STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATE OF NEED COMMISSION

COMMISSION MEETING

BEFORE JAMES FALAHEE, CHAIRPERSON

333 South Grand Avenue, Lansing, Michigan

Thursday, December 6, 2018, 9:30 a.m.

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TABLE OF CONTENTS

Lansing, Michigan

Thursday, December 6, 2018 - 9:32 a.m.

MR. FALAHEE: So let's call this meeting to order. The first item is call to order and introductions. I think we have one introduction. Melissa, welcome to the Commission.

DR. OCA: Thank you.

MR. FALAHEE: You missed the -- the first one. We introduced ourselves around the room then, but since you're the newbie, if you could introduce yourself and what you do in your real life? And make sure the microphone is drawn close to you, and I will remind everybody because if I don't, the people to my right will, we always need to identify ourselves when we're speaking, especially when we're onto the substantive part of the issues. Okay?

DR. OCA: Good morning, everyone. Thank you. It's nice to be here. I go by Lisa and, yes, the last name is Oca. I am a physician in Ann Arbor at St. Joe's. I practice neonatology and I have done that for over 20 plus years. I initially was at the University of Michigan. I did my training and fellowship there and then went on to Beaumont Hospital and worked there for a good 16 years. And then as I was -- how do we say -- aging and normal retiring, I came to St. Joe's in Ann Arbor and that's where we live anyway. Commuting to Beaumont got a little old and long.

But I'm happy to be here and I look forward to working with all of you.

MR. FALAHEE: Great. Glad to have you on board. Thank you. Full disclosure, I have a brother who's a spine surgeon there.

DR. OCA: I know your brother.

MR. FALAHEE: I know you do. My condolences, yes. Okay. Let's move on to the review of the agenda. And as always, Tania has made sure that a final-final agenda is in front of us. For those of you in the audience, we all look at the agenda as you do about a week ahead of time and then the packets come out, and then about a day before the meeting we get another packet, an updated packet, another updated packet, and an updated agenda. So I think this one is the final agenda which I'll turn to my people to the right to make sure.

MS. NAGEL: Uh-huh (affirmative).

MR. FALAHEE: Okay. Thank you. So I would entertain a motion to accept this as the final agenda for today's meeting, please.

MS. BROOKS-WILLIAMS: So moved. Commissioner Brooks-Williams.

MR. MITTELBRUN: Second. Mittelbrun.

MR. FALAHEE: Questions? All in favor, please say "aye."

ALL: Aye.

MR. FALAHEE: Great.

(Whereupon motion passed at 9:35 a.m.)

MR. FALAHEE: Next is the declaration of conflicts of interests. Does anyone have any conflicts of interest to declare or potential conflicts of interest to declare given the agenda in front of us? Okay. Thank you. I'd like to move on then. When this agenda first came out about a week ago, I looked and went "this is a very light agenda."

MS. ROGERS: Excuse me, Chip.

MR. FALAHEE: Yeah.

MS. ROGERS: We have the review of the minutes from September.

MR. FALAHEE: Oops. I goofed. See, I was so anxious to get this through. The minutes are in front of us and any comments about the minutes, otherwise I'll entertain a motion to accept the minutes as presented, please.

MR. MITTELBRUN: Motion to approve the minutes as presented. Tom Mittelbrun.

MS. GUIDO-ALLEN: Second.

MR. FALAHEE: All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Thank you. Thank you very much.

(Whereupon motion passed at 9:36 a.m.)

MR. FALAHEE: So the next agenda item is Psych

Beds and Services presentation and draft language. When the agenda first came out, this was not on there but I had received numerous phone calls and personal visits about this issue in my role as chair, as the chair and vice chair will often called. And we know when the Commission meeting was coming up because about two weeks before the Commission meeting we get called and detailed more often. So this came up and I said, "Look, let's put it on the agenda."

As you all know that have been here for awhile and for the new commissioners, we've looked at the psych bed issues multiple times. One of the former commissioners is Dr. Kathleen Cowling. Kathleen was the E.D. physician and she saw it firsthand what happens when adults and child and adolescent patients come in the E.D. and there's nowhere to put them when they need psych beds. So we've looked at the psych bed issue for multiple times and that's why I thought it was appropriate to put this on the agenda for us to listen to the proposal and ask any questions.

So before I introduce Lee Ann Odom from Beaumont, who I understand is going to speak on behalf of Beaumont, I'll turn this to the Department to see if they want to say anything ahead of time and then to remind us, the witness, any witness will have three minutes to make their remarks and then we have as much time as is needed for us to ask questions of the witness, of our friends from the

Department, you name it. So that's how we'll approach it. But let me turn it over to Beth if she wants to explain this. I will tell you that I had a discussion this morning with Brenda Rogers and this (indicating) is my discussion sheet with Brenda which looks like a football play. So having seen that, I wanted the Department to sort of explain what's going on here and then have our Beaumont representative come up. So Beth or Brenda, do you want to explain?

MS. NAGEL: Did you want the language explained right now?

MR. FALAHEE: Yeah. I think it would help to explain the language because then when we listen to the presentation, at least for me, it will give you a better understanding of what's being proposed.

MS. NAGEL: Okay. So, Tania, if you want to go the first highlight bar? I think it's Section 6. Okay. Right there. If you scroll up a little bit? It's actually Section 8, excuse me. This proposal is to relocate existing child/adolescent beds to a facility that doesn't currently have child/adolescent psychiatric beds and to start a new program of child/adolescent inpatient psychiatry. And so Section 8 is the relocating section and in CON, relocating means beds that are in operation in one existing location can be moved to another location. It's the physical moving

of beds. And you can see sub (6) says that, "The relocation of beds under this section shall not result in initiation of a new adult or child/adolescent service" and then the amended language gives an exception for child/adolescent beds that will be added under Section 9(11). And so essentially this adds a specific exception for child/adolescent beds that meet the criteria that -- Tania, if you scroll down a little bit? -- meet specific criteria in Section 9(11). And also that exception -- Brenda is reminding me, I didn't read it -- but there is some criteria in that language that you have to have an existing adult program and be in an area that's over bedded with child/adolescent beds, otherwise you wouldn't need this language. You could just initiate because beds are available.

So the very specific criteria in Section 9(11), the heading there in (11) just explains that they don't, that because it's an over bedded area, you don't need to be in compliance with the bed need methodology which would state that there is no beds available. So this is exempting this specific program from that. And then under A, this is an important part, it says that the approval of the -- these new child/adolescent beds do not represent an increase in beds in the planning area. It's a one-for-one switch. There were 10 to 20 beds at this location, now there are 10

to 20 beds at this other location in that planning area so there's isn't an increase.

The applicant has to meet the other -- under (b)(4), (5) and (6), those are some requirements that all applicants have to meet working with your local CMH and other things. And then (c) adds a limit of the beds between 10 as the minimum number of beds, 20 would be the maximum number of beds, and then sub part (d) has three specific areas of criteria. The applicant has to have an emergency room that treats child/adolescents with -- if you scroll down a little bit? -- with psychiatric, though that sees patients with psychiatric or developmental disability diagnosis on at least 100 visits per year for the last three years; sub (ii) states that the applicant has to have an agreement that gives primary consideration from that emergency room to their new psychiatric inpatient, essentially meant to decrease the amount of psychiatric boarding; and then (iii) is a collaborative agreement with an existing child/adolescent psychiatric hospital just to make sure that there's continuity of operations and that there is the ability to get consultive or other supportive services from someone who's already providing the service. Sub (e) essentially in CON language says you can only do this once. You can't do this multiple times. But the applicant can only use this provision one time. And then

(f), again, states that this is a change in bed capacity for that facility so they are adding new beds in that facility which meets that definition in CON, in the CON standards. And then (g) is another important piece for the CON program, that these beds aren't subject to comparative review. So in some other cases we compare applications against one another and in this case that, if you're using these provisions, we would not do that.

MR. FALAHEE: Great. Thank you very much, Beth. Why don't we hold off any questions until we hear from our speakers/witnesses. So I will invite Lee Ann Odom to come up. Tania, we don't have a blue card here, but her name is on the agenda so we're all set.

LEE ANN ODOM

MS. LEE ANN ODOM: Good morning and thank you for the inclusion today. Again, my name is Lee Ann Odom. I am the president of the Beaumont Taylor Hospital. And I've actually worked at that campus which historically had been called Oakwood Heritage Hospital, Oakwood Taylor Hospital, and now since 2014 Beaumont Taylor Hospital. And having the privilege of serving at that campus over more than 20 years, I have personally seen how many patients and experienced the dynamic of our patients that experience us through the emergency room. So while we look at the entire landscape of Beaumont Health, which is eight emergency rooms that are

hospital-based, we also have a freestanding one, and we're an entity that does over 500,000 emergency room visits per year serving those patients. At Beaumont Taylor, we actually have the second highest mental health population in our emergency department right under Royal Oak. So here you have this smaller community hospital, under 200 beds, and our daily routine is to care for mental health patients in our emergency room. And while we don't pretend that we can boil the ocean and solve all of those problems today, what we do want to address is how we meet the needs of our child and adolescent patients who often are with us. If we can get kids placed in a day or two, that's -- that's a win. The reality of the situation is it's typically multiple days that go into weeks. We recently had a child at our Wayne Hospital for 12 days and that's not uncommon. It's just the reality of what it -- of what it is.

So just thinking about that, that's the ones in our context. I know that everybody was sent pre-reading context. We have been very open to say we've been working on this, collaborating with colleagues, engaging the Department since 2017. This is certainly a parallel track with the workgroup, but something that we think that we have really engaged the conversation at a high level and has been open with speaking with our peers that we know we want to and need to do something. And there's this entire issue of

physician and professional shortage as well. You know, so this isn't just about beds, if you will.

We would -- Beaumont would like to commend Dr. Laura Hirshbein in her thoughtful leadership of the current Psychiatric Beds and Services workgroup. Participating in that group has been wonderful and we did present this topic at our last workgroup meeting and I know we had a lot of great conversation about it. A lot of peers at that meeting really dove into the conversation about, you know, what happens in the emergency department and how do you get -- how do you -- how do you get to a place where systems can offer the entire continuum of care for patients so that we can work with patients and family members to place patients expeditiously.

So I know that there's been a lot of speculation, you know, like "why now" and, again, we have been working on this since 2017. We would like to and have been very open about setting up and opening a psychiatric residency program. So we would like to make the commitment to attract more providers to our state and hopefully retain them and we know that we can do that through residency programs. When you look at the runway and what it takes to CM up a residency program, if we started right now recruiting our program director, writing an application, we would have residents in place by July 1 of 2021. So you can see where

it's a runway. We need the time to be able to plan and do that.

So, again, we know that this issue is extremely complex. It's multifaceted. It's really right or wrong. Our patients and communities view the emergency rooms as an access point. So this is really about how do we provide the continuum of care for patients and families so they're not languishing in our emergency rooms for days and oftentimes weeks. So I'm not going to go over all of the information that you had ahead of time around the need. We talk about the National Alliance on Mental Health, the Michigan Psychiatric Admission denial database as well stated about the top reason for kids not making it to beds is the at capacity citation, which in 2017. between July and December, 8.6 denials per denial event were stated as at capacity. I think everybody in this room is very familiar with the CARES task force notes which really talks about increasing the number of psychiatric residencies head on. So that is one of the CARES task force's recommendations around really addressing this shortage.

So with the review of the language prior to this context, I'll pause there. I welcome discussion and also welcome our Beaumont colleagues and the experts to participate as well.

MR. FALAHEE: Thank you very much. Questions?

MR. MITTELBRUN: Mittelbrun. Lee Ann, where would the residency program be located?

MS. LEE ANN ODOM: So when we sponsor our residency program and those multi-facets to academic medical programs that are both inpatient/outpatient as well as in psychiatry clinical liaison services, which involves emergency rooms as well as psychiatrists doing consults on medical floors, so it's multi-faceted. We review our inpatient hub, if you will, to be the new center that we're building. We would view the outpatient piece of that residency program to be distributed across our service area and we would envision the clinical liaison services component to be our emergency departments as well as medical floors. So it's a three-prong requirement in psychiatry.

MR. MITTELBRUN: Thank you.

MS. LEE ANN ODOM: You're welcome.

MR. FALAHEE: Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: Brooks-Williams. Hi, Lee Ann.

MS. LEE ANN ODOM: Hi.

MS. BROOKS-WILLIAMS: And we talked on the way in. I think I was telling Chip because Lee Ann and I have the benefit of serving in the same region and community and often talk about --

MS. LEE ANN ODOM: Worked together for years, yes.

MS. BROOKS-WILLIAMS: -- the challenges, exactly. So I just want to make sure from a proposal perspective I'm clear because you don't need the Commission support, right, for the residency piece of this.

MS. LEE ANN ODOM: Correct.

MS. BROOKS-WILLIAMS: But today is specifically about creating access for the child/adolescent psych beds. So can you just talk a little bit about specifically, right, what that, I guess, contributes to the residency?

MS. LEE ANN ODOM: How the two connect?

MS. BROOKS-WILLIAMS: Exactly.

MS. LEE ANN ODOM: Right. So in the academic arena, which I know that you are very familiar with, when we talk -- you know, when we sit down and we try to recruit program directors and faculty to program -- and I think I heard an example about an orthopedic surgeon here earlier and we recently went through the process of combining one of our -- two of our orthopedic surgery residencies and continually working to engage additional faculty. When we have engaged psychiatrists and we have spent time -- we went to visit some sites in Boston. We also went to a couple sites in Pennsylvania and talked with Penn Medicine quite honestly because they were standing up a new hospital as well.

Our challenge to date in really being able to get

a PIF over the table and to the ACGME, is candidates are telling us we want to see that you can offer the continuum. So, you know, the psychiatrists have been particularly focused on what is your clinical package and what's that runway? Because if I'm going to make a commitment to come and lead your training program, I have to know that you have all of those facets covered. And in psychiatry, it is a multi-facet requirement. So that's the specific linkage.

MS. BROOKS-WILLIAMS: So just one follow-up. I'm sorry. Brooks-Williams. So from a timing perspective help us to understand, right, is it imminent? Is it -- because one of the things I would I think ask as we get further into a discussion is could this be woven into the workgroup because if it is a true, you know, way I think for us to find a path forward, maybe deeper information might be helpful, but I don't know if there's a specific timing crunch or reason to --

MS. LEE ANN ODOM: Yeah; yeah. I think that's a great question because, again -- and I talked to Dr. Hirshbein on the phone earlier this week and we've exchanged some e-mails. Because, again, the context is really we've been working on this since 2017. My intention to her as a peer in that group -- or, you know, she obviously leads the group -- is not to usurp that process. These are definitely parallel paths and we did have great discussion at the last

meeting about this dynamic as well as the residency. From a timing perspective in the academic world it's typically ideal that you have secured a program director and some faculty that write the PIF and put the application in. I think that that' -- that's common practice.

Again, if we get that application in, thinking about the ACGME cycle, this upcoming '19 between what -- so that application would go in, I think the deadline is late summer/early fall of '19, and then you think about what has to be done after that and when the cycle is for the match. So the application would go in '19, we would hear in '20 if it was approved or not, the match process would play out in '20, and the first class would start July 1, 2021. So in my view it is very imminent because we have to be able to articulate to psychiatrists as we build that academic faculty that this is our plan and this is the complement we have in our continuum and we really have to be able to demonstrate we have a path for that. So it's the commitment to the path.

MS. BROOKS-WILLIAMS: Okay. So can I -- I'm sorry. Brooks-Williams with a question.

MS. LEE ANN ODOM: No, please.

MS. BROOKS-WILLIAMS: I'm looking at my fellow commissioners like I'm hogging the mic. I'm sorry. My other question was just going to be do you, then, have an

identified -- so the way the proposal is written, right, is it's the potential to have the child/adolescent beds moved. Is there a known entity? Because as I read the need, right, and some, you know, I don't -- similarly, like you, was frowning and just being mortified at, you know, how we are not serving this population well. So I want to be clear about that. But I also know that if this isn't incrementally more beds and it's just redistributing the beds that we have, even though I know it speaks in the proposal to that not being the intent and that not being a problem, I do worry that if we don't know exactly -- we, the commissioners -- where the beds are coming from, how could we assess that that's not going to be an access issue someplace else? If the net -- net issue -- because we are also saying here that CARES does tell us, right, that it's lack of availability or we can't match them, and we know sometimes that's the sex of the child and all these other things that can complicate it.

MS. LEE ANN ODOM: Oh, yeah; yup; yup.

MS. BROOKS-WILLIAMS: But I don't know that there's enough information here that, without knowing where the beds are coming from and what the impact might be wherever they're coming from to really be able to decide today. But maybe there's more you could share that could help us?

MS. LEE ANN ODOM: Yup. So we've explored a couple of different paths again, you know, with the intent of being able to demonstrate a clear path for the continuum. We have in our working with Havenwyck because they do not have any academic program today, but their psychiatrists are interested in exploring that opportunity, and there are other -- two other acute care hospital systems that we have talked about, you know, how could we even potentially do a training program together. So we feel that we have identified one what I'll call specific option and we have two other acute care hospitals that we're open to.

MS. NAGEL: Can I just add to that? I just wanted to address one other thing in your question. Is that in the language the beds have to come from the same planning area. And just so, you know, you were concerned about where they were coming from and as this language applies to all other over bedded areas in the state as well, not just the one that Lee Ann is from. And so the beds would have to come from that planning area.

MS. BROOKS-WILLIAMS: So now I want to ask Beth a question. Brooks-Williams. So the Department obviously is aware because you guys, I'm sure, have helped in the framing of this. So, again, my question is just so I understand they have to be -- we say it's over bedded, but a large part of this argument, right, is that we're not able to serve the

population with the beds that exist. So I think I'm just trying to -- again, I don't know that I have the answer. I think maybe something does need to be done, but I also feel like I don't want -- and we'll get into the discussion of what the other commissioners want to do -- but I don't want to feel like we're forced into making the decision just on the technical piece of it. So maybe the Department can shed light on what you've seen about utilization maybe of those beds that would suggest you don't create a -- you know, a problem in another part of that same planning area by making that redistribution because it's very nonspecific and so I think that's what I'm struggling with a little bit.

MS. NAGEL: Sure. And I think that some -- I hate to give you a non-answer.

MS. BROOKS-WILLIAMS: No, that's okay. It's okay.

MS. NAGEL: But I think that some of these concerns that you're specifically talking about are being addressed in the workgroup in different ways. So one of the main focuses of the workgroup, and we've engaged some national experts to help us, is to redo the entire methodology. So, yes, you know, the Department's concern has been so we have X number of beds. Is that enough? Is that the right number? You know, it's based on, you know, a 1970's formula, does that still make sense? And so that, I think, will be addressed through the workgroup. I think

this specific proposal doesn't impact that, which is one of the reasons why, you know, the Department supported this language is because this would happen outside of that formula or redistribution because it's a one-for-one exchange. If more beds became available through a methodology change, this wouldn't impact. This wouldn't be impacted or that change wouldn't be impacted by that actually is what I mean to say.

MS. BROOKS-WILLIAMS: Okay. So one final question and I'll let us move on to Lee Ann, that is. So if, in fact -- let's say as we have our dialogue, right, we don't get to a clear path to say a absolute "yes" today, right. What -- what does that do to your time line if somehow it was to move into the workgroup and it came back as a part of the workgroup recommendations as opposed to being decided today?

MS. LEE ANN ODOM: Well, I think as we are diligently working to securing a program director to do that very important work of writing a PIF to submit to the ACGME, I would worry that it would put securing that person at risk, although we've been very transparent with, you know, we're at the state level where, you know, there's a workgroup. We're working on a pathway. I think that we would be at risk to push a starting class back -- back yet another year if we couldn't get that in on time. So I think

it continues to proliferate or at least allow this shortage to stay at a status quo which is pretty unacceptable.

DR. WANG: Stewart Wang. The question -- this is for Beth or Lee Ann. The differentiation between the adult and the pediatric beds, so it sounds like this is a new unit, move to a new facility. You want some of the beds to be tagged as pediatric or adolescent. Is that a hard thing that you can't -- if you're at a single facility, that you can't flex between adult and adolescents?

MS. NAGEL: If you don't have child/adolescent beds today, you cannot flex between child/adolescent.

DR. WANG: But to get at the question of, you know, there's a overall shortage of care, you know, but the demands kind of fluctuate with time, when you go in there and you say you're going to do seven beds but, you know, for adolescents but, you know, at the time you don't have that much need but you have a lot of adults, right, because you're not allowing an overall increase in the beds, is there ability to have some flexibility there in how the bed is utilized is the question?

MS. NAGEL: Yeah. So in the standards there is a concept of a flex bed between an adult and a child, and a child/adolescent bed, but that's for a program that's been approved for both adult and child/adolescent. And I think the issue here is that we're trying to create new access

points for facilities that haven't been approved for both child/adolescent and adult.

MS. LEE ANN ODOM: So what you're asking is the exact discussion we had at the workgroup last time so I appreciate you getting it to a real concise. Our complete predicament here is that in current state at Beaumont we have adult only beds. We have no way of accessing child beds, yet we see over 500,000 emergency department visits. We have this huge, huge responsibility of caring for patients in the mental health space in our emergency room, yet no access to a key component of the continuum of care for mental health. So therein lies the very issue.

MS. BROOKS-WILLIAMS: So this is Commissioner Brooks-Williams. So I -- so I -- and this isn't probably directed at Lee Ann per se. But I guess I would just say -- and it's why I started with what was the compelling ti- -- because I think that issue, right, of not having the continuum for care delivery is maybe different than the issue of needing it from a completedness for the residency program because I just get back to timing.

MS. LEE ANN ODOM: Uh-huh (affirmative).

MS. BROOKS-WILLIAMS: And I have hopefulness that if the workgroup is thinking this through, so just as -- and I think the question was asked. I would think if the workgroup came back and challenged the Department and maybe

even the Commission to figure out is it our standard then around reapportioning the adult beds to child and adolescent beds because of the, you know, demand that you have, is that a path that's clearer than saying move them from a facility to the other, you know, facility. And so I just want to -- I just always am anxious, right, about making a kind of almost one off -- and I don't mean that disrespectfully whatsoever -- decision that don't -- you know, you don't know the full implications of what it will mean someplace else. I'm not suggesting that this is a high threshold of risk per se, but I do have issues reconciling why we have this kind of constant we can't place them anywhere. I mean, if, in fact, it is that they're going to Havenwyck currently today, then the beds to place them are there. But if the redistribution of the beds is more about the residency program or the incompleteness of the Beaumont network to have those beds, and I think that's legitimate to discuss, I don't hear that though coming through as the reason in the proposal. And so that's why maybe it's easier to work it all out in the workgroup and maybe you get where you want to get through that process, but then everybody is doing it together.

MS. LEE ANN ODOM: And if I could -- was that directed to me to respond or just a statement?

MS. BROOKS-WILLIAMS: No; no. It's not a

question. It's not a question.

MS. LEE ANN ODOM: You know, if I could, though, respond, is that appropriate from a statement perspective?

MS. BROOKS-WILLIAMS: Yeah.

MS. LEE ANN ODOM: I do think -- and, again, which has been a really collegial discussion at the workgroup level -- when you're the operator of the emergency room, why should you not have acc- -- why should you have to depend on another entity to take those kids? So in this example it's not that all of our kids go to Havenwyck. Quite honestly we try to get our kids wherever and it takes days. So there's many programs out there today that have kids programs that are not necessarily linked to the -- to health care systems that run emergency rooms. So their ability or willingness to accept might be less than perhaps and a lot of those programs do not have the underpinnings of an academic program that I think really speak to having multiple subspecialties. So it is about the continuum of care. And, again, standing up a residency program is largely dependent on your ability to demonstrate the continuum of care. So I do view those issues as very directly linked.

MR. FALAHEE: Other questions?

DR. OCA: Lisa Oca. At Beaumont currently in that system there is no psychiatric residency program?

MS. LEE ANN ODOM: There is not. So that's why

we're trying to -- we have been since 2017 trying to stand one up, engage a program director, you know, all of those things, and making national visits and, like I said, most recently collaborating with Penn Medicine to talk more about programmatic attributes to stand, you know, to be attractive to a program director as well as faculty candidates.

DR. OCA: Do you have any idea how many psychiatric residency positions are available every year in the country?

MS. LEE ANN ODOM: I don't have that total number. I apologize.

DR. OCA: That's okay. And, you know, and then obviously the need I think is great. I can just speak for being in the health care system and seeing pediatric patients being stuck in the ER. I think the child, if these are clearly just for child/adolescent because you have adult psychiatric --

MS. LEE ANN ODOM: We have adult today.

MS. OCA: Right. And you have that; correct?

MS. LEE ANN ODOM: Uh-huh (affirmative).

DR. OCA: And the comment about flexing, again, as a pediatrician, I always caution and try to advocate for our young patients. It is very different treating a child and adolescent than it is an adult. And if there is a center that is just focused on the child and adolescent with the

appropriate fellowship trained physicians overseeing the program, with appropriate nurses also that are -- you know, I can't stress enough the importance of making that distinction and the concern we have in just trying to find a bed and putting them in an adult situation that is not -- that is not appropriate. So, just my comment. And, again, sometimes difficulty in Michigan and we can certainly -- we have a lot of residency programs throughout our health systems and we train many, many, many residents, but we can't retain them. They don't stay in the state. So that's always the big dilemma that we have as health systems in trying to keep our young minds here.

MS. LEE ANN ODOM: Uh-huh (affirmative). And the feedback we've gotten is if you have a continuum package, it becomes more attractive to stay. And we've been successfully seeing that in other programs like our physical medicine and rehab program where we do have the continuum. We have now been able to retain our residents much better than we have in the past. So we have small demonstration of success in that logic and we believe standing this program up with the continuum will be key.

MR. FALAHEE: Don't leave yet. I think there's more.

MS. GUIDO-ALLEN: I just wanted to make a statement to support what Lisa said because from a nursing

perspective, our ECs, our emergency centers, our emergency departments are not set up to handle the adolescents and the kids and we see them every single day. It's heartbreaking. And their parents look to us to care for these kids and we are not -- that is not our expertise and it's day in and day out, and we can't find beds for them. And it is heartbreaking to be at their bedside. So I support your statement.

MR. DOOD: Lindsey Dood. A question for you. I'm not sure who's best to answer. But it seems like there's a shortage of beds for pediatric patients and the workers working on them and hasn't got that done and it's something left over from the 70's. So there's a difference between our standards for bed need and reality and that should be solved, I think. This seems like a way around solving that problem. Usually I'm not in favor of workarounds. Is there a reason we just can't get that done and fix the bed need methodology so we wouldn't have to do this?

MS. NAGEL: That's a great question. The workgroup started I think in August and as I said, we have a Ph.D. in health care geography that's helping us to write that methodology and it is -- we agree it's badly needed and the workgroup all agrees that it's badly needed. It is a complex process and it will take more time to bring that back to the Commission to make sure that it is complete and

it doesn't cause any unintended problems and that it is correct because these things, once they're in the standard, they tend to stay there for awhile so we want to make sure that it's right and that it'll work not only now but in the future as far as we can see as well. And so I think the answer to your question is, yes, the workgroup is working on that and you will see it in 2019 and, you know, I think that they're looking to solve the problems that were articulated.

MR. FALAHEE: Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: I know I'm reneging on my --

MR. FALAHEE: You're only allowed 25 more.

MS. BROOKS-WILLIAMS: I know. I'm reneging on my comments. But I think great, great question and I want to make sure I'm understanding correctly. So, but the standard says over bedded but it has not been over bedded specifically for a child and adolescent. So the rule that would allow this to happen says that we have to be in an over bedded situation. It's not a short -- because we're kind of saying both. We're saying there's a shortage of the beds, but we're saying the reason that we're able to do this is because it's over bedded. So I just want to get clarification on that from the Department. It's my first part of my question.

MS. NAGEL: Yes. It says that it has to be in an area that's over bedded with child/adolescent beds. So

there's no --

MS. BROOKS-WILLIAMS: So specifically --

MS. NAGEL: Specifically child/adolescent beds. And the meaning there is there's no way to initiate, there's no path to initiate new beds for child/adolescent.

MS. BROOKS-WILLIAMS: So it doesn't mean -- it's not a utilization definition of over bedded. It's just saying by our outdated calculation we would say we're over bedded?

MS. NAGEL: Yes, by the bed need methodology there are no beds available to initiate, to initiate a child/adolescent program.

MS. BROOKS-WILLIAMS: So then this is -- for our new commissioners this might not be fair, but it may not be fair to the Department either. But didn't we approve -- didn't we have a special hold for psych beds maybe two years ago, year and a half ago?

MS. NAGEL: Yes; yes.

MS. BROOKS-WILLIAMS: Okay. So --

MS. NAGEL: And it was three specific populations.

MS. BROOKS-WILLIAMS: Right. Was child and adolescent one? Help me to remember.

MS. NAGEL: It was geriatric and then --

MS. BROOKS-WILLIAMS: Uh-huh (affirmative). I remember that.

MS. NAGEL: -- adult and child/adolescent that have medical needs as well.

MS. BROOKS-WILLIAMS: So it was the subpopulation of medical needs? Okay.

MS. NAGEL: Yup. And then the third one was developmental disabilities and that was adult and child/adolescent as well.

MS. BROOKS-WILLIAMS: Okay. So it could be within the purview of the workgroup to come back and suggest that child/adolescent beds be in a special pool to be allocated? So that could be a path.

MS. NAGEL: Yeah.

MS. BROOKS-WILLIAMS: And I only say that, right, and I'm speaking kind of in support, not in opposition. But conceptually as a organization that I manage a hospital as well that has the same crisis and challenges there and we actually have child and adolescent beds in our system. So I'm simply challenging that I don't know that this single action fixes that and I think our conversation is kind of multi-factorial. Part of it is residency-based and then part of it is practically, how is it going to advance the care? And so if that over bedded statement isn't literal, and so that we really are saying we have a need and we move those beds out of a community, how do we know -- and I'm not -- how do we know that we're not creating an access

issue somewhere else if we're all having the problem today with the same number of beds available? We're just going to move them from one place to someplace else. Incrementally, how is that helpful? That's the simple question I'm hoping we would answer before we would say that it's just formulitically (sic) possible to do it because it's not that we really have too many beds I think is what I'm clarifying.

MS. NAGEL: Yeah. So it --

MS. BROOKS-WILLIAMS: Because our utilization would say that we don't have enough because we aren't able to place the child and adolescent patients in a timely manner.

MS. NAGEL: Right; yup.

MS. BROOKS-WILLIAMS: Okay.

DR. MCKENZIE: So Amy McKenzie. When is the workgroup plan being completed, their recommendation? I know that's a difficult question, but do you have any insight into that time line?

MS. NAGEL: That is a difficult question. With our Standard Advisory Committees there's a deadline in statute of six months, but with workgroups there is no deadline. And so as I said they've had three meetings. Their next meeting, their fourth meeting is next week. I anticipate that it'll be several -- just using my crystal ball, I don't think they're going to wrap up in December.

MS. LEE ANN ODOM: If I could? The methodology is so complex that sitting in the workgroup as you have, I mean, we've really looked at a ton of data. And, again, the context about this, this is just a very narrow piece of what the workgroup is working on. So it's not like we've been meeting regularly just focused on child and adolescent. So there's a lot of priorities on the board.

MR. FALAHEE: Other questions of Lee Ann? Some of these same questions may come up when we're just deliberating amongst ourselves but well said. Thank you very much.

MS. LEE ANN ODOM: Thank you. I appreciate your time and consideration and inclusion today.

MR. FALAHEE: You have one. Go ahead.

DR. MCKENZIE: If I could just ask one more question? If to Denise Brooks-Williams' point we were to add in those additional beds into those three categories, would that help the situation with the residency ramp that Beaumont needs or do you need to have this part of moving the beds? Would they be able to tap into that is what I'm saying, if we were to add the ability to flex additional beds as described?

MS. NAGEL: Yeah. If the workgroup comes back with a recommendation that increases the availability of child/adolescent beds, anybody would be able to take

advantage of that. The issue, it could depending on how many, you know, there's application and then if there are some competing for those same beds, it would be a comparative review process. And so just making the beds available doesn't necessarily mean that any entity can guarantee that they can take advantage of those.

MR. FALAHEE: And I've run into -- I've talked with another health care system when we opened up one of those pools. The system got together and said, okay, who would like to take advantage? Five or six hands went up. Then they came back about three months, four months later and went, "Eh, on second thought, no." So you can open it up and then somebody would, like -- this is Falahee -- would glob onto it, but later on. Other questions? Thank you very much.

MS. LEE ANN ODOM: Again, thank you.

MR. FALAHEE: We may have more later, so don't leave. Thank you. I've got a couple other cards. I know Mr. Gehle presented a card. Sean, I didn't know if you wanted to speak in response to all of this or not?

MR. SEAN GEHLE: No. We support.

MR. FALAHEE: Okay. Sean is with Ascension of Michigan for those that don't know Sean. And I had one other card, another veteran of the group, Melissa Cupp.

MS. MELISSA CUPP: I'm here. I actually no longer

need to speak. I apologize.

MR. FALAHEE: Okay.

MS. MELISSA CUPP: Thank you.

MR. FALAHEE: Okay. Thank you. All right. No further cards. So for the newer commissioners, at this point what we -- we can ask questions amongst ourselves, we can ask the Department for assistance, and then potentially come up with a decision. I will -- this is Falahee. I'll start off. The questions that all of you asked were some of the same ones that I had because I, too, don't like what Commissioner Dood called a "workaround." All right. And I think what's going on here, I, too, have been responsible for setting up residency programs. Some things may move even slower than CON. That would be a residency program. So I get it when we want to move something as fast as possible. We don't want to rush to judgment, though. And I think that the questions that came out were good ones. I wouldn't want to usurp the work of a workgroup, but we have a long way to go in my opinion before that workgroup is finished given the methodology. And knowing the professor that we've retained, he's spoken to us before as a Commission, he will be very thorough and that takes time. So can I anticipate that the workgroup would be finished by our March meeting? I don't know. June meeting? I don't know. So I think in the meantime, at least in my opinion,

this proposal makes sense to meet the desperate need out there in a limited function that's not tied just to one hospital system; it's available for others. That's where I'm coming from and I'd welcome other questions, comments, whatever. Commissioner McKenzie?

DR. MCKENZIE: So listening to all of this I do agree, you know, it doesn't fix the issue I think is really the big part, but we have a long -- potentially a long way to go until we have that recommendation. If we're going to get beyond where we're at currently as a state, we do need residents in the state to be able to help with this. We see it at the plant. We're seeing access issues. We're hearing from our PCPs, "We're being burdened." When I was in practice I was taking care of developmentally delayed children who I had to deal with their parents who couldn't get them beds. It's a very, very difficult and potentially dangerous situations for families to be dealing with. So I think that this is the right -- personally I think this is the right thing to do to be able to help get the ramp period for the residency so that we can start to look long term and solve that problem understanding that we're not creating new beds. We're moving beds to be able to facilitate that situation.

MR. HUGHES: I would just add as an editorial that there is -- nobody will be able to deny there's a big access

issue and that's not unique to Michigan and it's not the same situation when you have an acute child at a hospital that needs immediate help. But this whole psychiatric issue, telemedicine is providing access to people to try to get them before that happens, and in Michigan we have some laws that make telemedicine from out of state difficult. So my editorial is to push the legislature to address those laws to make it easier for telemedicine across border lines to be more effective.

MR. FALAHEE: We'll add that to their lame duck agenda. Other comments? Commissioner Dood?

MR. DOOD: Thanks. The language that would allow these beds requires it to be in an area that's over bedded which is the case now. When we fix the bed need, the methodology, whether it is March or June -- hopefully it could be sooner than that, it seems like a very urgent, pressing issue -- does this language still make sense, then, in six months or are we going to have to change this so we don't end up with more beds in an over bedded area?

MS. NAGEL: That's a great question and it is possible that this language would then need to change based on whatever changes the workgroup makes.

MR. FALAHEE: And this is Falahee. I can't guarantee a March or June, and even if it comes to us then and we deliberate, then it goes back out for public comment

for another three months, so not a quick fix. A needed fix, but not necessarily a quick fix. Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: Yeah. Brooks-Williams. I'm just curious. So kind of -- I think when Lee Ann was here kind of the questions that I was asking about, what are our options, right? So I guess one option is to approve it as presented. The other option is we go to the workgroup which I think we're all expressing a little bit of lack of confidence at the timeliness that that would happen. So my thought is, is there any other option? So, again, my questions were just to say I'd like a little bit more detail. So would it be acceptable, right, that we still say it'd be discussed in the workgroup, but that we also have some information that comes back just to have a little bit more information about no harm in this reallocation or whatever, or maybe the Department assures that as they, you know, partner with the entities to make it happen. Because what I don't know is just approving this without the actual action of moving the beds, does that clear the deck for the residency process to begin? If I'm making sense; right? So this action is -- is very broadly framed, but we're told that it does allow the residency activity to move forward. What I don't know is do the transfer of beds have to actually happen? Do they have to be operational? Because

that may allow us more time to get information.

MS. NAGEL: Does the transfer of beds have to -- do the beds have to be operational to start the residency program, is that your question?

MS. BROOKS-WILLIAMS: So the application process I think is what we were told, not the residency program itself; right? So this is a pre-step to being able to actually recruit the medical, or the program directors, excuse me, to start the program is kind of how it was described. So I think I'm saying I have additional questions so I'm asking for a third option. One is just to approve it like it is. I personally would like a little more information. The workgroup goes too far out, I'm okay with that. So I'm asking on a third level do we have time to maybe have a little bit more detail brought back to the Commission before we approve the request?

MR. FALAHEE: Well, recall that even if we approve it today, it's only preliminary. It goes out to public comment.

MS. BROOKS-WILLIAMS: That's what you were stating. Okay.

MR. FALAHEE: Right. Because then --

MS. BROOKS-WILLIAMS: Okay.

MR. FALAHEE: -- so even if -- let's say we say this makes sense, we approve, it'll go out to public comment

so we're back here in March.

MS. BROOKS-WILLIAMS: So it still would be March?

MR. FALAHEE: Correct. Which would then, since everybody was listening to what you would like to hear on that issue, you will hear answers to those questions come March, assuming we do something today.

MS. BROOKS-WILLIAMS: Okay. Thank you.

MR. FALAHEE: Other questions? Anything else the Department would like to add, Brenda or Beth or -- Tulika has been very quiet because she's got a standard --

MS. BHATTACHARYA: Since Chip put me on the spot. This is Tulika. I manage the CON evaluation section and we review all of the applications that the Department reviews and approves or denies. Some of the questions that were discussed and specifically asked by Commissioner Brooks-Williams, please understand that the planning area is a cluster of counties. It's a big area and that is already defined in the standard, number one. Number two, right now in the standards even if you don't approve this language, there are provisions for beds, adult and child/adolescent, to be relocated from one existing site to another existing site. So that is already happening right now. So all this is doing is allowing a little more flexibility to move the child/adolescent beds from one existing child/adolescent site to another site that does not have child beds but does

have adult psych beds. That's the only difference. So when you think about the big change, but when you compare what is happening right now, that's the only difference because relocation of beds is already happening in the planning area because we are not able to break down the planning area into more smaller clusters like cities or counties. It's the whole planning area. So even if you approve more beds, we don't know where it will go in that big geographic area. So it's not for a particular city or community, it's, you know, wherever we get applications for and they can demonstrate they meet the need and the requirements in the standard.

And like Beth was saying, this concept of allowing a little more flexibility of who can manage the beds more than the existing providers that currently has the beds are allowed in nursing home standards within the planning area, in hospital bed standards within the hospital groups. It's all about, you know, allowing a little more flexibility to solve an access problem without, you know, undermining the bed need and the community's access to those beds. It's about who can better manage the beds and giving that provider an opportunity to do so.

MR. FALAHEE: Tulika, thank you very much. Now you know when I have a CON question, there's the person I call. Commissioner Brooks-Williams, did you have another question in response to that?

MS. BROOKS-WILLIAMS: Never to Tulika, no. It's been clarified.

MR. MITTELBRUN: Well, I guess I do. Mittelbrun. So from what I hear, I don't hear the Department having any concerns with anything that's going on and I'm going to go back. The chairman referenced former Commissioner Cowling and all the things that she explained and this has been going on a long time and the problems that everyone has talked about has been going on a long time. So I don't see any negatives unless somebody is going to tell me one, and we've still got the process with the workgroup, and we're going to get more information. I don't see the harm in moving the ball forward. So I guess I'll -- and if you don't mind, I'll go to commission action and make a motion that this take its normal course and begin the process.

MR. FALAHEE: Is there support for that motion?

DR. MCKENZIE: I'll support.

MR. FALAHEE: And that's Commissioner McKenzie supporting. And what they're saying in shorthand, in CON speak, means this will go out for public comment and I believe it also goes to the JLC?

MS. ROGERS: This is Brenda. That is correct.

MR. FALAHEE: Did I miss anything else?

MS. ROGERS: No.

MR. FALAHEE: Okay. So there's the motion on the

floor. Any discussion? Hearing none, all in favor say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? That carries.

(Whereupon motion passes at 10:32 a.m.)

MR. FALAHEE: Thank you very much for the presentation, for addressing the issue. Thank you for this discussion on a very, very tough situation out there in the acute care field. Thanks to the physicians here as well because you've seen it firsthand and, like when Commissioner Cowling was here, that was invaluable to those of us that don't see it firsthand from a patient care perspective. So thank you.

So let's move on then. The next agenda item is a review of the draft of the biennial report which is in here and you'll see it in our packet. And Brenda, do you want to describe this at all? Obviously, it has Commissioner Mittelbrun and my name on it. Suffice to say all we do is review it and sign it. The folks to my right do a great job of putting it together and summarizing anything. So Brenda or Beth, any comments?

MS. ROGERS: This is Brenda. No. The only change from the September Commission meeting was there's a paragraph at the end of the memo that talks about some of the issues with psychiatric beds. And in working with Chip

on that, or Commissioner Falahee, we've added some language per your discussion in September. And, I'm sorry, I was not at that meeting, so I don't recall the details. But if you have questions on that particular language, I guess just feel free to ask.

MR. FALAHEE: And what Brenda's referring to is I think it was Commissioner Hughes that raised the issue. We have a scope of practice issue in Michigan and what's the scope of practice, how can we get more people who have been practicing to the top that are licensed. So that's why in that long paragraph at the very last page we talk about the scope of practice is defined by the Mental Health Code. That's not under the CON Commission purview. But we recommend that this be reviewed as legislatively as a solution to increasing access to psychiatric care to let more people be able to practice, whether it's advanced practitioners, nurse practitioners, whatever, to be able to take care of this large need out there. So that'd be the one change that we saw based on the September discussion. And, Brenda, we need a motion to accept; correct?

MS. ROGERS: This is Brenda. That is correct.

MR. FALAHEE: Any other, any questions or comments? I'd entertain a motion to accept the biennial report, please. Commissioner Dood?

MR. DOOD: In terms of the -- who's carbon copied

on it? Carl, should you be on there as Mr. Potchen?

MR. HAMMAKER: Yeah. That should have been updated.

MR. DOOD: With that change, I make a motion that we approve the report.

MR. FALAHEE: Thank you. Commissioner Dood makes the motion. Support?

MR. HUGHES: Support, second, Hughes.

MR. FALAHEE: Commissioner Hughes supported. Thank you. Any discussion? All in favor say "aye."

ALL: Aye.

MR. FALAHEE: All opposed? That carries.

(Whereupon motion passes at 10:35 a.m.)

MR. FALAHEE: I think that was giving Carl plausible deniability, but that was just taken away from him. So, there. So, all right. Moving on then. Next we have a written report from Dr. Kastner on the MRT SAC and that's in our packet. I don't think we need to read it, but it's there for your review. If you have any questions, now is the time to ask those. If not, we'll just accept that report as submitted. Brenda or Beth, anything to add on that?

MS. ROGERS: This is Brenda. No.

MR. FALAHEE: Thank you. You will note that in that report in response to our questions at the September

meeting, I believe, some additional language was added as to why the minimum volume in their opinion should be reduced and that explanation is in the report. So you can see that for your reading pleasure.

Next item is another written report. This is on the Psych Bed workgroup. And, again, this is a workgroup and they've submitted this written report. So any questions about that workgroup report? Okay. Hearing none, we'll accept that as well. Let me -- I've got one other -- I want an update on a -- I'll give an update later on a SAC that we're putting together that we started back in March of this year, so I'll give an update on that later.

So let's move on then to the legislative report. And I know Matt's not here. Anybody to --

MS. NAGEL: This is Beth. There's no report.

MR. FALAHEE: Okay. Thank you. All right. Moving on then to the administrative update. We'll start with Beth, planning and access.

MS. NAGEL: My update was going to be about the SAC that I believe you were referring to, so --

MR. FALAHEE: Oh, go ahead. I'm sorry. Go ahead.

MS. NAGEL: We are close to finalizing the Bone Marrow Transplantation Standard Advisory Committee. The nominations are into the chair at this time. And once that's done, we are hoping to start meetings in early 2019.

MR. FALAHEE: And to that, I have the list of the folks that have applied and it's a very good list of the qualified experts on both sides of the issue and an even number of experts on both sides of the issue which the chair and the vice chair like to have because then we can engender a very good discussion on the issue. And for those that weren't here or those that need a recollection, this back in March was the CAR-T issue. And I've sent out to the commissioners some articles about CAR-T for us lay people that go, "What's CAR-T?" So that's what this is about. But the role of the chair and the vice chair will go through the list, make sure everyone is appropriate, doesn't have a conflict of interest, and then we go ahead and appoint. What I think I'll do here is appoint two co-chairs of this SAC, and then let them begin deliberating this issue. So, Beth, thank you for teeing that up. Anything else, Beth, on that section?

MS. NAGEL: No.

MR. FALAHEE: Okay. Thank you very much. And then we turn it to Tulika for the CON evaluation section update, please.

MS. BHATTACHARYA: So there are two reports in the packet; one is on the compliance activities and the other one are the performance measures on the timeliness of all of the decisions and things like that. And if you have any

questions, I'm happy to answer.

MR. FALAHEE: Any questions of Tulika? I want to back up a little bit. It's not so much a legislative report, but some of you may have seen that HHS in DC issued their -- I'll call it "wish list." And on their wish list they talk about doing away with some or all of CON. So obviously CON is a state program and -- but it's always interesting to see where HHS is coming from. So stay tuned for what happens in the state. So if no questions of Tulika, we'll then move on to the next agenda item which is the legal activity report.

MR. HAMMAKER: Yes. This is Carl Hammaker from the Attorney General's office. I included a written legal activity report in the packet. I'd be happy to answer any questions that the commissioners may have.

MS. GUIDO-ALLEN: Just one. Guido-Allen. The first statement, July 10th, CON 13-, is it going to the administrative law judge on January 29th, '19?

MR. HAMMAKER: Yes. That's a typo. Apologize.

MR. FALAHEE: And for those of you fairly new to the Commission, we work very closely with the Attorney General's office not just the day of the meeting, but in between meetings to the extent we've got questions or Carl has questions. They'll work with the chair and the vice chair and the Department to get those resolved before we

show up here. So it's a great relationship. Glad you're here.

MR. HAMMAKER: Thank you.

MR. FALAHEE: Next, we have the future meeting dates. We've announced those, but just so those in the audience want to make sure we've got -- January 31, which is a special commission meeting like we do every year in January; then March 21; June 13; September 19; and December 5th. That's the slate for 2019.

Next, I open it up for public comment and I have a blue card from -- I may pronounce the last name badly, I apologize -- Jay Dworkin. Step up to the podium please and you may know the rules, but three minutes and the alarm goes off and then we can ask questions.

JAY DWORKIN, PH.D.

DR. JAY DWORKIN: Thank you all very much. I hope you've gotten the handouts that were supposed to be there.

MR. FALAHEE: Yeah. This was in our packets everybody.

DR. JAY DWORKIN: Electronically also, but I handed them out today. Now, as the CV that you have in front of you indicates, my name is Jay Dworkin. You pronounced that right, Chairman Falahee. I am a physicist who after earning my Ph.D. in experimental elementary particle physics at the University of Michigan Ann Arbor --

I hope you won't hold that against me given our location -- has spent 30 years working in the MRI industry at a company called Fonar Corporation in New York.

And the reason that I'm here is to introduce you to a different type of MRI unit which, as you can see in the handout you received, is named the Upright Weight-Bearing Multi-Position MRI. You may notice in the first slide that it's a little different. The patient can be upright. The bed rotates from upright to recumbent. There's a removable seat. There's also nothing in front of the patient's face, so you can do flexion and extension which is a very good test of biomechanical issues. We've installed about 140 machines worldwide with about two dozen overseas.

Now, as the top slide on page 2 reports, there is plenty of published evidence that the upright MRI provides medical benefits that are not duplicated by any other MRI. So I'll show you some of these in a moment, but the question I'd like to pose to you in terms of the serious charge you have is what should you do when there's an unmet diagnostic need? The handout illustrates how this MRI solves problems that occur when traditional MRIs fail. And an example of that would be something that happens to me frequently when I meet folks, surgeons, radiologists, pain management neurologists. They'll say, "I send my patient out for a scan, the scan comes back. Tell the patient there's nothing

wrong and they say, 'yeah, but it doesn't hurt when I'm lying down.'" Typical example: Positive EMG, negative MRI.

So on the fourth page -- and this is really the key since I only have three minutes -- there's a description of a study that was done where 25 patients who all had a negative MRI, and these were all patients with chronic pain and sciatica, were told "have an MRI." They had an MRI. They were told, "We don't see anything. There's nothing we can get out of this from you, for you." They all went to the MRI, upright MRI at the University of Aberdeen in the UK and they were scanned upright and recumbent the same day, because this machine does both, and just over half, 13 of them, 52 percent, had abnormalities on one or more of the upright images and nothing on the recumbent, which is not unexpected. And those patients all had surgery and six months post-op they were symptom free. So this an issue of a good outcome for folks that were having problems.

The other example I'd give you is people in your family or you've seen people with back pain. What do a lot of people who have back pain do to get rid of it? They lie down. So why scan them that way? So that's kind of an interesting look at things.

The next thing I wanted to do is explain the little weird looking diagram on the bottom under that slide. I attached an article from the New York Times magazine last

May which is written by a physician named Lisa Sanders who often writes their "Diagnosis" column. Oh, my, look at you guys. You're so -- that's wonderful. Thank you. This diagram was about the New York Times article, so you may want to go back up. She's a very prolific writer and a physician. She writes about interesting cases.

And the diagram is about a young lady who went through the system, had a very complicated journey and it shows the kind of thing that, you know, we all struggle with is how do you get things -- get the decisive diagnosis? She saw several eye doctors when she was young. They didn't understand why she had these black spots, eventually they went away. They said maybe it's something called emotional blindness. All of a sudden she's a teenager. She can't see. The screen is jumping around. She went to a neuro-ophthalmologist who proposed it might be a nystagmus where, you know, the coordination isn't right. Sometimes that's from the inner ear, sometimes it's from the cerebellum. She had an MRI scan to see if there was a clot or a mass which is often the case. There wasn't. But there was an odd thing where there was something called a Chiari malformation where just a sliver of the cerebellum, a sliver of the brain tissue kind of fell down in the spinal canal about five millimeters, which according to standard fare is not something to worry about because about one in 200 people

have these things, they're incidental findings. So she was told "we don't think that's the problem." Went to a neurosurgeon. He said, "you know, that's really too small, not related." To the fact, she also had something called Ehlers-Danlos Syndrome where you have heightened mobility of the joints because the connective tissue is lax. She went to a neurologist, still don't know. Doesn't seem to be the problem.

And then her parents went online and found -- wanting to know if there was a connection between this Ehlers-Danlos Syndrome and the Chiari malformation -- found a surgeon at UCLA named Ulrich Batzdorf who really did think there was a relationship. They went to try to get an appointment with him, they didn't get the appointment. He recommended a pediatric neurosurgeon. The pediatric neurosurgeon says, "Well, you know, it's only 5 millimeters. I really don't know if it's a problem. But let's maybe get you an appointment with, you know, the guru." And he said, "Why don't you go to one of those upright MRIs where you can kind of stand up and, you know, have weightbearing issues." And she did. And what they found was the bottom of the cerebellum extended nine millimeters down, another positional dependent effect. And as a result, she had surgery -- and if you can go to the top of the slide for the -- it's a little bit higher, or on your handout -- what

was in the article as, again, this is written by Lisa Sanders, the M.D. You know, not to be dramatic, but the fact is she was fine and it was all because a sliver of her brain was falling down and it only happened because she was upright.

Parts of our body move around. It happens. If you look at the top of page 3, the first slide, there are four examples of the kinds of things that we see frequently. In the spine, in the case on the right, that is actually a case of a uterine prolapse which gets worse when your patient is -- yup, there you go. Just go down a little bit. Boy, this is like when my -- in the old days when I would give slide projections and my kids would, you know, do it for me. I'd say "next," "next." That's a case of uterine prolapse where the patient was recumbent, the patient was upright and you see that, again, the upright scan sees this problem. This is an example of what happened to this young lady where in this sideways brain image, the cerebellum is falling down into the spine a little bit when the patient is lying down.

MR. FALAHEE: How are we doing on the time limit, Tania?

DR. JAY DWORKIN: We're done. We're done. So here are the questions.

MR. FALAHEE: Okay.

DR. JAY DWORKIN: The question is what's the right way to get an upright MRI into Michigan? My understanding from some folks that we've talked to is that the standards would really preclude having this machine, you know, being able to be granted a CON and the thing I wanted to emphasize is this is a machine that is kind of a secondary machine. So go ahead.

MR. FALAHEE: Thank you.

DR. JAY DWORKIN: Yeah.

MR. FALAHEE: So your question is can this be approved in Michigan?

DR. JAY DWORKIN: Yes.

MR. FALAHEE: Thank you. Any questions of our witness?

MR. HUGHES: Commissioner Hughes. Can you give me the price difference in this machine versus a typical MRI machine and the facility requirements to have it versus typical facility requirements?

DR. JAY DWORKIN: Well, that's a -- I guess the answer to that question is it's similar depending on which machine you have. Right now there are high field machines, 1.5 Tesla, 3 Tesla. There are things called classic open machines, they're a different field strength. So it's in the same neighborhood, you know. It requires --

MR. HUGHES: Well, some neighborhoods have really

expensive houses and there's houses that are more like everyone else's. So in an apples-to-apples comparison can you give me a ballpark?

DR. JAY DWORKIN: I think it's pretty similar. I mean, in fact, a lot of people are -- because of the economic constraints, a lot of people are purchasing refurbished machines in which, I mean, in which case, you know, they're similar.

MR. MITTELBRUN: Mittelbrun. I'm just curious. You've made the comment that this type of machine would be precluded, right, I think was the term you used.

DR. JAY DWORKIN: Would what?

MR. MITTELBRUN: Precluded, not allowed under our standard?

DR. JAY DWORKIN: Well, it isn't that it isn't allowed, but my impression is that, number one, it can't be used in a mobile room because it's a heavy machine. Number two, my understanding, if I may be incorrect, is that generally the fixed machines go into the hospitals, and the other thing is that it serves a portion of the population that is hard to diagnose. So it really isn't competing with what I would say is a standard situation. It's kind of a -- it does things that are special which help people and right now those people can't get help with the standard machines. Maybe that's a good way to say it.

MR. FALAHEE: So this is Commissioner Falahee. I'll turn to the Department in a second. But we don't enforce the standards. We develop the standards.

DR. JAY DWORKIN: Right.

MR. FALAHEE: I would welcome what the Department has to say about whether it has even looked at this issue or has an opinion on whether this format, I'll call it, meets, doesn't meet, or is silent as to the current standards that we have in place in Michigan. So I'll turn it over to Tulika or Beth or Brenda?

MS. BHATTACHARYA: This is Tulika. I'll start. So in the current review standards for MRI, if we don't restrict what type of MRI unit provider is going to purchase, 1.5, 3, open MRI, there are no restrictions. It's up to the provider. They will have to meet the requirements in the standards for initiation, expansion, in terms of volume projection because that's how we assess need in a community. So I don't under- -- well, I do understand, but so what you're saying that it will preclude you, that's not true. You just have to meet the standards for any diagnostic MRI scanners in the state. And there are freestanding fixed MRIs, dozens of them in Michigan if you look at our utilization report on the left side. They're not just hospital-based. There are many, many freestanding fixed MRIs.

DR. JAY DWORKIN: Okay. And they've been approved recently?

MS. BHATTACHARYA: For over decades.

DR. JAY DWORKIN: Well, I guess the only thing that I can say is that the people that we've spoken to that are enthusiastic about this have said that they didn't think that it was worth the trouble to try to apply and the only thing I said was, "Well, the fact is that if someone needs that kind of a test, then they'll have to go out of state."

MR. FALAHEE: Any other comments from anyone else? I would recommend you seek different advice.

DR. JAY DWORKIN: Okay.

MR. FALAHEE: I will leave it at that.

DR. JAY DWORKIN: Well, thank you for your time. And I really appreciate the fact you were scrolling through this. Too bad I wasn't looking at the screen.

MR. FALAHEE: Thanks for being here. Any other public comment? I don't have any other cards. Just making sure. Okay. Brenda, I'll turn it over to you for review of the Commission work plan, please.

MS. ROGERS: This is Brenda. You do have the draft work plan in front of you. The only change as of today's action that you took, you took proposed action on Psych Beds, so we will update the work plan to reflect that. We will schedule the public hearing and then bring that

language back to you for final action in March. Thank you.

MR. FALAHEE: Thank you very much. We need a motion to accept the work plan as presented by Brenda just now.

MS. BROOKS-WILLIAMS: So moved. Commissioner Brooks-Williams.

MR. FALAHEE: Thank you.

MR. HUGHES: Second.

MR. FALAHEE: All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Great.

(Whereupon motion passes at 10:55 a.m.)

MR. FALAHEE: Next, adjournment. I would like to thank everyone as I do every year for all your work on the Commission and those of you in the audience that have the opportunity to deal with us a few times a year. Thank you very much. Seasons greetings to everybody, safe travels, have a wonderful time with family and friends. Thank you. Motion to adjourn?

DR. OCA: Motion.

MR. FALAHEE: Support?

MS. GUIDO-ALLEN: Support.

(Whereupon motion passes at 10:56 a.m.)

MR. FALAHEE: We are adjourned. Thank you.

(Proceedings concluded at 10:56 a.m.)

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