**Date: December 23, 2013**

**Project**: **Capital Expenditure to Expand and Renovate OR Capacity**

**Proposal by: Maine Medical Center**

**Prepared by: Phyllis Powell, Assistant Director, Medical Facilities**

**Larry Carbonneau, Manager, Health Care Oversight**

**Richard S. Lawrence, Senior Health Care Financial Analyst**

**Directly Affected Party: Central Maine Healthcare, Mercy Hospital**

**CON Recommendation: Approval**

**Proposed Approved**

**Per Applicant** **CON**

Estimated Capital Expenditure $ 40,767,590 $ 40,767,590

Maximum Contingency $ 1,921,800 $ 1,921,800

Total Capital Expenditure with Contingency $ 42,689,390 $ 42,689,390

Pro-Forma Marginal Operating Costs $ 5,379,000 $ 5,379,000

# I. Abstract

**A. From Applicant**

“Maine Medical Center (MMC) proposes to make a capital expenditure of approximately $40.8 million to increase the number of operating rooms on its main campus (Bramhall) in Portland and create an operating room equipped for the performance of transcatheter aortic valve replacement procedures (“TAVR procedures”) at that site.”

“Bean 2 involves new construction and renovations to house 5 surgical / interventional procedure rooms, associated preparation / recovery capacity, associated support functions on MMC’s Bean Building Level 2, improvements to the vertical transport system between the Central Sterile Department in the Bean Building Sub-Basement and Bean Building Level 2, and renovations to develop a Cardiac Hybrid Operating Room in MMC’s Main Surgical Suite to support MMC’s Heart Valve Center’s Transcatheter Aortic Valve Replacement Program.”

“The estimated capital expenditure for this project is forty million seven hundred sixty seven thousand dollars ($40,767,000). The Bean 2 portion of the project is scheduled to come on line October 1, 2014, the beginning of MMC’s FYE 2015. The Cardiac Hybrid Operating Room renovations begin after the Bean 2 operating rooms open. The Cardiac Hybrid Operating Room is scheduled to come on line in January 2015.”

“MMC’s role as a tertiary care and referral center that addresses health care needs of the entire state of Maine is demonstrated by its market share of Maine residents’ inpatient surgical and interventional cardiovascular care, and by its patient origin for these services. MMC’s specialty and subspecialty clinical services, including several surgical and interventional cardiovascular services have significant reach beyond Cumberland and York counties, MMC’s primary service area.”

“MMC Surgical Services provides a scope and depth of specialty and subspecialty surgical care that is unparalleled in Maine. Maine Medical Center is the only Maine hospital and one of fewer than 100 in the United States reviewed and verified by the Committee on Trauma of the American College of Surgeons as an Adult Level 1 Trauma Center, providing a full range of services and equipment available 24 hours a day - including around-the-clock neurosurgical, orthopedic, surgical specialty, and surgical intensive care coverage.”

“Transcatheter Aortic Valve Replacement procedures (TAVR) are a viable clinical alternative for patients who are considered to be at too great a risk for traditional aortic valve replacement surgery. The Medical Center is the only hospital in Maine at which such procedures are performed.”

“Development of MMC’s TAVR program triggers the need for a dedicated cardiac hybrid operating room to support performing minimally invasive procedures requiring intraoperative imaging capabilities provided by fixed C-Arm angiography equipment.”

“To better support this work, an existing operating room and adjoining space will be turned into a dedicated “cardiac hybrid operating room” equipped with fixed C-Arm angiography equipment. MMC is the largest and most comprehensive cardiovascular center in Maine, performing more than 900 cardiac surgeries, 1,300 coronary interventions, and nearly 2,000 invasive electrophysiology procedures/device implantations annually. MMC accounts for nearly 30% of all inpatient cardiovascular discharges in the State of Maine.”

**“MMC’s Bramhall campus operating rooms are functioning at an unsustainably high utilization rate.”**

“The current utilization rate for MMC’s existing 24 Bramhall campus operating rooms is greater than 90%, which is unsustainable. The industry standard and Department guideline for optimal efficiency is 80%. Increasing utilization much beyond 80% to 85% increases the challenges of eliminating threats to patient safety, reduces operating room availability to address emergent and urgent demand, and increases the probability of delaying and canceling scheduled cases%. MMC has targeted an 85% utilization rate for its Bramhall surgical services.”

“Delays can be the result of longer than anticipated cases, wait times until a scheduled case is completed and an operating room becomes available or other factors such as equipment or instrument problems.”

“MMC believes that the demand for its complex and emergent surgical services will continue to increase and that improving timely access to MMC’s operating room capacity for the patients needing these services is essential. MMC is Maine’s only American College of Surgeons’ designated Adult Level 1 Trauma Center and offers the most extensive scope of surgical specialties and subspecialties in the state.”

“When emergent and urgent patients disrupt the operating room schedule, scheduled patients encounter delays and cancellations. These delays and cancellations often result in longer lengths of stay for inpatients or in the need to reschedule procedures and return on another day for outpatients. These delays, cancellations and rescheduled cases create disruptions in scheduling for surgeons and staff. These inefficiencies result in avoidable costs to the health care system.”

“The project is an initial step in replacing and modernizing MMC’s interventional capacity.”

“Although they were created less than thirty years ago, MMC’s operating rooms are too small to accommodate the surgical team and equipment required to perform many advanced procedures. MMC’s surgical capacity needs to be replaced with larger operating rooms with more robust infrastructure. MMC needs to increase its hybrid operating room capacity to support minimally invasive surgery requiring intraoperative imaging. Hybrid rooms require more space and place additional demand on infrastructure than routine operating rooms.”

“MMC’s existing operating rooms are undersized. More than half of MMC’s Bramhall operating rooms, built in the early 1980s, are smaller than 500 sf. Today’s standard calls for operating rooms to be a minimum of 600 sf. (Guidelines for Design and Construction of Health Care Facilities, 2006 edition, Facilities Guideline Institute, (American Institute of Architects).”

“Washington, DC), Section 5.3.2.2 (1), p. 78) Hybrid operating rooms are being designed and constructed in the 750 to 1,000 sf. range. MMC cannot increase the size of its operating rooms in their current location without major disruptions in service.”

“MMC’s surgical capacity requires upgraded electrical, ventilation and air conditioning infrastructure. The infrastructure supporting MMC’s operating rooms, designed in the early 1980s, is not engineered to support the electrical loads, cooling requirements and air exchange needs of contemporary surgical practice.”

“Hybrid operating rooms combine the facility requirements of an operating room with the high level/advanced fixed imaging equipment of an interventional lab. The demand for hybrid rooms is increasing with the emergence of transcatheter devices, such as aortic endografts and transcatheter valves with relatively large French sizes. The potential for procedures involving these devices to convert from endovascular to open surgery poses too high of a patient safety risk to be performed outside an OR setting. Several of these procedures also require advanced imaging and a sterile space because of surgical cut downs. Other cardiovascular cases combine both endovascular and open procedures in a single case; for example, minimally invasive cardiac bypass of one vessel and stenting of another vessel.”

# II. Fit, Willing and Able

**A. From Applicant**

**“Overview**

Maine Medical Center (MMC), a voluntary non-profit 501 (c) (3) organization, is a subsidiary of MaineHealth, a nonprofit organization located in Portland, Maine. MMC is licensed for 637 beds and 30 newborn bassinettes. MMC is a State-licensed, Federally-certified, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited hospital with its main campus located in Portland, Maine.”

**Maine Medical Center**

22 Bramhall Street

Portland, Maine 04102

<http://www.mmc.org>

Mission:

“Maine Medical Center is dedicated to maintaining and improving the health of the communities it serves by:

* caring for the community by providing high quality, caring, cost effective health services;
* educating tomorrow’s care givers; and
* researching new ways to provide care.”

**“MMC Service Area**

Primary: Cumberland and York counties;

Secondary: Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo counties;

Tertiary: Aroostook, Hancock, Penobscot, Piscataquis and Washington counties as well as Out of State.”

**“Licenses, Certifications & Accreditations**

MMC is licensed by the State of Maine, certified to participate in Medicare and accredited by JCAHO. MMC’s "Statements of Deficiencies" and site visit reports from the previous three years are on file with the Department of Health and Human Services’ Division of Licensing and Regulatory Services.”

**“Fit, Willing and Able**

MMC is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, the quality of the health care provided in the past by MMC and other MaineHealth members meeting industry standards. MMC provides the health care services that are being reviewed, is licensed in the State and MMC’s services are consistent with applicable licensing and certification standards.”

“The Certificate of Need Act states: “If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the requirements of this paragraph are deemed to have been met if the services previously provided in the State by the applicant are consistent with applicable licensing and certification standards.” (22 MRSA §335, sub-1 §7 A) MMC provides surgical and interventional cardiology services and is currently licensed by the State of Maine. Through multiple building projects during the past 30 plus years MMC has demonstrated its ability to develop new and renovated facilities that meet all licensure and certification requirements.”

“In early 2012 MMC reorganized its structure to focus care delivery on patient and family-centered service lines, which enhances care coordination and increases efficiency. All other functions are organized to support the service lines.”

“Please refer to Exhibit 2-A: MMC’s Organizational Chart

**“MMC Surgical Services**

MMC’s Surgical Services’ divisions, programs and services, their organization, conditions addressed and types of procedures performed include [further information on specific surgical units can be found in the application contained in the record]:

MMC’s Bariatric Surgery Program. an American College of Surgeons Accredited Bariatric Center, addresses morbid obesity.

The MMC Cancer Institute.

The MMC Joint Replacement Center. The Division of Ophthalmology. The Division of Oral & Maxillofacial Surgery.

The Division of Orthopedic Trauma.

The Division of Pediatric Surgery.

The Division of Plastic & Reconstructive Surgery.

The Division of General Surgery, Trauma & Surgical Critical Care

The Division of Urology.

MMC’s Women's Health including General Obstetrics and Gynecology, Gynecologic Oncology, Urogynecology.”

**“MMC Cardiovascular Services**

MMC Cardiovascular Services’ divisions, programs and services, their organization, conditions addressed and types of procedures performed include:

Adult and Pediatric/Congenital Cardiac Surgery Services including; coronary artery bypass, valve repair and replacement; minimally invasive bypass and valve repair, transcatheter valve replacement (TAVR), arrhythmia surgery, and thoracic surgery Cardiac Interventional Services, including adult invasive diagnostic catheterization, coronary intervention, including stent implantation, cardiac biopsies, carotid and peripheral vascular interventions, and pediatric/congenital invasive diagnostic and interventional procedures.”

“The Division of Vascular Surgery addresses abdominal aortic aneurysms, carotid artery disease, mesenteric artery disease, renal artery disease, peripheral artery disease, venous diseases and blood clots, claudication, stroke, varicose veins, venous skin ulcers. Performs angioplasty thoracic and aortic aneurysm repair (open and endo repair), carotid artery stent, carotid artery endarterectomy, dialysis access, lower extremity (leg) bypass (aortobifemoral, tibioperoneal, and femoropoplietal), lower extremity amputation, varicose veins, vein stripping, and vena cava filter. Performs procedures in MMC’s endovascular suite, a hybrid operating room.”

“Electrophysiology Services, including invasive diagnostic electrophysiology testing, catheter ablation procedures, cardioversions, electronic implantable cardiac device, such as pacemakers and implantable defibrillators, and laser lead extractions non-invasive Cardiac Diagnostics including EKGs, exercise stress testing, nuclear cardiology stress testing, stress echocardiography, holter monitor, event recorder, echocardiography, transesophogeal echocardiography, and CT angiography.”

**“MMC Maine Heart Valve Center**

MMC is the only hospital in Maine that meets the Centers for Medicare and Medicaid Services’ (CMS) required qualifications to perform TAVRs. “

**“Licenses, Certifications & Accreditations**

MaineHealth’s current member affiliates’ licenses, certifications and accreditations are numerous with all being State Licensed, CMS Certified and several are Joint Commission accredited. MaineHealth has demonstrated that its member organizations are capable of delivering the proposed services at the proper standard of care. MMC Surgical Services provides a scope and depth of specialty and subspecialty surgical care that is unparalleled in Maine. “

“Maine Medical Center is the only Maine hospital and one of fewer than 100 in the United States reviewed and verified by the Committee on Trauma of the American College of Surgeons as an Adult Level 1 Trauma Center, providing a full range of services and equipment available 24 hours a day - including around-the-clock neurosurgical, orthopedic, surgical specialty, and surgical intensive care coverage.”

“MMC has the only 24-hour orthopedic trauma service in Maine. MMC staff includes the only board-certified pediatric surgeons, pediatric cardiac surgeon, pediatric neurosurgeon and pediatric urologists in Maine.”

“MMC addresses a significant portion of Maine’s need for inpatient surgical care. MMC accounts for nearly one third of all Maine residents’ discharges from Maine hospitals for surgical care. MMC’s market share of Maine residents’ discharges from Maine hospitals for surgical care is more than 60% of its primary service area, more than 26% of its nine-county secondary service area and more than 6% for residents of the five northern and eastern Maine counties.”

“Transcatheter Aortic Valve Replacement procedures (TAVR) are a viable clinical alternative for patients who are considered to be at too great a risk for traditional aortic valve replacement surgery. The Medical Center is the only hospital in Maine at which such procedures are performed.”

“Development of MMC’s TAVR program triggers the need for a dedicated cardiac hybrid operating room to support performing minimally invasive procedures requiring intraoperative imaging capabilities provided by fixed C-Arm angiography equipment.”

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“MMC is the largest and most comprehensive cardiovascular center in Maine, performing more than 900 cardiac surgeries, 1,300 coronary interventions, and nearly 2,000 invasive electrophysiology procedures/device implantations annually. MMC accounts for nearly 30% of all inpatient cardiovascular discharges in the State of Maine.”

“MMC addresses a significant portion of Maine’s need for inpatient interventional cardiovascular care; MMC accounts for more than 40% of all Maine residents’ discharges from Maine hospitals for interventional cardiovascular care. MMC provides more than 75% of its primary service area’s inpatient interventional cardiovascular care needs, more than 45% of its secondary service area’s inpatient interventional cardiovascular care needs and more than 3% of the inpatient interventional cardiovascular care needs of the five northern and eastern Maine counties.”

**“MMC’s Bramhall campus operating rooms are functioning at an unsustainably high utilization rate.”**

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**B. CONU Discussion**

1. **CON Standards**

Relevant standards for inclusion in this section are specific to the determination that the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant's control meets industry standards. If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the requirements of this paragraph are deemed to have been met if the services previously provided in the State by the applicant are consistent with applicable licensing and certification standards.

**ii. CON Analysis**

MaineHealth was established to lead a community care network which provides a broad range of health care services for Maine and Northern New England. MaineHealth’s subsidiaries and affiliated organizations provide services along the full continuum of care in order to improve the health status of the population it serves. MaineHealth is the organizational parent of Maine Medical Center (MMC). MMC is the state’s largest medical center. It is licensed for 637 beds and employs more than 6,000 people.

In order to determine if the applicant is fit, willing and able we looked at three measures of quality for Maine Medical Center. These quality measures are available at <http://www.hospitalcompare.hhs.gov>.

Patient Survey Results:

The Centers for Medicare & Medicaid Services (CMS), along with the Agency for Healthcare Research and Quality, developed the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as Hospital CAHPS®, to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The HCAHPS Survey is administered to a random sample of patients continuously throughout the year. The following chart summarizes results for Maine Medical Center and compares them to Maine averages and National averages.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Survey Results |  | Maine | National |
|  | **MMC** | **Average** | **Average** |
| Patients who reported that their nurses "Always" communicated well. | 76% | 82% | 78% |
| Patients who reported that their doctors "Always" communicated well. | 77% | 83% | 81% |
| Patients who reported that they "Always" received help as soon as they wanted. | 60% | 72% | 67% |
| Patients who reported that their pain was "Always" well controlled. | 69% | 74% | 71% |
| Patients who reported that staff "Always" explained about medicines before giving it to them. | 64% | 68% | 63% |
| Patients who reported that their room and bathroom were "Always" clean. | 69% | 79% | 73% |
| Patients who reported that the area around their room was "Always" quiet at night. | 49% | 59% | 60% |
| Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home. | 84% | 88% | 84% |
| Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest). | 72% | 73% | 70% |
| Patients who reported YES, they would definitely recommend the hospital. | 78% | 77% | 71% |

Maine Medical Center is at or above the Maine average in 1 out of 10 categories and at or above the national average in 4 out of 10 categories.

Timely and Effective Care:

These quality measures show how often or how quickly hospitals give recommended treatments known to get the best result for people with common conditions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Timely Heart Attack Care | MMC | Maine Average | | National Average |
| Heart attack patients given PCI within 90 minutes of arrival  ***Higher*** *Percentages are better* | **99%** | | **96%** | **95%** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Effective Heart Attack Care | MMC | Maine Average | | National Average |
| Heart attack patients given aspirin at discharge  ***Higher*** *Percentages are better* | **100%** | | **100%** | **99%** |

|  |  |  |  |
| --- | --- | --- | --- |
| Heart attack patients given a prescription for a statin at discharge  ***Higher*** *Percentages are better* | **99%** | **99%** | **98%** |

|  |  |  |  |
| --- | --- | --- | --- |
| Effective Heart Attack Failure Care | MMC | Maine Average | National Average |
| Heart failure patients given discharge instructions  ***Higher*** *Percentages are better* | **98%** | **96%** | **93%** |
| Heart failure patients given an evaluation of Left Ventricular Systolic (LVS) function  ***Higher*** *Percentages are better* | **99%** | **100%** | **99%** |
| Heart failure patients given ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)  ***Higher*** *Percentages are better* | **98%** | **97%** | **97%** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Timely Surgical Care | MMC | Maine Average | | National Average |
| Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery)  ***Higher*** *Percentages are better* | **97%** | | **96%** | **97%** |
| Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection  ***Higher*** *Percentages are better* | **98%** | | **99%** | **98%** |
| Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)  ***Higher*** *Percentages are better* | **98%** | | **97%** | **97%** |
| Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery  ***Higher*** *Percentages are better* | **100%** | | **99%** | **98%** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Effective Surgical Care | MMC | Maine Average | | National Average |
| Outpatients having surgery who got the right kind of antibiotic  ***Higher*** *Percentages are better* | **99%** | | **97%** | **97%** |
| Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery  ***Higher*** *Percentages are better* | **100%** | | **98%** | **97%** |
| Surgery patients who were given the right kind of antibiotic to help prevent infection  ***Higher*** *Percentages are better* | **99%** | | **99%** | **99%** |
| Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery  ***Higher*** *Percentages are better* | **100%** | | **98%** | **96%** |
| Surgery patients whose urinary catheters were removed on the first or second day after surgery  ***Higher*** *Percentages are better* | **100%** | | **97%** | **96%** |
| Effective Surgical Care ***(Continued from previous page)*** | **MMC** | **Maine Average** | | **National Average** |
| Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery  ***Higher*** *Percentages are better* | **100%** | | **100%** | **100%** |
| Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries  ***Higher*** *Percentages are better* | **100%** | | **99%** | **98%** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Timely Emergency Department Care | MMC | Maine Average | | National Average |
| Average time patients spent in the emergency department, before they were admitted to the hospital as an inpatient  ***Lower*** *number of minutes is better* | **386 Minutes** | | **286 Minutes** | **274 Minutes** |
| Average time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room  ***Lower*** *number of minutes is better* | **214 Minutes** | | **110 Minutes** | **96 Minutes** |
| Average time patients spent in the emergency department before being sent home  ***Lower*** *number of minutes is better* | **209 Minutes** | | **119 Minutes** | **138 Minutes** |
| Average time patients spent in the emergency department before they were seen by a healthcare professional  ***Lower*** *number of minutes is better* | **28 Minutes** | | **28 Minutes** | **28 Minutes** |
| Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication  ***Lower*** *number of minutes is better* | **78 Minutes** | | **56 Minutes** | **60 Minutes** |
| Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival  ***Higher*** *Percentages are better* | **17%** | | **39%** | **46%** |

Maine Medical Center is consistently at or above Maine and National averages for effective heart attack Care, effective heart failure care, timely surgical care and effective surgical care. The only measure where Maine Medical Center lags Maine and National averages is in timely emergency department care.

Readmissions, Complications and Deaths:

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

|  |  |
| --- | --- |
| **Measures** | **MMC** |
| Death Rate for Heart Attack Patients | **ND** |
| Death Rate for Heart Failure Patients | **ND** |
| Death Rate for Pneumonia Patients | **ND** |
| Serious Surgical Complications | **W** |
| Death among patients with serious |  |
| Treatable complications after surgery | **W** |
| Central Line-Associated Bloodstream Infections | **ND** |
| Catheter Associated Urinary Tract Infections | **W** |
| Surgical Site Infections from colon surgery | **ND** |
| Surgical Site Infections from Abdominal |  |
| Hysterectomy | **ND** |
| Objects accidentally left in the body |  |
| after surgery | **W** |
| Air bubble in the bloodstream | **B** |
| Mismatched Blood Types | **B** |
| Severe pressure sores | **W** |
| Falls and injuries | **B** |
| Blood infection from a catheter in a large vein | **B** |
| Infection from a urinary catheter | **W** |

**Note:**

**B** = better than national rate

**ND** = no different than the national rate

**W** = worse than national rate

The results above indicate that while MMC is providing quality care and meets the standards for this section, questions remain unanswered as to its commitment to improving outcomes. That review is contained in Section VI.

Federal Survey

The latest full Federal Survey was conducted on August 22, 2008. A summary statement of deficiencies is on file at CONU. A providers’ plan of correction was submitted for all deficiencies by 12/15/2008.

State Survey

The last State Survey conducted was a Complaint Survey due to an allegation of poor quality of care. Based on document review and interviews with key personnel on August 19, 2010 there was no evidence to support the allegation of poor quality of care.

**iii. CON Analysis**

**CON RECOMMENDATION:** CONU recommends that the Commissioner find that the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant’s control meets industry standards.

# III. Economic Feasibility

**A. From Applicant**

“A. **Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project.”**

“Please refer to Exhibit III-A: MMC’s audited financial statements and Exhibit III-B: CON Unit Financial Module. These documents demonstrate MMC’s ability to support the project financially over its useful life.”

“B. **The applicant’s ability to establish and operate the project in accordance with existing and reasonable anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.”**

“MMC is fully licensed and accredited, and has been providing surgical services of this scale and scope for years. The Certificate of Need Act states: “If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the applicant is deemed to have fulfilled the requirements of this subparagraph if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with applicable licensing and certification standards.” (22 MRSA §335, sub-1 §7 B)”

“Through multiple building projects during the past 30 plus years MMC has demonstrated its ability to develop new and renovated facilities that meet all licensure and accreditation requirements.”

“The proposed project’s functional and space program, and design, developed by a team of health care architects and engineers, and hospital physicians and staff, are in conformance with Guidelines for Design and Construction of Health Care Facilities, 2006 Edition, Facilities Guidelines Institute, (American Institute of Architects, Washington, DC, 2006) as required by the Department of Health and Human Services’ Division of Licensing and Regulatory Services.”

“MMC submitted architectural plans to the Division of Licensing and Regulatory Services on February 2, 2013 and the State Fire Marshall on April 4, 2013 for their respective plan reviews. These reviews and approvals assure that the project meets Life Safety Code requirements and is consistent with Licensing and Certification requirements. MMC also submitted its plans to the City of Portland Fire Department on March 1, 2013.”

**“III. Economic Feasibility Exhibits**

Exhibit 3-A Maine Medical Center’s Audited Financial Statements

MMC’s Audited Financial Statements are submitted as a separate PDF file.

Exhibit 3-B CON Unit Financial Module

The CONU Financial Module is submitted as a separate Excel file.”

**B. CONU Discussion**

**i. CON Standards**

Relevant standards for inclusion in this section are specific to the determination that the economic feasibility of the proposed services is demonstrated in terms of the:

Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project.

The applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the applicant is deemed to have fulfilled the requirements of this subparagraph if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with applicable licensing and certification standards.

**ii. CON Analysis**

In order to assess the financial stability of Maine Medical Center, the CONU used financial ratios to measure profitability, liquidity, capital structure and asset efficiency. Financial ratios were obtained from the Maine Health Data organization Hospital Financial Information Part 1 and Maine Health Data Organization Hospital Financial Data Definitions available on MHDO’s website <http://mhdo.maine.gov/imhdo/>. National trend and forecast information was obtained from the 2012 Almanac of Hospital Financial and Operating Indicators.

PROFITABILITY RATIOS

CONU used three profitability ratios to measure the applicant’s ability to produce a profit (excess of revenue over expenses). Hospitals cannot be viable in the long term without an excess of revenues over expenditures. Cash flow would not be available to meet normal cash requirements needed to service debt and investment in fixed or current assets. Profitability has a large impact on most other ratios. For example, low profitability may adversely affect liquidity and sharply reduce the ability to pay off debt.

**Operating margin:** The operating margin is the most commonly used financial ratio to measure a hospitals financial performance. This ratio is calculated as follows: ***Operating Income/Total Operating Revenue***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Operating Margin** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 7.94% | 6.48% | 7.34% | 6.25% | 5.95% |
| All Maine Hospital Median | 2.37% | 1.61% | 2.08% | 0.98% | 2.34% |
| National Median | NAV | NAV | NAV | NAV | NAV |

**Net Operating Income (Loss):** Net operating income is calculated by subtracting operating expense from operating revenue. This measure is used to look at how a hospital’s net operating income performed in comparison with last years’ figure and whether or not there is a positive or negative trend in the future.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Net Operating Income (Loss)** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | $46,578,000 | $40,740,000 | $50,754,000 | $45,012,000 | $49,442,185 |
| All Maine Hospital Median | $1,354,376 | $720,298 | $1,419,993 | $762,435 | $1,549,111 |
| National Median | NAV | NAV | NAV | NAV | NAV |

**Return on Equity:** This ratio defines the amount of excess revenue over expenses and losses earned per dollar of equity investment. Most not-for-profit hospitals received their initial, start-up equity capital from religious, educational, or governmental entities, and today some hospitals continue to receive funding from these sources. However, since the 1970s, these sources have provided a much smaller proportion of hospital funding, forcing not-for-profit hospitals to rely more on excess revenue over expenses and outside contributions. Many analysts consider the Return on Equity measure a primary indication of profitability. A hospital may not be able to obtain equity capital in the future if it fails to maintain a satisfactory value for this ratio. This ratio was calculated as follows: ***Excess of Revenue over Expenses/Fund Balance-Unrestricted***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Return on Equity** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 12.74% | 10.18% | 13.90% | 10.76% | 13.29% |
| All Maine Hospital Median | 9.16% | 7.12% | 5.01% | 4.51% | 8.28% |
| National Median | 8.30% | 4.60% | 5.50% | 6.20% | 6.40% |

**Trends for Return on Equity:** Return on Equity saw continued improvement in 2010 nationally. Larger hospitals continue to out- perform smaller ones. Hospitals with a lower operating margin show lower overall values as lover total margin and less financial leverage combine to reduce Return on Equity.

**Forecast:** Return on Equity values should show a slight increase in the short term. Continued improvement will only be possible if hospitals can realize increased asset efficiency, especially in the area of fixed assets.

LIQUIDITY RATIOS

CONU used three liquidity ratios to measure the applicant’s ability to meet short-term obligations and maintain cash position. A poor liquidity ratio would indicate that the hospital is unable to pay current obligations as the come due.

**Current Ratio:** Current ratio is a liquidity ratio that measures a company’s ability to pay short-term obligations. The ratio is mainly used to determine if the hospital is able to pay back its short-term liabilities (debt and payables with its short-term assets (cash, inventory, receivables). From an evaluation stand point, high values for the Current Ratio imply a high likelihood of being able to pay short term obligations. A ratio under 1 suggests that the hospital would be unable to pay off its obligations if they came due at that point. This ratio is calculated as follows: ***Total Current Assets/Total Current Liabilities***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Current Ratio** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 2.149 | 2.74 | 3.019 | 2.53 | 2.54 |
| All Maine Hospital Median | 1.88 | 1.49 | 1.65 | 1.68 | 1.6 |
| National Median | 2.13 | 2.05 | 2.11 | 2.19 | 2.1 |

\*Without Board Designated/Undesignated Investments

**Current Ratio Trends:** Northeast hospitals have values for the Current Ratio that has been consistently lower than those of other regions. This is a direct result of relatively weak operating profitability. Continued erosion of margins in this region may impair the short-term liquidity positions of the weakest hospitals and may force some defaults.

**Forecast:** Little change in current ratios is expected over the next five years. Values will continue to fluctuate around 2.0.

**Days Cash on Hand:** Days cash on hand is a common measure that gives a snapshot of how many days of operating expenses a hospital could pay with its current cash available. High values for this ratio usually imply a greater ability to meet short term obligations and are viewed favorably by creditors.

This ratio is calculated as follows: ***Cash & Investments + Current Assets Who’s Use is Limited/Total Advertising + Salaries & Benefits + Other Operating Expenses + Interest/365 days***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Days Cash on Hand (Current)** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 224.6 | 161.7 | 162.9 | 160.2 | 113.6 |
| All Maine Hospital Median | 26.7 | 15.9 | 33.3 | 32.5 | 26.2 |
| National Median | 26.8 | 24.6 | 34.7 | 26.7 | 25.4 |

**Trends for Days Cash on Hand:** Values for Days Cash on Hand (Current) continue to increase because of hospitals caution with their cash positions. A reasonable norm for most hospitals would be 20 days of cash on hand for short-term working capital purposes.

**Forecast:** Days Cash on hand should remain steady or slightly increase as hospitals solidify their cash positions. The majority of hospitals should not expect any difficulty in maintaining short-term liquidity positions.

**Average Payment Period:** This ratio provides a measure of the average time that elapses before current liabilities are paid. Creditors regard high values for this ratio as an indication of potential liquidity problems. This ratio is calculated as follows: ***Total Current Liabilities/total Advertising + Salaries & Benefits + Other Operating Expenses + Interest/365***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Average Payment Period\*** | | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | | 117 | 76.9 | 68.1 | 82.2 | 62.1 |
| All Maine Hospital Median | | 50.8 | 54.3 | 59.9 | 60.5 | 62.8 |
| National Median | | 49.8 | 51.2 | 50.5 | 48.6 | 50.2 |
| \*Current Liabilities |  |  |  |  |  |

**Trends for Avg. Payment Period:** Median values in Average payment Period continued to decrease in 2010. Northeast hospitals have the highest values for Average Payment Period, which is consistent with their relatively low values for the Current Ratio.

**Forecast**: Overall Average Payment Period values should remain unchanged in the short term.

CAPITAL STRUCTURE RATIOS

CONU used three capital structure ratios in order to measure the applicant’s capacity to pay for any debt. The hospital industry has radically increased its percentage of debt financing over the past two decades making this ratio vitally important to creditors who determine if a hospital is able to increase its debt financing. The amount of funding available to a hospital directly impacts its ability to grow.

**Debt Service Coverage**: This ratio measures the amount of cash flow available to meet annual interest and principal payments on debt. A DSCR of less than 1 would mean a negative cash flow. This ratio is calculated as follows: ***Excess of Revenue over Expenses + Depreciation + Interest/Interest + Previous Years Current LTD***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Debt Service Coverage** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 13.539 | 8.635 | 6.52 | 6.291 | 7.622 |
| All Maine Hospital Median | 3.82 | 3.43 | 2.92 | 2.68 | 4.11 |
| National Median | 3.82 | 2.86 | 3.1 | 2.8 | 3.18 |

**Trends for Debt Service Coverage:** Debt Service coverage fell again in 2010 after 2009’s decrease. Some of the changes on a regional basis are more striking and variable indicating that local economic experience is more variable. The Northeast showed an increase while all other regions showed a decrease.

**Forecast:** Debt Service Coverage should stabilize or increase somewhat over the next few years. Values are predicted to remain between 2.8 and 3.0.

**Cash Flow to Total Debt**: This coverage ratio compares a company’s operating cash flow to its total debt. This ratio provides an indication of a hospitals ability to cover total debt with its yearly cash flow from operations. The retirement of debt principal is not a discretionary decision. It is a contractual obligation that has definite priority in the use of funds. Therefore, a decrease in the value of the Cash Flow to Total Debt ratio may indicate a future debt repayment problem. The higher the percentage ratio, the better the company’s ability to carry its total debt. This ratio is calculated as follows: ***Excess of Revenue over Expenses + Depreciation/Total Current Liabilities + Total Non- Current Liabilities***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cash Flow to Total Debt** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 28.39% | 26.47% | 24.51% | 20.78% | 22.93% |
| All Maine Hospital Median | 22.54% | 17.06% | 15.00% | 15.14% | 20.51% |
| National Median | 22.70% | 15.70% | 17.40% | 19.50% | 19.00% |

**Trends for Cash Flow to Total Debt:** Median Cash Flow to Total Debt continued to increase in 2010 although values still remain under 2007. Northeast hospitals continue to have the lowest median cash flow to total debt of any region. This results from both lower profitability and higher indebtedness as compared with other regions.

**Forecast:** Cash Flow to Total Debt should continue to have modest gains during the next few years.

**Fixed Asset Financing**: This ratio defines the proportion of net fixed assets (gross fixed assets less accumulated depreciation) financed with long-term debt. This ratio is used by lenders to provide an index of the security of the loan. Decreasing values are favorable. This ratio is calculated as follows: ***Long Term Debt/Net Plant, Property & Equipment***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Fixed Asset Financing** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 40.85% | 33.64% | 30.14% | 28.17% | 26.06% |
| All Maine Hospital Median | 49.49% | 52.37% | 54.22% | 47.59% | 46.06% |
| National Median | 52.50% | 60.30% | 49.80% | 48.20% | 50.80% |

**Trends in Fixed Asset Financing:** Median values for the Fixed Asset Financing Ratio continued to decrease in 2010 after a five year 2008 high.

**Forecast:** Fixed Asset Financing Ratios are expected to remain stable during the next five years as hospitals curtail their growth in new capital expenditures and reduce their reliance on long-term debt.

ASSET EFFICIENCY RATIOS

CONU used two asset efficiency ratios. These ratios measure the relationship between revenue and assets.

**Total asset turnover ratio:** Provides an index of the number of revenue dollars generated per dollar of asset investment. Higher values for this ratio imply greater generation of revenue from a limited resource base and are sometimes viewed as a positive indication of efficiency. This ratio is affected by the age of the plant being used by the hospital. Increasing values are favorable. This ratio is calculated as follows: ***Total Operating Revenue + Total non-operating Revenue/Total Unrestricted Assets***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Asset Turnover** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 0.682 | 0.741 | 0.770 | 0.740 | 0.846 |
| All Maine Hospital Median | 1.17 | 1.2 | 1.23 | 1.21 | 1.21 |
| National Median | 1.08 | 1.08 | 1.07 | 1.05 | 1.07 |

**Trends in Total Asset Turnover:** Total Asset Turnover values have remained generally constant over the past five years with a slight decline in 2010.

**Forecast:** Total Asset Turnover should improve over the next five years.

**Fixed Asset Turnover Ratio:** Measures the number of revenue dollars generated per dollar of fixed asset investment. High values for this ratio may imply good generation of revenue from a limited fixed asset base and are usually regarded as a positive indication of operating efficiency.

This ratio is calculated as follows: ***Total Operating Revenue/Net Plant, Property, & Equipment***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Fixed Asset Turnover** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Maine Medical | 1.671 | 1.568 | 1.617 | 1.680 | 1.933 |
| All Maine Hospital Median | 2.9 | 2.78 | 2.72 | 2.63 | 2.96 |
| National Median | 1.97 | 1.87 | 1.95 | 1.96 | NAV |

**Trends in Fixed Asset Turnover:** Fixed Asset Turnover is relatively unchanged in 2010, declining slightly.

**Forecast:** Fixed Asset Turnover ratios should remain stable during most of the next few years.

**CONU Summary of Financial Ratios:** Below is a chart summarizing the percentage of time Maine Medical Center Meets or exceeds Maine or National medians:

|  |  |  |  |
| --- | --- | --- | --- |
| **MAINE MEDICAL CENTER** | **RATIO** | **MAINE** | **NATIONAL** |
| Profitability | Operating Margin | 100.00% | NAV |
| Profitability | Net Operating Income | 100.00% | NAV |
| Profitability | Return on Equity | 100.00% | 100.00% |
| Liquidity | Current Ratio | 100.00% | 100.00% |
| Liquidity | Days Cash on Hand | 100.00% | 100.00% |
| Liquidity | Avg. Payment Period | 20.00% | 0.00% |
| Capital Structure | Debt Service Coverage | 100.00% | 100.00% |
| Capital Structure | Cash Flow to Total Debt | 100.00% | 100.00% |
| Capital Structure | Fixed Asset Financing | 100.00% | 100.00% |
| Asset Efficiency | Total Asset Turnover | 0.00% | 0.00% |
| Asset Efficiency | Fixed Asset Turnover | 0.00% | 0.00% |

NAV-Not available

Maine Medical Center meets or exceeds Maine performance averages in 8 out of 11 measures and exceeds National Averages in 6 out of 9 measures.

The applicant addressed this section by referring to their Certificate of Need financial module and their audited financial statements prepared by Deloitte & Touche LLP. The applicant’s financial module for year 1 through year 4 of the proposed project (2014 through 2017) shows sufficient revenues to cover the incremental increase in operating expense associated with this project. Based on Maine Medical Centers 2012 consolidated balance sheet and consolidated statements of operations Maine Medical Center has sufficient financial resources (Cash of $21,142,000, Investments of $204,718,000 and Income from Operations of $31,045,000) to support this proposed project in the event that financial projections are not realized.

It should be noted that Maine Medical Center has successfully completed two other capital expansion projects which required Certificate of Need approval. In 2007 MMC completed a $25,024,000 expansion of its’ Emergency Department and Diagnostic Imaging suite and in 2009 it completed a $5,136,500 renovation of its P-6 Medical/Geriatric Psychiatry Inpatient Unit. CONU is not aware of any upcoming regulatory changes which would adversely affect this proposed project.

**iii. Conclusion**

CON RECOMMENDATION: CONU recommends that the Commissioner determine that the applicant has met their burden to demonstrate: (1) the capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and (2) the applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.

# IV. Public Need

**A. From Applicant**

“Relevant criteria for inclusion in this section are specific to the determination there is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

* Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project.
* Whether the project will have a positive impact on the health status indicators of the population to be served.
* Whether the services affected by the project will be accessible to all residents of the area proposed to be served.
* Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.”

**“Community Health Needs: The project will substantially address specific health problems as measured by health needs in the area to be served by the project.”**

“MMC defines its service area in the following manner:

Primary: Cumberland and York counties (PSA);

Secondary: Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo counties (SSA);

Tertiary: Aroostook, Hancock, Penobscot, Piscataquis and Washington counties as well as Out of State (TSA).”

“MMC is a tertiary care and referral center that addresses health care needs for the entire state of Maine. MMC’s specialty and subspecialty clinical services, including several surgical services and interventional cardiovascular services (cardiac surgery, thoracic surgery, vascular surgery and interventional cardiology) have significant reach beyond MMC’s primary service area of Cumberland and York counties.”

“MMC’s Surgical Services address specific health problems and needs including cancer, cardiovascular diseases, eye diseases and injuries, gastric and intestinal diseases and injury, gynecological diseases and injury, joint and bone diseases and injury, neurological and spinal diseases and injury, obesity, trauma and urological diseases and injury.”

“MMC’s Cardiovascular Service Line addresses the treatment needs of patients with cardiovascular diseases such as coronary artery disease, valvular heart disease, congestive heart failure, arrhythmias, congenital heart disease and peripheral vascular disease.”

“MMC’s Marketshare of Maine Hospitals’ Inpatient Surgical Discharges

MMC addresses a significant portion of Maine’s need for inpatient surgical care; MMC accounts for nearly one third of all Maine residents’ discharges from Maine hospitals for surgical care. MMC provides more than 60% of its primary service area’s inpatient surgical care needs, more than 26% of its secondary service area’s inpatient surgical care needs and more than 6% of the inpatient surgical care needs of the five northern and eastern Maine counties.”

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **“Maine Hospitals’ Surgical Discharges, CY 2008 to 2010**  **Maine Medical Center Market Share of Surgical Discharges by Patient Residence** | | | | | | | | | | | |
| Calendar Year | | 2008 | | | 2009 | | | | 2010 | | |
|  | | MMC Cases | MMC Market Share | All Maine Hospitals | MMC Cases | MMC Market Share | | All Maine Hospitals | MMC Cases | MMC Market Share | All Maine Hospitals | |
| PSA | Cumberland | 5,536 | 67.5% | 8,198 | 5,347 | 69.5% | | 7,698 | 5,201 | 70.0% | 7,433 |
| York | 2,201 | 41.3% | 5,328 | 2,290 | 44.2% | | 5,178 | 2,233 | 45.7% | 4,884 |
| **PSA** | **7,737** | **57.2%** | **13,526** | **7,637** | | **59.3%** | **12,876** | **7,434** | **60.4%** | **12,317** |
|  |  |  |  |  |  | |  |  |  |  |  |
| SSA | Androscoggin | 495 | 13.8% | 3,597 | 545 | | 15.2% | 3,579 | 489 | 14.3% | 3,431 |
| Franklin | 223 | 21.5% | 1,036 | 204 | | 20.6% | 988 | 197 | 22.7% | 866 |
| Kennebec | 985 | 24.8% | 3,973 | 1,059 | | 27.6% | 3,837 | 1,049 | 27.9% | 3,760 |
| Knox | 409 | 30.9% | 1,323 | 456 | | 34.0% | 1,341 | 515 | 38.7% | 1,330 |
| Lincoln | 517 | 43.2% | 1,198 | 557 | | 46.9% | 1,187 | 560 | 47.6% | 1,177 |
| Oxford | 526 | 27.0% | 1,947 | 512 | | 28.2% | 1,813 | 505 | 27.9% | 1,810 |
| Sagadahoc | 415 | 38.9% | 1,066 | 417 | | 39.7% | 1,051 | 432 | 43.5% | 992 |
| Somerset | 262 | 15.8% | 1,661 | 311 | | 19.6% | 1,585 | 286 | 18.5% | 1,548 |
| Waldo | 189 | 14.3% | 1,324 | 194 | | 15.3% | 1,265 | 196 | 15.9% | 1,231 |
| **SSA** | **4,021** | **23.5%** | **17,125** | **4,255** | | **25.6%** | **16,646** | **4,229** | **26.2%** | **16,145** |
|  |  |  |  |  |  | |  |  |  |  |  |
| TSA | Aroostook | 178 | 7.0% | 2,541 | 225 | | 9.4% | 2,389 | 256 | 11.2% | 2,276 |
| Hancock | 90 | 4.9% | 1,826 | 107 | | 6.2% | 1,715 | 113 | 6.9% | 1,629 |
| Penobscot | 188 | 3.9% | 4,789 | 213 | | 4.5% | 4,735 | 195 | 4.5% | 4,350 |
| Piscataquis | 42 | 6.6% | 634 | 31 | | 5.3% | 590 | 41 | 7.0% | 583 |
| Washington | 54 | 4.0% | 1,334 | 54 | | 4.7% | 1,144 | 50 | 4.5% | 1,113 |
| **TSA** | **552** | **5.0%** | **11,124** | **630** | | **6.0%** | **10,573** | **655** | **6.6%** | **9,951** |
|  |  |  |  |  |  | |  |  |  |  |  |
| Maine | | 12,310 | 29.5% | 41,775 | 12,522 | | 31.2% | 40,095 | 12,318 | 32.1% | 38,413 |
| Out of State | | 703 | 51.3% | 1,370 | 741 | | 53.5% | 1,386 | 720 | 56.9% | 1,265 |
| **TOTAL** | | **13,013** | **30.2%** | **43,145** | **13,263** | | **32.0%** | **41,481** | **13,038** | **32.9%** | **39,678** |
| Source: Maine Health Data Organization’s Hospital Inpatient Discharges Databases, CY 2008, 2009, 2010.” | | | | | | | | | | | |

“MMC’s Marketshare of Maine Hospitals’ Inpatient Interventional Cardiovascular Discharges

MMC addresses a significant portion of Maine’s need for inpatient interventional cardiovascular care; MMC accounts for more than 40% of all Maine residents’ discharges from Maine hospitals for interventional cardiovascular care. MMC provides more than 75% of its primary service area’s inpatient interventional cardiovascular care needs, more than 45% of its secondary service area’s inpatient interventional cardiovascular care needs and more than 3% of the inpatient interventional cardiovascular care needs of the five northern and eastern Maine counties.”

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **“Maine Hospitals’ Interventional Cardiovascular Discharges, CY 2008 to 2010** | | | | | | | | | | | |
| **Maine Medical Center Market Share of Interventional Cardiovascular Discharges by Patient Residence** | | | | | | | | | | | |
|  | Calendar Year | | 2008 | | | 2009 | | | 2010 | | |
|  |  | | MMC Cases | MMC Market Share | All Maine hospitals | MMC Cases | MMC Market Share | All Maine hospitals | MMC Cases | MMC Market Share | All Maine hospitals |
| PSA | Cumberland | | 1,416 | 83% | 1,709 | 1,435 | 84% | 1,706 | 1,297 | 85% | 1,530 |
|  | York | | 751 | 68% | 1,108 | 804 | 71% | 1,125 | 729 | 72% | 1,012 |
|  | **PSA** | | **2,167** | **77%** | **2,817** | 2,239 | **79%** | **2,831** | **2,026** | **80%** | **2,542** |
|  |  | |  |  |  |  |  |  |  |  |  |
| SSA | Androscoggin | | 153 | 22% | 704 | 134 | 20% | 662 | 123 | 20% | 610 |
|  | Franklin | | 103 | 47% | 221 | 93 | 43% | 217 | 72 | 38% | 190 |
|  | Kennebec | | 428 | 54% | 790 | 463 | 60% | 774 | 422 | 55% | 763 |
|  | Knox | | 163 | 62% | 262 | 162 | 57% | 285 | 200 | 76% | 264 |
|  | Lincoln | | 225 | 81% | 278 | 206 | 80% | 256 | 233 | 85% | 273 |
|  | Oxford | | 187 | 44% | 421 | 173 | 47% | 367 | 156 | 42% | 373 |
|  | Sagadahoc | | 141 | 70% | 201 | 151 | 73% | 206 | 163 | 71% | 229 |
|  | Somerset | | 108 | 24% | 458 | 122 | 32% | 381 | 103 | 28% | 366 |
|  | Waldo | | 65 | 23% | 277 | 52 | 21% | 245 | 50 | 19% | 257 |
|  | **SSA** | | **1,573** | **44%** | **3,612** | 1,556 | **46%** | **3,393** | **1,522** | **46%** | **3,325** |
|  |  | |  |  |  |  |  |  |  |  |  |
| TSA | Aroostook | | 31 | 5% | 647 | 38 | 7% | 581 | 46 | 7% | 622 |
|  | Hancock | | 9 | 2% | 402 | 8 | 2% | 411 | 9 | 2% | 366 |
|  | Penobscot | | 34 | 3% | 1,164 | 29 | 3% | 1,124 | 23 | 2% | 981 |
|  | Piscataquis | | 8 | 5% | 163 | 5 | 3% | 145 | 6 | 4% | 155 |
|  | Washington | | 7 | 2% | 307 | 8 | 3% | 284 | 6 | 2% | 246 |
|  | **TSA** | | **89** | **3%** | **2,683** | 88 | **3%** | **2,545** | **90** | **4%** | **2,370** |
|  |  | |  |  |  |  |  |  |  |  |  |
| Maine | | | 3,829 | 42% | 9,112 | 3,883 | 44% | 8,769 | 3,638 | 44% | 8,237 |
| Out of State | | | 236 | 61% | 386 | 211 | 62% | 343 | 211 | 64% | 330 |
| **Total** | |  | **4,065** | **43%** | **9,498** | **4,094** | **45%** | **9,112** | **3,849** | **45%** | **8,567** |
| Source: Maine Health Data Organization’s Hospital Inpatient Discharges Databases, CY 2008, 2009, 2010.” | | | | | | | | | | | |

“MMC’s Patient Origin for Inpatient Surgical and Interventional Cardiovascular Discharges

MMC’s role as a tertiary care and referral center that addresses health care needs of the entire state of Maine is demonstrated not only by its market share of Maine residents’ inpatient surgical and interventional cardiovascular care but also by its patient origin for these care needs. MMC’s specialty and subspecialty clinical services, including these services have significant reach beyond Cumberland and York counties, MMC’s primary service area. More than 40% of MMC’s inpatient surgical care patients reside outside of its primary service area. More than 45% of MMC’s inpatient interventional cardiovascular care patients reside outside of its primary service area.”

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| “**“MMC’s Surgical Discharges CY 2008 -2010**  **Patient Origin by Patient’s Residence** | | | | | | | |
| Calendar Year | | 2008 | | 2009 | | 2010 | |
|  | | Cases | % of MMC Cases | Cases | % of MMC Cases | Cases | % of MMC Cases |
| PSA | Cumberland | 5,536 | 42.5% | 5,347 | 40.3% | 5,201 | 39.9% |
| York | 2,201 | 16.9% | 2,290 | 17.3% | 2,233 | 17.1% |
| **PSA** | **7,737** | **59.5%** | **7,637** | **57.6%** | **7,434** | **57.0%** |
|  |  |  |  |  |  |  |  |
| SSA | Androscoggin | 495 | 3.8% | 545 | 4.1% | 489 | 3.8% |
| Franklin | 223 | 1.7% | 204 | 1.5% | 197 | 1.5% |
| Kennebec | 985 | 7.6% | 1,059 | 8.0% | 1,049 | 8.0% |
| Knox | 409 | 3.1% | 456 | 3.4% | 515 | 3.9% |
| Lincoln | 517 | 4.0% | 557 | 4.2% | 560 | 4.3% |
| Oxford | 526 | 4.0% | 512 | 3.9% | 505 | 3.9% |
| Sagadahoc | 415 | 3.2% | 417 | 3.1% | 432 | 3.3% |
| Somerset | 262 | 2.0% | 311 | 2.3% | 286 | 2.2% |
| Waldo | 189 | 1.5% | 194 | 1.5% | 196 | 1.5% |
| **SSA** | **4,021** | **30.9%** | **4,255** | **32.1%** | **4,229** | **32.4%** |
|  |  |  |  |  |  |  |  |
| TSA | Aroostook | 178 | 1.4% | 225 | 1.7% | 256 | 2.0% |
| Hancock | 90 | 0.7% | 107 | 0.8% | 113 | 0.9% |
| Penobscot | 188 | 1.4% | 213 | 1.6% | 195 | 1.5% |
| Piscataquis | 42 | 0.3% | 31 | 0.2% | 41 | 0.3% |
| Washington | 54 | 0.4% | 54 | 0.4% | 50 | 0.4% |
| **TSA** | **552** | **4.2%** | **630** | **4.8%** | **655** | **5.0%** |
|  |  |  |  |  |  |  |  |
| Maine |  | 12,310 | 94.6% | 12,522 | 94.4% | 12,318 | 94.5% |
| Out of State | | 703 | 5.4% | 741 | 5.6% | 720 | 5.5% |
| **TOTAL** | | **13,013** | **100%** | **13,263** | **100%** | **13,038** | **100%** |
| Source: Maine Health Data Organization’s Hospital Inpatient Discharges Databases, CY 2008, 2009, 2010.” | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **“MMC's Interventional Cardiovascular Discharges CY 2008 -2010**  **Patient Origin by Patient’s Residence** | | | | | | |
|  |
|  | Calendar Year | 2008 | | 2009 | | 2010 | |
|  |  | Cases | % of MMC Cases | Cases | % of MMC Cases | Cases | % of MMC Cases |
| PSA | Cumberland | 1,416 | 35% | 1,435 | 35% | 1,297 | 34% |
|  | York | 751 | 18% | 804 | 20% | 729 | 19% |
|  | **PSA** | **2,167** | **53%** | **2,239** | **55%** | **2,026** | **53%** |
|  |  |  |  |  |  |  |  |
| SSA | Androscoggin | 153 | 4% | 134 | 3% | 123 | 3% |
|  | Franklin | 103 | 3% | 93 | 2% | 72 | 2% |
|  | Kennebec | 428 | 11% | 463 | 11% | 422 | 11% |
|  | Knox | 163 | 4% | 162 | 4% | 200 | 5% |
|  | Lincoln | 225 | 6% | 206 | 5% | 233 | 6% |
|  | Oxford | 187 | 5% | 173 | 4% | 156 | 4% |
|  | Sagadahoc | 141 | 3% | 151 | 4% | 163 | 4% |
|  | Somerset | 108 | 3% | 122 | 3% | 103 | 3% |
|  | Waldo | 65 | 2% | 52 | 1% | 50 | 1% |
|  | **SSA** | **1,573** | **39%** | **1,556** | **38%** | **1,522** | **40%** |
|  |  |  |  |  |  |  |  |
| TSA | Aroostook | 31 | 1% | 38 | 1% | 46 | 1% |
|  | Hancock | 9 | 0% | 8 | 0% | 9 | 0% |
|  | Penobscot | 34 | 1% | 29 | 1% | 23 | 1% |
|  | Piscataquis | 8 | 0% | 5 | 0% | 6 | 0% |
|  | Washington | 7 | 0% | 8 | 0% | 6 | 0% |
|  | **TSA** | **89** | **2%** | **88** | **2%** | **90** | **2%** |
|  |  |  |  |  |  |  |  |
| Maine | | 3,829 | 94% | 3,883 | 95% | 3,638 | 95% |
| Out of State | | 236 | 6% | 211 | 5% | 211 | 5% |
| **Total** | | **4,065** | **100%** | **4,094** | **100%** | **3,849** | **100%** |
| Source: Maine Health Data Organization’s Hospital Inpatient Discharges Databases, CY 2008, 2009, 2010.” | | | | | | | |

“MMC Patient Origin for Inpatient and Outpatient Surgical and Interventional Cardiovascular Patients

MMC’s role as a tertiary care and referral center that addresses health care needs of the entire state of Maine is further demonstrated by its patient origin for both inpatient and outpatient needs. MMC’s specialty and subspecialty clinical services, including these services have significant reach beyond Cumberland and York counties, MMC’s primary service area. Approximately 40% of all MMC’s surgical care patients reside outside of its primary service area. Approximately 45% of all MMC’s interventional cardiovascular patients reside outside of its primary service area.”

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **“MMC Total Surgical Cases, FY 2008 – FY 2012** | | | | | | | | |
| **MMC Patient Origin by Patient Residence** | | | | | | | | |
|  | **Cases / Fiscal Year** | | | | **% of MMC Cases** | | | |
| **Area** | **2009** | **2010** | **2011** | **2012** | **2009** | **2010** | **2011** | **2012** |
| Cumberland | 11,289 | 10,809 | 11,084 | 11,079 | 44% | 41% | 44% | 43% |
| York | 3,946 | 3,739 | 4,061 | 3,978 | 16% | 14% | 16% | 16% |
| **PSA** | **15,235** | **14,548** | **15,145** | **15,057** | **60%** | **55%** | **60%** | **59%** |
|  |  |  |  |  |  |  |  |  |
| Androscoggin | 1,027 | 965 | 1,017 | 1,059 | 4% | 4% | 4% | 4% |
| Franklin | 301 | 271 | 303 | 296 | 1% | 1% | 1% | 1% |
| Kennebec | 1,461 | 1,314 | 1,418 | 1,472 | 6% | 5% | 6% | 6% |
| Knox | 578 | 574 | 599 | 562 | 2% | 2% | 2% | 2% |
| Lincoln | 659 | 595 | 659 | 688 | 3% | 2% | 3% | 3% |
| Oxford | 922 | 838 | 906 | 943 | 4% | 3% | 4% | 4% |
| Sagadahoc | 596 | 541 | 569 | 611 | 2% | 2% | 2% | 2% |
| Somerset | 432 | 388 | 394 | 406 | 2% | 1% | 2% | 2% |
| Waldo | 281 | 46 | 251 | 280 | 1% | 1% | 1% | 1% |
| **SSA** | **6,257** | **5,732** | **6,116** | **6,317** | **25%** | **22%** | **24%** | **25%** |
|  |  |  |  |  |  |  |  |  |
| Aroostook | 367 | 333 | 408 | 379 | 1% | 1% | 2% | 1% |
| Hancock | 158 | 178 | 205 | 173 | 1% | 1% | 1% | 1% |
| Penobscot | 380 | 339 | 354 | 387 | 1% | 1% | 1% | 2% |
| Piscataquis | 53 | 56 | 66 | 67 | 0.2% | 0.2% | 0.3% | 0.3% |
| Washington | 58 | 53 | 58 | 52 | 0.2% | 0.2% | 0.2% | 0.2% |
| **TSA** | **1,016** | **959** | **1,091** | **1,058** | **4%** | **4%** | **4%** | **4%** |
|  |  |  |  |  |  |  |  |  |
| Maine | 22,508 | 21,239 | 22,352 | 22,432 | 88% | 80% | 88% | 88% |
| Other/Unknown | 2,943 | 5,198 | 2,944 | 3,1668 | 12% | 20% | 12% | 12% |
| **Total** | **25,451** | **26,438** | **25,296** | **25,598** | **100%** | **100%** | **100%** | **100%** |
| Source: MMC internal data” | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **“MMC Total Interventional Cardiovascular Cases, FY 2008 – FY 2012** | | | | | | | | |
| **MMC Patient Origin by Patient Residence** | | | | | | | | |
|  | **Cases / Fiscal Year** | | | | **% of MMC Cases** | | | |
| **Area** | **2009** | **2010** | **2011** | **2012** | **2009** | **2010** | **2011** | **2012** |
| Cumberland | 1,161 | 1,205 | 1,297 | 1,093 | 39% | 36% | 38% | 34% |
| York | 482 | 537 | 564 | 456 | 16% | 16% | 17% | 14% |
| **PSA** | **1,643** | **1,742** | **1,861** | **1,549** | **55%** | **51%** | **55%** | **49%** |
|  |  |  |  |  |  |  |  |  |
| Androscoggin | 73 | 90 | 74 | 83 | 2% | 3% | 2% | 3% |
| Franklin | 91 | 71 | 81 | 50 | 3% | 2% | 2% | 2% |
| Kennebec | 254 | 265 | 291 | 226 | 9% | 8% | 9% | 7% |
| Knox | 88 | 97 | 101 | 127 | 3% | 3% | 3% | 4% |
| Lincoln | 103 | 112 | 96 | 85 | 3% | 3% | 3% | 3% |
| Oxford | 123 | 120 | 117 | 96 | 4% | 4% | 3% | 3% |
| Sagadahoc | 78 | 70 | 79 | 50 | 3% | 2% | 2% | 2% |
| Somerset | 91 | 102 | 82 | 74 | 3% | 3% | 2% | 2% |
| Waldo | 47 | 64 | 42 | 45 | 2% | 2% | 1% | 1% |
| **SSA** | **948** | **991** | **963** | **836** | **32%** | **29%** | **28%** | **26%** |
|  |  |  |  |  |  |  |  |  |
| Aroostook | 33 | 39 | 31 | 38 | 1% | 1% | 1% | 1% |
| Hancock | 20 | 17 | 7 | 12 | 1% | 1% | 0% | 0% |
| Penobscot | 22 | 18 | 37 | 22 | 1% | 1% | 1% | 1% |
| Piscataquis | 6 | 7 | 7 | 5 | 0% | 0% | 0% | 0% |
| Washington | 6 | 4 | 1 | 1 | 0% | 0% | 0% | 0% |
| **TSA** | **87** | **85** | **83** | **78** | **3%** | **3%** | **2%** | **2%** |
|  |  |  |  |  |  |  |  |  |
| Maine | 2,678 | 2,818 | 2,907 | 2,463 | 90% | 83% | 86% | 78% |
| Other/Unknown | 302 | 572 | 485 | 715 | 10% | 17% | 14% | 22% |
| **TOTAL** | **2,980** | **3,390** | **3,392** | **3,178** | **100%** | **100%** | **100%** | **100%** |
| Source: MMC internal data” | | | | | | | | |

**“Health Status: The project will have a positive impact on the health status indicators of the population to be served.”**

“This project is one aspect of MMC’s integrated approach to chronic disease. MMC’s Surgical Service Line addresses the treatment needs of patients with such chronic illnesses as cancer, cardiovascular disease, chronic lung disease, diabetes, and obesity. MMC’s Cardiovascular Service Line addresses the treatment needs of patients with cardiovascular diseases such as coronary artery disease, valvular heart disease, congestive heart failure, arrhythmias, congenital heart disease and peripheral vascular disease. These treatment needs will continue to exist and be necessary to a comprehensive full-spectrum approach to chronic diseases and their impact.”

“MMC participates in MaineHealth’s health status improvement, clinical integration and quality improvement initiatives, which should over time impact utilization positively. Management of populations with chronic diseases has become a major focus of MaineHealth’s clinical integration initiatives.”

“Please see Section VII. Service Utilization for further information on these MaineHealth initiatives.”

**“Access to Care: The services affected by the project will be accessible to all residents of the area proposed to be served.”**

“MMC’s facilities are open to all physicians who meet its Medical Staff credentialing and privileging requirements. MMC provides a full range of health care services to all patients regardless of ability to pay.”

“Surgical and interventional cardiology services provide the necessary revenue, which is used by MMC to fund services needed by the community that are not adequately funded and to offset the shortfalls resulting from payments by Medicare and Medicaid, which do not cover costs. MMC uses the revenues from services such as these, which due to the vagaries of health care financing, are reimbursed at rates that more than cover their costs to subsidize other critical services which do not generate sufficient revenue to cover even their direct costs. These services include 24-hour emergency services, trauma, high risk obstetrics, neonatal intensive care, mental health, specialized pediatrics, intensive care, and community clinics.”

“MMC provides care to patients who meet certain criteria under its free care policy without charge or at amounts less than its established rates. Because MMC does not pursue collection of amounts determined to qualify as free care, they are not reported as net patient service revenue.”

“MMC provided charity care estimated to cost $19.5 million in fiscal year 2012. In addition to this care for which charges were never made, MMC provided care to those either unable or unwilling to pay estimated to cost an additional $17.6 million in fiscal year 2012.”

“As a not-for-profit institution dedicated to community service, MMC provides many services to the community in addition to its range of health care services. These include more than 20% of all the free care delivered in Maine, an International Clinic for Portland’s growing immigrant and refugee population, the AIDS Consultation Service, and the Northern New England Poison Center.”

“MMC has programs designed to affect both the direct health of the community and also the overall quality of life of the community. These programs include CarePartners, a health care program for those who can’t afford to buy insurance but are above the guidelines for government programs; the Ah! Asthma Health for Children program, which improves the chronic care of children with asthma; Raising Readers, which aims to provide all Maine children between ages 0 and 5 years with books; and a Vocational Services program that leverages $368,000 in federal funds during FY 2012 to integrate people with physical and psychological disabilities into the community.”

“Services and programs include:

* Outpatient Clinics: Provide primary care to financially disadvantaged and special patient populations. Include Adult Cystic Fibrosis, Broncho-Pulmonary, Burn, Cardiac, Colposcopy, Cystic Fibrosis, Dermatology, Diabetes, Enterostomal, Endocrine, Geriatric, G. I., Infectious Disease, International, Nerve Block, Surgical, Primary Care, Displasia, General Pediatric, Pediatric G. I., Neonatal Intensive Care Unit Follow-Up, Pediatric Continuity, Pediatric Pulmonary, Spina Bifida, TB, Urgent Care, Virology, Wound Care.
* Portland Family Medicine (formerly Family Medicine Institute): Provides primary care to East End Portland emphasizing community-based, long-term, comprehensive, preventive care on a sliding fee scale.”
* “Community Mental Health Center: A principal source of outpatient mental health and vocational rehabilitation services for residents of greater Portland.
* Northern New England Poison Center: Provides 24-hour toll-free hotline services throughout Maine, New Hampshire and Vermont.”

“In addition to MMC’s credentialing and privileging policies, free care policies and clinic services, Maine Medical Partners (MMP) surgical practices provide local access surgical services by operating outreach clinics at various MaineHealth member and affiliate hospitals. (Otolaryngology outreach clinics at Stephens Memorial Hospital and Southern Maine Medical Center, Urology outreach clinics at Stephens Memorial Hospital and St. Mary’s Regional Medical Center – pending final contract) MMP surgical practices also provide call coverage at various MaineHealth member hospitals, a critical support that helps maintain local surgical care in those communities. (Orthopedic Trauma – Miles Memorial Hospital and Pen Bay Medical Center under development, Otolaryngology - Stephens Memorial Hospital and Southern Maine Medical Center, General Surgery, Trauma and Critical Care – Miles Memorial Hospital, and Urology – Stephens Memorial Hospital) **Access to Care: MMC’s Bramhall operating rooms are functioning at an unsustainably high utilization rate.”**

“MMC’s 24 Bramhall operating rooms are functioning at a greater than 90% utilization rate, which is not sustainable. Industry standards and Department guidelines recommend an 80% utilization rate for optimal efficiency. MMC has targeted an 85% utilization rate for its surgical services. Increasing utilization much beyond 80% to 85% increases the challenges of eliminating threats to patient safety, reduces operating room availability to address emergent and urgent demand, and increases the probability of delaying and canceling scheduled cases.”

“The following tables’ present information on MMC’s Bramhall Surgical Services actual and forecast utilization. Annual case hours (case hours include cleaning and set up time) that occurred during Bramhall Surgical Services’ normally scheduled hours are divided by available OR time based on each OR being available an average of 2,375 hours per year (9.5 hours x five days per week x 50 weeks per year). The 24th Bramhall OR was available for the last 3 months of FY 2012, the equivalent of .25 OR.”

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| “**MMC Bramhall Surgical Services** | | | | | |
| **Actual Operating Utilization FY 2008 - 2012** | | | | | |
| **FYE** | **2008** | **2009** | **2010** | **2011** | **2012** |
| Inpt. Cases | 11,748 | 12,488 | 12,815 | 12,461 | 12,676 |
| Outpt. Cases | 7,365 | 7,001 | 7,351 | 7,657 | 7,598 |
| Total Cases | 19,113 | 19,489 | 20,166 | 20,118 | 20,274 |
|  |  |  |  |  |  |
| Demand during Scheduled Hours (excludes off shift cases) | | | | | |
| Case Hours | 47,081 | 48,078 | 50,043 | 49,788 | 50,313 |
|  |  |  |  |  |  |
| Available ORs. | 21 | 21 | 23 | 23 | 23.25 |
| Note: OR 24 opened in 4thQ FY12, the equivalent of ¼ OR for yr. | | | | | |
| Scheduled Hrs. | 49,875 | 49,875 | 54,625 | 54,625 | 55,219 |
|  |  |  |  |  |  |
| Utilization | 94.4% | 96.4% | 91.6% | 91.1% | 91.1%” |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **“MMC Bramhall Surgical Services** | | | | | |
| **Forecast Operating Utilization FY 2013 - 2017** | | | | | |
|  |  |  | **Project’s 1st 3 Years** | | |
| **FYE** | **2013** | **2014** | **2015** | **2016** | **2017** |
| Inpt. Cases | 13,108 | 13,515 | 13,760 | 13,988 | 14,182 |
| Outpt. Cases | 7,784 | 7,976 | 8,095 | 8,186 | 8,222 |
| Total Cases | 20,892 | 21,491 | 21,855 | 22,174 | 22,404 |
|  |  |  |  |  |  |
| Demand during Scheduled Hours (excludes off shift cases) | | | | | |
| Case Hours | 48,794 | 50,219 | 51,083 | 51,850 | 52,428 |
|  |  |  |  |  |  |
| Available ORs. | 24 | 24 | 28 | 28 | 28 |
| Scheduled Hrs. | 53,400 | 53,400 | 62,300 | 62,300 | 62,300 |
|  |  |  |  |  |  |
| Utilization | 91.4% | 94.0% | 82.0% | 83.2% | 84.2%” |

“MMC believes that the demand for complex and emergent surgical and cardiovascular services will continue to increase and that improving timely access to operating room capacity for these patients is essential. MMC is Maine’s only American College of Surgeons’ designated Adult Level 1 Trauma Center and offers the most extensive scope of surgical specialties and subspecialties in the state. MMC’s Heart Valve Center is Maine’s only provider of TAVR procedures, offering a viable treatment alternative to patients with severe aortic stenosis who are at too high a risk for Surgical AVR.”

“When emergent and urgent patients disrupt the operating room schedule, scheduled patients encounter delays and cancellations. These delays and cancellations often result in longer lengths of stay for inpatients or in the need to reschedule procedures and return on another day for outpatients. These delays, cancellations and rescheduled cases create disruptions in scheduling for surgeons and staff. These inefficiencies result in avoidable costs to the health care system.”

**“Quality of Care: The project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project”**

“This project will improve the quality of health care delivery in the following manner:

* Improve availability of care for complex inpatient, emergency and trauma surgery patients at the Bramhall campus, which is the appropriate site for such services.
* Improve timely access to MMC’s Bramhall operating rooms for patients with emergent and urgent surgical needs.
* Improve timely access to MMC’s Bramhall hybrid operating rooms for patients undergoing minimally invasive surgical and interventional procedures requiring intraoperative imaging.
* Minimize delays and cancellations experienced by scheduled inpatients and outpatients when emergent and urgent cases disrupt the Bramhall operating room schedule.
* Reduce disruptions in scheduling for surgeons and staff, and the associated avoidable costs to the health care system caused by delays and cancellations.
* Decompress strain placed on MMC’s surgical services capacity by higher than recommended utilization.”
* “Enable MMC to manage the utilization of its operating rooms to levels more sustainable and more “consistent with industry standards.”

“MMC Surgical Services’ Quality of Care

MMC Surgical Services participates in the MaineHealth Surgical Quality Collaborative (MHSQC), a voluntary collaboration of MaineHealth hospitals that provides professional competence review activities including analysis and feedback in support of the quality review, outcomes review, and provider education activities in participating hospitals.”

“MHSQC is involved in the American College of Surgeons National Surgical Quality Improvement Program (NSQIP), the first nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care.”

“MMC Cardiovascular Services’ Quality of Care

MMC is founding member of the Northern New England Cardiovascular Study Group (NNECSG), a regional voluntary consortium founded in 1987 to provide information about the management of cardiovascular disease in Maine, New Hampshire, and Vermont. NNECSG maintains registries for all patients receiving coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI), and heart valve replacement surgery.”

“MMC also submits clinical data regarding its cardiovascular surgery program to the Society of Thoracic Surgery Database (STS). The STS National Database was established in 1989 as an initiative for quality improvement and [patient safety](http://www.sts.org/quality-research-patient-safety/patient-safety) among cardiothoracic surgeons.”

“MMC outcomes as reported in both the NNECSG and the STS compare very favorably to regional and national benchmarks, including top quartile performance for overall quality in the STS Registry. Most recent data from STS show MMC risk-adjusted operative mortality rates for all cardiac surgeries to be approximately 0.7% compared to a peer group (like programs) and national rates of 2.3% and 2.3% respectively.”

“Please see Section VI. Outcomes and Community Impact for further information.”

**“This project is an initial step in replacing and modernizing MMC’s interventional capacity.”**

“MMC’s surgical capacity needs to be replaced with larger operating rooms with more robust infrastructure. MMC’s operating rooms are undersized. More than half of MMC’s Bramhall operating rooms, built in the early 1980s, are smaller than 500 sf. Today’s standard calls for operating rooms for cardiovascular, orthopedic and neurosurgical procedures to be a minimum of 600 sf. (Guidelines for Design and Construction of Health care Facilities, 2006 edition) Hybrid operating rooms require 750 to 1,000 sf. MMC is unable to enlarge its operating rooms in their current location without major disruptions to the delivery of patient care, reduction in capacity, major facility expansion or some combination.”

“To determine the appropriate size of future operating rooms on the Bramhall campus, MMC surgeons, interventional cardiologists, interventional radiologists, neuro-intervention lists, anesthesiologists, angiography suite staff and operating room staff in cooperation with Perkins + Will, the project architect, and Suffolk Construction, the project construction manager, tested staff flow, patient flow, material flow and equipment placement for a variety of surgical case types (cardiac, neurosurgery, orthopedic, spine, etc.) and a variety of interventional angiography case types (cardiac catheterization, electrophysiology, neuro-endovascular, interventional radiology) in an interventional room mock up with movable walls to determine the appropriate dimensions of the interventional rooms capable of supporting MMC’s interventional services (surgery and angiography).”

“As a result of these trials, MMC is planning operating rooms and angiography suites of 650 sf., which meet today’s standard. The Bean 2 operating rooms are the first installation of these interventional rooms. The rooms are sized to accommodate a wide range of current and future technologies, support the continuing convergence of surgery and endovascular technology and are designed to easily convert to angiography service in the future if desirable.”

“MMC intends to perform a similar set of trials to determine the appropriate size for hybrid interventional rooms that support both minimally invasive and open surgery. In the interim, given existing conditions, MMC has identified one of its larger operating rooms as a suitable site for conversion to a hybrid operating room.”

“The project also adds 20 Preparation and Recovery bays (net increase of 18) to support the proposed Bean 2 operating rooms and the existing Joint Center program that is adjacent to Bean 2.”

“MMC’s surgical capacity requires upgraded electrical, ventilation and air conditioning infrastructure. The infrastructure supporting MMC’s operating rooms, designed in the early 1980s, is not engineered to support the electrical loads, cooling requirements and air exchange needs of contemporary surgical practice.”

“The following table identifies the location, square footage, current and proposed uses of MMC’s existing and proposed Bramhall Operating Rooms. The project involves building 5 ORs on Bean 2, converting 1 OR to a Cardiac Hybrid OR in the Main Surgical Suite and decommissioning another (undersized) OR in the Main Surgical Suite for use as storage.”

“Operating Rooms affected by this project appear in emboldened, italicized text."

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **“MMC Bramhall Campus Existing and Proposed Operating Rooms** | | | | |
| **Location** | **OR** | **SF** | **Current Use** | **Proposed Use** |
| **Main Surgical Suite** | **1** | **611** | **CardioThoracic OR** | **Cardiac Hybrid OR** |
| Main Surgical Suite | 2 | 638 | CardioThoracic OR | CardioThoracic OR |
| Main Surgical Suite | 3 | 453 | General OR | General OR |
| Main Surgical Suite | 4 | 460 | General OR | General OR |
| Main Surgical Suite | 5 | 600 | CardioThoracic OR | CardioThoracic OR |
| Main Surgical Suite | 6 | 451 | General OR | General OR |
| Main Surgical Suite | 7 | 494 | General OR | General OR |
| Main Surgical Suite | 8 | 482 | General OR | General OR |
| Main Surgical Suite | 9 | 475 | General OR | General OR |
| **Main Surgical Suite** | **10** | **449** | **General OR** | **Storage** |
| Main Surgical Suite | 11 | 622 | General OR | General OR |
| Main Surgical Suite | 12 | 653 | General OR | General OR |
| Main Surgical Suite | 13 | 611 | General OR | General OR |
| Main Surgical Suite | 14 | 451 | General OR | General OR |
| Main Surgical Suite | 15 | 495 | General OR | General OR |
| Main Surgical Suite | 16 | 460 | General OR | General OR |
| Main Surgical Suite | 17 | 736 | Endovascular Suite | Endovascular Suite |
| Main Surgical Suite | 18 | 370 | General OR | General OR |
| Main Surgical Suite | 19 | 603 | General OR | General OR |
| Main Surgical Suite | 20 | 381 | General OR | General OR |
| Joint Center | 21 | 585 | Joint Replacement | Joint Replacement |
| Joint Center | 22 | 519 | Joint Replacement | Joint Replacement |
| Joint Center | 23 | 476 | Joint Replacement | Joint Replacement |
| Joint Center | 24 | 520 | Joint Replacement | Joint Replacement |
| **Bean 2 Project** | **25** | **650** | **New** | **Neurosurgery/Spine** |
| **Bean 2 Project** | **26** | **650** | **New** | **Neurosurgery/Spine** |
| **Bean 2 Project** | **27** | **650** | **New** | **Neurosurgery/Spine** |
| **Bean 2 Project** | **28** | **650** | **New** | **Neurosurgery/Spine** |
| **Bean 2 Project** | **29** | **650** | **New** | **Neurosurgery/Spine** |

“

**B. CONU Discussion**

**i. CON Standards**

The relevant standard for inclusion in this section are specific to the determination there is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

* Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;
* Whether the project will have a positive impact on the health status indicators of the population to be served;
* Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and
* Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

**ii. CON Analysis**

The applicant has demonstrated that there is a current need to modernize MMC’s Bramhall Maine Surgical Suite. Over half of Bramhall’s surgical suites were built in the early 1980’s with less than 500 sf. of space. The 2010 Guidelines for Design and Construction of Health Care Facilities recommend that room for surgical procedures that require additional personnel and/or large equipment (e.g., some cardiovascular, orthopedic, and neurological procedures) need a minimum of 600 sf. of clear floor area. Hybrid operating rooms are being designed and constructed in the 750 to 1,000 sf. range. MMC’s 24 Bramhall operating rooms are functioning at a greater than 90% utilization rate which exceeds industry standards and DHHS guidelines which recommends an 80% utilization rate for optimal efficiency. Utilization beyond 85% increases the challenges of eliminating threats to patient safety, reduces operating room availability to address emergent and urgent demand, and increases the probability of delaying and canceling scheduled cases.

The applicant further states that there is a public need for this project because MMC is a tertiary care and referral center that addresses health care needs for the entire State of Maine. The applicant submitted surgical discharge data by patient residence which shows that MMC provides more than 60% of its primary service area’s (Cumberland and York counties) inpatient surgical care needs, more than 26% of its secondary service area’s (Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo counties) inpatient surgical care needs and more than 6% of the inpatient surgical care needs of the five northern and eastern Maine counties (Aroostook, Hancock, Penobscot, Piscataquis and Washington counties) as well as Out of State residents.

As stated above MMC’s Surgical Services address specific health problems that include: cancer, cardiovascular diseases, eye diseases and injuries, gastric and intestinal diseases and injury, gynecological diseases and injury, joint and bone diseases and injury, neurological and spinal diseases and injury, obesity, trauma and urological diseases and injury.

The services affected by the project will be accessible to all residents of the area proposed to be served. The applicant believes that the demand for complex and emergent surgical and cardiovascular service will continue to increase and provides supporting documentation forecasting a 7% growth in Bramhall operating utilization between 2013 and 2017 due to an aging Maine population, improved access to care through the Affordable Care Act, changing surgical practices resulting in specialty surgeons concentrating their practices at larger hospitals and increased physician recruitment at MMC in response to existing and forecasted demand.

The applicant lists several benefits resulting from this project that will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project:

* Improve availability of care for complex inpatient, emergency and trauma surgery patients at the Bramhall campus, which is the appropriate site for such services.
* Improve timely access to MMC’s Bramhall operating rooms for patients with emergent and urgent surgical needs.
* Improve timely access to MMC’s Bramhall hybrid operating rooms for patients undergoing minimally invasive surgical and interventional procedures requiring intraoperative imaging.
* Minimize delays and cancellations experienced by scheduled inpatients and outpatients when emergent and urgent cases disrupt the Bramhall operating room schedule.
* Reduce disruptions in scheduling for surgeons and staff, and the associated avoidable costs to the health care system caused by delays and cancellations.
* Decompress strain placed on MMC’s surgical services capacity by higher than recommended utilization.
* Enable MMC to manage the utilization of its operating rooms to levels more sustainable and more consistent with industry standards.

MMC surgeons, interventional cardiologists, interventional radiologists, neuro-intervention lists, anesthesiologists, angiography suite staff and operating room staff will work with project architects and construction managers to determine the future size of operating rooms based on staff flow, patient flow, material flow and equipment placement for different surgical and interventional procedures.

SURGERY VOLUME PROJECTIONS

The CONU conducted a public hearing regarding this project on July 30, 2013. Public Comments were received from Central Maine Healthcare and Mercy Hospital. Both parties expressed concern about the accuracy of forecasted volume increases for surgical services given that minimal increase or decreases in certain inpatient surgical services were presented in the CON application. MMC presented data further in their application which isolated actual utilization of the Bramhall operating rooms which show increased utilization. MMC’s response to this concern is included below:

Current utilization of MMC’s Bramhall Main Surgical Suite operating rooms exceeds the Department’s recommended guidelines and industry standards. Additional case volume exacerbates an existing condition that already demonstrates the need for additional capacity.

Past Growth

From FYE 2008 through FYE 2012 MMC’s Bramhall Main Surgical Suite experienced a

6% growth in cases.

See MMC, Bean 2 CON application, “MMC Bramhall Surgical Services Actual Operating Utilization FY 2008 – 2012”, p. 129.)

During that period MMC’s Surgical Services experienced a 7% growth in cases and its Scarborough Surgery Center case volume grew by 9%.

MMC Surgical Services

Actual Operating Utilization FY 2008 - 2012

FYE Bramhall Scarborough Total

2008 19,113 7,222 26,335

2009 19,489 7,912 27,401

2010 20,166 8,227 28,393

2011 20,118 7,652 27,770

2012 20,274 7,845 28,119

% Growth 6% 9% 7%

Projected Growth

The following table presents MMC’s forecast of surgical cases for the period FYE 2013 through FYE 2017. MMC is forecasting 7% growth in case volume for the Bramhall Main Surgical Suite and a more conservative 5% growth in total cases. This higher proportion of cases requiring service at the Bramhall campus is due to the various factors discussed above under the heading “Focus on Bramhall Main Surgical Suite’s capacity and utilization.”

MMC forecasts a modest 1% growth in Scarborough Surgery Center case volume during the forecast period. The Scarborough Surgery Center is capable of absorbing the additional forecasted volume for that facility. The Bramhall Main Surgical Suite requires additional capacity to meet current demand. This need becomes more acute in light of forecasted volume.

**MMC Surgical Services**

**Forecast Operating Utilization FY 2013 – 2017**

FYE Bramhall Scarborough Total

2013 20,892 7,864 28,756

2014 21,491 7,883 29,374

2015 21,855 7,902 29,757

2016 22,174 7,921 30,095

2017 22,404 7,926 30,330

% Growth 7% 1% 5%

Factors that MMC considers in forecasting increased case volume for its Bramhall Main Surgical Suite includes:

**Changing Demographics:** Maine’s population is aging at an increasing rate, and an older population (45 and older) requires surgery at a higher rate and for higher acuity, more complex surgery than younger age cohorts (44 and younger), which increases the number of surgeries statewide. In Cumberland and York counties, MMC’s primary service area, the overall population including younger age cohorts, is projected to grow, which increases the number of surgeries in MMC’s primary service area.

**Improving Access to Care:** The Maine economy continues to recover from the recession; the Accountable Care Act individual insurance mandate is taking effect. More people will be insured and will have improved access to health care, including surgery.

**Changing Surgical Practices:** Surgical specialties such as urology and pediatric surgery are experiencing labor shortages. Surgeons in these specialties are concentrating their practices at larger hospitals. Oncological surgeons, an emerging subspecialty of general surgery, also concentrate their practices at larger hospitals. These surgical practices are becoming referral practices serving larger geographic areas; this is especially true in rural states such as Maine with a widely dispersed population.

**Physician Recruitment:** MMC and Maine Medical Partners continue to recruit new surgeons to practice at MMC in order to meet the clinical needs of residents of greater Portland, the state of Maine and northern New England. Many of these surgeons are introducing new practices and procedures to Maine, supporting MMC’s role as a tertiary and quaternary referral center and reducing the need for Maine residents to leave the state to receive necessary surgical care. Other surgeons are being recruited to address existing demand on MMP’s surgical practices. Mercy Hospital also asked for an explanation about MMC’s methodology for arriving at operating room utilization rates. MMC’s explanation is included below in italics.

**Method used to determine needed operating room capacity**

MMC uses the following method published by the Department to determine the utilization rate and needed capacity for its Bramhall Campus Main Surgical Suite:

Surgical Suite (Inpatient)

Determine the number of ORs needed:

Volume of surgical procedures x average time/procedure Annual hours of operating time per OR x 80%

NOR = HOSY

DPY x HPD x .80

**Where:**

NOR = number of operating rooms needed

HOSY = hours of surgery including prep and clean-up time per year in scheduled OR hours

DPY = days per year of scheduled surgery

HPD = hours per day scheduled

.80 = desired average OR utilization percentage

**Assumptions:**

1) 80% utilization

2) 250 days/year

3) 7.5 hours/day

4) 1,500 hours/OR/Year

(Health Care Facility/Agency Space Needs and Guidelines, Department of Human Services, July 1998, p. 22)

Mercy Hospital uses the same method in its Certificate of Need Application to Develop Phase 1 of its Replacement Facility on the Fore River approved by the Department in February 2005.

(Preliminary Staff Assessment of a Proposal by Mercy Hospital to Develop Phase I of its Replacement Facility on the Fore River in Portland, December 17, 2004, p. 18) Eastern Maine Medical Center (EMMC) uses the same method in its Certificate of Need Application to construct a new Inpatient Tower approved by the Department in October 2008.

(EMMC, CON Application to construct a new Inpatient Tower, Table 16, January 2, 2008, p. 52)

MMC presents an explanation of the method used to compute the utilization rate for its Bramhall surgical capacity, actual utilization for FYE 2008 through 2012 and forecast utilization based on proposed Bramhall surgical capacity for FYE 2013 through 2017.

(MMC, Bean 2 CON Application, pp. 128 – 129)

The method involves forecasting annual case volume and case hours during routine scheduled hours. Case hours include patient in-room, preparation and clean up time. Case hours do not include unused block scheduling time. The number of operating rooms needed is determined based on annual routine scheduled hours and a target utilization rate.

The following table presents a comparison of the various values used by the Department, EMMC and MMC.

**Comparison of Values used to Determine Number of ORs Needed**

**Formula Element Department EMMC Inpatient MMC Bean 2**

**Guideline Tower Project Project**

Scheduled Days/Year 250 250 250

Scheduled Hours/Day 7.5 8 8.9

Scheduled Hours/Year 1,500 2,000 2,225

Target Utilization Rate 80% 75% 85%

Effective Hours / OR / Year 1,200 1,500 1,891

MMC schedules its Bramhall Main Surgical Suite operating rooms for longer hours and at a higher utilization rate than what the Department’s guideline contemplates, and what Mercy and EMMC use in the above referenced approved CON applications.

MMC’s more efficient use of its operating rooms results in more effective surgical hours per operating room than the State’s guideline indicates. MMC targets 1,891 hours of effective surgical hours per operating room compared to the 1,200 in the State guideline. This is a 57.6% greater rate of effective hours / operating room than the State guideline recommends.

**iii. Conclusion**

The Certificate of Need Unit recommends that the Commissioner find that the applicant has met their burden to show that there is a public need for the proposed project.

# V. Orderly and Economic Development

1. **From Applicant**

**“Impact on Health Care Expenditures: Project’s Benefit and Potential Impact on Other Providers’ Costs”**

“The project’s benefits are discussed throughout this application. The project provides an appropriate built environment to support MMC’s provision of necessary surgical and interventional cardiovascular care to residents of Maine and others.

”Approval of this project does not affect the cost of care delivered by other existing Maine service providers. This project primarily involves the day-to-day operation of MMC’s Surgical and Cardiovascular Service Lines. There are no changes to clinical services. The project should have no impact on other providers’ volume of services, quality of care or costs.”

“This project does not alter referral patterns that may impact the viability of rural providers. As noted elsewhere in this application, Maine Medical Partners’ surgical practices support local access to surgical care through clinics and call coverage at various MaineHealth member and affiliate health care delivery systems including rural sites.”

**“Availability of state funds: Impact on MaineCare**

Approval of this project has no impact on MaineCare. MaineCare currently reimburses MMC for surgical and interventional cardiovascular services at rates that are less than MMC’s current cost of providing care. Additional costs as a result of this project will not be reimbursed by MaineCare. MaineCare’s rate setting is independent of MMC’s fee schedule and costs of care. As a result, there is no impact on the availability of state funds to cover any increase in state costs associated with utilization of the project's services.”

**“Alternatives: Potential of More Effective, More Accessible or Less Costly Technologies or Methods”**

“MMC has implemented several effective, accessible and less costly methods of addressing its capacity requirements prior to proposing this project.”

“MaineHealth Shared Decision Making

The MaineHealth Shared Decision Making Resource Center defines Shared Decision Making (SDM) as an integrative process between a patient and a clinician. The process involves the patient and clinician in making health decisions together that take into account both the scientific evidence, and patient values and preferences. The patient is fully informed of all treatment options and their potential benefits and risks, and is provided with the support to make an informed individualized treatment decision.”

“The process is especially beneficial in decisions involving preference sensitive conditions. Most clinical trials show for these conditions a net reduction in demand for more invasive surgical options as a result of SDM programs.”

“The following MMC Surgical Services physicians, practices and programs have collaborated with the MaineHealth Shared Decision Making Resource Center to develop a coordinated approach to shared decision making within the MaineHealth system.”

“Moritz Hansen, MD practices urology within the MMC Genitourinary Cancer Program and studies clinical outcomes, risk communication, personalized risk assessment, and shared decision making related to prostate cancer.”

“The Maine Medical Center Joint Replacement Center offers decision aids to patients who are considering knee or hip replacement surgery, and also has a nurse educator-based decision support model.”

“Maine Medical Partners Neurosurgery and Spine has implemented a SDM program using decision aids to improve quality of care for patients considering herniated disc surgery.”

“MMC Surgical Services participation in SDM programs has the potential to reduce the patient population’s surgical utilization rate, which reduces the demand placed on MMC’s surgical capacity.”

“MMC Surgical Services support of other MaineHealth Members’ Surgical Services

MMC Surgical Services provides support to other MaineHealth system hospitals, enabling those hospitals to maintain their surgical services. This allows patients to receive surgical care at their local hospitals rather than seeking their surgery at MMC, reducing the potential demand for surgical capacity at MMC.”

“Scarborough Surgery Center

In 2007 MMC opened the Scarborough Surgical Center (SSC) and shifted a significant portion of its outpatient surgery from the Bramhall campus to the SSC, moving approximately four operating rooms of outpatient surgery cases from the Bramhall campus to the SSC. That project improved access for all patients seeking surgical care at MMC by decompressing MMC’s Bramhall surgical capacity and improved ease of access for those patients receiving their care at the SSC.”

“Surgeons continue to perform ambulatory surgery at the Bramhall campus in cases when it is clinically indicated by virtue of the patient’s medical condition or comorbidities, the procedure requires the use of specialized equipment that is not available at SSC, there is the potential for an unplanned procedure or scheduling an outpatient surgery into the midst of inpatient procedures is an efficient use of a surgeon’s time.”

“Additional surgeries are being performed on an inpatient basis on the Bramhall campus due to Centers for Medicare and Medicaid Services (CMS) policies. CMS has identified a number of procedures that it will not reimburse if the procedures are performed on an outpatient basis. As a result of this CMS policy Medicare, MaineCare and other insurers do not reimburse hospitals and physicians for these procedures unless they are performed on an inpatient basis. MMC and other hospitals continue to perform these procedures on an inpatient basis in order to receive compensation for services delivered.”

“While further expansion of SSC capacity may become necessary in the future, SSC expansion does not address the current and increasing demand for surgical capacity on MMC’s Bramhall campus.”

“Bramhall Campus Surgical Capacity

As demand for operating rooms on the Bramhall campus has continued to grow since the opening of SSC, MMC has re-equipped and reactivated the Bean Building C-section operating rooms that were vacated with the opening of the East Tower. These reactivated operating rooms are located on the 2nd floor of the Bean Building and support MMC’s Joint Replacement Center. The Joint Replacement Center occupies the space adjacent to the proposed Bean 2 project.”

“More than half of MMC’s operating rooms on the Bramhall campus are 500 square feet or smaller while the recommended size for today’s operating room is a minimum of 600 square feet. MMC’s current compliment of operating rooms are smaller than recommended, which challenges MMC’s clinical staff as they perform procedures and in some instances limits the types of cases that can be performed in some of these operating rooms, limiting MMC’s effective operating room capacity. Further, MMC is unable to enlarge its operating rooms in their current location without major disruptions to the delivery of patient care, reduction in capacity, major facility expansion or some combination.”

“MMC is an academic medical center with a commitment to educating medical students, residents, nurses, surgical technicians, etc. The constrained size of the majority of MMC’s operating rooms presents challenges for MMC to accommodate learners in the operating rooms while cases are being performed, an essential element in educating tomorrow’s clinicians.”

“MMC’s operating rooms, with the exception of the newly constructed dedicated C-section operating rooms located in the East Tower, are located in the Bean Building and rely on that building’s 1980s era mechanical and electrical infrastructure.”

“Bean 2 proposes developing operating rooms meeting contemporary standards (650 square feet) and more robust infrastructure, avoiding continued reliance on these undersized systems.”

“Maine Heart Valve Center multidisciplinary patient evaluation

The Maine Heart Valve Center engages a multidisciplinary team of imaging cardiologists, interventional cardiologists and cardiac surgeons in the evaluation of patients with severe aortic stenosis to determine whether Surgical Aortic Valve Replacement, Transcatheter Aortic Valve Replacement or medical therapy is the preferred approach prior to making a recommendation to referring physicians and their patients. The FDA has approved TAVR only for patients who have an unacceptably high risk for standard Surgical Aortic Valve Replacement.”

“MMC’s Endovascular Suite

During the introductory phase of performing TAVR procedures, MMC clinicians used the Endovascular Suite for these procedures as well as for treating thoracic and abdominal aneurysms with endovascular stent grafts or complex aortic reconstructions, performing carotid intervention for the prevention of stroke, including carotid angioplasty and stenting and treating peripheral arterial disease with a full range of minimally invasive therapies.”

“The Endovascular Suite can no longer adequately support these programs. Many minimally invasive procedures are highly complex and require four to five hours to perform. In some instances a procedure can take more than six hours to complete; a single case can effectively tie up a hybrid operating room for the entire day.”

**B. CONU Discussion**

**i. CON Standards**

Relevant criteria for inclusion in this section are specific to the determination that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

* The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;
* The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and
* The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available.

**ii. CON Analysis**

MMC provided a detailed analysis of its primary, secondary and tertiary service areas and its’ surgical utilization data which shows that MMC’s provision of surgical and interventional cardiovascular care is a necessary component of health care in Maine. Total projected 3rd and 4th year incremental operating costs in the CONU financial model show minimal additional costs due to this project. Increased use of MaineCare funds will be mostly due to inflation or changes in volume unrelated to this transaction through the 4th year of this project (2017).

State funds should not be materially impacted by this transaction. There should not be any increased utilization of services because of this proposed transaction.

ALTERNATIVES TO THIS PROJECT

The CONU conducted a public hearing regarding this project on July 30, 2013. Public Comments were received from both Central Maine Healthcare and Mercy Hospital. Both parties expressed concern that other alternatives were not explored before proposing this project. The following alternatives were proposed by the commenters (MMC’s response is below the underlined alternatives proposed):

Utilize the Scarborough surgery center for excess capacity

MMC’s Scarborough Surgery Center does not provide a viable solution for patients requiring their surgical care at the Bramhall campus. MMC anticipates that there will be an increase in cases best served at the Scarborough Surgery Center as well as increased demand appropriately treated at MMC’s Bramhall campus. Even if it were possible to shift additional cases from Bramhall to Scarborough, the need to modernize the Bramhall Main Surgical Suite capacitycontinues to exist and must be addressed. Additional capacity needs to be located at the appropriate site where the clinical teams are available and most able to provide safe, effective patient care, which in this case is MMC’s Bramhall campus.

Utilize existing capacity at other Southern Maine Hospitals

Similarly other MaineHealth hospitals’ operating room capacity does not provide a viable solution for these patients requiring their surgical care at the Bramhall campus. Primary care physicians, medical specialists and surgeons practicing at those other MaineHealth facilities are referring their patients to MMC for surgical care that requires the clinical capabilities that are available at MMC’s Bramhall campus. These practitioners are aware of the clinical capabilities available locally and are referring patients to MMC practitioners based on clinical capabilities of the surgeons and the other members of the clinical teams that practice on MMC’s Bramhall campus.

Schedule operating rooms for Six Days a Week/50 or 52 weeks a year

It has been suggested that MMC consider adding a 6th day per week of routine surgery, asserting that MMC “operates the largest surgery program in Maine so it is feasible to have regularly scheduled Saturday surgeries.”

(Chuck Gill, Letter to Phyllis Powell RE: Maine Medical Center Bean 2 and Cardiac Hybrid Operating Room Project CON Application, August 26, 2013).

The assertion that adding a 6th day per week of routine surgery presents a feasible alternative to the proposed Bean 2 Project is erroneous. There are several factors that make a full day of Saturday surgery impractical and most likely explain why 6-day surgical schedules are not an industry standard practice. First and foremost for MMC, this alternative does not address MMC’s need to modernize its Bramhall Main Surgical Suite operating rooms.

Scheduling weekend surgery does not address the need to modernize MMC’s Bramhall Main Surgical Suite operating rooms.

The need to invest in facilities and infrastructure upgrades does not go away; the capital investment is still required to modernize of MMC’s surgical capacity.

MMC has delayed this investment for a number of years and now needs to move forward with this capital project.

Scheduling weekend surgery does not address the need to decommission two operating rooms to develop an appropriately sized Hybrid Operating Room.

MMC already provides a limited amount of surgery on Saturdays; there is not much demand for scheduling surgery on weekends.

Patients are not seeking to schedule routine surgical cases on weekends.

Other than when they are on call, surgeons perform minimal routine surgery on weekends.

Scheduling weekend surgery would require a significant and costly increase to weekend staffing.

Staffing increases would be necessary in the following areas:

Perioperative Services: Surgery, Anesthesiology, Preparation, Recovery, Ambulatory Surgery Unit and Short Stay Surgery Unit.

Patient Care Services – Inpatient Units and Care Management.

Ancillary Services - Pharmacy, Radiology, Laboratory, Cytology, Pathology, Rehabilitation, Central Sterile Department, Environmental Services and Transport.

Weekend surgery would result in inefficient and costly services.

Due to the reluctance of patients and physicians to schedule surgery on weekends, it is highly unlikely that the weekend case volume would justify the required increases in staffing, resulting in an inefficient staffing pattern.

An inefficient staffing pattern results in a higher cost per case than necessary.

In addition to costs of an inefficient staffing pattern, weekend services would require salary and wage premium / shift differential costs that would exacerbate the cost per case.

MMC offers the following explanation of this last point:

MMC proposes scheduling four operating rooms five days per week for a total of 20 additional operating room days per week. (4 ORs x 5 Days per Week = 20 OR Days per Week). To gain the same scheduling capacity using a 6-day surgery schedule, MMC would need to operate 20 operating rooms on a Saturday. (20 ORs x 1 Day per Week = 20 OR Days per Week) MMC has identified the incremental staff required to support its Project. The same staff would be required to support twenty operating rooms on Saturdays. Maine Medical Center, Bean 2 and Cardiac Hybrid Operating Room Project Certificate of Need Public Hearing Written Comments, August 29, 2013. By shifting the schedule from the routine Monday through Friday surgery scheduleMMC would incur off-shift premium costs for these incremental staff. In addition the project is able to leverage current staff available during the routine Monday through Friday surgery schedule before adding incremental staff; moving to a Saturday schedule would limit the ability to leverage staff and would require added salary and wage costs, again at premium rates.

1. **Conclusion**

CONU recommends that the Commissioner find that the applicant has met their burden to demonstrate that the proposed project is consistent with the orderly and economic development of health facilities and health resources for the State subject to including the recommended condition.

# Outcomes and Community Impact

**A. From Applicant**

**“MMC High Quality Outcomes**

MMC Surgical Services

MMC Surgical Services participates in the MaineHealth Surgical Quality Collaborative (MHSQC), which was initiated in September 2011. MHSQC is a voluntary collaboration of MaineHealth hospitals that provides professional competence review activities including analysis and feedback in support of the quality review, outcomes review, and provider education activities in participating hospitals. “

“MHSQC is involved in the American College of Surgeons National Surgical Quality Improvement Program (NSQIP), the first nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care. The program employs a prospective, peer controlled, validated database to quantify 30-day risk-adjusted surgical outcomes, which allows valid comparison of outcomes among all hospitals in the program. There are a number of NSQIP collaborative across the country, several of which have published results utilizing data from NSQIP.”

“The mission of the MHSQC is to support the participating hospitals in their efforts to review and improve the quality and safety of surgical care. Participating hospitals collect and submit data on certain surgical patients for analysis by the Collaborative. The hospital team includes a “surgeon champion” who advocates for the program and uses the reports to inform other members of the medical staff, a surgical case reviewer who actively reviews records and submits data on each surgical patient whose episode is included for analysis, and a quality assurance professional who optimizes the coordination of this program with others – such as infection control and prevention – in the hospital. These individuals and other interested surgeons participate in the Collaborative and provide feedback to hospital staff on hospital quality and outcomes in surgery, including regional (Collaborative) and national level comparative data, as well as surgical practice standards and guidelines recommended or discussed by the Collaborative.”

“MMC Cardiovascular Surgery

The MMC Cardiovascular Surgery program has been on the forefront of innovation in cardiac surgery and the provision of superior quality of care and outcomes. Patients undergoing cardiovascular surgery are assured a high quality care experience through the following:

* Maintenance of a vigorous quality and patient safety program, including a data infrastructure to analyze and interpret measures of quality
* Use of Clinical Microsystems improvement tools with demonstrated success in care process redesign.
* Commitment to defining, measuring, and adhering to standard processes for cardiac surgery which will ensure reliable and safe care.”

“MMC is founding member of the Northern New England Cardiovascular Study Group (NNECSG), a regional voluntary consortium founded in 1987 to provide information about the management of cardiovascular disease in Maine, New Hampshire, and Vermont. NNECSG maintains registries for all patients receiving coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI), and heart valve replacement surgery. During the last twenty-four years, data on approximately 190,000 procedures were collected and analyzed. The group meets three times per year to review data reports and to plan studies with a focus on quality improvement. Using the NNECDSG database, members have published over 100 articles in peer reviewed journals.”

“The database tracks the clinical outcomes of all revascularization procedures performed by the participating institutions. Regional and center specific data on isolated CABG procedures are available on the NNECSG website www.nnecsdg.org along with data collection tools, including CABG, valve, PCI, cardiovascular anesthesia, and perfusion. From these databases regional outcomes have been tracked and risk-adjusted models have been developed and are used to develop decision making tools for clinicians and their patients/families.”

“MMC also submits clinical data regarding its cardiovascular surgery program to the Society of Thoracic Surgery Database (STS). The STS National Database was established in 1989 as an initiative for quality improvement and [patient safety](http://www.sts.org/quality-research-patient-safety/patient-safety) among cardiothoracic surgeons. There are three components to the STS National Database, each focusing on a different area of cardiothoracic surgery—Adult Cardiac, General Thoracic, and Congenital Heart Surgery, with the availability of Anesthesiology participation within the Congenital Heart Surgery Database. The Database has grown exponentially over the years, both in terms of participation and stature.”

“MMC outcomes as reported in both the NNECSG and the STS compare very favorably to regional and national benchmarks, including top quartile performance for overall quality in the STS Registry. Most recent data from STS show MMC risk-adjusted operative mortality rates for all cardiac surgeries to be approximately 0.7% compared to a peer group (like programs) and national rates of 2.3% and 2.3% respectively.”

“An example of MMC focusing on and improving a key process of care for cardiac surgery is the amount of blood used during the intra-operative and post-operative period. Recent data show blood utilization for coronary artery bypass graft surgery at MMC to be approximately 23% compared to peer group and national rates of 49% and 52% respectively.”

“Although quality is of utmost importance, the MMC Cardiovascular Surgery program has expanded its sights to include overall value. The “value equation” focuses on improving quality while at the same time reducing costs, inefficiencies, and waste. In addition to pursing the highest quality in patient outcomes, the MMC program looks to optimize value by:

* Use of a multidisciplinary model of care to ensure the most efficient use of physician and advanced practice professional resources;
* Collaboration with the ambulatory and post-acute care to limit the episode of care;
* Focus on reducing complications such as infections and hospital readmissions;
* Standardization of clinical processes, including use of vendors and supplies; and
* Commitment to the implementation and measurement of decision making for complex cases, ensuring appropriate patient selection to limit overuse of medical care.”

**“Potential Impact on Existing Providers’ Quality of Care**

This project has no impact on other provider’s quality of care. Community demand for MMC Surgical Services continues to grow. MMC accounts for nearly one third of all Maine residents’ discharges from Maine hospitals for surgical care. MMC’s Bramhall operating rooms are functioning at an unsustainably high utilization rate. Bean 2 is an initial step in replacing and modernizing MMC’s interventional capacity.”

“MMC’s surgical capacity needs to be replaced with larger operating rooms with more robust infrastructure. MMC’s operating rooms are undersized. MMC’s surgical capacity requires upgraded electrical, ventilation and air conditioning infrastructure. Addressing these facility needs should have no impact on other providers’ quality of care.”

**B. CONU Discussion**

**i. CON Standards**

The relevant standard for inclusion in this section is specific to the determination that the project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.

**ii. CON Analysis**

MMC’s Bramhall operating rooms are functioning at an unsustainably high utilization rate while community demand for MMC Surgical Services continues to grow. Replacing and modernizing aging and undersized operating rooms and associated infrastructure will help ensure high quality outcomes. MMC will continue its collaboration with MaineHealth Surgical Quality Collaborative (MHSQC) which supports participating hospitals in their efforts to review and improve the quality and safety of surgical care. The applicant describes a number of quality and outcome initiatives that it is undertaking in the narrative above. CONU recommends that MMC report improvements in quality and outcome measures of the project this recommendation will be included as a condition and is discussed at the end of this section.

IMPACT ON OTHER PROVIDERS

The CONU conducted a public hearing regarding this project on July 30, 2013. Public Comments were received from both Central Maine Healthcare and Mercy Hospital. Both parties requested clarification regarding MMC’s assertion that “approval of this project does not affect the cost of care delivered by other existing Maine service providers” and that approval of this project should have no impact on other providers volume of services, quality of care or costs.” Central Maine Healthcare addressed the Guided Access HMO deal between Anthem and MaineHealth. Central Maine Healthcare believes that because six hospitals (Rumford, Bridgton, CMMC, Parkview, York and Mercy) were excluded from the network surgical volume will be shifted to MMC.MMC’s response is below:

Potential impact of this project on other providers’ volume, quality or costs:

The Bean 2 Project is a facility project addressing the current need to modernize MMC’s Bramhall Maine Surgical Suite operating room facilities and infrastructure, and the current need to decompress the exceedingly high utilization of MMC’s Bramhall Maine Surgical Suite capacity.

This Project does not cause any shift in market share. There are factors in play, independent of this Project, which may affect fluctuations in market share. Market share shifts can be the result of consumer choice and patient and/or clinician preference for one clinical setting over another.

Patients and referring physicians from throughout Maine and northern New England choose MMC based on its high-quality clinical services and clinical capabilities. The inpatient surgical discharge market share gains MMC experienced from 2008 to 2010, which precede this proposed project, reflect this phenomenon.

(MMC, Bean 2 CON Application, Maine Hospitals’ Surgical Discharges, CY 2008 to 2010, Maine Medical Center Market Share of Surgical Discharges by Patient Residence, p. 121)

Such choice is regarded by some interveners in this review process as a public good to be preserved or even fostered by the CON process. For example, Mercy Hospital leadership states for the record that Mercy supports community choice and believes choice has a positive impact on providers’ services, quality and costs.

“Choice is important to keep everybody on their game. It keeps quality up, keeps service up, keeps costs lower”

(Eileen Skinner, Testimony, May 7, 2013 Certificate of Need Public Hearing on Eastern Maine Healthcare Systems / Mercy Hospital Transfer of Ownership Transcript, pp. 21-2)

“Maintaining choice keeps pressure on to raise quality and affordability.” (Thomas Yoder, Mercy Hospital Board Chairperson, Testimony, May 7, 2013 Transcript, p. 36)

MMC performed planning and financial modeling demonstrating the need and financial feasibility of the Project. The assumptions did not include market share shifts, volume increases, payer mix changes or reimbursement changes associated with Anthem’s proposed guided access insurance product. The project does not anticipate or rely upon any additional volume or reimbursement related to Anthem’s proposed guided access insurance product. Any such changes in service mix would increase the need for the project and improve financially feasibility.

The applicant has reported that they are the only hospital providing TAVR service and that the current hospital facilities do not support the current level of activity in the surgical suites is not sustainable and may compromise the health of the patients. This project was developed to alleviate that stressor and improve outcomes. It is necessary to include the following condition to review the efficacy of the project.

**Condition:** The applicant is to report improvements in quality and outcome measures for services affected by the project on an annual basis within 90 days of its fiscal year end beginning with the time period when the Certificate of Need was approved until a full three years have elapsed since the date of project completion.

**iii. Conclusion**

CONU recommends that the Commissioner find that the applicant has met their burden to demonstrate that this project will ensure high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.

# VII. Service Utilization

**A From Applicant**

**“Risk of Inappropriate Increases in Service Utilization**

This project meets a documented health care need as opposed to creating a health care demand. This project will not increase health care utilization unnecessarily and will not create inappropriate or unnecessary demand.”

“MMC works in cooperation with insurers and third-party payers to avoid unnecessary surgeries. MMC works with insurers through Utilization Review to ensure that surgical services are not over-utilized. As a part of the utilization review process MMC uses Milliman Care Guidelines, Inpatient and Surgical Care as a resource to help in determining if a patient's condition meets criteria for surgical care. Milliman's Surgical Optimal Recovery Guidelines are used to identify patients who require an operative procedure, to plan the appropriate surgical setting, and to manage the perioperative care.”

“In addition, Maine Medical Center's Care Coordinators and Clinical Denials Coordinators have developed relationships with insurers so that patients can be brought in as bedded outpatients for observation of symptoms for up to 48 hours prior to what might otherwise be an emergency surgery. This observation period allows the physician time to determine if surgery is necessary while maintaining the patient in a safe environment. During this time patients can be observed for changes in their condition, receive intravenous fluids and medications to keep them safe and comfortable; and have diagnostic procedures performed to determine progression of illness or injury vs. response to non-surgical treatment. Within this environment unnecessary surgeries can be avoided.”

“MMC involves patients in Shared Decision Making programs addressing three preference sensitive conditions: prostate cancer, knee or hip osteoarthritis and lumbar herniated disc. Research indicates that SDM programs reduce the demand for surgery. Please refer to the discussion under Section V: Orderly and Economic Development, Subsection Alternatives: Potential of More Effective, More Accessible or Less Costly Technologies or Methods”

“CMS has established stringent coverage conditions for TAVR procedures. On May 1, 2012, CMS issued a National Coverage Determination (NCD) covering TAVR under Coverage with Evidence Development (CED) and only when specific requirements are met.”

“CMS covers TAVR for the treatment of symptomatic aortic valve stenosis under CED with the following conditions:

CED Coverage Conditions with Registry Participation

1. It is furnished according to a Food and Drug Administration (FDA)-approved indication and when all of the following conditions are met:
   1. It is furnished with a complete aortic valve and implantation system that has received FDA Premarket Approval (PMA) for that system’s FDA approved indication;
   2. Two cardiac surgeons have independently examined the patient face-to-face and evaluated the patient’s suitability for open Aortic Valve Replacement (AVR) surgery; and both surgeons have documented the rationale for their clinical judgment, and this rationale is available to the heart team;”
   3. “The patient (preoperatively and postoperatively) is under the care of a heart team: a cohesive, multi-disciplinary, team of medical professionals that embodies collaboration and dedication across medical specialties to offer optimal patient-centered care;
   4. It is furnished in a hospital with the appropriate infrastructure that includes (but is not limited to):

* On-site heart valve surgery program;
* Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering quality imaging;
* Non-invasive imaging such as echocardiography, vascular ultrasound, Computed Tomography (CT) and Magnetic Resonance (MR);
* Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications;
* Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures; and
* Appropriate volume requirements per the applicable qualifications (specifically, for hospitals without TAVR experience and for those with experience performing the procedure).”

**“MaineHealth Population-based Initiatives**

MMC participates in MaineHealth’s health status improvement, clinical integration and quality improvement initiatives, which should over time impact utilization positively.”

“The mission of MaineHealth is “Working together so our communities are the healthiest in America”. MaineHealth has made financial and human resource commitments to this mission, based on the following beliefs:

* Health care costs in Maine (and nationally) will continue to increase due to demographic, technological and normal inflation factors which are generally beyond our control;
* If healthcare is to remain affordable to the vast majority of our citizens, changes will need to be made to the manner in which we currently provide and finance that care;
* The long-term solution to balancing increased utilization is to improve the health of the people of Maine;
* The health care challenge requires short-term solutions which improve the quality (both care delivery and outcomes), cost-efficiency (both clinical and administrative) and access to health care.”

“MaineHealth’s approach to improving the health of its communities focuses on two major types of initiatives:

* Health status improvement initiatives which address a health issue which is amenable to intervention based on specific, scientifically based programs
* Clinical integration initiatives which seek to improve the delivery of coordinated, integrated services to selected populations, particularly those with chronic diseases or for conditions where clinical guidelines and protocols have been demonstrated to improve outcomes.”

“Management of populations with chronic diseases has become a major focus of MaineHealth’s clinical integration initiatives. During the next 15 years, the population in Maine over the age of 65 is expected to double. Based on national studies, it may be anticipated that 60% of the population will have at least one “chronic condition and 40% will have two or more. A recent study by researchers at Johns Hopkins, the US HHS Agency for Health Research and Quality and the University of Pennsylvania predicts that by 2030, 87% of the population will be overweight, 51% will be obese and the prevalence of overweight children will nearly double. Since 1999, MaineHealth has been building health status improvement and clinical integration initiatives to address these challenges, funding them through a combination of MaineHealth dues, investment income and grants.”

“MaineHealth and its members are clearly committed to population based health and prevention and are redirecting resources to support those initiatives. MaineHealth has been building health status improvement and clinical integration initiatives to address these challenges, funding them through a combination of MaineHealth dues, investment income and grants. Beginning in FY 2006, MaineHealth began providing partial support for these initiatives through fund balance transfers from member organizations.”

“Below are the MaineHealth budgets for these initiatives for FY 2010, 2011, 2012 and 2013.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MaineHealth Clinical Integration / Health Status Improvement Budgets**  **(in 000s)** | | | | |
|  | FY 2010 | FY 2011 | FY 2012 | FY 2013 |
| Clinical Integration | $4,733 | $4,995 | $6,173 | $6,913 |
| Health Status Improvement | 3,804 | 4,314 | 4,971 | $4,707 |
| Community Education | 2,537 | 2,573 | 2,540 | $2,359 |
| Total | $11,074 | $11,882 | $13,684 | $13,979” |

“MaineHealth has not asked for more than we thought could be well used, and we have continued to be successful in securing other support through grants. MaineHealth has adopted a strategy that recognized that, while it has been reasonably successful in its initiatives, MaineHealth must step up the scope and pace of these initiatives by committing over the next several years up to 1% of its net assets annually to support these initiatives.”

“MaineHealth emphasizes collaboration in developing and implementing clinical integration and health status improvement initiatives; all provider organizations are welcome to join us and use our tools. There are no competitors. Our approach is based on bringing together providers to design and implement evidence based approaches to the care of patients and on measuring results.”

“Presented [in the record] are brief summaries of the major health status improvement and clinical integration initiatives supported by these resources. Detailed descriptions of these initiatives and the outcomes they have produced to date to improve the health of communities MaineHealth serves are on file with the Certificate of Need Unit as part of the public record associated with MaineHealth and Waldo County Healthcare certificate of need application for WCH Membership in MaineHealth and are included in this application by reference.”

“MaineHealth and its members are clearly committed to population based health and prevention and are redirecting resources to support those initiatives. MaineHealth believes that these initiatives are entirely consistent with the best evidence-based practices regarding how to approach chronic disease. Evidence from our programs demonstrates that the Chronic Care Model can and does work [Letourneau et al, “Rural Communities Improving Quality through Collaboration, Journal for Healthcare Quality, (National Association for Healthcare Quality, Vol. 28, No. 5, pp. 15-27)].”

**B. CONU Discussion**

**i. CON Standard**

The relevant standard for inclusion in this section are specific to the determination that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum as established in Title 24-A, section 6951, when the principles adopted by the Maine Quality Forum are directly applicable to the application.

**ii. CON Analysis**

MMC is undertaking this project to meet an existing health care need to modernize and expand operating room capacity. This project does not result in the addition of new health services or the intended expansion of existing services. As stated previously, MMC works with third-party payers and insurers to avoid unnecessary surgeries through a utilization review process. MMC participates in MaineHealth’s Population-based initiatives (health status improvement, clinical integration and quality improvement) which will have a positive impact on utilization.

The applicant refers to the Milliman Care Guidelines (MCG). MCG is a tool developed to support and document effective care. Its goal is to provide patients with high quality effective care. This process is achieved by having providers identify quality care practices. These practices marshal treatment resources and when properly utilized avoid the overuse of medical resources. These tools should be able to provide an evidence-based foundation for care management, case management and utilization review.

There have been specific questions raised by other service providers in the service area that require ongoing monitoring of the utilization of these facilities. The following condition is necessary to ensure that the impact of this project is as productive as forecast by the applicant.

**Condition:** The applicant is to report operating room utilization for facilities affected by the project on an annual basis within 90 days of its fiscal year end beginning with the time period when the Certificate of Need was approved until a full three years have elapsed since the date of project completion.

**iii. Conclusion**

CONU recommends that the Commissioner find that the applicant has met their burden to demonstrate that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum.

# VIII. Timeline Criteria

Letter of Intent filed September 6, 2012

Technical Assistance Meeting held on October 17, 2012

CON Application filed June 12, 2013

CON Application certified as complete June 12, 2013

Public Hearing held July 30, 2013

Close of Public Record August 29, 2013

# IX. CON Findings and Recommendations

Based on the preceding analysis, including information contained in the record, the CONU recommends that the Commissioner make the following findings and recommendations subject to the conditions below:

**A.** That the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant’s control meets industry standards.

**B.** The economic feasibility of the proposed services is demonstrated in terms of the:

**1.** Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and

**2.** The applicant’s ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules;

**C.** The applicant has demonstrated that there is a public need for the proposed services as demonstrated by certain factors, including, but not limited to;

**1.** The extent to which the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

**2.** The project has demonstrated that it will have a positive impact on the health status indicators of the population to be served;

**3.** The project will be accessible to all residents of the area proposed to be served; and

**4.** The project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project;

**D.** The applicant has demonstrated that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

**1.** The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;

**2.** The availability of State funds to cover any increase in state costs associated with utilization of the project’s services; and

**3.** The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available was demonstrated by the applicant;

In making a determination under this subsection, the commissioner shall use data available in the state health plan under Title 2, section 103, data from the Maine Health Data Organization established in chapter 1683 and other information available to the commissioner. Particular weight must be given to information that indicates that the proposed health services are innovations in high quality health care delivery, that the proposed health services are not reasonably available in the proposed area and that the facility proposing the new health services is designed to provide excellent quality health care.

**E.** The applicant hasdemonstrated that the project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers; and

**F.** The applicant has demonstrated that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum.

**Condition:**

* The applicant is to report improvements in quality and outcome measures for services affected by the project on an annual basis within 90 days of its fiscal year end beginning with the time period when the Certificate of Need was approved until a full three years have elapsed since the date of project completion.
* The applicant is to report operating room utilization for facilities affected by the project on an annual basis within 90 days of its fiscal year end beginning with the time period when the Certificate of Need was approved until a full three years have elapsed since the date of project completion.