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

COMMISSION MEETING

BEFORE AMY L. MCKENZIE, M.D., CHAIRPERSON

333 South Grand Avenue, Lansing, Michigan

Thursday, June 16, 2022, 9:30 a.m.

COMMITTEE MEMBERS:	JAMES FALAHEE, VICE CHAIRPERSON AMY ENGELHARDT-KALBFLEISCH, D.O. ERIC FERGUSON, M.D. DEBRA GUIDO-ALLEN, R.N. MELANIE LALONDE LORISSA MACALLISTER, PH.D. RENEE TURNER-BAILEY
MICHIGAN DEPARTMENT OF ATTORNEY GENERAL:	MR. BRIEN WINFIELD HECKMAN (P76006) Assistant Attorney General PO Box 30736 Lansing, Michigan 48909 (517) 335-7632
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES STAFF:	TULIKA BHATTACHARYA BETH NAGEL KENNETH WIRTH
RECORDED BY:	Marcy A. Klingshirn, CER 6924 Certified Electronic Recorder Network Reporting Corporation Firm Registration Number 8151 1-800-632-2720

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Thursday, June 16, 2022 - 9:35 a.m.

DR. MCKENZIE: Good morning, all. Good morning, all. Thank you. Welcome to our June Certificate of Need Commission meeting. I'm going to call us to order this morning. I am Amy McKenzie, your chairperson. And our first order of business is the review of the agenda which is included in your packet. For those that are joining us online, that information has been published online as well. And so I'll give you a moment to review the agenda, and then for the Commissioners, I will take a vote.

Actually, before we start that, I just wanted to start off with a few reminders. Sorry. I moved my notes to the side. So in addition to welcoming you all, we are now in this hybrid environment so I just wanted to issue a couple of reminders. To remember to mute when you're speaking (sic), but then also to remind the Commissioners -- and this is a reminder to myself as well -- that we need to speak up. One moment. We have another technical issue we're trying to sort through. Hold on just a moment. So for those in the room, you also have to kind of mute your sound, otherwise you're going to get an echo in the room. So reminder for all of us that we also have to speak up when we're speaking because all of these notes are being recorded.

The other reminders I wanted to provide was that if you want to issue public comment, if you're here in the room, we do have comment cards. They're on the front table. They're the little blue cards. If you are online, please put those in the chat. All public comments are limited in time to three minutes, and that's so we can keep our meeting moving and be efficient. We will have some reports coming in from our chair- -- our workgroup chairs and those will be a little bit longer, but comments are limited to three minutes.

For voting for the Commissioners, as we've done in prior meetings we're going to be doing a roll call vote on the key topics, the key agenda items where we're approving proposed language changes. All other votes we'll do just a voice vote similar to what we've done in prior meetings. So, sorry for not remembering to give you those instructions up front.

So now we'll jump back over and we do have the agenda as I mentioned in front of you and so I will take a motion once someone is ready.

MR. FALAHEE: This is Commissioner Falahee. I'll vote to approve the agenda as presented.

MS. LALONDE: Lalonde, second.

DR. MCKENZIE: All in favor?

ALL: Aye.

DR. MCKENZIE: Any against? Okay. Agenda carries.

(Whereupon motion passed at 9:38 a.m.)

DR. MCKENZIE: Next order of business is declaration of conflicts of interest. You have a conflict of interest summary in your packet for your review. And for any of the Commissioners, we'll ask if there are any conflicts of interest that anyone wants to declare at this time. Okay. Hearing none, I'm going to move us forward to review of the minutes. The minutes are contained in your packet from the March 17th meeting. Once you've had an opportunity to review on those, I'll take either any comments or a motion to move forward with the minutes.

MR. FALAHEE: This is Commissioner Falahee. I'll make a motion to approve the minutes as presented.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt, second.

DR. MCKENZIE: Thank you. All in favor?

ALL: Aye.

DR. MCKENZIE: Any against? Okay. Minutes move forward.

(Whereupon motion passed at 9:39 a.m.)

DR. MCKENZIE: Our next order of business is an administrative update. We did slide the agenda around for those that have been attending with us for some time, just

to accommodate schedules with our presenters today. So we're going to be turning this over to Kenny and Tulika to present the administrative update for us this morning.

MR. WIRTH: Thank you. So administrative updates, we had a slight reorganization at the Department. And let me change the slide that I'm on so that you can all see. So we now have a -- sorry -- commissions and special projects section within the Department. Sorry. I'm struggling with technology today. So myself and Kate Tosto are the policy analysts under Brad Barron, who is the section manager for commissions and special projects, and Brad reports to Beth Nagel. This brings us up closer to Beth. She just didn't want to lose CON, she liked it so much. So what this does is this allows us to expand some of the administrative modes of how we've been operating CON as a Commission to apply those same ways of operating to other Commissions as well. So we're taking on Health IT and applying sort of how we've been running these meetings to that as sort of a test case to see if more commissions can be run in a similar manner. That's it for commission special projects update as far as I have it. Kate Tosto is joining us as a new policy analyst at CON, so, yeah. Tulika?

MS. BHATTACHARYA: Thanks, Kenny. Good morning, Commissioners. Good morning, this is Tulika. So for today's update we have --

MS. NAGEL: Tulika, we lost your audio.

MS. BHATTACHARYA: Do I need to unmute myself?

MS. NAGEL: Yes.

MS. BHATTACHARYA: Oh, sorry.

MS. NAGEL: That's all right.

MR. WIRTH: No, you're good.

MS. BHATTACHARYA: Good morning. This is Tulika. So for today's meeting, you have two of the regular reports in your packet, but I also have two special note to the Commission which we'll go into detailed discussion.

So as part of the program activity reports for the second quarter January through March 2022, as you can see we continue to maintain the timely processing of letters of intent applications and issuing decisions on a timely basis. We did receive three emergency CON application. Two were for additional hospital beds and one was for emergency replacement of psych beds within a psych hospital facility. Also, as part of the compliance report, we are actively monitoring approved projects for follow-ups. When appropriate, we are expiring projects because those are not going to be implemented. And if the provider is struggling to meet the timelines, we are working with them to allow for extensions for construction start or submitting contracts and things like that. And right now we are actively monitoring and following up on 279 approved CON projects

that are still ongoing. And just as a reminder, this year the Department decided to do the statewide compliance review for CT scanner services for hospitals, freestanding facilities, mobile networks. We are still in the process of analyzing data and reviewing everything. So once we know how many facilities are meeting their project delivery requirements and how many are not, we'll bring back the summary reports to the Commission probably towards the end of the year.

The next item in your packet that we would like to bring to your attention is the use of CON annual survey data. As you remember because of the impact of COVID on health care system, the Department has been allowing use of 2019 calendar year annual survey data, but a provider also had the option to use 2020 data if that was beneficial to them because some facilities did see increase in volume while others did not. But as of now, as we have concluded the annual survey and done some of our basic audits of the data for CY2021, it's not fully done yet, but we are at a position to propose that the Department is planning to end the use of CY2019 annual survey data for application reviews. And the annual survey, the 2021 annual survey reports are expected to be published by end of July if not sooner and we will provide notice to all parties when those reports are published on our web site, public web site.

So the Department typically requires using most recent annual survey data starting the September 1 window date of the current year, so that's what we are proposing, but a facility can use a more recent 12-month data other than calendar year January through December '21 if it is beneficial to them and if the review standards allow for more recent ruling 12-month data. Also, for physician commitment forms, the applicants should start utilizing the CY2021 survey data starting with the September 1 window date. However, for statewide compliance reviews, for example, CT, we will still review the 2019 survey data but we'll also look at their 2020 and '21 data on a case by case basis if it is beneficial to the facility. For example, a freestanding facility or hospital did not meet their volume in 2019, but they met it in '21, so we will say that they met the requirements in the project delivery section. Any questions on the annual survey data? Hearing none, we move on to the next special memo to the CON Commission.

It is related to physician commitments and how the applicants, the providers, are reporting data to the Department through the annual survey process and the MRI quarterly data submission process. So it has come -- so the CON review standards: CT, MRI, surgery and MRT, requires providers to not only submit their data for the procedures, but which physician made those referrals to the facility

where the cases are being done actually. So what we have observed is not only physicians are reporting those scans, but also other licensed health care professionals. For example, NPs, PACs or, like, limited educational licensed professionals who are practicing within the legal scope under the law, but the CON standards have the word "physician" in it and that has been that way for decades. So we are bringing this to the Commission's attention because when there is language in the standard, the Department follows that the way it is written and there's a discrepancy here. So we are looking for guidance from the Commission.

While we feel there may be many options, but we can talk about two. We can keep things as is, keep the physician in the review standards and whether an NP or PAC is referring those scans, they're reporting to a supervising position so we can ask or tell the providers you will always have to report under a physician but we know that's problematic because that's what is not happening. Or we can change the language in the review standards to say it is either a physician or any other licensed health care professionals that are acting within the legal scope of practice under their respective licenses. So we know that multiple standards will be affected by this change, but we worked on revising the language in the MRI standard because

it is up for review today. So that is a start and if it is approved by the Commission, then we will replicate that in the CT standard and surgical standard. MRT is very different than the CT/MRI being diagnostic imaging modalities. In the MRT standard it specifically states treating physicians will have the right to commit those cases. So that would need more discussion and in-depth review. So at this point we feel we would not change language in the MRT standard but, again, we are open to suggestions and discussions. Any questions on this issue?

MR. FALAHEE: This is Commissioner Falahee. Tulika, thank you very much for, number one, the report and handling some emergency applications, too. Beds are critical at certain locations. On the commitment question, as you said the language has been in there for decades. Let us not get stuck with old language that doesn't match what's going on in the field. And I think it makes sense, to me, at least, the second alternative you proposed which I think is how it's structured in the MRI; is that right? Okay.

MS. BHATTACHARYA: Yes.

MR. FALAHEE: Correct. Okay. To me that makes sense because it follows scope of license. And as scope of license changes, I think we need to make sure the standards for CON change along with those changes in scope of license. So I would support that second alternative as you've laid it

out in the MRI standards today.

DR. FERGUSON: Commissioner Ferguson. I would support the same. The decision making ought to be at the scope of practice level. You can debate back and forth scope of practice. That's not our job. But once the decision is made that somebody has a scope of practice of X, they should be entitled to basically the full breadth of input that goes with that which would include pledging cases toward CON numbers.

DR. MCKENZIE: This is Commissioner McKenzie. I also support. I think the recommendation makes sense. It's catching up the standards with something that's already occurring. If I understand correctly, the proposal is not that we would open all the standards today, but that as the standards come up for review, the charge would be that the Department would recommend language to make those changes to be consistent, but MRT will need additional review. Have I captured that correctly?

MS. BHATTACHARYA: That is correct.

DR. MCKENZIE: And just so I'm clear, there's no recommended proposed action from the Commission other than just this discussion. We don't have to take a vote or do anything specific today outside of the language that's coming forward with regards to MRI?

MS. BHATTACHARYA: Yeah. So if you approve the

change in the MRI standards, that's a green signal to us that we can make revisions to the CT standard and surgical standards and bring it back to you wherever, you know, Kenny and Beth feels is appropriate.

DR. MCKENZIE: Great.

MR. WIRTH: And I do want to add that we'll add those in as the standards come up for review when on their normal cycle.

DR. MCKENZIE; Great.

MS. GUIDO-ALLEN: Guido-Allen. I have a question for you. Are there --

MS. NAGEL: Can you unmute, please?

MS. GUIDO-ALLEN: I don't know. Oh, yes, I can unmute. Okay. So I have a question for you. Are there certain advanced practice providers, for example, nurse practitioners, that do not have to function under the supervision of a physician? And if there are, we need to clarify that.

DR. MCKENZIE: I know -- no, you're good.

MS. BHATTACHARYA: That's a great question.

MS. GUIDO-ALLEN: Because if you couple those together in your -- if you couple those together in your statement, it's going to be contradictory to the scope of practice.

MS. BHATTACHARYA: That's a great question and I

am not very familiar with the professional licensing part of it. But if you read the -- so in the memo we are just explaining the problem, but if you look at the actual language in the MRI standard, we are -- we are not naming any specific professions, like, not NP, PAC, da, da, da. It's whoever is licensed to practice health care within the legal scope of their licensing can order the scans and commit those scans. We are not naming any specific licenses in our language. So if an NP is not required to have a supervising physician under the medical practice law, then they are not required. We are not, you know, monitoring that for CON data reporting purposes. That's what we are --

MS. GUIDO-ALLEN: It's just that under your potential solution it says,

"updating the affected standards to allow non-physicians, licensed health care professionals acting within the scope of their practice and under the supervision of a physician."

So it's "and," the "and" that I'm worried about in your solution. As long as the wording in the regulations are -- is clearer, I'm okay with that.

MS. BHATTACHARYA: Okay. I think we will make a note of that when we are reviewing the MRI standard language today.

MR. WIRTH: Uh-huh (affirmative).

MS. BHATTACHARYA: Okay.

MR. FALAHEE: Yeah. This is Commissioner Falahee. I've looked ahead and the MR language -- MRI language says, first of all, it deleted "a doctor" and instead it substitutes in every spot I could see it says, "Licensed health care professional."

MS. GUIDO-ALLEN: Okay.

MR. FALAHEE: So I think, just my opinion, by using the word "licensed health care professional," it gets to Commissioner Guido-Allen's comment. So I think we're okay, but let's look at it again to make sure.

MS. GUIDO-ALLEN: I was looking at it last night, too. I just want to make sure we don't paint ourselves into a corner.

DR. MACALLISTER: Commissioner MacAllister. Yeah, so I would also just for clarification, the issue that we're deal- -- what you're trying to solve is the fact that the data input that you're receiving is not traceable to a physician or some type of licensed professional is what you're really trying to clean up the data extraction -- right? -- of what you're getting? Because it's not traceable now.

MS. BHATTACHARYA: Yes, that you can uplink the data to a physician.

DR. MACALLISTER: Yeah; yeah. Or a licensed

professional?

MS. BHATTACHARYA: Well, we don't know. We are getting NPI numbers, license numbers and we don't have a mechanism to verify that against the BPL licensing database.

DR. MACALLISTER: So is there a reason why we wouldn't want to get all of that now? I mean, when would we have -- basically what I'm hearing you say is that the data that we have been receiving isn't necessarily fully accountable or able to be traced to a phys-, or licensed professional. So why would we not want to have that understanding now for all of the proposed areas and wait for the cycle to go through? Because we wouldn't have that information for another year -- correct? -- accurate information if we let it go?

DR. MCKENZIE: I think the issue is -- this is Commissioner McKenzie. Sorry, Tulika, I'll try to clarify and if I can't, then others maybe. My understanding is that for the standards they require currently attestations of physicians --

DR. MACALLISTER: Right.

DR. MCKENZIE: -- basically saying, "hey, we're going to utilize this service" or collecting data and in the standards it states that that has to be a physician.

DR. MACALLISTER: Uh-huh (affirmative).

DR. MCKENZIE: But what is happening in reality is

we are also receiving others who have, you know, the scope of practice to be able to order those services. The standards are not tracking with what actual reality is and so we're looking --

DR. MACALLISTER: So the data is accurate?

DR. MCKENZIE: Yes.

DR. MACALLISTER: Got it. That's what --

DR. MCKENZIE: It's not that --

DR. MACALLISTER: -- I was trying to understand if it was the accurate data or if it was the opposite, so --

DR. MCKENZIE: Yeah; yeah.

DR. MACALLISTER: -- okay. Thank you.

DR. MCKENZIE: Any other comments or questions for Tulika?

DR. FERGUSON: Commissioner Ferguson. I may need some help with this question because it's -- it's kind of, like, at the edge of my awareness. We have a really nice compliance report and strong data that we're doing the job that we're charged with doing in turning stuff around, et cetera, et cetera. There was recently in the news in Michigan some mention or report of some struggles in I think it was nursing home visits or supervision, that we weren't doing what we thought we were doing at a state level. This was in the media I think this week. That's not our domain. My question for you and your team is, you know, do we take

that opportunity to look and say we are doing everything that we're charged with doing and have no holes in our process; right? So doing that and taking it as a learning moment and making sure that we're not the next ones in the spotlight for failing to do our job. And I apologize. I don't have the story quite right. The intent isn't so much the story, it's the opportunity to make sure that there are no holes in our process where we're failing to do something that we're charged with doing. That we've missed some timeline because of COVID or not because of COVID or whatever it may be. The report looks great. I have no reason to believe that we're not doing what we're supposed to do. I'm just asking, you know, to make sure we take a second look at all the nooks and corners.

MS. NAGEL: Thank you, Dr. Ferguson. I appreciate that. And I do know, happen to know the story that you're referencing. And, you know, I will say that that's something that is on our mind, surely Tulika and her staff as they go about all of their daily duties. We consult pretty frequently with Brien who is our assistant attorney general, to make sure that whenever we're approving an application or the new standards take place, that there's always that check point to make sure that we're following the law. I will say one thing is really important. The Department has, it is our responsibility to make sure that

there's compliance with Certificate of Need and so that's what Tulika has been doing on a regular basis. The Commission has the burden of making sure whatever standard gets passed also complies with state statute. And so Brien is the critical piece for that as well. But your point is well taken that, you know, we always want to make sure that we have a process in place to continually make sure that we're doing exactly what we need to do under the law and that is part of Tulika's compliance. So, you know, certainly open to new ideas to beef that up and make that better, but that is an important part of what we're doing on a daily basis now.

DR. FERGUSON: Yeah, I have no particular ideas. I have no direct reason to believe that we're not doing what we're supposed to do. I'm just trying to make sure that we don't inadvertently hurt patients ever along the line and that's what it comes down to. I'm less concerned about the appearance of politics or whatever. It's I want to make sure that patients are getting what they need.

MS. NAGEL: Absolutely. Thank you. And point well taken.

DR. MCKENZIE: Any other comments or questions for Tulika? Great job. Thank you, Tulika. Next up on our agenda is our legislative update. And I understand that there are several of the CON bills that are being discussed

today and there's testimony being received at the House Health Policy Committee, but there is no anticipated vote. There also have been some updates related to storage policies for CON materials and I'm going to turn it over to Kenny to describe that to the Commission.

MR. WIRTH: Yes. Thank you, Chairperson McKenzie. So Public Act 63 requires that all meetings of state bodies and commissions be recorded and stored in a format able to be reproduced for FOIA requests. So our CON meetings are already recorded. What we're doing now is keeping these in a folder. We're still working on getting a new folder for ourselves so we don't take over all of Tulika's data storage ability for all of their reports and data they keep. But we'll be able to reproduce these video recordings for any FOIA requests that come in.

DR. MCKENZIE: Thank you for that update. Anything further from any Commissioners? Questions? Okay. So next on our agenda is the MRI work group, final report and draft language. Do we have Dr. Mukherji on the line with us?

MR. WIRTH: We do.

DR. MCKENZIE: Dr. Mukherji has been our workgroup chairperson and just done a wonderful job, so I'm going to turn it over to him to get this final report.

DR. SURESH MUKHERJI: Hi. How are you? Hello,

everyone. Can you hear me?

MR. FALAHEE: Yes.

MR. WIRTH: Yes.

DR. SURESH MUKHERJI: Is that a "yes"? Okay. I have to get used to the Zoom minute. I think you're supposed to give a minute when you give a question until you hear back. So thank you very much.

SURESH MUKHERJI, M.D.

DR. SURESH MUKHERJI: The informal -- what I was charged with chairing was the workgroup. So the -- just for level setting, the informal workgroup was approved by the Certificate of Need Commission chairperson as delegated by the CON Commission on January 28th of 2021. The MRI informal workgroup is charged to review and recommend any necessary changes to the MRI services CON standards. In its deliberations, the informal workgroup shall consider and report on how each recommendation addresses health care cost, quality and/or access in Michigan.

The MRI workgroup was tasked with reviewing 11 individual charges. The committee had seven meetings which started in August and ended with the last one being in February of this year. Sorry, that should be 2022. Several of the changes are related and four subgroups were created to help analyze specific issues, generate consensus and provide recommendations. During the course of the

deliberations we had over 40 participants from 19 organizations and I've listed the participants on the left and the organizations on the right. I specifically want to thank the chairs who led the subgroups. They did an incredible amount of work. But not only the work, but I was very impressed with the collaborative efforts that were universally clear to come up with the recommendation that you'll see. And I also want to thank Abby Burnell who really was the vice chair of this committee and really helped with a lot of the organization. And so tremendous work to Abby and I public wanted to thank her.

These, the 11 charges -- and I have to admit when I saw these I was a little bit overwhelmed. I'm not going to read these out obviously because they're listed in your reports. But when we started, if you will, peeling back the onion, several things happened that helped facilitate our process. So of these 11, these three that are listed here, numbers five, seven, and eight, were not felt to be relevant at the time of the initiation of the workgroup so they were removed from our deliberations. Number six was consider the electronic review of imaging and transfer of records. This subgroup was specifically charged with MR, and when we look at electronic review of imaging and transfer of records, imaging is much more than MR. It includes CT, PET, so many things that are covered by CON and also imaging that's not

covered by CON. So overall, the group was supportive of this, but we felt that it was out of the full scope of the MR workgroup alone. So the recommendation for the CON is that we were highly supportive, but we felt it was out of our purview given that we were focused on MR.

Number 11 was essentially boilerplate language that to consider any technical change from the Department and that was an iterative process. So that left us essentially with six charges. And when we reviewed these six charges, what we found out that three of the charges were related and when we did look around the room -- and, again, many of you may not have been involved in this process for quite some time, there was consensus, overall consensus this time that there was a shortage of supply and there was really a problem with access. So these three charges which was review all volume requirements for fixed and mobile MRI, review the current equivalent weighting for patient sedation and general anesthesia, and review the addition of a mobile service to a fixed site were all felt to be volume related.

So as a result, charges one, four and nine were focused on volume requirements and we formed a specific subgroup. And this was led beautifully by Cheryl Martin from Henry Ford and also Marlena Hendershott from Sparrow. And the subgroup participants were open and they represented

both fixed and mobile MRI providers, hospitals, freestanding locations, as well as rural and micropolitan facilities.

So the recommendations for charge number one were an adjustment in the initiation of volume. So we allowed for a lower emergency room visits, volume for MRI host sites from 20,000 to 10,000. We applied provisions of standards that applied to rural and micropolitan services to expand all critical access hospitals regarding of county designation. For adjustment of expansion volumes, we reduced the annual volume to expand a mobile site from 9,000 to 7,000. We reduced the annual volume required to expand a fixed MR from 11,000 to 9,000. We reduced a reduction in the annual maintenance volume for mobile routes from 5500 to 3500. We reduced the initial minimum maintenance volume from 6,000 to 5,000 and created a new maintenance volume for geographically significant MR units to 2,000. And, again, these work -- workgroup passed these subgroup recommendations on January 13th of 2022, and we presented for the Commission to review.

The second charge for this subgroup was that we clarified the weighting for general sedation. So I'm not sure how familiar you are with inpatient sedation, but it clearly can be problematic. And with more, sicker patients being in the hospital, there's a greater need for sedation and that reduces our overall throughput in efficiency. So

there was clarification that the existing 0.75 factor should be applied to conscious sedation and a new 1.5 factor was applied for patients sedated under general anesthesia. And this change, again, was unanimously approved by the workgroup on November 18th of 2021.

For charge number three of that first work group, we also looked at the addition of a mobile service to a fixed site without physician commitments and there was consensus that we could add a mobile MR host site to an existing MR network without a volume requirement and we also recommend -- we used a collective volume from fixed and mobile host sites to be counted towards expansion volumes. And, again, this all addresses the need that there was a problem with -- there has been a problem with access.

The next charge that we looked at was reviewed by subgroup two, and this was led by Scott Bowers from St. Joseph Mercy, and this was specifically looked at to review the current limit for $750,000 of upgrades within 24 months. So the recommendations to the Commission are that we remove the 750,000 cap expenditure annual threshold when upgrading an existing unit and we clarified the term "replacement or MRI upgrade" does not include the replacement of the MR system on its own.

The next charge was looked at by -- was to review the access for MRI fixed and hospitals with a 24 by 7

emergency department. Now, after extensive deliberation, both the subgroup and the full workgroup, consensus was not reached with the subgroup -- excuse me -- and the subgroup chair reviewed this request. So there are no recommendations regarding this charge because this was felt -- because this charge was withdrawn.

And then finally, what we did is that there was new technology that has been available both globally and in the United States and that is with portable MRI units. And these are low field magnets that can be transported either from room to room or they can be sited in pediatric hospitals or they can be sited in stroke units. And this charge was discussed by subgroup four and it was led by David Walker from Spectrum. So what we ended up doing for this specific type of new technology is similar to what we had done in the past when we have had things like MRT, PET, MR, so on and so forth. So we created a definition for hospital portable-based MR, we created new sections for initiation expansion replacement in state statute, we excluded volume and hospital-based portable MR from being included to satisfy CON requirements. So, if you will, there's some guardrails placed on this. And as with any type of new technology, we created compliance and reporting requirements for the hospital MR system. And this change was unanimously approved by the workgroup on November 18th

of 2021.

So in summary, the full report is in your package. Special thanks again from me to all participants, the subgroup committee chairs, the Department for entrusting myself and this workgroup to make these important recommendations in state statute, and also to Abby for her help. And I'm happy to take any questions or comments.

DR. MCKENZIE: Thank you, Dr. Mukherji. We have a couple of questions in the room, so I will turn it over first to Commissioner Falahee.

MR. FALAHEE: This is Commissioner Falahee. First of all, Suresh, great to hear your voice again and thanks for participating. For those of you that may not be aware, Dr. Mukherji was a member of the CON Commission for many years, was a chair of the Commission. And so when these charges came out, in speaking with Chair McKenzie, I said I know the perfect person to head this up and Suresh didn't surprise me when he just took the 11 or 12 charges and threw half of them out. So, you know, well done. That hasn't been done before. But I leave it to you to come up with that novel theory and I get it.

The one question I've got is on the one, the access to fixed MRI for hospitals with 24 by 7 emergency departments. So it was closed out with no recommended changes. Can you explain why, what the discussion was, what

the issues were back and forth about that, please?

DR. SURESH MUKHERJI: Yeah. It's a great question. This was a pretty complicated topic. And, in fact, I think this was probably the last one we got to reach consensus on before we closed out the commission. So, and I'd have to go back and review the notes, but there was one specific hospital that was on the west side of the state -- and if anybody wants to jump in and provide more color, that's great. But it really was raised by one hospital on the west side of the state and the issue was a little bit more complex because it had -- not only was an emergency room issue, but it had to do with a unique joint venture that was on the west side of the state that pertained only to that hospital. So when we did start looking and try to change and look at federal guidelines regarding -- I try to align the state with the federal guidelines. It got a little bit too complex for the workgroup to fully accept. So therefore because it was unique to that part of the state and that system that was specifically had a joint venture underlying this, at the end of the day it was felt to just remove that statute and maybe work internally to see if those things can be resolved.

MR. FALAHEE: Okay. Thanks, Suresh. Thanks for the explanation. That works. Thank you.

DR. MCKENZIE: Any other questions or --

DR. MACALLISTER: This is Commissioner MacAllister. Thank you as well, Suresh, for this very well written report and detail. Curious in regards to the greater detail of the volume requirements and the adjustment of the volume requirements based on the limitations is on the machinery or of the facility operations? Is there -- was that all considered?

DR. SURESH MUKHERJI: Yeah. It's a great question. So, you know, as Chip kind of mentioned, you know, I've been involved with CON on and off for about 15 years or so. And in general the first thing that we always ask from a cost, quality, access standpoint is there a issue with access. And oftentimes you'll hear one group of stakeholders say yes, there is and the other one would say no. But in this case there was uniform need that there was a shortage of access regardless of stakeholder. So I think one of the wonderful collaborative things that we did do -- and I can go back and specifically talk about the members of that workgroup. Sorry about that. That really was composed of -- it was really led by representatives from fixed and mobile, MR providers, hospitals and freestanding locations in the micropolitan area to take into account some of the uniquenesses of the less populated areas of the state. So it really had to do with a really collaborative approach and I really compliment Cheryl and Marlena for working

beautifully to try to hear all voices and integrate this into recommendations that we could all unanimously approve.

And regarding specifically whether it's regarding operations or facilities, it's actually both. You know, what I can say as a person who does a lot of clinical work both inpatient and outpatient, is that what we have seen over time compared to 20 years ago is that there's been more of an emphasis to try to treat various diseases on an outpatient -- on an outpatient basis. And the people that are now getting admitted are much sicker. So if you do look at the criteria that analyzed the complexity of cases of inpatients, these complexity metrics are much higher now than they were ten years ago. So as a result, the patients in the hospital have multiple co-morbidities. They require more imaging studies. It's not like someone can walk into the magnet and jump on and jump off, off of these required teams. Secondly, it is the magnets are actually getting faster and faster to use. But when we look at a cycle time of a magnet, the magnets can be quicker, but we also have to have the operation standpoint. So we have to also have to have people check in. They're a lot of heterogeneity. There are 3 Tesla magnets, 1.5 Tesla magnets, there are more implants. And in order to maintain patient safety on MR, there are a lot more layers right now the patients have to go to, to ensure that when they do jump on the magnet, we

need to make sure that they're in the safest environment as possible.

And finally, there is just a greater acceptance of imaging. I mean, if you look at the overall volumes of imaging, you know, over the last ten years they just continue to go up and I think that just bodes well for the -- our overall field of imaging and radiology and the overall high value that we provide to patient care.

DR. MACALLISTER: Thank you. And in regards then what I'm hearing you say is that the volume that was calculated was just really to open up the capacity and also to accommodate the variation of complexities of cases potentially that would be seen in there that would take a longer duration in the MRI?

DR. SURESH MUKHERJI: Yeah. I would say that it allows for greater expansion. I know when I was at University of Michigan, I know we would have to call in inpatients to come and get MRs at 3:00 in the morning and that was literally the only time that we had available on the magnets. And, you know, people didn't like that and, you know, appropriately so. It was the only time they were sleeping. But we were running our magnets 24 by 7. And then the outpatients are going from, you know, 7:00 a.m. to 9:00 p.m. So I think in general there's a lot of focus right now on operational efficiency. So I look at all this

as trying to expand our overall total capacity in the state. And if you juxtapose this to places like California or Indiana or other places where there are no CONs that actually regulate the amount of MRs through various tactics, what this done is this eases our ability to expand more MRs. And the reason we expanded more MRs is because there was this consensus that there wasn't enough overall capacity for the citizens of the state.

DR. MACALLISTER: That's helpful. I was going to ask you if you did a comparison on other states and this is more right sizing our volume compared to that as well. Thank you.

DR. MCKENZIE: I'm not seeing any other hands raised. This is Commissioner McKenzie. Suresh, thank you so much for --

MR. WIRTH: You're on mute. Sorry.

DR. MCKENZIE: Oh, sorry. Sorry. I forgot that double mute. This is Commissioner McKenzie.

DR. SURESH MUKHERJI: Amy, I can't hear you. Sorry about that.

DR. MCKENZIE: Yeah. Sorry. I've got a little bit of a delay. Can you hear me now?

DR. SURESH MUKHERJI: Perfectly. Thank you.

DR. MCKENZIE: Okay. Great. So Suresh, I just wanted to thank you. I know when I gave you a call I was a

little overwhelmed by the number of charges as well that we were handing to you. We know that it's been a challenge seating SACs and the workgroup provides some flexibility, but this was a large body of work and a large number of charges to take on within a workgroup. And I agree with Chip on his recommendation, that you were the perfect candidate, but also recognize how busy you are and how many other commitments. And so really greatly appreciate you jumping in and helping us with this and I think you've just done a fabulous job in the way that you've organized this, so thank you.

DR. SURESH MUKHERJI: Thank you very much. And, again, credit really goes to the team and I appreciate the -- appreciate the opportunity and the confidence, but really it was a great team effort. So thank you for your kind words.

DR. MCKENZIE: Okay. So, sorry, I have a bit of a delay as I mute and unmute, so bear with me. So any Commission discussion at this point? Oh, public comment. Sorry. I skipped over that. Do we have any public comment?

MR. WIRTH: We do have one from -- well, do we want to do --

MS. NAGEL: Whatever you want to do, Kenny.

MS. BHATTACHARYA: Can we talk about the language changes?

MR. WIRTH: Yes.

MS. BHATTACHARYA: Chairman McKenzie, since Commissioner Guido-Allen pointed out the language or the problem in the language? So in the packet you have the revised language for the MRI standards. So it is page 39 in your packet, line 159 and 160. So we are proposing that we revise those two lines to say, "a non-physician licensed health care professional acting within the scope of their practice" and take out "and under the supervision of a physician." Because a scope of practice would include whether supervision is needed or not.

MS. GUIDO-ALLEN: Thank you.

DR. MCKENZIE: Thank you, Tulika. So the proposed language that's in front of you then would accommodate that additional change that was brought up earlier by removing the practicing under a physician. Commissioner Ferguson?

DR. FERGUSON: Yeah. Just a question of clarification. I presume that there is a very discrete list someplace -- and I'm not asking that it be included here, but a very discrete list someplace that says exactly what a non-physician licensed health care professional is. That's presumably a discrete list of, you know, a PA, APP, a podiatrist, whatever, whatever, whatever and that there's zero ambiguity on that list.

MS. GUIDO-ALLEN: Guido-Allen. That's in the

Michigan Health, the Public Health Code.

DR. FERGUSON: Yeah. So long as it's -- so long as there's no ambiguity on it, I think that's a perfect solution.

MS. GUIDO-ALLEN: It should be.

DR. MCKENZIE: Thank you. Do we have public comment?

MR. WIRTH: I do have one public comment and I apologize if I mispronounce the last name, but it's from Lili Petricevic.

LILI PETRICEVIC

MS. LILI PETRICEVIC: Very good. Thank you. Good morning. Can you hear me?

MR. WIRTH: Yes.

MS. LILI PETRICEVIC: Wonderful. Good morning. My name is Lili Petricevic, and I'm a chief executive officer from Sheridan Community Hospital. We are located in Montcalm County. I want to -- I appreciate the opportunity today to provide these comments on CON standards for MRI services. It seems like the groups have been working really hard on this and we do tremendously appreciate that hard work.

Sheridan Community Hospital actually supports those changes that are proposed to the standard for MRI services, and especially the recommendation for the existing

provisions in the standards for rural and metropolitan facilities that they can apply to all critical access hospitals regardless of county designation. Seems that that designation had some opportunities, so it is really appreciated that it's been proposed -- changes have been proposed.

Our hospital in Sheridan is a county -- is in a county that has been considered a rural county for a long period of time despite that we're a very much rural and agricultural area. Until -- that was all until the U.S. Department of Transportation updated the county designation which I believe was in 2010, basing it on community patterns and not a change in patient population or the population overall. On the federal level, Sheridan Community Hospital, for example, maintained critical access hospital status and it's providing much needed services in this area which is very underserved. We're not able to meet the current requirements that are set up, so for the initiated MRI services, but we believe with these changes it will allow us to utilize existing provisions for rural facilities and then critical access hospitals that can provide MRI services to patients and then expedite the care when those changes take place. So we're really appreciating this work.

We wanted to take the opportunity to thank MRI workgroup and the Department for supporting access to needed

MRI services for all critical access hospital, and not just ours, because the -- it seems like all bad has expanded to majority of those, and appreciate Department willingness, too, to think of creative solutions to -- and directing the MRI workgroup to believe that this will be really bringing a positive changes for patients in areas such as ours and the state. So that's all I wanted to add and I want to thank you for this opportunity to have a open comment on the standard.

DR. MCKENZIE: Thank you -- thank you very much. Any questions from the Commissioners? Thank you for your comments. Much appreciated. Do we have any other public comments?

MR. WIRTH: That was all I have on that one.

DR. MCKENZIE: Okay. Thank you. And I don't have any other comments from the room. So I will open it up for Commission discussion at this point. And if there's no -- you know, the options before us -- I'll just outline that, too, in case it's helpful and somebody can step in and correct me if I get this incorrect. But what's in front of us is to take action on the proposed draft language for MRI standards with the changes that Tulika just outlined, recognizing that we would make that change around the non-physician health care provider with removal of the "and" under physician. And then once action is taken today, that

will move the language forward for public hearing and also to the JLC, and then that language would come back to the Commission in September for final review and approval. So I will take a motion when anybody -- whenever --

MR. FALAHEE: This is Commissioner Falahee. I'll go ahead and make the motion as Commissioner McKenzie just laid it out. And, again, thank you to Suresh and the entire members of that workgroup, some of whom are in the room. So thanks for you all the work you did, but I would be happy to make that motion.

DR. FERGUSON: This is Ferguson. I'll second that.

DR. MCKENZIE: Great. Great. Thank you. So I will take a roll call vote at this point. I'll turn it over to Kenny to walk through the roll call vote.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Vote yes, support.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes; yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Lalonde?

MS. LALONDE: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

DR. MCKENZIE: Thank you very much.

(Whereupon motion passed at 10:30 a.m.)

DR. MCKENZIE: So on to our next order of business. And, again, thank you to everyone who participated in that workgroup. Just a great body of work that moved forward. So our next agenda item is on the MRT workgroup, final report and draft language. And we have Dr. Siddiqui who is going to be presenting that information. Dr. Siddiqui?

M. SALIM SIDDIQUI, M.D., Ph.D.

DR. M. SALIM SIDDIQUI: Yeah. Good morning, Chairperson McKenzie, Vice Chair Mr. Falahee, members of the Commission. First, before I proceed, can you hear me clearly and see me appropriately?

UNIDENTIFIED SPEAKER: (Nodding head in affirmative)

DR. M. SALIM SIDDIQUI: Very good. I appreciate that. I hope to be brief. I certainly -- I did not prepare

an extensive presentation as Dr. Mukherji did, but certainly I was tasked with a much lighter burden than Dr. Mukherji was. We -- I had the good fortune of being tasked to be the chairperson to address the approved charges by the Certificate of Need Commission regarding MRT services and specifically you should have the charges before you in the report. Charge number one, review the requirements for replacing existing MRT service to a new location. The second charge which I'll briefly discuss more in detail how it arose, review addition of CT guided realtime tracking to Section 10.4, to provide safe 3.0 additive factor, to visit weight as MR-guided realtime tracking. And then the third charge, to consider any other technical changes from the Department. For example, updates or modifications consistent with other CON review standards and the Michigan public health code.

To provide a brief background as to how charge one arose, there is an MRT service in Michigan that had planned to replace their MRT service to a new site approximately five miles from the original site. This service provides life-saving cancer treatments in the small community and it consists of one non-special MRT unit which was operating at about 5600 equivalent treatment visits, ETVs. And it's important to note that the maintenance volume is 4,000 ETVs, so they're well above the volume required for maintenance.

And despite the COVID pandemic, they continued to take care of the citizens of our state providing access to cancer care in their communities while in parallel working to open a new facility. And once that facility was open, when they went to relocate the MRT service, that's when the issue arose that was brought to CON Commission and then gave rise to the first charge.

And for that, the workgroup met in two meetings, the final meeting being last Thursday, June 9th. And the consensus was very quickly achieved that the standards be modified to allow all existing, non-special MRT services located in a rural or micropolitan statistical area county to replace to a new site if they meet or exceed the 5500 ETVs in the previous 12 months. Now, that -- it was -- it was really a credit to the members of the workgroup that we were able to quickly address this urgent matter, and a credit to the CON Commission to pull together the workgroup to address this urgent issue for our citizens and for that service that was offering that vital care. We think about the charge of quality, access, and cost that the CON looks at as we look at healthcare throughout the state and it was wonderful to see us quickly meet to address this and to come up with a solution where we are able to achieve consensus.

At the end of that first meeting, I opened to the group to ask if there were any other concerns or questions

and during that dialogue, a concern was raised that the current standards afford a greater visit additive factor or visit weight for MR-guided realtime tracking with adaptive technology. And there -- there was felt that the standards were not fair from the, in this regard from the perspective of CT-guided realtime tracking with adaptive technology that exists now. That, I guess, arose between 2019 when we first met to discuss the standards, the most recent standards and this current informal workgroup.

To the credit of the Department, recognizing the concern that was raised -- and I'd like to thank both Chairperson McKenzie and Vice Chair Falahee to quickly allow the additional charge to be added to address this concern and it was that additional charge that then necessitated the second meeting last Thursday. During that there was considerable discussion as to what are the -- what are the issues that really do increase the time that a patient is on the MRT unit from the perspective of the CT-guided or MR-guided realtime tracking. And there was a consensus that it's the capturing of the image and the contouring and replanning to modify the treatment while the patient is lying on the machine that takes the additive time. And so the workgroup then looked at the standards and to minimize any discordance between CT-guided realtime tracking and MR-guided realtime tracking, felt that CT-guided realtime

tracking radiation without adaptive -- so no modification of imaging, just -- no modification of volumes, just the imaging time, receive a 1.0 additive factor while CT-guided realtime tracking radiation with adaptive receive a 3.0 additive factor to keep it congruent with the additional time that you see when you do MR-guided realtime tracking with adaptive. And so those were how those two charges were addressed. The third charge we delegated authority to the Department to recommend any technical changes that they deem appropriate while preparing the above recommended charges.

That is the end of my brief report. I again want to thank Chairperson McKenzie, Vice Chair Falahee, the members of the Commission for addressing and bringing this charge forward to us. I'd like to thank the members of the workgroup who took time out of their schedules to help us address these issues and to put the work forward to arrive at this consensus. I'd also like to thank Kenny for all of his assistance and other members of the Department for their steadfast commitment to the care of the citizens of our state. Thank you.

DR. MCKENZIE: Thank you, Dr. Siddiqui. And while, you know, I know you were able to accomplish the body of work over the two meetings, very critical and important work that you guys took up and your workgroup took up and your leadership through that is very much appreciated. So

I'll open it up to any of the Commission members who may have some questions regarding the recommendations.

MR. FALAHEE: This is Commissioner Falahee. First, Dr. Siddiqui, thank you for chairing the workgroup in record time, I think. So well done. Well done. So you didn't need to cut off all the charges unlike somebody else that just spoke to us. But, no, thank you very much. One of the questions I've got is sometimes we ask was there any dissension, disagreement within the workgroup when you were discussing these items or was it pretty much a general consensus of the workgroup that, yes, what you've presented to us here is the right way to go?

DR. M. SALIM SIDDIQUI: Thank you, Vice Chair Falahee. That's a great question. The work was done in such a quick manner because there was uniform consensus. I think we recognized the need to address charge one immediately so as not to delay access to care in that region. As for the second charge, there was actually a more thoughtful discussion regarding the nuance difference between adaptive versus non-adaptive care on MRT units which from my perspective as a clinician was wonderful because it helped us try to address this very technical issue. So there was more conversation and there was more discussion about the adaptive portion. I think there was quick consensus that requires more time and a 3.0 additive factor.

For the non-adaptive, that was where there was a little bit more question about 1.0 versus 3.0. And the conversation was very thoughtful and I think the insight that the time needed for the actual adaption is what we are trying to reflect in the ETV additive factor was a real insightful comment that came up in that deliberation. At the end, we did have consensus amongst the group and then that's how the recommendation was then made.

MR. FALAHEE: Great. Thank you very much. I have no further questions.

DR. MCKENZIE: Seeing no other questions, thank you, Dr. Siddiqui. Appreciate it. We'll ask you to stay on the line for a couple minutes as we move into public comment and I'll open it up for public comment if there's any.

MR. WIRTH: Yes. First up we have Anita Stolaruk from ProMedica Health Systems.

ANITA STOLARUK

MS. ANITA STOLARUK: Good morning. Thank you for this opportunity to provide comments regarding the MRT workgroup recommendations.

In January we came to the Commission asking to have the workgroup review the volume requirements for relocating an MRT unit located in the rural or metropolitan county. I'd like to thank you for your support of that request. I'd also like to thank the Department for their

support and for getting the meeting and workgroup formed very quickly. I'd like to thank Dr. Siddiqui, the chair, and all of the members of the workgroup for their swift work and unanimous support. Because of these combined efforts, I'm thrilled to be back here today supporting the workgroup recommendations which will allow us to relocate our existing MRT service in Adrian, 4.8 miles away from our old campus to our new campus. And I'm happy to answer any questions that you may have about the recommendations. Thank you.

DR. MCKENZIE: Thank you for your comments. Any questions at all? Thank you very much for your comments. They're much appreciated and thank you for the work serving the citizens of Michigan as well. Any other public comments?

MR. WIRTH: Yes. We have Sean Gehle from Trinity Health and he is in the room, so give us one moment.

SEAN GEHLE

MR. SEAN GEHLE: Good morning, Madam Chairperson, and members of the Commission. I'm Sean Gehle. I serve as the advocacy leader for Trinity Health Michigan. Appreciate the opportunity to provide some comments.

I want to first thank Dr. Siddiqui and members of the workgroup for their work that they did on these issues. Trinity Health fully supports the recommendation of the workgroup related to the relocation provision for

micropolitan and rural areas. We believe that maintaining access to this essential service is vital in these less populated areas. We believe the proposed language effectively addresses the Commission's charge to the workgroup.

We do, however, want to express some concern with the proposed changes on charge two to the weights for specific types of MRT treatments and modalities. As you've heard, this issue was not part of the original charge to the workgroup and as a result came up fairly quickly in one meeting. Historically, changes in procedure values have occurred after the Commission has looked at this charge, the SAC or workgroup to evaluate needed changes, and then normally it takes several meetings and a number of studies and surveys and input from providers prior to making a recommendation. In this case, it was expedited and we understand how that originated, but we have some concern about understanding the implications of some of these changes.

Therefore, we would ask the Commission to support the relocation language, but defer approval of the language related to the CT-guided weights until a workgroup can more fully tackle this topic or until 2023 when MRT is scheduled for its normal three-year review. This deferral would allow the CON Commission to hear from more providers about new

treatment practices and technologies that are impacting the way MRT is delivered. We also believe this deferral would allow the Department and providers to create clearer definitions to ensure uniform understanding of the language for data reporting purposes. We don't believe that this deferral would cause harm as we question and would be happy to be corrected that this technology isn't prevalent in the state currently and just appreciate your time and consideration. But, again, want to thank the workgroup for the work it did and Dr. Siddiqui's leadership. Happy to answer any questions.

DR. MCKENZIE: Thank you very much.

MR. SEAN GEHLE: Thank you.

DR. MCKENZIE: Questions from the Commissioners?

MR. FALAHEE: This is Commissioner Falahee. Thanks, Sean, for your comments. Understand -- okay. Had to wait. Sorry. Thanks again for the comments. I understand where you're coming from. From at least the vice chair's position when this first came up and Dr. Siddiqui raised it, we said this is an important issue, let's see if we can get resolution on it and that's partly why I asked in my questions of Dr. Siddiqui, tell us, was there dissension, was there unanimous? And I'll turn it off to Dr. Siddiqui here in a second, but that's the process we went through. And to me if we're already going to look at it in '23, I'd

just as soon wait until 2023. We had a very good workgroup. Weight, I'd like to put it in place now as recommended, see what the public comments are coming back. But I'd like to turn it to Dr. Siddiqui. Mr. Gehle raised some very good questions and comments and the question of harm and the question of is this a big issue or not. And I'm a layperson. I don't know. So Dr. Siddiqui, I'll turn it over to you maybe to help all of us out, please.

M. SALIM SIDDIQUI, M.D., Ph.D.

DR. M. SALIM SIDDIQUI: Absolutely. Thank you, Vice Chair Falahee, and thank you, Mr. Gehle, for bringing up this concern. You know, I think the way I would look at it is the issue did arise at the meeting and -- at the informal workgroup meeting and there was uniform interest in having this addressed now and so that's why we went back to the chair and vice chair to see if this could be added. I want to make sure that the people that contributed to the workgroup that their sentiment and concern was valuable, enough that we did address their concern they raised. So I don't want to give the impression that this was not important enough to have to be addressed by the work group because it was raised by the workgroup. And these are all subject matter experts and providers, administrators, leaders who work in the MRT work space. That being said, once the charge was approved and we did meet to address it,

I wonder if given Mr. Gehle's concerns, if it may be a better solution to address those concerns between now and the public comments period because I would hate to give members of the workgroup the impression that their efforts in addressing this concern were felt to not be important enough to address now and rather to wait 'til the standards are revisited in 2023. So I think it would probably from my perspective as a chair representing the voice of the informal workgroup, be appropriate to approve this report and between now and the public hearings for Mr. Gehle and myself to discuss and see if we can find out what concerns there are and how we could best address those. While there may not be harm to the average citizen of the state, we could debate about what that harm is, I definitely do believe that those who contributed their time, their efforts to the mission of the CON and brought this concern, for us to just say that it gets deferred and that their time was not valuable I don't think is the message we want to send to those participants.

DR. MCKENZIE: Thank you for the response. Questions?

DR. FERGUSON: A process question. So the charge changed. I don't know the order of when we kind of list charges versus seek the workgroups and/or are the workgroups open to non-members being present and knowing what's going

on? If the composition of the workgroup might have been different with inclusion of the charge up front, meaning different volunteers or different seating, that I think is relevant. And so I just don't understand the order in which things go. Similarly, if the workgroups are open or not open and if they're open but people didn't know the topic was coming up to be present, I think there's some challenges here. I would love to find a way to move forward number one, which sounds non-controversial. I have some significant reservations over charge two trying to make sure that we get a broad-based input.

DR. MCKENZIE: Okay. Commissioner Falahee?

MR. FALAHEE: Let me answer some of your questions. I'll try. So first of all, on workgroups, as Dr. Siddiqui knows, they're unlike SACs, Standard Advisory Committees. You never know who's going to show up from meeting to meeting. So you could get a totally different group of people showing up. There's no set membership list. So you hope that those that are experts show up for the first one, the second or third one, however many there are unlike a SAC, when the SAC says you've got these 14 people and that's it. And then in terms of the charges, almost always the Commission will delegate to the chair and the vice chair the development of the charges, whether it's a SAC or a workgroup and that's what happened here. And then

when this other issue came up that Dr. Siddiqui and the workgroup brought to our attention, Chair McKenzie and I talked about it, we worked with the Department and we said this has come up right away, we've got the experts in the room already as Dr. Siddiqui said, therefore -- and I'm a process person as well, so I understood it. I said, all right, let's them -- let them discuss the issue as this workgroup and see what they decide and that's where we end up today.

DR. FERGUSON: I guess my concern would be in that it's an open forum -- which is good. Like, that's fine. I'm not objecting to the notion that the workgroup is open. If it's open but potential stakeholders are unaware that a topic is coming or going or being -- to me that's a challenge. Right? So I guess I'm -- that concerns me perhaps even more from a process perspective that we need to regroup on charge two in my opinion. Charge one -- I'd like to figure out a way to get charge one approved quickly.

MS. TURNER-BAILEY: Yeah, I would like -- this is Commissioner Turner-Bailey. I would also like to express my concerns around sort of the adding of a charge as we -- as we go along. I think of course we allow the chair and the chair and the vice chair to put together the charges, but it's always with input from the Commission. So we say, yes, we'll seat a workgroup, this workgroup will address this

issue, Madam Chair and Mr. Vice Chair, can you please, you know, finalize that charge? But I think coming up with the second charge, again, with the -- you know, with the concerns that have already been expressed around how many people actually know that this is coming up, that this is new, we haven't had a chance to -- "we" meaning the Commission -- haven't had a chance to address it. I, too, would like to maybe look at charge one moving forward and just thinking more about revisiting the charge two. And I -- and I think, you know, I for one know how difficult it is to pull experts and others together to participate in these -- in these workgroups. I know how hard it is to seat SACs. I'm glad we have the option of seating workgroups. But I don't think we should make it a slippery slope either. So, you know, we have a workgroup and we had a charge, so let's add a charge while we're here. I'm concerned about that as a process.

DR. MCKENZIE: Thank you. I know we're stepping into a little bit of discussion. I just want to pause for a moment to see if there's any other public comment that we have?

MR. WIRTH: Unh-unh (negative).

DR. MCKENZIE: Okay. And any other questions? And then we'll get back to the discussion.

MR. SEAN GEHLE: Thank you.

DR. MCKENZIE: Thank you. Didn't want to cut off the discussion. I just want to make sure we had all of the comments taken care of, so thank you. Any other Commissioners with input? I have some thoughts as well.

MS. GUIDO-ALLEN: Sorry. My computer died, battery died.

DR. MCKENZIE: Oh, okay.

MS. GUIDO-ALLEN: So could I still talk?

MR. WIRTH: If Ms. Lalonde would unmute? Yeah. Then you guys could share that one. Thank you.

MS. GUIDO-ALLEN: Thank you.

MS. LALONDE: Yup.

MS. GUIDO-ALLEN: My question is, is when a workgroup works, do they not post anything on a listserv or a site that adds -- that discusses what charges are --

MR. WIRTH: Yeah, I can answer that one. This is Kenny with the Department. So when the list of charges was updated, we did send out an updated charge list. We sent a listserv notification to I believe there's 9,500-something people on that list. So that e-mail was sent out with a link to our workgroup's page noting that the charge had been updated.

MS. GUIDO-ALLEN: And then is Dr. Siddiqui able to weigh in on the composition of the workgroup for us as far as the experts and from, you know, maybe what areas so that

we can see, was it a broad group? And I believe he said two meetings?

DR. MCKENZIE: Yeah. Dr. Siddiqui -- oh, go ahead.

DR. M. SALIM SIDDIQUI: Yes. Please, thank you. Thank you for the question. The group was representative of the organizations, health systems, and practices across the state and that was in the first meeting. And what I found is by the second meeting we had a broader group. I suspect with leaders, chair people, directors of radiation therapy services at the various institutions that joined in on the second workgroup I suspect because of the second charge.

MS. GUIDO-ALLEN: One more -- one --

DR. M. SALIM SIDDIQUI: So we had representatives that were practicing clinicians, leaders of the radiation therapy departments, administrators from the various radiation therapy departments. It was a broad group.

MS. GUIDO-ALLEN: So one more follow-up question to that. And I know we're not supposed to guess or project, you know, what we think but my thought is, is that if we were to pull another workgroup together or another, even a SAC, likely we are going to come up with the same recommendation. Dr. Siddiqui, what is your thought? I mean, you were there for all the discussion with all of, really, the subject matter experts both from a clinical side

and obviously an administrative side by the second meeting. What are your thoughts on that?

DR. M. SALIM SIDDIQUI: I would absolutely agree with that thought. I suspect we will end at the same place with the same recommendation and so I absolutely agree.

MS. GUIDO-ALLEN: Thank you.

DR. MCKENZIE: Thank you.

DR. M. SALIM SIDDIQUI: You know what? Not to -- not to -- go ahead. Sorry.

DR. MCKENZIE: No, please go ahead.

DR. M. SALIM SIDDIQUI: I was going to say that we -- we got lucky. What I mean by that is this work is hard. Pulling together people to participate and to help shape these important standards it's important work, it's difficult work, it requires time. It was fortuitous that the concern was raised and that we were able to quickly address it. I want to make sure that the participants and providers, organizations in the state recognize that their CON is nimble at addressing their concerns and so that's why I think it is important that we not give them the impression that we lack that nature to address concerns that are raised when it's an agreed upon concern by subject matter experts representing programs across the state.

DR. MCKENZIE: Thank you. Beth?

MS. NAGEL: If I could? This is Beth. The

Department -- I'm not -- from the Department's perspective, I'm not commenting on whether or not both of these charges should move forward or not, but just as in a general issue, certainly echoing some of the comments that have been heard. We do want to make sure that when the Commission sets a charge, that it is the Commission setting a charge. And we have seen, you know, kind of a move towards people adding things at the last minute. We are very concerned about that. In this case, you know, it may have worked out just fine and it may have worked out just fine in the past as well. However, we don't really want to take that chance again. And so something that the Department will be looking for from the Commission in the future as we set workgroups or even SACs is kind of a final and definite this is what the charge is and if any changes come up, it would need to come back to the Commission as a whole.

DR. MCKENZIE: Thank you, Beth. Commissioner Ferguson?

DR. FERGUSON: Can I ask a question with respect to -- I guess it's a little bit technical -- acknowledging that the rules exist for everybody. I don't know how many radiation therapy machines there are in this state. Somebody probably knows an approximate number. This notion of a 3.0 additive for realtime tracking, is that a clinical thing that we do on most of these scanners or is this a

clinical thing that we do on two scanners in the entire state? Like is this a broad-based technology or is this a narrow-based accommodation of one or two centers? I have no idea. I'm just trying to get a ballpark idea of what we're talking about.

DR. MCKENZIE: Dr. Siddiqui, are you able to answer that?

DR. M. SALIM SIDDIQUI: Yeah; absolutely. Commissioner Ferguson, I can't quote to you the exact number of such units across the state. But what I can comment on is how this technology is becoming more common. And the fact that we have CT-guided realtime tracking with adaptive, the ability to have that technology throughout the state, I suspect we're going to see more of that increasing over time while MR-guided tends to be a little bit more novel. The CT-guided technology which is a -- you know, a higher throughput technology offers adaptive and it's the adaptive portion, whether you're using an MR to image it, MRI to image it, or a CT to image it, it's that portion of the time it takes for the clinician to modify the tumor volumes and to adjust the normal organ volumes and then for the team to re-plan while the patient is laying on the machine. The 3.0 additive factor just reflects that work. So you have the patient on the machine, you do an initial image regardless of the modality, and then you quickly look, for example,

let's say like a pancreatic tumor and the small intestine and the bowel have moved and you want to adjust the plan to minimize the risk of harm toxicity to their normal structures. You need that time right there on the machine to make that change. The additive factor of 3.0, you know, is a reflection of 15 minutes times three, so an additional 45 minutes to do that work and then that's -- that's where that arose from. I -- I could see the concern why it was raised. There are -- you know, we at Henry Ford do have MR-guided technology. We're very fortunate that way and we participated in the SAC in 2019 and advocated for the need to add MR-guided realtime tracking with adaptive to the standards. We are fortunate that the SAC recognized the value and the concern in terms of utilization and access and so that weight was added. And by the same token, MR-guided technology costs more. The price point for CT-guided realtime tracking with adaptive is a little lower, and I suspect we're going to see more and more units as they're replaced offering that. And so when the concern was raised -- because there are programs in the state and I can't tell you how many that have CT-guided realtime tracking with adaptive, the concern that it wasn't fair the extra time and work that was being done for their patients not having the additive weight while a few select programs had the additional weight for MR-guided technology. Does

that address your question, Commissioner Ferguson?

DR. FERGUSON: Yeah. Thank you.

DR. M. SALIM SIDDIQUI: Thank you.

DR. FERGUSON: I have a separate process question still trying to figure out. Is there a desired kind of best operations or best practice of, I mean, it feels like we have a couple of options for additional feedback here; right? We can kind of send this section back to committee now or for next year, either way, whatever, and there's an opportunity to get more input or it can go out to the public comment and get input there. Does it matter where we get the public -- get the input?

DR. MCKENZIE: So that's what I was going to -- yeah. I was going to --

DR. FERGUSON: I don't know. I don't understand.

DR. MCKENZIE: -- yeah. I was going to outline kind of the options here. Also, before I do that, I'm going to weigh in a little bit. I tend to, you know, sit kind of where Chip has outlined in terms of, you know, being able to be nimble and move I think is something that I think is important. Certainly understand the concerns and I think, you know, Beth has appropriately raised, like, you know, there are some process issues that we'd want to think about and adhere to in the future. That said, we have something that was before us. It sounds like there's, you know,

technology that's being treated differently between CT and MR. This was posted online, the workgroup is open and we're also looking at proposed language, not final language. So we still have a period of public hearings to go and we will get some additional feedback. This will not -- this will come back to us in September where there's opportunity for others to weigh in during that time period as well as at the next Commission meeting. So that's just to tip my hand a little bit in terms of kind of where I'm leaning. But there are two -- you know, to me, two options. You know, we can -- I -- you know, move forward. I've heard nothing on kind of charge one, and so, you know, I know that there's, you know, this urgency around that piece and it seems like there's alignment around that. So we can either move forward the proposed language on charge one which addressed the issue that we've heard related to ProMedica and the relocation of the services only, or we can move forward all of the language, recognizing that this will go out for public hearing, this will go to the JLC, and then come back to this committee for final action and we will be able to hear additional testimony during that time period. So anything to add? Did I miss anything? Okay.

DR. FERGUSON: If it goes out for comment and comes back and all the comments is favorable and everything is great and we bust the whole thing and it passes and

that's wonderful, when it comes back do we at that point have an option to parse it or it's an all or nothing scenario? Right? So could you -- could you -- so right now we have an option to split charge one/charge two. At that next step is there an option? I'm not saying that I support splitting it. I'm just asking is that an option if there remains some controversial whatever?

DR. MCKENZIE: My understanding is, yes, that we still have that option to parse, --

DR. FERGUSON: That's fine then.

DR. MCKENZIE: -- you know, the language at any point. I'm seeing nods of heads, so agreement on that. So we would still have the option to parse the language at the next step.

DR. FERGUSON: Then I'm fine, right. I mean, so it goes, we get more feedback. Either way we can get more feedback, it goes, we get more feedback, it comes back. I'm sorry to kind of beat the thing to death here, but I'm trying to understand the process and make sure that we're -- whatever way we get at it, we get at an opportunity for all stakeholders to speak.

DR. MACALLISTER: Madam Chair? I also want to weigh in regards to the process and the precedent setting that we potentially will be sharing here in regards to the fact that this was an emergency kind of SAC to put -- or

workgroup to put together for the MRT. And I'm wondering, again, because we are up for review in '23, given the suggested language and the precedent potential setting that, you know, if there is an issue with access for this specific component that it -- again, for the Commission that we should be aware of that it is of urgency access that we need to grant and look at that, I would suggest that we could consider an additional charge to be brought forward. But I do feel like it is precedent setting for us to say yes, we're going to allow for this and when do we not allow it? And so I feel like maybe we should go back to the values and the purpose of the Commission to be able to understand and identify still honoring, as Commissioner Falahee mentioned, vice chair, that we want to be nimble, but I think that we need to have the data appropriate to demonstrate that we needed to make those modifications urgently.

DR. MCKENZIE: Thank you. So we have two options before us and, you know, definitely, you know, some feedback and I appreciate all the discussion. Are there any other comments or does anyone want to make a proposal of, you know, our next step in terms of what we act on?

MR. WIRTH: Amy?

DR. MCKENZIE: Yes.

MR. WIRTH: I did receive a question during this about sort of what the timeline looks like and how -- what

is -- what happens here today, how that progresses through our process. So is it okay if I just kind of walk through that?

DR. MCKENZIE: Yes, please.

MR. WIRTH: Okay.

DR. MCKENZIE: Yeah, please. That would be helpful.

MR. WIRTH: So if you take proposed action today, it would go out to the Joint Legislative Committee and also to a public hearing. It has to be with the JLC no less than 30 days before final action is taken. So if you send it out today, gets sent to the JLC, they'd have their 30 days, we'd have our public hearing, it would come back at the September meeting for final action, you'd have a chance to review the public comments, there'd also be a public comment item during that meeting so anyone attending the meeting could comment on that. If you take final action at that meeting, it would then go back out to the Joint Legislative Committee and the Governor's office for a 45-day review period. During those 45 days, there have to be nine legislative session days. So if you're taking final action at the September meeting, should be able to get those nine legislative session days. If it's bumped to December, with the holidays, it might be harder to get those nine legislative session days within that 45-day window, so we

would have to defer to the nine days when -- however many days it takes to get those nine session days. So, and then on that 46th day is when these standards become effective unless otherwise set by the Commission.

DR. MCKENZIE: Thank you. Commissioner Falahee?

MR. FALAHEE: Let me propose two motions, we'll go one by one. Hearing what others are saying, the first motion would be that we send out to public comment and to the JLC charge one, stop there, just charge one. You probably know what my second motion is now going to be. But for charge one, that would just -- first motion, send out charge one and I would make that motion.

DR. FERGUSON: I'll second that.

DR. MCKENZIE: So I will take a vote on sending out charge one.

MR. WIRTH: Yes. One second. Just want to note down who made the motion. Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Can I ask a clarifying question?

DR. MCKENZIE: Absolutely.

DR. ENGELHARDT-KALBFLEISCH: Sorry. If we send out just charge one, are we able to bring charge two back in September then?

DR. MCKENZIE: I think we're maybe taking up charge two in just a moment. I think we -- what

Commissioner Falahee is proposing is --

DR. ENGELHARDT-KALBFLEISCH: Got it. Okay.

DR. MCKENZIE: -- that we're going to split this and then vote on each independently.

DR. ENGELHARDT-KALBFLEISCH: I understand. Okay. Then, yes, I support. Thank you.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Lalonde?

MS. LALONDE: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

DR. MCKENZIE: Thank you all. And thank you, Commissioner Falahee, for the proposal.

(Whereupon motion passed at 11:12 a.m.)

DR. MCKENZIE: Any other further discussion or

proposals on charge two?

MR. FALAHEE: So this is -- this is Commissioner Falahee again. Sorry. I have different voices in my ear, so I -- I always hear voices, but now I hear more. My second motion would be that we as to charge two, that we also take that to public comment and to the JLC and I'll stop there at this point.

DR. MCKENZIE: Any discussion or would anyone like to second that?

MS. LALONDE: Lalonde, second.

DR. MCKENZIE: Thank you. I have a second. So we will take that -- a vote on that and I'll let Kenny walk through roll call.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: No.

MR. WIRTH: Lalonde?

MS. LALONDE: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: No.

MR. WIRTH: Motion carries.

DR. MCKENZIE: Thank you.

(Whereupon motion passed at 11:13 a.m.)

DR. MCKENZIE: And so both charges will move forward. We will have public hearing, they will go to the JLC, and we will be talking about this again in September. So Commissioner Falahee?

MR. FALAHEE: Let me just add as Mr. Gehle mentioned during public comment and Dr. Siddiqui, Mr. Gehle, if you've got specific concerns, please get them to Dr. Siddiqui so we can have those discussed in public comment. And I know you know that, but I'm just saying it so people know that I'm asking you to work, see if we can work that out. Because I heard Dr. Siddiqui say, yes, let's see what the issues are and what we can do if anything to work it out. And then as to the charge issue and the timing of charges and the setting of charges, there were times when as chair I did get a last minute request and I said no. The charges are set. None of this last minute stuff. On this one I felt otherwise but I understand the concerns and I'm glad with what Beth Nagel said, we can work together on that

because we as a Commission, we can't accept, we don't want to accept last minute "oh, look at this, too," kind of thing. And I'm very sensitive to that as well. So, thank you for those comments.

DR. MCKENZIE: Well said and I agree. Thank you. And I apologize. I'm having a big lag when I unmute on this and I'm trying to not conflict with Chip sitting here as well. So our next action item or item on our agenda is the legal activity report. There is a written report in your packet for you. And I'll ask Brien Heckman, assistant attorney general, if he has any comments on that?

MR. HECKMAN: Thank you, Chairman McKenzie. This is Assistant Attorney General Brien Heckman. Just to kind of summarize the Pine Rest litigation involving Pine Rest and Havenwyck Hospital has ceased. The proposal for decision was submitted and the Department issued a final decision on the 6th of June which means the appeal must be filed if Pine Rest takes an appeal by June 27th of this year. Thank you. Any questions? Okay.

DR. MCKENZIE: Thank you very much. Okay. Our next item is open public comment. So I think we have several, so we will turn it over to Kenny to navigate who is up on public comment.

MR. WIRTH: Thank you, Chairperson McKenzie. For anyone who has not yet left a message indicating they'd like

to make public comment, please leave your name and organization in the chat. For anyone in the room, there are blue cards by the front door if you'd like to speak at the podium. We'll go first to Jack Curtis, Oxford Township supervisor.

JACK CURTIS

MR. JACK CURTIS: I am unmuting. Hi, Commission. Thank you for letting me address your committee. First I want to thank Kenny, you know, and Megan Grohn (phonetic). They've educated me on the CON process in the last few months.

Since our tragedy in Oxford, our community working with Addison Township, Brandon Township, Orion Township, we really have a need for a hospital system here in our town. We worked with legislators. You know, it's an election year. A lot of them are busy doing other things and they're not taking up our call. We're working with each of the lobbyists from all of the health care systems who have -- are represented here today, some of them. But our concern still lies within the CON LAA methodology change and I'll reiterate some of these points.

Back in 2018, Oxford showed a need of 117 beds. Several hospital systems came forward and put their name in the ringer for application for those beds to build a hospital system. The Oxford Township invested over 2.5

million in infrastructure improvements in our township so that we could service our surrounding communities with a much needed hospital. Again, I reiterate in 2019, 121 beds were identified. And I heard a couple comments in the group about who gets notified in public. Well, in 2020 of November a Standard Advisory Committee took up the CON methodology for Hospital Beds and made some dramatic changes and switches. And in 2021, Oxford gets zero beds for a hospital. Now, a process that's been going on for many years applying hospitals -- we now have three hospital systems building hospitals at 26 Mile and I-94, several miles past the methodology from us. But now we're under the new methodology which really constricts and eliminates Oxford from having this hospital system come to our town. Hospital systems are willing to invest $200 million in hospitals, but yet the CON methodology has to be reviewed again. I heard Standard Advisory Groups, I have workgroups. I, too, am a process person. I don't come from government. While I'm an elected official, I come from manufacturing. And when we see something wrong, we change the process. We investigate the process. Your process is going to have to be reviewed this year with the number of beds. Again, this pandemic has thrown all the -- this methodology into have to being investigated again.

But I sincerely beg of this committee that we

would do something to look at this methodology to provide a hospital system for Oxford and our surrounding communities. Our fire chief couldn't be on the line today. Tell me if I'm going over, Kenny. Our fire chief couldn't be on the line today. But I want to reiterate, 20 minutes and 20 seconds from Oxford -- not from tone, from pickup to delivery to a hospital, 20 minutes; 20 minutes by ambulance taking three firefighter paramedics out of our community, putting a draw on mutual aid communities to respond to the other needs in our community. Our communities are growing rapidly. Hopefully Chris Barnett, Orion Township, will talk next. But, you know, Oxford is -- we're in our second graduating class of EMTs from our high school. We're preparing students for paramedic/EMT schools. We can't hire them fast enough. Right now we have orders for ambulances that are being destroyed and --

MR. WIRTH: Mr. Curtis, you're coming up on time.

MR. JACK CURTIS: Okay. I'll finish with we are replacing ambulances two years out; two years out because we can't get them and we're mileaging them out and ruining them and we're in dire need of a hospital system as proven by previous CON numbers. Thank you.

MR. WIRTH: Thank you, Mr. Curtis.

DR. MCKENZIE: Thank you, Mr. Curtis, for your comments. Any questions from the Commissioners for Mr.

Curtis?

MR. JACK CURTIS: I know I talk fast. I'll take any question. I've been studying this. Amy, I sent you a note. It was just out of a quick one, but --

DR. MCKENZIE: And I actually have a question directed toward the Department just for my memory because I know we talked a little bit about this last time in process. But my recollection was that the numbers against the Bed Need methodology which is one of our more complex methodologies, frankly, and, you know, I think that Mr. Curtis did a good job kind of walking through, you know, the history here. That we recently had a SAC that looked at this methodology that made some revisions, but that there are numbers that will be bumped up against that methodology this year, but then in addition to that, we're set to look at the Hospital Bed Need again in 2023. Is that correct? The Bed Need methodology?

MR. WIRTH: So the Bed Need methodology is being looked at right now by Dr. Delamater to re-run the bed need for this year. Hospital Beds are up for review next year by the Commission.

DR. MCKENZIE: By the Commission. Okay. Thank you. Thank you for that reminder. Any further questions at all from Commissioners? Thank you, Mr. Curtis, for being here today and continuing to advocate on behalf of your

community.

MR. JACK CURTIS: Thank you.

DR. MCKENZIE: I see Mr. Barnett. Is that who we have up next for public comment?

MR. WIRTH: (Nodding head in affirmative)

DR. MCKENZIE: Okay. Great. Mr. Barnett?

CHRIS BARNETT

MR. CHRIS BARNETT: Good morning, members of this distinguished committee. I am Chris Barnett. I am the Orion Township supervisor. I wear several hats, though. I am also the current chair of the Southeast Michigan Council of Governments. We represent about 4.8 million Michiganders, all of southeast Michigan. Sometimes our Metropolitan Planning Organization, we aggregate most of the data for road and transportation investments, but all kinds of things including I would encourage maybe this Commission to look at some of (inaudible) data as well. I also serve as the, I'm on the elected board of the U.S. Conference and Mayors and serve as the small cities taskforce. The reason I say that is I've built relationships across the country. I'm a serial networker. And Jack in Oxford is our neighbor to the north and great friends. And we've been studying this issue for some time. I've been in my role as the supervisor here for ten years. And we have been looking for some support in our region and if it's okay I'd like share

my screen and just show a map that we prepared and I'm happy to send this to the Commission as well as an attachment afterwards.

(Witness shares document via video)

MR. CHRIS BARNETT: Can you see that? Can you see the map?

MR. WIRTH: Yes, we can.

DR. MCKENZIE: Yes.

MR. CHRIS BARNETT: Okay. Great. Thank you. What you see on the screen is -- as a matter of fact, what I was saying is a previous supervisor in Independence Township was working on -- I think with this Commission as well -- on a potential hospital in Independence Township, our neighbor to the west. Oxford is our neighbor to the north. But what you can see on this map is -- my office helped me prepare this, but the five -- five mile radius circles. We chose Oxford in the center because we do know that they have a hospital group that owns property in the community that has gone through some of the planning processes. It's invested hundreds of thousands of dollars. It's obviously expressed interest in being there. The community has also invested hundreds of thousands of dollars in infrastructure, water and sewer infrastructure to prepare for this. That's why I chose Oxford as the center of the map.

But as you can see, those circles -- and it might

be hard to see on the screen. We included the populations in those circles. And what's of interest here is if you look at the 5 and 10 and 15 mile radius circles, you'll see in that 15-mile radius circle we have three hospitals that show up in that circle. And for comparison purposes -- and I didn't build a map for this -- but just using populations in that 15-mile we have 529,000 residents. And for comparison sake, looking at other major metros across the country, Kansas City has 508,000 residents, Kansas City; Atlanta, about 496,-. So the population in those areas are about the same. In those -- in Kansas City there are 17 hospitals that service those 508,000 people and Atlanta there's 39. Now, I understand we're Michigan and we're different and we have different ways we set things up, but that's a good comparison, at least for me looking at data. Data is important. In our 15-mile radius circle that services that same number of population, we have three hospitals. And I think it's really important -- one of the commissioners mentioned earlier in the meeting and I appreciated the comment, you know, he said -- and I apologize. I didn't catch his name. But he said on one of the items, "We want to make sure patients are getting what they need." I think that's really the ask from us is to really ask this Commission to look and understand as Mr. Curtis just referenced in his comments. You know, we have a

crazy shortage of first responders. We have four vacancies of full-time firefighters now and I know Oxford does as well. All our communities do. And one of the challenges we're facing is because we transport patients, you know, 15, 20, 30 minutes plus go round trip --

MR. WIRTH: Mr. Barnett?

MR. CHRIS BARNETT: -- yes. I'll wrap. I promise.

MR. WIRTH: Thank you.

MR. CHRIS BARNETT: That we are struggling. We send our ambulances to Pontiac and out of the community and we're short on staff. So we're really hopeful that we can continue to provide you data. Obviously the Oxford tragedy is what's really kind of brought this to the forefront again. But I appreciate your time and I'd entertain any questions as well now. Thank you.

DR. MCKENZIE: Thank you very much, Mr. Barnett. And I would ask that this map be forwarded so that we can include it in our materials as I said -- I know you said that you would for the Commission.

MR. CHRIS BARNETT: I will do it. Should I send it to --

DR. MCKENZIE: Any questions for -- yeah, perfect.

MR. CHRIS BARNETT: Sorry.

DR. MCKENZIE: No, it's okay. Any questions from

the Commissioners for Mr. Barnett? Great. Thank you very much for your comments and for being here today and for bringing us this information. We very much appreciate it.

MR. CHRIS BARNETT: Thank you.

MR. WIRTH: We do have one more public comment from Shurkela Mason.

SHURKELA MASON

MS. SHURKELA MASON: Hi. I'm Shurkela. My comment is I would like to -- I'm here today to express an interest in a special pool of beds specifically for perinatal psychiatric patients and low acuity patients when the beds are available. We would like to do this through the creation of a micro hospital and we're asking for ten beds. Please be advised that while nearly 80 percent of all new moms experience a mild form of depression and anxiety commonly referred to as the "baby blues," up to 20 percent of new moms develop a postpartum depression and three to five percent of new moms develop significant anxiety or obsessive symptoms. Sometimes the severity of these symptoms necessitates inpatient treatment for rapid stabilization.

When these moms are admitted to regular psychiatric hospitals, they can't see their babies and this has a negative impact on the bonding experience. They aren't allowed to continue their medications if they're

breastfeeding in most cases, and most of the time they don't understand why they are being hospitalized. When our parents don't receive the appropriate care during the perinatal period, and/or their mental health is just left untreated, perinatal mood and anxiety disorders can interfere with mother and child bonding and cause family problems as well. For mothers, untreated perinatal mood and anxiety disorders can last for months or longer. Sometimes it becomes a chronic disorder, even when the parent has been treated. PMADs increases a woman's risk of future episodes of major depression, anxiety, OCD, PTSD, and bipolar mood disorder. For fathers, perinatal mood and anxiety disorders can have a ripple effect. It can cause an emotional strain for everyone close to the new baby. When a new mother is depressed, the risk of depression in the child's father may also increase. New dads are already at an increased risk of depression whether or not their partner is affected. And for the child, the children of mothers who have untreated PMADs are more likely to have emotional and behavioral problems such as sleeping and eating difficulties, excessive crying and delays in language development. Thank you.

DR. MCKENZIE: Thank you very much, Ms. Mason, for your comments. Do we have any questions from the Commissioners or comments? I'll just make a quick note that, you know, psychiatric bed access is, you know, is

definitely a major issue. We have a workgroup that is finishing up and anticipate some recommendations coming forward. I think you're highlighting a very specific area around maternal health as it intersects in perinatal health as it intersects with psychiatric need and behavioral health need. So we appreciate you, the comments that you've made today and I appreciate you being here to represent that.

MS. SHURKELA MASON: Thank you.

DR. MCKENZIE: Any other public comments? Okay. Hearing none, we will move forward with the next item on our agenda which is the review of the Commission work plan.

MR. WIRTH: Okay. So out of this meeting today we will update this work plan -- actually, I don't -- I don't see any things that we'll need. We'll hit the MRI and MRT going to public hearing and JLC to come back for final action in September. We will amend Psych Beds to move the report and presentation of draft language to the September meeting and that will all be shifted down to following meetings. But other than that, I don't believe there were any more changes to the work plan out of this meeting.

DR. MACALLISTER: Just for clarification, the neonatal report, that was --

DR. MCKENZIE: Can you -- I think you're not mut- -- you're unmuted.

DR. MACALLISTER: Oh, sorry. Commissioner

MacAllister. Just for clarification, it looked like we were supposed to see the neonatal?

MR. WIRTH: At the September meeting or this -- this meeting?

DR. MACALLISTER: This meeting. It said June.

MR. WIRTH: Oh, my apologies. We will bring that at the September meeting.

DR. MACALLISTER: Okay. Thank you.

MR. WIRTH: Apologies on that.

DR. MCKENZIE: Any other questions or comments, discussion? Okay. I will take a motion on the work plan.

MR. FALAHEE: This is Falahee. I'll make that motion to approve.

MS. LALONDE: Lalonde second.

DR. MCKENZIE: All in favor?

ALL: Aye.

DR. MCKENZIE: Any against? Okay. The work plan carries.

(Whereupon motion passed at 11:34 a.m.)

DR. MCKENZIE: I will next cover our future meeting dates. They are laid out for you in the agenda. Next meeting is September 15th. We have a meeting December 8th, then January 26, 2023; and March 16th, 2023. It's hard to even believe we're talking about 2023, but those are our future dates. If you can make sure that you mark those down

on your calendars, that would be wonderful. And then that's the end of our meeting, so I can take a motion for adjournment.

DR. MACALLISTER: I move.

MS. LALONDE: Support.

DR. MCKENZIE: It's been moved and support. Great. All in favor?

ALL: Aye.

DR. MCKENZIE: Any against? Okay. Thank you all for being here today and for the great discussion. We appreciate your time and your commitment.

(Proceedings concluded at 11:35 a.m.)

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