STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH

BMT SERVICES, HEART/LUNG AND LIVER TRANSPLANTATION SERVICES,
MRI SERVICES, PANCREAS TRANSPLANTATION SERVICES,
AND PSYCHIATRIC BEDS AND SERVICES
Tuesday, January 31, 2006
Capitol View Building
201 Townsend Street
Lansing, MI

ORAL TESTIMONY

(Hearing schedule to start at (9:30 a.m.; actual start time was 9:47 a.m.)

MS. ROGERS: Good morning. My name is Brenda Rogers. I am Special Assistant to the Certificate of Need Commission from the Department of Community Health. Chairperson Norma Hagenow has asked the department to conduct today's hearing.

This is the first annual public hearing that will be held in January of each year to determine what, if any, changes need to be made for each standard scheduled for review. The following CON Review Standards are scheduled for revision in 2006, and this public hearing is to take testimony concerning these standards: Bone Marrow Transplantation or BMT Services, Heart/Lung and Liver Transplantation Services, Magnetic Resonance Imaging or MRI Services, Pancreas Transplantation Services, and Psychiatric Beds and Services. For a complete listing of all review standards scheduled for a three-year review pursuant to MCL 333.22215(1)(m), please refer to page 2 of the Certificate of Need Commission's Work Plan located at www.michigan.gov/con

Please be sure that you have signed the sign-in log. Copies of the current review standards can be found on the table. Please complete one comment card for each review standard that you will be providing testimony for. We will hear testimony on one review standard at a time. At the end, I will call for any additional comments for people that may have come in late. Please hand your card to me if you wish to speak. Additionally, if you have written testimony, please provide as well. As indicated on the Notice of Public Hearing, written testimony may be provided to the department through February 7th, 2006 at 5:00 p.m.

We will begin the hearing by taking testimony from those of you who wish to speak. The hearing will continue until all testimony has been given, at which time we will adjourn. Today is Tuesday, January 31st, 2006, and we will now begin testimony. We are going to start with Bone Marrow Transplantation Services.

MR. MEEKER: My name is Bob Meeker from Spectrum Health in Grand Rapids. And I would like to advocate that the CON Commission re-open the CON Review Standards for Bone Marrow Transplantation for review and revision. I think that the most fundamental reason is that the current requirements prohibit more than three bone marrow transplant programs in the state, which I think is insufficient given the -- I'm speaking specifically of adult bone marrow transplant now. That's insufficient, given the array of cancer and blood related conditions for which bone marrow transplant is an indication. Furthermore, in addition to the fact that I think the number three is insufficient, all of the existing full-service bone marrow transplant programs for adults in the State of Michigan are in southeastern Michigan.

So in addition to the fact that there are plenty of patients throughout the state, the patients who happen to be in west Michigan have at least 120 miles to go to the nearest bone marrow transplant program. This is a concern not only because they have to go for the treatment, but there is pre- and post-work for those patients, and for patients who have successfully received bone marrow transplant there are regular or routine follow-up visits, all of which would require the patients to be going out of the area for significant periods of time. In west Michigan, one Grand Rapids medical oncology group annually diagnoses more than 40 adult patients with clinical conditions indicating the need for bone marrow transplant. And obviously, all of these patients are currently referred at least 120 miles for this kind of treatment.

There are other issues throughout the standards, which I've identified in my written comment. The accreditation standards for bone marrow programs are in the process of being updated. The third edition of those standards is out for public comment and should be finalized in the next few months. They would indicate that whereas the standards currently -- the numbers currently in the standards for allogeneic and -- only programs and also allogeneic and autologous are consistent with those standards. The ones for autologous-only programs, the current requirements in the CON standards are more restrictive than what is proposed in national accreditation standards. And certainly I think that our state standard should be consistent with those.

Also in the standards there currently is no discussion of combined adult and pediatric programs, the implication being that they're really separate programs and they have their own volume requirements. Whereas, again, -- both the current second edition of the National Accreditation Standards and also the proposed third edition have distinct requirements for combined adult and pediatric programs. The current standard is four adult and four pediatric procedures a year; the proposed requirement is five of each per year.

There are also other specific provisions, perhaps the definition of an existing bone marrow transplant service with which a new service needs to contract as far as a consulting agreement is concerned. Again, the requirements are fairly restrictive and far exceed the current National Accreditation Standards.

There are also requirements for numerous services to be available on site to support a bone marrow transplant program, while a lot of these are laboratory services or things like radiation therapy services, many of which are being moved off the main campuses of existing medical centers. And so I think that if the language indicated that either they were on site or immediately adjacent to the proposed hospital site, that that would be a little more reasonable and would allow hospitals to move these kinds of support services out of expensive hospital space and still be able to legally support programs like bone marrow transplant.

There are other organizations in the current standards, which have changed. For instance, the Pediatric Oncology Group no longer exists, nor the Children's Cancer Group; they have combined into a new group. The national accreditation body has changed its name, and these changes need to be made in the standards as well. I think probably whereas some of these minor changes could easily be done without a Standards Advisory Committee, I think the need to look at how many bone marrow transplant programs ought to be available in the state or what the geographic availability should be probably warrants a more formalized process. And we would recommend that the commission initiate that process as soon as possible.

MS. ROGERS: Patrick O'Donovan, Beaumont Hospitals.

MR. O'DONOVAN: My name is Patrick O'Donovan, Director of Planning for Beaumont Hospitals. At each of the three most recent CON Commission meetings held in June, September and December 2005, Beaumont has asked the CON Commission to put the Bone Marrow Transplantation CON Review Standards on its work plan for reevaluation. We brought physician experts to provide testimony, and we provided a position paper to the commission entitled "The Need for Increased Access to Stem Cell Transplant Programs in Michigan." Each time we were reminded by the commission and the department that BMT was on the list to be reviewed in 2006 as part of a now-mandated three-year review of all CON Review Standards, and we were encouraged to testify at this public hearing, which we are now doing.

In short, the rationale in support of reviewing these standards to increase access is that BMT standards haven't been substantively reviewed since 1997, nine years ago. BMT is one of the only remaining standards that identify a fixed number of programs for the state without any need-based criteria to support that number. Currently there are only four hospitals in the state with adult BMT programs. The number of BMT procedures is projected to increase due to the ability to transplant older patients and the increasing number of patients with diseases that can be treated with bone marrow transplant. BMT is the standard of care for a variety of malignant and benign conditions. The technology and practice of BMT is rapidly changing such that many patients can have their transplants done on an outpatient basis, and oncologists at large cancer centers without a BMT program must refer patients to outside centers and outside physicians for this treatment. This interrupts their continuity of care and negatively impacts the strong doctor-patient relationships that are established. Referrals elsewhere also require significant retesting and restaging. These tests add substantial cost to the healthcare system and impose unnecessary hardships for these patients.

There are a variety of approaches that can be used to increase access to bone marrow transplants in Michigan. These include removing BMT from CON coverage, increasing the number of BMT programs allowed under the current standards, allowing for acquisition and relocation of existing BMT programs and developing a need-based methodology to project bone marrow transplant need. These approaches are not all mutually exclusive, and other approaches may be identified. Beaumont plans to meet with the department and others over the next month and hopes that will result in a recommended approach to the commission at the March CON Commission meeting. In any event, we urge the commission to keep bone marrow transplant on its schedule for a 2006 review.

MS. ROGERS: William Blaul, Karmanos, Cancer Institute.

MR. BLAUL: Good morning. I'm William Blaul, Vice President of Institutional Relations with the Karmanos Cancer Institute, and we appreciate the opportunity to provide public input regarding the state's current Certificate of Need standards for bone marrow transplant programs. The Karmanos Cancer Center, which is the Karmanos Cancer Institute's patient care enterprise, conducted 154 adult BMT procedure in 2005, as well as 20 pediatric BMT procedures last year. Our BMT program was the first in Michigan and we believe is now the highest volume BMT program in the state. The leader of the Karmanos bone marrow transplant program, Dr. Voravit Ratanatharathorn, chaired the state's first panel on setting BMT standards in 1984, and our expertise in this field is quite deep, historically rooted and currently very active.

Now, more than 20 years after the current BMT standards were established, we believe it is time to consider revisions and updates to reflect current science and clinical practice. We believe these updates to BMT standards should be in the framework of strengthening, if possible, the current BMT programs in Michigan rather than establishing a means to create new BMT programs. Our reasoning is guided within the context of three considerations; quality, cost and access. It's our estimation that of all the BMT programs in the state, only Karmanos is operating at close to capacity. Access is not a problem in southeast Michigan, where Karmanos and the University of Michigan both operate BMT programs and both are federally designated comprehensive cancer centers. Additionally, through our affiliate relationships with five community hospitals and practice groups in Michigan and northern Ohio, Karmanos provides access to BMT patients throughout the state. Our affiliates are Northern Michigan Hospitals in Petoskey, Mid Michigan Medical Center in Midland, the Toledo Clinic, Chittenden in Rochester and Mount Clemens General. The University of Michigan and Karmanos are historically the two highest volume BMT centers in the state. Henry Ford also operates a BMT center with minimal volume in Metro Detroit. Oakwood also has a BMT program.

Now, access could only be argued as a possible issue for patients on the west side of the state, as to a feasibly driven proximity to Karmanos or U of M, so there is merit to that argument. BMT programs are very expensive, to initiate, very expensive to maintain and properly administer. We believe that to properly focus resources and to ensure optimal patient outcomes and further the science of these procedures, BMT programs in Michigan should be linked directly or indirectly to federally designated comprehensive cancer research programs, thereby connecting research and patient care, which is optimal for oncology patients. The Karmanos Cancer Institute has prepared a more detailed analysis of issues regarding existing BMT centers and the lack of justification, in our view, for any new centers, which we have respectfully submitted for the CON Commission's consideration. Thank you for the time and for your interest in this matter.

MS. ROGERS: Do I have any comment for Heart/Lung and Liver Transplantation Services at this time? Okay. Hearing none, we will move to MRI Services. Walt Wheeler.

MR. WHEELER: My name is Walter Wheeler and I am here today to comment on the MRI standards on behalf of Bell Memorial Hospital, which is a 25-bed critical access hospital located in Ishpeming. By way of background, the Critical Access Hospital Program was created by the federal government in 1997 as a safety net to assure access to healthcare services in rural areas. It helps smaller rural hospitals to stay financially healthy and requires them to maintain quality, accessible and affordable services in their local communities. It's a good program for communities, it's good for economic development, and it's good for public health. Critical access hospitals, by definition, are small hospitals; 25 beds or less. They're situated in rural or micropolitan areas and are located more than 35 miles from any other hospital or more than 15 miles from another hospital

in areas with heavy snow history or only secondary roads. That's federal law. Michigan currently has 34 critical access hospitals, which are each fully licensed and fully subject to Certificate of Need.

Among other things, many critical access hospitals provide orthopedic services, a medical service that people need and people expect to have available close to where they live. By today's standards, quality orthopedic care involves MRI services, which, are available when the patient needs them, especially in emergencies. A continuously available fixed unit allows a hospital to provide this level of care much more effectively than if it is limited to a mobile unit available only a few days a week or a month at the hospital. In the case of rural hospitals such as Bell Memorial, the inability to obtain continuously available MRI services under the current standards undermines the continuity of community care and weakens programs that enhance access, such as the Critical Access Hospital Program.

Certificate of Need standards, which prohibit services in limited access areas must be carefully monitored, and they must be amended if the circumstances that gave rise to their enactment change. This has happened in 2004, when Section 3 of the MRI standards was first amended to reduce volume of cases required to convert from a mobile to a fixed unit from 6,000 cases to 4,000 cases in limited access areas. Unfortunately the problem remains, and that is because of their relatively small size and low patient volumes, individual critical access hospitals are still prevented from converting from a mobile to a fixed MRI unit when that conversion makes common sense. This means that their communities have access only to intermittent services purchased from a mobile MRI host site. When it comes to meeting the volume requirements for conversion from a mobile unit to a fixed MRI, rural hospitals are in a Catch-22 situation. On most days the cases requiring MRI services are there but the mobile MRI unit is not. A mobile unit available only for a limited number of days in a month is not at the hospital often enough to generate the volume requirement needed to convert to a fixed unit. The result is unfortunate, because in rural communities MRI waiting lists extend for months. In many cases citizens are required to travel to remote MRI units for service. This is particularly difficult for our rural senior citizens. They must travel to distant cities for services in large unfamiliar institutions. It is a situation that is exactly the opportunity of the purpose of the Critical Access Hospital Program, which is to keep services available in local areas.

Now, the reason the standards originally favored mobile units over fixed units was to contain MRI costs. This made sense when the cost of a fixed unit was extremely high and the cost of shared mobile services was relatively low. But with today's technology, the cost of a fixed MRI unit can actually be less than the cost of renting time on a mobile unit. First, the cost of fixed units has gone way, way down. Second, the mobile central service providers, they know that most host sites, under the current standards, have no chance of converting to a fixed unit and therefore they have no competition and no incentive to reduce or even contain costs. Here's a real example of the problem. In the case of Bell Memorial, the cost of renting time on an available mobile unit is now $3,972 a day -- almost $4,000 per day. Even a half-day costs $2100. Even when access is limited to two days a week or eight days a month, the monthly cost of this limited mobile service is about $32,000 to the hospital. At today's prices, however, Bell could purchase a brand new fixed unit for about a million dollars, and could finance that for about $19,000 per month. This would be a monthly savings of at least $13,000 for a more effective unit and a continuously available unit in the community. Now, a refurbished unit could cost much less than that, maybe half that cost.

The bottom line is that Michigan's rural communities can have greater access to quality MRI services at less cost if the MRI standards are amended to allow conversion from a mobile in a rural area when substantial cost savings can be shown and the other non-volume criteria can be met. We're not talking about a deluge of new conversions or changes that would materially change the standards. We're only talking about a tweak to the current standards that will permit conversion from a mobile to a fixed unit in a low access area when the applicant can demonstrate clear cost savings for its rural communities. This will be within the limited existing exceptions that are already there.

We'd like to work with the commission staff and the commission to draft a very limited amendment to Section 3 of the standards for MRI to increase access to fixed MRI services in rural communities when cost savings can be clearly demonstrated. This is common sense. It's totally consistent with the purposes of the CON program to promote cost containment, quality improvement and access to needed services. And we look forward to working with you toward this end.

MS. ROGERS: Bob Meeker, Spectrum Health.

MR. MEEKER: I'm Bob Meeker with Spectrum Health in Grand Rapids, and I would like to speak to what I think are minor tweaks to the CON Review Standards for MRI services. First of all, I'd like to say that I think that the current volume requirements, certainly for metropolitan areas, are reasonable. I think that they reflect a high level of utilization without an excessive level of utilization before increased capacity can be approved. And I think that for the most part, at least again in metropolitan areas, that those standards should be effect -- should be maintained.

There are a couple of fairly specific issues that I think need to be looked at. One is relative to research use of MRI's. Currently there is an exception for a dedicated research MRI unit. However, many community hospitals that are also academic medical centers, that are also involved in research, either cannot or don't really wish to dedicate an entire machine solely to research, but however would like the ability to use an existing MRI machine on a part-time basis for research. So I think that without having any specific recommendations, that some sort of an allowance for partial use of a clinical MRI for research needs to be explicitly addressed in the standards.

Secondly, we believe that a new definition needs to be added or a new category of patients needs to be added, which we're calling special needs patients. Currently the standards recognize that children -- and Spectrum Health has DeVos Children's Hospital and has a large pediatric volume on our imaging and on other services, as well. The current standards recognize that children do require more machine time than adults, and there are weights in the standards that take that into account. However, there is an additional category of patients -- and some of them may be children, others may be adults -- who also require additional time because of their unique characteristics. These would be patients with special needs, and we're specifically talking about patients with Down's Syndrome, autism, ADHD, developmental delay, agitation and other syndromes such as Hunter's Syndrome. So we feel that that category should be added and a weight of .5 added to the weights in the CON Review Standards.

The concept of a relocation zone, I think, needs to perhaps be reexamined; that currently the relocation zone in an urban area is five miles. As the use and applications of MRI's expand and as systems of care evolve where, as I said in previous testimony, many types of care that are currently or historically in the hospitals are moved to outpatient settings, perhaps the relocation zone for MRI needs to be increased. We would suggest that similar to the relocation zone for CT scanners, that ten miles for urban areas and 20 miles for rural areas might be more appropriate.

The concept of a teaching facility is also addressed, and there's a specific weight in the standards for that. But I think that the way it's defined is not consistent with current technology. It says that a teaching facility is one where there are residents or interns in radiologic services present. Because of the advent and common applications of PACS (phonetic) systems, which are digital and electronic connecting of various sites into a single computerized system, the person reading the image or interpreting the image may very well be in a different location than the patient and often those -- that interpretation can be real time. And if there are students involved in the interpretation, the patient may in fact need to be in the MRI for longer periods of time, even though there's no resident or intern at that location. So I think that the definition of teaching facility needs to be extended to those facilities that are also linked to teaching facilities via electronic imaging.

The current definition of upgrading an existing MRI includes an expenditure of half a million dollars or more over a two-year period on an existing machine. So that if you upgrade your machine and it cost half a million dollars or more over two years, that's considered to be a replacement and requires a Certificate of Need. Just because of costs and also because of the -- you know, the general applicability and changes that need to be made to existing pieces of equipment, which certainly don't need to be replaced but do need to be upgraded, we feel that the half a million dollar limit should probably be increased to perhaps $750,000 over a two-year period.

Pediatric sedation, I think -- without going into the specifics, I think the weight there -- the WEIGHT -- needs to be reexamined and perhaps increased because of the need often for pediatric patients who are in the magnet who are coming out of a sedation actually who need to be rescued in the magnet, have additional sedation administered, all of which takes magna time. Not doing it that way would require taking the patient out,

rescheduling them and bringing them back another time, which doesn't make sense either. So I think that additional weight for pediatric sedation needs to be added.

Finally, the issue of converting from mobile to fixed in rural areas. And I was particularly interested in Mr. Wheeler's comments related to critical access hospitals. The situations that we're running into within Spectrum Health aren't as severe as he described, although certainly I think that his suggestions bear examination. But the situations that we have found is that the current standards allow for a lower volume requirement for certain -- for hospitals in certain situations. Specifically, they have to be more than 15 miles from an existing MRI -- fixed MRI service and also be the first in their county to apply. We would submit that the first in the county issue is redundant and unnecessary; that certainly 15 miles from an existing fixed site makes sense but, you know, if you're in a large rural county, somebody in the northeast corner has a fixed MRI and you're 25 miles away in the southwest corner and you're also more than 15 miles from a fixed MRI in other counties, that perhaps the lower volume requirement should apply in that case too. So we would just recommend elimination of the phrase "only one per county" in the section dealing with conversion from mobile to fixed. Although, as I said, Mr. Wheeler's suggestions bear merit as well.

Primarily these are technical-type suggestions, which may not require convening of a Standards Advisory Committee. Based on whether or not other folks have more fundamental suggestions to the standards, such an advisory committee might need to be convened. But I would think that working with staff, that these issues could all be addressed without the use of an advisory committee.

MS. ROGERS: James Flickema, Northern Michigan Hospital.

MR. FLICKEMA: My name is James Flickema, and I'm the Director for Professional Services at Northern Michigan Hospital (NMH) in Petoskey. I would like to thank the commission for identifying the need for technical changes to the CON Review Standards for MRI Services.

Over the years the CON Commission has gone to great lengths to draft language in the CON Review Standards that makes a level playing field for the diverse planning areas throughout the State of Michigan. Accordingly, MRI language was created to equalize the weighting factor between rural and non-rural areas when demonstrating areas of need.

For example, Section 13(2)(a) of the MRI standards provides for MRI procedure adjustments for MRI scans performed in a rural area. Subsection (2)(a), to paraphrase, for a site located in a defined rural or micropolitan statistical area or county, the number of adjusted procedures shall be multiplied by a factor of 1.4. However, Section 13(2)(e) states that:

> "Subsection (2) shall not apply to the application proposing a subsequent fixed MRI unit (second, third, etc.) at the same site."

This language discriminates between new applicants and existing providers. New applicants seeking CON approval can utilize the rural multiplier, however existing providers with an established program cannot.

NMH would like to request a technical change to apply to the multiplier uniformly to all applicants by modifying the standards accordingly. We are pleased to work with the commission and with the department, as appropriate, to effectuate the identified proposed changes.

MS. ROGERS: Amy Barkholz, MHA.

MS. BARKHOLZ: I'm Amy Barkholz from the Michigan Health and Hospital Association. I just want to offer, on behalf of the MHA, that we believe based on some of the testimony you've heard today from Northern Michigan Hospital, from Spectrum, from Bell, that there appears to be a need to look at the MRI standards. I think they raise several good issues. And for that reason, the Hospital Association would support further review, in some manner, of the MRI standards.

MS. ROGERS: Andrew Richner, Northern Michigan Hospital, did you want to speak or not? Okay. Just for the record, he supports the repeal of Section 13(2)(e) of the MRI standards.

Do we have any testimony regarding Pancreas Transplantation Services? Okay. Hearing none, we will move to Psychiatric Beds and Services.

Cheryl Miller, representing St. Joe's Healthcare, Clinton Township.

MS. MILLER: Good morning. My name is Cheryl Miller. I'm Director of Strategic Planning at Trinity Health's Corporate Planning Department. This morning I'm here to read testimony on behalf of Barbara Rossmann, President and Chief Executive Officer of St. Joseph's Healthcare. St. Joe is a member of the Henry Ford Trinity Health Network in Clinton Township. This letter is addressed to Ms. Hagenow.

"Under the revisions to the CON statute enacted in 2002, PA 619, the CON Commission is required to review each set of CON standards at least once every three years. Although there were some minor modifications to the Michigan CON Review Standards for Psych Beds and Services in 2005, there were no comprehensive reviews.

As you are aware, the purpose of the public hearing is to take public comment on potential issues or concerns with existing CON standards. Therefore, since Psychiatric Beds and Services are scheduled for review in 2006, we are taking this opportunity to address some concerns and asking for comprehensive review of these standards.

CON standards are intended to balance cost, quality and access to healthcare services, and while the current set of CON standards for Psychiatric Beds and Services does a reasonable job in achieving this, there is room for improvement. Since the psychiatric standards were first adopted, the environment related to the care of the mentally ill has dramatically changed. With increasing cuts in funding, more and more healthcare providers can no longer afford to continue providing inpatient psychiatric care. As a result, an increasing number of programs have either reduced their size or closed their programs entirely, leaving no other place for people requiring inpatient mental health treatment to go other than the streets or to jail. This is not only a national trend but also a trend that exists right here in Michigan.

"This problem is evident which led Governor Granholm to charge the Michigan Mental Health Commission with the task of identifying the most pressing issues that face Michigan's public mental health system and to develop recommendations for improvements. In the Executive Summary of the MMHC's Final Report dated October 15th, 2004, Governor Granholm stated, quote, 'The mental health system in Michigan is broken,' end quote, which was verified by much of the public testimony to that commission.

As an organization committed to providing adult inpatient psychiatric care, St. Joe's Healthcare is finding it increasingly difficult to continue providing the compassionate quality care to the mentally ill in and around Macomb County at its current facility in Mount Clemens. The existing CON standards for Psychiatric Beds make it impossible to continue providing the same level of care in terms of services, license, and capacity and so forth at a more suitable location without the reduction of the program's licensed capacity. As earlier indicated, these programs are already being reduced in size at a time when these services continue to be needed. St. Joe's 85-bed adult inpatient psychiatric program has operated at an occupancy level of over 90 percent for the past several years. To reduce the size of St. Joe's program as a result of the current standards in order to provide these services in a more suitable location does not appear to be in the best interest of the communities served or the intended purpose of the standards to balance cost, quality and access to healthcare services.

Therefore, we would ask that a comprehensive review of these standards be undertaken by a Standards Advisory Committee with special consideration given to the following areas of concern:

1. Current bed need methodology,
2. Current relocation zone definition,
3. The current planning areas for both Adult and Child and Adolescent Programs,

4. The introduction of a high occupancy exception,
5. Utilize the MMHC Final Report as material input, and,
6. Any other issues other inpatient psychiatric programs may feel necessary to be given special consideration.

On behalf of Barbara Grossman, I'd like to thank the commission and the department for allowing St. Joe's Healthcare the platform and opportunity to discuss our concerns.

MS. ROGERS: Monica Harrison, Oakwood.

MS. HARRISON: Thank you for the opportunity to provide testimony concerning the CON Review Standards for Psychiatric Beds and Services. My name is Monica Harrison, and I'm a Senior Planning Analyst for Oakwood Healthcare System in Dearborn. Oakwood Healthcare, Inc. operates a 70-bed inpatient psych unit in its Oakwood Heritage location in Taylor.

Oakwood Healthcare System urges the CON Commission to add the CON Review Standards for Psychiatric Beds and Services to its current work plan. It has been a number of years since the last comprehensive review of these standards. Like other areas of healthcare, there have been considerable changes to the care delivery system for mental health services, including inpatient psychiatric services. Thus, we have concerns that the current CON standards are obsolete in some respects. In addition, we believe that for these standards to better meet the goals of cost, quality and access, a Standard Advisory Committee should review and consider:

1. The addition of a high occupancy exception to permit a hospital to add more psychiatric beds if certain occupancy targets are attained. This could be similar to the acute care hospital bed high occupancy exception.
2. The current replacement zone for psychiatric hospital beds, given the considerable consolidation of the provider community in this state and reduction in the total number of providers.

Thank you for the opportunity to provide comment on this issue.

MS. ROGERS: Phyllis Adams, Forest View Hospital

MS. ADAMS: My name is Phyllis Adams, and I'm a healthcare attorney with Dilemma Gossett. I'm here today representing Forest View Hospital and to provide comments at this public hearing on the CON Review Standards for Psychiatric Beds and Services. Forest View Hospital is located in Grand Rapids, and brings over 30 years of experience to the evaluation, diagnosis and treatment of a wide range of behavioral health problems. Forest View Hospital's services include an acute inpatient psychiatric program for adults and children and adolescents. The hospital also offers a partial hospital program and various other outpatient psychiatric services. It operates one of the few, if not the only, unique inpatient programs for adolescent eating disorders in the entire state. Other programs offered by Forest View include DBT, dialectical behavior therapy, and programs designed to treat co-occurring disorders. Not surprisingly, Forest View Hospital experiences consistently high occupancy of its inpatient psych beds.

Under the current systems that govern placement of inpatient psychiatric patients, Forest View receives patients from many communities outside of Grand Rapids, Kent County or the immediately adjacent counties. In fact, patients are placed at Forest View from areas north of Grand Rapids such as Traverse City and into the Upper Peninsula; areas south of Grand Rapids, including Indiana; areas west of Grand Rapids all along the lakeshore, including Holland and Muskegon; and areas east of Grand Rapids as far away as Detroit. Additionally, patients are placed at the Forest View trauma program from all over the Midwest.

Forest View Hospital urges the CON Commission to add the CON Review Standards for Psychiatric Beds and Services to its current work plan. These standards have been in place since 1995 with only minor revisions. However, the mental healthcare delivery system has changed significantly during the past ten years and the existing standards are outdated in many respects. We believe the standards could and should be updated to better reflect the goals of the CON program, including cost, quality and access. Specifically, we would suggest that a Standard Advisory Committee review whether it may be appropriate to address the uneven distribution of

psychiatric patients in Michigan by a review of the current bed need methodology, a review of current planning areas, or the addition of a high occupancy exception to permit a hospital to add more psychiatric beds if certain occupancy targets are attained. We understand that the CON Review Standards for Hospital Beds includes a high occupancy exception, and a similar exception may be appropriate for the psychiatric standards.

We also suggest that the Standard Advisory Committee review the current replacement zone for psychiatric hospital beds. It is possible that the replacement zone should be adjusted to reflect the more regional provision of these services.

We appreciate this opportunity to offer comments on these standards and, again, urge the commission to add these standards to its work plan for the earliest possible consideration.

MS. ROGERS: Thank you. Okay. I'm going to do one last call for each of the set of standards. Any additional testimony for Bone Marrow Transplantation? Heart/Lung and Liver Transplantation, any additional testimony? Any additional testimony for MRI Services? Pancreas Transplantation Services? Psychiatric Beds and Services?

Hearing none, thank you for attending today's hearing. This hearing is now adjourned at 10:39.

(Hearing concluded at 10:39 a.m.)