MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
OPEN HEART SURGERY
STANDARD ADVISORY COMMITTEE (OHSSAC) MEETING

August 7, 2012

Capitol View Building
201 Townsend Street
MDCH Conference Center
Lansing, Michigan 48913

APPROVED MINUTES

I. Call to Order

Chairperson Sell called the meeting to order @ 9:36 a.m.

A. Members Present:
Kourash Baghelai, M.D. Lakeland Healthcare
Craig Banasiak, Chrysler Group
Kevin Birchmeier, Covenant Healthcare
Alonso Collar, M.D. Sparrow Hospital
Alphonse Delucia III, M.D. Bronson Methodist Hospital
Duane DiFranco, M.D. BCBSM
John Fox, M.D. Priority Health
Ali Kafi, M.D. The Detroit Medical Center
Jan Penney, MidMichigan Medical Center
Gaetano Paone, M.D. Henry Ford HS
Richard Prager, M.D. University of Michigan
Dagmar Raica, **Vice-Chairperson**, Marquette General HS arrived @ 9:46 a.m. left @ 12:29 p.m.
Timothy Sell, M.D. **Chairperson**, Oakwood Healthcare
Francis Shannon, M.D. Beaumont Health System arrived @ 9:51 a.m.

B. Members Absent:

Charlie Heckman, AFSCME Local 999

C. Michigan Department of Community Health Staff present:

Tulika Bhattacharya
Sallie Flanders
Natalie Kellogg
Andrea Moore
Tania Rodriguez

Brenda Rogers

II. Review of Agenda

Motion by Dr. Fox, seconded by Dr. DiFranco, to modify the agenda to add Dr. Fox's presentation to the agenda after Economic Alliance for Michigan (EAM) presents. Motion Carried.

Motion by Dr. Paone, seconded by Dr. Kafi, to accept the modified agenda. Motion Carried.

III. Declaration of Conflicts of Interests

None.

IV. Review of Minutes from July 12, 2012

Motion by Dr. Paone, seconded by Ms. Penney, to accept the minutes as presented. Motion carried.

V. Review and Discussion of Project Delivery Requirements

Dr. Collar gave a verbal synopsis of the modifications to the project delivery requirements.

Discussion followed.

Motion by Dr. Collar, seconded by Dr. Paone, to reduce the number of surgeries performed by a cardiac surgeon from 75 to 50 within the project delivery requirements section.

Public Comment:

Al Burnaby, Crittenton Hospital
Dennis McCafferty, EAM

Motion Carried in a vote of 12- Yes, 1- No, 0- Abstained.

VI. Review and Discussion of Potential Initiation Volumes Requirements

Break @ 10:45 a.m. - 11:08 a.m.

Dr. Shannon gave a presentation on volume requirements to initiate an Open Heart Surgery program (see attachment A).
Discussion followed.

Chairperson Sell asked Dr. Shannon to provide data that shows how other states model OHS programs.

VII. Economic Alliance of Michigan (EAM)

Mr. McCafferty gave a presentation on volume as a determiner of need (see Attachment B).

Discussion followed.

VIII. Presentation by Dr. Fox and Dr. DiFranco

Dr. Fox gave a presentation on "Right-sizing the number of OHS programs" the OHS programs within the State of Michigan (see Attachments C and D).

Discussion followed.

IX. Charge II Sub-Committee

A. Dr. Paone stated that the topics for Charge II Subcommittee and quality measures approach had been discussed and to save time advised Chairperson Sell that the SAC could discuss the topics at the next SAC meeting.

X. Public Comment

Paul Kovack, Metro Health

XI. Next Steps and Future Agenda Items

Chairperson Sell asked for volunteers to review the OHS codes. Dr. Prager will work with the Coordinating Center of the Quality Collaborative to compare the current codes used against what is used in the national database.

XII. Future Meeting Dates

A. September 6, 2012
B. October 2, 2012

XIII. Adjournment

Motion by Dr. Prager, seconded by Dr. Shannon, to adjourn the meeting at 1:04 p.m. Motion Carried.

OHS Case Volume Predictive Formula Review

Frank Shannon, M.D.
Craig Banasiak, R.N.
Dagmar Raica, DNP, RN

Initiation Volume Requirements
Open Heart Surgery Programs (OHS)

- CON prediction formula based on weighted coefficients that translate Principal Diagnosis codes into potential OHS cases
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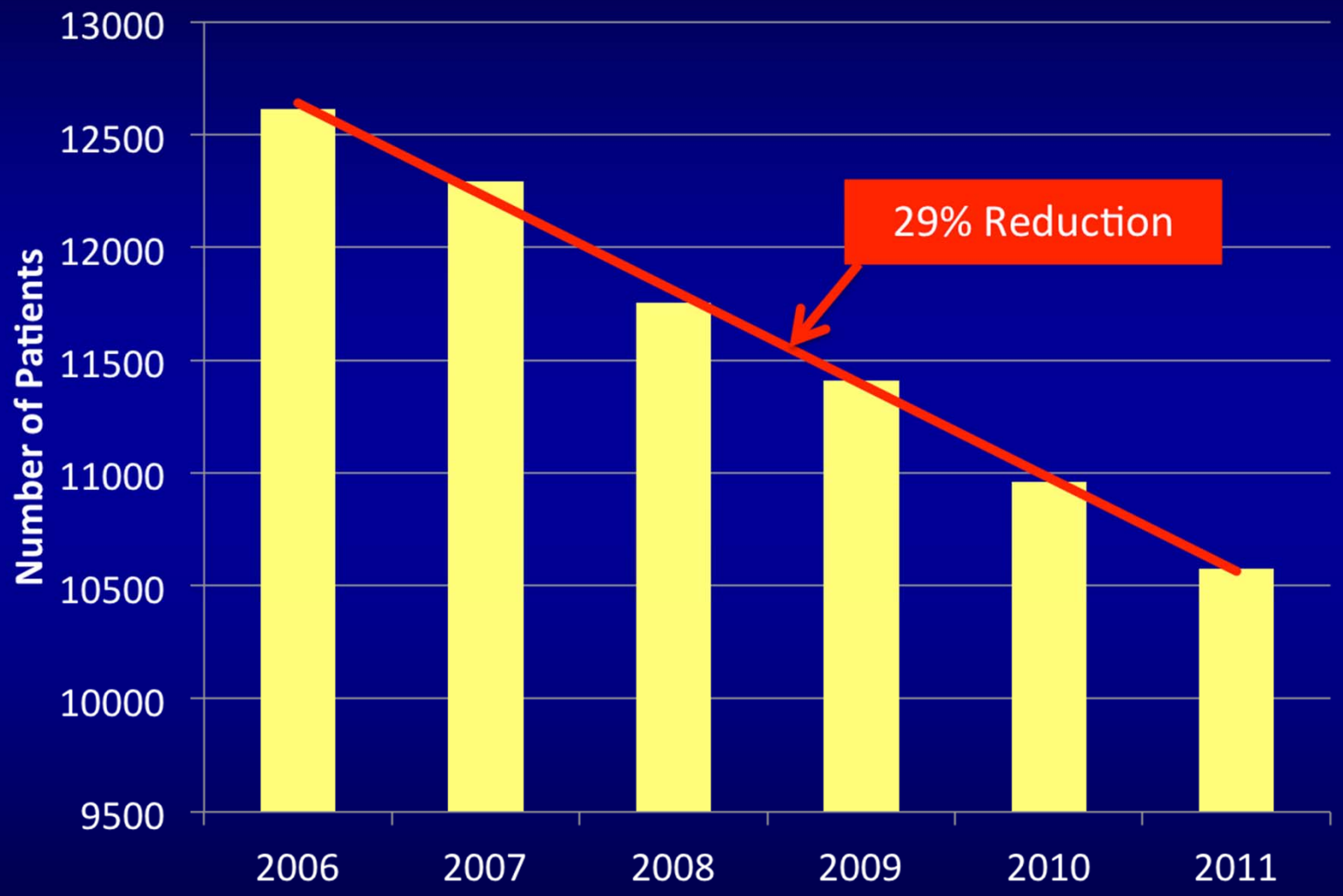
Nash Formula Revision

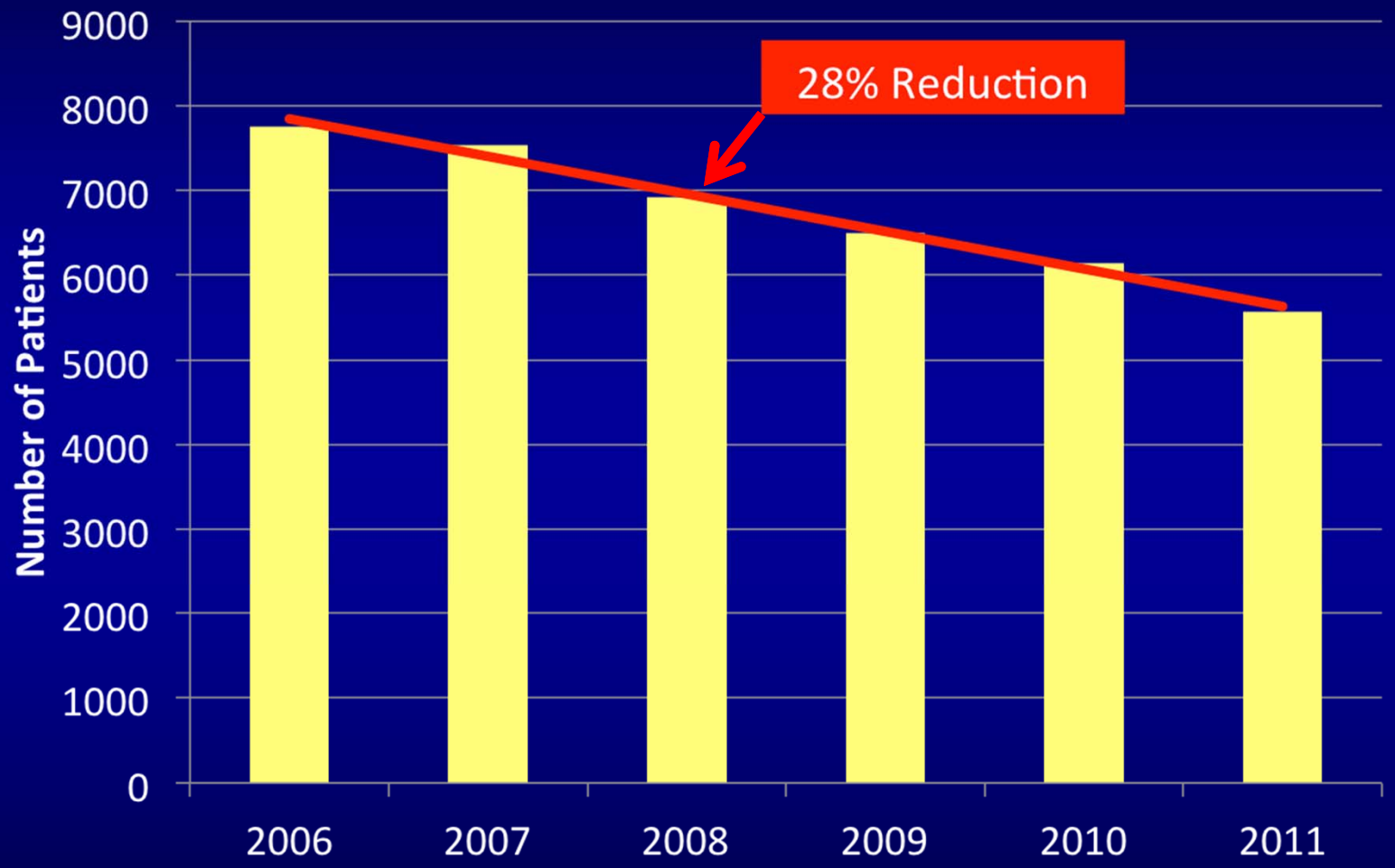
- SAC 2007 revised historical formula to include changes in:
  - Weighting of primary *and* secondary diagnosis codes
  - OHS program volume
- Formula tested *only* on the Primary and Secondary Diagnosis code profile of *existing* OHS programs
- Revision accepted and adopted 2/25/08

Total OHS Case Volume Trend*



*STS Cardiac Surgery Database

Isolated CAB Volume Trend*



*STS Cardiac Surgery Database

Nash Proportion adjustment
Revision Enacted 2/25/08
Metro Health Application
Number of Patients
13000
12500
12000
11500
11000
10500
10000
9500
2006
2007
2008
2009
2010
2011

SAC Statutory Task

- Review the predictive value of formula with existing OHS discharge profiles
- Review the results of formula use in OHS program applications
  - Metro Health application denied after new formula adoption in 2008

Cardiac Surgery Environment 2012

- Only 11/33 OHS programs performed > 200 cardiac surgery procedures in 2011
- Reduction in state population in 2010 census (0.9%) with redistribution in top 5 counties
  - 9.7% increase in US population
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Recommendations of Procedure Volume Study Group

- Maintain same volume requirement for new programs (300)
- Test revised 2007 formula against random sample of existing OHS programs
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DIST BY D. McCAFFERTY
8-7-12
ATTACHMENT B

Certificate of Need Standard For Open Heart Surgery
Dennis McCafferty of the Economic Alliance for Michigan
August 7, 2012

1. Open Heart Surgery is but one of the 16 different medical services that the Michigan Certificate of Need program regulates.

2. Many of these other CON regulated services have annual minimum volume requirements for obtaining or expanding this regulated service.
   a. These annual volume limits are strictly enforced.
   b. Applicants failing to project the need for a new or additional service, where NEED is defined as providing an annual minimum volume, their CON application is denied.

3. Under the OHS Standard each applicant has to establish that there is a NEED for an additional OHS program,
   a. Initially, when the NEED for OHS programs was unknown and we had only a few OHS programs in the state, there was no annual minimum volume under CON to establish the NEED for an additional OHS program.
   b. As the number of OHS programs in the state grew and we knew more about the demand for this service, the annual minimum volume of 200 was established in the CON Standards as a predictor of a <u>community's NEED</u> for an additional OHS program.
   c. Years later, as the number of OHS programs in the state increased and the community's NEED for this service was better understood, the annual minimum was increased from 200 to 300.

4. When many of the existing OHS programs applied for a Certificate of Need, they based their application upon <u>their</u> projection of being able to exceed the minimum annual volume under the OHS CON Standards.
   a. Some of these OHS programs have exceeded the annual minimum volume they claimed in their CON application and continue to do so.
   b. Some of these OHS programs have exceeded the annual minimum volume they claimed in their CON application but have since fallen below this minimum.
   c. Some of these OHS programs have never achieved the annual minimum volumes they claimed in their CON application.

5. If the Michigan Department of Community Health fails to revoke a OHS CON from an applicant that has <u>never</u> met the annual minimum volume for determining the NEED for an additional OHS program, how is the Department able to enforce rules for any new OHS applicant or, even more troubling, how can the Department revoke any CON application for any other CON covered service that used exaggerated and unrealized projections of the need?

6. If we have one set of rules for those who already have an OHS program and a different set of rules for anyone wishing to get a new OHS program, then we open the entire CON process to challenges in both the legislature and in the courts as just protecting the existing providers from competition.

7. Option to consider:
   a. Allow the Department to enforce the existing rules for OHS programs that have failed to <u>ever</u> meet the annual minimum volume that was applicable when they submitted their application for an OHS CON. The justification being that this applicant failed to establish that there was <u>ever a NEED</u> for this additional OHS program.

   b. Revise the OHS CON Standard by establishing a "CAP" on the number of OHS programs that are needed in Michigan.
      - Numerical caps exist for other CON Standards
      - Demand for this service is continuing to decrease
      - We already have more OHS programs than are needed in Michigan
      - Geographic access is currently not an issue, but an exception to the cap could be made if geographic access ever becomes an issue.
      - Cap should be something less than the 33 programs we currently have, say 25. (Based upon the average volume per program in year 2000)

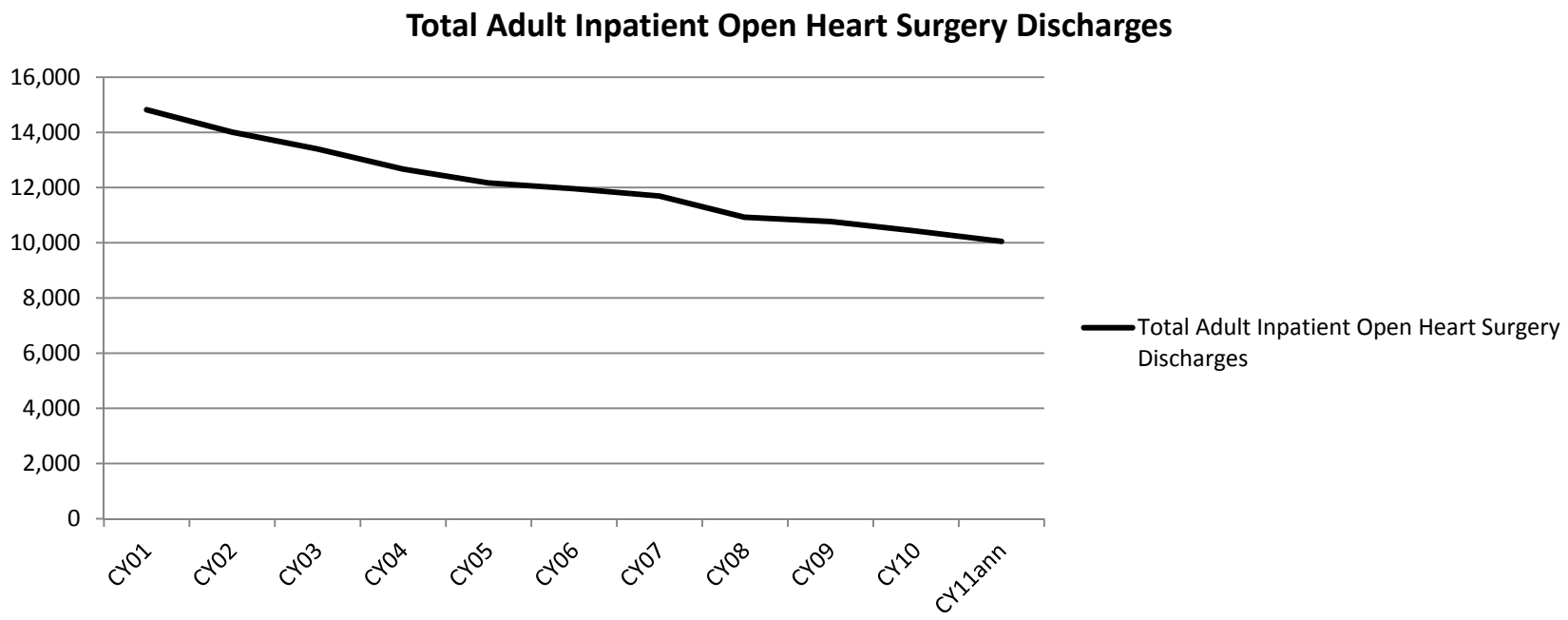
   c. No new programs should be approved until we drop below this numerical cap or if geographic access becomes an issue.

Right-sizing the number of OHS programs

John Fox, MD

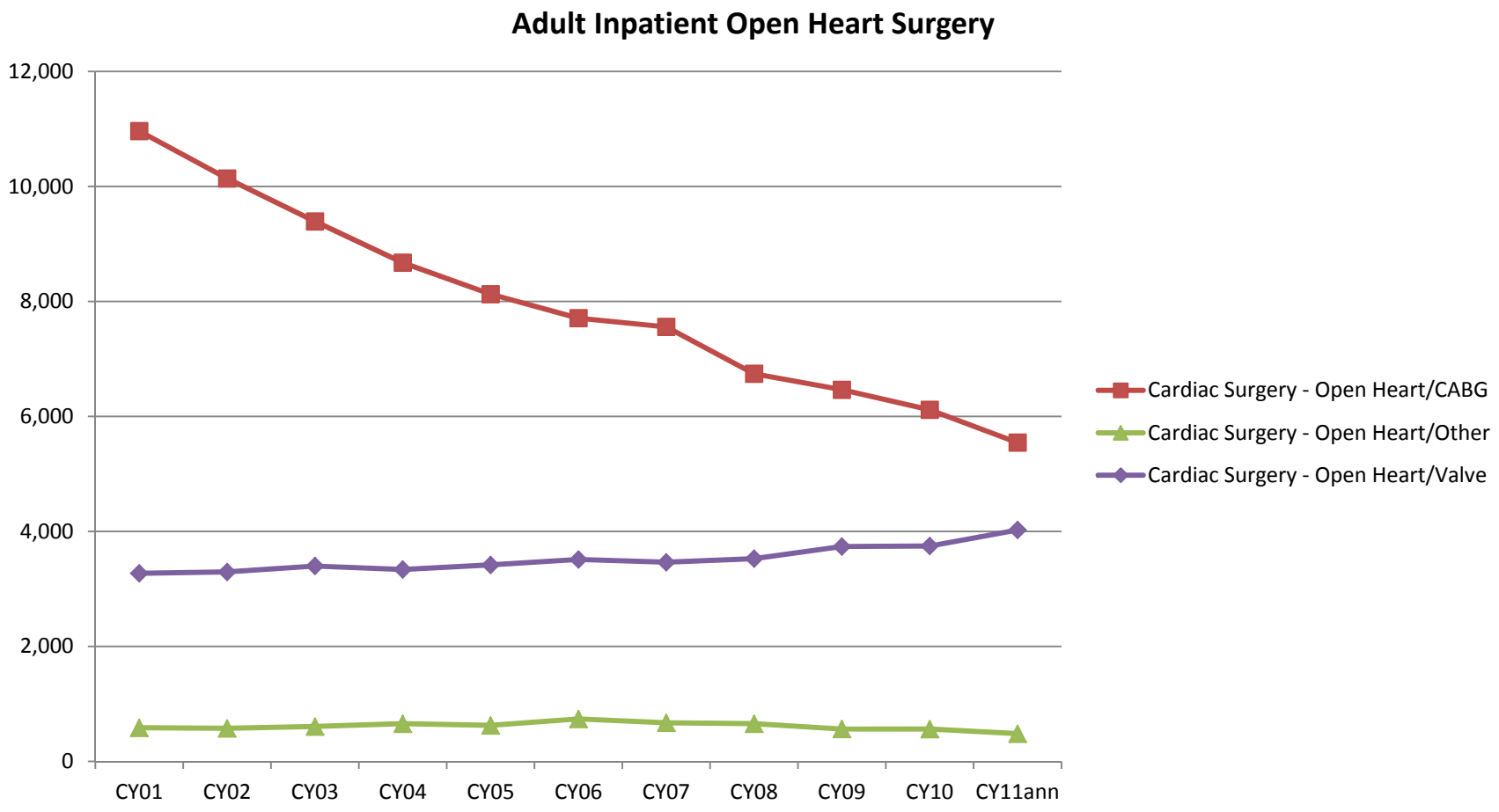
Duane DiFranco, MD

Adult Cardiothoracic Inpatient Surgery Discharges from Michigan Hospitals 2001 - 2011



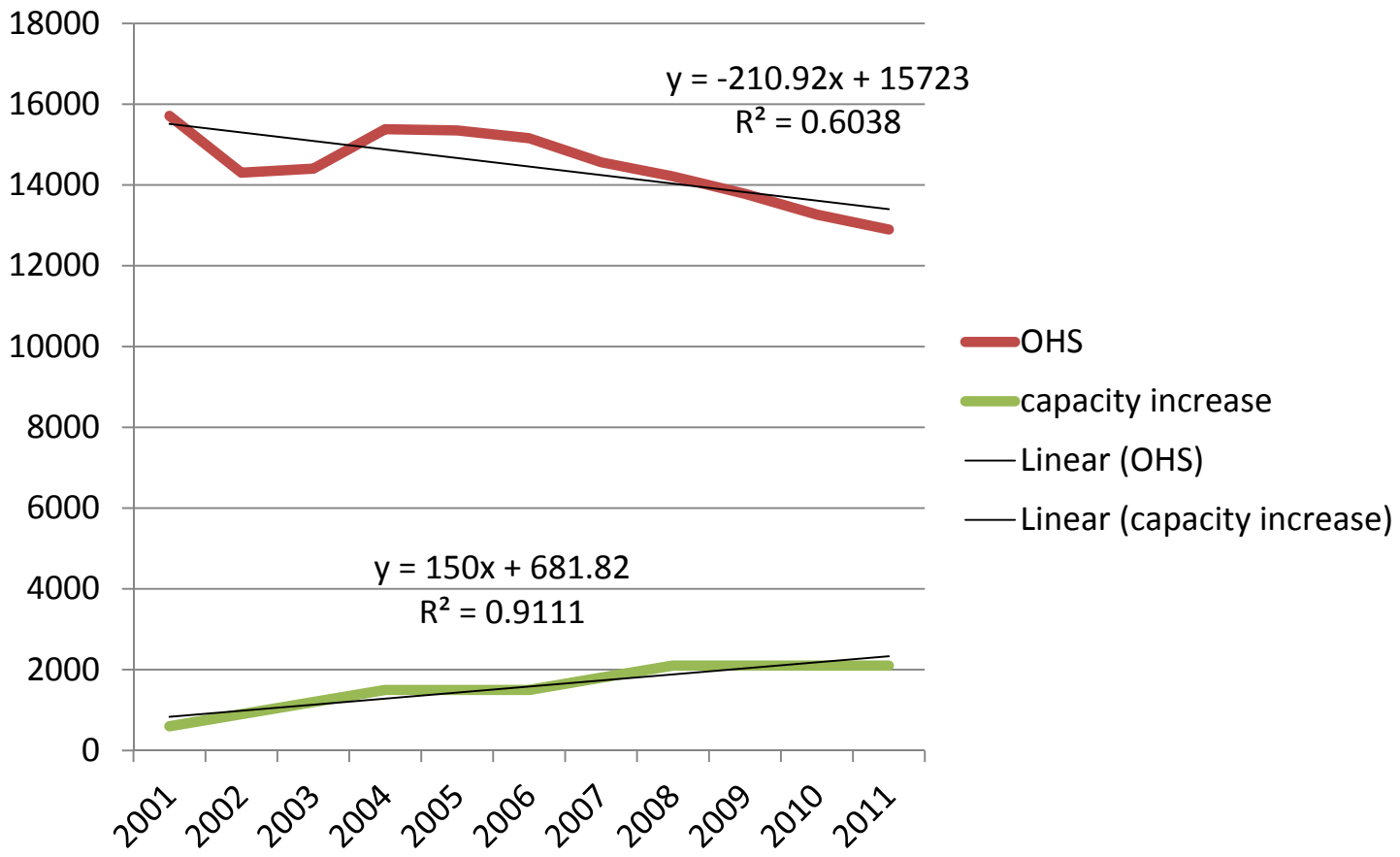
- Source: MHA MIDB

Adult Cardiothoracic Inpatient Surgery Discharges, by Type, from Michigan Hospitals 2001 - 2011



Source: MHA MIDB

Supply for OHS outstrips demand, 2001-2011



Case Volume, Quality of Care, and Care Efficiency in Coronary Artery Bypass Surgery. *Archives of Internal Medicine* (July 26, 2010), Auerbach A, et al.

Study:

An observational study of patients 18 years or older who underwent CABG in a network of U.S. hospitals.

Multivariable hierarchical models were used to estimate the effects of case volume and quality on hospital cost and LOS.

Results:

In analysis adjusted for patient and site characteristics, **lowest-volume hospitals had 19.8% higher costs (95% CI, 3.9%-38.0% higher); adjusting for care quality did not eliminate differences in costs.**

Low surgeon volume was also associated with higher costs, though less strongly - 3.1% higher costs (95% CI, 0.6%-5.6% higher).

Estimating cost savings from regionalizing cardiac procedures using hospital discharge data. *Cost Effectiveness and Resource Allocation* (June 29, 2007), Ho V and Peterson LA.

Study:

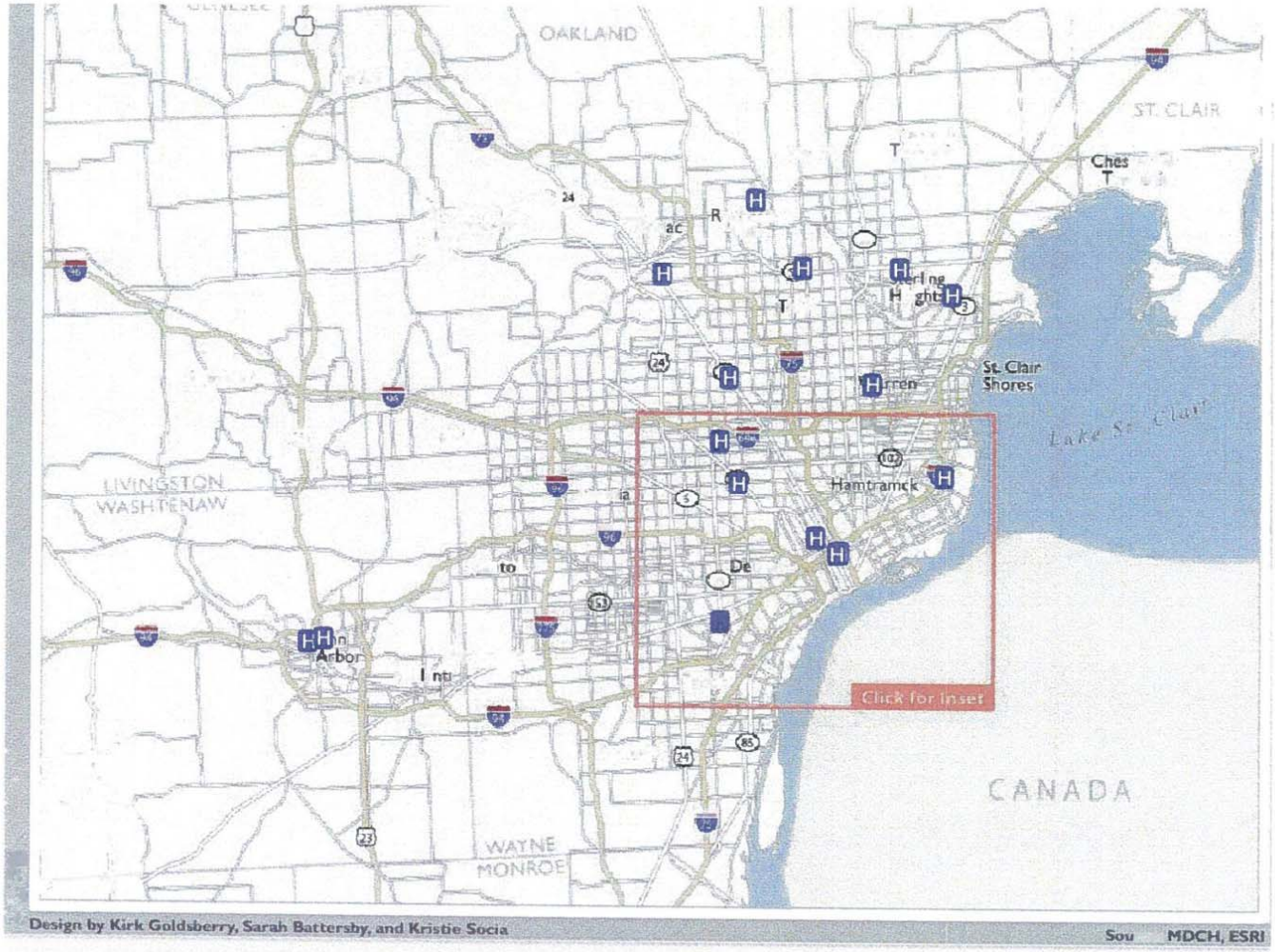
The goal was to use nationally representative data to determine whether higher cardiac procedure volumes were associated with lower average costs per procedure, and to estimate potential cost savings from regionalizing procedures. Admissions for CABG (and PCI) were studied from a nationally representative sample of hospitals between 1988 and 2000 to test for a volume-cost relationship.

Results:

For CABG, a 10% increase in volume for the average hospital was associated with a 2.8% reduction in average costs. The predicted savings from regionalizing all CABG procedures from lower to high-volume hospitals were estimated to be 3.5%.

Open-Heart Surgery Facilities in Michigan

Open-Heart Surgery Facilities in Southeastern Michigan



In 2010, the majority of procedures are performed by a few hospitals

- 10% of all OHS procedures are at 7 facilities with a combined capacity of 1800 procedures operating at 61% capacity
- 65% of all OHS procedures are done by 14 facilities
- 90% of all OHS procedures are done by 26 facilities

Right-sizing Proposal

- Cap the number of programs at 26 programs
  - Rationale
    - Consistent with other CON programs such as transplant
    - 26 of the existing 33 programs provide 91% of 2010 services
- Downsize the number of programs by revoking CON
  - 29 programs by December 31, 2013 with emphasis on programs that have never met their volume requirements
  - 26 programs by December 31, 2014 with emphasis on programs that have not met volume requirements for 3 of the last 6 years

2010: annual volume > 300
14 facilities (43%) perform 65% of procedures

	Hospital	2008	2009	2010	2011
GF	University of Michigan Hospitals	863	906	992	934
GF	Spectrum Health - Butterworth	972	952	960	1045
GF	William Beaumont Hospital - Royal Oak	706	711	711	785
>200	Oakwood Hosp & MC-Dearborn	669	671	659	554
GF	St. Joseph Mercy Hospital	665	704	648	605
>200	Munson Medical Center	687	655	600	573
>300	Bay Medical Center	359	437	457	538
GF	Borgess Medical Center	693	461	430	376
GF	Henry Ford Hospital	381	385	365	375
GF	McLaren Regional Medical Center	361	359	344	340
GF	Ingham Regional Medical Center	337	331	306	230
GF	Genesys Regional Medical Center	434	365	305	250
GF	St. John Hospital & Medical Center	384	325	304	286
>300	William Beaumont Hospital - Troy	324	286	303	290

2010: annual volumes between 200-300

	Hospital	2008	2009	2010	2011
GF	St. Mary's Medical Center	334	258	290	200
>200	Edward W. Sparrow Hospital	216	246	269	245
>300	MidMichigan Medical Center	279	246	267	228
>200	Covenant Medical Center	311	280	267	285
>200	Mercy General Health Partners	285	301	258	250
>200	Providence Hospital	299	307	258	235
>200	Bronson Methodist Hospital	241	297	243	206
GF	Northern Michigan Hospital	298	220	228	221
>300	St. John Macomb Hospital	262	217	215	195
>300	Henry Ford Macomb Hospital	300	222	210	256
>200	St. Joseph Mercy Hosp/Oakland	194	200	202	173

2010: Annual volumes < 200

	Hospital	2008	2009	2010	2011
GF	Marquette General Hospital	205	203	191	152
>200	Port Huron Hospital	164	143	161	140
GF	Harper University Hospital	138	186	158	210
>200	Lakeland Med. Cntr. - St. Joseph	180	170	151	143
>200	Mt. Clemens General Hospital	181	242	146	132
>300	Allegiance Health	105	148	145	132
>300	Sinai-Grace Hospital	164	115	127	117
>300	Crittenton Hospital	115	97	98	98

Forward-looking proposal

- Enforce the existing standards with a range of options statute 333.22247
  - including civil fines, public reporting
  - Revoke CON if facilities have not met volume requirements in 3 of the last six years
- Maintain current volume standards for new programs at 300 (section 7.1(c)(i)) recognizing program cap

Questions

If 7 OHS programs were terminated under existing statutory requirement:

1. would the remaining 26 facilities have extra capacity?
2. would geographic access issues be created?
3. would access issues for elective cardiac catheterization be created?

Motion

- Cap the number of programs at 26 programs
- Enforce the existing standards with a range of options statute 333.22247
- Maintain current volume standards for new programs at 300 (section 7.1(c)(i) recognizing program cap

333.22247 Monitoring compliance with certificates of need; investigating allegations of noncompliance; violation; sanctions; refund of charges. Sec. 22247. (1)

- A person shall not charge to, or collect from, another person or otherwise recover costs for services provided or for equipment or facilities that are acquired in violation of this part. If a person has violated this subsection, in addition to the sanctions provided under subsection (2), <u>the person shall, upon request of the person from whom the charges were collected, refund those charges, either directly or through a credit on a subsequent bill</u>.

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ATTACHMENT D

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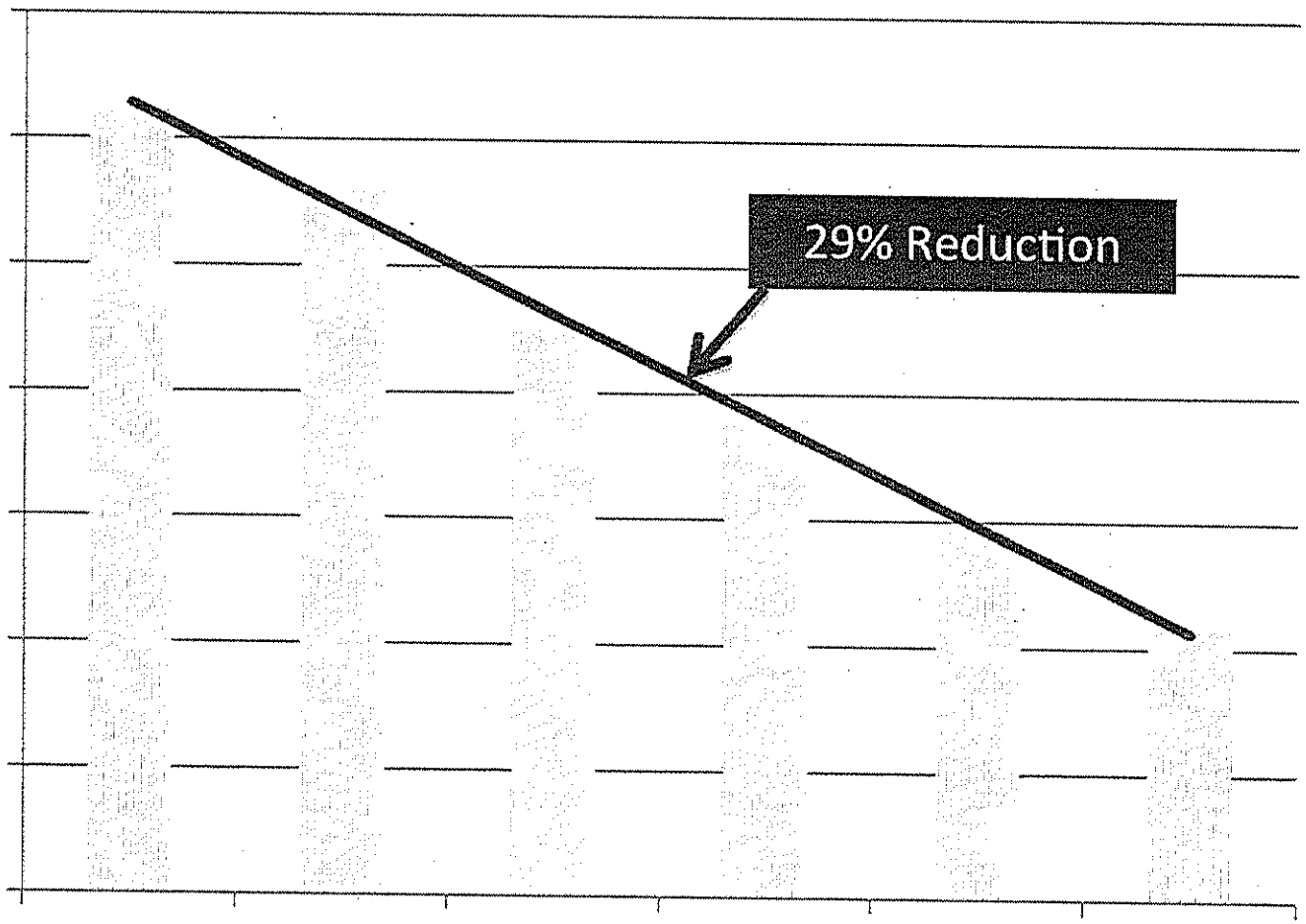

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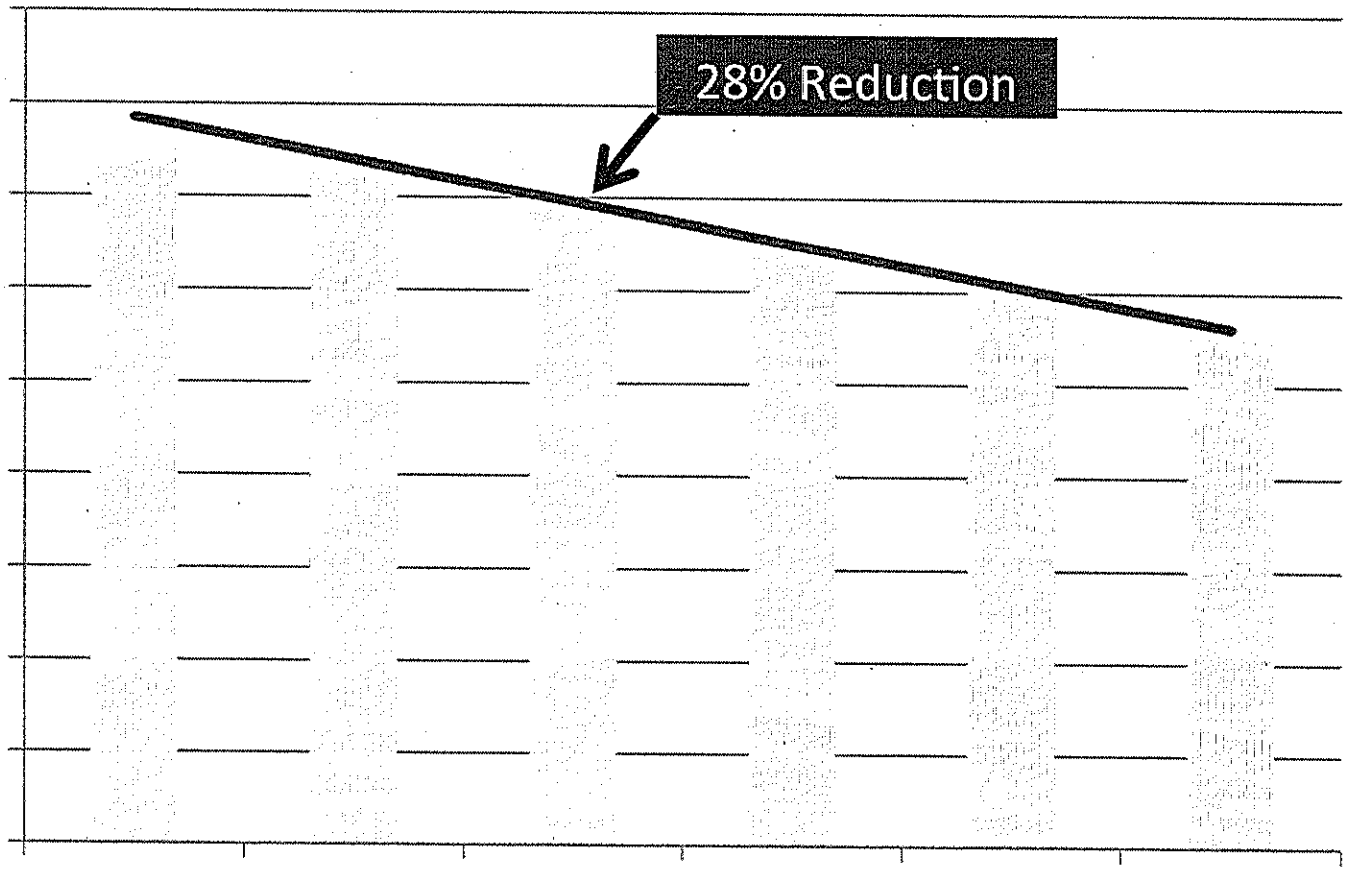
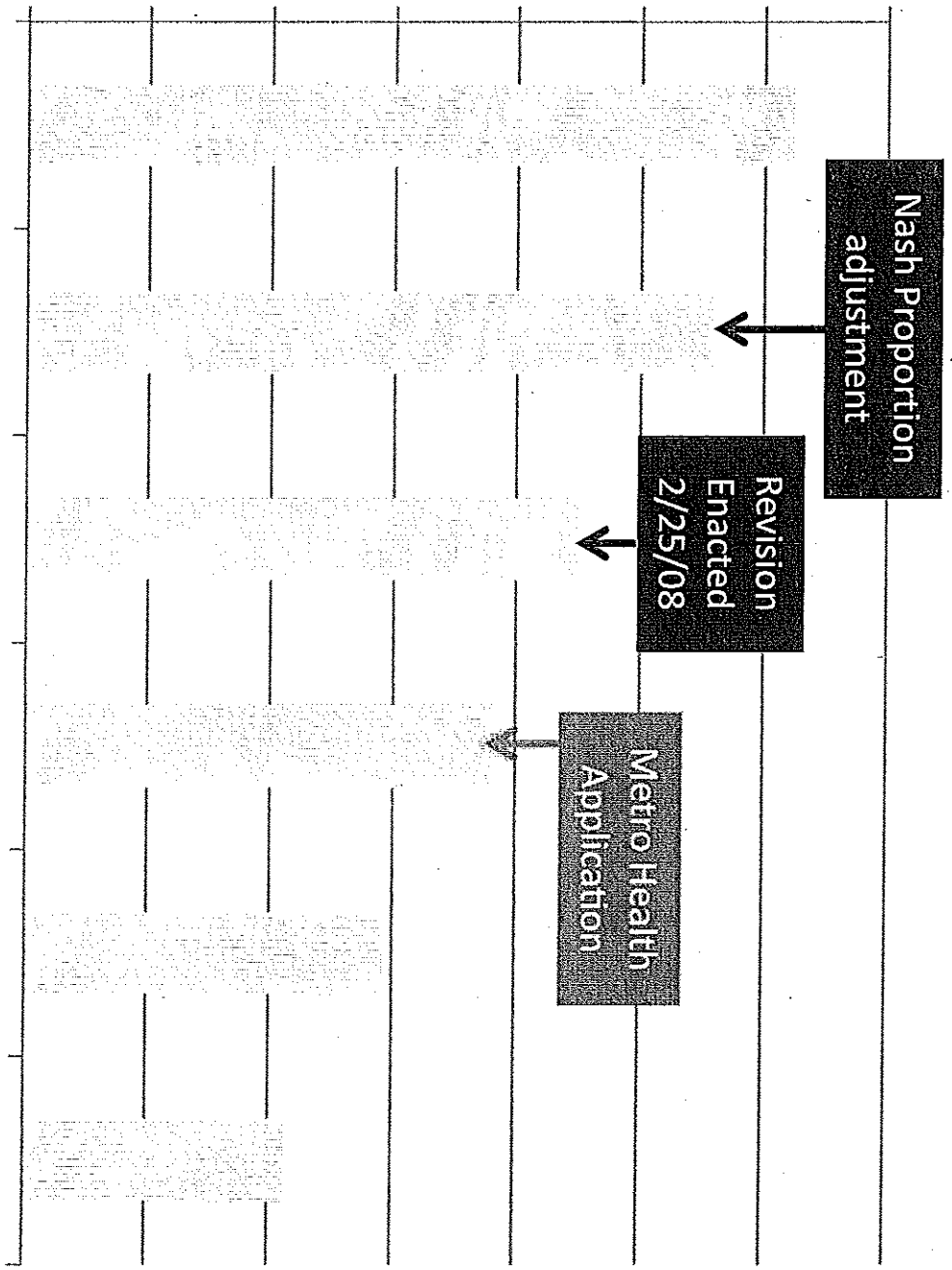


*STS Cardiac
Surgery Database

ATTACHMENT D


Nash Proportion adjustment
Revision Enacted 2/25/08
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