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September 1992

HEALTH POLICY BULLETIN

FOCUS: FURTHER CON COMMISSION ACTIVITY

The Certificate of Need Commission elected Douglas L. Wood, D.O., Ph.D., Dean of the College of Osteopathic Medicine, Michigan State University, chairperson at its September 14 meeting. Wood, one of the two Democratic members of the commission, was the unanimous choice of his colleagues. Robert McDonough, director of public policy, The Upjohn Company, was elected vice-chairperson (statute requires the vice-chairperson of the commission to be an appointee from a different political party than the chairperson). Carla O'Malley, senior vice-president and chief operating officer for the Annapolis-Westland Division of Oakwood United Hospitals, was chosen as second vice-chairperson, a position that requires her to act as the commission's liaison to the State Health Planning Council.

The commission took up the Michigan Department of Public Health (MDPH) recommendations for amending the standards for open-heart services. Although the ad hoc advisory committee, composed of experts and providers, recommended increasing the number of procedures from 200 to 300 per facility per 12-month period and setting a minimum volume requirement for cardiac surgeons of 100 to 150 procedures per 12-month period, the MDPH did not accept those recommendations. Instead, the MDPH set a lower limit of 200 procedures per facility and did not set a volume standard for surgeons. The department said that while the literature appears to show that a relationship exists between the volume of procedures performed and desirable outcomes, it does not indicate conclusively the optimal number of procedures per facility or per surgeon. The department also observed that tracking the number of procedures done by individual attending surgeons would be administratively difficult. Finally, the department expressed the view that making the data-sharing provisions more restrictive would control the proliferation of open-heart surgery programs.

The proposed minimum standards came under fire from several speakers. Larry Horwitz, executive vice-president, Economic Alliance for Michigan, made clear his opposition to the proposed standard when he asked, "Do we want to establish a low quality standard?" He noted that as long ago as 1972 the American College of Cardiology had set 200–300 cases annually as a rockbottom minimum standard; he referred to a study in New York that concluded a minimum of 700 procedures annually in a facility was necessary for optimal quality. He also observed that a clear majority of the advisory committee (its recommendations are not binding on the MDPH) had wanted to set a minimum of 100–150 procedures per surgeon annually. Bob Parrish, senior vice-president, Greater Detroit Area Health Council, commented that four of the five surgeons on the advisory committee had favored increasing minimum volumes for facilities to a level between 450–500 procedures performed annually.

After considerable discussion, the commission adopted a standard of 300 procedures annually for facilities and 50 procedures each annually for attending surgeons; both standards must be met by a program. Parrish, who had served on the ad hoc advisory committee, noted that hospitals already have mechanisms in place to track the number of procedures performed by a particular surgeon. The only commission member who expressed reservations about attaching specific numbers to open-heart procedures was Harold Knight, a certified public accountant with business and manufacturing interests in East Tawas and a particular interest in access problems in rural areas.

Other areas creating considerable discussion were data sharing and joint ventures. Data sharing refers to the provision allowing one hospital to use another hospital's data in a CON application for open-heart services. The revised standard proposes allowing a hospital to lend its data to another hospital only once to a particular program rather than every three years and requires the hospital lending the data to be in the same health planning area as the hospital borrowing the data; in other words, a hospital located in Grand Rapids could not borrow data from a hospital located in Detroit.

The lone exception to the new standard for lending data applies to hospitals in a planning area that currently does not have open-heart surgery services available. In that situation one or more hospitals could lend data to a hospital in support of a CON for open-heart services, provided there was a formal joint venture agreement in place. The ensuing discussion focused on the meaning of the phrase *formal joint venture*. Robert Yellan, vice-president for governmental affairs, Detroit Medical Corporation, pointed out that geographic proximity and organizational relationships between facilities were necessary elements in the definition. The commission adopted language specifying that a formal joint venture agreement had to have organizational and administrative relationships and had to encourage the referral of patients for open-heart surgery.

The revised CON review standards for cardiac services were approved by the commission and released for public comment at a hearing on October 19, 1992.

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In other business, the commission received progress reports from the MDPH staff on the review standards for psychiatric beds for children and adolescents and partial day hospitalization programs and on the activities of the Ad Hoc Advisory Committee on Long-Term Care. That group will meet this fall to look at the revisions made to review standards for long-term care in 1991, to examine the concepts in the revised bed need methodology, and to consider the implications for long-term care of the report of the Human Services Directors Interagency Work Group. The MDPH staff noted that final CON review standards for long-term care, psychiatric services, and megavoltage radiation therapy will be ready for final action by the commission at its December 14–15 meetings. The commission is expected to approve the standards for transmittal to the legislature and the governor for their review.

During the public comment portion of its meeting, the controversy over extra-renal organ transplant standards and the regulation of autologous (self) and allegeneic (other donor) transplants came up. Most speakers urged that autologous transplants should be reviewed under different standards than allegeneic transplants. Robert Meeker, Butterworth Hospital, urged that the geographic distribution and number of centers in the state need to be considered by the commission. In his view, the western part of the state was significantly disadvantaged because existing transplant centers are all located in southeast Michigan. Lodewyk (Lodi) Zwarensteyn, executive vice-president, Alliance for Health, was concerned about the commission's failure to put a priority on mobile cardiac catheterization services; he characterized such services as "inviting problems of liability" (because the services might be performed under circumstances that limit the patient's access to appropriate care should an emergency arise). The department's staff will brief the commission on the issues surrounding autologous transplants and quality issues concerning mobile cardiac catheterization services during the December meetings.

The commission has scheduled a two-day meeting for December 14–15 beginning at 10 a.m. in the Michigan State Chamber of Commerce Building, 600 South Walnut Street, Lansing. During that meeting the commission will take note of the public comment on the proposed open-heart surgery standards.

Although the table that follows contains data only for hospitals in southeast Michigan, we have included it because we think it is important for our readers to have some idea of the availability of open-heart surgery services. We also note that there are 30 open-heart surgery programs operating in the state, 15 in southeastern Michigan and 15 outstate. Current survey data for outstate programs are not available. Existing 1988 data from the MDPH indicate that approximately 4,800 open-heart procedures were performed outstate and 5,800 were performed in southeastern Michigan.

1991 Open Heart Surgery Volume for Southeastern Michigan Hospitals

Hospitals	Open Heart Surgeries
Children's[1]	229
Detroit Osteopathic[2]	84
Harper	703
Henry Ford	554
Oakwood	759
Providence	416
St. Joseph Mercy—Ann Arbor	778
St. Joseph Mercy—Pontiac	291
St. John	1,184
Sinai	702
University	1,487
Veterans Administration—Ann Arbor	233
William Beaumont	1,058
TOTAL[3]	8,478

SOURCE: Greater Detroit Area Health Council 1991 Hospital Utilization Survey.

[1]Pediatric open-heart only.
[2]Program is being phased out.
[3]The GDAHC data does not reflect two additional open-heart programs in southeastern Michigan; according to the MDPH, there are fifteen such programs in the area.

OF INTEREST

In the next thirty days, the Senate Committee on Health Policy will report out four smoking-related bills: HB 4324 (50 percent of restaurant seating capacity for nonsmokers), HB 5017 (prohibits sale of tobacco products in vending machines), HB 5225 (prohibits sale of single cigarettes), and HB 5646 (prohibits promotion and/or sale of tobacco products through the mails). The House will adjourn on October 1 and the Senate on October 8 until after the November elections.

Correction: In our August issue, we committed two errors of fact. We apologize to the Michigan Department of Public Health and our readers for stating that the report of the Human Services Directors Interagency Work Group recommended removing nursing home beds from the certificate of need process—the report did not make that statement. Second, we said that the disapproval of the proposed CON review standards for psychiatric programs and beds left the state without review standards for those programs; the disapproval of the proposed standards meant that current standards remain in place.

Frances L. Faverman, Editor

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