Ascension

October 21, 2022

Chairperson Amy L. McKenzie, MD
Certificate of Need Commission
c/o Michigan Department of Health and Human Services
Certificate of Need Policy Section
South Grand Building, 4th Floor
333 S. Grand Ave
Lansing, Michigan 48933

Via E-Mail: MDHHS-ConWebTeam@michigan.gov

Dear Chairperson McKenzie,

On behalf of Ascension Michigan please accept this correspondence as written testimony regarding Ascension Michigan's recommendations on the following CON standards scheduled for review in 2022: Cardiac Catheterization Services.

Cardiac Catheterization Services

Ascension Michigan supports the continued regulation of Cardiac Catheterization Services. We strongly urge the CON commission to align the Cardiac Catheterization Standards with the most recent Society for Cardiovascular Angiography and Interventions (SCAI) recommendations, *SCAI Expert Consensus on Best Practices in the Cardiac Catheterization Laboratory.* Specifically, collaboration between interventional cardiology and cardiac electrophysiology, as well as catheterization laboratory governance. As you may know the SCAI recommendations are currently under review for updates, and are taking public comment; there will likely be an updated recommendation for consideration this year or early 2023.

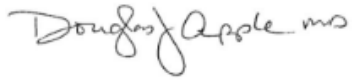
With consideration of our recommendation to the Commission to align with the most recent SCAI recommendations, we urge the Commission to consider that a hospital that has a mature Cardiac Catheterization program, would be allowed to maintain their programs and services, in a non open heart hospital to perform procedures such as high risk PCI and Left sided Atrial fibrillation procedures.

Ascension Michigan would be happy to work with the Department in providing any additional information they need in order to draft an appropriate charge, if the CON Commission deems a Cardiac Catheterization Standard Advisory Committee is appropriate to address the Cardiac Catheterization standards in 2023.

Ascension

Thank you for the opportunity to provide written comments on the CON Review Standards for review in 2023. We look forward to working with the Commission this, and the coming year.

Sincerely,



Douglas J. Apple, MD, MS, FHM
Chief Clinical Officer, Ascension Michigan

Beaumont

October 7, 2022

Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
South Grand Building
333 S. Grand Avenue
Lansing, MI 48933

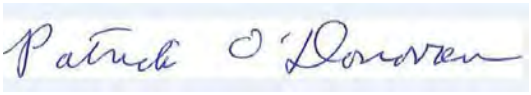
Re: Cardiac Catheterization Services

Dear Certificate of Need Commission:

Thank you for the opportunity to provide comment on the CON Review Standards for Cardiac Catheterization Services, which are up for review in 2023. Beaumont Health supports the continued regulation of these services, and given that significant changes to these standards were made in 2021, no additional changes are recommended at this time.

However, please note that Beaumont Health is recommending potential changes to the Surgical Services Standards which could impact Cardiac Catheterization Services. These recommendations are being sent under separate cover.

Sincerely,



Patrick O'Donovan
Director, Strategy & Business Development
Beaumont Health

Corewell Health™

corewellhealth.org

October 19, 2022

Chairperson Amy L. McKenzie, MD
Certificate of Need Commission
c/o Michigan Department of Health and Human Services
Certificate of Need Policy Section
South Grand Building, 5th Floor
333 S. Grand Ave
Lansing, Michigan 48933

Dear Chairperson McKenzie,

Corewell Health West thanks the CON Commission for the opportunity to provide written testimony on the CON Review Standards for Cardiac Catheterization Services. This letter complements the letter submitted by our legacy Beaumont division.

Corewell Health West supports continued regulation of cardiac catheterization services. However, we believe the Commission should form a Standard Advisory Committee (SAC) to continue the work of the previous SAC from 2021. The previous SAC took great strides to improve access to lower cost cardiac services by allowing catheterization labs in freestanding surgical outpatient facilities (FSOF), while still maintaining quality. However, Corewell Health West believes more work is needed, including modifying the definition of diagnostic cardiac catheterization service to allow permanent pacemaker and ICD implantation procedures to be performed in an operating room located in an FSOF approved to operate a CIED service. Additionally, we believe a SAC should review the definitions to ensure that they align with what CMS has approved for the ASC setting.

We appreciate the Commission's consideration of our comments. Should you have any questions regarding these comments or if you would like any additional information, please contact David Walker, Advisor, Corewell Health Government Affairs, David.Walkerii@spectrumhealth.org.

Sincerely,

Darryl Elmouchi, MD, MBA
President
Corewell Health West

MidMichigan Health
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

4000 Wellness Drive
Midland, Michigan 48670
Phone (989) 839-3000
www.midmichigan.org

October 21, 2022

Dr. Amy McKenzie, MD
Chairperson, Certificate of Need Commission
Michigan Department of Health and Human Services
South Grand Building, 4th Floor
P.O. Box 30195
Lansing, Michigan 48909

Re: Certificate of Need Review Standards for Cardiac Catheterization Services

Chairperson McKenzie,

Thank you for this opportunity to provide public comments regarding the CON Review Standards for Cardiac Catheterization Services. MyMichigan Health supports the continued regulation of cardiac catheterization services under Michigan's CON program. However, we do feel that work needs to be done to improve access to these critically important services in the more rural areas of our state.

Specifically, we request that the Commission form a workgroup or standards advisory committee (SAC) to review opportunities to improve access in hospitals that are located in rural or micropolitan statistical area counties. In particular, we now have standards that make it easier for a freestanding surgical outpatient facility (FSOF) to initiate elective PCI than a hospital, and especially a hospital located in a rural or micropolitan county. An FSOF can initiate both diagnostic and elective PCI simultaneously whereas a hospital must first initiate diagnostic cardiac cath, then primary PCI, and finally elective PCI, with at least a year of operations in between each step.

We appreciate your time in considering our request. We would be happy to discuss this further as well as participate in a SAC or workgroup addressing this issue in the coming year.

Sincerely,

Dana M. Thering, MBA
System Vice President of Business Development
MyMichigan Health

OSF HEALTHCARE

October 21, 2022

Amy McKenzie, M.D.
Chairperson, Certificate of Need Commission
Michigan Department of Health and Human Services
P.O. Box 30195
Lansing, Michigan 48909

Re: Certificate of Need Review Standards for Cardiac Catheterization Services

Chairperson McKenzie,

On behalf of OSF St. Francis Hospital, thank you for this opportunity to provide feedback regarding the CON Review Standards for Cardiac Catheterization Services. As a general supporter of Michigan's Certificate of Need program, we do support the continued regulation of cardiac cath services within the CON program. However, as a health care provider in the Upper Peninsula of Michigan, we do have concerns with some of the provisions within the standards and the resulting lack of geographic access to cardiac cath services in the UP.

There is only one provider of cardiac cath services in the entire Upper Peninsula of Michigan. This means that patients located in Manistique, Michigan, for instance, have to travel more than 90 minutes to Marquette for these life-saving services. Being a provider in the Upper Peninsula, we understand that not every service can be provided locally. However, we do believe there are provisions in the cardiac cath standards that could be modified to help improve access in rural areas. For example, the standards currently make it more difficult for a hospital to initiate elective PCI than an FSOF. FSOF-based access to cardiac cath is not practical in rural areas because there are not sufficient surgical volumes in these areas to even establish an FSOF. Creating provisions for elective PCI in rural areas specifically would go a long way toward improving access.

Many of our CON standards contain specific provisions to improve access in rural areas. For example, the CT and MRI standards allow for the collection of physician commitments used to demonstrate need from existing services located within 75 miles of the proposed service if that proposed service is located in a rural area (as opposed to 20 miles if located in an urban area). The PET standards include similar but slightly different provisions. The MRT standards reduce the projected volume required to initiate a new service if that proposed service is located in a rural area. The PET standards include a lower volume requirement for expanding an existing PET service or convert an existing mobile host site to a fixed service located in a rural area.

We are requesting that a Standards Advisory Committee (SAC) be formed in the coming year to consider provisions that could improve access to cardiac cath services in rural areas, including initiation requirements for elective PCI. We would appreciate the opportunity to participate and be a part of the solution. Thank you for your consideration of our request. Please don't hesitate to reach out with any questions or feedback.

Sincerely,

Kelly A. Jefferson
President

Trinity Health

Trinity Health Michigan

October 18, 2022

Amy L. McKenzie, MD
Chair, CON Commission
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Public Comment for Cardiac Catheterization Certificate of Need Standards

Dear Chairman McKenzie:

Trinity Health Michigan would like to thank the Certificate of Need Commission for the opportunity to comment on the Certificate of Need Review Standards for Cardiac Catheterization Services. While Trinity Health Michigan supports continued CON regulation of Cardiac Catheterization Services, Trinity Health would encourage the CON Commission to consider changes to the CON standards that would allow elective PCI hospital programs to perform left-sided cardiac ablations.

In 2014, the Heart Rhythm Society's (HRS) Expert Consensus Statement on Electrophysiology Laboratory Standards identified a range of facilities that have the resources and supports needed to perform these procedures. Several of our Trinity Health hospitals located in other states, perform left-sided heart ablation without open heart surgery back up. In addition, in those facilities and our facilities in Michigan who perform left-sided heart ablations (e.g. Trinity Health Ann Arbor and Trinity Health Oakland) we have not experienced a need for emergent open heart surgery in the 100's of cases we perform annually. By restricting these procedures to hospitals with open heart surgery in Michigan, many patients must undergo a second catheterization session at a different facility for the ablation. We believe this restriction unnecessarily increases costs to patients, their employers, and insurers, and certainly diminishes the patient experience. Although the 2020 Cardiac Cath SAC did briefly review this issue, the 2020 SAC was exclusively comprised of cardiac interventionalists who were uncomfortable with voting on a change related to an electrophysiology procedure outside their scope of expertise. Trinity Health believes this issue merits a full review by appropriate, qualified experts.

Trinity Health encourages the CON Commission to establish a Standards Advisory Committee comprised of clinical experts to review the current CON Review Standards and to recommend changes that align with contemporary clinical society guidelines. As always, Trinity Health would be happy to support a SAC by nominating an electrophysiology expert should the Commission determine a SAC is merited.

We appreciate the CON Commission's consideration of our comments.

Sincerely,

Rob Casalou

Rob Casalou
President and CEO
Trinity Health Michigan & SE Regions

UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

T. Anthony Denton, JD, MHSA
Senior Vice-President & Chief Operating Officer

300 N. Ingalls St, SPC 5474
Ann Arbor MI 48109-5474

T: (734) 764-1505

tadpole@med.umich.edu

October 21, 2022

Amy L. McKenzie, MD - CoN Commission Chairperson
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Cardiac Catheterization - Certificate of Need Standards Review

Dear Commissioner McKenzie:

This letter is written as formal testimony pertaining to the Certificate of Need Review Standards for Cardiac Catheterization Services. University of Michigan Health supports the continued regulation of this covered service and does not believe any specific revisions to these standards are currently necessary.

Thank you for allowing University of Michigan Health to provide these comments for consideration.

Respectfully submitted,

T. Anthony Denton, JD, MHSA
Senior Vice-President and
Chief Operating Officer
University of Michigan Health
Michigan Medicine

Addison Township

1440 Rochester Road
Leonard, Michigan 48367

www.addisontwp.org
Tel. (248) 628-3317
Fax (248) 628-2207

October 17, 2022

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

Dear Commission Members:

I am writing to support the Charter Township of Oxford's request to have the current CON methodology re-examined.

According to the 2020 U.S. Census, Oxford Township and the neighboring communities of Orion, Brandon, Addison and Metamora townships are home to more than 87,000 residents. As citizens and businesses continue to flock to Oakland County's northern communities, populations in these municipalities are growing at a rapid pace. As such, we need to ensure that these communities can provide residents and workers with access to life-saving medical care. Currently, the five closest hospitals are 16 to 22.4 miles away.

When it comes to healthcare access in communities, I firmly believe decisions should be made at the local level, not the state level. Local governments, working in close partnership with healthcare systems, are the best ones to determine what their residents and communities need when it comes to something as important as hospital beds. Local officials who live and work in underserved areas are better equipped to identify any existing flaws in the current CON methodology because they are closer to the situation than officials in Lansing.

Local officials know that M-24 is the most direct route to four of the five closest hospitals and that at certain times of day, gridlocked traffic is the norm. They know that each medical call can take a fire department's ambulance and crew out of the community for up to two hours. While numbers don't lie, the numbers being used by the state, in this case, don't paint an accurate picture of the complex, multi-faceted situation in Oxford. Decision-making regarding healthcare access should be based on grassroots partnerships, not a top-down approach.

Based on the evidence provided by Oxford Township Supervisor Jack Curtis' Oct. 7, 2022 public comment letter to the CON Commission, there are clearly some flaws in the existing CON review standards. I ask that the commission please consider re-evaluating the current methodology that's used to determine where hospital beds are needed. The residents of Oxford Township and its surrounding communities deserve to have equal access to life-saving medical care.

Respectfully,

Bruce Pearson
Addison Township Supervisor
BPearson@addisontwp.org

Addison Township Fire Department

4026 Forest Street - Leonard, Michigan 48367 - (248) 628-5600 - Fire Chief, Jerry Morawski

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

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Committed to Public Safety

Chief Jerry Morawski

From: Bobby Langley
To: MDHHS-ConWebTeam
Subject: Hostipal
Date: Wednesday, October 12, 2022 4:39:27 PM

We need a hospital in Oxford there are not any in the 30 to 40 min to get to

Sent from my iPad

INSERT LETTERHEAD

Charter Township of Brandon
395 Mill St. PO Box 929
Ortonville, Mi. 48462
www.brandontownship.us
(248) 627-4918

Jayson Rumball, Supervisor
Roselyn Blair, Clerk
Scott Broughton, Treasurer
Dana DePalma, Trustee
Robert Marshall, Trustee
Kathy Thurman, Trustee
Steve Unruh, Trustee

October 19, 2022

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

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Respectfully,

Jayson W. Rumball, Supervisor

Brandon Township

BRANDON FIRE DEPARTMENT
53 SOUTH STREET ORTONVILLE, MI 48462
Ph. 248-627-4000 Fax 248-627-3181

David Kwapis
Fire Chief

October 19, 2022

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

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Respectfully,

David M. Kwapis, Fire Chief

From: Catherine c
To: MDHHS-ConWebTeam
Subject: CON process
Date: Wednesday, October 19, 2022 3:32:48 PM

Hello -

I am writing to express my concern that the CON process for hospitals and emergency services is not locally controlled.

I live in Oxford Michigan and last year the MDHHS denied Oxford a CON stating that the area did not meet the criteria. This is of course after the MDHHS said that Oxford was an underserved area for emergency services. Based on this alone the process is clearly broken. However, on November 30, 2021 there was a high school shooting in Oxford. It took one of the victims more than 30 minutes to be transported to an acceptable emergency department. How can this be acceptable? I would like someone from the MDHHS to tell a shooting victim, or the parents of a shooting victim, that they need to wait more than 30 minutes for acceptable emergency care. If a person is transporting themselves from Oxford without a vehicle with sirens, it takes 45 minutes to get to emergency services. This is unacceptable.

The current MDHHS process for granting a CON does not make sense. The requirements change on a whim. It creates red tape and bureaucracy that serves only to slow the process down and delay the development of crucial medical services for an area. Why not allow for local control of these issues? If a hospital wants to build facilities and the local city, township, or village wants the hospital - why does the MDHHS need to be involved.

Please consider de-regulating this process and allow essential medical services to be provided to the areas that are in need.

Very Truly Yours,

Catherine Colvin

From: Claudia Rowe
To: MDHHS-ConWebTeam
Subject: We need a hospital in Oxford
Date: Thursday, October 13, 2022 4:27:00 PM

Hello,

My family and I live in Oxford. We will feel there is a great need in Oxford for a hospital to come to our city. I think this should definitely be looked into. And it would be a great asset to our community. Thank you. Claudia Rowe

From: Dave Nordstrom
To: Wirth, Kenneth (DHHS)
Subject: Beaumont Hospital in Oxford
Date: Wednesday, October 19, 2022 5:59:14 PM

I believe it would be a good idea to have a Beaumont Hospital in Oxford Township.

I can not understand how a hospital system would want to pay to build a hospital in a locate and the state of Michigan tells them they can not. I would think the hospital would look for a location that has the need.

I went to meeting at the Oxford Township Library to try to learn how it is that the state would not issue a certificate of need for the hospital. How it was explained the state determined if a hospital was needed made no since to me.

I went to a meeting at the Oxford Township Hall about the proposed Beaumont hospital. I heard a lot about how a hospital in Oxford was needed. The need was explained by the Oxford Township Fire Department, the Oxford Township council , other area Township supervisors and many more.

It appears that the Beaumont hospital in Oxford Township would be good for the citizens of Michigan.
.

Thank You
Dave Nordstrom
682 brooks Ln
Oxford MI 48371

From: Freda
To: MDHHS-ConWebTeam
Subject: Hospital in Oxford
Date: Thursday, October 13, 2022 7:46:35 AM

To Whom It May Concern,

As residents of Oxford Township, we are begging you to consider to allow a hospital be built in Oxford. Whenever a family member has to be rushed to the hospital, whether by ambulance or in our car, the closest hospitals are too far. This could be a matter of life and death and we don't feel there is any reason to NOT have a hospital in our area.

Hospitals should be no farther than 10 miles apart in the state of Michigan for the citizens to feel safe and have the best health care possible. As the Health Service of Michigan we know you understand that and just cannot understand why this is having delays on getting approved. Our community is growing more and more every year and the need is great! If our young people had a hospital in our town on November 30, 2021, perhaps the outcome for some of them may have been different. Instead, they were loaded in ambulances and taken to hospitals far away (the closest). If more immediate care was available for them right here in Oxford, perhaps their lives could have been saved. For those who were injured that day, their families had to travel several miles to see them on a daily and weekly basis. There is no reason for that when we have the property available to build and a community with full support and desire for the facility.

We just cannot understand the reasoning for NOT having a hospital here in Oxford. It is a definite need and we beg you to consider allowing it to happen for our great community. Thank you for your consideration.

David and Freda Wright
740 Phillips Dr
Oxford, MI. 48371

From: Heathen Peshe
To: MDHHS-ConWebTeam
Subject: Oxford and area need for hospital
Date: Wednesday, October 19, 2022 10:04:00 AM

Hello people.
I am writing this to show support for the 'certificate of need' for a hospital to be allowed to be built and operate in Oxford Michigan.
I'm sure there's plenty of support for this.
-The population density of the area has doubled in the last decade.
-There is a growing need of medical care of this population
-People want a hospital closer then the half hour drive in good traffic.
-The time emergency services have to spend in travel would be reduced.
-There is at least one hospital company that has bought land with the intention of building a hospital.
-I believe that the tremendous amount of regulatory requirements will be met.

More importantly, I am curious of why this would declined. If a business has done their due diligence in deciding on where and what to build, why not allow them to?

Thanks for reading this,
Heathen Peshe

From: JARRIT D WHITE
To: MDHHS-ConWebTeam
Subject: Oxford community hospital need
Date: Tuesday, October 11, 2022 8:36:28 PM

To whom it may concern;

Oxford township is in desperate need of a fully functional community hospital. Given the population of the community as well as the outer communities like Brandon, lake Orion, and metamora there is not a single hospital in a 40 mile radius. The area is continuing to expand as well with new residence moving in daily and let's not forget about our elders and all of the surrounding nursing and community homes. There is a dire need for not just a large urgent care but a full ER and hospital with large capacity for our residents. Given the recent tragedy in this community I feel lives could have been saved if there was a large hospital in our community and it would be received with open arms as the nearest hospital that fits the needs of Oxford and lake Orion is Ascension a 35-40 min drive to Rochester. I am lobbying for a hospital in Oxford as a concern parent, resident and military veteran. Please consider new construction of a large hospital here in Oxford Michigan.

Sincerely,

Jarrit white
100 Rivercrest ct
Oxford MI 48371

Sent from my iPhone

From: Joyce Nordstrom
To: Wirth, Kenneth (DHHS)
Subject: Oxford CON
Date: Wednesday, October 19, 2022 4:46:11 PM

When we moved to Oxford four years ago, we were very excited when we heard that Beaumont was going to build in Oxford. Not to long after we heard that Beaumont was not going to build because they could get a Certificate of Need from the State of Michigan.

I feel that if a hospital wants to build and put the money forward to build the state should approve the Certificate of Need.

This area is growing so fast that I feel there is a need for a hospital in this area.

I feel that a hospital would not only serve the community with emergency room care but it would also serve the community with a testing facility. We have had to drive to Royal Oak for cardiac testing and had to wait on an appointment because they are so busy.

I feel that if there is a hospital in Oxford it would serve so many of its residents.

Thank you

Joyce Nordstrom
682 Brooks Lane
Oxford, MI 48371

From: Larry Ridenour
To: MDHHS-ConWebTeam
Subject: NEW HOSPITAN IN OXFORD AREA
Date: Saturday, October 8, 2022 7:05:31 PM

MY WIFE AND I ARE SENIORS AND ARE CONCERNED ABOUT THE TIME IT TAKES TO GET TO A HOSPITAL IN TIMES OF EMERGENCY. HAVING A NEW HOSPITAL CLOSER COULD BE LIFE SAVING

From: Lee Feldmann
To: MDHHS-ConWebTeam
Subject: Hospital in Oxford
Date: Wednesday, October 12, 2022 8:12:22 AM

Please approve the new Hospital in Oxford, we need a hospital closer than 30 minutes away in case of emergency. Our Community is growing and Pontiac is too far to go in a life or death situation
Thank You
Lee Feldmann
5651Oakwood rd
Ortonville,Mi 48462

Sent from my iPad

From:	Mary Anne Ray
To:	MDHHS-ConWebTeam
Subject:	Con consideration for hospital in Oxford, Michigan
Date:	Thursday, October 13, 2022 9:57:18 AM

I respectfully request the Con requirements be amended to facilitate the building of an acute care hospital in Oxford, Michigan.

The population continues to grow with new residential development.

The Fire EMS units have had a dramatic increase in runs.

The population is growing older with all the health issues that vine with it.

The closest acute care hospital is 16 miles away. Trying to get there in rush hour traffic is incredibly difficult and adds precious minutes.

A new hospital would add jobs not only to our community, but to all those involved with building a structure and all it entails.

The 4 Oxford High School students that died and the 7 injured had to be flown out for assistance. Tate bled out in the back of a patrol car, trying to get to a hospital. This is unacceptable.

Governor Whitmer promised she would give Oxford whatever it needed in the wake of the shootings. This is what we need.

Thank you for your consideration.

Mary Anne Ray
524 Thornehill Trail
Oxford, MI. 48371

Sent from my iPhone

From: cmculver@charter.net
To: MDHHS-ConWebTeam
Subject: Certificate of Need Requirements for Hospital in Oxford
Date: Sunday, October 16, 2022 8:37:41 PM
Importance: High

Hello, I'm a resident of Oxford and writing to express my concerns over the outdated Certificate of Need requirements to consider whether a hospital can be authorized to be built in our community. And to ask for the CON Commission to please re-examine the criteria and methodology it uses to identify such a vital need so that a hospital can be considered for Oxford and the surrounding communities.

We moved to Oxford in 2000 and the community has grown substantially since then. The large neighborhood developments, coupled with new apartment complexes, condominiums and senior living facilities in Oxford and the surrounding area provide a logical population that needs healthcare. In addition, Lake Orion has also grown; as has Clarkston, north portions of Rochester and Metamora.

The current requirements are out of date and do not address the need for growing communities like ours. Not to mention the bevy of healthcare workers who call this area home but have to deal with a 30+ minute (or more) commute to the nearest hospitals for work every day, when they could be enjoying careers serving in their own community.

The events of November 30, 2021 at Oxford High School prove even further that this community needs and deserves more than an urgent care (that's not even open 24 hours). Our EMTs and first responders can only do so much. 4 lives were lost that day and 7 others were gravely injured and needed immediate treatment. If a hospital had been closer, I'm wondering if the outcome may have been different.

In addition, Lapeer Road is a busy state highway. Many accidents at poorly timed intersections, poorly marked lanes that you can't see in the dark, and ongoing aggressive driving contributes to accidents on Lapeer Road nearly every day, most requiring ambulances. The Polly Ann Trail, Legacy Center, large industrial district, thriving downtown, inland lakes and nearby parks and recreation areas also provide opportunities for need – to treat injuries sustained during work, outdoor and other activities, etc. Not to mention the large community of senior citizens and young families living in our community.

The recent census reports Oxford is a community of more than 22,000. When you add in the surrounding communities that could also benefit from a hospital closer to home, the number is exponentially larger – nearly 185,000 within a 10 mile radius of downtown Oxford. There is really plenty of need. For this area to be considered "too rural" for a hospital to be considered is outrageous. Our community and residents of the surrounding area deserve better.

Please consider making some changes to the certificate of need requirements to allow a medical enterprise to invest in bringing critical health care and local jobs to our hometown.

Many thanks for the work that you do; we look forward to a positive outcome for Oxford.

Michelle Culver
450 E. Peninsula Court
Oxford, MI 48371

From: Nancy Noppenberger
To: MDHHS-ConWebTeam
Subject: HOSPITAL
Date: Monday, October 10, 2022 7:17:25 PM

I am urging you to grant a CON for the construction of a hospital in the Oxford area. I am a resident of Brandon Twp and have an Oxford mailing address. As you are aware, the closest hospital is, at best, a 25 minute ride. That is far too long when urgent treatment is necessary. My neighbor recently had a stroke and the paramedics took him to St. Joe's in Pontiac. That is far too long of a distance to travel when critical care is required.

Please grant Oxford Township a CON so the population in northern Oakland County will have urgent medical care when needed.

Thank you.
Nancy Noppenberger
3168 Dartmouth Rd.
Oxford, MI 48371

Charter Township of Orion

3365 Gregory Road., Lake Orion MI 48359
www.oriontownship.org

Fire Department
Phone: (248) 391-0304, ext. 2000
Fax: (248) 309-6993

October 17, 2022

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

Dear Commission Members:

I am writing to support the Charter Township of Oxford's request to have the current CON methodology re-examined.

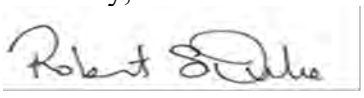
According to the 2020 U.S. Census, Oxford Township and the neighboring communities of Orion, Brandon, Addison, and Metamora townships are home to more than 87,000 residents. As citizens and businesses continue to flock to Oakland County's northern communities, populations in these municipalities are growing at a rapid pace. As such, we need to ensure that these communities can provide residents and workers with access to life-saving medical care. Currently, the five closest hospitals are 16 to 22.4 miles away.

When it comes to healthcare access in communities, I firmly believe decisions should be made at the local level, not the state level. Local governments, working in close partnership with healthcare systems, are the best ones to determine what their residents and communities need when it comes to something as important as hospital beds. Local officials who live and work in underserved areas are better equipped to identify any existing flaws in the current CON methodology because they are closer to the situation than officials in Lansing.

Local officials know that M-24 is the most direct route to four of the five closest hospitals and that at certain times of day, gridlocked traffic is the norm. They know that each medical call can take a fire department's ambulance and crew out of the community for up to two hours. While numbers don't lie, the numbers being used by the state, in this case, don't paint an accurate picture of the complex, multi-faceted situation in Oxford. Decision-making regarding healthcare access should be based on grassroots partnerships, not a top-down approach.

Based on the evidence provided by Oxford Township Supervisor Jack Curtis' Oct. 7, 2022, public comment letter to the CON Commission, there are clearly some flaws in the existing CON review standards. I ask that the commission please consider re-evaluating the current methodology that's used to determine where hospital beds are needed. The residents of Oxford Township and its surrounding communities deserve to have equal access to life-saving medical care.

Sincerely,



Robert S. Duke, EFO
Fire Chief

OXFORD COMMUNITY SCHOOLS
Ken Weaver, Superintendent
Sam Barna, Assistant Superintendent of Business & Maintenance
Anita Qonja-Collins, Assistant Superintendent of Elementary Instruction
Steve Wolf, Assistant Superintendent of Secondary Instruction

October 18, 2022

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

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Respectfully,

Kenneth B. Weaver, Superintendent

10 N. Washington St. Oxford, MI 48371 / Ph. 248.969.5000 / Fax 248.969.5013 / www.oxfordschools.org

OXFORD FIRE DEPARTMENT

96 N. Washington St. Oxford, Michigan, 48371
Ph. (248) 969-9483 • Fax. (248) 969-9489

10-19-2022

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

Dear Commission Members:

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Respectfully,

Chief Peter Scholz

Oxford Village
Department of Police
22 West Burdick Street * P.O. Box 94
Oxford, MI 48371

Site Phone: 248-628-2838
Fax Phone: 248-628-7030

Micheal D. Solwold
Chief of Police

October 18, 2022

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

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Respectfully,

MS

Chief Micheal Solwold

CHARTER TOWNSHIP OF OXFORD
300 Dunlap Road • Oxford, Michigan 48371
Phone: (248) 628-9787 • Fax: (248) 628-8139
www.oxfordtownship.org

October 7, 2022

To: Certificate of Need (CON) Commission

From: Charter Township of Oxford

Based on the facts and supporting data contained in this letter, Oxford Township firmly believes there is a dire need for an acute care hospital within its borders, especially in light of the Nov. 30, 2021 tragedy at Oxford High School that left four students dead and seven people injured. We are asking the CON Commission to please re-examine the criteria and methodology it uses to identify such a vital need.

Oxford Township is a rapidly growing community in northern Oakland County that is **16 to 22.4 miles** away from the nearest hospitals. Oxford is no longer a predominantly rural township where agriculture is the primary industry. Over the last 30 years, the community has become a much more suburban place with numerous residential developments, a revitalized downtown district, more than 500 acres of active parkland, modern schools and a thriving industrial sector.

Despite this, Oxford is still considered "rural" with regard to its proximity to area hospitals, based on a 2018 survey conducted by the Pew Research Center (Exhibit A). According to the center's analysis, "rural Americans live an average of 10.5 miles from the nearest hospital, compared with 5.6 miles for people in suburban areas and 4.4 for those in urban areas." The Pew Research Center found that 18 percent of Americans live more than 10 miles away from their nearest hospital, while 24 percent lived between 5 and 10 miles away and 58 percent live less than 5 miles away.

Four years ago, the State of Michigan agreed that Oxford needed a hospital. In September 2018, the state determined there would be a need for **117** acute care hospital beds in the Oxford area by 2021 (Exhibit B).

Oxford was considered part of an underserved area which the state had designated as Limited Access Area (LAA) 6. This geographic area included portions of three zip codes: Oxford 48371, Ortonville 48462 and Clarkston 48348. In 2020, the state updated the 2023 LAA 6 need to **121** acute care hospital beds (Exhibit C).

Due to a subsequent change in LAA methodology, the state now says zero hospital beds are needed in Oxford as LAA 6 no longer exists (Exhibit D).

Between 2019 and 2020, a health care system submitted plans to construct a 117-bed acute care hospital on a 24.94-acre parcel on M-24 in Oxford. Township officials, employees and consultants worked with representatives from this health care system for nearly a year on its plans to build a 325,000-square-foot medical campus. At its Dec. 12, 2019 meeting, the Oxford Township Planning Commission voted 7-0 to recommend approval of the preliminary Planned Unit Development for a two-phase medical campus (Exhibit E).

To accommodate the needs of such a large development, Oxford Township invested **$2.1 million** to expand its infrastructure. More than 7,000 feet of concrete sanitary sewer line (18-inch diameter) was installed beneath M-24 during the Michigan Department of Transportation's 2020 reconstruction of the state highway (Exhibit F).

Ultimately, this health care system's CON application was rejected and their subsequent appeal was denied. The Michigan Department of Health and Human Services indicated the documentation submitted by the health care system "did not demonstrate that there is a population of 50,000 or more people inside the LAA-6 and within 30 minutes' drive time of the proposed new hospital site," therefore it "did not meet the necessary requirements for approval."

Despite this, the health care system in question moved forward with its **$4 million** purchase of the 24.94-acre property.

The need for medical services in Oxford Township has also attracted the attention of two other health care systems. One system is planning to demolish its existing 42-year-old building on the west side of M-24 and construct a new two-story, 54,000-square-foot ambulatory facility. The other has purchased approximately 15 acres of vacant land on M-24.

Clearly, these three health care systems see the same need in Oxford that the township does.

The population in and around Oxford continues to grow and shows no signs of slowing down. According to the 2020 U.S. Census, Oxford's population (township and village combined) is **22,419**. That is a **9.2 percent increase** since 2010 (Exhibit G). Oxford's population has increased by **40.1 percent** since the 2000 Census.

Oxford and the four townships adjacent to it (Orion, Brandon, Metamora and Addison) have a combined population of **87,227** based on the 2020 U.S. Census. Three of the townships adjacent to Oxford are growing as well based on the 2020 U.S. Census: Orion Township 38,206 (7.94 percent increase); Brandon Township 15,384 (1.38 percent increase); and Metamora Township 4,962 (3.12 percent increase) (Exhibit H).

Population numbers are going to keep increasing as businesses continue to invest and grow in and around Oxford Township. For example, in January 2022, General Motors announced plans to invest **$4 billion** in the Orion Assembly plant in order to convert it into a facility that produces electric pickup trucks. When the plant is fully operational, GM's investment is expected to create **more than 2,350 new jobs** in Orion and retain **approximately 1,000 existing jobs** (Exhibit I). It's fair to assume that many of those employees will move to Orion or surrounding communities in order to be close to work, shorten their commute times and save on fuel costs. This influx of new workers and increased activity at the Orion Assembly plant will also lead to a significant increase in traffic on area roads, particularly M-24, which connects I-75 to the south and I-69 to the north.

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www.oxfordtownship.org

Currently, there are **183,887 people** living within a 10-mile radius of downtown Oxford (Exhibit J). The five hospitals closest to Oxford are **16 to 22.4 miles away** in communities such as Pontiac, Lapeer and Rochester Hills (Exhibit J).

The most direct route to four of the hospitals involves taking M-24, the north-south state trunkline highway that bisects Oxford Township. At certain times of day, traffic on M-24 is at a standstill in various areas. According to MDOT, based on 2021 counts – when many people were still working from home due to the COVID-19 pandemic – the Average Annual Daily Traffic on four segments of M-24 between Drahner Rd. and Davison Lake Rd. in Oxford Township ranges from **23,185 to 28,160 vehicles** (Exhibit K).

As a result of Oxford's growing population, the number of fire and medical calls handled by the Oxford Fire Department has **increased by 43.2 percent over the last 10 years.** The call volume went from **1,550** in 2011 to **2,220** in 2021 (Exhibit L). Of the 2,220 calls last year, **81.6 percent (1,812) were medical calls** (Exhibit M).

A medical call that requires patient transport to hospitals in Pontiac, Lapeer or Rochester Hills can take one of Oxford's ambulances and crews out of the community for **up to two hours**. The impact of having these units out of town for such long periods of time is **less coverage for the community** and **heavier reliance on receiving mutual aid** from surrounding fire departments, which can negatively impact their ability to effectively serve their own communities.

The Oxford Fire Department frequently receives multiple calls at the same time, which often leads to multiple ambulances leaving the township for up to two hours while transporting patients to area hospitals. **Every time an Oxford ambulance leaves the community, it takes two to three crew members with it.** Standard medical transports require two people: a paramedic in the back with the patient and an emergency medical technician (EMT) driving the ambulance. Priority medical calls require three people: two paramedics in back and an EMT behind the wheel.

Like many other departments, the Oxford Fire Department has been having trouble hiring full-time personnel and recruiting paid-on-call members. Having so many paramedics and EMTs leaving the community for long periods of time exacerbates staffing issues and hinders the fire department's ability to effectively serve Oxford.

The fire departments serving the Oakland County communities adjacent to Oxford are also responding to more and more calls every year (Exhibit N):

- **Orion Township Fire Department** – Over the last 10 years, the number of calls handled by Orion has increased by **102 percent**, from **1,769** in 2011 to **3,580** in 2021. Of the 3,580 calls handled last year, **2,478 (or 69.2 percent)** were medical-related and **12** were mutual aid provided to the Oxford Fire Department.
- **Brandon Township Fire Department** – Over the last 10 years, the number of calls handled by Brandon has increased by **69 percent**, from **940** in 2011 to **1,591** in 2021.

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Of the 1,591 calls handled last year, **1,070 (or 67.25 percent)** were medical-related and **39** were mutual aid provided to the Oxford Fire Department.

- **Addison Township Fire Department** – Over the last 10 years, the number of calls handled by Addison has increased by **35 percent**, from **553** in 2011 to **748** in 2021. Of the 748 calls handled last year, **432 (or 57.8 percent)** were medical-related and **62** were mutual aid provided to the Oxford Fire Department.

We hope this information provides a more complete picture of Oxford Township and its surrounding communities. Considering the above facts, Oxford Township is, again, asking the CON Commission to please re-evaluate the criteria and methodology it uses to identify where a hospital is needed.

Respectfully submitted,

Jack L. Curtis

Supervisor Jack Curtis

Charter Township of Oxford

cc: Gov. Gretchen Whitmer
Sen. Rosemary Bayer
CON Commission Chairperson Amy L. McKenzie
MDHHS Director Elizabeth Hertel
Oakland County Executive Dave Coulter
Oakland County Board of Commissioners Chairperson Dave Woodward
Oakland County Commissioner Michael Spisz
Oakland County Sheriff Michael Bouchard
Orion Township Supervisor Chris Barnett
Brandon Township Supervisor Jayson Rumball
Addison Township Supervisor Bruce Pearson
Oxford Community Schools Superintendent Ken Weaver
Oxford Village President Kelsey Cooke
Oxford Village Manager Joseph Madore
Oxford Village Police Chief Mike Solwold
Oxford Fire Chief Pete Scholz
Orion Township Fire Chief Robert Duke
Brandon Township Fire Chief David Kwapis
Addison Township Fire Chief Jerry Morawski

Exhibit A

DECEMBER 12, 2018

How far Americans live from the closest hospital differs by community type

BY ONYI LAM, BRIAN BRODERICK AND SKYE TOOR

Rural Americans are more likely than people in urban and suburban areas to say access to good doctors and hospitals is a major problem in their community. Nearly a quarter (23%) of Americans in rural areas say this, compared with 18% of urbanites and 9% of suburbanites, according to a Pew Research Center survey conducted earlier this year.

People living in rural areas have longer travel times to the nearest hospital

Average minutes of car travel time to nearest hospital by community type for ...

Source: Survey of U.S. adults conducted Sept. 24-Oct. 7, 2018, and Homeland Infrastructure Foundation-Level data.

PEW RESEARCH CENTER

One factor that may contribute to this view is that getting to a hospital is a longer trip – both in distance and time – for people in rural areas than those in suburbs and cities. Rural Americans live an average of 10.5 miles from the nearest hospital, compared with 5.6 miles for people in suburban areas and 4.4 for those in urban areas, according to a new Center analysis. Taking local traffic patterns into account, that works out to a travel time of 17 minutes for people who live in rural communities, 12 minutes for those in suburban areas and 10 minutes for those in urban areas.

The analysis plots the distance from the nearest acute care facility for a representative sample of more than 10,000 U.S. adults included in the Center's American Trends Panel. (In this analysis, community types are self-described; that is, survey respondents are asked whether they live in a rural, suburban or urban area.)

These findings come amid a wave of rural hospital closures in recent years that have raised concerns about access to health care. A report by the U.S. Government Accountability Office earlier this year found that 64 rural hospitals closed between 2013 and 2017, more than twice the number of rural hospital closures in the previous five-year period.

Overall, 18% of Americans live more than 10 miles away from their nearest hospital, while 24% live between 5 and 10 miles away and 58% live less than 5 miles away, according to the analysis. These figures reflect the fact that far more Americans live in suburban and urban areas than in rural ones.

This analysis aims to provide a concrete measure of the distance between Americans and their closest hospital in different community types across the United States. (Without a

measure of the quality and range of care provided at each hospital, we can't say much about how access to hospitals translates to well-being.)

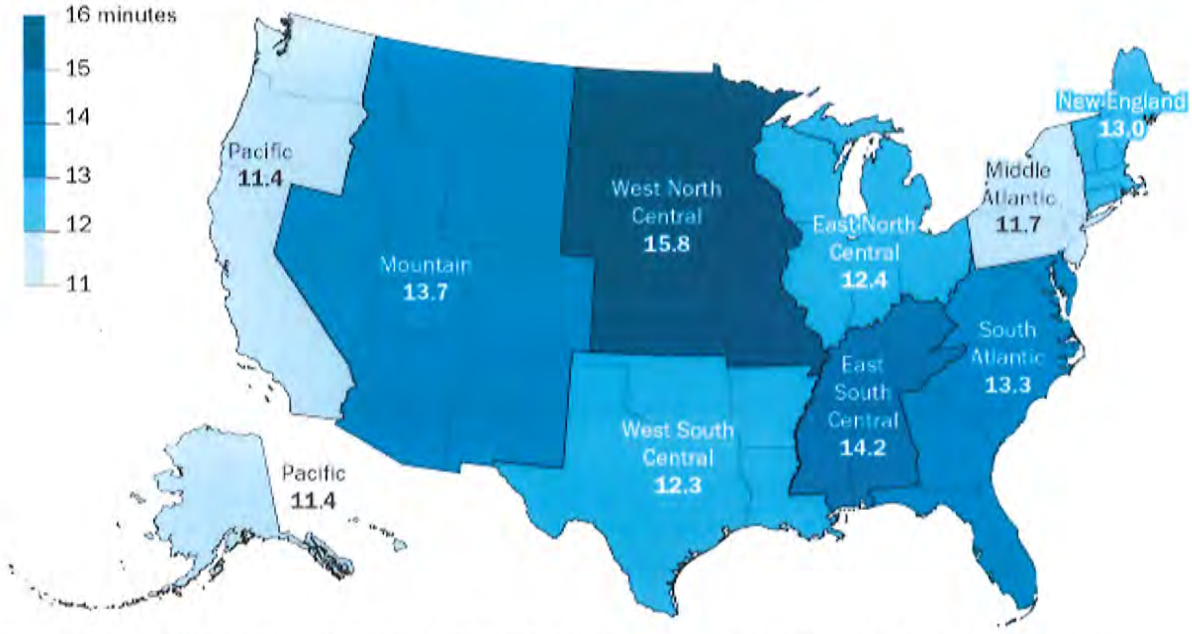
While rural Americans live slightly farther from the nearest hospital and have a slightly longer travel time when compared with suburban and urban Americans, the overall averages mask considerable variation in access within community types – especially rural areas.

For example, among the quarter of rural Americans whose travel time is the longest, it takes an average of 34 minutes to get to the nearest acute care facility, compared with just six minutes for the quarter of rural Americans whose travel time is the shortest. The discrepancy is smaller among urban Americans: It takes an average of 19 minutes for the quarter of urbanites who have the longest travel time, compared with five minutes for the quarter of urban Americans on the other end of the spectrum. In other words, while some parts of rural America are especially far from hospital access, other rural Americans have similar travel times to the closest hospital as their urban counterparts.

In addition to differences by community type, there are also differences by geographic region. Americans living in the census region known as West North Central (comprised of Kansas, Iowa, Minnesota, North Dakota, South Dakota, Nebraska and Missouri) have an average travel time of 15.8 minutes to the closest hospital. By comparison, people in the Pacific region (comprised of Alaska, California, Hawaii, Oregon and Washington) have the shortest average travel time, at 11.4 minutes.

People living in northern Plains states have the longest travel times to the nearest hospital

Average minutes of car travel time to nearest hospital by census region

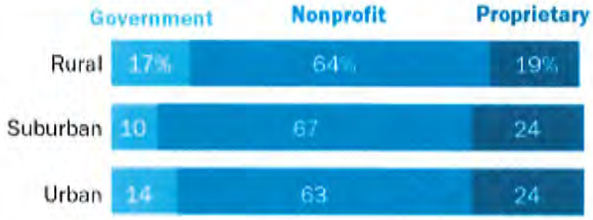


Source: Survey of U.S. adults conducted Sept. 24-Oct. 7, 2018, and Homeland Infrastructure Foundation-Level data.

PEW RESEARCH CENTER

Government-run hospitals are least common in suburban areas

% of U.S. adults who live closest to each kind of hospital, by community type



Note: Hospitals whose ownership is unknown not shown.
Source: Survey of U.S. adults conducted Sept. 24-Oct. 7, 2018, and Homeland Infrastructure Foundation-Level data.

PEW RESEARCH CENTER

The analysis also examined the kinds of hospitals Americans live closest to. Nationally, two-thirds of Americans (65%) live closest to a nonprofit hospital, but people in rural areas are more likely than those in suburban and urban areas to live closest to a government-run hospital. Around one-in-six rural Americans (17%) live closest to a hospital run by the government. While this is about the same as the share in urban areas (14%), it's larger than the share in suburban areas (10%) Whether a hospital is nonprofit,

for-profit or owned by the government can have implications for the types of services it provides, previous research has found.

To conduct this analysis, researchers used the addresses of a random sample of over 10,000 Americans using Pew Research Center's nationally representative American Trends Panel. They then calculated the linear distance between the respondent's address and the hospitals, using hospital locations listed in a database known as Homeland Infrastructure Foundation-Level Data. The dataset contains a total of 7,570 hospitals, including 4,511 that are classified as "general acute care" hospitals, which are the focus of this analysis. (Other categories include long-term care, psychiatric and children's hospitals.) After identifying the closest hospital by linear distance, researchers used the Google Maps API to calculate the travel time and distance to the nearest general acute care facility.

Note: The full methodology can be found here (PDF).

Topics Health Policy, Health Care, Medicine & Health, Data Science, Rural, Urban and Suburban Communities

SHARE THIS LINK: https://pewrsr.ch/2L2nthb

Onyi Lam *is a former computational social scientist who focused on data science at Pew Research Center.*

POSTS BIO EMAIL

Brian Broderick *is a senior data engineer at Pew Research Center.*

POSTS BIO EMAIL

Skye Toor *is a former data science assistant focusing on internet and technology at Pew Research Center.*

POSTS BIO EMAIL

RELATED

SHORT READ | SEP 29, 2020

Exhibit B

Acute Care Hospital Bed Need and Limited Access Areas
2018 Update

Jonnell C. Sanciangco[1], Paul L. Delamater, Ph.D.[2], and Ashton M. Shortridge, PhD.[3]
August 22, 2018

[1]Department of Geography, Environment, and Spatial Sciences, Michigan State University, sancian1@msu.edu
[2]Department of Geography, University of North Carolina at Chapel Hill, pld@email.unc.edu
[3]Department of Geography, Environment, and Spatial Sciences, Michigan State University, ashton@msu.edu

Summary

This report provides updated results for the Acute Care Hospital Bed Need and Limited Access Areas (LAAs). An increasing trend in patient days over prior years is noted. The LAA map is similar to past implementations. Tables and figures contained within this report are also provided in separate files.

Determination of Needed Hospital Bed Supply

The planning year used for the updated bed need is 2021, five years from the most recent MIDB data (2016). The output of the methodology is found in Table 1. In this analysis, the most recent hospital beds inventory (Dept Inv 2018) is compared to the predicted number of beds needs in 2021. The difference between the actual utilization in 2016 and the predicted utilization in 2021 is also included in Table 1. In 16 of the 33 Hospital Groups, the predicted bed need in 2021 is less than current utilization (2016). In 13 Hospital Groups, the predicted bed need in 2021 was less than current utilization, and in four Hospital Groups, it was the same as the current utilization.

The predicted statewide bed need for 2021 is 18,718 beds, which is slightly more than 2,000 beds greater than the previous estimate (bed need for 2019, calculated in 2016). The rise is attributed to large increases in acute care hospitalization occurring in 2015 and 2016. Figure 1 shows the patient day utilization from 2000 to 2016 and clearly shows the substantial increase in the last two years since the last bed update (which used 2010-2014 data). In the county-level patient day prediction phase of the Bed Need Methodology, 15 out of 84 county units (83 counties plus one "out-of-state" unit) demonstrated a significant positive linear trend in patient day utilization. Only nine counties had a negative linear trend in patient day utilization. No significant linear trend was detected in 60 counties. Despite these increases, all Hospital Groups will continue to have excess hospital beds given the large number of currently licensed beds and the state, overall, is expected to have 6,775 excess beds.

Limited Access Areas

Figure 2 provides the map of the Limited Access Areas. The bed need for each LAA can be found in Table 2, while the zip codes associated with each LAA are listed in Table 3. Based on 2016 hospitalization data, the minimum number of predicted patient days for an underserved area to be considered an LAA was 26,851. This value was calculated using the overall state rate of 0.537 patient days per person and a minimum population of 50,000, per the Review Standards.

Six LAAs were identified in the 2018 update, an increase from the five identified in the 2016 update. LAAs 1, 2, 3, and 5 are nearly identical to the LAAs 1-3 and 5 from the 2016 update (Upper Peninsula, East/Central Northern Lower Peninsula, Northwest Lower Peninsula, and East Southern Lower Peninsula). LAA 4 and LAA 6 were identified as underserved areas in the previous report but were slightly under the patient day threshold to be considered LAAs. A previous LAA (LAA 4 in 2016 report) is now only considered an underserved area, as the predicted patient days value was well beneath the threshold.

Given the increasing trend in patient day utilization in some regions, the identification of additional LAAs is not surprising, especially when considering that the two new LAAs were near the threshold in the 2016 calculation. However, the differences in the LAAs from the previous update could also be due to several reasons not related to health. First, the MSU/UNC team utilized a more recent roads data layer from the Michigan CGI. Minor changes in the roads (e.g., new roads) and/or road speed limits have the potential to affect the size of the underserved areas (outside of a 30-minute drive to the nearest acute care hospital). The team also used an updated Zip Code boundary layer. Minor shifts in the boundaries of Zip Codes could also have affected which Zip Codes are assigned to the underserved areas, which would affect the predicted number of patient days.

Table 1. Bed Need Results for 2018. Source Data: 2012–2016 MIDB. Excess Bed Need is calculated as the difference between Bed Need 2021 and Dept Inv 2018.

HG	ADC 2016	Bed Need 2021	Diff	Diff(%)	Bed Need 2021	Beds 2018	Dept Inv 2018	Excess Bed Need
1	3,058	2,964	*-94*	*-3.07*	2,964	4,070	4,044	1,080
2	2,753	2,827	74	2.69	2,827	3,507	3,507	680
3	1,652	1,687	35	2.12	1,687	2,030	2,030	343
4	1,374	1,292	*-82*	*-5.97*	1,292	1,973	1,973	681
5	1,294	1,287	*-7*	*-0.54*	1,287	1,788	1,783	496
6	248	259	11	4.44	259	375	375	116
7	823	802	*-21*	*-2.55*	802	1,086	1,086	284
8	322	306	*-16*	*-4.97*	306	389	389	83
9	67	64	*-3*	*-4.48*	64	113	113	49
10	730	770	40	5.48	770	899	899	129
11	298	319	21	7.05	319	417	427	108
12	233	184	*-49*	*-21.03*	184	316	316	132
13	64	63	*-1*	*-1.56*	63	237	237	174
14	1,375	1,409	34	2.47	1,409	1,842	1,862	453
15	323	322	*-1*	*-0.31*	322	462	462	140
16	175	170	*-5*	*-2.86*	170	311	311	141
17	134	129	*-5*	*-3.73*	129	237	237	108
18	79	79	0	0.00	79	143	143	64
19	1,208	1,279	71	5.88	1,279	1,441	1,441	162
20	1,134	1,147	13	1.15	1,147	1,708	1,688	541
21	47	47	0	0.00	47	188	188	141
22	62	59	*-3*	*-4.84*	59	192	192	133
23	62	63	1	1.61	63	160	160	97
24	430	426	*-4*	*-0.93*	426	550	550	124
25	167	181	14	8.38	181	227	227	46
26	82	84	2	2.44	84	124	124	40
27	60	64	4	6.67	64	102	102	38
28	222	255	33	14.86	255	314	282	27
29	53	50	*-3*	*-5.66*	50	89	89	39
30	56	50	*-6*	*-10.71*	50	111	111	61
31	72	69	*-3*	*-4.17*	69	107	107	38
32	7	7	0	0.00	7	23	23	16
33	4	4	0	0.00	4	15	15	11
State	**18,668**	**18,718**	**50**	**0.27**	**18,718**	**25,546**	**25,493**	**6,775**

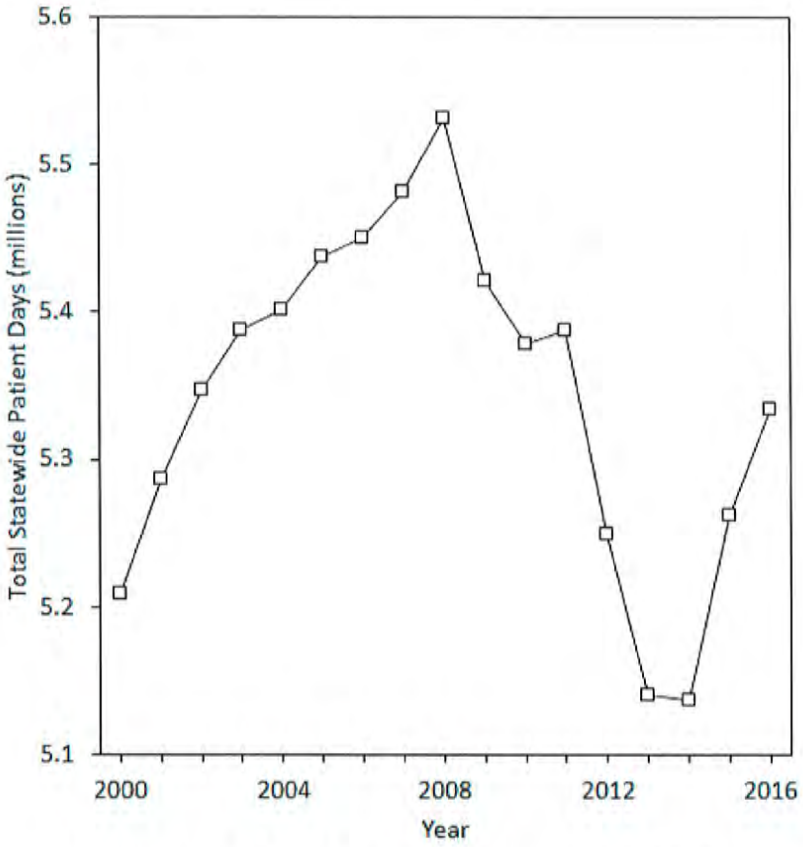
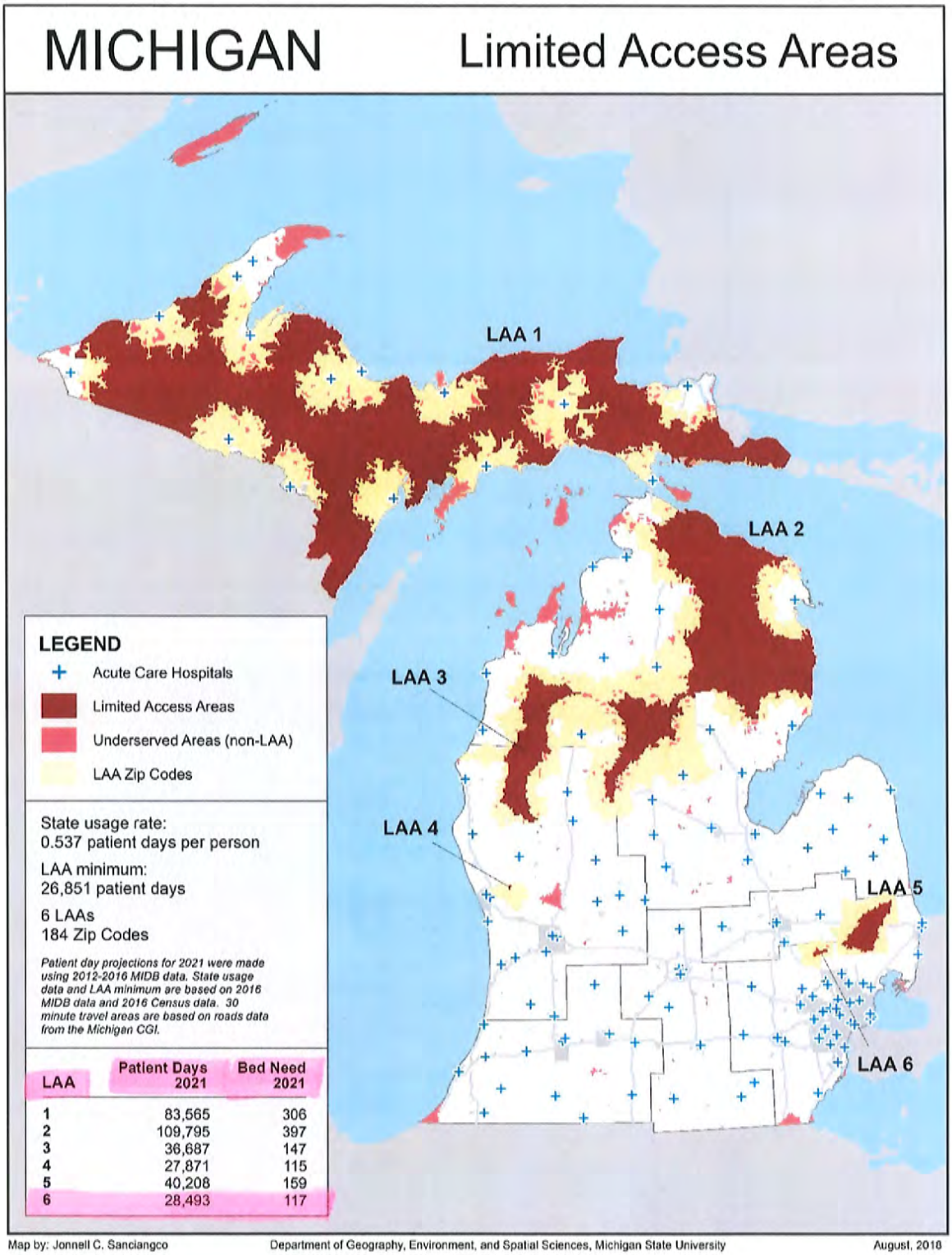


Figure 1. Statewide Patient Days, 2000–2016

Table 2. Bed Need for Limited Access Areas

LAA	Predicted Patient Days	Bed Need 2021
1	83,565	306
2	109,795	397
3	36,687	147
4	27,871	115
5	40,208	159
6	28,493	117



LAA	Patient Days 2021	Bed Need 2021
1	83,565	306
2	109,795	397
3	36,687	147
4	27,871	115
5	40,208	159
6	28,493	117

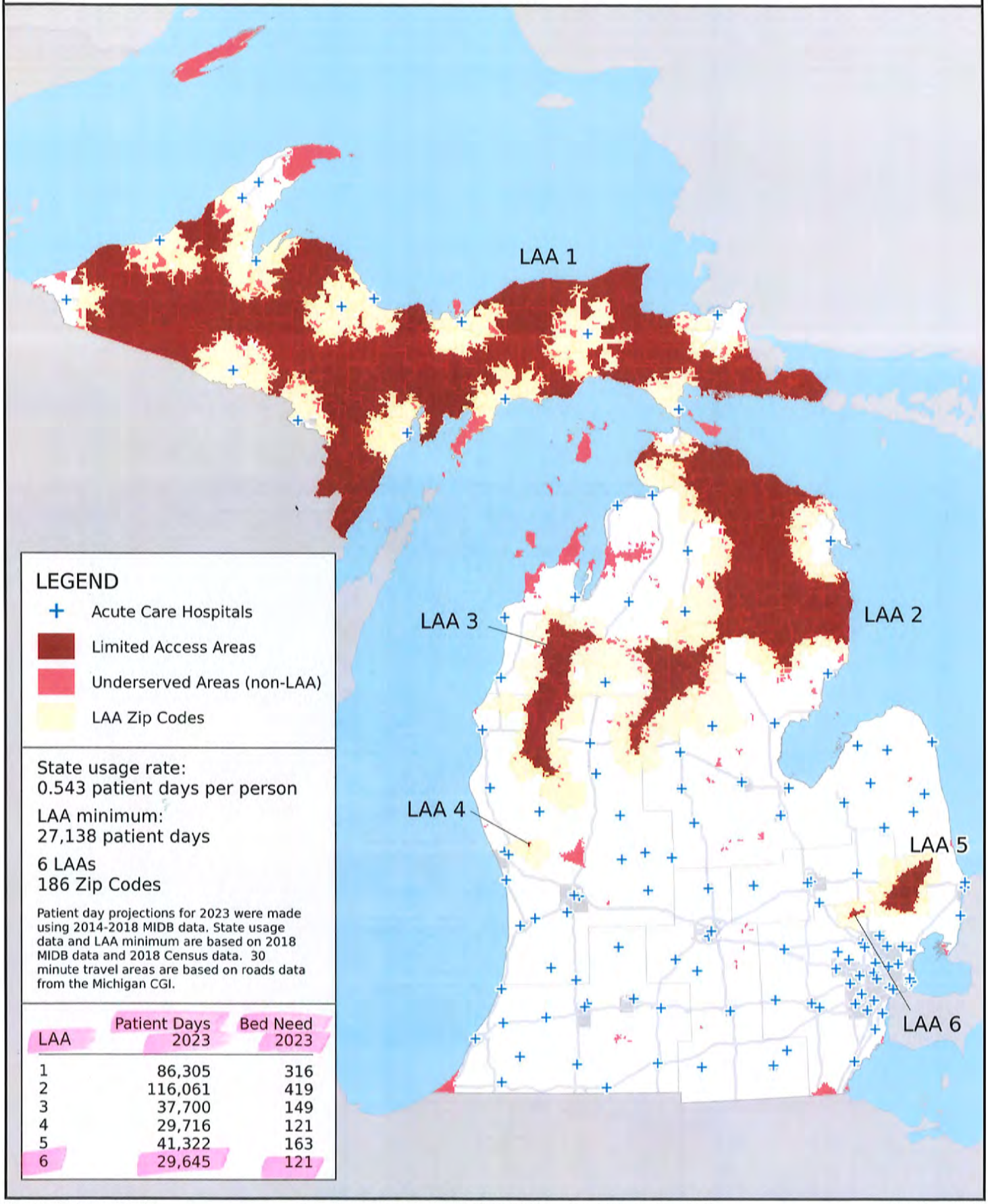
Figure 2. Limited Access Areas

Table 3. Limited Access Areas, Zip Codes

LAA 1			LAA 2		LAA 3	LAA 4	LAA 5	LAA 6
49710	49829	49885	48619	49651	49304	49442	48002	48348
49715	49831	49886	48621	49665	49309	49451	48003	48371
49719	49833	49887	48624	49667	49402		48005	48462
49725	49834	49891	48625	49679	49411		48006	
49726	49835	49892	48629	49705	49459		48014	
49728	49836	49893	48630	49706	49601		48022	
49736	49837	49895	48632	49709	49619		48041	
49745	49838	49896	48635	49716	49620		48062	
49752	49839	49905	48636	49721	49625		48065	
49760	49840	49910	48647	49738	49633		48097	
49762	49841	49912	48651	49743	49637		48367	
49768	49847	49916	48653	49744	49638		48428	
49774	49848	49919	48654	49746	49643		48444	
49780	49849	49920	48656	49747	49644			
49781	49853	49925	48705	49749	49645			
49801	49854	49935	48721	49751	49649			
49806	49855	49946	48728	49753	49656			
49807	49858	49947	48737	49756	49663			
49812	49861	49948	48738	49759	49668			
49814	49862	49952	48739	49765	49683			
49815	49866	49953	48740	49766	49689			
49816	49868	49958	48742	49769				
49817	49873	49962	48743	49776				
49818	49874	49965	48745	49777				
49820	49878	49967	48750	49779				
49821	49879	49968	48761	49792				
49822	49880	49969	48762	49799				
49825	49881	49970	49305					
49826	49883		49631					
49827	49884		49632					

Exhibit C

MICHIGAN Limited Access Areas



LEGEND

- Acute Care Hospitals
- Limited Access Areas
- Underserved Areas (non-LAA)
- LAA Zip Codes

State usage rate:
0.543 patient days per person

LAA minimum:
27,138 patient days

6 LAAs
186 Zip Codes

Patient day projections for 2023 were made using 2014-2018 MIDB data. State usage data and LAA minimum are based on 2018 MIDB data and 2018 Census data. 30 minute travel areas are based on roads data from the Michigan CGI.

LAA	Patient Days 2023	Bed Need 2023
1	86,305	316
2	116,061	419
3	37,700	149
4	29,716	121
5	41,322	163
6	29,645	121

Map by: Paul L. Delamater Department of Geography,University of North Carolina at Chapel Hill November, 2020

For a detailed and dynamic map of the LAA geographic areas, please contact the MDHHS-CON Section

Acute Care Hospital Bed Need and Limited Access Areas–2020 Update

Table 1: Bed Need for Limited Access Areas (LAA)

LAA	Predicted Patient Days 2023	Bed Need 2023
1	86305	316
2	116061	419
3	37700	149
4	29716	121
5	41322	163
6	29645	121

Acute Care Hospital Bed Need and Limited Access Areas (LAA) – 2020 Update

Table 2: Limited Access Areas, Zip Codes

LAA 1	LAA 1	LAA 1
49710	49839	49946
49715	49840	49947
49719	49841	49948
49725	49847	49952
49726	49848	49953
49728	49849	49958
49736	49853	49962
49745	49854	49965
49752	49855	49967
49760	49858	49968
49762	49861	49969
49768	49862	49970
49774	49866	
49780	49868	
49781	49873	
49801	49874	
49806	49878	
49807	49879	
49812	49880	
49814	49881	
49815	49883	
49816	49884	
49817	49885	
49818	49886	
49820	49887	
49821	49891	
49822	49892	
49825	49893	
49826	49895	
49827	49896	
49829	49905	
49831	49910	
49833	49912	
49834	49916	
49835	49919	
49836	49920	
49837	49925	
49838	49935	

LAA 2	LAA 2
48619	49721
48621	49738
48624	49740
48625	49743
48629	49744
48630	49746
48632	49747
48635	49749
48636	49751
48647	49753
48651	49755
48653	49756
48654	49759
48656	49765
48705	49766
48721	49769
48728	49776
48737	49777
48738	49779
48739	49792
48740	49799
48742	
48743	
48745	
48750	
48761	
48762	
49305	
49631	
49632	
49651	
49665	
49667	
49679	
49705	
49706	
49709	
49716	

LAA 3
49304
49309
49349
49402
49411
49459
49601
49619
49620
49625
49637
49638
49643
49644
49645
49649
49656
49663
49668
49683
49689

LAA 4
49442
49451

LAA 5
48002
48003
48005
48006
48014
48022
48041
48062
48065
48097
48367
48428
48444

LAA 6
48348
48371
48462

For a detailed and dynamic map of the LAA geographic areas, please contact the MDHHS-CON Section

Exhibit D

2021

Attachment C

HOSPITAL BED SAC MEETING DATES

Hospital Bed SAC Meeting Dates
November 12, 2020
December 3, 2020
January 21, 2021
February 11, 2021
March 11, 2021
April 15, 2021
May 6, 2021

CHARGE 1 - REVIEW THE REQUIREMENTS AND PROVISIONS FOR LIMITED ACCESS AREAS

Considerations in the review of possible modifications:

- The current methodology is identifying Limited Access Areas that cannot meet the project delivery requirements in Section 6(5)
- The geographic identification, population assignment, and travel time methodology supports a refresh with modern assessment and analysis tools
- The current methodology identifies LAAs that reference large areas creating gaps in addressing access (Example: LAA #1 encompasses the Upper Peninsula where a hospital in the Eastern UP does not address access to the majority of the individuals in LAA #1)
- Analysis should reference existing rural healthcare models (Critical Access Hospital, Sole Community Hospital, Rural Healthcare)

(g) Select candidate solutions by finding those with peak values in f_{inc} scores such that $f_{inc,\,i}$ is greater than both $f_{inc,\,i-1}$ and $f_{inc,\,i+1}$.

(h) Remove all candidate solutions in which the largest single cluster contains more than 20 hospitals.

(i) Identify the minimum number of single hospital clusters from the remaining candidate solutions. Remove all candidate solutions containing a greater number of single hospital clusters than the identified minimum.

(j) From the remaining candidate solutions, choose the solution with the largest number of clusters (k). This solution (k clusters) is the resulting number and configuration of the hospital groups.

(k) Rename hospital groups as follows:

(i) For each hospital group, identify the HSA in which the maximum number of hospitals are located. In case of a tie, use the HSA number that is lower.

(ii) For each hospital group, sum the number of current licensed hospital beds for all hospitals.

(iii) Order the groups from 1 to k by first sorting by HSA number, then sorting within each HSA by the sum of beds in each hospital group. The hospital group name is then created by appending number in which it is ordered to "hg" (e.g., hg1, hg2, ... hg$k$).

(iv) Hospitals that do not have patient records in the MIDB - identified in subsection (1)(a) - are designated as "ng" for non-groupable hospitals.

(2) For an application involving a proposed new licensed site for a hospital (whether new or replacement), the proposed new licensed site shall be assigned to an existing hospital group utilizing the methodology described in "A Methodology for Defining Hospital Groups" by Paul L. Delamater, Ashton M. Shortridge, and Joseph P. Messina, 2011 as follows:

(a) Calculate the road distance from proposed new site (s) to all existing hospitals, resulting in a list of n observations (s_n).

(b) Rescale s_n by dividing each observation by the maximum road distance between any two hospitals identified in subsection (1)(c).

(c) For each hospital group, subset the cluster center location identified in subsection (1)(e)(i) to only the entries corresponding to the road distance between hospitals. For each hospital group, the result is a list of n observations that define each hospital group's central location in relative road distance.

(d) Calculate the distance ($d_{K,S}$) between the proposed new site and each existing hospital group

where: $$d_{k,s} = \sqrt{(HG_{k,1} - s_1)^2 + (HG_{k,2} - s_2)^2 + (HG_{k,3} - s_3)^2 + \ldots + (HG_{k,n} - s_n)^2}$$

(e) Assign the proposed new site to the closest hospital group (HGk) by selecting the minimum value of $d_{k,s}$.

(f) If there is only a single applicant, then the assignment procedure is complete. If there are additional applicants, then steps (a) – (e) must be repeated until all applicants have been assigned to an existing hospital group.

(3) The Department shall amend the hospital groups to reflect: (a) approved new licensed site(s) assigned to a specific hospital group; (b) hospital closures; and (c) licensure action(s) as appropriate.

(4) As directed by the Commission, new hospital group assignments established according to subsection (1) shall supersede the previous subarea/hospital group assignments and shall be posted on the State of Michigan CON web site effective on the date determined by the Commission.

Section 4. Determination of ~~the needed~~ hospital bed ~~supply~~ NEED AND LIMITED ACCESS AREAS

Sec. 4. (1) The determination of the ~~needed~~ hospital bed ~~supply~~ NEED for a hospital group for a planning year shall be made using the MIDB and the methodology detailed in "New Methodology for Determining Needed Hospital Bed Supply" by Paul L. Delamater, Ashton M. Shortridge, and Joseph P. Messina, 2011 as follows:

(a) All hospital discharges for normal newborns (DRG 391 prior to 2008, DRG 795 thereafter) and psychiatric patients (ICD-9-CM codes 290 through 319, see Appendix D for ICD-10-CM Codes, as a principal diagnosis) will be excluded.

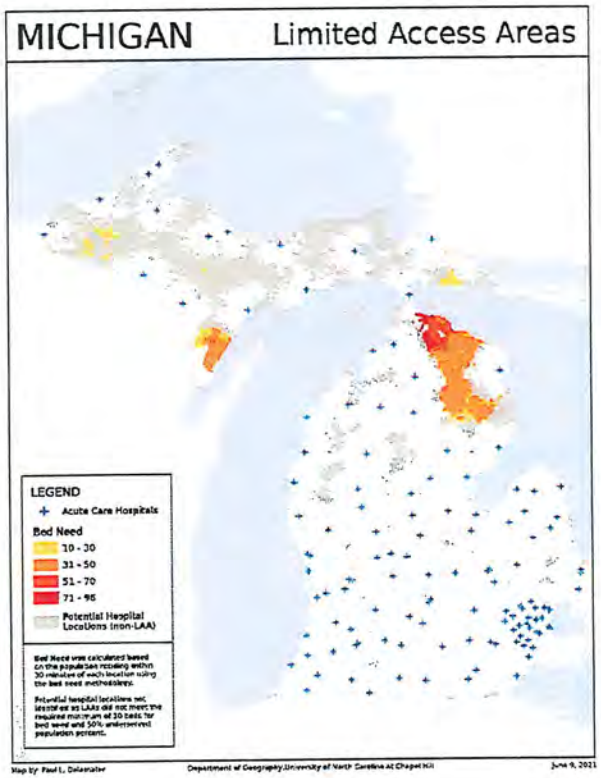
Form

Attachment C

CHARGE 1 - REVIEW THE REQUIREMENTS AND PROVISIONS FOR LIMITED ACCESS AREAS

The SAC approved the following Limited Access Area methodology:

- Methodology based on travel time and a definition of underserved population
  - Travel time determined using ESRI online services
  - A geographically underserved area is defined as a place located more than 30 minute travel time to another hospital
- A minimum hospital bed threshold of ten (10) beds
- A minimum of 50% of people identified as being currently geographically underserved
- Proposed methodology creates 1km hexagons that function as individual Limited Access Areas
- Proposed update to LAA comparative review detail



LAA data will be published as an online map

LAA #6
NO LONGER HAS A "NEED" ACCORDING TO NEW METHODOLOGY

CHARGE 1 - REVIEW THE REQUIREMENTS AND PROVISIONS FOR LIMITED ACCESS AREAS

Detailed Methodology:

1. **Calculated patient day use rate**
    1. Average Patient Day Use Rate = IP Patient Days for Base Year / Estimated Michigan Population (patient days exclude normal newborns and IP Psych)
2. **Identify geographically underserved areas**
    1. Using ESRI Online Network create 30 minute drive time around each licensed hospital with a 24/7 Emergency Department
    2. Identify regions with greater than 30 minute drive time
3. **Create potential hospital locations in 1km LAAs**
    1. Overlay of 1km hexagon tessellation over state
4. **Calculate bed need and underserved patient population percent**
    1. Create 30 minute travel time
    2. Identify number of people residing within 30 minute travel time service area
    3. Assign each population as currently Underserved or Served – sum the total for both groups
    4. Expected Yearly Patient Days = Underserved Population x Average Patient Day Use Rate
    5. Underserved Population % = Underserved Population / Total Population x 100

CHARGE 1 - REVIEW THE REQUIREMENTS AND PROVISIONS FOR LIMITED ACCESS AREAS

Proposed standards modifications:

- Section 2(1) definition updates
  - (o) "geographically underserved"
  - (z) "limited access area"
  - (kk) "potential hospital location"
- Section 4(2) determination of hospital bed need and Limited Access Area updates
  - Detailed calculation methodology
- Section 6(5) requirements for approval – new beds in a hospital updates
  - Alignment with methodology
- Section 12(4) additional requirements for applications included in comparative reviews
  - Updates to comparative scoring tied to Limited Access Area applicants

CHARGE 2 - EVALUATE WHETHER PATIENTS WHO ARE IN A LICENSED BED, AND WHO ARE OR MAY BECOME OBSERVATION STATUS, SHOULD BE INCLUDED/EXCLUDED IN THE PATIENT COUNT.

The Standard Advisory Committee supported the exclusion of Observation Status patients from the patient count.

Proposed clarifying standards and MDHHS annual survey language :

- Section 2(1)(a) – Definitions

  (r) Hospital bed" means a bed within the licensed bed complement at a licensed site of a hospital licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in Section 20106(6) of the Code and (ii) unlicensed newborn bassinets and (iii) Observation Beds.

  "This term does not include admitted patients who are or were later identified to be in observation presence" added to: (gg) "Obstetrics patient days of care", (ii) "Pediatric patient days of care", and (nn) " Remaining patient days of care"

- MDHHS Annual Survey Licensed Inpatient Hospital Beds Template Update

  "Report the number of inpatient days of care provided by the facility during survey year by bed type. This term does not include admitted patients who are or were later identified to be in observation status.

CHARGE 4 - REVIEW POSSIBLE MODIFICATION TO THE REPLACEMENT ZONE DEFINITION.

Considerations in the review of possible modifications:

- Current replacement zone definition has not been updated in over 30 years
- Hospitals should have greater flexibility to optimize access and replace themselves in the highest value location to optimally serve their community
- Proposed update supports community need, cost, access, and quality
- Proposed update keeps the current replacement zone definition with the addition of a supplemental enhanced replacement zone

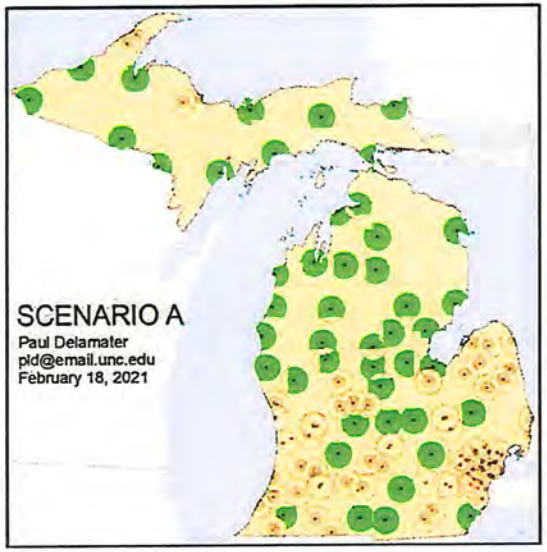
<u>Proposed standards addition:</u>

Addition of an enhanced replacement zone definition in Section 2(1)(rr) of the standards

CHARGE 4 - REVIEW POSSIBLE MODIFICATION TO THE REPLACEMENT ZONE DEFINITION.

SAC approved supplemental enhanced replacement zone definition:

- Enhanced replacement zone of 10 miles in Counties with a population of less than 200,000 if the hospital is the only acute care hospital in the County
- Cannot be closer than 10 miles from another acute care hospital
- May cross into an adjacent County if the other County has a population of less than 200,000 and does not have an acute care hospital



Enhanced Eligibility: 46 Acute Care Hospitals * 52 Counties

CHARGE 5 - REVIEW HOW THE EMERGENCY CONS WERE HANDLED DURING THE PANDEMIC AND IF CHANGES NEED TO BE MADE

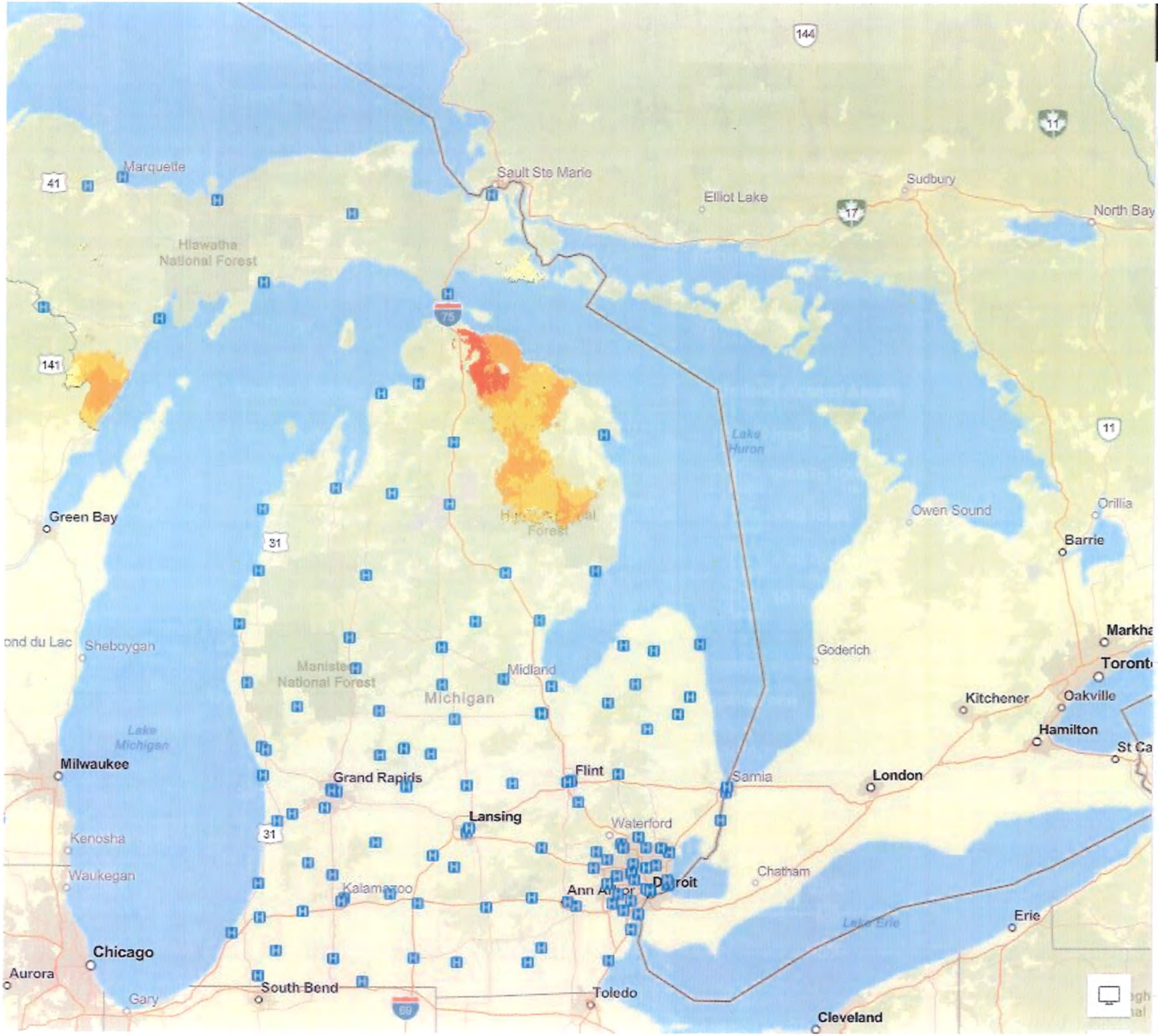
- SAC members shared their appreciation for the departments' responsiveness and support with continued COVID related emergency CON applications
- No recommendations for changes to the CON department's pandemic response

CHARGE 3 & CHARGE 6 REPRESENT LANGUAGE UPDATES

Charge 3 - Add definition "Verifiable data" which is already used in the Surgical Services standards. Department can draft language.

- Updated within Section 2(l)(uu) of the draft updated standards

Charge 6 - Consider any other technical changes from the Department, e.g., updates or modifications consistent with other CON review standards and the Michigan Public Health Code.



Limited Access Areas

Properties

Use the selector abov
layers in the map.

Information

Symbology

Limited Access Areas

Bed Need

- > 60 To 100
- > 40 To 60
- > 20 To 40
- 10 To 20

Appearance

Blending

Normal

Transparency

25%

25%

Exhibit E

(New Business Item 10.A.)
PRELIMINARY SITE PLAN: Applicant William Beaumont Hospital proposed to develop a two phased medical facility: a 100,000 SF ambulatory building as Phase 1 and a 225,000 SF hospital building as the Phase 2 , located on undeveloped property tax parcel P 04-22-200-004 along the east side of Lapeer Road (M-24), south of Market Street and north of Elm Park Subdivision.

Commissioner Curtis moved, Commissioner Nold seconded, that the Planning Commission recommend to the Township Board approval of the Preliminary PUD for Beaumont Medical Campus; Parcel #04-22-200-004 located on Lapeer Road; currently zoned C-2, General Commercial; Applicant: William Beaumont Hospital. This recommendation of approval is based upon the finding that the proposed PUD meets the eligibility requirements of Section 14.2. Further, this recommendation of approval is contingent upon the following:

1. Any unresolved items contained within the Township Planner's review, dated December 5, 2019;
2. Any additional unresolved contained within the Township Engineer's review, dated December 3, 2019;
3. Any additional unresolved items contained within the Fire Chief's review, dated December 2, 2019;
4. Requesting that the applicant consider a better screening fence other than wood on the south side of the property, and enhance the water feature for the front detention pond shown on the landscape plan.

Ayes: Knauf, Nold, Spisz, Berger, Curtis, Hunwick, Young
Nays: None
Absent: None
Motion Carried

Chairperson Young called for a 3 minutes recess at 8:55 p.m.

The purpose of this hearing is to receive public comments on proposed amendments to Zoning Ordinance 67A, regarding Article 3 Schedule of Use Regulations, Section 5.O. I-1, Light Industrial.
It was discovered that the Ordinance does not provide for the Automobile Service Station use in the I-1 or I-2 districts. This district is compatible with this type of use and site necessary, and the use to be appropriate to support other businesses that exist in these Township districts. To provide for this use in the district and still require strict oversight, the ORSC is proposing the use as a Special Land Use, requiring Planning Commission and Township Board approval of any proposed site plan.

Commissioner Berger moved, Commissioner Nold seconded, to open the Public Hearing at 8:59 p.m.

Ayes: 6 Nays: 1 Absent: 0 Motion Carried

Hearing no public comments, Commissioner Berger moved, Commissioner Nold seconded, to close the Public Hearing at 8:59 p.m.

Ayes: 6 Nays: 1 Absent: 0 Motion Carried

Commissioner Curtis moved, Commissioner Nold seconded that based upon the draft zoning ordinance text dated November 14, 2019, received from the Township Planner and reflected in the minutes of this

Exhibit F

M-24 Water Main and Sewer Projects				
Sanitary Sewer	**Unit**	**Unit Price**	**Quantity**	**Cost**
Remove less than 24"	Ft.	$8.57	30	$257.10
Erosion Control, Sediment Trap	Ea.	$219.25	20	$4,385.00
Sewer Bulkhead 15"	Ea.	$185.90	10	$1,859.00
Drain Structure, Tap, 18"	Ea.	$887.26	1	$887.26
Conc. Pipe, 18" Tr. Detail B1	Ft.	$262.19	7065	$1,852,372.35
Structure Add depth of 48" Dia. 8'-15'	Ft.	$0.01	106	$1.06
Structure Add depth of 48" Dia. >15'	Ft.	$0.01	21	$0.21
Structure Add depth of 72" Dia. 8'-15'	Ft.	$0.01	7	$0.07
Structure Add depth of 72" Dia. >15'	Ft.	$0.01	9	$0.09
Structure Cover Type Q	Ea.	$423.69	20	$8,473.80
Structure 48" Dia.	Ea.	$11,167.90	19	$212,190.10
Structure 72" Dia.	Ea.	$24,180.42	1	$24,180.42
			Total:	**$2,104,606.46**
Water Main	**Unit**	**Unit Price**	**Quantity**	**Cost**
Fire Hydrant	Ea.	$7,516.41	4	$30,065.64
Gate Valve 12"	Ea.	$4,745.90	4	$18,983.60
Water Main DI 6" Tr. Detail G	Ft.	$120.44	20	$2,408.80
Water Main DI 12" Tr. Detail G	Ft.	$185.33	2060	$381,779.80
Gate Well 60" Dia.	Ea.	$4,039.51	4	$16,158.04
Flowable Fill, Non Structural	Cyd.	$255.14	4	$1,020.56
			Total:	**$450,416.44**
			Total:	$2,553,721.60
		Estimated Cost:		$2,727,886.26
			Difference:	$174,164.66
				6.82% of
				$2,553,721.60

Exhibit G

Population and Households

oxford TWP. (excluding Oxford village)

Population and Households	Census 2020	Census 2010	Change 2010-2020	Pct Change 2010-2020	SEMCOG Jul 2021	SEMCOG 2045
Total Population	18,927	17,090	1,837	10.7%	18,995	19,449
Group Quarters Population	36	119	-83	-69.7%	36	69
Household Population	18,891	16,971	1,920	11.3%	18,959	19,380
Housing Units	7,166	6,467	699	10.8%	7,210	-
Households (Occupied Units)	6,890	6,063	827	13.6%	6,933	7,857
Residential Vacancy Rate	3.9%	6.2%	-2.4%	-	3.8%	-
Average Household Size	2.74	2.80	-0.06	-	2.73	2.47

Source: U.S. Census Bureau and SEMCOG 2045 Regional Development Forecast

Components of Population Change

Components of Population Change	2000-2005 Avg.	2006-2010 Avg.	2011-2018 Avg.
Natural Increase (Births - Deaths)	84	23	7
Births	164	103	126
Deaths	80	80	119
Net Migration (Movement In - Movement Out)	439	375	84
Population Change (Natural Increase + Net Migration)	523	398	91

Source: Michigan Department of Community Health Vital Statistics, U.S. Census Bureau, and SEMCOG

Population and Households

oxford village

Population and Households	Census 2020	Census 2010	Change 2010-2020	Pct Change 2010-2020	SEMCOG Jul 2021	SEMCOG 2045
Total Population	3,492	3,436	56	1.6%	3,538	2,890
Group Quarters Population	34	110	-76	-69.1%	34	0
Household Population	3,458	3,326	132	4.0%	3,504	2,890
Housing Units	1,522	1,468	54	3.7%	1,524	-
Households (Occupied Units)	1,447	1,335	112	8.4%	1,474	1,275
Residential Vacancy Rate	4.9%	9.1%	-4.1%	-	3.3%	-
Average Household Size	2.39	2.49	-0.10	-	2.38	2.27

Source: U.S. Census Bureau and SEMCOG 2045 Regional Development Forecast

Components of Population Change

Components of Population Change	2000-2005 Avg.	2006-2010 Avg.	2011-2018 Avg.
Natural Increase (Births - Deaths)	163	104	54
Births	218	168	90
Deaths	55	64	36
Net Migration (Movement In - Movement Out)	-149	-139	-113
Population Change (Natural Increase + Net Migration)	14	-35	-59

Source: Michigan Department of Community Health Vital Statistics, U.S. Census Bureau, and SEMCOG

Exhibit H

Population and Households

Orion TWP. (excluding Lake Orion)

Population and Households	Census 2020	Census 2010	Change 2010-2020	Pct Change 2010-2020	SEMCOG Jul 2021	SEMCOG 2045
Total Population	35,330	32,421	2,909	9.0%	35,541	37,032
Group Quarters Population	121	140	-19	-13.6%	121	212
Household Population	35,209	32,281	2,928	9.1%	35,420	36,820
Housing Units	13,885	12,515	1,370	10.9%	14,018	-
Households (Occupied Units)	13,219	11,673	1,546	13.2%	13,361	14,652
Residential Vacancy Rate	4.8%	6.7%	-1.9%	-	4.7%	-
Average Household Size	2.66	2.77	-0.10	-	2.65	2.51

Source: U.S. Census Bureau and SEMCOG 2045 Regional Development Forecast

Components of Population Change

Components of Population Change	2000-2005 Avg.	2006-2010 Avg.	2011-2018 Avg.
Natural Increase (Births - Deaths)	132	50	94
Births	275	172	260
Deaths	143	122	166
Net Migration (Movement In - Movement Out)	78	75	349
Population Change (Natural Increase + Net Migration)	210	125	443

Source: Michigan Department of Community Health Vital Statistics, U.S. Census Bureau, and SEMCOG

Population and Households

village of Lake Orion

Population and Households	Census 2020	Census 2010	Change 2010-2020	Pct Change 2010-2020	SEMCOG Jul 2021	SEMCOG 2045
Total Population	2,876	2,973	-97	-3.3%	2,905	3,295
Group Quarters Population	96	118	-22	-18.6%	105	155
Household Population	2,780	2,855	-75	-2.6%	2,800	3,140
Housing Units	1,454	1,483	-29	-2.0%	1,455	-
Households (Occupied Units)	1,295	1,304	-9	-0.7%	1,308	1,370
Residential Vacancy Rate	10.9%	12.1%	-1.1%	-	10.1%	-
Average Household Size	2.15	2.19	-0.04	-	2.14	2.29

Source: U.S. Census Bureau and SEMCOG 2045 Regional Development Forecast

Components of Population Change

Components of Population Change	2000-2005 Avg.	2006-2010 Avg.	2011-2018 Avg.
Natural Increase (Births - Deaths)	230	147	47
Births	317	230	112
Deaths	87	83	65
Net Migration (Movement In - Movement Out)	-241	-85	-58
Population Change (Natural Increase + Net Migration)	-11	62	-11

Source: Michigan Department of Community Health Vital Statistics, U.S. Census Bureau, and SEMCOG

Population and Households Braudon TWP. (excluding Ortonville)

Population and Households	Census 2020	Census 2010	Change 2010-2020	Pct Change 2010-2020	SEMCOG Jul 2021	SEMCOG 2045
Total Population	14,008	13,733	275	2.0%	14,042	14,811
Group Quarters Population	109	97	12	12.4%	109	102
Household Population	13,899	13,636	263	1.9%	13,933	14,709
Housing Units	5,402	5,150	252	4.9%	5,426	-
Households (Occupied Units)	5,145	4,799	346	7.2%	5,190	5,822
Residential Vacancy Rate	4.8%	6.8%	-2.1%	-	4.3%	-
Average Household Size	2.70	2.84	-0.14	-	2.68	2.53

Source: U.S. Census Bureau and SEMCOG 2045 Regional Development Forecast

Components of Population Change

Components of Population Change	2000-2005 Avg.	2006-2010 Avg.	2011-2018 Avg.
Natural Increase (Births - Deaths)	35	2	21
Births	92	55	95
Deaths	57	53	74
Net Migration (Movement In - Movement Out)	79	-15	45
Population Change (Natural Increase + Net Migration)	114	-13	66

Source: Michigan Department of Community Health Vital Statistics, U.S. Census Bureau, and SEMCOG

Population and Households

ortonville (in Brandon TWP.)

Population and Households	Census 2020	Census 2010	Change 2010-2020	Pct Change 2010-2020	SEMCOG Jul 2021	SEMCOG 2045
Total Population	1,376	1,442	-66	-4.6%	1,367	1,064
Group Quarters Population	29	32	-3	-9.4%	29	30
Household Population	1,347	1,410	-63	-4.5%	1,338	1,034
Housing Units	571	574	-3	-0.5%	571	-
Households (Occupied Units)	529	511	18	3.5%	531	457
Residential Vacancy Rate	7.4%	11.0%	-3.6%	-	7.0%	-
Average Household Size	2.55	2.76	-0.21	-	2.52	2.26

Source: U.S. Census Bureau and SEMCOG 2045 Regional Development Forecast

Components of Population Change

Components of Population Change	2000-2005 Avg.	2006-2010 Avg.	2011-2018 Avg.
Natural Increase (Births - Deaths)	68	43	20
Births	93	62	44
Deaths	25	19	24
Net Migration (Movement In - Movement Out)	-66	-63	-35
Population Change (Natural Increase + Net Migration)	2	-20	-15

Source: Michigan Department of Community Health Vital Statistics, U.S. Census Bureau, and SEMCOG

Population and Households

Addison TWP. (excluding Leonard village)

Population and Households	Census 2020	Census 2010	Change 2010-2020	Pct Change 2010-2020	SEMCOG Jul 2021	SEMCOG 2045
Total Population	5,879	5,948	-69	-1.2%	5,864	6,008
Group Quarters Population	67	69	-2	-2.9%	67	74
Household Population	5,812	5,879	-67	-1.1%	5,797	5,934
Housing Units	2,336	2,382	-46	-1.9%	2,350	-
Households (Occupied Units)	2,187	2,161	26	1.2%	2,188	2,416
Residential Vacancy Rate	6.4%	9.3%	-2.9%	-	6.9%	-
Average Household Size	2.66	2.72	-0.06	-	2.65	2.46

Source: U.S. Census Bureau and SEMCOG 2045 Regional Development Forecast

Components of Population Change

Components of Population Change	2000-2005 Avg.	2006-2010 Avg.	2011-2018 Avg.
Natural Increase (Births - Deaths)	9	1	-8
Births	35	17	25
Deaths	26	16	33
Net Migration (Movement In - Movement Out)	46	-88	24
Population Change (Natural Increase + Net Migration)	55	-87	16

Source: Michigan Department of Community Health Vital Statistics, U.S. Census Bureau, and SEMCOG

Population and Households

village of Leonard (in Addison TWP.)

Population and Households	Census 2020	Census 2010	Change 2010-2020	Pct Change 2010-2020	SEMCOG Jul 2021	SEMCOG 2045
Total Population	377	403	-26	-6.5%	378	348
Group Quarters Population	0	0	0	-	0	0
Household Population	377	403	-26	-6.5%	378	348
Housing Units	158	162	-4	-2.5%	160	-
Households (Occupied Units)	142	153	-11	-7.2%	142	161
Residential Vacancy Rate	10.1%	5.6%	4.6%	-	11.3%	-
Average Household Size	2.65	2.63	0.02	-	2.66	2.16

Source: U.S. Census Bureau and SEMCOG 2045 Regional Development Forecast

Components of Population Change

Components of Population Change	2000-2005 Avg.	2006-2010 Avg.	2011-2018 Avg.
Natural Increase (Births - Deaths)	20	15	5
Births	35	30	22
Deaths	15	15	17
Net Migration (Movement In - Movement Out)	-22	1	-10
Population Change (Natural Increase + Net Migration)	-2	16	-5

Source: Michigan Department of Community Health Vital Statistics, U.S. Census Bureau, and SEMCOG

Census: County up 300 residents in 10 years

Imlay City, Lapeer both experienced nearly 2% growth

AUGUST 21, 2021

BY JEFF HOGAN 810-452-2640 • JHOGAN@MIHOMEPAPER.COM

LAPEER COUNTY — The U.S. Census Bureau on Aug. 12 released additional 2020 census results that showed Lapeer County's population remained virtually unchanged from what it was in 2010 — the last time a national headcount was conducted.

The most recent census data reported Lapeer County's current population is 88,619 — up 300 people from 88,319 in 2010.

Michigan's population increased just shy of 2%. The state has 10,077,331 people in 2020, up from the 9,883,640 people who lived in the state a decade prior.

While the overall Lapeer County population hardly changed in 10 years, where people call home in the county did. By percentage, southern Lapeer County communities saw the largest population increase — ;h there were exceptions. The Village of North Branch saw a 6.1% population increase — from 1,033

North Branch Village President Kelly Martin is pleased with the population growth in the community and believes it reflects the strength of the North Branch Area Schools district that draws students from seven townships and three counties. "The school district is probably the biggest economic engine in the village. It (population growth) speaks well for the schools and the great community we have here," said Martin.

There are 24 fewer people in Clifford (300) than there were in 2010 (324). Population in the Village of Columbiaville declined from 787 in 2010 to 702 in 2020, a decrease of 85 residents.

The 2020 Census represents where people were living as of April 1, 2020, in Lapeer County and across the country.

The 2020 data shows Lapeer County's two cities — Imlay City and Lapeer — grew their population by approximately 2%. Imlay City's population increased from 3,597 in 2010 to 3,703 in 2020, an additional 106 residents. In Lapeer, the population increased by 182 residents from 8,841 in 2010 to 9,023 in 2020.

"That is good for us going forward," said Lapeer City Manager Dale Kerbyson. He credits the growth data reflected by the census to a robust Lapeer citizen response to the 2020 Census surveys. "We work hard to have an accurate count so that Lapeer will receive its fair share of federal revenue sharing. Each person included in our census has a revenue-sharing value to the city of approximately $1,800. That is a federal statistic."

Said Kerbyson, "We sent out Christmas cards with a note reminding people to make it a Christmas in July for the city of Lapeer to fill out your census. We also did direct mailers to people who were less likely to

- **Village of Almont:** 2,846, up 6.43%, from 2,674 in 2010;
- **Almont Twp.:** 6,961, up 5.74%, from 6,583;
- **Arcadia Twp.:** 3,148, up 1.12%, from 3,113;
- **Attica Twp.:** 4,706, down 1.03%, from 4,755;
- **Burlington Twp.:** 1,414, down 4.33%, from 1,478;
- **Burnside Twp.:** 1,904, up 2.15%, from 1,864;
- **Village of Clifford:** 300, down

- **Village of Columbiaville:** 702, down 10.80%, from 787;
- **Deerfield Twp.:** 5,764, up 1.21%, from 5,695;
- **Village of Dryden:** 1,023, up 7.57%, from 951;
- **Dryden Twp.:** 4,799, up 0.65%, from 4,768;
- **Elba Twp.:** 5,235, down 0.29%, from 5,250;
- **Hadley Twp.:** 4,547, up 0.42%, from 4,528;
- **Imlay City:** 3,703, up 2.95%, from

- **Imlay Twp.:** 3,115, down 0.42%,

from 3,128;

- **Lapeer:** 9,023, up 2.06%, from 8.841;

- **Lapeer Twp.:** 4,956, down 1.98%,

from 5,056;

- **Marathon Twp.:** 4,467, down 2.21%,

from 4,568;

- **Mayfield Twp.:** 7,988, up 0.41%,

from 7,955;

- **Village of Metamora:** 594, up 5.13%,

from 563;

- **Metamora Twp.:** 4,368, up 2.80%,

from 4,249;

Exhibit I

GM announces $4 billion investment in Orion Assembly plant

By mmkelley (https://lakeorionreview.com/author/mmkelley/) on January 26, 2022 · No Comment (https://lakeorionreview.com/gm-announces-4-billion-investment-in-orion-assembly-plant/#respond)

By Jim Newell

Review Editor

General Motors Co. announced on Tuesday that the auto manufacturer will invest more that $7 billion in four Michigan manufacturing sites, including $4 billion in the GM Orion plant.

Orion Assembly will become the second U.S. plant building Chevrolet Silverado EV and electric GMC Sierra and GM will invest $4 billion to convert the plant for the production of full-size EV pickups.

The investment is part of GM's effort to lead in the electric vehicle (EV) industry. By the end of 2025, GM wants to have more than 1 million units of electric vehicle capacity in North America, according to the company.

"Today we are taking the next step in our continuous work to establish GM's EV leadership by making investments in our vertically integrated battery production in the U.S., and our North American EV production capacity," said Mary Barra, GM Chair and CEO. "We are building on the positive consumer response and reservations for our recent EV launches and debuts, including GMC HUMMER EV, Cadillac LYRIQ, Chevrolet Equinox EV and Chevrolet Silverado EV. Our plan creates the broadest EV portfolio of any automaker and further solidifies our path toward U.S. EV leadership by mid-decade."

The investment is expected to create 4,000 new jobs and retain 1,000 other jobs and significantly increasing battery cell and electric truck manufacturing capacity, GM stated.

In addition to the conversion at Orion Assembly, GM will construct a new Ultium Cells battery cell plant in Lansing.

"GM's $7 billion investment in Michigan—the largest in their history—will create and retain 5,000 good-paying jobs and enable us to build on our legacy as the place that put the world on wheels," said Governor Gretchen Whitmer. "When it comes to investing in Michigan, GM and I have the same philosophy: 'Everybody In.' Michigan's future is bright, and I will continue working with anyone to make transformational investments in our economy, create good-paying jobs, and empower working families."

GM is also investing in its two Lansing-area vehicle assembly plants for near-term product enhancements.

"The Orion and Ultium Cells Lansing investments announced today will support an increase in total full-size electric truck production capacity to 600,000 trucks when both Factory ZERO and Orion facilities are fully ramped," a GM press release stated.

Specific points about the investment in the Orion Assembly plant at 4555 Giddings Road:

• Converting the Orion Assembly plant to produce electric trucks using the GM-developed Ultium Platform will give the company the flexibility to build vehicles for every customer and segment.

• This investment is expected to create more than 2,350 new jobs at Orion and retain approximately 1,000 current jobs when the plant is fully operational.

• GM estimates the new jobs at Orion will be filled by a combination of GM transferees and new hires. Electric truck production, including the Chevrolet Silverado EV and electric GMC Sierra, will begin at Orion in 2024.

• The Orion investment will drive significant facility and capacity expansion at the site, including new body and paint shops and new general assembly and battery pack assembly areas. Production of the Chevrolet Bolt EV and EUV will continue during the plant's conversion. Site work begins immediately, according to GM.

"We're thrilled that the partnership with General Motors, Michigan, Oakland County and Orion Township is still thriving and geared toward the environmentally sustainable vehicles of the future," said Oakland County Executive David Coulter. "This investment reinforces the confidence General Motors has in the Orion plant, the abundance of a skilled workforce in southeast Michigan and the appeal of Oakland County as an attractive place to locate advanced technology manufacturing."

"Through site conversion and new facilities, GM is uniquely positioned to stay ahead of the growing demand for electric vehicles while balancing the need to aggressively compete to win in today's market with strong products," GM stated.

In addition to the EV-related investments in Michigan, GM is investing more than $510 million in its two Lansing-area vehicle assembly plants to upgrade their production capabilities for near-term products:

• Lansing Delta Township Assembly — Investment is for production of the next-generation Chevrolet Traverse and Buick Enclave.

• Lansing Grand River Assembly — Investment is for plant upgrades.

"These important investments would not have been possible without the strong support from the Governor, the Michigan Legislature, Orion Township, the City of Lansing, Delta Township as well as our collaboration with the UAW and LG Energy Solution," added Barra. "These investments also create opportunities in Michigan for us to bring our employees along on our transition to an all-electric future."

GM announces $4 billion investment in Orion Assembly plant added by **mmkelley (https://lakeorionreview.com/author/mmkelley/)** *on January 26, 2022*

View all posts by mmkelley →
(https://lakeorionreview.com/author/mmkelley/)

Exhibit J

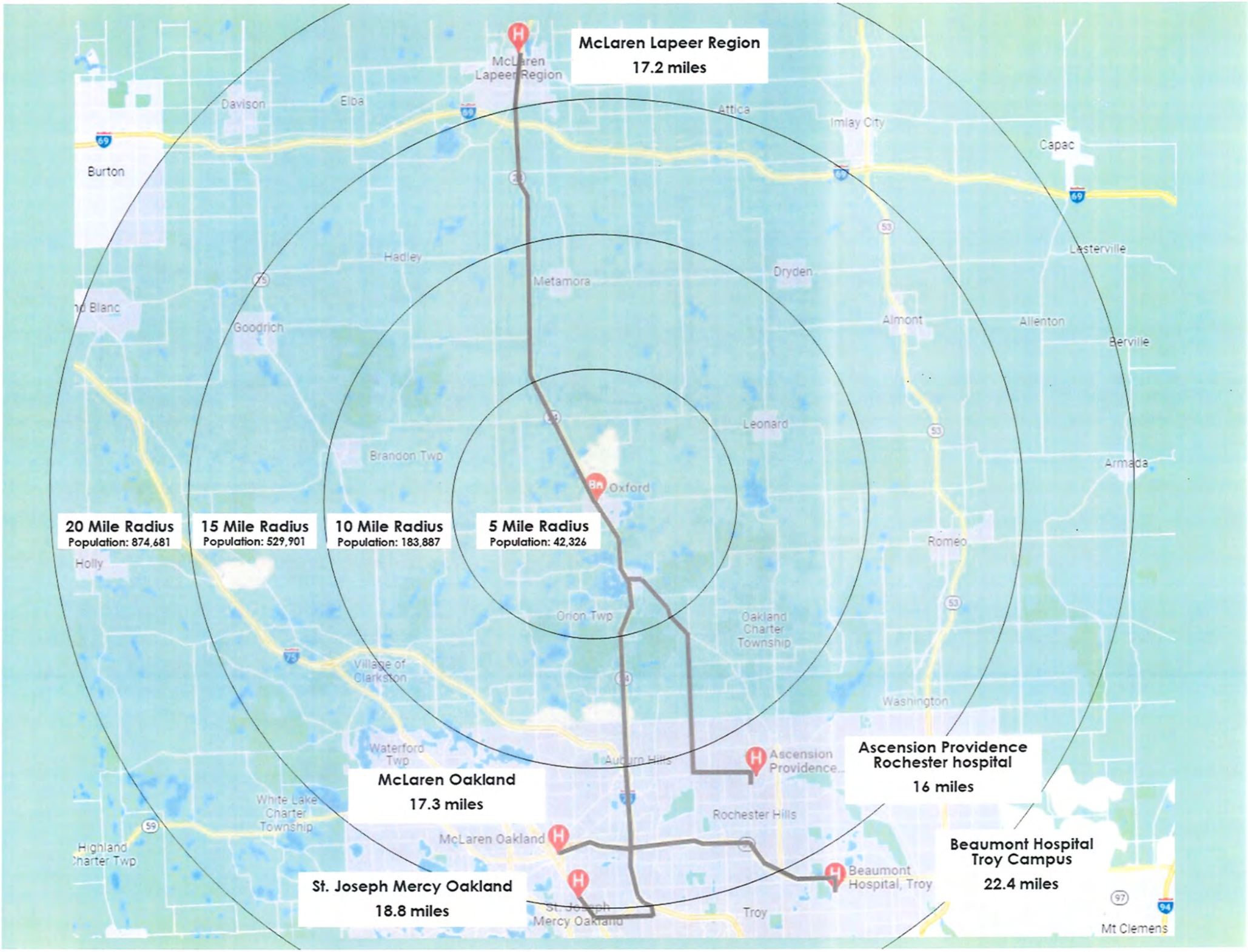
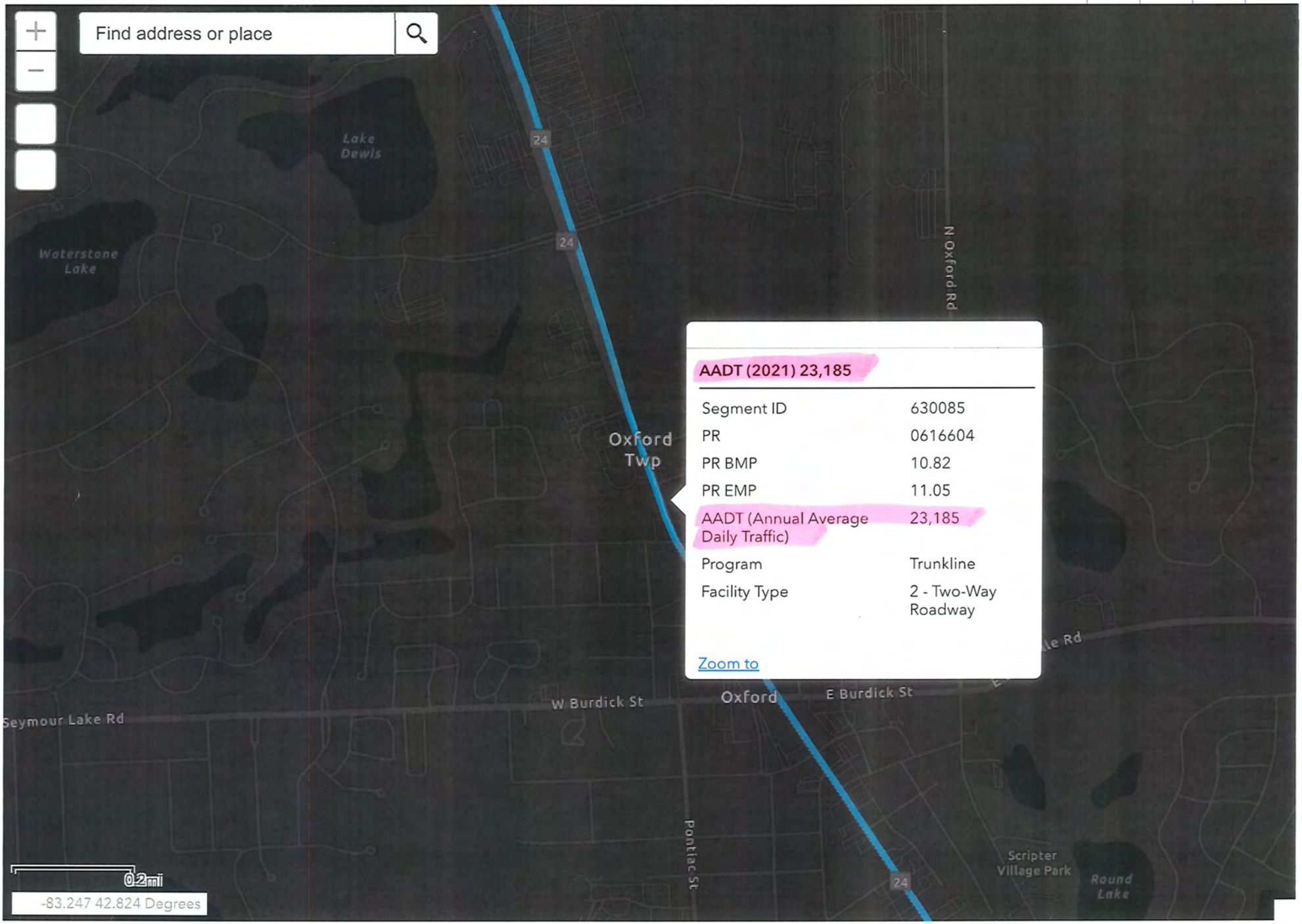
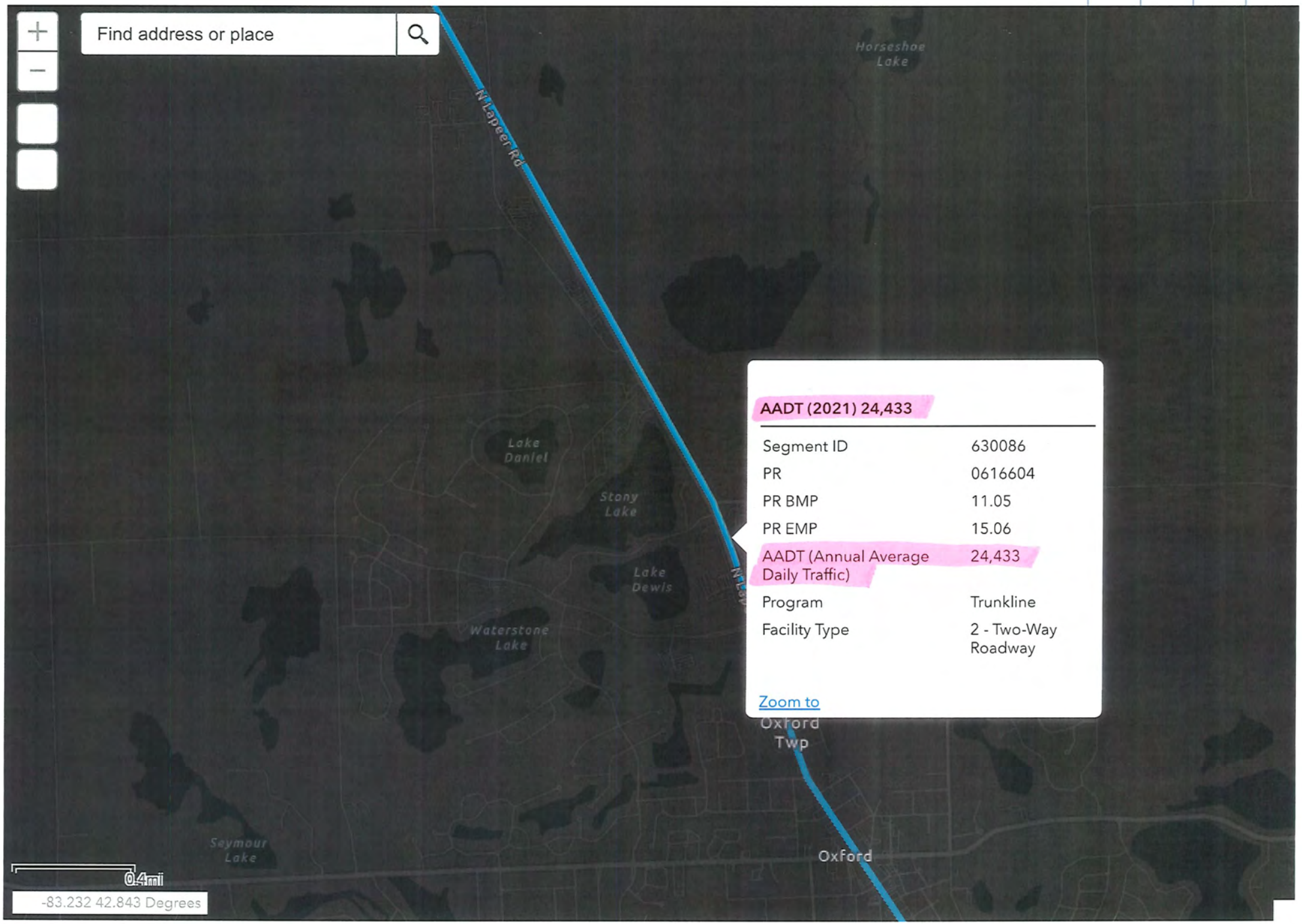

McLaren Lapeer Region
17.2 miles
McLaren Lapeer Region
Davison
Elba
Attica
Imlay City
Capac
Burton
Lasterville
Hadley
Metamora
Dryden
Goodrich
Almont
Allenton
Berville
Leonard
Brandon Twp
Armada
Oxford
20 Mile Radius
Population: 874,681
15 Mile Radius
Population: 529,901
10 Mile Radius
Population: 183,887
5 Mile Radius
Population: 42,326
Romeo
Holly
Orion Twp
Oakland Charter Township
Village of Clarkston
Washington
Waterford Twp
Auburn Hills
Ascension Providence...
Ascension Providence Rochester hospital
16 miles
McLaren Oakland
17.3 miles
White Lake Charter Township
Rochester Hills
McLaren Oakland
Highland Charter Twp
Beaumont Hospital, Troy
Beaumont Hospital Troy Campus
22.4 miles
St. Joseph Mercy Oakland
18.8 miles
St. Joseph Mercy Oakland
Troy
Mt Clemens

Exhibit K

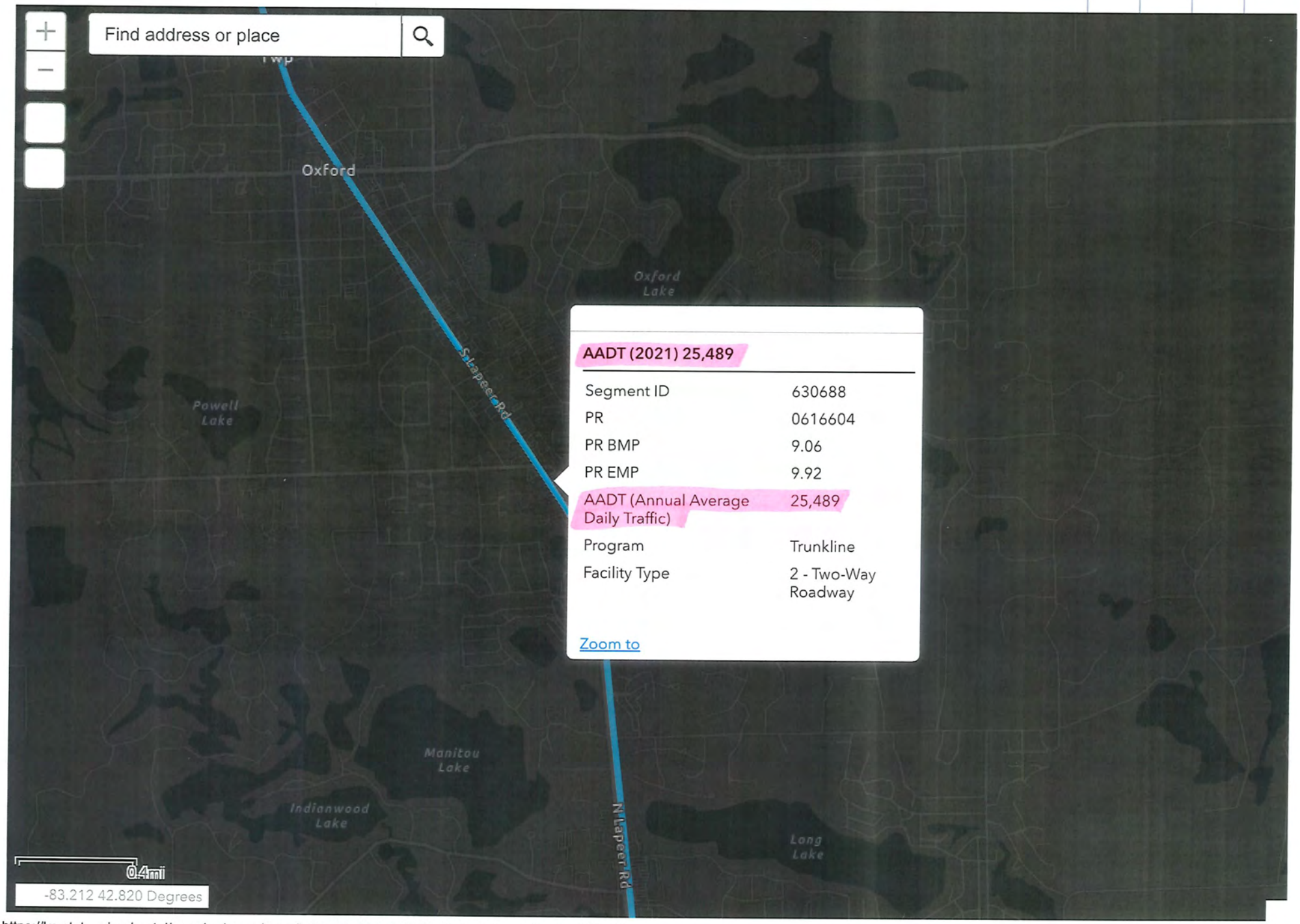
Traffic AADT Map



Traffic AADT Map



Traffic AADT Map



Traffic AADT Map

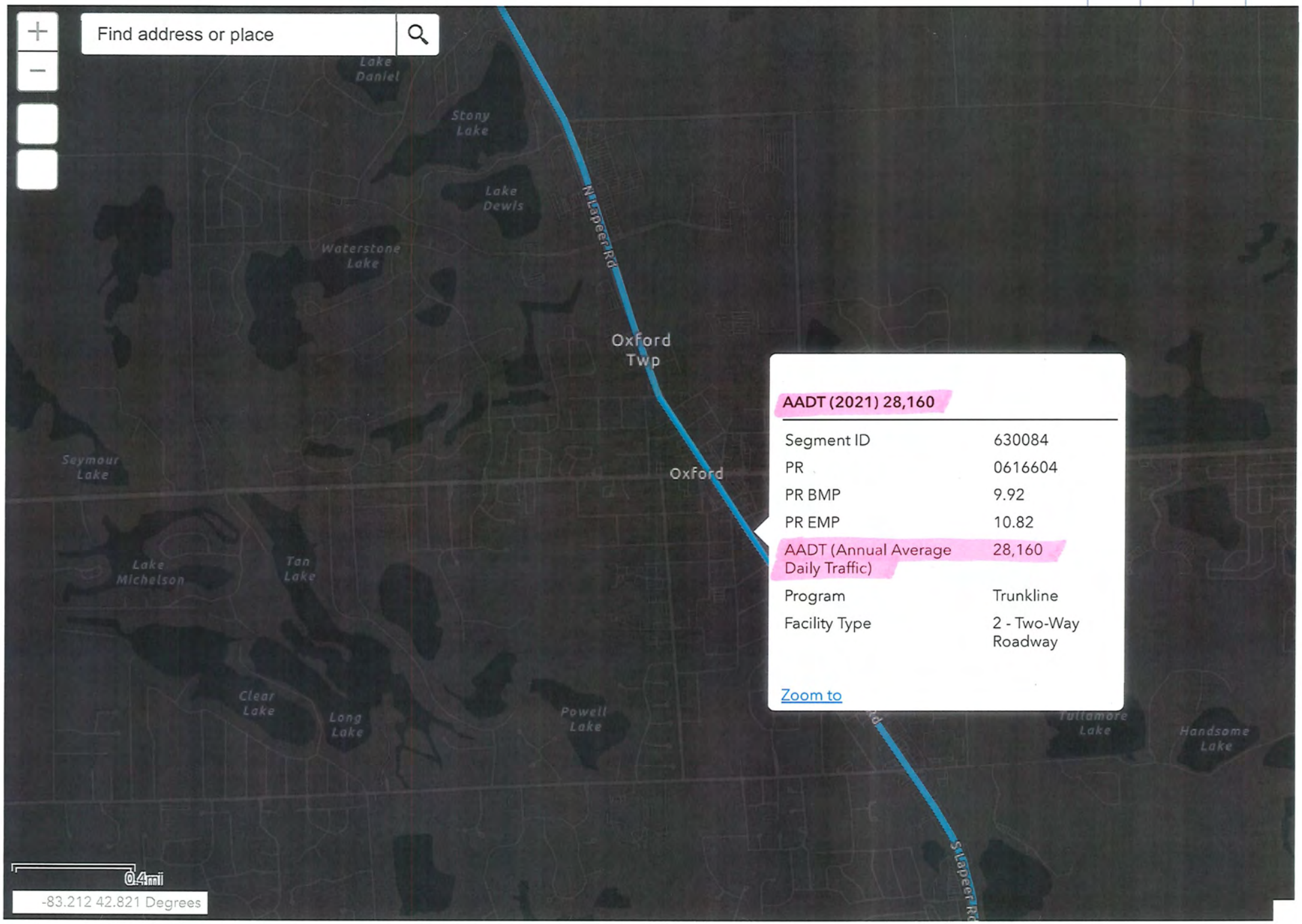
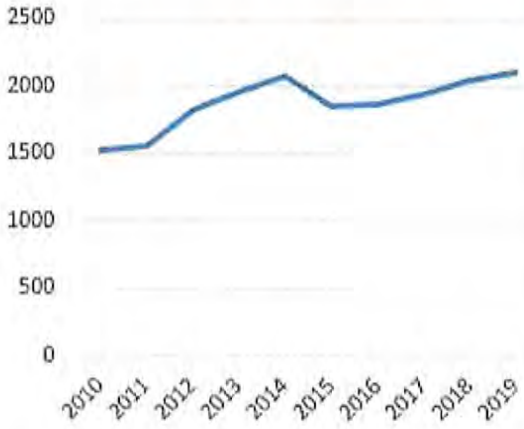


Exhibit L

medical emergency or fire. Helping people and their families through an incident is often as important as the treatment an injured person receives. We treat everyone involved the way we'd want our families treated.

We are ALWAYS looking for healthy men & women to join our team, click here if you are interested in helping your community!

Calls to date: 1688 (call volume updated: 10/05/22)



Total Calls 2021: 2220
Total Calls 2020: 2022
Total Calls 2019: 2107
Total Calls 2018: 2048
Total Calls 2017: 1937
Total Calls 2016: 1871
Total Calls 2015: 1850
Total Calls 2014: 2072
Total Calls 2013: 1955
Total Calls 2012: 1825
Total Calls 2011: 1550
Total Calls 2010: 1527

1565 W. Drahner
Oxford MI 48371
Phone: (248) 969-9483
Fax: (248) 969-9489
Burn Permit: (248) 628-3870
Email:
oxfd@oxfordfiredept.com

Oxford Fire Department Facebook

Thank you to Johnston Photography for providing the

Exhibit M

C.J. Carnacchio

From: Lindsay Young <lyoung@oxfordfiredept.com>
Sent: Friday, January 28, 2022 2:11 PM
To: C.J. Carnacchio
Subject: Fire Runs 2021

Here is the information you requested. Please let me know if there is anything else I can provide. Take care.

Medical= 1812
Fire= 408
Total 2220

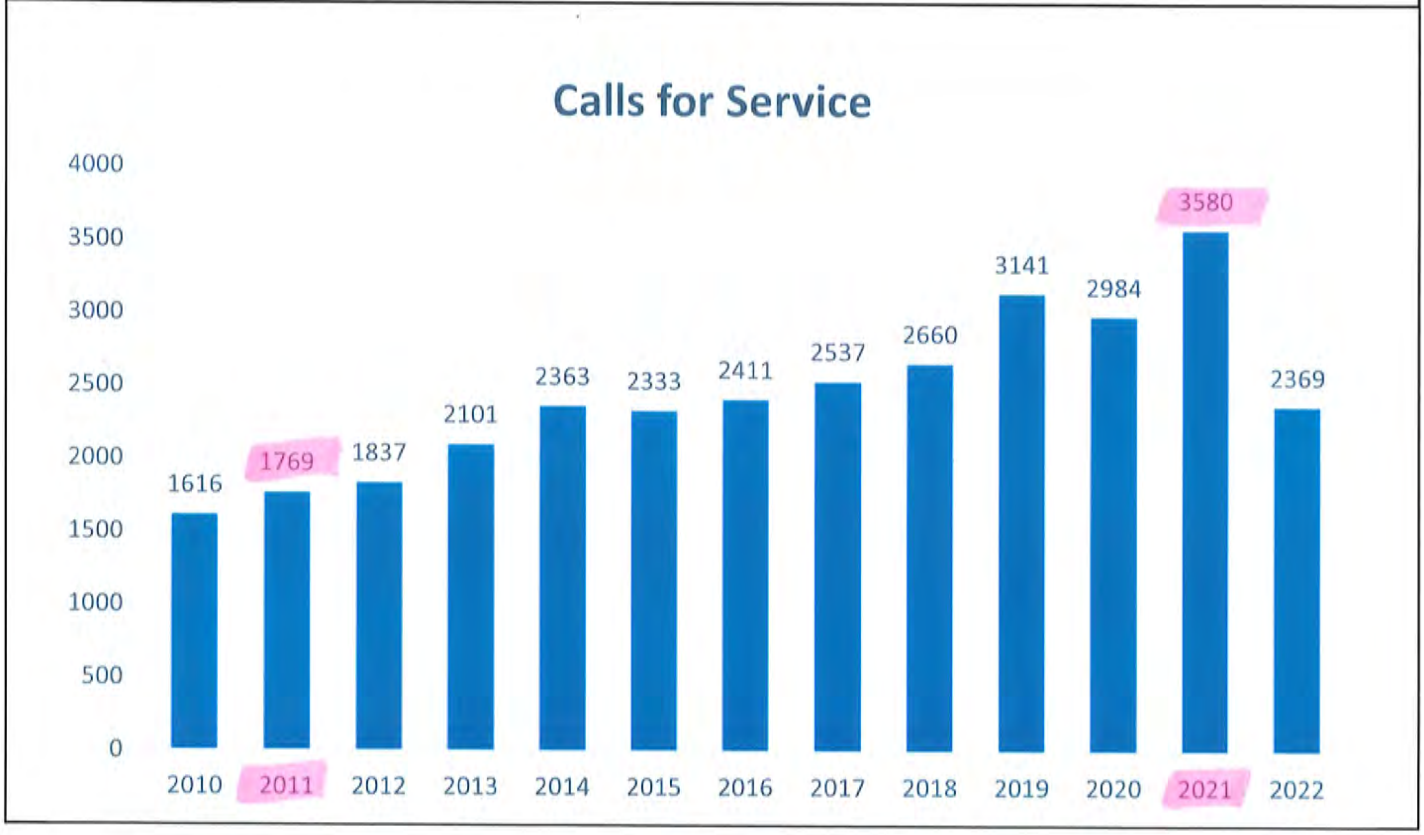
Lindsay Young
Oxford Fire Department
96 North Washington St. | Oxford, MI 48371
Tel: 248 969 9483

oxfordfiredept.com

Exhibit N

- Downed Power Lines
- Community Risk Reduction
- Outdoor Warning Sirens
- Fireworks

Yearly Incident Totals



Orion Township Fire Department

(https://brandontownship.us/)

FIRE ALARM STATISTICS

Back

851 Alarms to date (7/31/2022)

1591 Alarms in 2021

1247 Alarms in 2020

1367 Alarms in 2019

1316 Alarms in 2018

1323 Alarms in 2017

1232 Alarms in 2016

1135 Alarms in 2015

1203 Alarms in 2014

1149 Alarms in 2013

1132 Alarms in 2012

940 Alarms in 2011

980 Alarms in 2010

965 Alarms in 2009

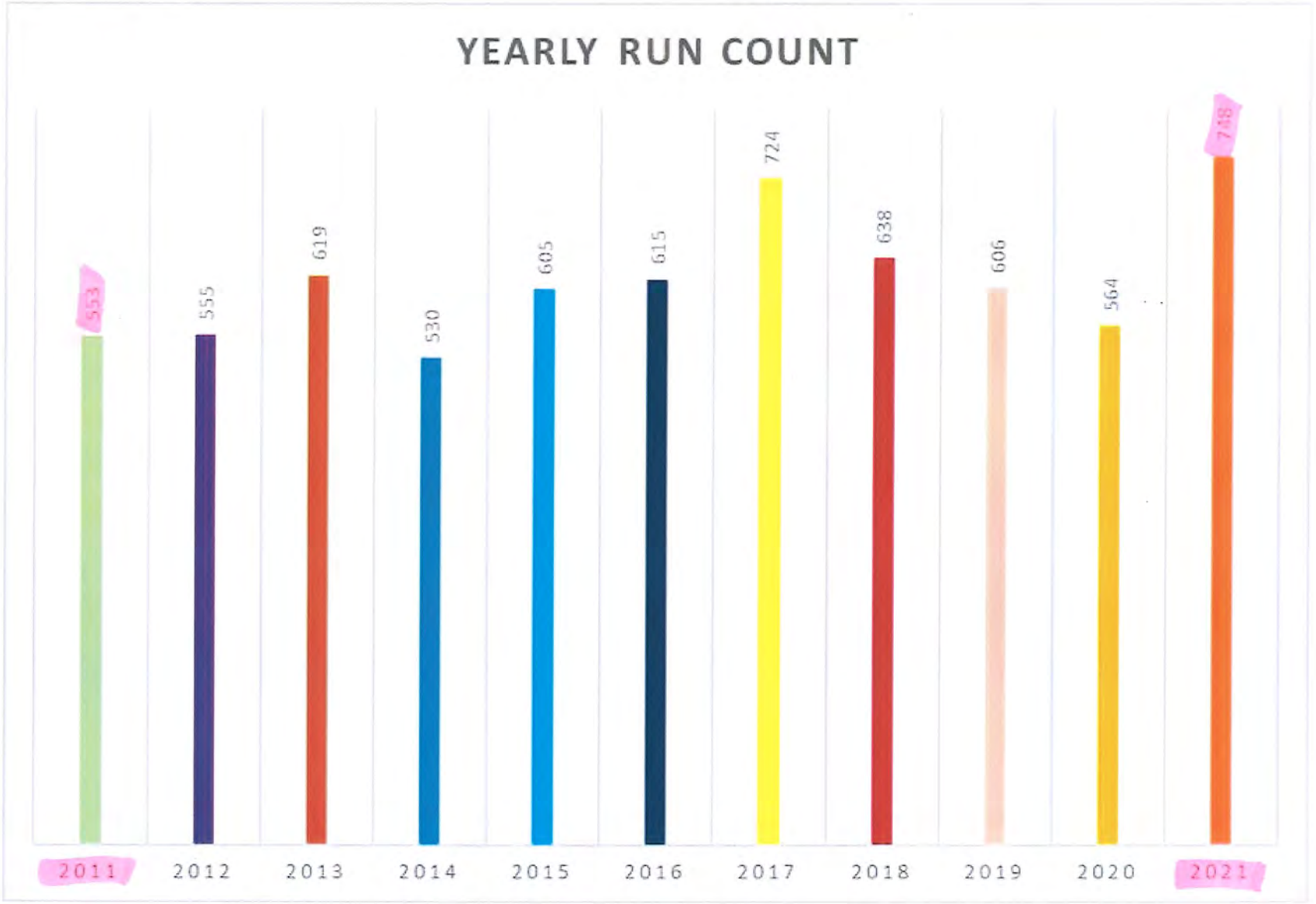
BACK TO HOME (https://brandontownship.us/)

CONTACT

395 Mill Street
P.O. Box 929
Ortonville, MI 48462
(https://www.google.com/maps/place/Charter+Township+of+Brandon/@42.8528718,-83.4447797,20z/data=!4m13!1m7!3m6!1s0x882485151439bcdf:0x4fd01582339d79a!2s395+Mill+St,+Ortonville,+MI+48462!3b1!8m2!3d42.8529621!4d-83.4445544!3m4!1s0x882485151439fadf:0x591c7a9bb864c97!8m2!3d42.852833!4d-83.4444619)

(248) 627-2851

Home
Personnel
Apparatus
Job Opportunities
More
+



From: Robert Daniele
To: MDHHS-ConWebTeam
Subject: Oxford , Michigan CON
Date: Monday, October 17, 2022 4:54:45 PM

To whom it may concern:

We moved to Oxford a little over a year ago. We have seen more people coming up to this area. As this area is growing so does its needs for basic civic and health services. I am writing you in support for a Certificate of Need for this area.

It is my understanding that it was granted in 2018. Since then this area has grown over 40%. The need is greater now than it was 4 years ago.

I would like to briefly share my personal story as it relates to this. On March 27th of 2022, I was home alone on a Sunday night. I began to feel chest pains that would not subside by "just lying down". I called 911 and an ambulance was sent to my house . They arrived in less than 10 minutes. It was quickly determined that I was having a heart attack. I was asked, what hospital I wished to be taken to ,since the 3 in the area were all about the same distance; 20 to 30 minutes! I chose Rochester Hills Ascension. It seemed to take forever! While my pains were getting more severe and moving down to my arm, I was able to glance out the ambulance window and notice I was still in downtown Oxford!

As I finally arrived to emergency in Rochester Hills, the last thing I remember was being rolled through the doors. I was out ! My heart had stopped! I was revived with a defibrillator. When I woke up I was told that I was a lucky man and survived a Widow-Maker. I had 2 stents in me. I thank god for the dedication and professionalism of the entire staff for my recovery. I feel fortunate that it was early on a Sunday night without a lot of people on the road. If it weren't for my timing , I may not have been so lucky.

A few months after I felt the need to meet with that emergency team that saved me. They filled me in on a lot of details I did not know. The important one for you to consider is that from 911 call to delivery to the emergency room: total time it took was 44 minutes. The EMS Driver and First Responder said that as runs go, the time was ok but not ideal. They added ,had it not been for the fact that I was a relatively young man ,63, and in decent health I would not be alive.

There must be several stories like mine in this area. Some without the positive outcome as mine. PLEASE; we need a Hospital in the Oxford-Lake Orion Area!

Sincerely;

Robert Daniele
810-343-4699

From: r_renaud@msn.com
To: MDHHS-ConWebTeam
Subject: Certificate Of Need CON for Hospital in Oxford Township.
Date: Friday, October 7, 2022 9:01:39 AM
Importance: High

To whom it may concern and may help,

We in the Oxford area, an area that has grown enormously, need a local hospital. As the closest ones are over 25-35 minutes away BY AMBULANCE! What if an individual was trying to get their injured to the hospital on their own? 45-70 minutes, maybe more? You know what would happen in those scenarios: Death or more complications to their recovery.

Everyone has seen and knows of the tragedy that happened in our community. We know that if a local hospital could have been available it may have saved the lives of the 4 children and helped with the recovery of the others.

Please approve the CON, Certificate Of Need for a hospital to be centrally located in Oxford. It is just plain common sense when you look at all that has happened and what the area population is currently and is projected.

Many kind regards,

Ron Renaud
2673 East Oakwood road
Oxford, Michigan 48370

Ronald J. Meyer
P.O. Box 107 248-259-6500
Oxford, MI 48371

14 October 2022

Department of Health & Human Services,
C.O.N. Section, South Grand Building
333 S. Grand Avenue, 4th Floor
P.O. Box 30195
Lansing, MI 48909

To whom it may concern:

I am writing this letter with comments for the requested permission to build a satellite William (Wm.) Beaumont Hospital in Oxford Michigan. I received been educated in beginning and advanced level planning training from the Michigan Society of Planning Officials as well as having spent six years on a planning commission. I have also been educated in beginning and advanced level planning training from the Michigan Society of Planning Officials as well as having spent over five years on a board of appeals. My opposition to Beaumont Hospital expanding in Oxford Michigan is not from an uneducated perspective.

I lost my wife to Parkinson's just last January. Diana was sixty-nine and I am seventy-two years of age. Diana also had Parkinson's and due to complications she had to a hospital's emergency rooms multiple times, once by ambulance. I have been taken by ambulance once on 15 June 2017. Based on this one may think that we would be in favor of putting a hospital within five miles from our home. NOT SO! There is more to consider than just our convenience. I and until my wife passed, Diana, have and are strongly against the approval for Beaumont Hospital expanding in Oxford Michigan.

This is being sold as a need for a hospital, when there is not the need. There are four hospitals within a thirty minute drive. This is nothing more than land developers using their political influence with the Republican Party to over develop an area that does not have the proper info structure to handle a hospital. By now, it would be interesting to see how much money has been donated to both the republican and democrat election funds. According to the local newspaper township officials even asked the Lt. Governor to put pressure for the approval. It appears on behalf of the land developers. I lived and saw the poor treatment that happens when too many hospitals are competing with each other. I remember the closing of Maybury Hospital, Brent Hospital, Cheboygan Memorial Hospital, Blain Hospital and many more. That is why the state wisely put safeguards in place to protect the patients. Please keep your standards and **SAY NO!**

At a previous public hearing, the room was stacked with people, including members of the republican lead sheriff's department stating they were in favor of the new hospital. Anyone in that room should have been able to see how stacked the people allowed to speak were

handled. As I wrote earlier this is more about land developers profiting and attempting to buy political favors than a need for another hospital. Having served as a city council member, I found that a company doing a study for a certificate of need, will generally fine the need when the people who want the need are paying that company for the study. All you have to do is look in the flaws in their certificate of need and report that used to create it.

Please consider the following:

First: According to The Leader (our local newspaper) a study was run and it found that there was need for a new hospital to over the areas of Clarkston, Ortonville and Oxford. If that is the case, why is the placement in the far North-West corner of the three areas where it will at least serve all concerned? Logic states if the hospital is to cover the three ZIP codes, it should be placed near the middle, approximately M-15 and I-75, of the area in need, not in the extreme northeast corner, Oxford. Such location is ludicrous and does not even meet the needs shown by the study. Why is the picked location in the north-east corner of the area instead of in the center of the Clarkston, Ortonville and Oxford area of coverage? It will take longer for ambulances to get to the proposed site from parts of Clarkston, than to get to all three hospitals in Pontiac. Oxford is not the best location for a hospital covering meant to serve the area.

Second: The Leader also stated that same study found that there was no hospital within a thirty minute drive. **That is WRONG!** According to all three, Rand-McNally, MapQuest and Google maps, from the farthest south border (Indianwood Road & M-24, aka Lapeer Rd.) of Oxford Twp. north to the Hospital in Lapeer is less than thirty minutes and from the farthest north point (Davison Lake Rd. & M-24, aka Lapeer Rd) of Oxford Twp. to three hospitals in Pontiac, is also less than thirty minutes. I have timed the drive to the farthest of three hospitals in Pontiac and my drive time was about 20 minutes or less. I have also driven to the farthest hospital to the North and my drive time was less than 25 minutes. The study fails to mention that Lapeer Rd. (M24) already is limited to its width and can't be expanded because of the commercial buildings in the downtown only a mile south of the proposed site. **The study is incomplete and flawed!**

There is one exception to the travel times I have given. Quite often M-24 is congested do to trying to put way more traffic than the road should handle safety, there is already major congestion. Then it could take over thirty minutes to get to the proposed new hospital site. However an ambulance south of the congested area can just drive south of the area of major congestion to one of the hospitals in Pontiac and should be able to make the trip in less than 30 minutes. An ambulance north of the congested area can just drive north of the area of major congestion to the hospital in Lapeer and should be able to make the trip in less than 30 minutes. Knowing this, **the study is still flawed**.

Third: Originally, The Leader states that the new hospital will be built on only twenty-five acres and be five stories high plus equipment on the roof. That is higher than the Oxford Township Code allows for property in that zoning. The Oxford Township board of Appeals can't grant a variance to the hospital because the hospital is creating its own hardship by over building and Michigan State law states no board of appeals can grant a variance for a self-created hardship. However The Township has changed some of its codes since you already wisely denied the earlier request. While we don't need the hospital build in Oxford, there are larger land parcels

only across the road (on the west side of I-24 aka Lapeer rd.) and about only about one mile north that would allow a lower height hospital with a larger footprint to handle the 121 beds Wm. Beaumont is requesting to build. There is no room for future growth on only twenty-five acres. If Wm. Beaumont management wanted a hospital, be a good neighbor and to meet current zoning codes, they would have picked property to the north of the current proposed site. There are hundreds possible thousands of undeveloped acres just to the north. I understand business and spending as little as possible, but by doing so, Wm. Beaumont management is creating its own hardship.

Forth: There is no room for growth. When Wm. Beaumont opened it hospital in Troy the residents were told, only 200 beds, now it has expanded to 520 beds. The traffic jams at shift change are a nightmare for those who have no choice but to use the adjoining roads. Although Crooks Rd is similar to I-24, the Troy Beaumont Hospital is less than one mile to M-59 (a major east/west highway) and it takes most of the traffic away from that area. Even knowing M-59 greatly reduces the amount of traffic on the nearby roads, there still are traffic jams that are nightmares to drive through, especially at shift changes. The Oxford site selected for the Wm. Beaumont has no major east west roads. There is only one road that is not partly gravel and it has only one lane in each direction. Portions of that east/west road are limited to 25 miles per hour, with limited vision due to the hilly conditions sharp curves and bike path crossing. The next best roads have portions that are only gravel roads and certainly can't handle the added traffic. Allowing a hospital to be built at this location is a prescription for additional accidents and should be a profit windfall for the new emergency room. A case of Beaumont helping profiting by Beaumont creating the hazards at the peoples expense.

Fifth: M-24, the road that the proposed hospital will be build adjacent to is only a two lane in each direction road that already has major congestion. Even CJ Carnacchio, the then editor, of The Leader has written about how his vehicle was badly damaged and why he avoids driving on M-24 (AKA Lapeer Rd. and N. & S. Washington St.) whenever possible because of the congestion and hazardous conditions. On the 15th of June 2017, my wife and I had our vehicle struck from behind resulting in my having permanent spinal damage and a totaled vehicle. Fortunately my wife sustained no major injuries. At the time of the accident before the ambulance took me, my wife accompanying me, to one of the hospitals in Pontiac, one of the officers on the scene commented about how dangerous the traffic on I-24 is due to the amount of traffic congestion. That accident happened at approximately 2:30 PM, the middle of the afternoon and not rush hour when traffic is like driving through a gauntlet in gridlock conditions. Adding traffic on roads that are not safe before you added the traffic would be an irresponsible act on behalf of the state and the township.

Wm. Beaumont is proposing adding substantial traffic with patients, visitors, and hospital staff, People getting test at the hospital, patient's visitors and trucks bringing supplies. Beaumont seems to recognize the traffic problems that this hospital will add as even Beaumont Hospital expansion team has offered to pay for a traffic light thus allowing the added traffic from the proposed hospital to dump on a road that is already carrying more traffic than is safe. The traffic light will ease Beaumont New location to dup traffic onto the already congested road, and not ease congestion on Lapeer Rd (M-24). The new hospital will bring nearby medical buildings

and the traffic for those buildings. This is not just 121 beds adding 121 more vehicles; it is adding thousands of vehicles every day onto roads that are too congested now. As I said earlier, that is a prescription for increased profits at William Beaumont's proposed emergency room. For the state to allow this would be irresponsible.

The location is wrong for multiple reasons. The current roads are not built to handle the added traffic. The data in the study used as bases for building a new hospital is flawed. We already have plenty of hospitals within reasonable distance serving the area. The Leader stated that you have already denied Wm. Beaumont's request and that Wm. Beaumont was appealing your decision. I implore you to deny Wm. Beaumont's request and appeal again for the safety of the people in Oxford.

I lived and saw the poor treatment that happens when too many hospitals are competing with each other. I remember reading the newspaper articles covering the poor treatment of patients when too many hospitals cover an area and the closing of Mayberry Hospital, Brent Hospital, Cheboygan Memorial Hospital, Blain Hospital and many more. That is why the state wisely put safeguards in place to protect the patients. Approving Wm Beaumont's request would be the state ignoring the very requirements put in place to protect patients.

Ronald J. Meyer

From: Tammy Barber
To: MDHHS-ConWebTeam
Subject: Oxford Hospital
Date: Wednesday, October 12, 2022 8:25:51 PM

To whom this may concern:

We NEED a hospital closer to our community than a 30 minute drive on a good day! Oxford would be a great place to constuct a new hospital. It would provide local jobs and it would allow care close to home. Please consider this request.

Thank you,
Tammy Barber
632 Thornehill Trail
Oxford, MI 48371
989-284-4156

MDHHS-ConWebTeam

From: Eleanora <eldan0508@gmail.com>
Sent: Tuesday, October 18, 2022 9:16 PM
To: MDHHS-ConWebTeam
Subject: Oxford Michigan CON

Hello, I am writing this letter in hope that the county would consider the certificate of need for health services.
My husband and I moved to this area in July 2021. He had suffered a heart attack(widow maker) in March of 2022. He was alone and had to call EMS on his own. I was out of town visiting our son and his family.
The first responder's took wonderful care of him and I am forever grateful for them.

What we didn't realize prior to moving into the area is that there was not a trauma center. Not really thinking that we would need one for awhile , but life does take a different turn from time to time.
I would hope that everyone could get past the politics of this issue and consider the well being of everyone in the community for the young and old that may need the service of a hospital in our area.

Again, I hope you please consider a hospital in the Oxford and Lake Orion area that is desperately needed .
Thank you,
Eleanora Daniele
1409 Glass Lake Cir, Oxford 48371
Sent from my iPad

Trinity Health

Trinity Health Michigan

October 14, 2022

Amy L. McKenzie, MD
Chair, CON Commission
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Public Comment for Hospital Beds Certificate of Need Standards

Dear Chairman McKenzie:

Trinity Health Michigan would like to thank the Certificate of Need Commission for the opportunity to comment on what, if any, changes need to be made to the Certificate of Need Standards for Hospital Beds in 2023.

Trinity Health Michigan supports the current CON Standards for Hospital Beds. Specifically, we support the changes made in 2021 to the Limited Access Area and replacement requirements, as well as the clarifications regarding observation-status patients. We believe the 2021 Hospital Bed Standards Advisory Committee engaged in thoughtful and thorough dialogue of the issues, and that the current Standards now incorporate appropriate, data-driven methodologies that are rooted in the most accurate datasets available.

Trinity Health Michigan believes the current Certificate of Need Standard ensures that Michigan's citizens have appropriate access to affordable, high-quality inpatient care. For this reason, Trinity Health Michigan supports the continued regulation of hospital beds without any further modification to the existing CON Standards.

We appreciate the CON Commission's consideration of our comments.

Sincerely,

Rob Casalou

Rob Casalou
President and CEO
Trinity Health Michigan & SE Regions

THE VILLAGE OF Oxford MICHIGAN

October 17, 2022

Department of Health and Human Services – Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

Dear Commission Members:

I am writing to support the Charter Township of Oxford's request to have the current CON methodology re-examined.

According to the 2020 U.S. Census, Oxford Township and the neighboring communities of Orion, Brandon, Addison, and Metamora townships are home to more than 87,000 residents. As citizens and businesses continue to flock to Oakland County's northern communities, populations in these municipalities are growing at a rapid pace. As such, we need to ensure that these communities can provide residents and workers with access to life-saving medical care. Currently, the five closest hospitals are 16 to 22.4 miles away.

When it comes to healthcare access in communities, I firmly believe decisions should be made at the local level, not the state level. Local governments, working in close partnership with healthcare systems, are the best ones to determine what their residents and communities need when it comes to something as important as hospital beds. Local officials who live and work in underserved areas are better equipped to identify any existing flaws in the current CON methodology because they are closer to the situation than officials in Lansing.

Local officials know that M-24 is the most direct route to four of the five closest hospitals and that at certain times of day, gridlocked traffic is the norm. They know that each medical call can take a fire department's ambulance and crew out of the community for up to two hours. While numbers don't lie, the numbers being used by the state, in this case, don't paint an accurate picture of the complex, multi-faceted situation in Oxford. Decision-making regarding healthcare access should be based on grassroots partnerships, not a top-down approach.

Based on the evidence provided by Oxford Township Supervisor Jack Curtis' Oct. 7, 2022, public comment letter to the CON Commission, there are clearly some flaws in the existing CON review standards. I ask that the commission please consider re-evaluating the current methodology that's used to determine where hospital beds are needed. The residents of Oxford Township and its surrounding communities deserve to have equal access to life-saving medical care.

Respectfully,

Joseph M. Madore

Joseph M. Madore
Village Manager

Ascension

October 21, 2022

Chairperson Amy L. McKenzie, MD
Certificate of Need Commission
c/o Michigan Department of Health and Human Services
Certificate of Need Policy Section
South Grand Building, 4th Floor
333 S. Grand Ave
Lansing, Michigan 48933

Via E-Mail: MDHHS-ConWebTeam@michigan.gov

Dear Chairperson McKenzie,

On behalf of Ascension Michigan please accept this correspondence as written testimony regarding Ascension Michigan's recommendations on the following CON standards scheduled for review in 2022: Megavoltage Radiation Therapy (MRT) Services/Units.

Megavoltage Radiation Therapy (MRT) Services/Units

Ascension Michigan supports the continued regulation of Megavoltage Radiation Therapy (MRT) Services/Units. We would like to put forth to the CON Commission a recommendation to review the MRT standards to create consistency among standards by revising the MRT standards to allow for the acquisition of an MRT unit of a multi-unit service, consistent with Section 6 of the MRI standards and CT standards.

Thank you for the opportunity to provide written comments on the CON Review Standards for review in 2023. We look forward to working with the Commission this, and the coming year.

Sincerely,

Douglas J. Apple, MD, MS, FHM
Chief Clinical Officer, Ascension Michigan

OSF HEALTHCARE

October 21, 2022

Amy McKenzie, M.D.
Chairperson, Certificate of Need Commission
Michigan Department of Health and Human Services
P.O. Box 30195
Lansing, Michigan 48909

Re: Certificate of Need Review Standards for Megavoltage Radiation Therapy (MRT) Services

Chairperson McKenzie,

On behalf of OSF St. Francis Hospital, thank you for this opportunity to provide feedback regarding the CON Review Standards for MRT Services. As a general supporter of Michigan's Certificate of Need program, we do support the continued regulation of MRT services within the CON program. However, as a health care provider in the Upper Peninsula of Michigan, we do have concerns with some of the provisions within the standards and the resulting lack of geographic access to MRT services in the UP.

As I'm sure you know, MRT services are fairly unique within Michigan's CON program in that it is a treatment that requires daily visits to the service for multiple weeks on end. At the same time, most patients, given the right circumstances, can continue most aspects of their normal lives such as working, taking care of their families, etc. and are often encouraged by their health care providers to do so as it helps to keep them active and in a positive mindset. However, this is only a realistic option if MRT treatments are accessible within a reasonable distance/time of their home/community.

In years past the CON Commission has recognized the unique nature of MRT service and added provisions to the standards to try to create greater geographic access to this service in rural areas of our state, including the UP. However, we submit that the provisions intended to address this issue in the UP do not go far enough. The current provisions allow for the initiation of a new MRT service in the UP as long as there is not another existing MRT service located within 90 driving miles of the proposed site. Under the best of circumstances, this equates to a 90 minute drive each way for daily treatment. Not including the time at the treatment facility itself, this means over 3 hours in the car daily to receive treatment for as many as 6 weeks continuously. Not only is this extremely taxing on the patient, but presumably they require assistance in driving to and from treatment. When you add in the time to check-in, the wait to be seen, simulation, set-up, and actual treatment, there is no way a patient would be able to maintain any sense of normal daily activities including work or taking care of family. This is not just a hardship to the patient and their family, but to the community at large.

This also does not take into consideration the practical realities of the weather in the Upper Peninsula. As I'm sure you know, we experience a tremendous amount of snow most winters and our winters last a bit longer than they do in other parts of the state. If you incorporate winter driving conditions into the 90 driving mile

restriction, travel times at least double when conditions don't prohibit the drive altogether. Six hours round trip daily for 6 weeks is just not practical, let's not forget that this is life saving treatment we are talking about.

I understand that the CON standards are scheduled for review in 2023 and I am asking that you please review the provisions related to initiation new MRT services in the UP (HSA 8) to specifically consider reducing the driving distance restriction to something that will allow more reasonable access to the patients in the Upper Peninsula. If you choose to form a workgroup or Standards Advisory Committee, we would appreciate the opportunity to participate and be a part of the solution.

Thank you for your consideration of our request. Please don't hesitate to reach out with any questions or feedback, (906) 786-5707 EXT 5500.

Sincerely,

Kelly A. Jefferson
President

Trinity Health

Trinity Health Michigan

October 14, 2022

Amy L. McKenzie, MD
Chair, CON Commission
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Public Comment for Megavoltage Radiation Therapy Certificate of Need Standards

Dear Chairman McKenzie:

Trinity Health Michigan would like to thank the Certificate of Need Commission for the opportunity to comment on what, if any, changes need to be made to the Certificate of Need Standards for Megavoltage Radiation Therapy (MRT) in 2023.

As noted in our comment to the CON Commission in July, Trinity Health Michigan believes the weights and additive values for MRT treatments within the MRT CON standard require a holistic review to address the many technologies now being used for MRT treatment. The weights that were added for MRT-CT in 2021 reflect just a small portion of changes that are needed. The 2021 MRT workgroup agreed that new time studies and surveys are needed to update how Michigan providers are using MRT technology, but this review did not occur because it was outside the workgroup's charge. This update is needed to ensure all providers are receiving adequate and equitable credit for the time it takes to provide MRT treatments.

To this end, Trinity Health Michigan recommends a SAC or workgroup to review all weights, additive values, and associated definitions during 2023. We do not believe any volume requirements will need to be revisited if such a SAC or workgroup upholds the current understanding of a ETV as equal to 15 minutes of treatment time on an MRT unit. As always, Trinity Health would be happy to support a SAC should the Commission determine one is needed.

We appreciate the CON Commission's consideration of our comments.

Sincerely,

Rob Casalou

Rob Casalou
President and CEO
Trinity Health Michigan & SE Regions

Beaumont

October 7, 2022

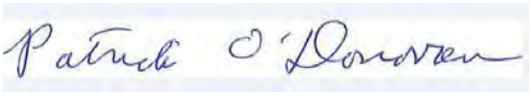
Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
South Grand Building
333 S. Grand Avenue
Lansing, MI 48933

Re: Megavoltage Radiation Therapy (MRT) Services/Units
Open Heart Surgery Services
Positron Emission Tomography (PET) Scanner Services

Dear Certificate of Need Commission:

Thank you for the opportunity to provide comment on the CON Review Standards up for review in 2023. Beaumont Health supports the continued regulation of these services, and no changes to these standards are recommended at this time.

Sincerely,



Patrick O'Donovan
Director, Strategy & Business Development
Beaumont Health

Corewell Health™

corewellhealth.org

October 19, 2022

Chairperson Amy L. McKenzie, MD
Certificate of Need Commission
c/o Michigan Department of Health and Human Services
Certificate of Need Policy Section
South Grand Building, 5th Floor
333 S. Grand Ave
Lansing, Michigan 48933

Dear Chairperson McKenzie,

Corewell Health West thanks the CON Commission for the opportunity to provide written testimony on the CON Review Standards for Open Heart Surgery (OHS) Services. This letter complements the letter submitted by our legacy Beaumont division.

Corewell Health West believes that continued regulation of OHS Services will serve the citizens of Michigan well. We do not believe that any changes are necessary to the current standards.

We appreciate the Commission's consideration of our comments. Should you have any questions regarding these comments or if you would like any additional information, please contact David Walker, Advisor, Corewell Health Government Affairs, David.Walkerii@spectrumhealth.org.

Sincerely,

Darryl Elmouchi, MD, MBA
President
Corewell Health West

Trinity Health

Trinity Health Michigan

October 18, 2022

Amy L. McKenzie, MD
Chair, CON Commission
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Public Comment for Open Heart Surgery Certificate of Need Standards

Dear Chairman McKenzie:

Trinity Health Michigan would like to thank the Certificate of Need Commission for the opportunity to comment on what, if any, changes need to be made to the Certificate of Need Standards for Open Heart Surgery in 2023.

Trinity Health Michigan believes the current Certificate of Need Standard ensures that Michigan's citizens have appropriate access to affordable, high-quality Open Heart Surgery. For this reason, Trinity Health Michigan supports the continued regulation of Open Heart Surgery without any further modification to the existing CON Standards.

We appreciate the CON Commission's consideration of our comments.

Sincerely,

Rob Casalou

Rob Casalou
President and CEO
Trinity Health Michigan & SE Regions

UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

T. Anthony Denton, JD, MHSA
Senior Vice-President & Chief Operating Officer

300 N. Ingalls St, SPC 5474
Ann Arbor MI 48109-5474

T: (734) 764-1505

tadpole@med.umich.edu

October 21, 2022

Amy L. McKenzie, MD - CoN Commission Chairperson
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Open Heart Surgery - Certificate of Need Standards Review

Dear Commissioner McKenzie:

This letter is written as formal testimony pertaining to the Certificate of Need Review Standards for Open Heart Surgery Services. University of Michigan Health supports the continued regulation of this covered service and does not believe any specific revisions to these standards are currently necessary.

Thank you for allowing University of Michigan Health to provide these comments for consideration.

Respectfully submitted,

T. Anthony Denton, JD, MHSA
Senior Vice-President and
Chief Operating Officer
University of Michigan Health
Michigan Medicine

Ascension

October 21, 2022

Chairperson Amy L. McKenzie, MD
Certificate of Need Commission
c/o Michigan Department of Health and Human Services
Certificate of Need Policy Section
South Grand Building, 4th Floor
333 S. Grand Ave
Lansing, Michigan 48933

Via E-Mail: MDHHS-ConWebTeam@michigan.gov

Dear Chairperson McKenzie,

On behalf of Ascension Michigan please accept this correspondence as written testimony regarding Ascension Michigan's recommendations on the following CON standards scheduled for review in 2022: Positron Emission Tomography (PET) Scanner Services.

Positron Emission Tomography (PET) Scanner Services

Ascension Michigan commends the work completed by the Positron Emission Tomography (PET) Service Standard Advisory Committee in 2022. We have no recommended changes for PET services and we do not believe there are any necessary changes that need to be made to the standards at this time.

Thank you for the opportunity to provide written comments on the CON Review Standards for review in 2023. We look forward to working with the Commission this, and the coming year.

Sincerely,

Douglas J. Apple, MD, MS, FHM
Chief Clinical Officer, Ascension Michigan

Trinity Health

Trinity Health Michigan

October 14, 2022

Amy L. McKenzie, MD
Chair, CON Commission
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Public Comment for Positron Emission Tomography Certificate of Need Standards

Dear Chairman McKenzie:

Trinity Health Michigan would like to thank the Certificate of Need Commission for the opportunity to comment on what, if any, changes need to be made to the Certificate of Need Standards for Positron Emission Tomography (PET) in 2023.

The PET CON standards were most recently reviewed by a workgroup in 2021, and again by a Standards Advisory Committee in 2022. Trinity Health Michigan participated in both processes. Trinity Health Michigan believes the resulting updates to the PET CON Standards has ensured that Michigan's citizens have appropriate access to affordable, high-quality PET services. For this reason, Trinity Health Michigan supports the continued regulation of PET without any further modification to the CON Standards in 2023.

We appreciate the CON Commission's consideration of our comments.

Sincerely,

Rob Casalou

Rob Casalou
President and CEO
Trinity Health Michigan & SE Regions

UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

T. Anthony Denton, JD, MHSA
Senior Vice-President & Chief Operating Officer

300 N. Ingalls St, SPC 5474
Ann Arbor MI 48109-5474

T: (734) 764-1505

tadpole@med.umich.edu

October 21, 2022

Amy L. McKenzie, MD - CoN Commission Chairperson
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Positron Emission Tomography - Certificate of Need Standards Review

Dear Commissioner McKenzie:

This letter is written as formal testimony pertaining to the Certificate of Need Review Standards for Positron Emission Tomography Services. University of Michigan Health supports the continued regulation of this covered service, and with the recent completion of an Informal Workgroup and Standards Advisory Committee, does not believe any specific revisions to these standards are currently necessary.

Thank you for allowing University of Michigan Health to provide these comments for consideration.

Respectfully submitted,

T. Anthony Denton, JD, MHSA
Senior Vice-President and
Chief Operating Officer
University of Michigan Health
Michigan Medicine

Beaumont

October 7, 2022 **DRAFT**

Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
South Grand Building
333 S. Grand Avenue
Lansing, MI 48933

Re: Surgical Services

Dear Certificate of Need Commission:

Thank you for the opportunity to provide comment on the CON Review Standards up for review in 2022. Beaumont Health supports the continued regulation of Surgical Services, and recommends that a Standards Advisory committee (SAC) be formed to include at least the following charges:

1. Review the ownership and volume requirements for applicants proposing to relocate an existing surgical service or one or more operating rooms
    a. Discussion: This relates to Section 5(6) of the current Surgical Services standards.
        i. With regard to ownership, the Surgical standards do not say that the surgical service from which the OR's will be relocated and the surgical service to which the OR's will be relocated must have common ownership; however the Department has interpreted this standard as requiring common ownership for relocation of OR's. Increasingly, hospitals are partnering with physicians and others through JV's to develop FSOF's, which often results in migration of outpatient surgical procedures from hospitals to FSOF's. While the hospital and FSOF may not have common ownership, they are working in cooperation with each other to meet the needs of the community in a lower cost setting. If the hospital is unable to relocate OR's to the FSOF, the hospital is at risk of compliance action for not meeting minimum volumes due to the shift of cases to the FSOF.
        ii. With regard to volume requirements, the Department's current interpretation of the Surgical standards is that both the surgical service from which the OR's will be relocated from, and the surgical service to which the OR's will be relocated to must be meeting minimum at the time they are relocated. Consideration should be given to increasing flexibility for relocating of OR's by reviewing these volume requirements, in order to assure appropriate access to care in the most cost effective settings.

2. Review whether excess cardiac cath volume performed in cardiac cath labs should be able to be used to meet the initiation volume requirements for a FSOF, if the FSOF is to be used exclusively for cardiac cath cases.
    a. Discussion: This relates to Sections 3 and 11 of the current Surgical Services standards.
        i. Currently, the only way to establish a new FSOF is to get physician commitments of excess volume that is currently performed in CON approved OR's. This means that an entity wanting to establish a new FSOF that is dedicated to cardiac cath cases must get

commitments from physicians utilizing surgical facilities that do not perform cardiac cath cases. This is the case regardless of whether or not the physicians providing the commitments (or any physicians for that matter) plan to perform surgical cases in the new FSOF. If a new FSOF is approved in this currently required way, and there is not surgeon support for the new OR, the facility would be at risk of closure due to low volume, which would also place the cardiac cath cases performed there at risk of losing their CON, even at high cardiac cath volumes.

ii. To address this issue, the Surgical standards could allow for commitment of cardiac cath excess volume to count toward the FSOF initiation volume *if* the FSOF will be used exclusively for cardiac cath cases (the applicant would also have to meet the Cardiac Cath standards).

Thank you for your consideration.

Sincerely,

David Claeys
President, Beaumont Dearborn and Ambulatory Partnerships

Corewell Health™

corewellhealth.org

October 19, 2022

Chairperson Amy L. McKenzie, MD
Certificate of Need Commission
c/o Michigan Department of Health and Human Services
Certificate of Need Policy Section
South Grand Building, 5th Floor
333 S. Grand Ave
Lansing, Michigan 48933

Dear Chairperson McKenzie,

Corewell Health West thanks the CON Commission for the opportunity to provide written testimony on the CON Review Standards for Surgical Services. This letter complements the letter submitted by our legacy Beaumont division.

Corewell Health West supports continued regulation of surgical services. However, we believe some modifications are necessary in light of the recent modifications to the CON Review Standards for Cardiac Catheterization Services to allow cardiac catheterization labs in freestanding surgical outpatient facilities (FSOF). Specifically, Corewell Health West recommends the Commission form a Standard Advisory Committee (SAC) to review options for volume requirements for FSOFs solely dedicated for cardiovascular services.

A small adjustment to the surgical standards could help Michigan keep pace with the rest of the country in providing access to outpatient cardiovascular services.

We appreciate the Commission's consideration of our comments. Should you have any questions regarding these comments or if you would like any additional information, please contact David Walker, Advisor, Corewell Health Government Affairs, David.Walkerii@spectrumhealth.org.

Sincerely,

Darryl Elmouchi, MD, MBA
President
Corewell Health West

Nephrology Associates of Michigan, P.C.

www.kidneyaa.com

Clinic Locations: *Ypsilanti • Adrian • Brighton • Monroe • Chelsea • Plymouth*

St. Joseph Mercy - Reichert Health Center 5333 McAuley Drive, Suite 4003 Ypsilanti, MI 48197
Phone: (734)712-3470 Phone: (800)482-3972 Fax: (734)712-2935

George M. Behrend, M.D.
Paul A. Berkowitz, M.D.
Javeria Syed, M.D.
Jariatul Karim, M.D.
Sushma N. Pandrangi, M.D.
Vidooshi G. Maru, M.D.
Mustafa Mawih, M.D.
Rakesh Kanipakam, M.D.
Judith M. Mayer, M.D.
Ahmad Masood, M.D.
Rakesh Kanipakam, M.D.
Linda Lou Mixter, APRN-BC
Paula Nau, PA
Teriana Sharp, NP
Kimberly Horka, APRN
Terri Trombley, CNP
Edvennia Fizer-Washington, APRN
Martha McAleer, NP
Ashley Draves, FNP-C
Shanique Rubens-Welch, ACNP-BC
Argylle Binguit, APRN
Stephanie Weston, NP

October 21, 2022

Dr. Amy McKenzie, MD
Chairperson, Certificate of Need Commission
Michigan Department of Health and Human Services
South Grand Building, 4th Floor
P.O. Box 30195
Lansing, Michigan 48909

Re: Certificate of Need Review Standards for Surgical Services

Chairperson McKenzie,

On behalf of Nephrology Associates of Michigan, thank you for this opportunity to provide comments regarding the CON Review Standards for Surgical Services. As a provider of vascular access services in Michigan, I am requesting that the CON Commission create an informal workgroup or Standards Advisory Committee (SAC) in the coming year to review the surgical services standards to find ways to improve End-Stage Renal Disease (ESRD) patient access to vascular access services.

Nephrology Associates of Michigan provides care to ESRD patients requiring dialysis treatment. In order for ESRD patients to receive dialysis treatments, they must undergo a surgical procedure to place a catheter, graft, or fistula (i.e., vascular access). Historically these vascular services have been provided in office-based procedure rooms. However, changes in CMS policy are driving these procedures into ambulatory surgery centers (ASCs) nationally. Medicare has created kidney specific ACOs (Accountable Care Organizations) such as the ESCOs (ESRD Seamless Care Organizations), and now the KCCs (Kidney Care Choices models), in an attempt to streamline care for ESRD patients, resulting in better outcomes and lower costs. However, in Michigan these efforts have been difficult to implement due to the barriers created by the CON standards for surgical services.

ESRD patients require regular dialysis in order to live. However, access to dialysis requires a functioning fistula, graft, or catheter and those fail. Statistically 20% of fistulas, 40% of grafts, and 80% of catheters fail at least once per year. The average ESRD patient will require 2.2 surgical interventions per year and when their vascular access fails, they require urgent repair in order to not miss a dialysis treatment. Missed treatments result in increased mortality, increased hospitalizations, and increased costs. Ensuring that these patients have access to outpatient surgical services is imperative to their survival.

As vascular access procedures have historically been performed in procedure rooms, the current CON standards do not take into account these historical volumes in demonstrating need for a new FSOF. Additionally, given the complex nature of these ESRD patients, traditional non-nephrology ASCs are not interested in providing these

services. Dialysis patients are frail, and sick, and on their best day, 30% of dialysis patients who present to an ER will be admitted for "something". As an illustration, when looking at hospital readmission data from our practice, ESRD (dialysis) patients get readmitted at a rate of about 27-30% (Q2 2022 data). That means after they have been admitted, treated, and discharged in good condition, 1 in 3 of those patients will be readmitted within 30 days of discharge. For frame of reference, our non ESRD patients have a readmission rate of 10-15% in the same time frame. Patients who go in and out of the hospital end up weaker, and then discharge to subacute rehabilitation facilities for further care.

If we are not able to convert our facility to an ASC, the 800+ patients we care for on dialysis will need to get their procedures done at the hospital. The hospital is not equipped to handle this additional volume on an urgent basis. They won't be able to get to them in the time sensitive manner required as an outpatient within the 24 hours needed to maintain their dialysis schedule. Instead, patients will be admitted and monitored, and will get the procedures when there is an open slot, or when it becomes emergent. This is not the quality of care our patients deserve. Moving these patients to the hospital setting will also result in skyrocketing costs, completely going against the aims of the ACOs we participate in. We are already seeing this with patients from other dialysis clinics that no longer are able to offer in-house vascular access. They end up in our emergency department for these kinds of vascular issues. We all know patients do better when they are home, and supporting us in our efforts to continue providing timely high quality vascular access care to these patients will achieve that end. Revising the CON standards to allow for vascular access dedicated FSOFs would be a way to improve outcomes for these patients while reducing costs and ensuring high quality.

Nephrology Associates of Michigan has prepared a Certificate of Need application for submission to initiate an FSOF at our existing location, converting our procedure room into an operating room. We are not looking to do more procedures, but rather hoping to be able to continue providing this critical care to our vulnerable patient population. This application is ready for submission with the one exception of being able to use our existing volumes to demonstrate need, which will stay at our facility and be performed in the licensed OR once approved and licensed.

Thank you for your consideration of our request to form a workgroup or SAC to discuss this issue and recommend specific changes to the standards. Please don't hesitate to reach out with any questions or feedback.

Sincerely,

Vidooshi Maru, MD

DocuSigned by:
Vidooshi Maru, MD
DB24F1AC08044DA...

Lifeline VASCULAR CARE

October 21, 2022

Dr. Amy McKenzie, MD
Chairperson, Certificate of Need Commission
Michigan Department of Health and Human Services
South Grand Building, 4th Floor
P.O. Box 30195
Lansing, Michigan 48909

Re: Certificate of Need Review Standards for Surgical Services

Chairperson McKenzie,

We wanted to take this opportunity to thank you for allowing us to provide you with context on how the CON Review Standards for Surgical Services is affecting patient care within the state of Michigan. We realize that the Standards for Surgical Services are up for review in 2023, and as a manager of several vascular access centers in Michigan, we are requesting that the CON Commission create an informal workgroup or Standards Advisory Committee (SAC) to review the surgical services standards to find ways to improve End-Stage Renal Disease (ESRD) patient access to vascular access services.

For context, Lifeline Vascular Care is a management services provider for a network of approximately forty (40) outpatient office-based and ambulatory surgical centers in 24 states, which are focused on providing vascular access repair and maintenance services to End Stage Rental Disease ("ESRD") patients. Nephrology Associates of Michigan ("NAMI") is one of our clients who provides care to ESRD patients requiring dialysis treatment. The center that we manage for NAMI provides dialysis access maintenance and repair services, which is a critical part in maintaining good blood flow to a patient's fistula (the part of the anatomy where they receive dialysis). In turn, with good access repair and maintenance services, the patient gets more effective dialysis treatments, which are essential for sustaining the patient's life. Simply put, without our services and the ability to receive dialysis, the patient will die.

In the early 2000's many nephrology practices (including NAMI who started their own center in 2004-5) began creating their own office based procedure rooms dedicated to vascular access maintenance and repair. For over a decade, superior care was delivered to ESRD patients with better outcomes than the hospital. This superior care continued until 2017, when, at the national level, CMS determined that the more clinically appropriate setting for ensuring that quality dialysis access maintenance and repair treatment was delivered to patients was in a CMS accredited facility such as an ambulatory surgical center ("ASC"). As a result of this decision, they begin shifting their policies away from the office-based laboratory/extension of practice ("EOP") setting, towards an ambulatory surgical center.

This significant policy change has resulted in many EOP centers electing to close their centers since they were either cost prohibitive to convert to an ASC, or were not able to be physically converted without an entirely new structure. These numerous closures have resulted in patients going back to the hospital for treatment, which is not the best place of service for our patients for several reasons:

1) Our procedure types are generally emergent in nature, whereby a patient generally needs to be seen within 24-48 hours and many hospitals cannot commit to being able to provide operating room time, in a medically necessary time frame, and also one that is acceptable for a patient to be waiting.
2) The fragility of our patients, even when they are seen in the hospital setting, their 30 day readmission rate has ranged from 27.4% to 29.8%, compared with that of a non-ESRD patient with chronic kidney disease of 8.3% to 14.1%.
3) Hospital reimbursement rates are ~75% higher than ASC rates and increase the overall cost to deliver the medically necessary care.

In light of these policy changes at the national level, many of Lifeline's centers have opted to convert their existing EOP to an ASC. Lifeline has assisted and continues to be in the process of assisting at least 50% of our network to convert from an EOP to an ASC for continuity and ease of patient care. The current CON rules in place in Michigan disproportionately penalize nephrology and vascular care physicians who were proactive in establishing office based surgical centers by not allowing their current cases to be counted in order to meet CON requirements during the time that CMS is making seismic changes at the national level. An ASC is the only option for these specialty practices to remain open, economically viable and continue to provide high quality life-saving service to their patients.

As currently drafted, the Michigan CON requirements would automatically exclude NAMI from being eligible for a Certificate of Need because vascular access procedures have historically been performed in EOP's and the standards do not permit NAMI to consider these historical volumes in demonstrating need for a new FSOF. Revising the CON standards to allow for vascular access dedicated FSOFs would be a way to improve outcomes for these patients while reducing costs and ensuring that high quality care is delivered to patients.

Thank you for your consideration of our request to form a workgroup or SAC to discuss this issue and recommend specific changes to the standards. In the interim, please reach out to me with any clarification questions or feedback you may have. We look forward to finding a path whereby the NAMI center, and others like it, may be appropriately granted a CON to continue to deliver care to our extremely fragile patient population.

Sincerely,

Linda Rahm
Managing Partner
Lifeline Vascular Care

Trinity Health

Trinity Health Michigan

October 14, 2022

Amy L. McKenzie, MD
Chair, CON Commission
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Public Comment for Surgical Services Certificate of Need Standards

Dear Chairman McKenzie:

Trinity Health Michigan would like to thank the Certificate of Need Commission for the opportunity to comment on what, if any, changes need to be made to the Certificate of Need Standards for Surgical Services in 2023.

Trinity Health Michigan believes the current Certificate of Need Standard ensures that Michigan's citizens have appropriate access to affordable, high-quality surgical care. For this reason, Trinity Health Michigan supports the continued regulation of Surgical Services without any further modification to the existing CON Standards.

We appreciate the CON Commission's consideration of our comments.

Sincerely,

Rob Casalou

Rob Casalou
President and CEO
Trinity Health Michigan & SE Regions

UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

T. Anthony Denton, JD, MHSA
Senior Vice-President & Chief Operating Officer

300 N. Ingalls St, SPC 5474
Ann Arbor MI 48109-5474

T: (734) 764-1505

tadpole@med.umich.edu

October 21, 2022

Amy L. McKenzie, MD - CoN Commission Chairperson
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Surgical Services - Certificate of Need Standards Review

Dear Commissioner McKenzie:

This letter is provided as formal testimony pertaining to the Certificate of Need (CoN) Review Standards for Surgical Services. University of Michigan Health (UMH) supports the continued regulation of this service; however, UMH would like the CoN Commission to consider developing CON Standards that recognize the evolution and ongoing changes occurring in today's health care environment.

Health care delivery has evolved significantly since Michigan CoN was first enacted half a century ago in 1972. Fifty years ago, "site specific" regulations were appropriate as most every, if not all, acute care hospitals in the state were independent. Over the past many years, there has been a paradigm shift as only a few hospitals today remain independent health care providers located only at one site. The vast majority have experienced organic growth or have joined together to create more efficient and geographically diverse "health system" organizations. As the consolidation that has occurred, there has also been a major shift toward delivering health care in outpatient settings in local communities to create networks of care, including ambulatory surgical procedures.

Surgical procedures that once required an inpatient admission are now routinely performed in a Freestanding Surgical Outpatient Facility (FSOF), with patients returning home just hours after surgery. While health care delivery has evolved and become more efficient since the 1970's, the CoN Standards that regulate this service for our State have not been modernized to align with these improvements as organizations seek to enhance patient care access across different settings.

Health systems today are geographically dispersed throughout multi-county service areas in Michigan. Allowing greater geographic planning flexibility to these organizations beyond the current 10-mile (metropolitan) or 20-mile (rural/micropolitan) relocation zones for the replacement of existing licensed Operating Rooms could be a significant step toward improving access. Greater flexibility beyond the current 20-mile planning area for the initiation of a new Surgical Service could also be a significant improvement. Providing appropriate access to state-of-the-art health care in lower cost environment is a potential and beneficial outcome, consistent with principles of certificate-of-need regulations.

UMH recognizes there may be challenges to defining what a "health system" is on a consistent basis to enable efficient administration term throughout the CoN Standards. A simple and logical definition would be sites that are operated under the same provider number or which have been formally integrated under a system consolidation. We don't suggest we have the answer, but do propose that it may be time to determine a new framework to provide alignment to determine location of operating rooms within a system context rather than site-specific assessments which have been the norm.

UMH recommends that the CoN Commission form a Standards Advisory Committee or Workgroup to further study the points referenced in this letter and work toward developing new CoN Standards that recognizes today's health system, allowing for more efficient and flexible deployment of licensed OR's across a system to reflect the new normal of what is included in many health systems across our State. Finally, this may be a reasonable discussion to have for other covered services (e.g. MRI, CT).

Thank you for allowing University of Michigan Health to provide these comments for consideration.

Respectfully submitted,

T. Anthony Denton, JD, MHSA
Senior Vice-President and
Chief Operating Officer
University of Michigan Health
Michigan Medicine