1.+Name: Robert Meeker
2.+Organization: Spectrum Health
3.+Phone: (616) 391-2779
4.+Email: robert.meeker@spectrum-health.org
5.+2008: CC
7.+Testimony: Spectrum Health supports the work of the recent Cardiac Catheterization Standards Advisory Committee and believes that no additional revisions are warranted at this time to the CON Review Standards for Cardiac Catheterization Services. We recommend that the currently proposed changes to these Standards be adopted and that the Standards not be reopened for another three (3) years

1.+Name: Fred Morady, MD
2.+Organization: University of Michigan
3.+Phone: 734-763-7392
4.+Email:
5.+2008: CC
7.+Testimony: October 12, 2007

Recently, I have been informed that the State of Michigan has a regulation prohibiting catheter-based radiofrequency ablations from being performed in hospitals that do not have on-site cardiac surgery programs. The rationale behind this rule is not clear, nor is it evidence based. Ablation is simple arrhythmias such as AV node reentry, AV reentry, right-sided atrial flutters, atrial tachycardia and ablation of the AV node have well established safety records. The risk of cardiac perforation is exceedingly low. in addition, if a perforation were to occur, this is almost always successfully treated with percutaneous pericardiocentiesis (a procedure performed by cardiologists).

Neither the Heart Rhythm Society, nor the American College of Cardiology have policies in place prohibiting qualified electrophysiologists from perfroming these procedures at facilities without on-site cardiac surgery. Given this, I reccomend reconsideration of this policy.

Sincerely,

Fred Morady, MD
Professor of Internal Medicine

1.+Name: Dan Witt
2.+Organization: Metro Health
3.+Phone: 616-252-5208
4.+Email: daniel.witt@metrogr.org
5.+2008: CC
7.+Testimony: October 31, 2007

Certificate of Need Commission:

Metro Health Hospital recently was preparing an application for Certificate of Need for a second cardiovascular laboratory when a question came forward.

The area in question is related to terminology and descriptions for diagnostic and therapeutic electrophysiology. Historically diagnostic electrophysiology has been referred to as mapping of the electrical pathways of the heart, no intervention occurs. Therapeutic electrophysiology involves a therapeutic event such as an implant of a pacemaker, implant of a cardiac defibrillator, implant of a biventricular pacemaker/defibrillator and radiofrequency ablation.

According to the State of Michigan, on a recent phone call, Metro Health would be well within the standards to perform all of the above diagnostic and therapeutic procedures listed except for radiofrequency ablations. It was conveyed to us the State had solicited a letter from the American College of Cardiology asking for an opinion on this matter. Their opinion was that ablations should be excluded from being performed at hospitals that do not have open-heart surgery capability. Metro Health would fall into this category.

With that said, we are respectfully requesting that this statement be reconsidered in light of the fact we donÆt agree in total with the statement. Rather, we would prefer to see amended language that allows for non-complex ablations to be performed at hospitals without open heart surgery. Cases we would agree are complex would include atrial fibrillation ablation, and procedures requiring transeptal approach. Our logic in requesting this change is based on scientific evidence and the fact that both the American College of Cardiology and Heart Rhythm Society do not have policies prohibiting these procedures in non open heart programs.

Your support in amending this issue would be greatly appreciated.

John Key DO. FACC
Medical Director
Cardiovascular Services

Dan Witt
Director
Cardiovascular Services

1.+Name: Dan Witt
2.+Organization: Metro Health
3.+Phone: 616-252-5208
4.+Email: daniel.witt@metrogr.org
5.+2008: CC
7.+Testimony: October 31, 2007

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Your support in amending this issue would be greatly appreciated.

John Key DO. FACC
Medical Director
Cardiovascular Services

Dan Witt
Director
Cardiovascular Services

1.+Name: Barbara Allen
2.+Organization: Northern Michigan Regional Hospital
3.+Phone: 231-487-7285
4.+Email: ballen@northernhealth.org
5.+2008: HB
7.+Testimony: The Northern Michigan LTACH Coalition is a group of hospitals in Northern Michigan dedicated to the development of a Freestanding LTACH to serve the patients in our communities. We want to work jointly to provide access to our patients at a location that can efficiently be used by all of our members.

We are adding our comments to the Standards Review of Hospital Beds as they relate to LTACHs. We recommend that the current CON Standards be modified to allow for Freestanding Long Term Acute Care Hospitals that would operate as separate and distinct facilities outside the physical plant of an existing hospital.

Under the current CON Reviews Standards, the language basically limits LTACH operation to that within the boundaries of a licensed hospital facility. The only possibility for a freestanding LTACH would be to acquire an entire acute care hospital license and convert the facility to an LTACH.

The probability of obtaining an existing hospital license is very slim. Further, if in fact, a license were available costs would most likely preclude the ability to make a project feasible economically.

Whereas, initiation of a new freestanding facility where our coalition would be willing to give up existing hospital beds to support the project, our various communities could benefit from access to the much needed service at a reasonable cost.

Thank you for your consideration of these comments as they relate to the Standards of Hospital Beds.

1.+Name: Monica Harrison
2.+Organization: Oakwood Healthcare, Inc.
3.+Phone: 313-586-5478
4.+Email: monica.harrison@oakwood.org
5.+2008: HB
7.+Testimony: Public Testimony Regarding Hospital Bed Standards
Presented at MDCH Public Hearing û October 31, 2007
By: Oakwood Healthcare, Inc.

Oakwood Healthcare, Inc., located in Dearborn, Michigan, operates four licensed hospitals with 1,307 inpatient hospital beds in west and southwest Wayne County and offers an array of hospital outpatient, diagnostic, physician, and other medical services, including inpatient psychiatric services.

Oakwood remains concerned as to current CON policies for replacement of existing licensed hospital beds to new physical plant and the scope of the current hospital replacement zone. Many valid concerns about this issue were raised but not resolved during the Hospital Bed SAC and Work Groups that were convened in 2006 and early 2007. We do not believe that the current Standards are consistent with the CON statutory goals of addressing cost, quality and access specifically as it relates to aging physical plant/hospital buildings. In the long term, maintenance of old buildings will be more costly to the health care system and make it more difficult for older hospital facilities to continue to deliver quality health care. The CON regulatory process should not include disincentives to quality improvements to the healthcare system in Michigan. The continued aging of hospitals in this State will challenge such hospitals to cope with projected health professional staffing sh
ortages in upcoming years as many existing facilities are outmoded, inefficient, and in many instances, may require more staff than a new hospital facility with a modern efficient design and labor saving technologies.

Currently, of the four hospitals operated by Oakwood, three hospitals are located in buildings that are 45 years in age or older. Although Oakwood continues to maintain and improve these facilities, we anticipate that at some point in the reasonably near future, it may be more cost-effective for Oakwood to simply replace one or more of its existing hospitals to new physical plant. With respect to OakwoodÆs service area, there are potential barriers to situating new hospital facilities within the current two-mile replacement zone.

The Commission, the Department, providers, payors and the citizens of the State of Michigan would be well served by further consideration of these issues.

Thank you for the opportunity to provide these comments.

1.+Name: Robert Meeker
2.+Organization: Spectrum Health
3.+Phone: (616) 391-2779
4.+Email: robert.meeker@spectrum-health.org
5.+2008: HB
7.+Testimony: Spectrum Health believes that the existing CON Review Standards for Hospital Bed Standards, as they currently exist, are reasonable and have served the state well. From our perspective, there are no major changes which need to be made.

1.+Name: Patrick O'Donovan
2.+Organization: William Beaumont Hospital
3.+Phone: 248-551-6406
4.+Email: podonovan@beaumonthospitals.com
5.+2008: HB
7.+Testimony: November 6, 2007

Norma Hagenow, Chair
Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Ms. Hagenow,

This letter is written as formal testimony about the C.O.N. Review Standards for Hospital Beds, MRT Services, PET Services, Surgical Services, Cardiac Catheterization Services, and Open Heart Surgery Services that are scheduled for review in 2008. Beaumont appreciates the opportunity to comment on these Standards. In addition to comments on C.O.N. review standards referenced above, Beaumont will also provide comment on NICU C.O.N. review standards, as well as criteria for comparative review versus institution specific standards.

Hospital Beds Services:
A new SAC for Hospital Beds is not warranted given the recent revisions that have been made. However, the comparative review criteria should reviewed by the Commission because 45% of the possible points in a comparative review are determined by payor mix. This does not reflect an appropriate balance of healthcare costs, quality and access which are the goals of the C.O.N. program.

MRT Services:
Beaumont supports the continued regulation of MRT services and does not have any recommended changes for 2008.

PET Services:
Beaumont supports the continued regulation of PET services. We also believe that the PET standards should specifically address Positron Emission Mammography (PEM). PEM is an organ specific, high resolution PET scanner that involves the injection a radioactive isotope.

Surgical Services:
Beaumont supports the continued regulation of surgical services. In addition, we believe that the methodology for documenting projections needs to be revised. Specifically, Section 11 does not provide a methodology for deducting previously committed surgical cases or hours from a hospitalÆs current volumes even though the required Surgical Commitment Form (CON-704A) indicates that the physician commitments are tied for 3 years. Lastly, we feel that a new provision should be added for freestanding outpatient surgical facilities (FSOF) that allows a FSOF with one operating room to be exempt from volume requirements, if that FSOF is contiguous to a freestanding emergency department that accepts ambulances. The rationale is that the FSOF is used to provide emergency back up and is a licensing requirement for a freestanding emergency department that accepts ambulances.

Cardiac Catheterization Services:
Beaumont supports the continued regulation of cardiac catheterization services and supports the recent recommendations of the SAC. As such, Beaumont does not have any recommended changes for 2008.

Open Heart Services:
Beaumont supports the continued regulation of open heart services. We would further like to commend the SAC for its recent work in revising the Standards, specifically its recommendation to maintain the current standard minimum of 300 adult open heart procedures. We further support the efforts of the MDCH staff and the Commission in revising the methodology used to project need. As a result of these recent proposed revisions, Beaumont does not feel it is necessary for the Commission to review the Standards in 2008. Beaumont also urges the Commission to continue pressing the Department to routinely and consistently enforce C.O.N regulation; including volume requirements.

NICU Services:
While NICU is not on the rotating schedule for review in 2008, Beaumont Hospitals would nonetheless like to suggest two changes to the NICU Standards. First, Beaumont would like to recommend that NICUÆs that achieve a sustained level of high occupancy be allowed to increase the number of NICU beds, regardless of area bed need, provided they remain in compliance with the Hospital Bed Standards. Research suggests that a NICU should operate at a 75-80% occupancy rate and should not exceed 85% in order to remain open to emergencies and transport . This allows a hospital with an NICU to care for its captive patient population, without the need to transfer babies to other hospitals; as such transfers raise patient safety and cost concerns including separation of the baby and its mother. This proposed provision is consistent

with the high occupancy provision currently contained in the Hospital Bed C.O.N. Standards. Second, hospitals that reach a specified number of births (perh
aps 2,000-2,500), should be permitted to establish NICU services regardless of area bed need, for the reasons previously specified.

Criteria for Comparative Review vs Institution Specific Review:
Currently there are no criteria or guidelines adopted by the Commission as to whether C.O.N. Review Standards for specified C.O.N. covered services should be reviewed on a comparative or institution specific basis. The trend has clearly been towards institution specific, and Beaumont supports this shift. However, current C.O.N. Review Standards are inconsistent. For example, Bone Marrow Transplant is comparative, Pancreas Transplant is institution specific, and Kidney Transplant is not covered under C.O.N. This may be an appropriate issue for the New Technology Committee to study and make recommendations.

Thank you for the opportunity to provide comment on the C.O.N. Review Standards.

Sincerely,

Patrick OÆDonovan
Director, Planning

PC: L. Horvath

1.+Name: Nelson L. Adamson
2.+Organization: Dickinson County Healtcare System
3.+Phone: nladamson@msn.com
4.+Email: 906-776-5975
5.+2008: MRT
7.+Testimony: October 31, 2007

To Whom It May Concern:

I am writing to provide public comment on the Certificate of Need Review Standards for Megavoltage Radiation Therapy Services. It is my understanding that these standards are now in a public comment period prior to their 3 year review cycle. I am the physician overseeing the radiation oncology service that is a joint venture between Dickinson County and Marquette General Health Systems. This service has been in operation for nearly seven years. Prior to this partnership, patients traveled long distances to obtain the type of care now provided locally. Currently, I am the only radiation oncologist on the medical staff. We offer a range of radiation therapy services at our hospital, including the highly technical intensity modulated radiation therapy as well as providing patients access to clinical research trials that may lead to advances in treatment.

My comments pertain to Section 15(B)(iv) on page 11 of the CON standards. It reads as follows: ôAll MRT treatments shall be performed under the supervision of a radiation oncologist and at least one radiation oncologist will be on site at the geographic location of the unit during operation of the unit(s)ö.

I would like to propose that the wording of this particular passage be changed to the following: ôAll MRT treatments shall be performed under the supervision of a radiation oncologist. At least one physician will be on site at the geographic location of the unit during the operation of the unit(s).ö I believe this minor change in the wording would benefit patients and practioners while maintaining sufficiently high level of care.

The first reason I think this change would be beneficial has to do with staffing. This minor change in the wording of the document would simplify the staffing for solo practice rural facilities like mine and would not do any harm to patient care. Radiation therapy is universally administered on a M-F schedule unless there is an emergency requiring Saturday or Sunday treatments. Daily treatments are administered by radiation therapy technologists supervised by a radiation oncologist. While it is desirable that a radiation oncologist be present at all times during treatment administration, it is not necessary for the daily execution of treatment.

Flexible coverage requirements that can be fulfilled by any physician would allow radiation oncologists in solo practice settings to pursue state, federal, and specialty board mandated requirements for recertification and continuing medical education. Many of these educational offerings take place during the weekdays. For a solo practice, this would involve hiring a locum radiation oncologist for one or two days at great expense, not to mention the occasional inability to find a suitable replacement.

Similarly, there are many occasions when I would like to attend events in the community that could potentially enhance my practice such as a hospital fundraiser, like a golf outing or comparable event. Other unexpected events may include school activites for children or illness that affects the radiation oncologist. The rules as currently stated would mandate that I find a replacement or come to work ôillöor miss that childÆs event.

A second reason for flexible scheduling would allow small rural based practices to accommodate patients that travel great distances for treatment. It is not uncommon for patients to travel 40-50 miles each way for daily radiation sessions. If that same individual has a full time job, which is not unusual, then arriving at the clinic early or late would make it easier. Having a radiation oncologist present for a somewhat irregular time slot is not necessary.

A third reason for allowing slight modification of the CON document has to do with patient followup. It is somewhat related to the second reason. After completing radiation therapy, it is desirable that patients are followed for a period of time by the treating physician. This allows for adequate documentation and treatment of any unexpected outcomes. In a rural practice such as ours, it would make sense for some patients to be seen closer to home, perhaps at a clinic in their community. This would be of great benefit for frail elderly patients or any others who may have limited means of travel. The current CON regulations would require us to not provide radiation therapy treatment while I was away from the hospital to make these visits.

Finally, if one looks at the wording of Section 15(B)(,v) on page 11, the last sentence reads: ôA physician shall be on-site in or immediately available to the MRT unit at all times when patients are treatedö. This wording seems inconsistent with the previous section (iv) which requires the presence of a radiation oncologist.

Hopefully, you would consider this small change in the CON standards for megavoltage radiation therapy services. I do not believe this would compromise patient care or safety in any way. This would allow small rural solo practices to

maintain adequate staffing while promoting a robust Continuing Medical Education program. Flexible scheduling of patient treatments would allow many individuals to attend daily radiation treatments with less fear of job loss or disruption. We could also create a more convenient followup clinic for individuals who have to travel great distances.

I realize that this change in the CON standards could potentially lead to abuse. A reasonable approach to insure that the radiation oncologist of record is available for patients under his/her care should include some wording that stipulates a minimum requirement. Being present for 80 percent of the treatment sessions is seems reasonable. This would mean being in the clinic 4 out of 5 days. Such language is not currently a part of the document, but could easily be added.

I thank you for considering the above comments. If there are any questions, I can be reached at 906-776-5975.

Nelson L. Adamson MD

1.+Name: Kenneth Chu
2.+Organization: Marquette General Hospital
3.+Phone: 906-225-4495
4.+Email: kchu@mgh.org
5.+2008: MRT
7.+Testimony: In CON-211 Section 15(1) (iv) on page 11 of 16 (approved 12/13/05 and Effective 1/30/06)
"All MRT treatments shall be performed under the supervision of a radiation oncologist and
at least one radiation oncologist shall be on-site in or immediately available to the MRT unit at all times when patients are being treated".

I am a Medical Physicist, and I would ask the CON committee re-exam the choice of words in this clause. The current wording is not necessarily in the best interest of patient care. I understand that the clause is there to prevent abuse by certain radiation oncologist practices where there may be one radiation oncologist servicing several clinics, and not being available to all the patients most of the time.

However, in my opinion, I would like to see an addition clause:
ôIn cases where there is only a solo radiation oncologist (in Rural or Micropolitan statistical areas) who does not service any other clinics, a radiation oncologist shall be on-site 90% of the hours when patients are being treated. At least one physician shall be on-site in or immediately available to the MRT unit at all times when patients are being treated.ö

I ask that such an exception be added so that patient treatments are not stopped when a radiation oncologist is ill and locum coverage is not immediately available, or if the radiation oncologist is delayed by bad weather. In Marquette county...15.4 feet annual snow fall according to the State of MI data ( http://www.co.marquette.mi.us/information/2004%20Directory/part%202.pdf )). In summary, in a solo practice, the current clause does not allow for the radiation oncologist to be ill, late, visit other hospitals for inpatient consults or attend meetings except outside of treatment hours.

Please consider my request for this change as I believe it is best for the patient's care and convenience.

Thank you

Kenneth Chu, Ph.D., A.B.R., P.Eng.
Chief Medical Physicist
Marquette General Hospital
580 W. College Avenue
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906-225-3102
906-225-4495 direct
906-250-0445 cell
kchu@mgh.org

1.+Name: Robert Meeker
2.+Organization: Spectrum Health
3.+Phone: (616) 391-2779
4.+Email: robert.meeker@spectrum-health.org
5.+2008: MRT
7.+Testimony: This is formal testimony about the CON Review Standards for Megavoltage Radiation Therapy (MRT) Services, which went into effect on June 4, 2004. In general, Spectrum Health supports maintaining the Standards in their current form, with only minor modifications, as follows:

Definitions

Replace an existing MRT unit --The current standards include a definition of ôReplace/Upgrade,ö of existing MRT units which is ambiguous. Following the recommendations of the CT SAC regarding the definition of replacement of a CT scanner, Spectrum Health recommends that the definition of replacement for MRT units be revised as follows:

"Replace an existing MRT unit means an equipment change of an existing MRT unit, {necessitating a change in the radiation safety certificate,} which results in the applicant operating the same number of non-special and the same number and type of special MRT units before and after the equipment change.

Expansion with a Special-Purpose MRT Unit

The existing requirements for adding a special purpose MRT unit to an existing MRT service specify that the special purpose unit must be placed at the same location as the existing MRT units. With the physicial expansion of large medical centers, this requirement may be too restrictive, taken at face value. For example, on a large multi-building hospital campus, the MRT service may be located in an outpatient facility, while the surgical department, where intraoperative MRT would be located, may be located in an adjacent hospital building. In order to allow hospitals maximum flexibility, while permitting use of patient-friendly outpatient centers, Spectrum Health recommends that the location requirement for adding a special-purpose MRT be broadened slightly to parallel the CMS definition of "campus,ö currently defined as within 250 yards of the main hospital building(s). Suggested language is as follows:

Sec. 5. (2) (a) àöthe applicantÆs non-special MRT units at the same location, {or in an adjacent location qualifying as part of the main campus under CMS rules,} where the special purpose unit is to be located."

Equivalent Treatment Weights

With the advent of new procedure technology, the list of treatments and the corresponding procedure weights is constantly in need of updating. Spectrum Health recommends the addition of ôImage-Guided Radiation Therapyö (IGRT), with an equivalent treatment weight of 2.5, which is the same as IMRT.

Modification of Appendices û Section 3

Section 3 allows the Commission to modify the Duplication Rates and Factors, in Appendix A, and the Distribution of MRT Courses of Treatment, in Appendix B, without going through the formal process of revising the Standards. Spectrum Health recommends that the language in Section 3 be strengthened so that, rather than modification of these factors being permitted, such modifications should be required to be performed automatically when more current data becomes available. For example, after completion of the latest yearÆs hospital annual survey, a statewide calculation of the distribution of courses of treatments (Appendix B) should be routinely performed by MDCH and presented to the Commission for inclusion in the Standards. Likewise, when the statewide cancer registry has been completed for a new year, the duplication rates and factors should be similarly recalculated and submitted to the Commission. Furthermore, the year for which new cancer case data can be used in a

CON application should be the same year for which the duplication factors and rates are available. Consistent use of data from the same year will assure 1) that the most current data available is used to determine need for MRT, and 2) that such determination of need is not artificially inflated by using different components of the need formula based on data from different years. Requiring MDCH to perform these calculations routinely in the course of their regular responsibilities will allow regular updating of the mathematical components of the Standards without separate requests from the Commission.

Spectrum Health appreciates the opportunity to comment on the CON Review Standards for Radiation Therapy Services, and we urge that the CON Commission implement these recommendations as soon as possible. We will be pleased to participate in this process as appropriate.

1.+Name: Melissa Cupp
2.+Organization: Wiener Associates
3.+Phone: 517-374-2703
4.+Email: melissacupp@wienerassociates.com
5.+2008: OHS
7.+Testimony: My comments pertain specifically to the CON Standards for Open Heart Surgery Services with Proposed Amendments (S-3). On page 8 of this version, the Department has added language to allow them to update the utilization weights on an annual basis, without having to go through the CON Commission for permission to do so. Although I do not take issue with the premise, I would like to suggest the following modifications to the language in an attempt to clarify the Department's intent:

(3) The major ICD-9-CM groupings and Open Heart utilization weights in Appendix A are based on the work of the Bureau of Health Policy, Planning and Access, Michigan Department of Community Health, utilizing the 2005 Michigan Inpatient Data Base.
(A) The Department shall UPDATE the open heart utilization weights on an annual basis, ACCORDING TO THE METHODOLOGY DESCRIBED IN (1) ABOVE, utilizing the most current MIDB data available to the Department.
(B) UPDATES TO THE UTILIZATION WEIGHTS made pursuant to this subsection shall not require standard advisory committee action, a public hearing, or submittal of the standard to the Legislature or Governor in order to become effective.
(C) The Department shall notify the Commission when THE UPDATES ARE made and the effective date of the UPDATED UTILIZATION WEIGHTS.
(D) The UPDATED open heart utilization weights established pursuant to this subsection shall supercede the weights shown in Appendix A and shall be included as an amended Appendix to these standards.

I believe this language will allow the Department to update the utilization weights, but makes it clear that those updates will be executed pursuant to the approved methodology.

1.+Name: Marsha Manning
2.+Organization: EAM/General Motors
3.+Phone: (313)665-1816
4.+Email: marsha.manning@gm.com
5.+2008: OHS
7.+Testimony: CON Commission Public Hearing on CON Work Plan for 2008 û October 31, 2007
Testimony presented on behalf of The Economic Alliance for Michigan
By Marsha Manning, Manager, Southeast Michigan Health Care Initiatives
General Motors Corp.

These comments represent the consensus perspective of business and labor members of the Economic Alliance for Michigan (EAM). These comments regarding the 2008 Michigan CON Work Plan are intended to assist the Michigan Department of Community Health and the Commission in determining priorities for 2008.
I preface my EAM remarks by reporting that General Motors and our colleagues at Chrysler and Ford have found that strong CON programs in the U.S. have been effective in controlling costs and improving the quality of healthcare services for our employees and retirees if they are strong and well developed, both in concept and implementation. We have found that the Michigan CON Standards are among the most effective CON programs in accomplishing this objective in the approximately ten states in which our companies have significant membership.

EAM agrees that the Commission should comply with the CON statutory requirement that each CON Standard be reviewed every 3-years for possible revision. This should mean that Standards are not considered for possible review until 3-years AFTER the last time they were reviewed UNLESS there is some compelling reason, such as new developments in medical practice or other factors affecting the service. Except for the overall process considerations we suggest below, EAM is not aware of any substantive service-specific reason for any standards to be updated outside of the statutory requirements. Some of the Standards posted for this hearing includes several of the standards that have undergone reviews in 2006 (Hospital Beds) and in 2007 (Cardiac Cath, Open Heart Surgery). To undertake another review so soon after the last review and prior to the effective date of the implementation of the Cardiac Standards, would seem to be unnecessary, and require inappropriate use of MDCH staff resources, the CommissionÆs time and the time and energy of SAC members. Accordingly, we would recommend that the next possible review of the hospital bed Standards, last modified in 2006, be rescheduled for possible review in 2009. The next review of the two cardiac standards should be rescheduled for possible review in 2010.

The following process changes should be approved by the commission for all CON standards:
1. All CON Standards that rely upon data should automatically use the most currently available data from either the MIDB or the MDCH Annual Surveys. The update of data should not require a request of the Commission or the approval of a SAC. Annually updating the data and its impact upon the Standards should be done no later than 60 to 90-days following receipt of the data.
2. Every CON Standard that requires a projection of minimum volumes to justify a new program should be based on actual, historical referral data and NOT based upon the unverifiable projections of future referrals.
3. Organizations/providers seeking to start a new CON-approved program should not use any data to support their application that would result in a current CON-approved program falling below the CON minimum volume for that service

The above three process changes should be approved by the Commission in all of the CON Standards. Specifically, using the most current data, basing projection of need for new programs on actual historical data and not allowing data to be committed to a new program to that would push an existing program below CON minimums, should all be approved by the Commission as a uniform process change. The review of individual CON Standards by a SAC to implement these standard administrative changes should not be required. In EAMÆs opinion, the above proposed process improvements will significantly improve the administration of the Michigan CON program.

In addition to my comments regarding the 2008 CON Work Plan, we would like to express our support to the comments made on behalf of EAM presented by Mr. Wayne Cass, from the International Union of Operating Engineers. Local 547, regarding the CommissionÆs proposed actions approved at its September meeting. In particular, the members of EAM support the proposed changes in the CON Standards for Cardiac Catheterization and Open Heart Surgery, including the modification to the formula for predicting the need for any additional open heart surgery programs.

Thank you for your attention to these matters.

1.+Name: Robert Meeker
2.+Organization: Spectrum Health
3.+Phone: (616) 391-2779
4.+Email: robert.meeker@spectrum-health.org
5.+2008: OHS
7.+Testimony: Spectrum Health endorses the work of the recently completed Open-Heart Surgery Standards Advisory Committee and recommends final adoption of the proposed CON Review Standards for Open-Heart Surgery Services, with the inclusion of the S-3 need methodology. We do not believe that any additional modifications are required to these Standards at this time, and we recommend that they not be reopened for substantial revision for three (3) years.

1.+Name: Sean Gehle
2.+Organization: The Michigan Health Ministries of Ascension Health
3.+Phone: 517-482-1422
4.+Email: sean.gehle@stjohn.org
5.+2008: PET
7.+Testimony: The Michigan Health Ministries of Ascension Health submit the following comments pursuant to the Public Hearing held on October 31st regarding changes to be made to CON Standards for Hospital Beds, MRT Services/Units, PET Scanner Services, Surgical Services, Cardiac Catheterization Services and Open Heart Services scheduled for review in 2008. We look forward to participating in a deliberative and open discussion on any potential changes proposed to these standards consistent with statutory language requiring the Commission to review and if necessary revise each set of Certificate of Need Review Standards at least every three years. We wholeheartedly support the review of CON standards on the required three year schedule;not as some have suggested three years from the last time the standard was modified.

Thank you for the opportunity to comment.

1.+Name: Meg Tipton
2.+Organization: Spectrum Health Hospitals
3.+Phone: 616-391-2043
4.+Email: meg.tipton@spectrum-health.org
5.+2008: PET
7.+Testimony: November 7, 2007

Norma Hagenow, Chair
Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Ms. Hagenow,

This letter is written to offer the formal comments of Spectrum Health on suggested changes to the CON Review Standards for Positron Emission Tomography (PET) Scanner Services. We believe that the CON Review Standards should address the following distinct areas for PET Scanner Services.

Definitions:
ò ôPET scanner servicesö: It is the position of Spectrum Health that the CON Commission considers the addition of PET MR as a modality that should be included in the PET scanner services definition, similar to the treatment of PET/CT. According to sources researched, PET/MR imaging is an emerging technology in the field of molecular imaging. Currently, the technology is still in the early stages of testing but it holds promise for improving patient care and workflow and could potentially be a diagnostic tool to help physicians determine in greater detail the loss of neurological function in patients with stroke or AlzheimerÆs disease. With the possibility of PET/MR technology being developed before the next review of the PET scanner standards, we respectfully request the addition of this modality to the PET scanner definitions in the current review of the PET scanner standards.

Commitment of data:
Spectrum Health suggests that the current CON limit on the commitment of data should be for the lifetime of the PET scanner service instead of five (5) years from the start of operations of a service as stated in the current PET scanner CON standards. By limiting the commitment of data to the lifetime of a service, as is the requirement for MRT CON standards, the possibility of double-counting cancer cases is eliminated. Similarly, in an effort to eliminate or reduce the possibility of artificially inflating the need for open heart programs, the open heart SAC has recommended a lifetime limit on the use of commitment data for hospitals who commit their open heart data. We recommend that this same concept be adopted for the PET scanner service CON standards to eliminate the possibility of artificially inflating the need for additional PET scanner services in an area where the need has been adequately met.

Spectrum Health appreciates the opportunity to present our potential issues with the current CON Review Standards for Positron Emission Tomography (PET) Scanner Services and look forward to the opportunity to provide a fair and objective remedy.

Sincerely,

Meg Tipton
Strategic Regulatory Associate
Spectrum Health Hospitals

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7.+Testimony: November 1, 2007

Norma Hagenow, Chair
Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Ms. Hagenow,

This letter is written as formal testimony for the CON Review Standards for Surgical Services. It is the position of Spectrum Health that the Surgical Services Standards should not be opened for review at this time. We believe that the CON Review Standards for Surgical Services have served Michigan based hospitals and healthcare organizations very well. These standards have assured the availability of sufficient surgical facilities to meet the needs of Michigan citizens, while enabling MichiganÆs health care organizations to provide quality surgical care to their patients and therefore we do not suggest revisions or review of the current CON Review Standards for Surgical Services.

Spectrum Health appreciates the opportunity to present our comment on the current Standards for Surgical Services.

Sincerely,

Meg Tipton
Strategic Regulatory Associate
Spectrum Health Hospitals