgis that were admitted to hospitals in the first six months of 2003. In that same period of time, only 9 percent of Sturgis residents sought care in Indiana." He goes on to say: "In addition to this discharge data, it is clear that Sturgis physicians routinely refer their patients to hospitals in Kalamazoo, when those patients require care that cannot be obtained at Sturgis. These referral patterns to Kalamazoo have been in place for many years and are very strong." And, lastly, Mr. LaBarge concludes by saying: "Based on the market share data, physician referral patterns and the general pattern of care for Sturgis residents, it is clear that Sturgis Hospital was correctly included in the proposed hospital subarea 3A. Sturgis

Hospital does not need, nor does it desire, to be in its own subarea." In addition to the facts of the referral patterns, I would also like to speak to patient care for a moment. Bronson Methodist Hospital and our friendly competitor in town, Borgess, were both on divert in 2003. I'm not sure of the percentage for Borgess, but in Bronson's case, we were on divert -- meaning we could not take ambulance traffic -- approximately 20 percent of the time, because we did not have capacity for those patients that wanted to come through our doors. If Sturgis were added to Hospital 3A, the proposed 3A, under the current CON standards, there's the possibility that beds could be relocated from Sturgis Hospital to Bronson to alleviate the diversion and therefore provide better care. To argue that Sturgis should not be included not only flies in the face of the facts, but flies in the face of what's best for the patients. It's best for them to receive their care locally, to not be diverted to other institutions from as far away as Grand Rapids, for example.

So, based on the facts, based on the patient care, and based on my involvement as a member of the ad hoc, I strongly support the recommendations before the CON Commission. Thank you.

MS. ROGERS: Thank you. Bob Meeker, Spectrum Health.

MR. MEEKER: My name's Bob Meeker from Spectrum Health and I too am wearing two hats. Not being a member of the ad hoc, I was a member of the TAC, and so on behalf of the TAC, I'd like to thank Mr. Falahee for his comments. I think they carry more weight from someone like him, who was not directly involved in the process, than it would from me, although I, too, think that the TAC went out of its way to be as objective and as scientific as possible in completing its task. Its task had two purposes, both of which are reflected in the proposed changes to the bed need standards. One, as we've heard about and we probably will hear more about, is the whole aspect of reconfiguring the subareas for hospital planning. Certainly any reconfiguration or any configuration of subareas, even if you used counties as an example, would be arbitrary, because county boundaries are no more firm than any other boundaries. However, I think that we applied the methodology, which was developed at the University of Michigan, as unbiasedly as we could, and then did apply, as the methodology requires, professional judgment representing points of view from across the state in taking care of situations which didn't seem quite to fit what we knew about patient origin in this state. So I think that the hospital subareas are probably more reflective now of patient care patterns now than the subareas that were developed 25 years ago, because those patterns have changed. And I think that they -- the subarea definitions need to be endorsed as submitted.

I would like to say, though, as a member of the TAC, that most of our time was spent on refining the bed need methodology, which I really think was the most important and the most significant improvement that we have put forth. By the silence afforded the bed need methodology, I'm assuming that everybody thinks that those improvements are a good idea, and regardless of what happens with the subareas, I would strongly support -- we, at Spectrum Health, would strongly support that the changes to the bed need methodology be also included in the CON Review Standards and finally adopted. I think that refinements like abandoning the normative approach, which 25 years ago was necessary to reduce unnecessary capacity in the state, and using actual use rates is a significant improvement. Separating pediatrics and obstetrics from the bed need calculation before recombining them is also an improvement, using a sliding scale for medical surgical target occupancy, and finally exclusion in rural areas of critical access hospitals from the bed inventory for the purposes of counting bed availability. I think all of these changes are significant improvements, and I think that they bear being adopted by the CON Commission. Spectrum Health will prepare formal written comments and send them on to the Department.

MS. ROGERS: Thank you. Patrick O'Donovan, Beaumont.

MR. O'DONOVAN: My name is Patrick O'Donovan, Director of Planning for Beaumont Hospitals. I participated on both the ad hoc committee and the Technical Advisory Committee that developed the proposed hospital standards that are before the CON Commission and were approved for the purposes of public comment back on December the 9th. Beaumont supports these standards, and we urge the Commission to take final action approving these standards.

Beaumont supports these proposed standards, because they were developed using a comprehensive planning methodology. It was applied to determine hospital bed need throughout the state. We hope that any future proposals to authorize new beds or new hospitals remain under the scrutiny of the CON process and are evaluated using rational planning criteria.

An alleged shortcoming of the bed need methodology is that it doesn't account for population shifts within geographic areas served by groups of hospitals known as hospital subareas. However, rather than relying on anecdotal evidence pertaining to bed need and bed distribution, this issue should be evaluated using valid quantitative planning methodologies. For example, a drive time analysis would be one approach for looking at hospital access in various areas of the state where population shifts may be occurring, such as in Oakland County, Macomb County, Livingston County, or other areas of the state. It is important to recognize that the bed need methodology in the proposed standards does take into account overall population growth within geographic areas served by hospital subareas.

As the Commission discussed at the December 9 meeting, there are additional hospital bed standard issues that may warrant further review by the Commission, including high occupancy hospitals, hospital bed relocation zones and criteria for the establishment of new hospitals. I believe that the Commission passed a motion to draft a charge relating to these issues for discussion at the March 9th CON Commission meeting.

Beaumont would urge the Commission to move forward with developing such a charge that could then be looked at by a standards advisory committee or in some other forum as deemed appropriate by the Commission. These issues should be taken up after passage of the proposed hospital bed standards before the Commission, which we urge the Commission to take final action on at the March 9 meeting. Thank you for the opportunity to provide comment.

MS. ROGERS: Thank you. Liz Palazzolo, Henry Ford Health System.

MS. PALAZZOLO: Good morning. My name is Liz Palazzolo. I'm with Henry Ford. And, as I've listened to all the testimony this morning, I find that there are pieces in all of it that I agree with, the normative approach, the separating out the various populations, using the actual use rates. I think those are all very good approaches, and I think that those are all improvements over the former proposal. However, there are a couple of areas where we do have some concerns and, specifically, as we testified in December of last year, we don't think that the methodology that was used by the Technical Advisory Committee adequately addresses the population changes that have taken place since 1979, when this methodology was created.

Furthermore, it does rely on an element of professional judgment that has the potential to introduce bias to the process, despite one's best efforts to remain objective. And this is certainly not meant as a personal criticism of any of the members of the team that worked to craft this, because we recognize that it was a very diverse group that worked very hard and worked for a long time and diligently to come up with their final product. But, really, this is a flaw

in the methodology, itself. A further problem is that it does not account for shifts in population. As populations move, consumers must travel from growth areas to access care at existing hospital locations, since they have no other alternatives. Therefore, the methodology credits these existing locations with discharges that are driven to their site, not because of consumer choice, but because of the lack of alternatives. When the Technical Advisory worked on their assignment, they did research processes that were used in other states to determine the need for beds, and the majority of those states used some other type of boundary to come up with planning areas. And we believe that county boundaries or other population-based approaches would be a much simpler and more realistic methodology. For example, an approach that allows for subareas to be created in urban counties that would serve increments of 500,000 persons represents what we think is a reasonable approach. And this could also incorporate distance to access care. All of those things need to be factored in. We certainly are grateful to the Department and to the Certificate of Need Commission for allowing us the opportunity to comment on these standards, but we would urge that the Commission ask either the existing group, the advisory group, to really look at some alternatives to this methodology.

MS. ROGERS: Thank you. Do we have any further testimony regarding the hospital bed standards? Hearing none, this hearing is adjourned at 10:42. Thank you.

(Proceedings concluded at approximately 10:42 a.m.)