MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED (CON) COMMISSION MEETING

Thursday December 13, 2012

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

DRAFT MINUTES

I. Call to Order & Introductions

Chairperson Falahee called the meeting to order @ 9:32 a.m.

A. Members Present:

Gail J. Clarkson RN, Medilodge
James B. Falahee, Jr., JD, Chairperson
Charles Gayney
Edward B. Goldman
Robert Hughes
Marc Keshishian, MD, Vice-Chairperson
Brian Klott
Kathleen Cowling, DO

B. Members Absent

Gay L. Landstrom, RN
Suresh Mukherji, MD
Luis Tomatis, MD

C. Department of Attorney General Staff:

Joseph Potchen

D. Michigan Department of Community Health Staff Present:

Tulika Bhattacharya
Scott Blakeney
Natalie Kellogg
Abigail Mitchell
Beth Nagel
Brenda Rogers

II. Review of Agenda

Motion by Commissioner Goldman, seconded by Commissioner Hughes, to approve the agenda as presented. Motion Carried.

III. Declaration of Conflicts of Interests

None.

IV. Review of Minutes of September 27, 2012

Motion by Commissioner Clarkson, seconded by Commissioner Gayney, to approve the minutes of September 27, 2012 as presented. Motion Carried (see Attachment A).

V. Introduction of James Haveman, Director, Michigan Department of Community Health (MDCH)

Director Haveman introduced himself to the CON Commission and gave a brief introductory statement.

VI. Bone Marrow Transplantation (BMT) Services - Technical Edits

Ms. Rogers gave a brief overview of the public hearing testimony on the proposed changes to BMT Services Standards (see Attachment B).

A. Public Comment:

None.

B. Commission Discussion

None.

C. Commission Final Action:

Motion by Commissioner Goldman, seconded by Commissioner Cowling, to approve the proposed language and move it forward to the Joint Legislative Committee (JLC) and Governor for the 45-day review period. Motion Carried in a vote of 8- Yes, 0- No, and 0- Abstained.

VII. Psychiatric Beds & Services Workgroup Report

Ms. Rogers gave a brief overview of the public hearing testimony on the proposed changes to Psychiatric Beds and Services Standards (see Attachment C).

A. Public Comment

None.

B. Commission Discussion

Discussion followed.

C. Commission Final Action

Motion by Commissioner Cowling, seconded by Commissioner Clarkson, to approve the proposed language and move it forward to the JLC and Governor for the 45-day review period. Motion Carried in a vote of 8- Yes, 0- No, and 0- Abstained.

Motion by Commissioner Cowling, seconded by Vice-Chairperson Keshishian, to make the Psychiatric Bed Need numbers effective immediately. Motion Carried in a vote of 8- Yes, 0- No, and 0- Abstained.

VIII. Open Heart Surgery (OHS) Standard Advisory Committee (SAC) Final Report and Draft Language

Dr. Sell presentated the OHSSAC's final report and recommendations (see Attachment D).

Ms. Rogers gave a brief overview of the draft language and the process.

A. Public Comment:

Melissa Cupp, Wiener Assoc.
Dennis McCafferty, Economic Alliance for Michigan (EAM)
Dr. Richard Prager, University of Michigan (U of M)

B. Commission Discussion

Discussion followed.

C. Commission Proposed Action

Motion by Commissioner Goldman, seconded, by Commissioner Hughes, to not take proposed action nor send the standards for public hearing, but to have the Department review Section 7 for clarity and propose a recommendation for the maintenance volume. Motion Carried in a vote of 8- Yes, 0- No, and 0- Abstained.

Motion by Vice-Chairperson Keshishian, seconded by Commissioner Klott, to amend the OHS Standards proposed language with the addition of CMS regulation language for Transcatheter Aortic Valve Implantation (TAVI) procedures. Motion failed in a vote of 4- Yes, 4- No, and 0- Abstained.

Public Comment:
Melissa Cupp, Wiener Assoc.
Dr. Gaetano Paone, Henry Ford Health Systems (HFHS)

Break @ 12:00 p.m. - 12:23 p.m.

IX. Megavoltage Radiation Therapy (MRT) Workgroup Report and Draft Language

Commissioner Cowling declared a conflict of interest.

Vice-Chairperson Keshishian presented the results and conclusions of the MRT workgroup (see Attachment E).

A. Public Comment:

Nancy List, Covenant Health
Greg Dobis, McLaren Health

B. Commission Discussion

Ms. Rogers gave a brief overview of the draft language and changes to the standards (see Attachment F).

C. Commission Proposed Action

Motion by Commissioner Goldman, seconded by Commissioner Gayney, to approve the proposed MRT language and move it forward for public hearing and the JLC. Motion carried in a vote of 7- Yes, 0-No, and 1-Abstained.

X. Standing New Medical Technology Advisory Committee (NEWTAC)

Vice-Chairperson Keshishian stated no new updates.

XI. Legislative Report

Mr. Blakeney gave a brief update.

XII. Administrative Update

A. Planning & Access to Care Section Update

Ms. Nagel stated there were no updates.

B. CON Evaluation Section Update

Ms. Bhattacharya gave a brief overview on the FY2012 CON Annual Activity Report (see Attachment G). Mr. Blakeney gave comment on increasing the CON fees.

Ms. Bhattacharya gave an update on both compliance and quarterly performance activity (see Attachments H & I).

XIII. 2-Year Report to the Joint Legislature Committee (JLC)

A. Commission Discussion

Chairperson Falahee provided an overview and discussion followed (see Attachment J).

B. Commission Action

Motion by Commissioner Goldman, and seconded by Commissioner Cowling, to approve the JLC report with amendments and authorize the Department to use electronic signatures. Chairperson Falahee and Vice-Chairperson Keshishian will give final approval. Motion carried in a vote of 8- Yes, 0-No, and 0- Abstained.

XIV. Legal Activity Report

Mr. Potchen gave a brief status update on the legal activities (see Attachment K).

XV. Future Meeting Dates

A. January 29, 2013 (Special CON Commission Meeting), March 28, 2013, June 13, 2013, September 26, 2013, & December 12, 2013

XVI. Public Comment

Dr. Michael Sandler, HFHS

XVII. Review of Commission Work Plan

Ms. Rogers gave a brief overview of the Work Plan (see Attachment L).

A. Commission Discussion

None.

B. Commission Action

Motion by Commissioner Gayney, seconded by Commissioner Cowling, to approve the work plan as presented. Motion Carried in a vote of 8- Yes, 0- No, and 0- Abstain.

XVIII. Adjournment

Motion by Commissioner Goldman, seconded by Commissioner Klott, to adjourn the meeting @ 1:02 p.m. Motion Carried in a vote of 8- Yes, 0- No, and 0- Abstain.

Attachment A:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED (CON) COMMISSION MEETING
Thursday September 27, 2012
Capitol View Building
201 Townsend Street
MDCH Conference Center
Lansing, Michigan 48913

DRAFT MINUTES

I. Call to Order & Introductions

Chairperson Falahee called the meeting to order @ 9:29 a.m. He introduced Commissioner Tomatis and Beth Nagel from the Department.

A. Members Present:
Gail J. Clarkson RN, Medilodge
James B. Falahee, Jr., JD, Chairperson
Charles Gayney
Robert Hughes
Marc Keshishian, MD, Vice-Chairperson
Brian Klott
Gay L. Landstrom, RN in at 9:38 a.m.
Suresh Mukherji, MD
Kathleen Cowling, DO
Luis Tomatis, MD

B. Members Absent
Edward B. Goldman
Brian Klott

C. Department of Attorney General Staff:
Joseph Potchen

D. Michigan Department of Community Health Staff Present:
Tulika Bhattacharya
Scott Blakeney
Natalie Kellogg
Beth Nagel
Tania Rodriguez
Brenda Rogers

II. Review of Agenda

Motion by Commissioner Gayney, seconded by Commissioner Mukherji, to approve the modified agenda, adding Senator Kowall's assistant Mike Murray to speak on behalf of the Senator. Motion Carried.

III. Declaration of Conflicts of Interests

None.

IV. Review of Minutes of June 14, 2012

Motion by Commissioner Cowling, seconded by Vice-Chairperson

Keshishian, to approve the minutes of June 14, 2012 as presented. Motion Carried (see Attachment A).

V. Mike Murray on Behalf of Senator Mike Kowall

Mr. Murray read a statement to the Commission on behalf of Senator Kowall. Discussion followed.

VI. Bone Marrow Transplantation (BMT) Services - Technical Edits

Ms. Rogers gave a brief overview of the proposed technical amendments to the BMT Services Standards (see Attachment B).

A. Public Comment:

None

B. Commission Discussion

None.

C. Commission Final Action:

Motion by Commissioner Landstrom, seconded by Commissioner Mukherji, to approve the proposed language and move it forward for Public Hearing and to the Joint Legislative Committee (JLC). Motion Carried in a vote of 9- Yes, 0- No, and 0- Abstained.

VII. Psychiatric Beds & Services Workgroup Report

Dr. Sandler gave a presentation based on the results from the Psychiatric Beds Workgroup (see Attachment C).

Ms. Rogers gave a brief overview of the proposed language (see Attachment D).

A. Public Comment

Robert Nykamp, Pine Rest (See attachment F)
Michael Sandler, MD, Henry Ford Health System
Andy Ball, Kheder Davis & Associates, Inc.

B. Commission Discussion

Discussion followed.

C. Commission Final Action

Motion by Commissioner Cowling, seconded by Commissioner Gayney, to approve the proposed language and move it forward for Public Hearing and to the JLC. Motion Carried in a vote of 9- Yes, 0- No, and 0- Abstained.

VIII. Megavoltage Radiation Therapy (MRT) Workgroup Update

Vice-Chairperson Keshishian gave a brief verbal update on the progress of the MRT workgroup.

IX. Open Heart Surgery (OHS) Standard Advisory Committee (SAC) Update

Chairperson Falahee verbally referenced the written report from Dr. Sell (see Attachment E)

X. Standing New Medical Technology Advisory Committee (NEWTAC)

Vice-Chairperson Keshishian stated there were no updates for the NEWTAC.

XI. Legislative Report

Mr. Blakeney gave a brief verbal overview of the legislative activity, including updates on SB 1237 and 1269.

Discussion followed.

XII. Administrative Update

A. Planning and Access to Care Section
Mr. Blakeney introduced Beth Nagel and stated that the new director for MDCH is James Haveman.

1. Ms. Nagel provided a status update for the Magnetic Resonance Imaging (MRI) Workgroup.
Commissioner Mukherji, Chairperson for the MRI Workgroup, stated that a survey will be sent, and the results will be shared at the first meeting.
B. CON Evaluation Section Update
1. Compliance Report
2. Quarterly Performance
Ms. Bhattacharya gave an update on both compliance and quarterly performance activity (see Attachments F & G).

XIII. Legal Activity Report

Mr. Potchen gave a brief status update on the legal activities (see Attachment H).

XIV. Future Meeting Dates

A. December 13, 2012, January 29, 2013 (Special CON Commission Meeting), March 28, 2013, June 13, 2013, September 26, 2013, & December 12, 2013

XV. Public Comment

Brett Jackson, Economic Alliance for Michigan

XVI. Review of Commission Work Plan

Ms. Rogers gave a brief overview of the Work Plan (see Attachment I).
A. Commission Discussion
None.
B. Commission Action
Motion by Commissioner Mukherji, seconded by Commissioner Cowling, to approve the work plan as presented. Motion Carried in a vote of 9- Yes, 0- No, and 0- Abstain.

XVII. Adjournment

Motion by Commissioner Mukherji, seconded by Commissoner Cowling, to adjourn the meeting @ 11:09 a.m. Motion Carried in a vote of 9- Yes, 0- No, and 0- Abstain.

Attachment B & C

Michigan Department of Community Health (MDCH or Department)
MEMORANDUM
Lansing, MI

Date: November 21, 2012

TO: Brenda Rogers

FROM: Natalie Kellogg

RE: Summary of Public Hearing Comments on Bone Marrow Transplantation (BMT) Services and Psychiatric Beds and Services Standards

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Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission "...shall conduct a public hearing on its proposed action." The Commission took proposed action on the HB Standards at its September 27, 2012 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed BMT and Psych Bed Standards on November 8, 2012. Written testimony was accepted for an additional 7 days after the hearing via an electronic link on the Commission's website. Testimony was received from (3) three organizations and is summarized as follows:

The Department did not receive any testimony on the BMT Standards.

Janice Coates, M.D., Spectrum Health

- Supports the proposed revisions and modifications to the Psych Bed Services Standards.

Robert Nykamp, Pine Rest Christian Mental Health Services

- Generally supportive of the proposed changes to the Psych Bed Standards.
- Specifically, the flex bed concept will allow existing adult psychiatric beds to be "flexed" to accommodate the mental health needs of children and adolescents who frequent the ER's of local community hospitals because of a lack of access.
- The proposed revisions to the standards facilitating relocation of existing psych beds within the planning area will benefit West Michigan communities.
- Pine Rest maintains the position that the reduction in the length of "high occupancy" period from 24 to 12 months is unnecessary, especially given the other proposed changes noted above. Supports the maintenance of existing language regarding high occupancy.

Alexander N. Luvall, Esq., Acadia Healthcare/Pioneer Behavioral Health

- Supports the proposed changes to the Psych Bed Services Standards which includes the following:
    - Creation of Flex Unit - The revised standards would allow facilities that provide care to both child/adolescent and adult patients to designate some of their adult beds as “flex beds,” allowing child/adolescent patient to use those beds when the child/adolescent unit is full.
    - Relocation of Beds - The proposed changes would bring the Psych bed Services standards in line with hospital and nursing home bed standards by creating a mechanism to allow existing licensed facilities to move beds between licensed entities.
    - High Occupancy - The proposed changes will reduce the demonstration period for high occupancy down to 12 months, which should help to bring additional beds on more quickly and alleviate capacity concerns.

Attachment D

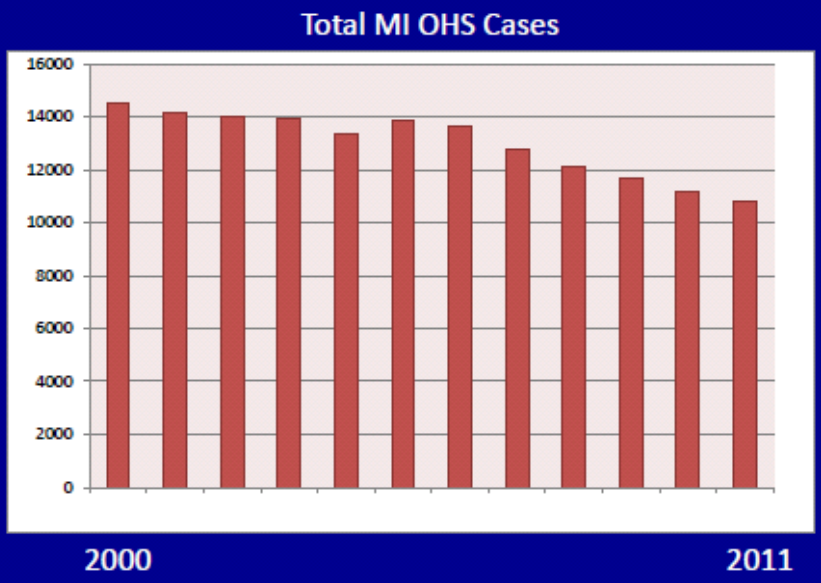
Open Heart Surgery SAC Recommendations December 13, 2012

Timothy Sell, M.D.

SAC Charge

1. Review and update, if necessary, the initiation and maintenance volume requirements given that OHS volumes are declining.
2. Review project delivery requirements to assure quality, measurability, and affordability for both the provider and consumer.
3. Review and update, if necessary, the methodologies to assure that they accurately reflect community need for OHS services.
4. Propose standards for percutaneous insertion of heart valves.
5. Consider any necessary technical or other changes, e.g., updates or modifications consistent with other CON review standards and the Public Health Code.

1. Review and update, if necessary, the initiation and maintenance volume requirements given that OHS volumes are declining.



25% decline

Initiation Volume

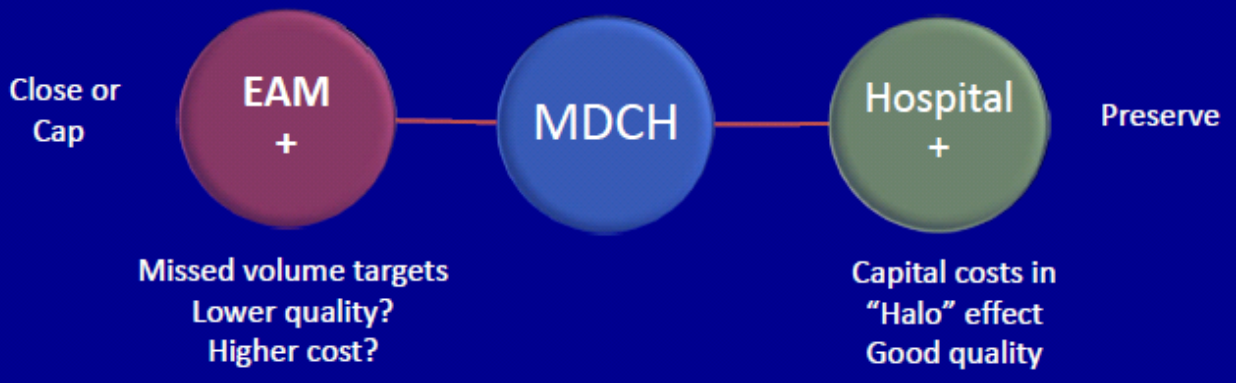
- Minimum volume requirement acts as a "barrier to entry"
  A major concern – capital cost to start an OHS program
- Multiple CON states have initiation volumes 150-350 / year
- Maintenance volumes 200-350 / year by year 3
- 1972 – Intersociety Commission for Heart Disease Resources recommended a 200 case / year minimum
- 1991 – Am. College of Cardiology / Am. Heart Assoc. Task Force recommended 2-300 case / year minimum

Initiation Volume

- Some recently approved OHS programs have failed to achieve the number of cases predicted by the methodology used to compute open heart surgical cases prior to 2007-8.
- The formula was updated in 2007-8 and has been used once since then to assess one new OHS program application.
- The denied application had a projected volume of approximately 150 / year, comparable to actual numbers observed in other recent programs.
- Given the realistic prediction of case numbers, no change was recommended except for already mandated utilization weight updates.
- Due to declining OHS volume, significant capital costs to start an OHS program, and concerns about potential excess OHS capacity, no change in the minimum initiation volume requirement was felt to be prudent.

Maintenance Volume

- 11 of 33 programs failed to meet their volumes in 2011
- 6 programs have never achieved their initiation volumes

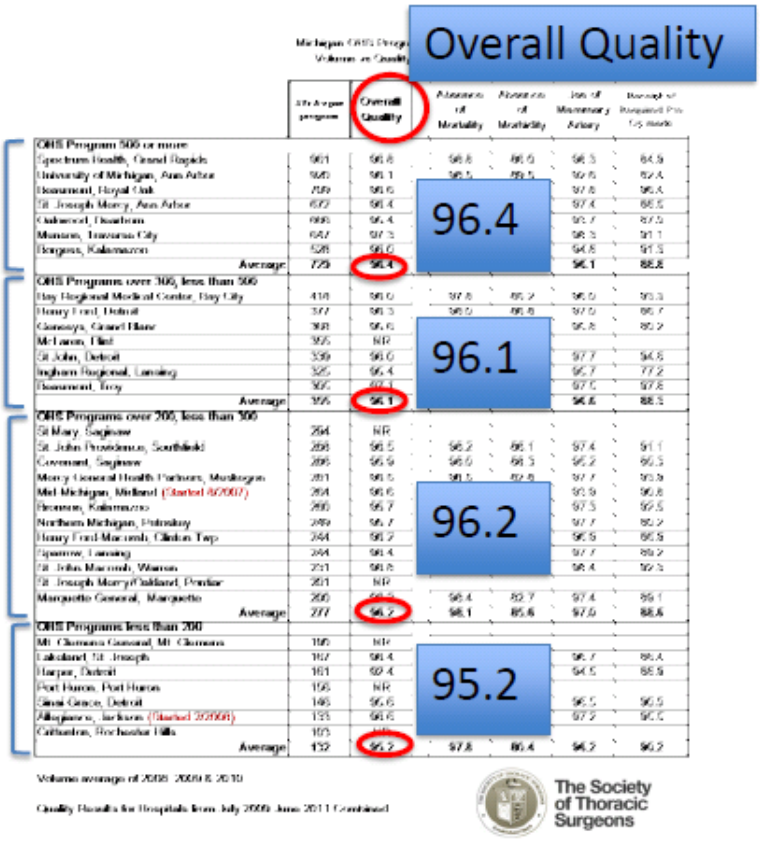


500+ cases

300-499 cases

200-299 cases

<200 cases



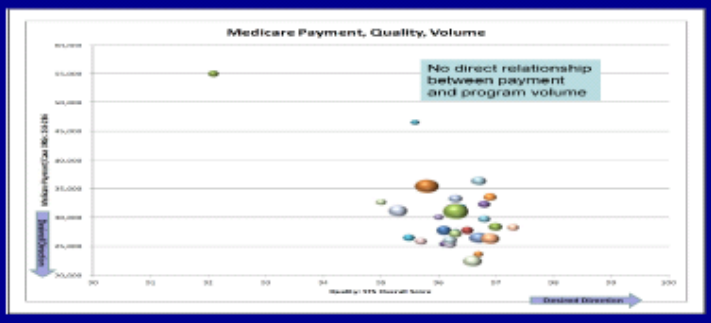
	Volume	Overall Quality	Absence of Mortality	Absence of Morbidity	Lack of Mortality Artery	Length of Hospital Stay
OHS Program 500 or more						
Spectrum Health, Grand Rapids	961	96.8	98.8	98.0	98.3	84.9
University of Michigan, Ann Arbor	940	96.1	98.5	89.5	96.6	82.4
Beaumont, Royal Oak	789	96.6			97.8	96.4
St. Joseph Mercy, Ann Arbor	672	96.4			97.4	86.5
Oakwood, Dearborn	668	96.4			98.7	87.9
Munson, Traverse City	647	97.3			98.3	91.1
Bronson, Kalamazoo	528	96.0			94.8	97.3
Average	729	96.4			96.1	88.8
OHS Programs over 300, less than 500						
Bay Regional Medical Center, Bay City	418	96.0	97.8	95.2	96.0	93.3
Henry Ford, Detroit	377	96.3	98.0	88.8	97.0	86.7
Genesys, Grand Blanc	368	96.6			96.8	89.2
McLaren, Flint	365	NR				
St John, Detroit	339	96.0			97.7	94.5
Ingham Regional, Lansing	325	96.4			96.7	77.2
Beaumont, Troy	306	96.1			97.5	97.8
Average	355	96.1			96.6	88.3
OHS Programs over 200, less than 300						
St Mary, Saginaw	284	NR				
St John Providence, Southfield	268	96.5	98.2	86.1	97.4	91.1
Covenant, Saginaw	266	96.9	98.0	88.3	96.2	86.3
Mercy General Health Partners, Muskegon	261	96.5	98.5	82.8	97.7	93.9
Mid Michigan, Midland (Started 8/2007)	254	96.6			98.9	96.8
Bronson, Kalamazoo	250	96.7			97.3	99.5
Northern Michigan, Petoskey	249	96.7			97.7	86.2
Henry Ford Macomb, Clinton Twp	244	96.2			96.5	86.5
Sparrow, Lansing	244	96.4			97.7	89.2
St. John Macomb, Warren	231	96.8			98.4	99.3
St Joseph Mercy/Oakland, Pontiac	201	NR				
Marquette General, Marquette	200	96.0	98.4	82.7	97.4	86.1
Average	277	96.2	98.1	85.6	97.6	88.6
OHS Programs less than 200						
Mt. Clemens General, Mt. Clemens	196	NR				
Lakeland, St. Joseph	192	96.4			96.7	86.4
Harper, Detroit	161	69.4			94.5	86.9
Port Huron, Port Huron	156	NR				
Saint Grace, Detroit	146	96.6			96.5	96.9
Allegiance, Jackson (Started 2/2008)	133	96.6			97.2	96.0
Crittenton, Rochester Hills	103	NR				
Average	152	95.2	97.8	80.4	96.2	90.2

Volume average of 2008, 2009 & 2010

Quality Results for Hospitals from July 2009- June 2011 Combined

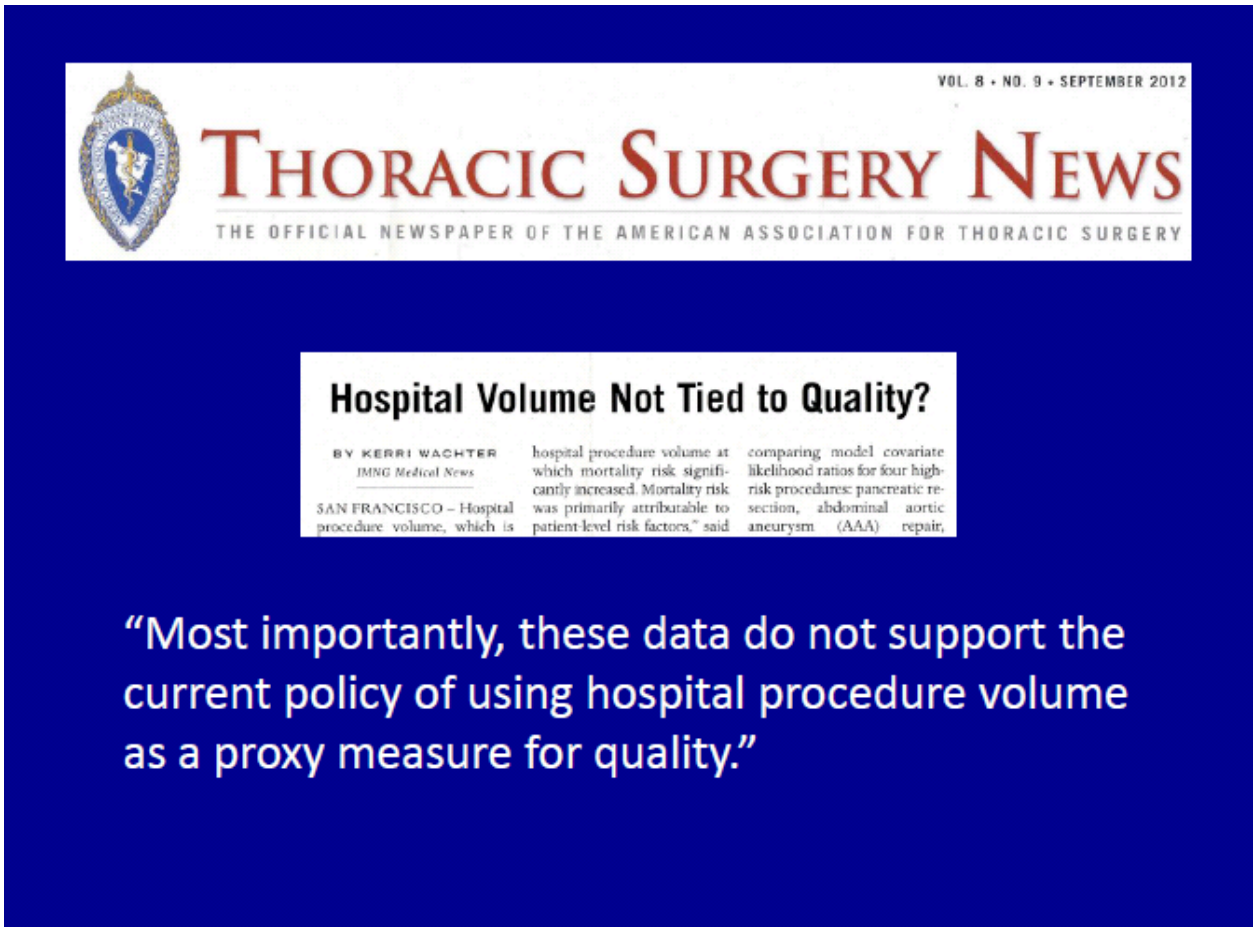
The Society of Thoracic Surgeons

[File]S:\CONGROUP\Commission & Policy Section\Covered Services\OHS\OHSAC 2011 2012\3 June 7, 2012\6 AM Copy of OHS 3 year avg & Quality Data.xls



- Size of bubble represents the 2011 CON program volume reported. The larger the bubble, the higher the volume.
- Hospitals without STS quality data (3) were left off of this grid
- An additional graph using cost instead of payment available in the appendix
- Medicare payment data supplied by Cleverley + Associates. They are a privately owned, professional service organization specializing in core financial strength services for the hospital industry. They provide independent, objective information to hospitals and to organizations serving the healthcare industry.
- Cost graph in appendix

11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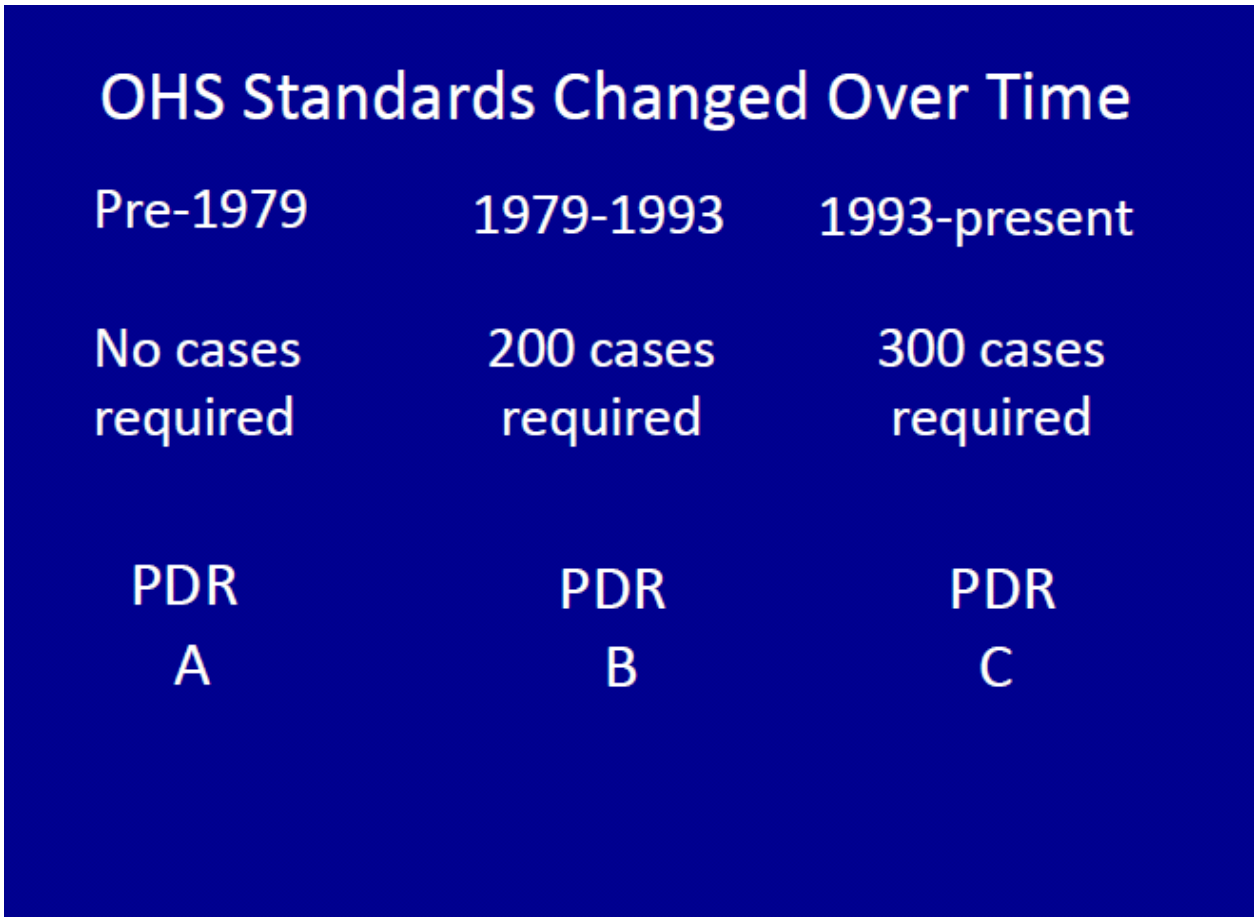
THORACIC SURGERY NEWS
THE OFFICIAL NEWSPAPER OF THE AMERICAN ASSOCIATION FOR THORACIC SURGERY
Hospital Volume Not Tied to Quality?
BY KERRI WACHTER
IMNG Medical News
SAN FRANCISCO – Hospital procedure volume, which is
hospital procedure volume at which mortality risk significantly increased. Mortality risk was primarily attributable to patient-level risk factors," said
comparing model covariate likelihood ratios for four high-risk procedures: pancreatic resection, abdominal aortic aneurysm (AAA) repair,
"Most importantly, these data do not support the current policy of using hospital procedure volume as a proxy measure for quality."

Maintenance Volume

- Program volume tells us:
  - How busy a program is
  - If case number projections are met
- Program volume does not tell us:
  - Processes employed
  - Outcomes
  - Efficiency / Economy
  - Community impact
- Should the MDCH make decisions regarding compliance actions based predominantly on volume?


OHS Standards Changed Over Time
Pre-1979
1979-1993
1993-present
No cases required
200 cases required
300 cases required
PDR A
PDR B
PDR C

Options?

1. Reduce maintenance volume requirements:
   Not fair due to other programs having no volume requirement

2. Eliminate maintenance volume requirement:
   Only "fair" approach
   Might incorrectly suggest program volume is meaningless
   Volume may be more important in non-CABG procedures

3. Committee view:
   Maintenance number is primarily a trigger to evaluate an OHS program
   Volume is not robust enough to drive compliance action
   No equitable fix to tiered CON structure
   No recommendation for change

2. Review project delivery requirements to assure quality, measurability, and affordability for both the provider and consumer.

Open Heart Coalition

Proposed Quality Measures
Isolated CAB Only

"Must Have" Measure	STS Range	National 50th %tile
Mortality Avoidance	94.7 – 99.4%	98.1%

AND

4 out of 6 Measures	STS Range	National 50th %
Renal Failure	0.31 – 6.28%	0.97%
Stroke (CVA)	0.55 – 2.49%	0.96%
Deep Sternal Wound Infection	0.26 – 12.93%	0.77%
Prolonged Ventilation	0.27 – 8.12%	0.98%
Intraop/Postop Blood Products Used*	53.9% (mean)	56.4%
Internal Mammary Artery (IMA) Use	64.5% – 99.6%	95.9%

Data Source: STS report ending 12/31/10 (2011 Harvest Report 1)

* Not included in composite score

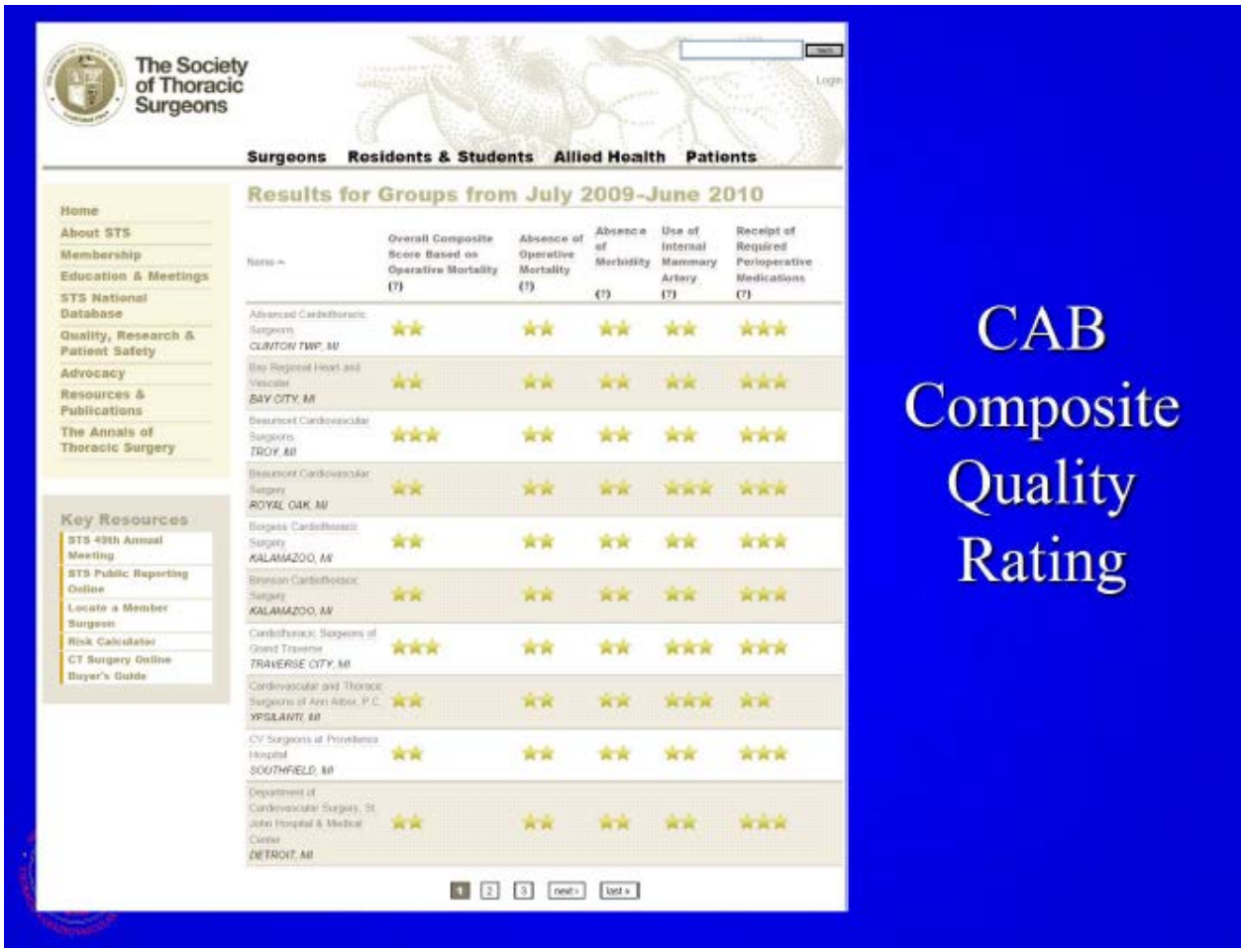
9

5. Consider what your report should look like. View the example as only two examples of how we might do this. The left is an actual numbers report that directly reports our STS data. The second is one that relies on composites and statistical determination that a program is outside of 1 or 2 standard deviations of the mean. There are advantages and disadvantages to each approach. In addition, there may be debate as to what represents a structure vs. process issue.

Structure	Actual Numbers
MSTCVS CQI participation	Y/N
Heart Team	Y/N
Data Accuracy	1-3 Stars
Other	
Process	
IMA use	actual %
Pre-op BB/ASA	actual %
Outcomes	
CABG Composite	1-3 Stars
Aortic Composite	1-3 Stars
Mortality	actual %
CVA	actual %
Etc.	

Structure	Composites, etc.
MSTCVS CQI participation	Y/N
Heart Team	Y/N
Data Accuracy	1-3 Stars
Other	
Process	
IMA use	In range/outlier
Pre-op BB/ASA	In range/outlier
Outcomes	
CABG Composite	1-3 Stars
Aortic Composite	1-3 Stars
Mortality	In range/outlier
CVA	In range/outlier
Etc.	

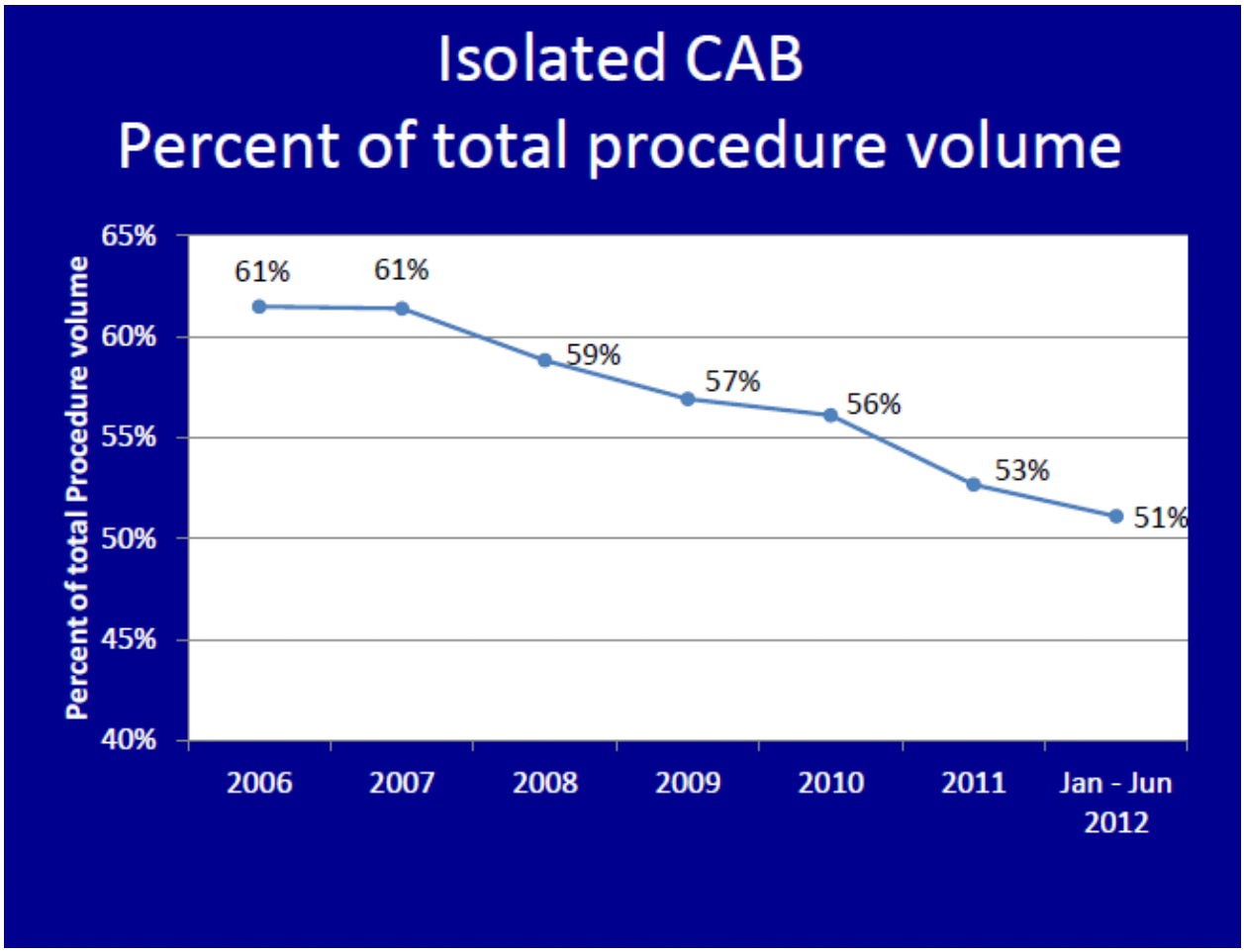
BG Composite measure


The Society of Thoracic Surgeons
Surgeons
Residents & Students
Allied Health
Patients
Home
About STS
Membership
Education & Meetings
STS National Database
Quality, Research & Patient Safety
Advocacy
Resources & Publications
The Annals of Thoracic Surgery
Key Resources
STS 49th Annual Meeting
STS Public Reporting Online
Locate a Member Surgeon
Risk Calculator
CT Surgery Online Buyer's Guide
Results for Groups from July 2009-June 2010
Name
Overall Composite Score Based on Operative Mortality
Absence of Operative Mortality
Absence of Morbidity
Use of Internal Mammary Artery
Receipt of Required Perioperative Medications
CLINTON TWP, MI
BAY CITY, MI
TROY, MI
ROYAL OAK, MI
KALAMAZOO, MI
KALAMAZOO, MI
TRAVERSE CITY, MI
YPSILANTI, MI
SOUTHFIELD, MI
DETROIT, MI
CAB Composite Quality Rating

Recommendation

That the MDCH adopt use of the composite star rating system developed by the Society of Thoracic Surgeons as the measure of OHS program quality, using the currently available CABG rating and incorporating all future adult cardiovascular procedure star ratings as they become available from the Society of Thoracic Surgeons.

Y-10, N-2, A-0


Isolated CAB
Percent of total procedure volume
Percent of total Procedure volume
65%
60%
55%
50%
45%
40%
61%
61%
59%
57%
56%
53%
51%
2006
2007
2008
2009
2010
2011
Jan - Jun 2012

Recommendation

That all current and future open heart surgery programs be required to:

1. Participate with the STS and the Michigan Society of Thoracic & Cardiovascular Surgeons (MSTCVS) quality collaborative.

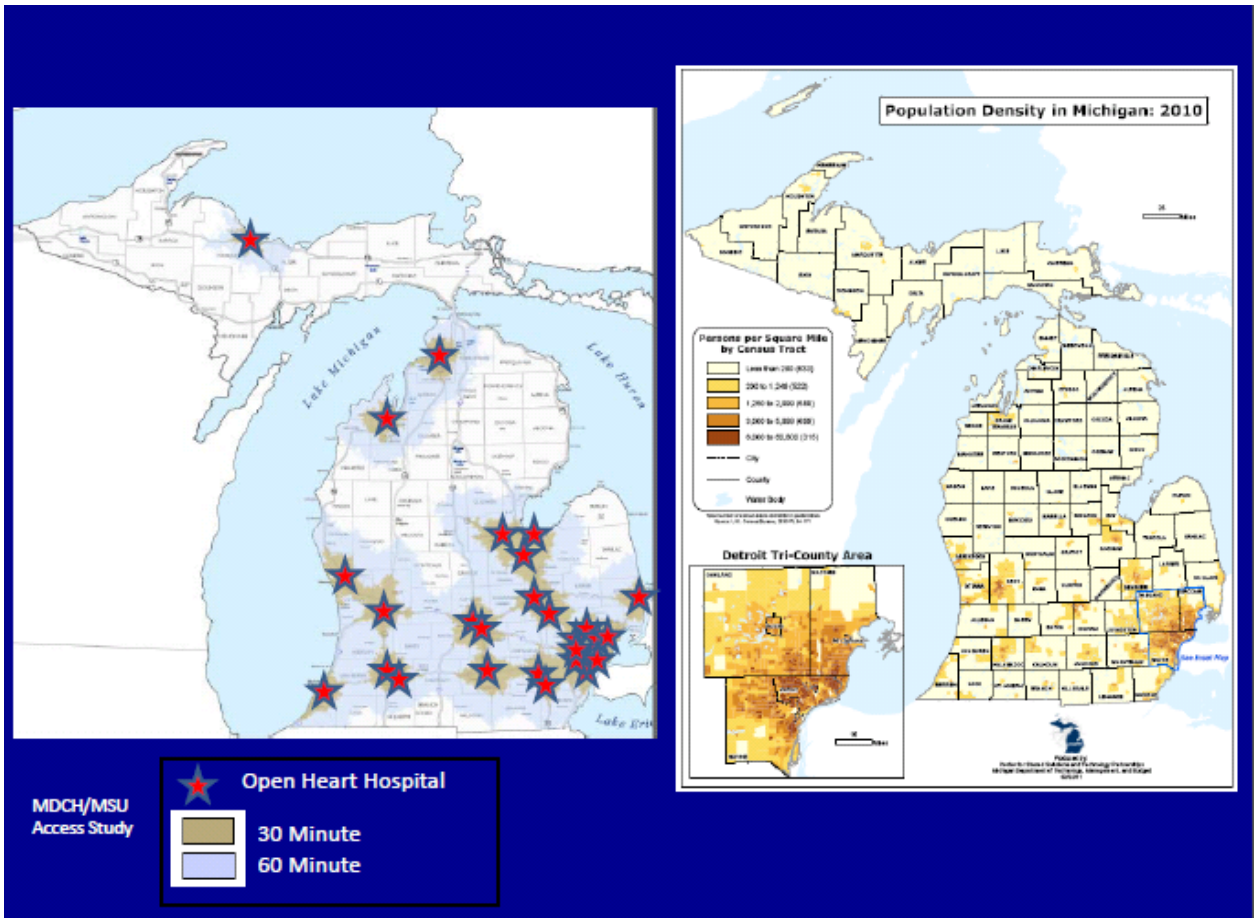
2. Submit composite STS / MSTCVS data to the MDCH.

Y-13, N-0, A-0

Recommendation

That the MDCH apply the composite and star quality metric to all OHS programs in the state of Michigan.

Y-12, N-0, A-0


Lake Michigan
Lake Huron
Lake Erie
Open Heart Hospital
30 Minute
60 Minute
MDCH/MSU
Access Study
Population Density in Michigan: 2010
Persons per Square Mile
by Census Tract
Detroit Tri-County Area

4. Propose standards for trans-catheter insertion of heart valves.

SPECIAL REPORT FROM THE SOCIETY OF THORACIC SURGEONS

2012 ACCF/AATS/SCAI/STS Expert Consensus Document on Transcatheter Aortic Valve Replacement

Developed in collaboration with the American Heart Association, American Society of Echocardiography, European Association for Cardio-Thoracic Surgery, Heart Failure Society of America, Mended Hearts, Society of Cardiovascular Anesthesiologists, Society of Cardiovascular Computed Tomography, and Society for Cardiovascular Magnetic Resonance

Writing Committee Members:
David R. Holmes, Jr., MD, Chair*, Michael J. Mack, MD, Vice Chair†, Sanjay Kaul, MBBS, Vice Chair*, Arvind Agnihotri, MD‡, Karen P. Alexander, MD*, Steven R. Bailey, MD§, John H. Calhoon, MD‡, Blase A. Carabello, MD*, Milind Y. Desai, MBBS‖, Fred H. Edwards, MD†, Gary S. Francis, MD*, Timothy J. Gardner, MD¶, A. Pieter Kappetein, MD, PhD**, Jane A. Linderbaum, MS, CNP*, Chirojit Mukherjee, MD††, Debabrata Mukherjee, MD*, Catherine M. Otto, MD*, Carlos E. Ruiz, MD, PhD§, Ralph L. Sacco, MD‡‡, Donnette Smith§§, James D. Thomas, MD‖‖

CMS Decision Memo – May 1, 2012

CMS Decision Memo

- FDA Approved device
- Patient selection
- Composition of pre and postoperative care team (Heart Team)
- Hospital infrastructure (room type, imaging systems)
- Program volume
- Surgeon and Interventional Cardiologist experience requirements

Recommendation

That the MDCH should utilize the STS database for cardiac procedures to reflect accurate maintenance volume reports.

Y-13, N-0, A-0

Project Delivery Requirements

Current Project Delivery Requirements require that cardiovascular surgeons perform a minimum of 75 open heart procedures annually, with prior standards requiring 50.

Given the decline in OHS cases, an equitable distribution of all cases among all cardiovascular surgeons, would allow each to perform about 79 cases per year.

Therefore, it was recommended that the MDCH scale back the individual surgeon OHS volume requirement to the prior level of 50 within the project delivery requirements section.

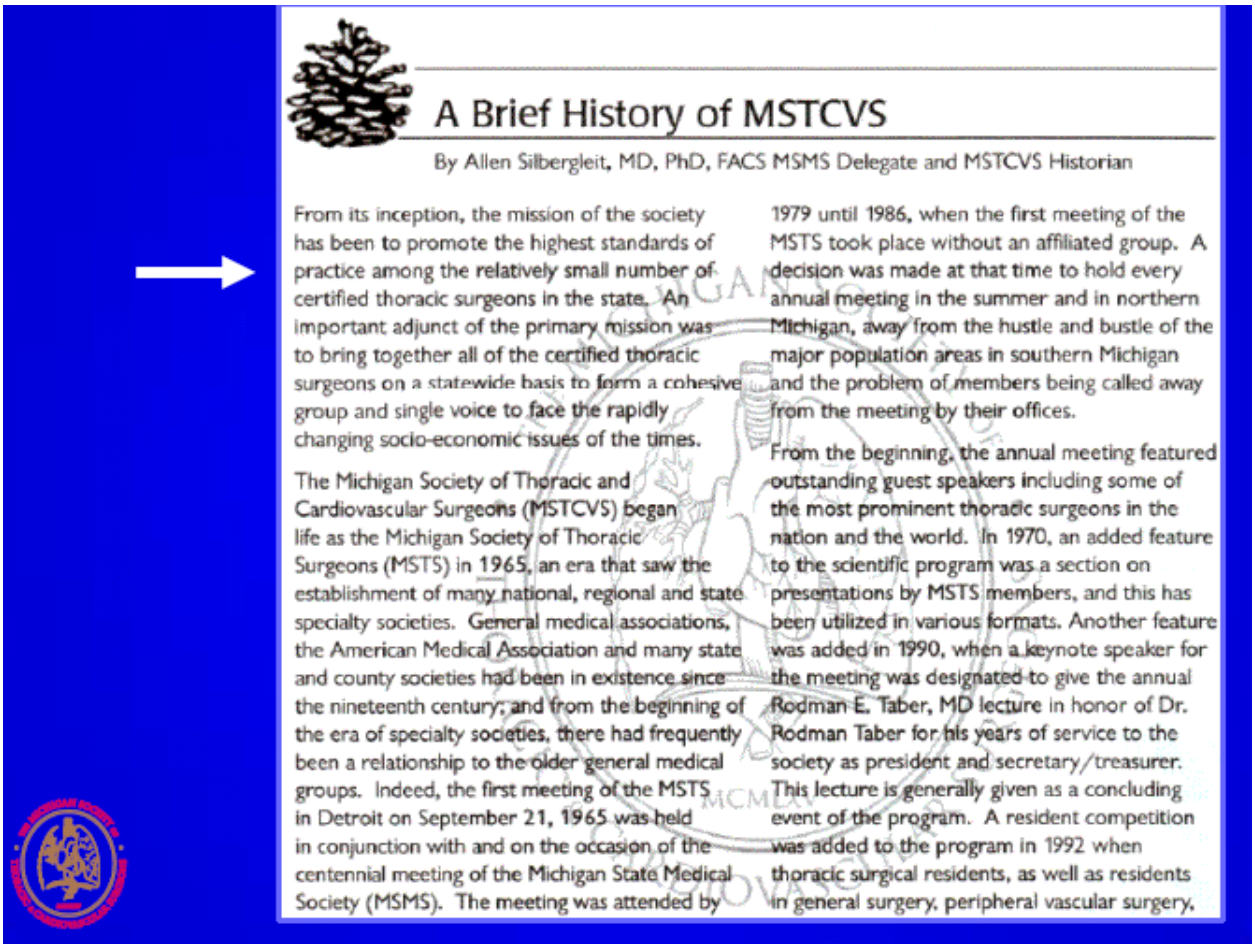
Y-12, N-1, A-0

The Michigan Society of Thoracic and Cardiovascular Surgeons Quality Initiative: A Model for the Country

Richard L. Prager, M.D.
Project Director

Open Heart Surgery Standard Advisory Committee

July 12, 2012



A Brief History of MSTCVS

By Allen Silbergleit, MD, PhD, FACS MSMS Delegate and MSTCVS Historian

From its inception, the mission of the society has been to promote the highest standards of practice among the relatively small number of certified thoracic surgeons in the state. An important adjunct of the primary mission was to bring together all of the certified thoracic surgeons on a statewide basis to form a cohesive group and single voice to face the rapidly changing socio-economic issues of the times.

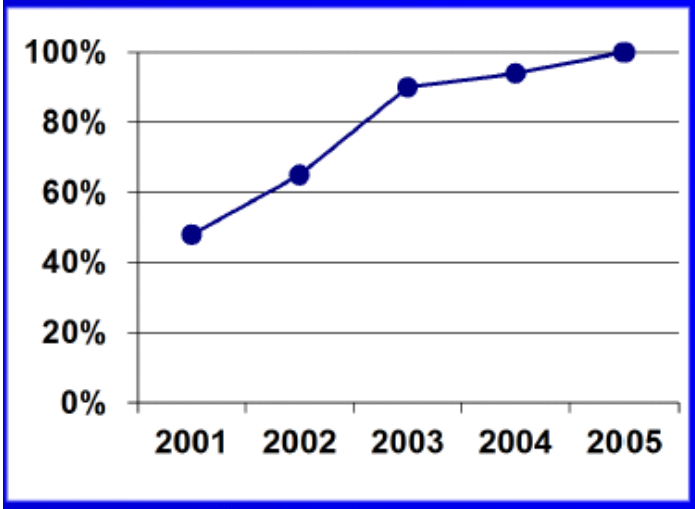
The Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) began life as the Michigan Society of Thoracic Surgeons (MSTS) in 1965, an era that saw the establishment of many national, regional and state specialty societies. General medical associations, the American Medical Association and many state and county societies had been in existence since the nineteenth century; and from the beginning of the era of specialty societies, there had frequently been a relationship to the older general medical groups. Indeed, the first meeting of the MSTS in Detroit on September 21, 1965 was held in conjunction with and on the occasion of the centennial meeting of the Michigan State Medical Society (MSMS). The meeting was attended by

1979 until 1986, when the first meeting of the MSTS took place without an affiliated group. A decision was made at that time to hold every annual meeting in the summer and in northern Michigan, away from the hustle and bustle of the major population areas in southern Michigan and the problem of members being called away from the meeting by their offices.

From the beginning, the annual meeting featured outstanding guest speakers including some of the most prominent thoracic surgeons in the nation and the world. In 1970, an added feature to the scientific program was a section on presentations by MSTS members, and this has been utilized in various formats. Another feature was added in 1990, when a keynote speaker for the meeting was designated to give the annual Rodman E. Taber, MD lecture in honor of Dr. Rodman Taber for his years of service to the society as president and secretary/treasurer. This lecture is generally given as a concluding event of the program. A resident competition was added to the program in 1992 when thoracic surgical residents, as well as residents in general surgery, peripheral vascular surgery,

Growth of the Early Collaborative

Cardiac Surgery Program Participation
MSTCVS / STS Regional Database



Michigan Cardiac Surgery Sites

MSTCVS Quality Collaborative
Surgeon Directed Quality Collaborative

University of Michigan Hospital
Ann Arbor

- Quarterly Collaborative meetings
- Quarterly data manager training
- Yearly data audits
- Focused efforts on select quality indicators
- Quarterly data submission with rapid data analysis and report turn around
- MSTCVS data warehouse

Borgess Hospital
Kalamazoo

Sparrow Hospital
Lansing

Mercy General Health
Partners, Muskegon

St. Joseph Mercy Hospital
Ypsilanti

Genesys Hospital
Grand Blanc

MSTCVS Quality Committee

- Quarterly review of mortality cases
- Site Visits
- POCMA
- Reverse Site Visits
- Improvement Plan sharing

The MSTCVS and Public Reporting

	Consumers Union	STS Website
STS Participants (1062)	396	425
Michigan Participants (33)	31	27

Composite Metric Scores:
July 1, 2010 – June 30, 2011

Dr. Douglas Mathisen's STS Presidential Address:

- Highlighted his visit last August to our Michigan Meetings:

"An atmosphere of self-improvement has been fostered as best practices are shared among 33 sites. ….This is a model we can all learn from."

**Appointed an STS task Force to help states and regions develop similar programs.

The STS Meeting Bulletin

47TH ANNUAL MEETING & EXHIBITION • JANUARY 31 - FEBRUARY 2, 2011
SAN DIEGO CONVENTION CENTER • SAN DIEGO, CALIFORNIA

Michael Mack Named STS President

Michael J. Mack, MD, was elected President of The Society of Thoracic Surgeons at its Annual Membership Meeting on Monday. Dr. Mack, who has long been active in the Society, works for the Big for Healthcare System in Dallas, Texas.

Dr. Mack graduated from Boston College with degrees in philosophy and biology. He received his medical degree from St. Louis University, went on to the University of Minnesota, where he became board certified in internal medicine, and continued his surgical training at the University of Texas Southwestern Medical School at Dallas.

Throughout his career, Dr. Mack has been actively active in the Society, especially serving on the Council on Quality Research and Patient Safety and the Council on Health Policy and Advocacy.

One of Dr. Mack's goals for the upcoming year is to increase collaboration between STS and other societies, including the American Association for Thoracic Surgery and the American College of Cardiology.

Another goal stems from Dr. Mack's interest in minimally invasive surgery. "We need to make the specialty as new techniques so it will be better equipped to adapt to the future," Dr. Mack said.

"Another challenge for the upcoming year is to help the specialty negotiate the landscape of health care reform."

As President, Dr. Mack also plans to focus on the STS National Database. "There are plans to develop and expand the Database beyond its current role," Dr. Mack said. "We have only begun to scratch the surface with use of the Database."

As he accepted the gavel from outgoing STS President Douglas J. Mathisen, MD, Dr. Mack thanked the membership for their vote of confidence.

"As a private practice physician, I have a good understanding of the needs of the practicing surgeon," he said. "Being named President of STS is the ultimate honor as a cardiothoracic surgeon, and I will do my best to serve the membership and the specialty."

Michael J. Mack, MD (left) accepts the STS presidential gavel from Douglas J. Mathisen, MD.

Mathisen Presidential Address Emphasizes Journey, Not Destination

Douglas J. Mathisen, MD, began his presidential address with a tribute to the many mentors who helped shape his career and a thriving reputation of appreciation to his family for their ongoing support. Dr. Mathisen, who called the Society his "professional home" and said "it has been a great honor to serve," delivered the address, "It's the Journey; It's Not the Destination, at the Monday morning plenary session in a packed ballroom.

Dr. Mathisen began his address by recognizing the many achievements of future CT surgeons, are and should continue to be ongoing priorities for the specialty. Dr. Mathisen said that if interest in the specialty is to increase, it must be through the efforts of current practicing cardiothoracic surgeons.

"We need to do more to tell our specialty, we have to reach out to college and medical students, along with general surgery residents. Early exposure to our field will stimulate increasing knowledge base, and the potentially negative impact of restrictive regulations. In addition, he expressed concern about how educational opportunities due to resident work hour restrictions. But he also thanked various initiatives from STS, AATS, and TSDA among other organizations that have helped engage medical students and general surgery residents, igniting interest and passion for cardiothoracic surgery.

Dr. Mathisen discussed the STS National Database and, noting the increasing number of participants, also emphasized the growing influence of the Database. He applauded the decision to implement an independent audit process for the Database and praised the development of a fair and balanced star-rating system. This system has been instrumental in STS's public reporting efforts, including the recently launched STS

Surgery
November 2005

Partnering with payers to improve surgical quality: The Michigan plan

Nancy J. O. Birkmeyer, PhD,[a] David Share, MD, MPH,[c] Darrell A. Campbell Jr, MD,[a] Richard L. Prager, MD,[a] Mauro Moscucci, MD,[b] *and* John D. Birkmeyer, MD,[a] *Ann Arbor and Detroit, Mich*

From the Michigan Surgical Collaborative for Outcomes Research and Evaluation, Departments of Surgery[a] and Medicine,[b] University of Michigan, Ann Arbor, and Blue Cross/Blue Shield of Michigan,[c] Detroit

WITH GROWING RECOGNITION that surgical outcomes vary widely across providers,[1-4] employers and payers are becoming more actively involved in strategies for improving the quality of surgical care.[5] Employers have obvious interests in minimizing

Although interest in P4P continues to gain momentum, there are several reasons for pessimism about the ultimate effectiveness of these strategies. First, as currently formulated, bonuses in P4P plans are too small to motivate major infrastructure

MSTCVS/BCBSM
Cost Savings Analysis

FY 2009 and 2010 improvement in specific quality related measures resulted in:

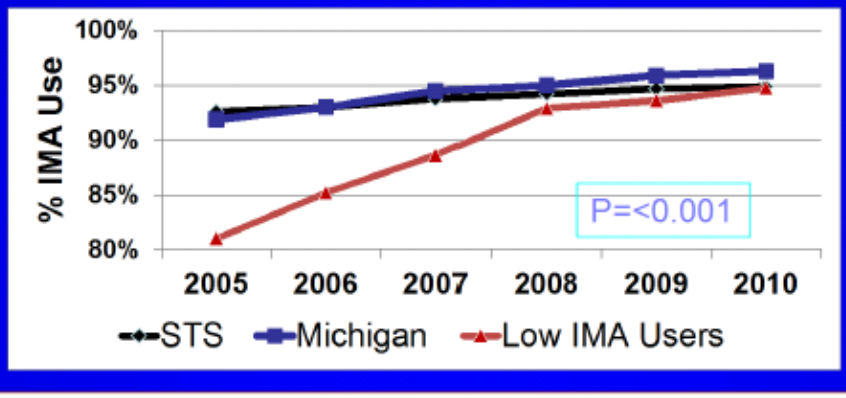
	FY 2009 Cost Savings	FY 2010 Cost Savings
BCBSM /BCN patient population	$1.3M	$1.1M
Statewide All Payor patient population	$17.1M	$13.2M

** Quality Indicators analyzed = transfusion, prolonged ventilation, renal failure, readmissions

The Michigan Improvement Plan

- Physician/Surgeon 'Champion'
- Quarterly Data Review: un-blinded, identifying NQF/composite metric indicators
- Education: lectures, open discussion
- Sharing 'best practice' protocols
- Site visits/Reverse Site visits

IMA Use in Isolated CAB
STS, Michigan and Low IMA Users



A Statewide Quality Collaborative for Process Improvement: Internal Mammary Artery Utilization

Scott H. Johnson, MD,* Patricia F. Theurer, BSN, Gail F. Bell, MSN, Luigi Maresca, MD, Thomas Leyden, BA, and Richard L. Prager, MD, for the Michigan Society of Thoracic and Cardiovascular Surgeons

Division of Cardiovascular and Thoracic Surgery, Sparrow Hospital, Lansing; Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative, Ann Arbor; Division of Cardiothoracic Surgery, St. Mary's of Michigan, Saginaw; Blue Cross Blue Shield of Michigan, Southfield; and Department of Surgery, Section of Cardiac Surgery, University of Michigan, Ann Arbor, Michigan

(Ann Thorac Surg 2010;90:1158–64)
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Ventilator Weaning Recommendations

Associate Professor, Department of Surgery
Medical Director, ECMO Program
Associate Director, Cardiovascular Intensive Care Unit

MSTCVS POST-OP CARDIAC SURGERY VENTILATOR WEANING RECOMMENDATIONS

All post-op cardiac surgery patients will be considered a candidate for early wean with the exception:

1. **Advanced age**
2. **Prolonged operative time**
3. **Aggressive intra-operative blood transfusions required**
4. **Hemodynamic instability or arrhythmias**
5. **Post-operative bleeding concerns**
6. **Morbid obesity**
7. **Open chest**

If patient does not meet above criteria, continue light dose of Propofol for sedation supplemented by Morphine sulfate or Fentanyl for pain.

Vent weaning is to begin when following criteria are met.

1. **Pt. is hemodynamically controlled**
2. **There are no concerns for ongoing bleeding**
3. **Pt. is warm**
4. **Evidence of clearance of neuromuscular blockers (spontaneous movement)**

Gradual wean of Propofol when patient follows commands. Obtain spontaneous ventilator wean parameters.

Expectable extubation parameters:

CPAP 5	**VT >5cc/kg**
RR <25	**VC 10 cc/kg**
NIF > -20	**RSBI < 100**

PaO2 >70%on <=50% FIO2 and PEEP not > 5

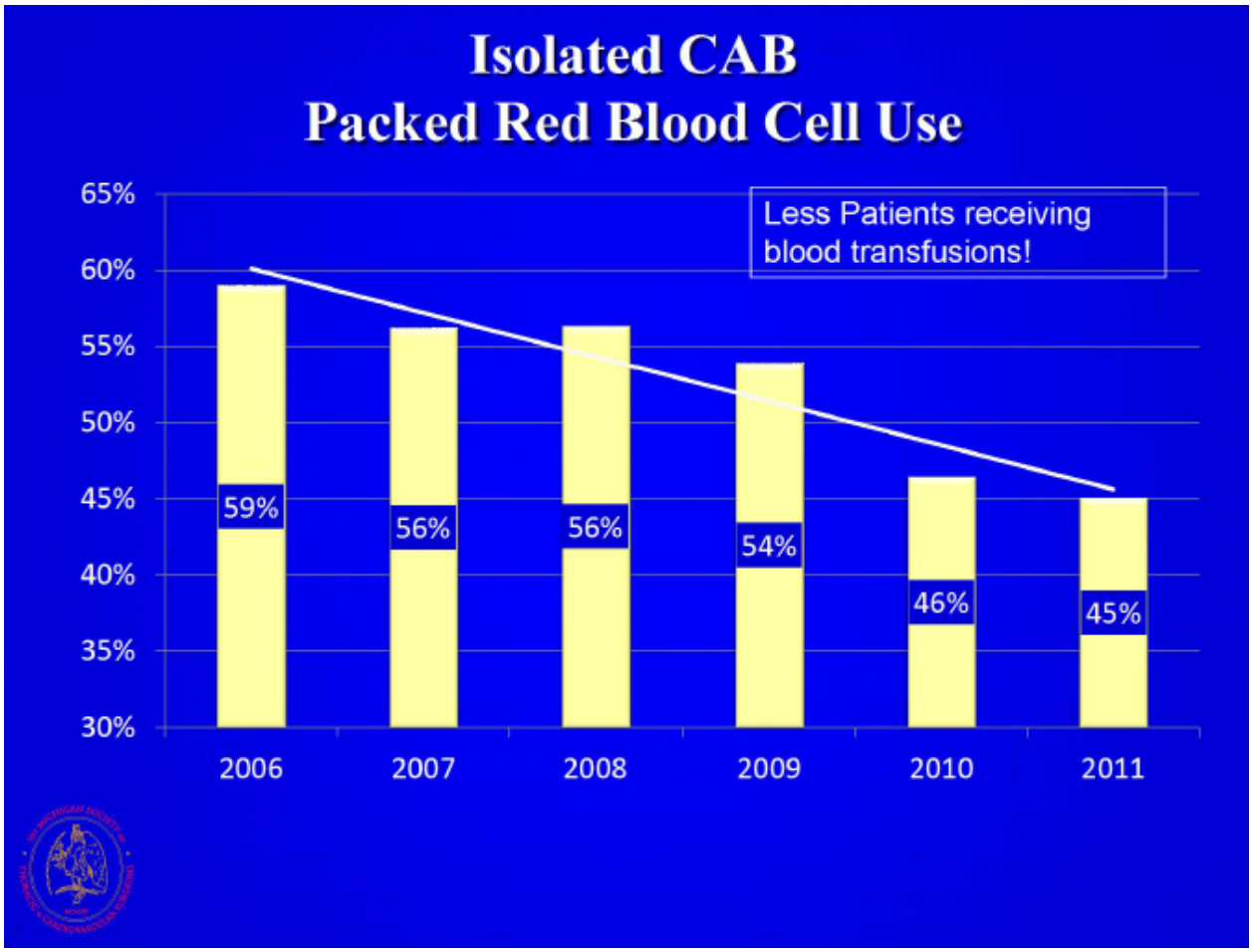
BORGESS
Medical Center

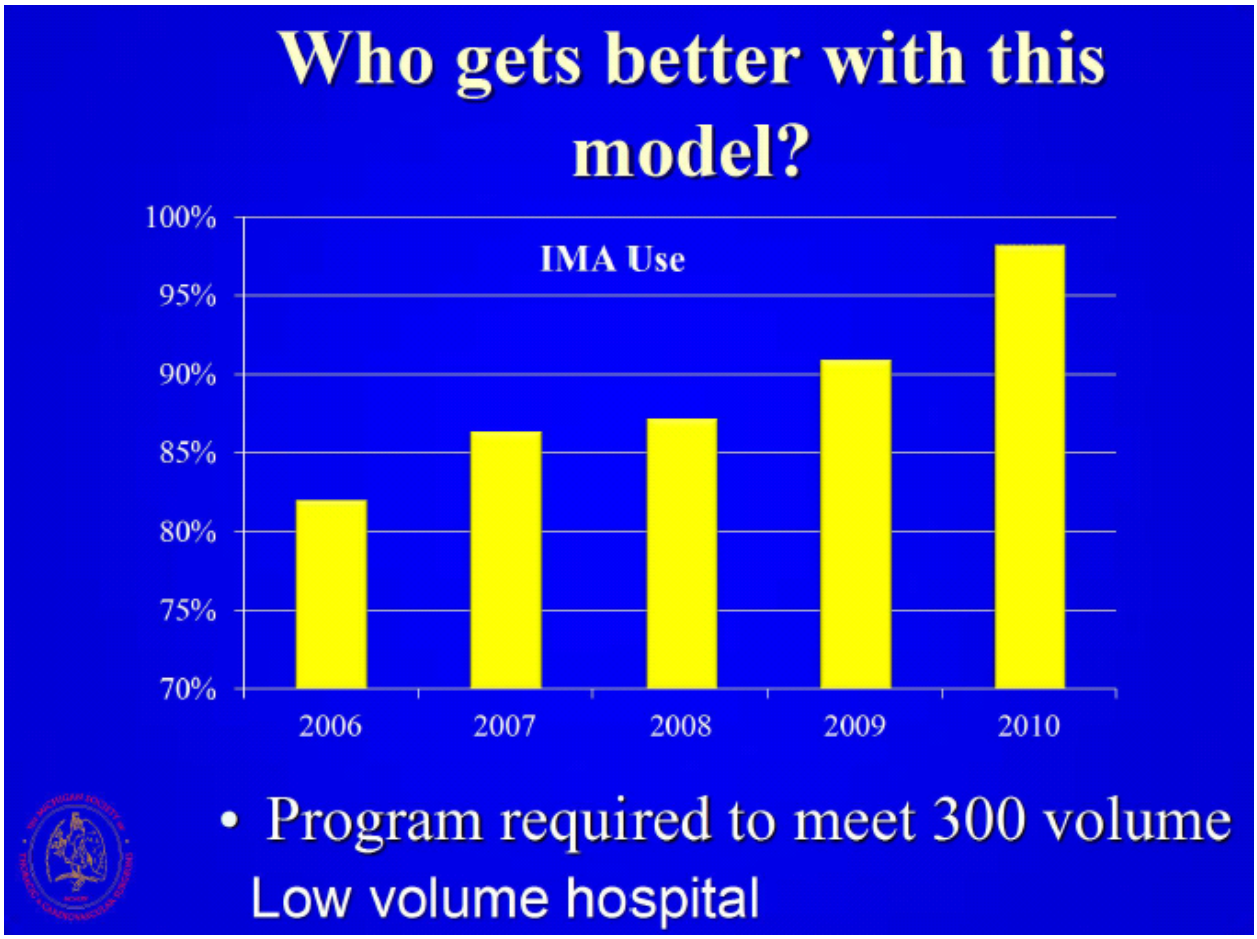
P-3 ANESTHESIOLOGY GUIDELINES FOR WEANING CSU POST-CABG PATIENTS

1. Upon arrival to CSU the anesthesiologist will determine if the patient may not be an "early wean" candidate. The following protocol will ensue if no problem.
2. The weaning process will begin as soon as possible post-op, as long as there are not surgical or ventilatory problems. We will strive for extubation in 2 to 7 hours.
3. The following factors shall be considered prior to extubation:
   a. Patient's level of consciousness, acid-base abnormalities, post-op bleeding.
   b. Capnograph trending.
   c. Strive for SaO_2 of > 92% at an FIO2 of < 70. Exceptions to these values occur often.
   d. Serious cardiac dysrhythmias.
   e. Pulse and Blood Pressure trending.
   f. Cardiac Output considerations, when available.
   g. SVO2 trending, when available.
   h. Urine output status, commensurate with patient's condition.
   i. Measure the patient's ventilatory reserve to help with extubation decision. Guidelines for optimal respiratory status include: TV >5 cc/Kg, NIF > 20 cm H20 pressure; VC > 10cc/Kg, and an unassisted head-lift of > 5 seconds (this criteria may not be possible in some patients).
4. After the above mentioned patient parameters have been evaluated, and it has been determined by the Nurse, Respiratory Therapist and Anesthesiologist that the patient can be weaned, the following shall occur:
   a. The IMV rate will be decreased as tolerated.
   b. The FIO_2 shall be decreased to < 70 and maintained at this level in order for the wean to proceed.
   c. If the respiratory function parameters are within acceptable limits, the patient will then be extubated by the RN/Respiratory Therapist and be placed on appropriate oxygen therapy. An attempt will be made to maintain an SaO_2 of > 92%, but exceptions to this level occur often.
   d. The RN/RPT will instruct the patient in the use of the incentive Spirometer, and encourage its use.
   e. Continuous pulse oximetry will be maintained for a minimum of 4 hours, post-extubation. Further necessity will be determined by the RN/RPT.
5. If the patient experiences respiratory problems, the "on-call" anesthesiologist shall be contacted for evaluation.
6. Frequently, the guidelines mentioned on this page, cannot be strictly followed. It is often in the patients best interested to be extubated in spite of marginal weaning parameters. An example would be the patient who needs the cough reflex in order to better expel secretions.

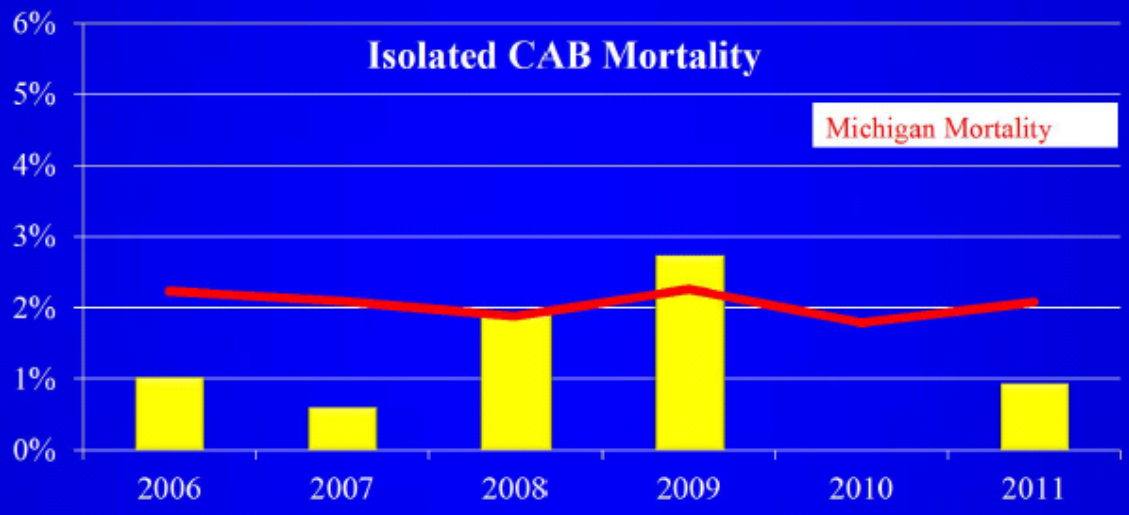
MSTCVS Blood Utilization

G. Paone, MD
Henry Ford Hospital


Isolated CAB
Packed Red Blood Cell Use
65%
60%
55%
50%
45%
40%
35%
30%
Less Patients receiving blood transfusions!
59%
56%
56%
54%
46%
45%
2006
2007
2008
2009
2010
2011


Who gets better with this model?
IMA Use
100%
95%
90%
85%
80%
75%
70%
2006
2007
2008
2009
2010
• Program required to meet 300 volume
Low volume hospital

Who gets better with this model?



Program required to meet 200 volume

Low volume hospital

STS Composite Quality Rating
Michigan Adult Cardiac Surgery Programs

	Jul 2006-Jun2007	Jul 2007-Jun 2008	Jul 2008 – Jun 2009	Jul 2009-Jun 2010	Jul 2010 – Jun 2011
Overall Score	**	**	***	***	***
Avoidance of Mortality	**	**	**	**	**
Avoidance of Morbidity[1]	**	*	**	**	**
Use of IMA	***	***	***	***	***
Medications[2]	***	***	***	***	***

1 Includes re operations, post op renal failure, post op deep sternal wound infections, prolonged ventilation and post op CVA

2 Includes pre op beta blocker, discharge beta blocker, discharge anti lipids and discharge antiplatelets.

Overall, Michigan's performance is significantly higher than the STS mean based on 99% Bayesian probability.

Recommendation

That the State of Michigan will engage in a formal dialogue with the Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) for the purpose of analyzing open heart surgery outcomes data and recommending quality initiatives.

Y-11, N-0, A-0

Summary

1. OHS programs should be judged based on quality metrics rather than volume.
2. If possible, the same quality metrics should apply to all programs.
3. There is no need to change program initiation or maintenance volume requirements.
4. All programs should participate with the STS national database and the MSTCVS quality collaborative and their database.
5. All programs should submit composite STS/MSTCVS data to the MDCH.
6. The STS/MSTCVS database should be the reference for actual program numbers.
7. Individual surgeon OHS requirement should be changed to 50 cases annually.
8. No additional regulations are needed for TAVR.
9. The MDCH should use the MSTCVS as a resource to help interpret data and improve OHS programs throughout the state.

Surgeon	Hospital	Category		Member	Employer	Category
Kourosh Baghelai	Lakeland Healthcare	Expert		Craig Banasiak	Chrysler	Purchaser
Alonso Collar	Sparrow Hospital	Expert		Kevin Birchmeier	Covenant Healthcare	Expert
Alphonse DeLucia, III	Bronson Methodist	Expert		Duanne DiFranco	BCBSM	Payer
Ali Kafi	DMC	Expert		John Fox	Priority Health	Payer
Gaetano Paone	Henry Ford	Expert		Charlie Heckman	AFSCME Local 999	Consumer
Richard Prager	U of M	Expert		Jan Penny	MidMich. Med. Ctr.	Provider
Timothy Sell	Oakwood	Expert		Dagmar Raica	Marquette Gen. Hosp.	Expert
Francis Shannon	Beaumont	Expert				

MEGAVOLTAGE RADIATION THERAPY (MRT)

Marc Keshishian, MD
Chair, MRT Work Group

MRT based on number of new cancer cases…

excluded: basal, epithelial papillary and squamous cell carcinomas of the skin other than genital area.

Change the standards from cancer cases to volume…

delete the section on documentation of new cancer cases.

Equivalent Treatment Visit (ETV):

A unit of measure, based on the type of treatment visit that reflects the relative average length of time one patient spends in one treatment visit in MRT.

One exception:

- Hospital-based in planning area 8.
- Site of the proposed MRT service is 90 driving miles or more, verifiable by department from the nearest RT service.
- Applicant provides comprehensive imaging service
  - Fixed magnetic resonance imaging (MRI)
  - Fixed computed tomography services (CT)
  - Mobile positron emission tomography (PET)
- Proposed MRI unit is not a special purpose MRT unit

Treating physician:

Means the physician of the MRT service directing and providing the MRT service, not the referring physician.

Quality issues:

An applicant shall submit evidence of accreditation by the American College of Surgeons Commission on Cancer or the Joint Commission on the Accreditation (JCAHO) within the first three years of operations and maintain accreditation thereafter (instead of continue to participate annually).

Quality issues:

An applicant shall submit evidence of accreditation by the American College of Radiology/American Society of Radiation Oncology (ACR/ASTRO) or the American College of Radiation Oncology (ACRO) within the first three years of operations and maintain accreditation thereafter (instead of continue to participate annually).

(j) "High MRT unit" or "HMRT unit" means a heavy particle accelerator or any other MRT unit operating at an energy level equal to or greater than 30.0 million electron volts (megavolts or MEV).

(k) "Intensity modulated radiation therapy" or "IMRT" means a visit utilizing only the computer controlled multi-leaf collimator part of the CMS definition for IMRT.

(l) "Intraoperative MRT unit" or "IORT unit" means an MRT unit that is designed to emit only electrons, located in an operating room in the surgical department of a licensed hospital and available for the treatment of a patient undergoing a surgical procedure with megavoltage radiation.

(m) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and1396r-8 to 1396v.

(n) "Megavoltage radiation therapy" or "MRT" means a clinical modality in which patients with cancer, other neoplasms, or cerebrovascular system abnormalities are treated with radiation which is delivered by a MRT unit.

(o) "MRT service" means the CON approved MRT utilization of a MRT unit(s) at one geographic location.

(p) "MRT unit" or "unit" means a CON approved linear accelerator; cobalt unit; or other piece of medical equipment operating at an energy level equal to or greater than 1.0 million electron volts (megavolts or MEV) for the purpose of delivering doses of radiation to patients with cancer, other neoplasms, or cerebrovascular system abnormalities.

(q) "Michigan Cancer Surveillance Program" means the program for the collection and analysis of information on cancer in Michigan operated by the Department mandated by Act 82 of 1984, being Section 333.2619 of the Michigan Compiled Laws.

~~(r) "New cancer case," means a person with any newly diagnosed cancer excluding basal, epithelial, papillary, and squamous cell carcinomas of the skin from other than a genital area.~~

(s) "Non-special MRT unit" or "non-special unit" means an MRT unit other than an MRT unit meeting the definition of a special purpose MRT unit or an HMRT unit.

(t) "Simulation" means the precise mock-up of a patient treatment with an apparatus that uses a diagnostic x-ray tube and duplicates an MRT unit in terms of its geometrical, mechanical, and optical properties.

(u) "Special purpose MRT unit" or "special purpose unit" or "special unit" means any of the following types of MRT units: (i) gamma knife, (ii) dedicated stereotactic radiosurgery unit, (iii) dedicated total body irradiator (TBI), (iv) an OR-based IORT unit, or (v) cyber knife.

(v) "Total body irradiator" or "TBI" means a specially modified dedicated cobalt unit certified as a total body irradiator by the Nuclear Regulatory Commission (NRC) or a permanently modified dedicated linear accelerator that uses a very wide beam of gamma rays or x-rays to irradiate the entire body simultaneously.

(w) "Treatment site" means the anatomical location of the MRT treatment.

(x) "Treatment visit" means one patient encounter during which MRT is administered. One treatment visit may involve one or more treatment ports or fields. Each separate encounter by the same patient at different times of the same day shall be counted as a separate treatment visit.

(2) The definitions in Part 222 shall apply to these standards.

Section 3. ~~**Modification of the Appendices**~~

~~Sec. 3. The Commission may modify the appendices as follows.~~

~~(1) The Commission may modify the Duplication Rates and the Duplication Factors set forth in Appendix A based on data obtained from the Michigan Cancer Surveillance Program and presented by the Department.~~

~~(2) The Commission may modify the Distribution of MRT Courses by Treatment Visit Category set forth in Appendix B based on data obtained from the Department Annual Survey of MRT providers and presented by the Department.~~

Attachment G - Click on document for full access to document

Michigan Department of

Rick Snyder, Governor
James K. Haveman, Director

http://www.michigan.gov/con

MDCH is an Equal Opportunity Employer, Services and Program Provider.

CERTIFICATE OF NEED
4th Quarter Compliance Report to the CON Commission
October 1, 2011 through September 30, 2012 (FY 2012)

This report is to update the Commission on Department activities to monitor compliance of all Certificates of Need recipients as required by Section 22247 of the Public Health Code.

MCL 333.22247

(1) The department shall monitor compliance with all certificates of need issued under this part and shall investigate allegations of noncompliance with a certificate of need or this part.

(2) If the department determines that the recipient of a certificate of need under this part is not in compliance with the terms of the certificate of need or that a person is in violation of this part or the rules promulgated under this part, the department shall do 1 or more of the following:
(a) Revoke or suspend the certificate of need.
(b) Impose a civil fine of not more than the amount of the billings for the services provided in violation of this part.
(c) Take any action authorized under this article for a violation of this article or a rule promulgated under this article, including, but not limited to, issuance of a compliance order under section 20162(5), whether or not the person is licensed under this article.
(d) Request enforcement action under section 22253.
(e) Take any other enforcement action authorized by this code.
(f) Publicize or report the violation or enforcement action, or both, to any person.
(g) Take any other action as determined appropriate by the department.

(3) 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), 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.

Activity Report

Follow Up: In accordance with Administrative Rules 325.9403 and 325.9417, the Department tracks approved Certificates of Need to determine if proposed projects have been implemented in accordance with Part 222. By rule, applicants are required to either implement a project within one year of approval or execute an enforceable contract to purchase the covered equipment or start construction, as applicable. In addition, an applicant must install the equipment or start construction within two years of approval.

Activity	4th Quarter	Year-to-Date
Approved projects requiring 1-year follow up	92	386
Approved projects contacted on or before anniversary date	52	266
Approved projects completed on or before 1-year follow up	57%	
CON approvals expired due to noncompliance with Part 222	19	69
Total follow up correspondence sent	223	871
Total approved projects still ongoing	322	

CERTIFICATE OF NEED

4th Quarter Program Activity Report to the CON Commission

October 1, 2011 through September 30, 2012 (FY 2012)

This quarterly report is designed to assist the CON Commission in monitoring and assessing the operations and effectiveness of the CON Program Section in accordance with Section 22215(1)(e) of the Public Health Code, 1978 PA 368.

Measures

Administrative Rule R325.9201 requires the Department to process a Letter of Intent within 15 days upon receipt of a Letter of Intent.

Activity	4th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Letters of Intent Received	89	N/A	422	N/A
Letters of Intent Processed within 15 days	89	100%	422	100%
Letters of Intent Processed Online	89	100%	422	100%

Administrative Rule R325.9201 requires the Department to request additional information from an applicant within 15 days upon receipt of an application, if additional information is needed.

Activity	4th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Applications Received	67	N/A	307	N/A
Applications Processed within 15 Days	54	81%	290	95%
Applications Incomplete/More Information Needed	47	70%	175	57%
Applications Filed Online*	67	100%	275	90%
Application Fees Received Online*	8	12%	55	18%

* Number/percent is for only those applications eligible to be filed online, potential comparative and comparative applications are not eligible to be filed online, and emergency applications have no fee.

Administrative rules R325.9206 and R325.9207 require the Department to issue a proposed decision for completed applications within 45 days for nonsubstantive, 120 days for substantive, and 150 days for comparative reviews.

Activity	4th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Nonsubstantive Applications	31	100%	155	100%
Substantive Applications	34	100%	115	100%
Comparative Applications	0	N/A	3	100%

Note: Data in this table may not total/correlate with application received table because receive and processed dates may carry over into next month/next quarter.

MEMORANDUM

Date: December 13, 2012

To: Joint Legislative Committee (JLC)

From: Certificate of Need (CON) Commission

RE: Recommendations Pertaining to the CON Program

MCL 333.22215(1)(f) requires the Commission, by January 1, 2005, and every 2 years after January 1, 2005, to "make recommendations to the joint committee regarding statutory changes to improve or eliminate the certificate of need program."

Accordingly, the Commission respectfully submits the following:

Based on our continuous review of the program, the Commission believes and unanimously recommends that the program should be fully supported as it is serving a valuable need. We are well aware of Senate Bill 1269 and its' supporters efforts to amend the CON Standards and the make-up of the Commission. Nevertheless, in our bipartisan judgment, we strongly believe the current CON process meets the three statutory objectives for the program, i.e., affordability, accessibility, and quality of health care in Michigan. The only statutory change to the current list of covered services that we would recommend at this time would be the removal of Pancreas Transplantation Services, which was deregulated effective September 28, 2012.

In addition to the responsibility of submitting the 2-year report to the JLC, MCL 333.22215(1)(e) of the CON law requires the Commission to "Annually assess the operations and effectiveness of the certificate of need program based on periodic reports from the department and other information available to the commission." Copies of FY2011 and FY2012 CON Program Annual Activity Reports are being provided with this Memo. Along with these annual reports, the Department provides quarterly program section performance reports to the Commission. These reports demonstrate the effectiveness of the CON program in processing letters of intent, applications, emergency applications, and amendments, as well as issuing decisions within the specified time frames set forth in the Administrative Rules. Further, the Commission is recommending an increase in the fees to support the CON program.

Pursuant to MCL 333.22215 (1)(m), the CON Commission is to "… review and, if necessary, revise each set of certificate of need review standards at least every 3 years." A Public Comment Period is held in October prior to the review year to determine what, if any, changes need to be made for each standard scheduled for review. The following review standards are up for review in 2013: Air Ambulance Services, Computed Tomography (CT) Scanner Services, Neonatal Intensive Care Services/Beds (NICU), Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups, and Urinary Extracorporeal Shock Wave Lithotripsy Services/Units. Currently, there is a workgroup reviewing CON Review Standards for Magnetic Resonance Imaging (MRI) Services. The Commission actively seeks input from the public and always includes opportunities for public comment/hearings prior to any Commission action.

Finally, we would like to provide the JLC a brief summary of our activities and accomplishments since the January, 2011 report. A summary of the approved changes to various CON Review Standards is attached.

CERTIFICATE OF NEED LEGAL ACTION

(12.13.12)

Case Name	Date Opened	Case Description	Status
Medilodge of Howell v MDCH and Trilogy—Howell Health Campus Livingston County Circuit Court No: 11-25961-AV	04/22/11	Application for Leave to Appeal relating to DCH's decision to remand a comparative review involving nursing home beds.	On October 2, 2012, The Court of Appeals denied Medilodge of Howell's application for leave to appeal for lack of merit. We have closed our file in this matter.

Case Name	Date Opened	Case Description	Status
Metro Health Hospital – CON Application: 10-1026 MAHS	01/07/11	Metro Health requested a hearing relating to DCH's 11/20/10 proposed decision to deny Metro Health's application for open heart surgery services and cardiac and catheterization services.	The Director issued her Final Order adopting the ALJ's Proposal for Decision in its entirety. We have closed our file in this matter.

Attachment L- Click on document for full access to document

Note: New or revised standards may include the provision that make the standard applicable, as of its effective date, to all CON applications for which a final decision has not been issued.

DRAFT CERTIFICATE OF NEED (CON) COMMISSION WORK PLAN

	2012												2013											
	J*	F	M*	A	M	J*	J	A	S*	O	N	D*	J*	F	M*	A	M	J*	J	A	S*	O	N	D*
Air Ambulance Services										PC	•	•	•R											
Bone Marrow Transplantation Services	•R		D	•	•	•	•	•	• R—	•	•P	•▲F												
Computed Tomography (CT) Scanner Services										PC	•	•	•R											
Magnetic Resonance Imaging (MRI) Services	•R	•	•R—S	•S	•PS	•▲F•S	•S	•	•	•	•	•	•	•	•R—	•	•P	• ▲F						
Megavoltage Radiation Therapy (MRT) Services/Units							•	•	•	•	•	• R—	•	•P	• ▲F									
Neonatal Intensive Care Services/Beds (NICU)										PC	•	•	•R											
Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups										PC	•	•	•R											
Open Heart Surgery Services	•S	•S	•S	▮	▮	▮	▮	▮	▮	▮	•	•R—	•	•P	•▲F									
Psychiatric Beds and Services	•R					•	•	•	• R—	•	•P	•▲F												
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units										PC	•	•	•R											
New Medical Technology Standing Committee	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M												
Commission & Department Responsibilities			M			M			M			M												