STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED

PUBLIC HEARING

BONE MARROW TRANSPLANTATION (BMT) SERVICES and
MAGNETIC RESONANCE IMAGING (MRI) SERVICES and
HEART/LUNG and LIVER TRANSPLANTATION SERVICES and
PANCREAS TRANSPLANTATION SERVICES and
PSYCHIATRIC BEDS and SERVICES

BEFORE ANDREA MOORE, DEPARTMENT TECHNICIAN TO CON COMMISSION

201 Townsend Street, Lansing, Michigan

Thursday, October 16, 2008, at 9:30 a.m.

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Lansing, Michigan

Thursday, October 16, 2008 - 9:46 a.m.

MS. MOORE: Good morning, again. I am Andrea Moore, Department Tech to the Certificate of Need Commission from the CON Health Policy Section of the Department of Community Health. Chairperson Ed Goldman has directed the department to conduct today's hearing.

Comment cards can be found on the back table and need to be completed if you wish to provide testimony today. Please make sure that you have signed in to the sign-in log.

This is the annual public hearing to determine if any changes need to be made to the standards scheduled for review. Bone Marrow Transplant Services, Heart/Lung and Liver Transplant Services, MRI Services, Pancreas Transplant Services and Psychiatric Beds and Services are scheduled for commission review in 2009. The three-year review cycle for all standards is listed on the second page of the Commission Work Plan located at www.Michigan.gov/con.

If you wish to speak on any of the scheduled standards, please turn in your comment card to me. If you have written testimony, please provide a copy, as well. Just as a reminder, all cell phones and pagers need to be turned off or set to vibrate during today's hearing.

As indicated on the Notice of Public Hearing, written testimony may be provided to the department via the

electronic form on our Web site at www.Michigan.gov/con through Thursday, October 23rd at 5:00 p.m.

Today is Thursday, October 16th, 2008. We will begin taking testimony in the following order: BMT, Heart/Lung and Liver, MRI, Pancreas, and finally Psych. The hearing will continue until all testimony has been given, at which time we will adjourn.

Starting with MRI, we're going to hear from Dennis McCafferty.

MR. McCAFFERTY: Dennis McCafferty, Economic Alliance for Michigan. Last year the three domestic auto companies conducted a study of their own data, combined it together, looking at MRI services. They compared MRI services in Michigan versus nine other states in which they have significant covered populations. The results of this survey were that in Michigan, which was the only state of the ten states in which the autos have significant covered populations that has strong CON controls, Michigan's costs for MRI were 20 percent less than they were in the other states. The autos are persuaded by this data that this significant cost differential does give Michigan an advantage and that it is attributable to the MRI standards -- CON Standards for MRI. For both of the -- for these reasons, the Economic Alliance does not think that there's any reason to open up the MRI Standards. We are, of

course, always open to new compelling information that supports changing the standards to improve access, quality and lower the cost. We're here today to see if there is such testimony.

MS. MOORE: Thank you. Is Barb Jackson in the room?

AUDIENCE: I think she ducked out to Beaner's.

MS. MOORE: Well, we'll come back to her, then. Dennis, if you'd like to come back and speak about the transplant services?

MR. McCAFFERTY: I have some tables we've put together I'd like to pass out (indicating). The Economic Alliance for Michigan's position on transplant services has for a long time been that unless new compelling evidence can be presented, additional transplant capacity in Michigan is not needed. Organ transplant services are quite expensive and, even more importantly, are extremely interventional, typically to rescue the lives from significant disease situations. Well established evidence from a range of activities indicate that concentrating volumes in a few places helps assure greater proficiency and better and safer outcomes for patients. Last month our health group concluded that there was no current information that justifies recommending modifications of prior -- of our prior EAM Board position.

We have completed this little analysis of the last eight years of volumes of all transplant services -- CON regulated transplant services in the state and noted that the annual volumes for different organ transplants may vary significantly from year to year. Some years they're higher and some years they're lower, but overall there hasn't been a significant increase. Notably, in 2007 the annual volume for most CON regulated transplants was close to the average annual statewide volume for the last eight years, one exception being bone marrow transplant, with almost all the 2007 increase attributable to the large increase at Karmanos.

The one area where the Economic Alliance remains open to possibly urging the commission to consider additional services would be to achieve greater distribution of Bone Marrow Transplant Services. A year ago we testified to the commission that we could see that there is potential need for two planning areas for adult bone marrow transplant, one on the east side and a second on the west side of the state as there have been -- on the west side of the state, as there has been for some time for pediatric bone marrow transplant. That is because bone marrow transplants are unique and is often requiring more extensive periods of time for the patient for the process and even more others -- even more than other services. We did

emphasize that we thought that going beyond the limits of three Bone Marrow Transplant Services to have a western Michigan program should require a demonstration that there be significant volume in western Michigan, which two years our health staff group was advised by the eminent BMT experts as properly being about 50 cases per year. An interested western Michigan hospital has assured us that they can present indications of significant volumes, though possibly closer to 36. Our communities look forward to hearing the presentations at the January meeting -- at our January health staff group meeting and prior to the January commission meeting setting the work standards -- work schedule for next year.

We are open to new information regarding changes affecting these standards. For example, we have heard that the Gift of Life of Michigan contends that the requirements for pancreas transplant programs should significant be eased because that would assure more pancreas transplants being done in Michigan. We understand that the Gift of Life organization would first look to starting with a number of pancreatic programs in Detroit and, again, increasing from one to three. We also look forward to hearing from this group to present its arguments for this change in position to our health staff group meeting on January the 9th, as well as any other interested parties changing these

standards.

If others would like to meet with our health staff group regarding transplant issues, we ask them to contact us in the next week or so. For one reason, we would like to receive any written materials for the group by early December. This would give our staff members opportunity to review this during the holidays and in preparation for the January 9th meeting. If our committee is persuaded to recommend EAM changes on its position on other transplant issues, we would certainly testify to that at the January commission meeting. So we remain open and willing to listen to new information. Thank you.

MS. MOORE: Thank you, Dennis. I think that we'll go ahead and back up and let Barb Jackson from Blue Cross Blue Shield of Michigan provide her testimony on MRI and then the transplant services.

MS. JACKSON: Good morning. I'm still Barbara Jackson. I'm still representing Blue Cross/Blue Shield of Michigan and Blue Care Network. Regarding -- I wanted to talk about the transplant services first. For the reasons listed below, which you can't see, we believe there's no need to formally address the BMT Services Standards at this time. An informal work group facilitated by CON Commissioner Dr. Michael Young met multiple times during 2006. The work group was comprised of expert physicians,

providers and purchasers. The majority of the members requested that the commission determine whether a Standard Advisory Committee should be appointed, however a very vocal minority indicated there was no need. Ultimately the commission did not appoint a SAC, as they didn't feel it was necessary at that time.

Since that work group was convened, public testimony has been given almost routinely at commission meetings by providers interested in initiating new BMT programs. However, no compelling evidence has been provided as to the need for additional programs, only anecdotal accounts have been described. While the geographic distribution of existing programs may not be perfectly distributed, the current programs appear sufficient to support current patient volumes. Annualized statewide bone marrow transplant trends show that the volume of these procedures has stabilized, with some decreases observed. Due to low volumes, Oakwood Health Care voluntarily surrendered its program. Opening up the standards for review could result in more programs, which could seriously deplete existing programs, patient volumes and staffing, reduce quality of care and increase health care costs.

The recent commission action to modify the BMT Standards allowed for an expedient technical solution, allowing for the retention of a highly regarded program with

a long history of service to residents throughout the state of Michigan. However, we would consider supporting a review of BMT Standards if compelling evidence of community need in terms of cost, quality and/or access concerns were provided.

Regarding Heart/Lung and Liver Transplantation Services, a review of statewide data shows stable individual program volumes with no evidence of need for increased access. Thus, we see no need to review these standards.

Regarding Pancreas Transplantation Services, a review of statewide data shows relatively consistent individual program volumes for these services. And in fact, due to low patient volumes, Harper and St. John Hospitals voluntarily surrendered their CON's for this service. Thus, we're not aware of any access issues and see no need to review these standards.

And then regarding -- can I talk about MRI and Psych Beds or just MRI or just transplant?

MS. MOORE: How about you go ahead and do MRI, and then we're going to --

MS. JACKSON: Okay.

MS. MOORE: -- finish up pancreas, and then we'll finish with Psych at the end.

MS. JACKSON: Got it. Thank you. Regarding MRI, BCBSM and BCN has provided statewide reviews of MRI access over the past few years and found no access to care issues.

We are also not aware of any compelling new applications or scientific evidence that would merit a complete review of these standards. Additionally, based on the commission's ability to address issues on an ad hoc basis, a potential problem was addressed expeditiously to allow the use of intraoperative MRI units in the acute care setting. We strongly supported the commission's action that allowed for this application and felt that this action resulted in improved patient safety and quality of care.

The majority of our testimony indicates no compelling need to address the standards. We do want to go on record as supporting the process. And if others feel that one or more of these standards should be reviewed and the commission concurs, we will be an active participant. Thanks. And I'll give you the testimony all at the same time.

MS. MOORE: Thank you, Barb. Next we're going to hear from Richard Pietroski from Gift of Life.

(Begin Power Point Presentation)

MR. PIETROSKI: Good morning. I'd like to thank the commission for the opportunity to provide public comment, and I'd also like to point out that Gift of Life is greatly appreciative of the openness, the collegiality and the transparency in which dialogue has occurred leading up to today's discussion regarding the impact of the Pancreas

CON on Gift of Life Michigan. Representatives from the Economic Alliance, the department and all of the commissioners which we've met with one on one, either face-to-face or by conference call, have been very informative in their direction and guidance to us and also in an attempt for Gift of Life to try to bring everybody up to a common understanding of this issue. Next slide.

Gift of Life fully appreciates the Certificate of Need process in the state of Michigan. And I personally was involved when the first CON metrics were established some many years ago. But back then, which didn't exist then but does exist now, is a federal process for establishing organ donation and allocation throughout the United States. Gift of Life Michigan is one of 58 federally designated organ procurement organizations. And again, because we're federally designated and we generally don't have a place in what you consider mainstream health care, we may be considered a nonentity. But indeed, because we are nationwide and we all have non-overlapping areas of service, the federal government gives us the opportunity to recruit donors, recover organs and allocate them not just within our state, but under a national allocation and sharing system. Next slide.

Gift of Life Michigan has a board of directors which not only represents the eight organ transplant centers

in the state of Michigan -- and here you have a list of our 19 board members -- but also two additional health care facilities, including Gift of Life Michigan, which has its own histocompatibility laboratory. So there's a large degree of oversight. And the position -- the draft position that I'm going to share with all of you later is adopted by all the centers, in solidarity behind Gift of Life in presenting this position here today. Next slide.

Back when the commission deliberated on the certificate requirement for pancreas transplantation, the number of organ donations back in 1990 was about 135. And as you can see, we estimate in 2008 that we are going to recover organs for transplant from nearly 330 patients who died in Michigan hospitals. You can see in the blue bar that back in 1990, the number of pancreas transplants was relatively low and was just beginning in its science and understanding in the state of Michigan. And so that's when the commission established its performance metrics through the Certificate of Need Commission. The number of pancreas transplants in the state of Michigan in 19- -- I'm sorry -- 2006 was our zenith, with 51, but really has not changed to a great degree since the early 1990's because there is a limited supply of pancreas in the state of Michigan. But there's also limitations at the transplant center level to transplant pancreas because of the variability in which

donors occur on a day-to-day basis. We may have eight organ donors in a single day, we may have zero or just one. It's quite variable. Also, the science behind evaluating pancreas is quite variable. The donor management strategies, these patients who become candidates for organ donation are on ventilators, they're brain dead, they have lost all their hormonal regulatory systems, so the mechanisms that we use to try to manage and maintain hemodynamics of the donor -- giving insulin, giving I.V. solutions which are free of sugar -- are also contrary sometimes to pancreas donation. Next slide.

One of the things that has also changed over the past number of years is the way in which pancreas are allocated. As you can see, in 2008 we estimate only about 20 pancreas being transplanted in the state of Michigan, which is less than half of what we saw just back in 2006. But also the distribution of how pancreas are transplanted, there's been a change in the science. So the number of pancreas that are available for transplant has also changed, and how they're utilized.

The more mauve bars (indicating) represent the pancreas after kidney transplantation; that is, the recipient would receive a kidney transplant first and at some point later receive a pancreas. That therapy has changed more recently nationwide, as less of a common

practice but still to some degree utilized. But you can see, in the blue shaded areas (indicating), that the more common practice is simultaneous kidney and pancreas transplant so you get the pancreas and the kidney from the same donor. So you not only have to have a donor who has a brain injury and they've been on a ventilator for an extended period of time, but we also then are limited to having both pancreas and kidney being suitable for a single patient, which is more complex. Next slide.

We looked at the National Certificate of Need profile, and indeed we found that there were five states that have a CON for pancreas. And they're listed in parentheses. Michigan has 12, Maryland 12, New Jersey 15, North Carolina 10 and Virginia 12. When we looked at the data published by the Organ Procurement and Transplantation Network at optn.org, there are 19 pancreas centers in these CON states approved by the federal OPTN -- and again, the data is publicly available through optn.org -- and these centers number between two and five for pancreas in those states. If you look at their frequency of pancreas transplantation versus their Certificate of Need requirement, only four of the 19 pancreas centers in those states met their state CON requirement for all five years, and no state has had all centers meet the CON. And I can give you some specific examples. Next slide.

This is the state of Maryland, where it has some very aggressive centers, and it looks that both of their pancreas centers are doing quite well in meeting their CON of 12. Next slide.

New Jersey, however, has currently no states -- or none of their five pancreas centers that are meeting their CON, but they continue to transplant pancreas. Next slide.

North Carolina, another pancreas CON state, two of four centers are meeting their pancreas CON, but the other two don't -- of ten -- and they continue to transplant pancreas. Next slide.

And then lastly, Virginia has four centers. One meets CON requirements of 12 per year for four of the last five years, but the other three continue to transplant pancreas, not meeting their state CON.

I'm not sure of the mechanisms in those states, but it goes to say that there is a federal oversight process currently, which was not in place when the CON process in the state of Michigan was put in place. My supposition is that the states have let the federal government do its job, which now has oversight for this process. Next slide.

Now, why I'm here is because Gift of Life, again, is one of the 58 organ procurement organizations in the state of Michigan (sic). In may of '06, the Federal

Register published rules and performance measures for procurement organizations. So when we look at these rules and what Gift of Life Michigan has to meet, we have to be within one standard deviation of the national median of all 58 OPOs for performance metrics in order to remain in business. Currently we're on a four-year cycle and we're near the end. At the end of 2008, we'll be at the end of our second year of that four-year cycle. Next slide.

If we look at the first year of our organs transplanted per donor -- and these are all organs recovered from all donors and transplanted anywhere -- that's the metric of organs transplanted per donor. And this shows Gift of Life in the 36th position at 2.93 compared to the other 58 organ procurement organizations. Gift of Life, while it's not at the national mean, which we were in 2006 -- we're below the national mean but we're also above that one standard deviation, which if we're not there at the end of our four-year cycle, if we're not above the national standard deviation, then Gift of Life will discontinue to exist as an organ procurement organization. The federal government will give our service area to the states that surround us. Next slide.

With St. John and Harper pancreas programs discontinuing, our organs transplanted per donor became even dire and we're only four positions from the standard

deviation. And if we get to that fifth position, then, again, in 2010 Gift of Life's position as an organ procurement organization for the state of Michigan will discontinue. And again, our service area will be carved up and given to other states that surround us. Next slide.

So what we are proposing is a marriage, in essence, between the state CON and the federal oversight that exists for transplant centers. Currently the CON for pancreas requires that there be a minimum of 80 kidneys transplanted in a two-year period leading up to the application. We're recommending, because of data reporting changes and availability, that that metric be changed to 80 renal transplants in any 24 consecutive months over a three-year period.

The second bullet point addresses what currently exists in the federal system under the Organ Procurement and Transplantation Network, or OPTN. If a center does not transplant at least one pancreas every six months, it invokes a federal review. Our draft proposal is that a hospital be considered to be active by performing at least one pancreas transplant in a sixth-month period, otherwise a center must submit any required federal OPTN center status review documents for examination by the CON Commission. Again, what this would do is it would minimize to some degree the level of oversight at the state level, not

supplant it, but also be augmented by federal oversight.

And then lastly, a hospital that has met the requirements for the above two criteria and who had voluntarily surrendered its pancreas certificate may have its pancreas transplant program reinstated by means of submitting a formal application to the CON Commission. And that would be the existing process. Next slide.

The OPTN Program Activity Survey is a 14-page document which we will provide to the department as part of our written testimony, 70-plus questions. I believe there are 74 questions that have to be answered when you don't transplant at least one pancreas every six months. And that questionnaire is then blinded and reviewed by the OPTN membership and professional standards committee to determine if the federal program is going to allow that center to remain active. So we believe that there is a sufficient federal oversight for pancreas transplantation centers, and that there can be a marriage between what occurs on the federal level and also the state level. Next slide.

These are the states that surround our great state of Michigan. And in Michigan -- with the exception of two counties in the western Upper Peninsula, we service all of the hospitals in those counties for organ donation. We have some 145 acute care facilities that may potentially provide us with an organ donor. And we also share about one-third

of our organs nationally, under federal requirements for organ allocation. Next slide.

If Gift of Life ceases to exist, the counties of Michigan will be divided and then allocated to organ procurement organizations in Wisconsin, Indiana and Ohio. Gift of Life Michigan has about 200 employees around the state. Our main office is in Ann Arbor. That's one economic impact. The other economic impact is re-listing all the Michigan patients on the transplant wait lists in other states. The transplant centers will now have to receive organ allocation, notifications and process change through those other states and their programs, and the effect on them is untold. So again, there is an unintended consequence of the State Certificate of Need for 12 pancreas transplants per year. But there was not federal oversight back then, and there was not the federal metric bound by the organ procurement organizations under the centers of Medicare and Medicaid services to stay in business as we do today.

Lastly, I'll leave you with the number that -- for the last year that data was available for the 145 pancreas transplant programs nationally, the national median number of pancreas transplanted in a center was six. More than three-quarters of those 145 pancreas programs transplanted six or fewer pancreas, but yet they remain intact under the

federal oversight program.

Again, I appreciate this opportunity to provide you with public comment and for entertaining me with my slide show. Thank you.

MS. MOORE: Thank you. Next we're going to hear from Dr. Scott Gruber.

DR. GRUBER: Well, thank you. It's a real, real privilege to be here. And I'd like to extend some of the testimony that Mr. Pietroski just gave. I'm actually here as the President-elect of Gift of Life, although I'm also the head of the transplant program at Harper. If I could have the next slide, please?

There are generally considered to be three assumptions that go into the rationale for establishing a Certificate of Need for a complex surgical procedure like pancreatic transplantation. If we decide to restrict the performance of a procedure to certain institutions, it's assumed that by doing this we'll get better outcomes, it's assumed that it will be more cost efficient, that we'll be able to draw on economies of scale, and that we'll avoid unnecessary duplication of both resources and expenditures. And it's also assumed that by doing these first two, we will make things better off in the end for our patients. And if I could have the next slide here?

I'm here today to actually run through each of

those three assumptions and show how they just do not hold for pancreas transplantation in the country, and particularly so in our state. I show here a table, and these are outcomes obtained on the more than thousands of simultaneous pancreas and kidney transplants. This is reported in 2006 by the Scientific Registry of Transplant Recipients. And what you see here are the outcomes in terms of patient survival; that is, how long a recipient of a transplant survives; according to the volume of transplants that are done by the center. And as you can see, as the volume increases there's really no consistent statistically significant change at all in terms of outcome at one year or three years or even five years after a transplantation in terms of survival of the patient. Next slide, please.

The same thing holds true for survival of the graft. And we are really strict about how we define survival of the pancreas, and that means that the recipient remains off insulin for these times after a transplant. And again, as the volume of the center increases there is no consistent relationship between the volume and the graft survival at one, three or five years after transplantation. Next slide, please.

So I would conclude that across our country there is no correlation between the number of transplants performed and outcomes. Now, I'm not going to show you the

individual outcomes in terms of graft and patient survival for the programs in our state, but these are available to all of you on the SRTR and you're free to go to the site. And I can assure you that the outcomes of the lower-volume programs in our state, in particular the two that have voluntarily surrendered their Certificates of Need, are at least as good as those of the higher-volume programs. Next slide, please.

Now, you might ask, Well, how come this is the case? Because generally speaking, like for cardiac surgery and for other complex procedures, there often is a correlation between volume and outcome. How come this is not the case with pancreas? Well, the two explanations are shown on this slide, and I use my own program at Harper as an example here. The first is the individual prior experience of the surgeons and the team who are involved. For example, before I came to Harper, I started two other successful programs from scratch and I myself performed over about 80 cases. My partner who joined me had done approximately 50 cases at other institutions before he came to Harper. So between the two of us, we had actually done more transplants than the entire state over a four- or five-year period. But we came here in order to start a program, for example at Harper, in a very challenging group of patients. So just by choosing to come to Harper, we didn't

all of a sudden forget all the background, training and exposure that we had to doing pancreas, and we have ongoing experience with doing the kidney transplants.

And I'll point out to you all that the preoperative, intraoperative and postoperative care of a kidney transplant patient is very similar to that of the pancreas. We have the same teams, we use the same instruments, we use the same retractors, we use the same sutures. We sew the kidney into the same blood vessels as we do the pancreas. So as long as you have prior excellence and experience and continue to keep your team greased and ready, as I've shown here -- if you're continuing to do kidneys and have the prior experience with doing pancreas, you're very able to do well with performing the occasional pancreas transplant as it comes up, even though you're only doing three, four, five, six per year. Next slide, please.

The next argument concerns the idea of cost. And I would submit to all of you that the pancreas is a no-cost add-on over and above that to performing kidneys. And that is, to establish our pancreas transplant program, for example at Harper, we did not need to purchase any additional capital or equipment. We didn't need any extra personnel. We used the same pre- and post-transplant staff. And social workers, nutritionists and pharmacists, financial people, the clinic staff, the nurses, the doctor and

surgeons, the OR teams, the instruments, everything is the same for kidneys. So if you have an active kidney transplant program, we're not incurring any additional costs or inefficiencies by adding the pancreas. Next slide, please.

And the final assumption is that by increasing the volume and, we think, we're going to cut costs, in the end we should be doing what's best for our patients. Well, that's not the case either. Because for example, at our program -- and I think you'll hear a little bit more about this from Dr. Granger. For example, at Harper we care for a very challenging group of patients who, in virtually all cases, have had all their history, their dialysis access, their prior general surgery, in some cases their kidney transplant and other health care -- all their health care has been with us. They know us, they get close to us and they have an attachment to us, and they do not want to or cannot afford to or don't have the insurance coverage to go elsewhere. And really, why should they? If the outcomes are at least as good, if not better, at our institution and the cost is not increased, why should they go elsewhere? Next slide, please.

So in conclusion, then, I hope I've shown you that there doesn't appear to be any rational basis for continuing the volume criteria as part of the Certificate of Need for

pancreatic transplantation in our state beyond that which already exists at the federal level. Thank you very much for the opportunity to give testimony.

(End Power Point Presentation)

MS. MOORE: Thank you, Doctor. Next we're going to hear from Andrea Spraggins from Harper University.

MS. SPRAGGINS: Good morning. My name is Andrea Spraggins and I actually hold a couple of roles on Harper University's organ transplant team. First off, I am an organ transplantation myself. In 1993 I was transplanted with a kidney transplant. And since we are -- our focus this morning is pancreas transplant, I am also a pancreas-after-kidney transplant recipient, who received a pancreas on January 26th of 2005.

And the gentleman that started the presentations gave out a handout that I thought was so suitable for me to kind of discuss when I came up here this morning. But it states for Harper University Hospital in 2005 there was one pancreas transplant. That one was me. And I told myself I was not going to get emotional this morning, because in regard to the Certificate of Need being taken from, first off, Harper University Hospital, if in 2005 that Certificate of Need was pulled, I would not be standing here this morning to share my experience and to share with you how I feel that this Certificate of Need should not be taken to I

believe the number is 12 per year. One transplant pancreas for an individual is one that will save that one individual's life. It should not be a criteria on the number that needs to be done per year for whatever transplant center in the state of Michigan. Again, I would not be here this morning if the Certificate of Need was pulled back in 2005.

My patient population -- I am also the transplant social worker at Harper University Hospital. So in regard to my patient population, unfortunately the majority of our patients at Harper are Medicare, Medicaid recipients who do not have the finances and the ability to go to other transplant centers. I believe the only available location for a pancreas transplant at this time is U of M in Ann Arbor. Transportation is a major need -- or issue for my patients just to get down to Harper. So if those individuals that have transportation needs need to get all the way up to Ann Arbor, then they're not able to get pancreas transplants. So that definitely will affect their lives in regard to getting that needed pancreas transplant. Again, if we were to use myself as an example, if the Certificate of Need were pulled and I needed to get to Ann Arbor, I wouldn't be able to go. I would be able to travel there with transportation. But in regard to my insurance, being a DMC employee, I don't think U of M takes DMC

insurance. So that would be a major issue with me, as well.

So I would like to thank you, the commission, this morning for allowing me to come up and share my personal experience. And I'm very adamant about this issue, so I would really pray that the commission throws that need in regard to the number per year for each transplant in the state of Michigan, because Michigan needs pancreas transplantation. Thank you.

MS. MOORE: Thank you. Next we're going to hear from Darla Granger from St. John Health.

DR. GRANGER: I, too, would like to thank the department for allowing me the opportunity to share some of the issues that we're facing at St. John similar to what Ms. Spraggins has already described. I

First, I too appreciate the sheet that you presented, Mr. McCafferty. But just to correct a couple of errors, in 2002 we did not actually do no kidney transplants at St. John Hospital, we did 49. That's a matter of public record. You can -- as Dr. Gruber alluded to, you can find out that data on the SRTR. And likewise, in 2002 and in 2003, we did four pancreas transplants in 2002 and one in 2003.

Last night I was really depressed to hear, as I was listening to the debate, it being described that a Cadillac health plan included plastic surgery and organ

transplants. I think, as Ms. Spraggins alluded to, that organ transplants really aren't like plastic surgery and it actually really does save lives. And so it was really depressing for me to be lumped in with the plastic surgeons, no offense I hope they take.

Beyond that, though, I just want to address the issues that we're facing at St. John. At the time that we were -- at the time that we voluntarily withdrew our Certificate of Need application for pancreas at St. John Hosp, I had 14 patients on my list for pancreas transplants. I met with each of those patients individually for over an hour because I felt very, very strongly that these were people that would really truly benefit from pancreas transplants; that either those organs would be life-saving, as they were for Ms. Spraggins -- I can tell you having the door broken down at her apartment to get her glucagon when her sugar is bottomed out. But I also can tell you that these were patients that I had that were very, very brittle diabetics that couldn't be managed with conventional insulin therapy. That's a rule-out at our institution for a pancreas transplant. If you can be managed with an insulin or insulin injections, you shouldn't get a pancreas transplant because there's risks associated with that organ.

When I started my surgery training, like everybody else, they tell you three things; each when you can, sleep

when you can, and don't mess with the pancreas because the pancreas is this evil organ and it doesn't like being irritated and things like that. And so when a pancreas is not taken out exactly properly, or if it sits on ice too long, it's not like a kidney; where if I take a kidney out and it sits on ice, it may not work right away but it will kick in eventually, and I just dialyze the patient until that happens. With a pancreas organ it's just very fragile, and it will develop pancreatitis if it sits around too long. And so that's the problem that Mr. Pietroski has in trying to place organs out of state, is that because they're much more likely to have pancreatitis and they're much more likely, then, to have graft failure and clot off, people tend to not take organs from out of state as much. And that's why for him it's really important to have pancreas programs in state.

But as I said, I started to meet with these 14 patients that I felt strongly needed to have pancreas transplants. And I was required by the feds to then give each of the patients the results -- as Dr. Gruber alluded to on the SRTR, I had to give those patients the results for the centers both in the state of Michigan and in the surrounding area. Of those 14 patients, one opted to get transplanted at the Cleveland Clinic because she had already been seen there for other procedures, and so she went there

to get her care because she knew the physicians there. One patient decided to go to the University of Minnesota because they decided if they couldn't stay with me and the physicians that they knew, they would go to the place that has done them the longest, which is the University of Minnesota.

The other patients opted to stay on our list and just get kidneys, which I think is really wrong because it's not taking optimum care of those patients. But these are our most fragile diabetics. They usually all have vision problems, because diabetes affects not only your kidney but your nerves in your eyes, and so many of them require somebody else to drive them to appointments. So if they're coming to see me, it means someone takes a day off of work or, as Ms. Spraggins alluded to, they have to have Medicaid transportation bring them. And again, that's very, very difficult to get outside the area. And as gas prices have gone up, we've seen that the Medicaid drivers have been even more restrictive in where they want to bring people. And too, if you get sick, the ambulance is going to bring you to the nearest hospital, they're not going to bring you to the transplant center. And so these are patients that we've been caring for a number of years, you know. We've got -- you know, their physicians are all at St. John Health. They've wanted -- you know, they've gotten their care there

for years, their records are there, all those kinds of issues. And so these patients opted to stay on my list for kidneys only and not get pancreas transplants, and that's just wrong.

But it's -- you know, it's just -- as I said, you know, as both Gruber and Andrea alluded to, with the situation in Michigan right now, I mean with gas being what it is, my patients can't get in to see me as it is, and that's when they're close. Fortunately for us, UAW Local 160, Jerry Gillespie, there by the GM Tech Center, they're very, very kind and they share their union hall with us once a year, and we have a big spaghetti dinner that our transplant patients put on themselves and they raise money. And we also have another recipient -- actually another gentleman who donated a kidney to his mom, and they have a golf outing and they raise money too. And we take that money and we buy gas cards to give to our patients so they can come to see us. Because the thing after a transplant is you have to follow these people really closely or they're going to lose their organ, and then the whole process was for nothing. And so between, you know, having to get people gas cards, you know, getting, you know, people -- the support that we can, more importantly we form bonds. People sit on the list for a few years. It's unfortunate. But we get to know these people pretty well. And it was just

heartbreaking for me to have to meet with these people and to see them not getting the care that I really think they should get because they want to stick with me. And I'm like, "No, no, these people can do a good job." And they're like, "But I can't get there," you know. I mean, I have people that walk to my office. I have people that take the bus to my office, you know. It's just it's a really good idea to have people go to, you know, one center or go to two centers, but in practical reasons it's just not working out. And so that's why the numbers would be affected by Gift of Life and that's why the numbers didn't just shift, as was anticipated, over to Henry Ford and to U of M.

So I mean, I'm sorry I didn't present all these -- you know, pretty slides and lots of data, but I wanted you to understand what I'm going through with my patients on a daily basis. And it really breaks my heart. Because, I mean, no one really likes doing pancreas transplants. These are the sickest people; they're the most work. But for those of us that chose to do it, I mean, we did it because we loved it. And it's just very, very hard to not be able to take care of the patients the way I want to. Thanks so much.

MS. MOORE: Thank you. We will move on to Psych Beds, and we will hear from Barb Jackson.

MS. JACKSON: Hi, I'm still Barbara Jackson.

Psych Beds and Services, BCBSM, BCN commends the results of a Psychiatric Work Group that included, you know, a variety of folks that was facilitated by Commissioner Deremo last year. This work group's recommendations were supported and moved forward by the commission and resulted in timely, well articulated modifications of the standards. Given this recent work, we see no need to address these standards at this time. So thank you very much.

And like I said before, we sound like we're saying no. We're not saying no, we're just saying if there's compelling information and these standards -- any of these standards need to be reopened, we will certainly be an active participant because we believe in serving the communities of the state. Thank you.

MS. MOORE: Thank you. Next we have Dennis McCafferty.

MR. McCAFFERTY: Dennis McCafferty, Economic Alliance. My comments are very similar to Blue Cross' comments. We feel that the standards were reviewed in 2007 and took effect in January of this year. We think the effort, headed up by Commissioner Deremo, was exceptional. We'd like to commend the commission and Commissioner Deremo for their efforts in this endeavor. And we don't know of any other reasons why these standards need to be reviewed in 2009.

MS. MOORE: Thank you. Is there anyone else in the room that would like to provide testimony on any of the five standards up for 2009 review? Seeing none, we will adjourn today's hearing. Thank you for coming today.

(Hearing concluded at 10:44 a.m.)

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