

The Green Mountain Surgery Center

ACTD LLC

Certificate of Need Application
Development of Ambulatory Surgery Center

Docket Number GMCB-010-15con

July 2, 2015

ACTD LLC (“ACTD”) submits this Certificate of Need Application (the “Application”) to the Green Mountain Care Board (“GMCB”) in accordance with 18 V.S.A. § 9434(a)(6) and GMCB Rule 4.302(1). The Application requests a Certificate of Need (“CON”) to open a multi-specialty ambulatory surgical center called the Green Mountain Surgery Center in Colchester, Vermont (the “Project”).

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FOREWORD

The healthcare industry as a whole is faced with an economic crisis. The United States spent roughly \$2.9 trillion on healthcare in 2013;¹ Vermont spent \$5.3 billion the same year, the most recent year for which there is complete national and Vermont data.² Though national and state health care reform efforts have slowed the runaway inflation that characterized health care costs up until the passage of the Affordable Care Act, health care costs continue to grow at an unsustainable rate and presently account for approximately 17 percent of the Gross Domestic Product, the second-highest percentage in the world.³ Vermont's proportionate health care spending is even higher, constituting approximately 18 percent of the state's Gross State Product.⁴

Though high levels of spending on health care have not translated into better outcomes in the United States,⁵ no one expects or wants to sacrifice the quality of care we presently have for lower costs. Accordingly, cost and quality are central to today's health reform discussion. Health policymakers are interested in stabilizing health spending and ensuring quality health services to ultimately improve the health of all Americans and create a sustainable health care system.

Ambulatory Surgical Centers (ASCs) are widely accepted as an important tool for lowering the costs of surgical procedures and are prime examples of how "right-sizing" the location of non-acute services to be in line with the acuity of the procedure and needs of the patient can result in health care savings.⁶ ASCs not only lower cost, they are associated with high levels of patient satisfaction.⁷ There are more than 5000 licensed ASCs throughout the United States, including

¹ *National Health Expenditures 2013 Highlights*, Centers for Medicare and Medicaid Services 1 (last visited June 4, 2015), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

² GREEN MOUNTAIN CARE BOARD (GMCB), *2013 VERMONT HEALTH CARE EXPENDITURE ANALYSIS LEGISLATIVE VERSION 4* (Mar. 2015).

³ Only Tuvalu has a higher percentage (19.7%) according to 2013 data from the World Health Organization Global Health Expenditure Database. *Health Expenditure Total (% of GDP)*, THE WORLD BANK (last visited June 4, 2015), <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>.

⁴ GMCB, *supra* note 2, at 22.

⁵ Although the United States health care system is the most expensive in the world, the United States underperforms relative to other countries on most quality, access, efficiency and equity measures. Karen Davis, Kristof Stremikis, David Squires & Cathy Schoen, *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, THE COMMONWEALTH FUND (June 16, 2014), <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>.

⁶ *Right-Sizing Healthcare: The Migration of Non-Acute Care to Outpatient Settings*, AVANZA HEALTHCARE STRATEGIES (last visited June 4, 2015), <https://avanzastrategies.com/right-sizing-healthcare/>.

⁷ *Ambulatory Surgery Centers: A Positive Trend in Health Care*, AMBULATORY SURGERY CENTER ASSOCIATION (ASCA) 3 (last visited June 4, 2015), <https://higherlogicdownload.s3.amazonaws.com/ASCACONNECT/142533d1-73af-4211-9238-7f136c02de93/UploadedImages/About%20Us/ASCs%20-%20A%20Positive%20Trend%20in%20Health%20Care.pdf> (noting that patients have reported a 92% satisfaction rate with both the care and

175 in New England (not including Vermont) and another 116 in New York.⁸ The Centers for Medicare and Medicaid (CMS) has reimbursed procedures performed at ASCs since 1982. Yet, Vermont has only one ASC (The Eye Surgery Center) and no multi-specialty ASCs, so unlike residents of every other state, Vermonters do not have access to a local lower cost alternative to hospital-based outpatient surgery.

Table 1

AMBULATORY SURGERY-CENTER PROCEDURES BY STATE⁹

Number of procedures per 100,000 population performed at Medicare-certified ASCs in 2012

Rank	State	Number of Procedures*	State Population**	Procedures per 100K population
1	Mississippi	57,970	2,986,450	1,941.1
2	Delaware	15,621	917,053	1,703.4
3	Maryland	95,401	5,884,868	1,621.1
4	Florida	306,076	19,320,749	1,584.2
5	South Carolina	70,312	4,723,417	1,488.6
6	Tennessee	91,318	6,454,914	1,414.7
7	Arkansas	38,326	2,949,828	1,299.3
8	Kansas	35,112	2,885,398	1,216.9
9	Nebraska	21,918	1,855,350	1,181.3
10	New Jersey	104,747	8,867,749	1,181.2
11	Louisiana	50,590	4,602,134	1,099.3
12	Arizona	70,583	6,551,149	1,077.4
13	Indiana	70,300	6,537,782	1,075.3
14	Alabama	51,653	4,817,528	1,072.2
15	Idaho	16,779	1,595,590	1,051.6
16	Georgia	100,617	9,915,646	1,014.7
17	Nevada	27,498	2,754,354	998.3
18	Montana	9,937	1,005,494	988.3
19	New Hampshire	12,860	1,321,617	973.1
20	South Dakota	7,929	834,047	950.7
21	North Dakota	6,647	701,345	947.8
22	Missouri	57,050	6,024,522	947.0
23	Wyoming	5,419	576,626	939.8
24	Kentucky	39,251	4,379,730	896.2
25	Washington	61,712	6,895,318	895.0

service they receive from ASCs).

⁸ Dani Gordon, *How Many Licensed ASCs Are In Your State*, BECKER'S HOSPITAL REVIEW (Aug. 28, 2014), <http://www.beckershospitalreview.com/hospital-management-administration/how-many-licensed-ascs-are-in-your-state.html>.

⁹ Data included in this table originally published in MODERN HEALTH CARE, 31 (May 5, 2014).

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26	Pennsylvania	112,756	12,764,475	883.4
27	Colorado	42,569	5,189,458	820.3
28	Oklahoma	31,124	3,815,780	815.7
29	Massachusetts	52,050	6,645,303	783.3
30	Ohio	89,530	11,553,031	774.9
31	Texas	196,932	26,060,796	755.7
32	North Carolina	73,402	9,748,364	753.0
33	Oregon	27,529	3,899,801	705.9
34	Michigan	69,094	9,882,519	699.2
35	Maine	9,046	1,328,501	680.9
36	Virginia	51,893	8,186,628	633.9
37	Illinois	81,559	12,868,192	633.8
38	Connecticut	22,291	3,591,765	620.6
39	California	231,318	37,999,878	608.7
40	New Mexico	12,678	2,083,540	608.5
41	Wisconsin	32,016	5,724,554	559.3
42	Iowa	15,959	3,075,039	519.0
43	West Virginia	9,211	1,856,680	496.1
44	Rhode Island	5,069	1,050,304	482.6
45	Utah	13,553	2,854,871	474.7
46	Alaska	3,255	730,307	445.7
47	Hawaii	5,375	1,390,090	386.7
48	New York	67,206	19,576,125	343.3
49	Minnesota	18,369	5,379,646	341.5
50	Vermont	1,165	625,953	186.1
51	District of Columbia	728	633,427	114.9
	U.S.	2,701,303	313,873,685	860.7

* Data from 25 selected procedures covered by Medicare and tracked by CMS. They do not include services for beneficiaries enrolled in Medicare Advantage plans.

** Population estimate as of 2012.

Sources: CMS, U.S. Census Bureau

ASCs provide outpatient surgical procedures to patients who do not require overnight stays. They are tightly regulated by CMS, and receive Medicare reimbursement at roughly half the rate given to hospital-based outpatient surgeries for the same procedure,¹⁰ without sacrificing quality.¹¹ ASCs also provide a more pleasant experience for many patients with routine

¹⁰ Elizabeth L. Munnich & Stephen T. Parente, *Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up*, 33(5) HEALTH AFF. 764, 765 (May, 2014).

¹¹ CMS is requiring ASCs to collect and report quality data starting in 2013, but to date, data has not been released by CMS. Recent peer-reviewed studies, however, have offered evidence that ASCs offer high quality care. See, e.g., *id.* at 768 (concluding that “the findings in this article indicate that ASCs are a high-quality, lower-cost substitute for hospitals as venues for outpatient surgery”); Jed Grisel & Ellis Arjmand, *Comparing Quality at an*

surgical needs and provide patients with price transparency in advance.

Vermont is an outlier when it comes to ASCs. There is just one ASC in Vermont, despite the fact that ASCs are widely accepted to be safe and less expensive than hospital-based outpatient care¹² and, significantly, are increasingly being embraced and owned by hospitals.¹³ All 50 states host them; our sister state New Hampshire has 29 licensed ASCs and nearby Maine has 17.¹⁴ States that have populations of fewer than 1,000,000, like Vermont, have on average 16.2 licensed ASCs.¹⁵ These states have recognized that ASCs play an important role in a health care system, in that they offer patients an affordable, high quality alternative to hospital-based outpatient surgeries, and that for many patients they offer a smaller scale, more patient-friendly environment than the more typically institutional hospital setting.

Ambulatory Surgery Center and a Hospital Based Facility: Preliminary Findings, 141(6) OTOLARYNGOLOGY-HEAD AND NECK SURG. 701 (Dec. 2009) (comparing performance at an ASC with a hospital based facility and concluding that the ASC generally outperformed the hospital based facility).

¹² See Munnich & Parente, *supra* note 10, at 765, 768.

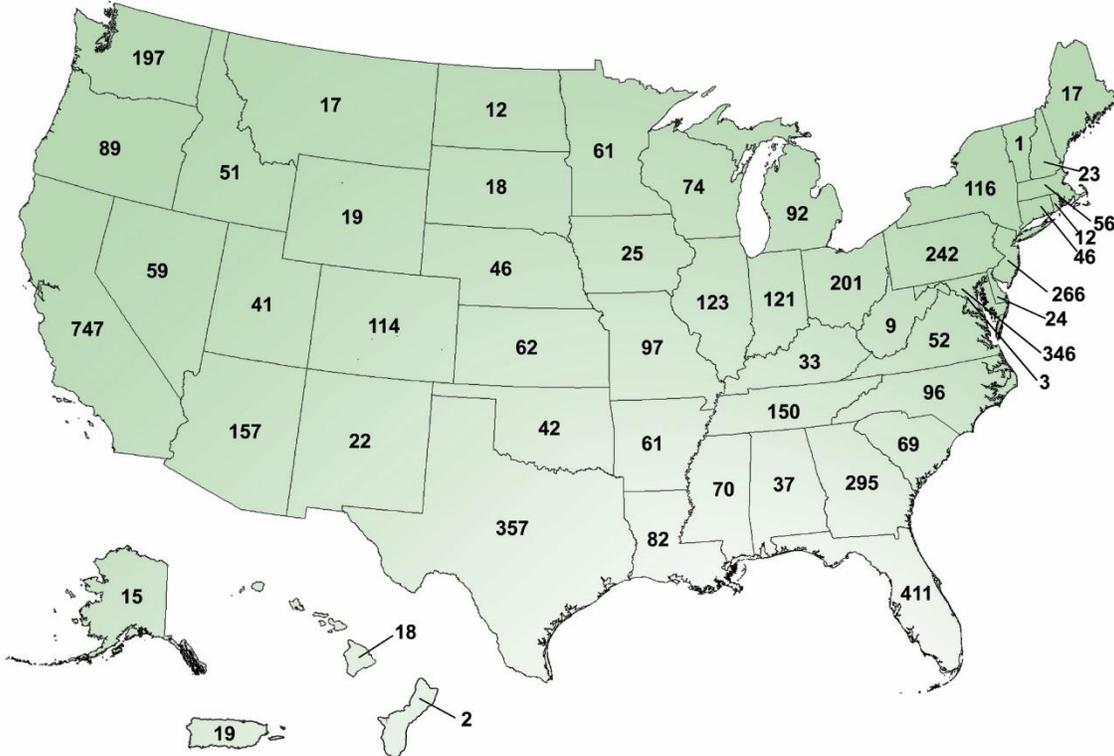
¹³ ASCA, *supra* note 7, at 1.

¹⁴ Gordon, *supra* note 8.

¹⁵ *Id.*

Figure 1

Medicare-Certified ASCs



Based on data provided by the Centers for Medicare & Medicaid Services (CMS), July 2014

The lack of development of lower-cost alternative settings of care in Vermont may contribute to our relatively high overall health care costs compared to other states despite the state’s recent efforts and commendable progress in addressing the high cost of health care and containing its growth. The ASC proposed in this Application is offered as an alternative so that in the future the state does not have to rely exclusively on expanding the current higher-cost, hospital-based healthcare infrastructure. Once open, the proposed ASC will immediately reduce the financial burden borne directly by Vermonters and the state’s health care system as a whole.

Accordingly, this application is for a Certificate of Need for a multi-specialty ASC located in Chittenden County. If a Certificate of Need is granted, we anticipate the proposed ASC will be an important addition to the state’s health care system and welcomed by Vermont’s health care consumers, employers, physicians and insurers, as indicated in the Medicare Payment Advisory Commission’s¹⁶ 2014 Report to Congress:

For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to hospital outpatient departments; for physicians, ASCs may offer more control over their work environment and specialized staff.

¹⁶ MedPac is a nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program.

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Because Medicare pays ASCs less than hospital outpatient departments for procedures, movement of surgical services from HOPDs [Hospital Outpatient Departments] to ASCs can reduce aggregate program spending and beneficiary cost sharing.

We believe it is desirable to maintain beneficiaries' access to ASCs because the services provided there are less costly to Medicare and beneficiaries than services provided in hospital outpatient departments.

Medicare Payment Advisory Commission Report to Congress: Medicare Payment Policy |March 2014

In sum, we believe our proposal to open a multi-specialty outpatient surgery center will help Vermont achieve the Triple Aim of health care reform, namely lower costs, an improved patient experience and improved population health. We submit this proposal as a common sense, incremental step for the State to take on the path of health care reform.

SECTION I: PROJECT NARRATIVE

A. Project Description

1. Ambulatory Surgery Centers (ASCs) – A brief overview

An ASC is defined by CMS as “any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of [Part 416].”¹⁷

Forty years ago, it was accepted practice that all surgeries should be performed in hospitals, but around that time physicians were becoming increasingly frustrated at the scheduling delays, limited operating room availability, slow operating room turnover and their lack of input in purchasing new and improved equipment within the hospital budget and policy process. In 1970, a group of physicians first developed an ASC, which gave them more control over the clinical environment and quality of care delivered to patients.

Today, there are more than 5000 licensed ASCs nationwide.¹⁸ Technological advancement, faster acting and more effective anesthetics and less invasive techniques (like arthroscopy) have driven the growth of ASCs. Procedures that only a few years ago required major incisions, long acting anesthetics and extended convalescence can now be performed using smaller incisions, short-acting anesthesia and minimal recovery time. In the four decades since ASCs were first developed, they have been associated with high quality care, satisfactory patient experience and reduced costs.¹⁹

a. ASCs provide high quality care

ASCs are highly regulated by federal and state entities. The safety and quality of care in ASCs is evaluated by independent observers at three levels – state regulation, Medicare certification, and voluntary accreditation.

i. State regulation

The Department of Aging, Disabilities and Independent Living (DAIL) is responsible for surveying and regulating ASCs, as it does for all health care facilities. Though Vermont, unlike most other states,²⁰ has not yet established a regulatory regime specifically focused on ASCs,

¹⁷ 42 C.F.R. § 416.2.

¹⁸ Gordon, *supra* note 8.

¹⁹ See Munnich & Parente, *supra* note 10, at 765, 768; ASCA, *supra* note 7, at 3.

²⁰ See *ASC Regulations by State*, RPI (Sep. 2013), <http://reimbursementprinciples.com/wp-content/uploads/ASC->

DAIL has regulatory oversight over the quality and safety of care at ASCs through its Survey and Certification program, which is the designated Medicare survey authority in Vermont.²¹

ii. Federal regulation

ASCs that receive Medicare reimbursement are required to be certified and meet the Medicare Conditions of Coverage, 42 C.F.R. Part 416. The Conditions of Coverage are standards developed to ensure patient safety, the quality of the facility, its physicians and staff, as well as the services offered and management of the ASC. ASCs are required to initially demonstrate compliance with these standards and must continue to meet the Conditions on an ongoing basis. Medicare health and safety requirements are the same for ASCs and hospital outpatient facilities.²²

The Conditions of Coverage also specify the procedures that are eligible for Medicare reimbursement when performed at an ASC. Currently, there are about 3700 such procedures covered by the Medicare program.²³

iii. Private accreditation

The following independent accrediting organizations accredit ASCs: the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for the Accreditation of Ambulatory Surgery Facilities, and the American Osteopathic Association. ASCs must meet specific standards by any of these organizations to be accredited, and they all require an ASC to engage in external benchmarking to compare its performance with that of other ASCs.

Because delivering high quality care has been a hallmark of ASCs from their earliest days, the profession voluntarily developed the ASC Quality Collaboration. Six (6)²⁴ of the measures the Collaboration developed have been endorsed by the National Quality Forum (NQF), which is a non-profit dedicated to improving the quality of health care in America. The NQF is the entity Medicare consults when seeking appropriate measures for quality of care.

[State-Regulations-2013.pdf](#) (identifying ASC regulations in the 50 states).

²¹ *Department of Aging and Independent Living 2012 Annual Report*, AGENCY OF HUMAN SERVICES 26 (Mar. 2013), <http://dail.vermont.gov/dail-publications/publications-annual-reports/dail-annual-report-2012-1>.

²² Compare 42 C.F.R. § 416, with 42 C.F.R. § 482.

²³ MEDICARE PAYMENT ADVISORY COMMISSION (MPAC), REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 123 (Mar. 2014).

²⁴ Patient Burn, Prophylactic IV Antibiotic Timing, Patient Fall in the ASC, Wrong Site, Side, Patient, Procedure or Implant, Hospital Transfer/Admission, Appropriate Surgical Site Hair Removal. *Quality Measures and Guide*, ASC QUALITY COLLABORATION (last visited June 5, 2015), <http://www.ascquality.org/qualitymeasures.cfm>.

At the urging of the ASC community, CMS has established a uniform reporting system to allow ASCs to publicly report their performance on quality measures. Starting in 2012 and 2013, ASCs began reporting on patient burns; patient falls; wrong site, side, patient or procedure; hospital admissions; and prophylactic IV antibiotic timing.²⁵ As of 2016, in addition to the foregoing criteria, ASCs must report on safe surgery checklist use; ASC facility volume data on selected ASC surgical procedures; influenza vaccination coverage among healthcare personnel; endoscopy/poly surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients; and endoscopy/poly surveillance: colonoscopy interval for patients with a history of adenomatous polyps – avoidance of inappropriate use.²⁶

ASCs' emphasis on quality has paid off. For instance, in a study of Medicare patients over time that was controlled for acuity of patients, treatment in an ASC yielded better health outcomes than hospital outpatient departments; in fact, high-risk patients were less likely to be admitted to an inpatient hospital within zero (0), seven (7) and thirty (30) days from outpatient surgery.²⁷

b. ASCs have high levels of patient satisfaction

Patient surveys show a 92% satisfaction rate with both the care and service received from an ASC.²⁸ High patient satisfaction is likely due to numerous factors including high quality care, efficient operations, a smaller, more intimate setting, convenience, reduced wait-times and lower, predictable costs.²⁹

The ASC care delivery model helps reduce frustrating wait times for patients and allows physician specialists to exercise better control over scheduling so few procedures get delayed or rescheduled due to institutional demands like unforeseen emergency surgeries. Physicians focus

²⁵ *ASC Quality Reporting*, CENTERS FOR MEDICARE & MEDICAID SERVICES (Aug. 16, 2012), <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting/>.

²⁶ *ASCQR Program Reference Checklist*, AMBULATORY SURGICAL CENTER QUALITY REPORTING PROGRAM, <http://qualitynet.org/dcs/ContentServer?c=Page&pagename=OnetPublic%2FPage%2FQnetTier2&cid=1228772497737>.

²⁷ Elizabeth L. Munnich & Stephen T. Parente, *Returns to Specialization: Evidence from the Outpatient Surgery Market*, 24 (Apr. 2014) (unpublished paper), http://louisville.edu/faculty/elmunn01/research/Munnich_Parente_ASC_Quality.pdf; accord Gabor Mezei & Frances Chung, *Return Hospital Visits and Hospital Readmissions After Ambulatory Surgery*, 230(5) ANNALS OF SURGERY 721, 726 (Nov. 1999) (concluding that the study's results support the view that ambulatory surgery is a safe practice and finding an "extremely low rate" of complication-related hospital visits and readmissions within 30 days after ambulatory surgery).

²⁸ ASCA, *supra* note 7, at 3.

²⁹ See Munnich & Parente, *supra* note 10, at 765 (noting praise that ASCs have received for their potential to provide less expensive, faster services for low-risk procedures and more convenient locations for patients and physicians, compared to outpatient departments); Clifford Bleustein, David B. Rothschild, Andrew Valen, Eduardas Valaitis, Laura Schweitzer, & Raleigh Jones, *Wait Times, Patient Satisfaction Scores, and the Perception of Care*, 20(5) AM. J. MANAG. CARE 393, 399 (May 2014) (documenting the negative impact of longer wait times on patient satisfaction); Grisel & Arjmand, *supra* note 11, at 701 (concluding that ASC completed a greater percentage of procedures on time than hospital based facility and cost less).

on a small number of procedures in a single setting, as compared to a hospital setting that has large scale demands for space, resources and the attention of management. An ASC's focus enhances quality control procedures because of the limited number of procedures and operating rooms, and the smaller size of an ASC compared to a hospital.

ASCs are paid for their services based upon a global fee for each surgical procedure, a payment method that is similar to approaches such as bundled payments that are being used with increasing frequency to further health reform efforts aimed at bringing down costs. A global fee arrangement is ideal for patients, especially low income patients or patients with high deductibles and co-pays, who want to determine exactly how much they will be out of pocket prior to committing to their surgery. This is typically not the case for patients having their surgery performed at a hospital, where charges are often not known or calculated until after a patient is discharged.

c. ASCs reduce costs

The reimbursement for a procedure at an ASC is typically 45-60% less than the same one performed in a hospital, and, depending on the procedure in question, the savings could be more.³⁰ For this reason, ASCs have been an important counter-weight to soaring medical cost growth throughout the country. On average, the Medicare program and its beneficiaries share in more than \$2.6 billion³¹ in savings each year because of the lower payment rates for procedures performed in ASCs when compared to the rates paid to hospitals for the same procedures.³²

Likewise, Medicaid and other insurers, which typically benchmark their reimbursement rates off of the Medicare rate established by CMS, benefit from lower prices for services performed in the ASC setting, which translates into much lower employer and patient costs when care is received in an ASC.

Many patients with insurance coverage are now covered by plans with high deductibles and co-pays. The option of having their surgery performed in an ASC where the costs are both

³⁰ As of 2012, payments to ASCs are to be no more than 59 percent of payments made to hospitals. Munnich & Parente, *supra* note 10, at 765. In 2014, the Medicare rates were 81 percent higher in hospital outpatient departments than in ASCs. MPAC, *supra* note 23, at 122.

³¹ ASCA, *supra* note 7, at 2. If just half of the eligible surgical procedures moved from hospital outpatient departments to ASCs, Medicare would save an additional \$2.4 billion a year or \$24 billion over the next 10 years. *Id.*

³² Despite the fact that ASCs and HOPDs offer the same services, the Centers for Medicare & Medicaid Services (CMS) applies two different measures of inflation to update each payment system, which causes reimbursement to ASCs to be at present approximately 56-59% of the HOPD reimbursement. Munnich & Parente, *supra* note 10, at 765; Melissa Szabad, Melesa Freerks & Megan Michelle Bushee, Reverse Migration?: A Trend of ASC Conversion to HOPD 3 (McGuire Woods, White Paper, 2013), http://www.mcguirewoods.com/news-resources/publications/health_care/reverse-migration-whitepaper.pdf.

For HOPDs, CMS uses the hospital market basket, which measures the cost of medical expenses. For ASCs, CMS uses the Consumer Price Index –Urban (CPI-U), which measures the cost of goods such as milk and bread. Not only is the CPI-U based on changes entirely unrelated to medical costs, the inflation update is historically lower than the hospital market basket.

predictable and significantly lower than hospital costs may make the difference between having a recommended surgical procedure or not. Forgoing a minor surgical procedure may increase the chance that the patient's condition progresses and becomes more expensive to treat later in a hospital emergency department or operating room; possibly requiring an expensive in-patient stay and/or jeopardizing the health of the patient as well.

In short, ASCs are the embodiment of the Triple Aim of health care reform: they improve patient experience by offering high quality care in a smaller, less institutional setting, as reflected by characteristically high patient satisfaction scores. They improve the health of populations and individuals by improving access to and reducing the cost of high quality care, including expanding access to many important routine and preventive care procedures. And, procedures performed at ASCs earn a lower Medicare reimbursement rate, which lowers the cost of healthcare for all consumers and payers since Medicare rates tend to be the guide star for setting Medicaid, third party payer, and private pay charges. Plus, ASC rates are knowable in advance, allowing consumers much sought-after pricing certainty.

2. Outpatient Surgery Capacity in Chittenden County

There is presently an identifiable need for expanded outpatient surgery capacity in Chittenden County. Chittenden County is the fastest growing county in Vermont. Its population is projected to exceed 250,000 by 2035, a 69 percent increase from 2000 levels.³³ And while Chittenden County is expected to grow, Vermont's population is projected to age considerably. By 2030, the portion of Vermonters aged 65 or older will have increased by nearly twelve percentage points.³⁴ This combination of an aging population and a growing population within Chittenden County will increase pressure on existing outpatient surgery programs in Chittenden County. Presently, other than The Eye Surgery Center, Vermont's only ASC, which focuses exclusively on eye procedures, the UVM Medical Center is the only healthcare provider offering outpatient surgical services in Chittenden County. The Medical Center recently acknowledged an existing strain on its outpatient surgical program, stating that "Clinical capacity in the Ambulatory Care Center has been reached (and in many areas exceeded)," ³⁵ and this pressure will only be exaggerated by the confluence of a growing and aging population.

Anecdotal data from local physician practices, discussed in further detail in Section III of this Application, also supports the conclusion that additional outpatient capacity in Chittenden County is needed. Lengthy patient wait times and lack of access to the hospital's surgical facilities are concerns echoed by several independent specialists in Chittenden County. Similarly, ACO quality data, also discussed in greater detail in Section III, supports the conclusion that efficient outpatient surgical capacity is needed in Chittenden County in order to improve patient access to specialists.

³³ ECONOMIC & POLICY RESOURCES, INC., ECONOMIC AND DEMOGRAPHIC FORECAST: NORTHWEST VERMONT AND CHITTENDEN COUNTY 2000 TO 2035 AND BEYOND, 33 (2000).

³⁴ U.S. CENSUS BUREAU, POPULATION DIVISION, INTERIM STATE POPULATION PROJECTIONS, RANKING OF STATES BY PROJECTED PERCENT OF POPULATION AGE 65 AND OLDER: 2000, 2010, AND 2030 (2005).

³⁵ CON Application by Fletcher Allen Healthcare, Inc. to Acquire Real Estate in South Burlington, Dated June 2, 2014.

3. The Green Mountain Surgery Center

ACTD LLC (ACTD) proposes to open a multi-specialty ASC to offer a new lower-cost, high quality alternative for outpatient surgery procedures in Chittenden County. The proposed facility, to be called the Green Mountain Surgery Center, will be a free-standing surgery center of approximately 12,879 SF with two sterile operating rooms and four procedure rooms. It will be located at 535 Hercules Drive in Colchester, Vermont, less than a 40 minute drive from even the most remote communities in Chittenden County, its primary service area, and approximately ten minutes from downtown Burlington.

The primary planners of the ASC are Amy Cooper, MBA, the Executive Director of HealthFirst, a Vermont non-profit organization started by several Vermont physicians, and Dr. Thomas Dowhan, a local ophthalmologist and part-owner of the state's only ASC. The planning process involved the participation of a wide range of local specialty physicians in many other private practices. If this CON is awarded, the facility will be wholly owned and operated by Vermonters, the vast majority of whom will be physicians who live and practice in the State. It will have no out-of-state or corporate ownership. Its medical staff will be open to any Board certified or Board-eligible specialty physicians practicing in the service area and able to accept responsibility for patient post-operative care and follow-up, and who satisfy other customary criteria set forth in the ASC's medical staff bylaws. The Green Mountain Surgery Center will seek Medicare and Medicaid certification, accreditation from the Accreditation Association for Ambulatory Health Care and/or the Joint Commission, and will serve a broad cross-section of the community, including low-income and indigent patients who will benefit from the ASC's generous charity care policy, described in greater detail elsewhere in this Application.

The ASC's initial scope of service will include gastroenterology (GI), obstetrics/gynecology, pain medicine, general surgery, and orthopedics procedures. There is a particular need to add operating capacity for affordable GI procedures (e.g., diagnostic, preventive and screening colonoscopies), because screening colonoscopies are a quality measure for the state's commercial, Medicaid and Medicare shared-savings programs. Currently, physicians in Vermont have found that patients are putting off colonoscopies due to their high cost and slow scheduling times. In the future, the state's ACO provider organizations will find it more difficult to meet their goals of meeting or exceeding quality measure targets unless new lower-cost, more efficient settings are available in which these procedures can be performed.

In accordance with 42 C.F.R. 416.166, the Green Mountain Surgery Center will only host procedures that are not expected to pose a significant safety risk to a patient when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure. The rapidly changing technology in health care makes it impossible to pin down precisely the procedures that will be performed in the future at the proposed Green Mountain Surgery Center. When Medicare first began approving reimbursement for procedures performed at ASCs in 1982, it approved 200.³⁶ Today, it approves reimbursement for approximately 3700,³⁷ and it

³⁶ *Right-Sizing Healthcare*, *supra* note 6.

adds approved procedures annually. Some of the procedures performed today were unknown or still experimental in 1982.

The proposed ASC will offer many advantages over existing options for outpatient surgical care. It will offer high quality health care at a lower cost than current options. The costs for services performed at the ASC will be knowable by patients in advance of treatment, eliminating the financial uncertainty often associated with health care. Due to the efficiencies inherent in the ASC concept, the ASC will offer reduced wait times for procedures. The ASC facility will be smaller and less institutional than a typical hospital setting, and will be designed to be patient-friendly and easily accessible, featuring easy parking and convenient transportation options.

³⁷ MPAC, *supra* note 23, at 123.

B. Applicant's Identification, Organization and Ownership

ACTD LLC was formed in the fall of 2014 with a community-based mission to provide Vermonters with a low-cost, high-quality option to access needed outpatient surgical procedures by obtaining a CON to own and operate the Green Mountain Surgery Center, a multi-specialty ambulatory surgery center in Chittenden County. The largest equity owners of the company are Amy Cooper and Dr. Thomas Dowhan, who are primarily responsible for planning the project, in consultation with local physicians.

Ms. Cooper is the Executive Director of HealthFirst Inc., Vermont's independent physician association. Prior to her involvement with HealthFirst, Ms. Cooper served for three years as a management consultant to health care providers and insurers as an associate at L.E.K. Consulting in Boston. She then transitioned to working in the e-commerce industry, holding positions at Barnes & Noble and Amazon.com, before co-founding her own consumer-internet company. Ms. Cooper holds a Masters of Business Administration from the Wharton School at the University of Pennsylvania, and graduated with a Bachelor of Arts, magna cum laude, from Harvard College. Ms. Cooper moved to Vermont with her husband and three young daughters in 2013.

Dr. Thomas Dowhan is board certified in Ophthalmology and a graduate of UVM College of Medicine. He completed his residency at University of Medicine and Dentistry of New Jersey / Robert Wood Johnson College of Medicine (Formerly Rutgers University). He is presently in solo Ophthalmology Practice at St. Albans Eye Center, with a satellite office in Essex Junction, Vermont. Dr. Dowhan is a member/manager of The Eye Surgery Center, currently Vermont's only ambulatory surgery center. Dr. Dowhan is also President of the Franklin County Medical Society and serves on the board of directors of HealthFirst, Inc. He has been practicing in Vermont and performing surgeries at Northwestern Medical Center for 15 years. Since its opening, Dr. Dowhan has also been performing surgeries at the Eye Surgery Center.

In addition, ACTD LLC has seven minority owners. Six are local physicians, the majority of whom intend to perform surgery at Green Mountain Surgery Center should this CON be awarded. The other minority owner is a Chittenden County resident who works full time in the health care field. The company expects to add additional minority owners, anticipated to consist of local physicians, upon approval of this Application.

In preparing this CON application, ACTD has relied on the advice and expertise of Avanza Healthcare Strategies, a national health care consulting firm that specializes in outpatient services support, as well as population health and preventive care as the health care system switches from volume to value. Avanza's core competency is assisting providers in ASC development, operational oversight and troubleshooting. With more than 125 ASCs in its portfolio, over 15 years of direct ASC experience and frequent contributions to national healthcare publications, Avanza is one of the leading ASC experts in the country. Further evidence of this is their repeated placement on Becker's Healthcare listing of "ASC Companies to Know." Avanza's founder and CEO, Joan Dentler has been working in the ASC industry since the late 1990s and is seen as one of the industry's leading experts in the maturation of the ASC industry, in particularly when it comes to hospital-physician joint ventured ASC development and ownership. Though Avanza has a national presence and scope, the firm has

strong experience with the unique needs of New England. Avanza assisted Dartmouth Hitchcock in the development, licensing and accreditation of its freestanding Outpatient Surgery Center in Lebanon, New Hampshire. Currently Avanza is engaged supporting outpatient projects in New Hampshire, Connecticut, Massachusetts and the North Country of New York.

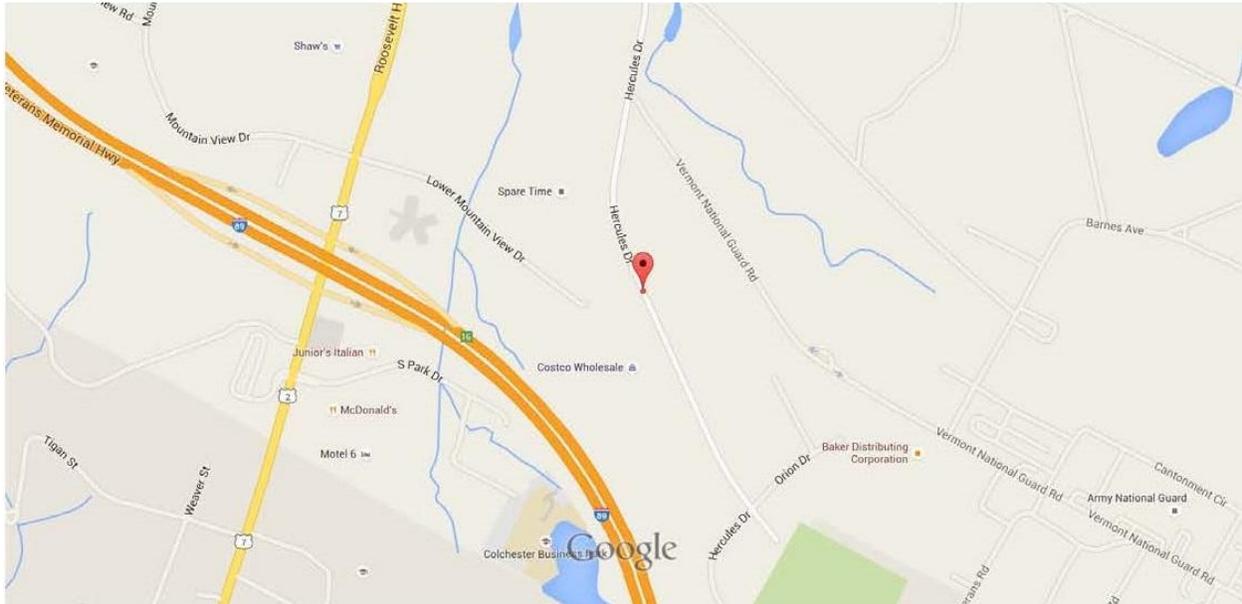
ACTD has also engaged the experienced healthcare architectural firm AMB Development Group, led by Jack Amormino, its president and CEO. AMB has over 35 years of experience and has developed hundreds of outpatient facilities nationwide, including ambulatory care centers, surgery centers, medical office buildings, and clinics. Additionally, its senior team has decades of experience in healthcare strategic planning, architectural design and medical space planning, and healthcare marketing and business development.

The Green Mountain Surgery Center will apply to CMS for its provider number and certification and enrollment as a Medicare-approved freestanding Ambulatory Surgery Center as designated in Code of Federal Regulations Title 42, Chapter IV, Subchapter B, Part 416. In conjunction with its Medicare application, it will also apply for accreditation from the Accreditation Association for Ambulatory Health Care and/or the Joint Commission, the two preeminent accrediting bodies for ambulatory health care facilities.

C. Project Location

ACTD presently holds an option to lease the site of the proposed ASC, which is located at 535 Hercules Drive in Colchester, Vermont. The property is conveniently sited just off of I-89, and is proximate to several other health care resources, such as the offices of OneCare ACO and various medical offices of the UVM Medical Center. The ASC will be a short ten-minute drive from Burlington, and only five minutes from neighboring Winooski. It will be accessible by CCTA and SSTA, and will offer plentiful, easy parking access.

Figure 2



D. Facility Design, Lease Provisions and Project Cost

ACTD holds an option to lease space within an office building to be constructed at 535 Hercules Drive in Colchester, which will be the site of the Green Mountain Surgery Center. The leased premises will consist of approximately 12,879 square feet of interior space, and will include two 427 square foot operating rooms, four 200 square foot procedure rooms, and fourteen pre-operative/post-operative beds. The facility will include a nurse’s control station, a centrally located sterile processing room, and other ancillary storage, office and related space to support the daily operations of the center. A floorplan of the proposed ASC is submitted with this Application as **Exhibit 1**.

If ACTD exercises its lease option, the annual rent for the space will be \$38 per square foot for the first lease year, which base amount includes tenant fit-up costs amortized over a ten-year period (as described below). The rent will increase by three percent annually during the lease term. The lease will have an initial term of ten years, and ACTD will have the option to renew the term for an additional ten year period for a rent to be determined by good faith negotiations between the landlord and ACTD.

The landlord will front the initial cost of fitting up the interior of the office building for use as an ambulatory surgery center, and ACTD will reimburse the landlord for such costs over the initial term of the lease. The total construction budget for fitting up the interior of the building for ACTD’s use is \$1,609,875. An itemized summary of the interior fit-up construction budget is set forth in **Table 2**:

Table 2

Green Mountain Surgery Center		
Interior Fit-Up Construction Budget		
<i>Item</i>	<i>Cost per Square Foot</i>	<i>Total Cost</i>
Concrete	\$1.25	\$16,099
Metals	\$2.58	\$33,196
Finish Carpentry	\$5.15	\$66,327
Cabinets and Casework	\$6.15	\$79,206
Doors, Frames and Hardware	\$4.75	\$61,175
Automatic Door Openers	\$1.00	\$12,879
Aluminum Blind Windows	\$1.50	\$19,319
Studs and Drywall	\$18.00	\$231,822
Tile	\$0.35	\$4,508
Acoustical Ceiling	\$5.15	\$66,327
Flooring	\$4.75	\$61,175
Painting and Wallcovering	\$2.25	\$28,978
Wall Protection	\$0.75	\$9,659
Lockers and Benches	\$0.90	\$11,591
Cubicle Curtains and Tracks	\$0.75	\$9,659
Fire Extinguishers and Cabt	\$0.10	\$1,288
Misc. Toilet/Bath Equip	\$0.25	\$3,220

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Signage (Interior)	\$0.25	\$3,220
Miscellaneous Specialties	\$0.25	\$3,220
Window Treatment	\$0.50	\$6,440
Plumbing	\$13.15	\$169,359
Fire Protection	\$2.00	\$25,758
HVAC	\$20.00	\$257,580
Electrical	\$23.25	\$299,437
		<hr/>
		\$1,481,439
General Conditions (5.00%)		\$74,072
		<hr/>
		\$1,555,511
GC Fee (3.50%)		\$54,364
Total		<hr/>
		\$1,609,875

E. Staffing

The Green Mountain Surgery Center plans to open with a staff of 22 FTEs. The staff is anticipated to include 15 registered nurses, 4 surgical technologists, and 3 administrative and clerical staff. A fulltime Administrator, who will be under the direct supervision of the Board of Managers, will have day-to-day management responsibilities for the ASC. The Administrator will collaborate with a physician Medical Director, appointed by the Green Mountain Surgery Center's Board of Managers, who will be responsible for clinical operations. The staff will maintain valid clinical licenses and CPR, ACLS (Advanced Cardiac Life Support) and/or BCLS (Basic Cardiac Life Support) certifications where required under federal or state law. The Green Mountain Surgery Center will augment and support staff by contracting with outside experts when needed. Some of the areas where we may need to bring in outside expertise include infection control and regulatory compliance.

The Green Mountain Surgery Center will develop an annual staff in-service program and will provide comprehensive initial and on-going staff training opportunities for its staff to ensure that the staff is continually informed and educated on issues related to their job responsibilities as well as industry trends and best practices (including evidence-based practices). The ASC will contract with hospitals and licensed providers in the area to provide needed diagnostic and clinical support services such as pharmacy, laboratory, and x-ray.

The anticipated staffing plan for the Green Mountain Surgery Center is in line with industry standards and complies with Medicare and ASC independent accrediting bodies standards.

F. Scope of Services

The Green Mountain Surgery Center will be a multi-specialty ASC that provides elective, non-emergent ambulatory surgical procedures.³⁸ The Center will only host procedures that are not expected to pose a significant safety risk to a patient when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.³⁹ It is anticipated that the majority of procedures performed at the ASC will be GI procedures, such as diagnostic and screening colonoscopies and endoscopies. In addition, the center will perform pain management procedures (e.g. epidural injections) and general surgery procedures (e.g. umbilical hernia repair). Due to interest from surgeons and patients in an ASC that offers lower costs, easier scheduling and greater efficiency for non-emergent surgeries and procedures than alternative sites of care, we anticipate that once the Green Mountain Surgery Center is up and running, there will be strong demand to provide operating and procedure room time for physicians working in other specialties, including orthopedics, gynecology and plastic surgery.

There are presently over 5,000 licensed ambulatory surgery centers in the U.S.⁴⁰ Over half of these facilities provide more than one type (specialty) of surgery. Multi-specialty surgery centers are cost effective and convenient for communities, allowing for all different specialties to share in one location, minimizing the construction, capital and overhead costs of performing surgery and avoiding a duplication of facility, staffing and operating costs.

The proposed ambulatory surgery center will house two fully equipped operating rooms and four fully equipped procedure rooms, along with supporting pre-operative, post-operative and PACU areas and other required support space and design elements. It is anticipated that the Center will be open Monday through Friday from 6 a.m. to 5 p.m. Saturday and evening hours will be considered if demand warrants.

Many CMS-approved procedures that will be performed at the Green Mountain Surgery Center first require the authorization of a patient's primary care provider, plus the surgeon and, where general, regional or local anesthesia is indicated, the approval of the Center's anesthesia provider. Patients with an American Society of Anesthesiologists (ASA) classification of I ("A normal healthy patient") and II ("A patient with mild systemic disease") will be seen at the Center, after being cleared for surgery by the requisite provider(s). The Center may also accept certain patients with an ASA classification of III ("A patient with severe systemic disease") on a case-by-case basis, only after having been cleared for surgery by their primary care provider, the surgeon, and the Green Mountain Surgery Center's anesthesia provider. Patients who are clinically high-risk as assessed by their primary care and specialty care providers due to the presence of co-morbidities, very advanced age, or other factors will have their procedures scheduled at a local hospital that is equipped to deal with complex cases.

³⁸ An unanticipated medical circumstance may arise that would require an ASC patient to stay in the ASC longer than 24 hours, but such situations should be rare.

³⁹ 42 C.F.R. § 416.116.

⁴⁰ Gordon, *supra* note 8.

The Green Mountain Surgery Center will not make determinations on whether or not to accept a patient based on the patient's reimbursement status (insured vs. uninsured) or ability to pay. Rather, the decision as to whether to accept a patient will be based upon the patient's condition and medical needs. The Center will accommodate both self-pay patients as well as patients with little or no resources for payment. Our preliminary financial forecasts assume that five percent (5%) of the Green Mountain Surgery Center's patients will be unable to pay for care.

Only physicians and allied professionals that are credentialed members of the Green Mountain Surgery Center and have been granted privileges at the Center will be allowed to provide medical surgical services at the Center. A Medical Director, appointed by the Green Mountain Surgery Center's Board of Managers, will be responsible for overseeing the quality of medical care. The staff, as explained in Section E of this Application, will include licensed registered nurses with Basic Cardiac Life Support (BCLS) and/or Advanced Cardiac Life Support (ACLS) certifications. The ASC will contract with hospitals and licensed providers in the area to provide all needed diagnostic and clinical support services such as pharmacy, laboratory, and x-ray.

If anesthesia is indicated, patients will be required to be seen by a representative of the anesthesia service supporting the Green Mountain Surgery Center. All patients will receive both a pre-op phone call the day before surgery (to ensure they are indeed eligible for surgery at the ASC) and post-op call the day after surgery (to follow-up on discharge instructions and report any post-operative complications). The Green Mountain Surgery Center will be equipped with the required emergency equipment, including a fully stocked crash cart and malignant hyperthermia cart. Any patient with an unexpected complication during or post-surgery will be immediately transferred to an area hospital.

G. Charge Structures and Patient Savings

Medicare currently reimburses ASCs approximately 56% of what hospitals are paid for the exact same cases performed by the same surgeon.⁴¹ And data published by the Ambulatory Surgery Center Association (ASCA) based on 2012 Medicare data shows that hospital and hospital affiliated departments are paid close to double (172%) for the same procedures compared with Ambulatory Surgery Centers.⁴² For instance, a very common procedure, like an upper GI endoscopy, which can be used for biopsies or to treat ulcers, can cost the patient and healthcare system up to \$320 more per procedure at a hospital outpatient department.⁴³ Based on the current reimbursement rate, an ASC performing the same procedure would receive not more than \$189.

A recent study addressed the price differential between hospitals and community settings for commercial payers. In it, the authors demonstrated that the average hospital outpatient department price paid by commercial insurers for a basic colonoscopy was \$1,383 compared to \$625 in community settings like physicians' offices and ASCs.⁴⁴ The study, which was published in 2014, looked at commercial insurance claims data for approximately 590,000 active and retired autoworkers and their dependents across 18 American cities. Colonoscopies are considered to be the most effective colon cancer screening tool available, and the claims analysis focused on the three most common kinds of screening colonoscopies. The authors found nearly 45,000 of these three kinds of colonoscopies were conducted for the study population in 2011, accounting for roughly \$23 billion in spending excluding the cost of related services like anesthesia, pathology tests and drugs. On average, prices for colonoscopies were twice as high in hospital outpatient departments as in ASCs.

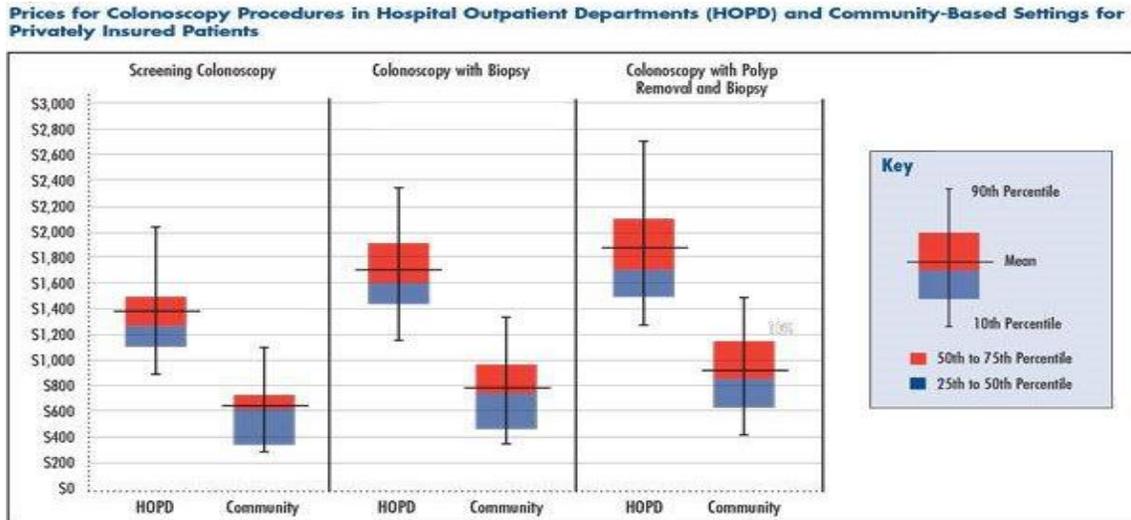
⁴¹ Szabad et al., *supra* note 32, at 3.

⁴² *Wilmington Health Approved for Ambulatory Surgery Center Expanded Service Offering*, WILMINGTON HEALTH (last visited June 5, 2015), <http://www.wilmingtonhealth.com/news/wilmington-health-approved-for-ambulatory-surgery-center-expansion>.

⁴³ *Id.*

⁴⁴ JAMES D. RESCHOVSKY & CHAPIN WHITE, NATIONAL INSTITUTE FOR HEALTH CARE REFORM, RESEARCH BRIEF NO.16, LOCATION, LOCATION, LOCATION: HOSPITAL OUTPATIENT PRICES MUCH HIGHER THAN COMMUNITY SETTINGS FOR IDENTICAL SERVICES 2-3 (June 2014), <http://www.nihcr.org/Hospital-Outpatient-Prices>.

Figure 3



The proposed ASC will have inherent cost advantages over the only other surgical option in the area, a tertiary care hospital. It will have low building and equipment overhead due to its size and the relatively low complexity of the cases being performed in the facility. Single-shift and cross-trained staffing costs tend to be lower than hospital-based staffing. The concentrated operational emphasis promotes quality of care, high staff expertise, focus and efficiency. Also, due to the fact that all cases performed at the proposed Green Mountain Surgery Center will be scheduled in advance and non-emergent in nature, there is no need for the redundancies in supplies, equipment and staffing that are typically required in a tertiary facility that must be prepared for emergencies and open 24/7.

The Center will not employ physician staff. It will not lease its operating rooms to physicians. Its billings, income, and expenses will be totally separate from those of the surgeons who will perform surgical cases there. The ASC's charges for surgery, which include room time, medications, and recovery, will be separate and independent of the surgeons' and/or anesthesiology providers' professional charges for performing the surgeries.⁴⁵ Therefore, unless otherwise stated, any financial comparisons to hospitals provided in this application are facility-to-facility cost comparisons. They do not include physician charges. Surgeons' fees are not relevant, being identical in both settings.

The Green Mountain Surgery Center's operational differences will allow it to offer lower charge structures and lower-cost contracts with insurers than hospitals would find feasible to accept. The proposed Center will be price-competitive with similar facilities in adjoining states and give patients and payers (including governmental payers) significant savings compared to what they are currently required to pay hospitals in connection with the same cases, by the same doctors, on the same patients.

⁴⁵ The surgeons' and anesthesiology providers' charges will not be collected by the Green Mountain Surgery Center unless the surgeons, anesthesiologists and the Center enter into any global (i.e., complete service) pricing arrangements.

It is difficult to quantify the total cost savings across all payers for the cases we anticipate being performed at the proposed Green Mountain Surgery Center since there are no comparable ASCs in the Vermont with which to compare payment rates. We are able to quantify cost savings with respect to Medicare patients since the ASC payment rates are set as a percentage of the current rate that hospitals are paid for the same procedure. Simply stated, future cases that can be performed in a freestanding ASC versus a hospital-owned outpatient department will save Medicare at least 41% and current data indicates savings of approximately 44% on average.⁴⁶ Since most private insurers set their outpatient surgery rates based on a percentage of the current Medicare rates, we anticipate a similar, if not greater, savings to be passed on the private insurers and their patients. Patients without insurance coverage will be welcome at Green Mountain Surgery Center, where their patient charge will also be less than what would be required for elective surgery at a hospital. And qualified patients with little means will be able to receive the Green Mountain Surgery Center's services at a discount or free of charge under the center's charity care policy, an initial draft of which is included in **Exhibit 2** to this Application.

We estimate that once the Green Mountain Surgery Center is open, approximately 40%⁴⁷ of the cases that will be performed there will be reimbursed by Medicare, resulting in a savings to Medicare alone of over \$2 million dollars per year after year one and a cumulative savings of over \$8 million dollars in the first four years of operations, as depicted in **Table 3**.

Table 3

GREEN MOUNTAIN SURGERY CENTER

TOTAL ASC MEDICARE SAVINGS (COMPARED TO HOPD)

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL (4 YEARS)
PROJECTED MEDICARE CASES	2,053	2,370	2,393	2,417	9,233
PROJECTED MEDICARE NET REVENUE	\$2,223,399	\$2,605,211	\$2,669,951	\$2,737,179	\$10,235,740
ADJUSTMENT FACTOR (ASC as % HOPD)	56.0%	56.0%	56.0%	56.0%	56.0%
HOPD NET REVENUE	\$3,970,355	\$4,652,163	\$4,767,770	\$4,887,820	\$18,278,107
ASC MEDICARE SAVINGS	\$1,746,956	\$2,046,952	\$2,097,819	\$2,150,641	\$8,042,367

In an effort to illustrate the savings to both patients and payers the Green Mountain Surgery Center will bring, we have chosen five representative procedures that we anticipate will regularly

⁴⁶ Munnich & Parente, *supra* note 10, at 765; Szabad et al., *supra* note 32, at 3.

⁴⁷ This estimate is based on the current payer mix experience of the Vermont surgeons who intend to perform surgery at the Center.

be performed at the proposed ASC and compared the proposed Center’s hypothetical Medicare reimbursement to a hospital’s Medicare reimbursement for the procedures. The procedures we used are Lumbar Injections, Colonoscopy, Hysteroscopy, Laparoscopy and Hernia Repair. The savings are illustrated in **Table 4**. The savings range from over \$300, on the low end, to over \$1500, on the high end, per case. Again, although this data is only for the Medicare cases, we anticipate savings to insurers, who often use Medicare’s reimbursement rates as a basis for their own, and to patients, who will benefit from reduced out-of-pocket costs.

Table 4

**GREEN MOUNTAIN SURGERY CENTER
 MEDICARE SAVINGS - SELECTED SURGICAL CASES**

CPT CODE	CPT - SHORT DESCRIPTION	ASC MEDICARE RATE	HOPD MEDICARE RATE	MEDICARE SAVINGS PER CASE
	PERCUT			
22521	VERTEBROPLASTY,LUMBAR	\$1,404.48	\$2,508.00	\$1,103.52
45380	COLONOSCOPY AND BIOPSY	\$401.76	\$717.43	\$315.67
58558	HYSTEROSCOPY, BIOPSY	\$961.46	\$1,716.89	\$755.43
58571	LAPAROSCOPY	\$1,989.30	\$3,552.32	\$1,563.02
49585	REPAIR UMBILICAL HERNIA	\$1,417.42	\$2,531.11	\$1,113.69

H. Utilization, Revenues and Profitability

At the time of this application, ACTD has identified a minimum of 16 physicians who are extremely interested in performing cases at the proposed ambulatory surgery center. The most prevalent reason given was to give their patients an option of a lower cost location for their routine, elective procedures. This reason was closely followed by the physicians' desire for their patients and their families to have the option of a more efficient and friendly environment for their ambulatory procedures. The physicians also anticipate that scheduling procedures at the ASC will be easier and that their patients will be able to receive outpatient surgical services in a more timely manner than is presently possible.

The physicians who have expressed interest in the ASC represent several specialties that are typically seen in ambulatory surgery centers around the country. These specialties include GI, gynecology, orthopedics, pain management and general surgery.

In year one, we are projecting 5,132 total cases will be performed at the ASC. The projections are based on actual historical outpatient cases (based on average 2014 monthly volumes) performed by the physicians who have expressed interest in the project, as reported by those physicians. Based on physician input, we determined a separate capture rate based on the percentage of surgical cases that each physician expects to perform at the proposed ASC. While these capture rates ranged from 12-100%, in aggregate, the projections assume that 67% of the physician's projected cases will be performed at the ASC. The remaining 33% will continue to be performed at local hospitals. The determination of whether procedures will be scheduled at the ASC or a local hospital would be driven by the acuity of the patient, the type of procedure, and patient preference.

We have also discounted the cases projected in year one to reflect a six month ramp-up period which is typical when opening a new facility. Our projections show a very conservative annual rate of case growth at 1%, an estimate typically used for ASC financial modeling. Year two cases were projected assuming that year one was fully stabilized. This equates to 5,924 cases in year two, 5,983 cases in year three and 6,043 cases in year four. **Table 5** shows projected case volumes by physician and specialty. **Table 6** shows the same information, but totaled by specialty.

Table 5

**GREEN MOUNTAIN SURGERY CENTER
 PROJECTED CASES BY PHYSICIAN**

Physician	Specialty	Year 1	Year 2	Year 3	Year 4
Physician A	GI	1,050	1,212	1,224	1,236
Physician B	GI	1,050	1,212	1,224	1,236
Physician C	GI	1,050	1,212	1,224	1,236
Physician D	OB/GYN	85	98	99	100
Physician E	OB/GYN	58	67	68	68
Physician F	OB/GYN	95	110	111	112
Physician G	OB/GYN	105	121	122	123
Physician H	OB/GYN	105	121	122	123
Physician I	OB/GYN	42	48	48	49
Physician J	OB/GYN	42	48	48	49
Physician K	OB/GYN	47	55	56	56
Physician L	ORTHO	284	327	330	334
Physician M	PAIN MGT	91	105	106	107
Physician N	PAIN MGT	756	873	882	891
Physician O	GEN SURG	101	116	117	118
Physician P	GEN SURG	67	78	79	80
Other Physicians	GEN SURG	105	121	122	123
TOTAL BY PHYSICIAN		5,132	5,924	5,983	6,043

Notes: Projected case volumes have been adjusted for acuity as only a certain percentage of physician cases will be performed at the proposed surgery center. Case volumes were projected assuming there would be a ramp up period during the first year of operation.

Table 6

**GREEN MOUNTAIN SURGERY CENTER
 PROJECTED CASES BY SPECIALTY**

Specialty	Year 1	Year 2	Year 3	Year 4
GI	3,150	3,636	3,672	3,709
OB/GYN	579	668	675	681
ORTHO	284	327	330	334
PAIN MGT	847	978	988	998
GENERAL SURGERY	273	315	318	321

TOTAL BY SPECIALTY	5,132	5,924	5,983	6,043
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Notes: Projected case volumes have been adjusted for acuity as only a certain percentage of physician cases will be performed at the proposed surgery center. Case volumes were projected assuming there would be a ramp up period during the first year of operation.

Tables 7 and 8 illustrate the revenue projections for the proposed ASC. The payer distribution that we modeled follows the actual current payer mix of the interested physician participants. **Table 9** shows the annual breakdown of cases by payer. We estimate that forty percent (40%) of the surgeries performed in the proposed ASC would be reimbursable by Medicare, twelve percent (12%) of the cases would be reimbursable by Medicaid, thirty five percent (35%) by commercial payers, eight percent (8%) would be paid for by the patients themselves and five percent (5%) would be a combination of charity care and uncollectible debt.

Table 7

**GREEN MOUNTAIN SURGERY CENTER
 REVENUE (BEFORE DEDUCTIONS) BY PAYOR CATEGORY**

	Year 1	Year 2	Year 3	Year 4
Medicare	\$2,221,818	\$2,604,440	\$2,668,195	\$2,736,866
Medicaid	\$566,720	\$664,074	\$681,023	\$697,878
Commercial	\$2,435,229	\$2,852,448	\$2,925,109	\$2,998,647
Self Pay	\$624,939	\$731,382	\$750,354	\$767,960
Total	\$5,848,706	\$6,852,344	\$7,024,680	\$7,201,351

Table 8

**GREEN MOUNTAIN SURGERY CENTER
 REVENUE PER CASE BY PAYOR CATEGORY**

	Year 1	Year 2	Year 3	Year 4
Medicare	\$1,082	\$1,099	\$1,115	\$1,132
Medicaid	\$920	\$934	\$949	\$963
Commercial	\$1,356	\$1,376	\$1,397	\$1,418
Self Pay	\$1,521	\$1,543	\$1,567	\$1,590
Total	\$1,140	\$1,157	\$1,174	\$1,192

Table 9

**GREEN MOUNTAIN SURGERY CENTER
 CASES BY PAYOR CATEGORY**

	Year 1	Year 2	Year 3	Year 4
Medicare	2,053	2,370	2,393	2,417
Medicaid	616	711	718	725
Commercial	1,796	2,073	2,094	2,115
Self Pay	411	474	479	483
Charity Care	128	148	150	152
Bad Debt	128	148	149	151
Total	5,132	5,924	5,983	6,043

In terms of net revenues, we project that based on our anticipated case mix, 9.7 percent of our net patient revenues will come from Medicaid, 38% from Medicare and 52.3% from commercial/self-pay. For purposes of comparison, the UVM Medical Center’s projected net patient revenue for hospital services in 2015 is allocated 11.4% to Medicaid payments, 31.6% to Medicare, and 57.0% to commercial/self-pay/worker’s compensation.⁴⁸

We used the 2014 ASC Payment Schedule published by the Ambulatory Surgery Center Association to determine the projected reimbursement (net revenue) that would be collected by

⁴⁸ GREEN MOUNTAIN CARE BOARD, FLETCHER ALLEN HEALTH CARE FISCAL YEAR 2015 BUDGET ANALYSIS 15 (Aug. 2014). According to UVM Medical Center’s 2015 budget projections, the hospital anticipates net revenues for hospital services of \$94,227,954 from Medicaid patients, \$259,949,728 from Medicare patients and \$468,762,753 from commercial/self-pay/worker’s compensation. *Id.*

the proposed Green Mountain Surgery Center. This schedule provides a list of surgical procedures that were reimbursed by Medicare in an ASC in 2014. The reimbursement amount is geographically adjusted by incorporating a local wage index. It should be noted that this schedule is only used to determine Medicare reimbursement from CMS. A blended reimbursement rate of 109% of Medicare was utilized for non-Medicare payers. Most commercial payers reimburse ASCs at a rate higher than the published CMS rate, but based on the current CMS rate. **Tables 7 and 8** show the annual breakdown of anticipated net revenue per case by payer and the total revenue by payer that will be collected by the ASC.

Avanza, our ASC consultant, used these case and revenue numbers in developing comprehensive financial projections for the ASC. Published and respected ASC-industry benchmarks were used to project expenses for the proposed Green Mountain Surgery Center. The expense assumptions incorporated start-up, operating, facility, economic, equipment, and staffing costs from comparable ASCs. The benchmark sources included Becker's ASC Review, Accreditation Association for Ambulatory Healthcare, Ambulatory Surgical Centers of America, Ambulatory Surgery Center Association, HealthCare Appraisers, Provista, RemitData, MedPAC, Objective Health, VMG Health, The Advisory Board Company, and Avanza's client database. The projections show modest profits in each year of operation, as shown in **Table 10**.

Table 10

**GREEN MOUNTAIN SURGERY CENTER
 INCOME STATEMENT**

	Year 1	Year 2	Year 3	Year 4
Revenue				
Patient Revenues	\$5,848,706	\$6,852,344	\$7,024,680	\$7,201,351
Deductions from Revenue:				
Bad Debt	(\$94,693)	(\$137,047)	(\$140,494)	(\$144,027)
Charity Care	<u>(\$94,693)</u>	<u>(\$137,047)</u>	<u>(\$140,494)</u>	<u>(\$144,027)</u>
Total Deductions from Revenue	(\$189,387)	(\$274,094)	(\$280,987)	(\$288,054)
Net Patient Revenue	\$5,659,319	\$6,578,250	\$6,743,693	\$6,913,297
Expenses				
Clinical Personnel Costs	\$1,991,808	\$2,031,644	\$2,072,277	\$2,113,723
Clinical Expenses (Non Personnel)	\$1,786,547	\$2,124,135	\$2,229,807	\$2,340,749
Administrative Expenses	\$803,847	\$925,321	\$955,715	\$990,249
Lease Expense	\$489,402	\$504,084	\$519,207	\$534,783
Equipment Expense	\$638,843	\$638,843	\$638,843	\$579,559
Interest Expense	\$47,088	\$45,918	\$44,664	\$43,320
Depreciation Expense	\$28,571	\$28,571	\$28,571	\$28,571
Total Expenses	\$5,786,106	\$6,298,517	\$6,489,084	\$6,630,954
Income Before Taxes	(\$126,787)	\$279,733	\$254,609	\$282,343

In submitting this Application, we are mindful of the concerns that have been raised as to whether ASCs increase utilization of health care.⁴⁹ The concern that the addition of a facility increases utilization is in our case counterbalanced by the fact that the Green Mountain Surgery

⁴⁹ This concern was prominently raised by claims data prepared by the Lewin Group, which suggests that procedures are performed more frequently when they are conducted in outpatient settings. MCKINSEY CENTER FOR U.S. HEALTH SYSTEM REFORM, ACCOUNTING FOR THE COST OF U.S. HEALTH CARE: PRE-REFORM TRENDS AND THE IMPACT OF THE RECESSION 19 (Dec. 2011). As a preliminary matter, we wish to note that this data shows that the major increase in frequency is associated with arthroscopic knee and shoulder procedures, which are not expected to constitute a significant percentage of procedures performed at the proposed ASC. The Lewin Group's data actually shows a decline in frequency for some GI procedures and a minimal increase in other GI procedures, and, as we describe elsewhere, we anticipate the largest volume of procedures performed at our ASC will be GI procedures.

Center would be the only multispecialty ASC operating in the entire state and by the fact that current outpatient surgical resources in Chittenden County are at capacity. Another important consideration is that an increase in frequency is a natural result of expanded access to health care, which is one of Vermont's fundamental goals of health care reform and a key criterion for obtaining a certificate of need. Our ASC will expand access to health care (as described in greater detail elsewhere in this application), consistent with these goals, and the causal result of doing so will be some increase in utilization of health care. Finally, to the extent that utilization increases due to expanded access to health care, the aggregate costs to the health care system will nevertheless be reduced due to this project, as the cost savings of an ASC as compared to hospital-based services will more than offset any modest increase in utilization. As an example, in North Carolina, a 28% increase in utilization attributable to ASCs nevertheless resulted a \$224,000,000 in savings to that state's health care system.⁵⁰

⁵⁰ David J. French, *2005 Change in CON Law for GI Endoscopy Procedure Rooms: Cost Savings and Justification for Changes to CON Law to Allow Single-Specialty Ambulatory Surgery Centers*, STRATEGIC HEALTHCARE CONSULTANTS & NORTH CAROLINA ORTHOPAEDIC ASSOCIATION 4 (Sep. 2012), <http://www.ncleg.net/documents/sites/committees/HSCCONPRHI/09-27-12/09-27-2012%20Presentation%20%283%29%202005%20Change%20in%20the%20CON%20Law%20for%20GI%20Endoscopy%20Procedure%20Rooms.pdf>.

I. Policies and Procedures

ACTD and its ASC consultant Avanza are developing appropriate and compliant policies, procedures and processes for the proposed Green Mountain Surgery Center. All applicable standards required by CMS and the accreditation bodies will be adopted by the Green Mountain Surgery Center to ensure compliance with all required regulations and statutes, and that the care provided at the ASC will be of the highest quality. The Center will adopt industry-standard policies and procedures in the following areas:

- Governance
- Patient Rights
- Compliance
- Administration
- Quality Management
- Clinical Records
- Facilities and Environment
- Infection Prevention and Control and Safety
- Anesthesia Services
- Surgical Services
- Human Resources/ Employee Health
- Charity Care

SECTION II: CONSISTENCY WITH THE HRAP CON STANDARDS

CON STANDARD 1.2: Applicants seeking to expand or introduce a specific health care service shall show that such services have been shown to improve health. To the extent such services have been the subject of comparative effectiveness research, an applicant shall show that the results of this research support the proposed project.

The proposed Green Mountain Surgery Center would expand affordable outpatient surgery service options available in Chittenden County. The project is likely to improve population health in that it will offer numerous screening and diagnostic services aimed at detecting serious health conditions in their early stages, when they are often more easily treated.⁵¹ For instance, the Center will offer colonoscopies to screen for colorectal cancer which, excluding skin cancers, is the third most common cancer diagnosed in both men and women in the United States.⁵² A recent study published in the *New England Journal of Medicine* concluded that colonoscopies were associated with a reduced incidence of cancer and also reduced mortality from cancer.⁵³ Other screening and diagnostic tests aimed at detecting cancers and other illnesses in their early stages also are associated with improved health outcomes.⁵⁴ For a list of the initial services to be performed at the Center, including screening and diagnostic services, please refer to **Exhibit 3** to this Application.

In addition, the performance of outpatient surgery services by ambulatory surgery centers has been linked to improved health outcomes for patients.⁵⁵ For instance, a May 2014 publication in *Health Affairs*, a leading peer-reviewed journal of health policy thought and research, found that, controlling for patient characteristics, ASCs performed procedures faster than did hospital outpatient departments, and also reported better health outcomes for their patients than did hospitals, holding patient risk constant.⁵⁶ Elsewhere the authors of the study found that high-risk patients treated in an ASC were less likely to be admitted to an inpatient hospital within 0, 7, or 30 days of outpatient surgery.⁵⁷ In addition, according to a 2008 report, patient surveys indicate

⁵¹*Disease Screening – Statistics Teaching Tools*, NY DEPT. OF HEALTH, (Apr. 1999), <https://www.health.ny.gov/diseases/chronic/discreen.htm>.

⁵²*Importance of Colorectal Cancer Screening*, AMERICAN CANCER SOCIETY (Feb. 5, 2015), <http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-importance-of-crc-screening>.

⁵³ Nishihara, Reiko, et al., *Long-Term Colorectal-Cancer Incidence and Mortality after Lower Endoscopy*, 369(12) NEW ENG. J. MED. 1095 (Sept. 19, 2013).

⁵⁴ See *Disease Screening – Statistics Teaching Tools*, *supra* note 51.

⁵⁵ See, e.g., Grisel & Arjmand, *supra* note 11, at 701 (comparing performance at an ASC with a hospital based facility and concluding that the ASC generally outperformed the hospital based facility).

⁵⁶ Munnich & Parente, *supra* note 10, at 765-67.

⁵⁷ Munnich & Parente, *supra* note 27, at 24.

an impressive 92% satisfaction rate with both the care and service they receive from ASCs.⁵⁸

In addition, pain management procedures that will be offered at the Green Mountain Surgery Center will help Vermonters stay healthy and may obviate the need for more complicated procedures in the future. For example, early intervention in cervical and lumbar radiculopathy (sciatica, etc.) using epidural steroid injections allows for aggressive conservative multi-disciplinary management and can avoid costly advanced imaging, surgery, and disability, returning patients to work sooner.

Improving Vermonters' access to pain management procedures as an alternative to neurosurgery is critical to improving patient outcomes and lowering costs. Nationwide, we spend more money on spinal fusions, for instance, than on any other operation—thirteen billion dollars in 2011. And if there are complications, the costs of the procedure go up further. The medical and disability costs can be enormous, especially if an employee is left permanently unable to return to work. As Atul Gawande pointed out in his recent article “Overkill,”⁵⁹ one study found that between 1997 and 2005 national health-care expenditures for back-pain patients increased by nearly two-thirds, yet population surveys revealed no improvement in the level of back pain reported by patients. In order to avoid costly and potentially unnecessary advanced in-patient surgical interventions, such as spinal fusions, a local health system must be able to offer easy access to rehab-medicine specialists who can offer medication, exercise advice, and steroid injection-procedures such as those that will be performed at the Green Mountain Surgery Center. In addition to back pain, treating joint and ligament generated pain with interventional pain management procedures also can lessen the need for advanced imaging and surgery for the spine and extremities.

⁵⁸ ASCA, *supra* note 7, at 3.

⁵⁹ Atul Gawande, *Overkill: An Avalanche of Unnecessary Medical Care is Harming Patients Physically and Financially*, THE NEW YORKER (May 11, 2015), <http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande>.

CON STANDARD 1.3: To the extent neighboring health care facilities provide the services proposed by a new health care project, an applicant shall demonstrate that a collaborative approach to delivering the service has been taken or is not feasible or appropriate.

UVM Medical Center presently offers outpatient surgical services in Chittenden County and other local hospitals also offer outpatient surgical services outside of Chittenden County. In establishing the state's first multi-specialty ambulatory surgical center, we intend to become an integrated part of the state's health care system and to collaborate and cooperate with hospitals and other health care providers to improve the patient experience within the health care system, to alleviate pressure on area hospital operating rooms and procedure rooms, to improve health outcomes for Vermonters, and to reduce health care costs. We believe that there is ample opportunity to work with willing hospitals to coordinate care and to provide patients with meaningful choice to ensure that patients are seen at the appropriate time in the appropriate setting and in a setting in which the patient is comfortable.

Many other communities that support tertiary-care academic medical centers in New England also support ASCs within the same community. Of particular note, Portland, Maine, a city with an estimated population of approximately 66,000,⁶⁰ and to which Burlington is often compared in terms of demographics and size, hosts the Maine Medical Center as well as four ASCs, the Intermed Surgery Center, the Orthopaedic Surgery Center, the Portland Endoscopy Center and the Western Avenue Day Surgery Center. While the tertiary care center offers specialized services for complex patients and more routine procedures for lower acuity patients who prefer hospital care, the local ASC offers a lower cost, more convenient and less imposing environment for local residents to access routine surgical care. Therefore, each entity plays a role in, and makes its own unique contribution to, the health care system.

With respect to the Green Mountain Surgery Center, when a patient presents complex health conditions that are most appropriately addressed at the state's academic medical center or one of the other local hospitals, the patient would be referred to the appropriate hospital. Similarly, local hospitals may find it beneficial to have the option of referring certain patients to specialists performing surgeries at the proposed Green Mountain Surgery Center when their operating or procedure rooms are stressed and delays in performance of the procedure could exacerbate a health condition, pose risk of a health condition worsening or lead to other adverse health outcomes or patient dissatisfaction. The Green Mountain Surgery Center would welcome such collaboration with the hospitals.

Decades ago when ASCs first started to appear, the relationship between hospitals and physician-owned ASCs was often tense or competitive. That has long since changed, and throughout the nation the relationship between ASCs and local hospitals is now one of co-existence and collaboration. For instance, the Bedford Ambulatory Surgery Center in Bedford, New Hampshire is a joint venture between the Catholic Medical Center and physicians. Weymouth Endoscopy is an ASC in Weymouth, Massachusetts that is "affiliated exclusively with South

⁶⁰ *State & County QuickFacts: Portland (city), Maine*, U.S. CENSUS BUREAU, (last rev. Apr 22, 2015), <http://quickfacts.census.gov/qfd/states/23/2360545.html>.

Shore Hospital.”⁶¹ And Concord Endoscopy Center, an ASC located in Concord, New Hampshire, is a joint venture between Concord Gastroenterology, Mary Hitchcock Concord and Concord Hospital. We hope and expect that our proposed ASC will be yet another example of hospital-ASC cooperation and collaboration.

The proposed Green Mountain Surgery Center also intends, and will use good faith efforts, to enter into transfer agreements with UVM Medical Center to coordinate the transfer of its patients in emergency situations, as further described in CON STANDARD 3.17. In addition, we expect that many, if not all, of the physicians utilizing the Green Mountain Surgery Center will continue to perform procedures at UVM Medical Center and other area hospitals, primarily depending on the needs of the patient and the physician. We would also be interested in pursuing opportunities to collaborate with UVM Medical Center or other local hospitals on physician training and education.

⁶¹*About Weymouth Endoscopy*, WEYMOUTH ENDOSCOPY (last visited June 8, 2015), <http://www.weymouthendoscopy.com/about-us/>.

CON STANDARD 1.4: If an application proposes services for which a higher volume of such service is positively correlated to better quality, the applicant shall show that it will be able to maintain appropriate volume for the service and that the addition of the service at the facility will not erode volume at any other Vermont facility in such a way that quality at that facility could be compromised.

We do not believe that our application proposes services for which there is *unique* positive correlation between volume and quality, such as open heart surgery. Rather, the Green Mountain Surgery Center would offer routine outpatient procedures that are not anticipated to require an overnight stay and that can be performed safely in an ASC.

While there is a demonstrated positive correlation between quality and surgical volume,⁶² as is true with most activities (thus, the familiar adage that practice makes perfect), we do not anticipate that the proposed Center would have a material impact on volumes at any other Vermont facility, and certainly no impact that would threaten quality at any such facility. Viewing the impact at the most general level, our survey of peer-reviewed studies on PubMed indicates a reduction of between 2% and 5% in outpatient surgeries performed at the local hospital when an independent ASC opens in the market.⁶³ Even a 5% drop in volume at the UVM Medical Center would leave the hospital with sufficient numbers of routine outpatient procedures so as not to erode quality.

Furthermore, a drop in volume of procedures performed at the hospital does not mean that the *physicians* performing procedures at the hospital will experience any drop in volume. Rather, we expect that physician volume will remain largely unchanged as a result of this project. Any shift in outpatient procedures away from the hospital will result from decisions by individual physicians and their patients to perform a particular procedure at the ASC rather than at the hospital. While the hospital would lose volume, the procedure volumes of the physician performing the surgery would remain the same. Because there will be no drop in aggregate patient volume among physicians performing surgical procedures at the hospital, there should be no resulting decline in the quality of care offered by those physicians.

In addition, UVM Medical Center in particular is very unlikely to feel any material impact from the proposed ASC. First, the Medical Center employs a large number of specialists, whose procedures, it seems safe to assume, will remain at the hospital. Thus, any loss in volume will result from the migration of cases performed by independent surgeons from the hospital to the ASC, who are greatly outnumbered by hospital-employed physicians. For instance, with respect to GI, the UVM Medical Center employs eight gastroenterologists, as compared with just three

⁶² Grisel & Arjmand, *supra* note 11, at 701.

⁶³ See, e.g., John Bian & Michael A. Morrissey, *Free-Standing Ambulatory Surgery Centers and Hospital Surgery Volume*, 44(2) INQUIRY 200 (Summer 2007) (concluding that an increase of one ASC per 100,000 was associated with a 4.3% reduction in hospital outpatient volume), <http://inq.sagepub.com/content/44/2/200.full.pdf>; Charles Courtemanche & Michael Plotzke, *Does Competition from Ambulatory Surgery Centers Affect Hospital Surgical Output?*, 29(5) J. HEALTH ECON. 765 (Jul. 15 2010) (concluding that ASC entry only appears to influence a hospital's outpatient surgical volume if the facilities are within a few miles of each other and, even then, the average reduction in hospital volume is only 2-4 percent), http://libres.uncg.edu/ir/uncg/f/C_Courtemanche_DoesCompetition_2010.pdf.

independently practicing gastroenterologists in Chittenden County. And, as discussed in Section I.H of this Application, we expect that even the independent physicians will continue to perform a sizable number of procedures at a local hospital.

It is also worth bearing in mind that the UVM Medical Center has among the largest revenues of any company in any industry in the State of Vermont, with projected gross revenues for 2015 of \$2,425,019,304, exceeding all other community hospitals in the state combined. The risk that the Green Mountain Surgery Center, with only two operating rooms and four procedure rooms, will have any material impact on the hospital's quality of care or financial stability is negligible.

With respect to the Green Mountain Surgery Center, we expect that we will be able to maintain the projected volumes. As discussed in Section I.H, the projected volumes are based on the actual historical volumes of the physicians who have indicated that they intend to perform surgeries at the Center. We are not aware of any circumstances that would cause the projected volumes for these physicians to materially differ from their historic volumes.

CON STANDARD 1.6: Applicants seeking to develop a new health care project shall explain how the applicant will collect and monitor data relating to health care quality and outcomes related to the proposed new health care project. To the extent practicable, such data collection and monitoring shall be aligned with related data collection and monitoring efforts, whether within the applicant’s organization, other organizations or the government.

The proposed Green Mountain Surgery Center will maintain an ongoing active, integrated, organized, peer-based quality improvement program. The center will utilize a systematic approach for performance improvement through multi-disciplinary cooperation, both internal and external. The quality improvement program activities demonstrate the systematic, “closing the loop” process. This process incorporates an improvement model that includes design, identification of problems/concerns in the care of patients; evaluation of the frequency, severity and source of these problems/concerns; resolution measures; re-evaluation; and reporting. Using quality indicators, the plan will address clinical, administrative, cost-of-care issues and patient outcomes. The focus will be activities that affect the majority of patients serviced and consider high-risk, high-volume, and problem-prone patients. A current draft of the Green Mountain Surgery Center’s Quality Improvement Plan is included in **Exhibit 2** to this Application.

In addition, the proposed Center will comply with the Medicare conditions of participation. In accordance with 42 C.F.R. § 416.41, the Green Mountain Surgery Center will have a governing body that assumes full legal responsibility for determining, implementing, and monitoring all policies governing the Center’s operation, and its governing body will have oversight and accountability for the quality assessment and performance improvement program and ensure that the Center’s policies and programs are administered so as to provide quality health care in a safe environment. The governing body will, among other things, oversee the Green Mountain Surgery Center’s Medical Executive Committee, who shall in turn oversee the Quality Improvement Committee. The Quality Improvement Committee will implement and directly oversee the Quality Improvement Plan. The proposed Center’s complete Continuous Quality Improvement Flowchart organizational flowchart is included in **Exhibit 2**.

As a Medicare accredited facility, the Green Mountain Surgery Center will collect and monitor health care quality and outcome data in accordance with CMS requirements and it will report to CMS annually on all quality measures specified by the Secretary of the Department of Health and Human Services. These quality measures presently include the following measures:

ASC-1: Patient Burn,

ASC-2: Patient Fall,

ASC-3: Wrong Site/Side/Patient/Procedure/Implant,

ASC-4: Hospital Admission/Transfer

ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing.

ASC-6: Safe Surgery Checklist Use

ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures

ASC-8: Influenza Vaccination Coverage among Healthcare Personnel

ASC-9: Endoscopy/Poly Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

ASC-10: Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of

*Adenomatous Polyps – Avoidance of Inappropriate Use*⁶⁴

The Green Mountain Surgery Center's reports on quality measures will also be made available to the public on the Center's website.

⁶⁴ *ASCQR Program Reference Checklist, supra* note 29, at 1-2.

CON STANDARD 1.7: Applicants seeking to develop a new health care project shall explain how such project is consistent with evidence-based practice. Such explanation may include a description of how practitioners will be made aware of evidence based practice guidelines and how such guidelines will be incorporated into ongoing decision making. (2005 State Health Plan, page 48.)

The proposed Green Mountain Surgery Center is consistent with evidence-based practice. First, as described in our answer to CON STANDARD 1.2, recent empirical research concluded that ASCs perform procedures faster than hospital outpatient departments and also report better health outcomes for their patients than hospitals.⁶⁵ ASCs also boast low rates of infection.⁶⁶ Thus, at the most general level, available evidence indicates that the incorporation of an ASC into Vermont's health care system should improve patient outcomes, in addition to reducing system costs.

In addition, the proposed ASC will incorporate evidence-based practices into both facility design and operation. The Green Mountain Surgery Center has been designed to meet or exceed the guidelines set forth in the Guidelines for the Design and Construction of Hospitals and Outpatient Facilities, 2014 Edition, published by the FGI. The FGI Guidelines represent the industry best practices for facility architecture and design, and embody conclusions drawn from evidence-based research.⁶⁷ The FGI Guidelines are based upon the recommendations and input of health care providers, designers and regulators, and, when possible, "are performance oriented for desired results."⁶⁸

The Green Mountain Surgery Center will adopt policies to promote the use of evidence-based medicine by physicians and staff utilizing the facility. The Center's policy will be implemented and monitored by the Medical Executive Committee. Specifically, the policy will provide that the Green Mountain Surgery Center will utilize nationally-available resources based on scientific methods and guidelines focused on evidence based medicine to identify evidence-based clinical care processes and incorporate those processes into its operation. A quality improvement committee, comprised of members of the Center's medical staff and operating under the supervision of the Medical Executive Committee,⁶⁹ will participate in the adoption and promotion of specific evidence-based practices throughout the Green Mountain Surgery Center. Evidence-based guidelines will be utilized where possible to implement patient care based on the conditions or clinical needs identified. Protocols to be utilized within the ASC include:

- Pre-visit planning;

⁶⁵ Munnich & Parente, *supra* note 10, at 765-66; Grisel & Arjmand, *supra* note 11, at 701.

⁶⁶ Pamela L. Owens, Marguerite L. Barrett, Susan Raetzman, Melinda Maggard-Gibbons, & Claudia A. Steiner, *Surgical Site Infections Following Ambulatory Surgery Procedures*, 311(7) J. AM. MED. ASS. 'N 709 (Feb. 19, 2014), <http://jama.jamanetwork.com/article.aspx?articleid=1829988>.

⁶⁷ See Facility Guidelines Institute's 2014 Guidelines for Design and Construction of Hospitals and Outpatient Facilities, xxvi.

⁶⁸ *Id.* at xxiii.

⁶⁹ See the discussion of the Quality Improvement Committee in CON Standard 1.6.

- Clinical (practitioner-driven) and non-clinical standing orders;
- Patient education tools;
- Patient self-coordination support tools and processes including counseling for adopting health behaviors;
- Individual Care Plan development and processes to determine challenges that may be barriers to meeting treatment goals;
- Process for monitoring medication reconciliation;
- Patient-centered tools that develop resources to meet the cultural and linguistic needs of the patients and their families;
- Community resources and referrals, including identifying specialty care related to important conditions;
- Specific plans for preventing emergency room visits and hospitalizations and post-visit follow-up, including communicating with patients with conditions who are overdue for visits/services or who have not kept planned care visits;
- Referring high-risk patients and/or non-compliant patients for further care coordination services;
- Appropriate utilization of procedures (National/society guidelines);
- Procedural quality measures;
- Safety monitoring; and
- Quality Improvement initiatives.

Medical staff will utilize the following tools within the Electronic Medical Records (EMR) or appropriate documentation system that provide support for EBM protocols:

- Clinical documentation system (EMR; hospital system; care coordination system);
- Proven knowledgebase and patient education tools (ex: Healthwise);
- Approved online sites where EBM guidelines are available (defined by practice or specialty); and
- Community resources with specialty expertise.

CON STANDARD 1.8: Applicants seeking to develop a new health care project shall demonstrate, as appropriate, that the applicant has a comprehensive evidence-based system for controlling infectious disease.

The proposed Green Mountain Surgery Center will have a comprehensive, evidence-based system for controlling infectious disease, which is set forth at length in the infection control policies included with this application in **Exhibit 2**. The system includes mandated employee and infection control practices, as well as precautions related to patients. It establishes procedures for the proper preparation, storage, handling and disposal of sterile medical instruments. The policy also establishes certain environmental requirements and provides for regular training programs for infection control.

It is also worth noting that all Medicare-certified ASCs must comply with an extensive set of infection prevention standards that are monitored at each ASC daily and evaluated by external inspectors.⁷⁰ ASCs nationally have maintained an excellent track record of providing safe patient care. According to a study published in the *Journal of American Medical Association* that included nearly 300,000 patients from eight states who underwent ambulatory surgery, the overall rate of postsurgical acute care visits within 14 days for clinically significant surgical site infections was relatively low (3.09 per 1,000 ambulatory surgical procedures).⁷¹

⁷⁰ *Quality of Care in ASCs*, AMBULATORY SURGERY CENTER ASSOCIATION (last visited June 6, 2015), <http://www.ascassociation.org/AdvancingSurgicalCare/qualityandpatientsafety/qualityofcareinasc>.

⁷¹ Owens, et al, *supra* note 66.

CON STANDARD 1.9: Applicants proposing construction projects shall show that costs and methods of the proposed construction are necessary and reasonable. Applicants shall show that the project is cost-effective and that reasonable energy conservation measures have been taken.

To ensure that costs and methods of constructing the ASC are necessary and reasonable, ACTD has engaged the service of AMB Development Group and Avanza Strategies (the “ASC Consultants”). The ASC Consultants specialize in the programming, planning and development of ambulatory surgery centers nationwide. ACTD directed the ASC Consultants to plan and design an efficient and cost-effective facility compared to other surgery centers nationwide. The proposed Green Mountain Surgery Center includes 2 Class C operating rooms and 4 special procedure rooms and totals 12,879 square feet. Each operating room will consist of approximately 427 square feet and each procedure room will consist of approximately 200 square feet, which is below the median size for ambulatory surgery centers nationwide, while complying with FGI requirements. At the same time, the budgeted cost of fitting up the surgery center is a modest \$1.6 million (the fit-up budget is set forth at length in Section I.D).

The project was designed with the following features to minimize cost while maintaining the highest levels of quality:

- Use of building materials common to the geographic area;
- Use of construction specifications that are well known to the general building trades in the geographic area;
- The building is a single story, rectangle shaped structure thereby increasing efficiency and eliminating stairs and elevators;
- Use of cost efficient flat roof for roof mounted HVAC units;
- Space temperature conditioning will be accomplished with a highly efficient roof mounted unit delivering 90% filtered air to the interior space. The unit will utilize economizer cycle to save energy. Interior heating will be accomplished with a gas-fired furnace in the roof mounted unit and interior electric or hydronic terminal heat as allowed by code;
- The HVAC, electrical, and plumbing systems, together with the building envelope design are planned to meet all required energy efficiency codes and Efficiency Vermont standards (See CON Standard 1.10 for discussion of energy conservation measures); and
- The interior design will not utilize high-end, expensive materials and products. Nevertheless, finishes will meet healthcare facility standards for durability, maintenance and safety and be aesthetically pleasing.

CON STANDARD 1.10: Applicants proposing new health care projects requiring construction shall show such projects are energy efficient. As appropriate, applicants shall show that Efficiency Vermont, or an organization with similar expertise, has been consulted on the proposal.

ACTD has engaged a local architecture firm with special expertise in sustainable design, Wiemann Lamphere Architects, to work in tandem with AMB Development Group, our ambulatory surgery center design experts, on development of the design of the Center. Wiemann Lamphere will further consult on the construction design and value engineering phases of the project should a CON be awarded. Wiemann Lamphere's principal place of business is located at 525 Hercules Drive, abutting the Green Mountain Surgery Center's proposed location.

Wiemann Lamphere has similar expertise to Efficiency Vermont, and is among the growing number of building and design firms who exclusively develop high-performance, sustainable buildings. Wiemann Lamphere Architects have 5 professionals who are LEED (Leadership in Energy & Environmental Design) certified on their team focused on implementing sustainable practices and design into each project. Their staff works collaboratively with owners, design professionals, and contractors to develop projects that perform at high levels and set new standards across the five essential Sustainable Design Categories: Sustainable Site; Water Efficiency; Energy and Atmosphere; Materials and Resource; and Indoor Environmental Quality. Wiemann Lamphere has constructed 8 LEED Certified buildings for clients in Vermont and New York across a wide range of applications from university buildings to office buildings and restaurants.

Wiemann Lamphere has recently adopted the "2030 Global Challenge" which is a global effort to develop net-zero energy buildings by the year 2030. By adopting this challenge, they have taken a responsible, incremental approach to their net-zero goals by educating clients on the use of fossil fuels and renewable energy alternatives, utilizing building energy modeling to determine specific rates of return on building investments, paying careful attention to detail in the construction of building envelopes and using materials that are responsible to the environment both in their use and ultimate disposal or re-use. Many of their recent projects have realized energy savings of approximately 60-70% above and beyond national averages.

CON STANDARD 1.11: Applicants proposing new health care projects requiring new construction shall demonstrate that new construction is the more appropriate alternative when compared to renovation.

ACTD has engaged the firm of Donahue Associates (“Donahue”), an experienced realtor located in Burlington, Vermont. Donahue has undertaken an extensive analysis of existing buildings in the area that could be renovated for an ambulatory surgical center. AMB has evaluated the sites selected by Donahue utilizing the FGI requirements for an ambulatory surgery center, as well as requirements by ACTD for patient and physician focused functionality. The costs of retrofitting an existing building for an ambulatory surgical center with FGI compliant mechanical systems, emergency power systems, fire protection separations, adequate floor to ceiling heights, among other things, were higher than fitting up a newly construction building designed with our proposed use in mind. In addition, the unique design requirements for an ambulatory surgery center could not be met within the existing buildings that were evaluated.

For example, ACTD considered leasing approximately 12,500 square feet of space in an existing building located at 40 IDX Drive in South Burlington. Architects from AMB Development Group did an in-depth inspection of the site, including having detailed conversations with the original architecture firm and property managers, and obtaining engineering and mechanical systems drawings in addition to site plans, elevations and floor plan layouts.

While the space initially seemed promising for the purposes of hosting an ambulatory surgery center, the space was originally designed as a normal commercial office building with mixed-use tenants. Maintaining access for the public and other tenants to entrances and exits, elevators, and shared restrooms while trying to maintain efficiency in the layout for a surgery center would add significantly to the cost of construction if ACTD chose to pursue the renovation option. The added cost of renovation, plus the operating inefficiencies that would be caused by having to accommodate access for the public and other tenants, ultimately led us to decide in favor of new construction.

The construction budget that was put together for renovating the space at 40 IDX Drive to accommodate an ambulatory surgery center shows some of the other specific drivers of cost and inefficiency when compared with the project being proposed in this Application, whereby ACTD will lease space in a building to be constructed at 535 Hercules Drive and whose exterior shell and building site have been specifically designed to accommodate an ASC.

Under the renovation scenario, there are changes and associated costs necessary to make the building compliant with FGI standards. For instance, membrane roofing, and additional aluminum and glass would have to be added to the existing building at some cost, whereas they would be included in the shell of the newer building. Higher ticket items that would be significantly affected are the plumbing, that would cost an extra \$2 per square foot to retro-fit in the existing building, and the HVAC system, which would cost a total of \$31 per square foot in the renovation scenario as opposed to \$20 per square foot in the newly constructed building. Altogether, the construction cost budget for an ASC build-out is \$25.27 per square foot less expensive under the new construction scenario at 535 Hercules Drive than the renovation option at 40 IDX Drive.

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It is the objective of ACTD to provide a best in class surgical center with a strong focus on patient safety and satisfaction, and operational efficiency. ACTD also desires to develop a facility that optimizes energy usage and minimizes on-going operating costs. It is the opinion of ACTD and its ASC Consultants that the Hercules Drive site will meet these goals.

CON STANDARD 1.12: New construction health care projects shall comply with the Guidelines for Design and Construction of Health Care Facilities as issued by the Facility Guidelines Institute (FGI), 2014 edition.

The proposed Green Mountain Surgery Center has been designed to comply with the Guidelines for Design and Construction of Health Care Facilities as issued by the Facility Guidelines Institute (FGI), 2014 edition. ACTD has engaged the firm of AMB Development Group, LLC to assist in the programming, design and specification of the surgery center. AMB has significant experience nationally with the FGI standards and has never failed to obtain licensure, certification and accreditation on any surgical center which it has developed. A table setting forth the applicable FGI Guidelines and a statement as to how the project will comply with each such Guideline is included as **Exhibit 4**.

CON STANDARD 2.2: Applicants seeking to introduce new ambulatory care services, including hospital ambulatory care center or physician office based services, shall show how such services are consistent with Vermont's focus on health promotion. Services to prevent the onset of disease and to minimize the effects of disease shall be given the highest priority.

The proposed Green Mountain Surgery Center is consistent with and intentionally aimed at promoting Vermont's focus on health promotion and wellness. The Center will offer a wide array of screenings and diagnostic procedures aimed at detecting health concerns in the earliest stages, when they are generally the most treatable.

The highest volume procedures at the new surgery center are expected to be screening and diagnostic colonoscopies. Improving access to more affordable colonoscopies will allow Vermonters to better comply with U.S. Preventative Services Task Force recommendations that all adults between the ages of 50-75 receive regular colorectal cancer screenings. Regular screening can identify colorectal cancer at early stages when it is easiest and least expensive to treat and when the possibility of cure is the greatest. As described earlier, aside from skin cancers, colorectal cancer is the third most common cancer and cause of death from cancer in men and women in the United States.⁷² Recent estimates suggest that more than 143,000 people are diagnosed with colorectal cancer annually, with nearly 52,000 Americans dying from this disease each year.⁷³ The cost of treating colon cancer can be very high, especially so for advanced forms of colorectal cancer.⁷⁴ Yet according to a report published by the Henry J. Kaiser Family Foundation, the high costs of treating advanced colorectal cancer and the premature deaths due to this disease are largely avoidable, through regular screenings of the type that will be offered by the ASC. The report states that regular screening can identify colorectal cancer at early stages when it is easiest and least expensive to treat and when the possibility of cure is the greatest and that regular screening can actually prevent colon cancer by detecting and removing precancerous polyps before they progress to cancer.

Several other diagnostic and preventative procedures, aimed at promoting the health of Vermonters will be offered at the proposed ASC. Please also see our answer to CON STANDARD 1.2 for additional discussion of diagnostic and preventative services to be offered at the ASC.

⁷²American Cancer Society, *supra* note 59.

⁷³ Karen Pollitz, et al., *Coverage of Colonoscopies Under the Affordable Care Act's Prevention Benefit*, KAISER FAMILY FOUNDATION (Aug. 31, 2012), <http://kff.org/report-section/coverage-of-colonosopies-under-the-affordable-care-acts-prevention-benefit-report/>.

⁷⁴ *Id.*

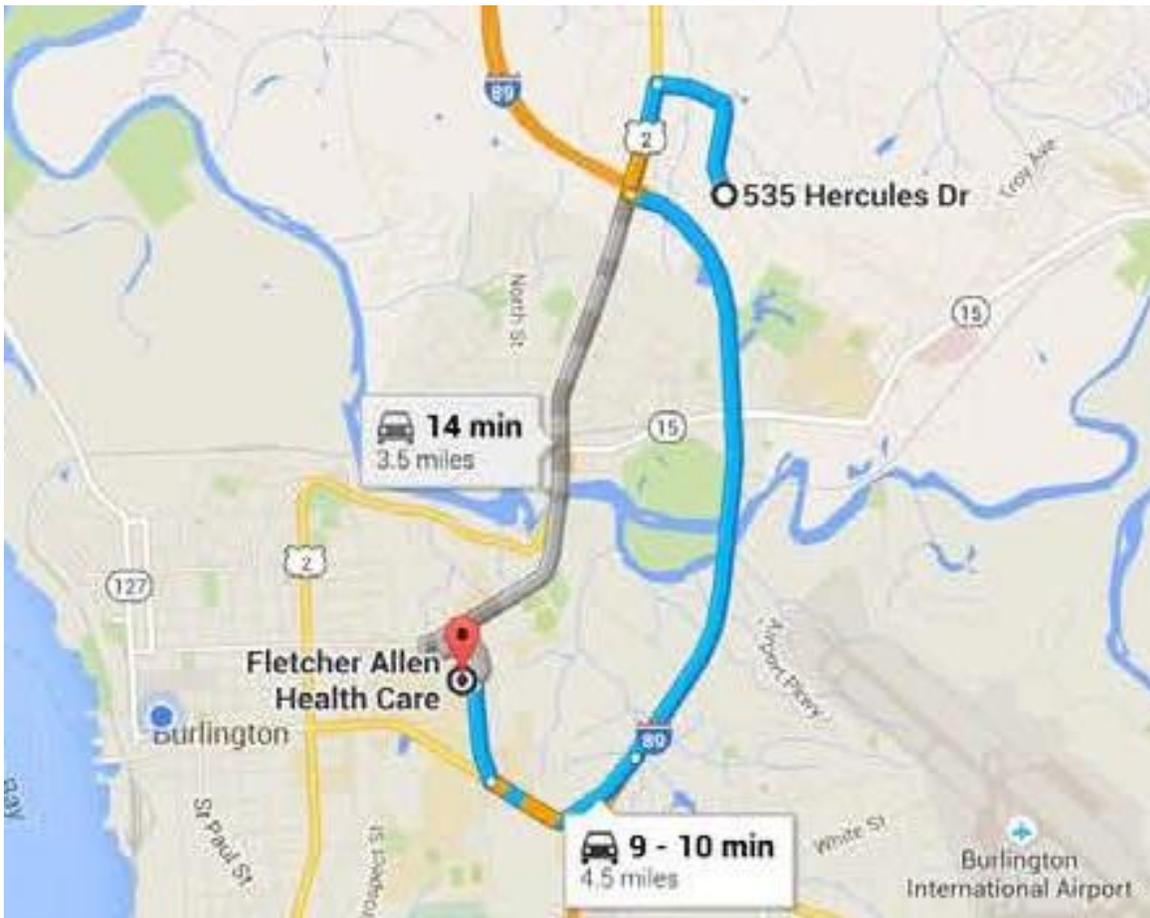
CON STANDARD 3.13: An applicant proposing to establish an ambulatory surgical center shall demonstrate that the procedures performed at the facility will be limited to those procedures that are not anticipated to require an overnight stay and that can be performed safely in an ASC.

As with the other 5000 ASCs that are licensed throughout the country, the Green Mountain Surgery Center will only host procedures that are not expected to pose a significant safety risk to a patient when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure, consistent with the standard set forth in 42 C.F.R. 416.166. The Center will obtain and maintain Medicare certification throughout its operations and will seek private accreditation from the Accreditation Association for Ambulatory Health Care and/or the Joint Commission, and will operate under the supervision of such organizations, consistent with applicable regulatory and accreditation requirements. A list of the procedures initially to be performed at the Green Mountain Surgery Center is attached as **Exhibit 3**. While the list of procedures will evolve over time, for instance in response to technological changes and advances in health care practices, it will be a prerequisite that a procedure satisfy the foregoing criteria and regulatory and accreditation requirements for it to be offered at the ASC.

CON STANDARD 3.14: An applicant proposing to establish an ambulatory surgical center shall show that the ASC is located within the appropriate travel time to one or more licensed general hospitals where there are three or more operating rooms.

UVM Medical Center is the licensed general hospital with three or more operating rooms that is closest to the proposed site for the facility. The most direct route from the site of the proposed Green Mountain Surgery Center to the Medical Center, via U.S. Route 2 is approximately 3.5 miles, and the alternate route, via Interstate 89, is approximately 4.5 miles. Either route takes approximately 10-15 minutes by car, based upon local speed limits. A map indicating various routes from the proposed ASC site to the UVM Medical Center is included as **Figure 4** below.

Figure 4



CON STANDARD 3.15: An applicant proposing to establish an ambulatory surgical center shall demonstrate that the facility will provide services for post-operative complications and inquiries by ASC patients on a 24-hour basis.

All patients undergoing care at the Green Mountain Surgery Center will be given written instructions for after-hours care. Every patient at the Green Mountain Surgery Center will have access to the surgeon who performed the procedure after-hours, based on the normal coverage procedures of that physician's office. The ASC will ensure that, for physicians performing surgery at the Center, all physicians' offices have an after-hours on-call policy that will be available to patients in advance of surgery and have twenty-four hour per day on call coverage to answer patient inquiries.

Patients will also be instructed in writing to call 911 if their condition warrants immediate attention and to go to the nearest emergency room. The Green Mountain Surgery Center's main telephone line will also include an after-hours recording that instructs the patient to call 911 or go to the nearest emergency room in the event of complications.

Patients who develop complications during the hours of operation of the proposed Green Mountain Surgery Center, and prior to departure from the Center, will be brought back to the PACU area of the facility. Nursing staff will consult with the anesthesiologist and physician regarding follow-up care. If transfer to an acute care facility is needed, the Center will arrange appropriate transfer, to include appropriate transport to the designated facility by the physician or, in his absence, the anesthesiologist. The Green Mountain Surgery Center intends, and will use good faith efforts, to enter into a transfer agreement with UVM Medical Center to admit patients to the hospital in a safe and timely manner when warranted by their medical conditions. See CON STANDARD 3.17 for discussion of the Green Mountain Surgery Center's transfer arrangements.

CON STANDARD 3.16: An applicant proposing to establish an ambulatory surgical center shall demonstrate how the applicant will provide access to all residents of each community within the identified service area without regard to an individuals' payer type, insurance status or ability to pay for necessary services.

One of the foremost motivations for the proposed project is to expand timely access to affordable healthcare for all Vermonters. Consistent with this goal, the proposed Green Mountain Surgery Center will accept all forms of insurance, including private pay, Medicare and Medicaid. In addition, the Center will offer financial assistance to needy Vermonters in accordance with a charity care policy. The charity care policy will provide for free care by the Green Mountain Surgery Center for eligible uninsured Vermonters with incomes below 200% of Federal Poverty Level. In addition, eligible uninsured Vermonters with incomes between 200% and 400% of the Federal Poverty Level may apply for discounted care from the Green Mountain Surgery Center. The proposed Center is committed to providing free and discounted care to needy patients at a level that is on par with Vermont non-profit hospitals. The ASC's draft charity care policy is included with this Application in **Exhibit 2**.

CON STANDARD 3.17: An applicant proposing to establish an ambulatory surgical center shall demonstrate the applicant will: secure and maintain Medicare certification, where appropriate; develop and maintain a transfer agreement with at least one nearby hospital, as well as a transport agreement with an emergency medical service for the ASC's emergency transport requirements; ensure that all staff are well qualified and that the clinical personnel are eligible for – or have privileges for – similar surgical procedures at a local hospital; institute a quality review system; cooperate with all public and private review organizations; and demonstrate that the ASC will institute best practices protocol.

The proposed Green Mountain Surgery Center will use its best efforts to secure and maintain Medicare certification; develop and maintain a transfer agreement with at least one nearby hospital, as well as a transport agreement with an emergency medical service for its emergency transport requirements; ensure that all staff are well qualified and that the clinical personnel are eligible for – or have privileges for – similar surgical procedures at a local hospital; institute a quality review system; cooperate with all public and private review organizations; and institute best practices protocol. We address each of these in turn below.

1. Medicare Certification. The proposed Green Mountain Surgery Center will use Avanza Strategies, which has successfully guided over one hundred other ASCs throughout the country to secure and maintain certification as a participating Medicare provider under the jurisdiction of CMS. Continuous compliance with certification requirements will be maintained. In the event that at any time the facility loses Medicare or Medicaid certification, all prospective patients will be notified of this status prior to registration; nonetheless, the viability of the Green Mountain Surgery Center's business proposal relies on receiving Medicare certification and the project will not proceed without it.
2. Transfer Agreements. The Green Mountain Surgery Center will diligently seek, and use good faith efforts, to enter into a transfer agreement with UVM Medical Center to admit patients to the hospital in a safe and timely manner when warranted by their medical conditions. Under such agreement, the decision to admit a patient to the hospital will be made by the attending physician or designee (i.e. anesthesiologist and/or certified registered nurse anesthetist). The Green Mountain Surgery Center's personnel will notify the Center's Medical Director and the Administrator of the pending admission and provide them with the following information:
 - a. Patient's name
 - b. Attending physician
 - c. Surgical procedure performed
 - d. Reason for admission
 - e. Patient's expected length of stay at the hospital

The Center's Medical Director will establish the appropriateness of the admission with the attending physician. If an admission is necessitated, the Medical Director or a Green Mountain Surgery Center's registered nurse will contact the hospital with the patient information and arrange for a bed. The attending physician or designee will determine the mode of transportation for admission to the hospital. The registered nurse will explain the transfer procedure to the patient and the responsible party. The registered

nurse will complete the patient's medical record and make copies to send with the patient to the hospital. The registered nurse will call and report to the admitting floor and document the admission.

If the patient's transfer is an emergency, 911 will be called and the appropriate transportation arranged. The registered nurse will notify the emergency room of the patient's eminent arrival and give a report. The registered nurse will notify the responsible party of the patient's pending emergency transfer to the hospital. A copy of the transfer form, patient's insurance information and documentation of any communication with the receiving hospital should be transported with the patient. The Green Mountain Surgery Center's Medical Director or clinical designee will review the patient's record for any unusual complications or occurrences.

The Center's Medical Director will review the medical records of all unscheduled admissions, if any, and present a summary to the Medical Executive Committee and the Governing Board on a quarterly basis.

3. Staff Qualifications. Physicians wishing to perform procedures at the Green Mountain Surgery Center must be admitted and privileged by the Center pursuant to its medical staff bylaws. One of the criteria for admission to the medical staff of the Green Mountain Surgery Center will be that the clinician maintain unrestricted admitting privileges at a local accredited hospital. The medical staff bylaws will also, among other customary provisions, require the Green Mountain Surgery Center's clinicians to maintain a valid license to practice medicine or osteopathy in the State of Vermont, strictly abide by the principles of medical ethics, and hold a M.D. or D.O. degree from a recognized medical or osteopathic school.
4. Quality Review System. The Green Mountain Surgery Center will maintain an extensive quality review system, as described in CON STANDARD 1.6 and in the Center's Quality Improvement Plan, a draft of which is included in **Exhibit 2** to this Application.
5. Cooperation with Public and Private Review Organizations. The proposed Green Mountain Surgery Center will cooperate with all public and private review organizations. The Center will adopt a policy of cooperation, a draft of which is included with this Application in **Exhibit 2**. In the event that a review organization identifies any deficiencies, the Green Mountain Surgery Center shall implement any needed corrections as soon as possible and shall maintain records of noted deficiencies and steps taken to correct them.
6. Best Practices Protocol. The proposed Green Mountain Surgery Center has incorporated a best practices protocol into its Facility Plan for Patient Care. The philosophy underlying this plan is that the Center can best maintain a community-based, family-oriented, consistently high level of service through a customer focus where we continually strive to understand and exceed the expectations of our customers. This focus is enabled through instituting best practices protocols, effective communication systems, staff education, team building, process improvement, work design and an empowered

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work force. The Green Mountain Surgery Center's Facility Plan for Patient Care is submitted along with this Application in **Exhibit 2**.

SECTION III: CONSISTENCY WITH 18 V.S.A. § 9437

18 V.S.A. § 9437. Criteria. A certificate of need shall be granted if the applicant demonstrates and the board finds that:

(1) the application is consistent with the health resource allocation plan;

See Section II of this Application.

(2) the cost of the project is reasonable, because:

(A) the applicant's financial condition will sustain any financial burden likely to result from completion of the project;

Our project budget indicates that the development and construction of the proposed project will cost approximately \$1,609,875. Please see Section I.D. of this Application for a detailed discussion of the project budget. The cost for the interior fit-up of the surgery center will be rolled into ACTD's lease payments and amortized over ten years. The capitalized lease payments (inclusive of the development and construction costs) over the full ten year initial term of the lease amount to \$5,610,445. As the financial projections indicate, during the first year of operations, when the volume at the Center is ramping up, the Center will need to use some working capital to cover lease payments and operating expenses. Thereafter, the Center projects sufficient revenues to satisfy lease payments and its other operating costs.

In addition to construction costs, we estimate that we will need an additional \$1,812,838 in project costs for initial inventory, furniture/fixtures, working capital and other start-up costs. We anticipate funding these costs through conventional bank financing, as well as private investment capital from Vermont physicians.⁷⁵ ACTD has had extensive discussions with a community bank and expects to obtain a commitment letter shortly for debt financing in the amount of up to \$1,800,000, subject to customary conditions and contingencies, including receipt of a certificate of need. The loan would have a twenty year term and a fixed interest rate consistent with current market conditions.⁷⁶ Also, to date, Vermont physicians have made \$216,000 in aggregate capital contributions to the limited liability company that will operate the ASC. ACTD will seek additional capital contributions from existing and new investors, contingent on receipt of the certificate of need for the ASC, to reduce the amount of debt financing required for the project. We expect to raise an aggregate amount of \$1,132,838 through equity, which would reduce our

⁷⁵ While Avanza used typical industry assumptions in determining the financing requirements for the project, factors such as the unknown length of the certificate of need approval process and unforeseen changes in financial markets and the health care industry make it impossible to predict financial requirements with certainty. Accordingly, final determinations regarding sources, amounts and terms of financing will not be made until the project has been approved by the Green Mountain Care Board. Nevertheless, we believe that our projections submitted with this application are reasonably accurate and that any deviations from our expectations will not have any material impact on the viability of the project.

⁷⁶ Our financial projections assume a fixed interest rate of 7.0%, which is in line with the parameters of our discussions with the community bank.

loan amount to \$680,000. We have had preliminary discussions with such investors, and based on those discussions we are confident that there will be strong interest in investing in our project once we have obtained a certificate of need.

(B) the project will not result in an undue increase in the costs of medical care. In making a finding under this subdivision, the board shall consider and weigh relevant factors, including:

The proposed project will decrease the costs of medical care borne by Vermonters and payers. The proposed Green Mountain Surgery Center will be price-competitive with similar facilities in other northeastern States. As described in Section I.G – Charge Structure and Patient Savings, one of the primary advantages of ASCs is that they can provide outpatient surgical services at a lower cost than hospitals, which, in Vermont, are presently the only alternative for multi-specialty surgery sites of care. ASCs characteristically have lower building, staffing and overhead costs than hospitals. These and other operational efficiencies enable ASCs to offer lower charge structures, and enter into lower-cost contracts with insurers than hospitals, resulting in reduced costs to patients and payers. Recent data indicates that Medicare reimburses ASCs at 56% of what hospitals would receive for the same procedure by the same physician.⁷⁷ And because most private insurers set their outpatient surgery rates based on a percentage of the current Medicare rates, we expect substantial savings to be passed on the private insurers and their patients for services offered by the proposed ASC.

(i) the financial implications of the project on hospitals and other clinical settings, including the impact on their services, expenditures, and charges;

We anticipate that the UVM Medical Center, being the hospital located closest to the proposed site for the ASC and the hospital where most of the specialists planning to utilize the Green Mountain Surgery Center currently perform outpatient procedures, will be most directly affected by the proposed ASC. It is our understanding that the hospital presently has 27 operating rooms. It is Vermont's largest and most profitable hospital, with projected total operating revenue for FY 2015 in excess of \$1.1 billion and excess of revenue over expense projected for FY 2015 at more than \$55 million.⁷⁸ The medical center accounts for more than half of all hospital gross patient revenues in the State.⁷⁹ For FY 2015, the hospital projects a projected operating margin of 3.8 percent, well above the average projected FY 2015 operating margin for Vermont hospitals of 2.44 percent.⁸⁰

When compared against other non-profit hospitals nationwide, it becomes even more apparent that the UVM Medical Center's size and financial strength are formidable by any standard. For instance, according to Moody's Investors Service, non-profit hospitals have median total

⁷⁷ Szabad et al., *supra* note 32, at 3.

⁷⁸ GMCB, *supra* note 51.

⁷⁹ See GMCB, *supra* note 51; Fiscal Year 2015 budget analyses for Vermont community hospitals.

⁸⁰ *Id.*

operating revenues of \$499.9 million in FY 2011.⁸¹ By comparison, the UVM Medical Center reported total revenues of \$903 million on its Form 990 filing for that year. Moody's similarly reports a median operating margin of 2.5 percent in FY 2012 for non-profit hospitals.⁸² The medical center, by contrast, reported a healthy actual FY 2012 operating margin of 3.4%.⁸³

The size and scope of the Green Mountain Surgery Center's proposed surgery center pales in comparison. The Center proposes just 2 operating rooms—compared to a national average of 2.6 operating rooms for urban ASCs and 2.2 operating rooms for rural ASCs—and 4 procedure rooms. The Center projects gross patient revenues in its second year of operation (by which time we expect volume at the center to be fully ramped up) at \$6,854,059. This is 0.67% of the medical center's projected outpatient gross patient revenues for 2015, and 0.28% of the medical center's projected total gross patient revenues for that year. And in keeping with the characteristics of most urban and rural ASCs, the Green Mountain Surgery Center will not have co-located pharmacy, laboratory, or radiology services. These ancillary services, when needed, will be referred to the local hospitals, further underscoring our intention to work collaboratively with local hospitals to meet the needs of our shared patient population.

Even with the addition of one average-sized ambulatory surgery center to the Burlington metropolitan area, we anticipate the vast majority of outpatient procedures will continue to be performed at the Medical Center both because of their large number of operating rooms and because of the relatively large number of physicians that are hospital-employed. According to the latest hospital budgets from 2014, the UVM Medical Center employs 520 physician FTEs. The physician directory on the UVM Medical Center website shows 82 employed specialists in gastroenterology, orthopedics, obstetrics/gynecology, general surgery and pain medicine among a list of over 120 specialties represented.⁸⁴ The 16 independent specialists who have expressed interest in performing some of their procedures at the Green Mountain Surgery Center represent a small fraction of the specialists employed by the UVM Medical Center.

It is also illustrative that the UVM Medical Center was not adversely affected in any material way by the opening of Vermont's only existing free-standing ambulatory surgery center, The Eye Surgery Center, in 2008. Since that time, the hospital's total revenues have grown from \$723,627,409 in fiscal year ending September 2007 to \$1,094,165,445 in fiscal year ending September 2013, representing a fifty-one percent increase over just six years and a stable annual growth rate of 7.1 percent.

Furthermore, peer-reviewed journals have analyzed the effect of ASCs on local hospitals and

⁸¹ Bob Herman, *Moody's: 132 Statistics on Nonprofit Hospital Medians*, BECKER'S HOSPITAL CFO (Aug. 26, 2013), <http://www.beckershospitalreview.com/finance/moody-s-132-statistics-on-nonprofit-hospital-medians-fiscal-year-2012.html>.

⁸² *Id.*

⁸³ GMCB, *supra* note 51.

⁸⁴ Based on our review of the UVM Medical Center Website, the hospital appears to employ 28 ob/gyns, 21 orthopedic surgeons, 22 general surgeons, 8 gastroenterologists and 3 pain medicine specialists. <https://www.uvmhealth.org/medcenter/Pages/PNRS/LandingPage.aspx>.

have found very little negative impact. For instance, John Bian and Michael Morrisey have concluded that an increase of one ASC per 100,000 people was associated with a 4.3% reduction in hospital outpatient surgical volume and was not associated with inpatient surgical volume.⁸⁵ Charles Courtemanche and Michael Plotzke similarly determined that “ASC entry only appears to influence a hospital’s outpatient surgical volume if the facilities are within a few miles of each other” and that “[e]ven then, the average reduction in hospital volume is only 2-4%.”⁸⁶ In sum, the above suggests that any impact to the UVM Medical Center will be slight, and that even were the ASC to outperform our expectations, the vast size of UVM Medical Center’s budget and exhaustive scope of the hospital’s resources will enable the hospital to absorb any impact of the proposed project without having to adjust its charges or services.

As an additional note, while the impact of a new health project on hospitals is a factor that must be taken into account in determining whether to issue a Certificate of Need under Vermont’s current statutory framework, it is important to bear in mind that not all justifications for protecting hospitals against financial harm are equally persuasive. One argument that critics of ASCs often make is that ASCs compete against hospital outpatient surgery programs, which are often among the most profitable hospital programs and are needed to cross-subsidize less profitable hospital programs. Relying on a cross-subsidization argument is a barrier to meaningful healthcare reform, as it precludes pursuit of innovation that is needed for long-term success in meeting our community’s health care needs. The Upper Midwest Rural Health Research Center reached this very conclusion in a 2010 report funded by the Federal Office of Rural Health Policy, concluding that “the cross-subsidization of lower margin services by high margin services is clearly not a sustainable option for rural hospitals. Efforts to restrict the ability of ASC’s to enter and compete in rural markets may preserve the financial viability of community hospitals but will not encourage the innovation or cost efficiencies needed to continue meeting local health care needs.”⁸⁷

The above discussion focuses on the likely impact of the project on the UVM Medical Center, because we do not expect that the proposed ASC will have a material impact on the volumes at any other hospitals or clinical settings in Vermont. Other than The Eye Surgery Center, which supports this Application, hospitals are the exclusive provider of outpatient surgery in Vermont. And, as noted above, peer-reviewed research has concluded that “ASC entry only appears to influence a hospital’s outpatient surgical volume if the facilities are within a few miles of each other.”⁸⁸ The UVM Medical Center is the only hospital that will be located within a few miles of the proposed ASC.

(ii) whether the impact on services, expenditures, and charges is outweighed by the benefit of the project to the public; and

⁸⁵ Bian & Morrisey, *supra* note 63, at 200.

⁸⁶ Courtemanche & Plotzke, *supra* note 63, at 765 (also noting that they found no evidence that entering ASCs reduce a hospital’s inpatient surgical volume).

⁸⁷ Rural Health Research Center, October 2010: The Impact of Freestanding Ambulatory Surgery Centers on Rural Community Hospital Performance, 1997-2006.

⁸⁸ Courtemanche & Plotzke, *supra* note 63, at 765.

As has been described at length elsewhere in this Application, the benefits of the proposed Project to the public are substantial, and the likely impact to UVM Medical Center is small. To summarize, the public benefits of the proposed ASC include:

- **Reducing the Cost of Health Care:** As described more fully in Section I.G – Charge Structure and Patient Savings and in our answer to Statutory Criterion 2(B), ASCs are reimbursed at a lower rate than hospitals by Medicare and other insurers. In addition, because of the operational efficiencies that are unique to ASCs, ASCs have a lower charge structure than do hospitals. ASCs have accordingly filled an important role in national health reform efforts by right-sizing outpatient care and reducing the cost of outpatient procedures to a level that is consistent with the relative complexity of such procedures.
- **High Quality Care and Patient Satisfaction:** As described more fully in our answer to CON STANDARD 1.2 in Section II of this Application, the performance of outpatient surgery services by ASCs has been linked to improved health outcomes for patients and high levels of patient satisfaction. The proposed ASC will be designed and constructed using modern facility standards that incorporate evidence-based medicine. The ASC will also adopt a Quality Improvement Plan and a Facility Plan for Patient Care incorporating a best practices protocol, drafts of which are included in **Exhibit 2**, and will have in place a governance structure to monitor whether high standards of care are maintained on a consistent basis.
- **Low Infection Rates:** As discussed more fully in our answer to CON STANDARD 1.8 of this Application, ASCs nationally have very good infection rates. We expect the proposed facility to meet or exceed the high standard that has been established by ASCs nationally. Our proposed facility has been designed to meet or exceed FGI Guidelines to minimize risk of infection, the ASC will adhere to rigorous CMS-established infection control guidelines, and will adopt industry standard infection prevention policies, drafts of which are included in **Exhibit 2**.
- **Quick, Efficient Care:** Recent data indicates that ASCs perform outpatient procedures faster than hospital outpatient departments, as they have inherent advantages in their design that enable operating rooms and procedure rooms to be used in an efficient manner. ASCs also are associated with reduced wait times for procedures, which have positive effects on patient satisfaction. Furthermore, the proposed facility has been designed with efficiency in mind, and will facilitate throughput.
- **Small-Scale, Patient-Friendly Environment:** The proposed ASC will also offer a smaller-scale, more intimate alternative to the hospitals. While some patients undoubtedly prefer to have procedures done at the hospital with its prestige and vast resources, many patients find a hospital environment intimidating or overwhelming, and feel more comfortable in a smaller-scaled health care environment. Combining a convenient location off the interstate, ease of parking, and a more modest and personal environment, the proposed ASC will offer a patient-friendly alternative to hospital care.

- **Expanded Access to Care:** The addition of the proposed ASC to Vermont's healthcare system will expand access to important healthcare services. As described in our response to CON STANDARD 1.2 in Section II of this Application, the ASC will offer important screening, preventive, and diagnostic procedures to patients throughout its service area. Patients nationally have found that they are able to schedule procedures more quickly at ASCs than at their local hospital,⁸⁹ and the proposed ASC at the very least will help reduce pressure on the State's hospital system operating room resources. When patients have their medical needs treated more quickly, there is a lower risk of the underlying health issue worsening or becoming more difficult to treat or manage. And as noted above, the smaller scale ASC may encourage patients who otherwise might be intimidated in the larger hospital environment to seek care when needed.

In comparison to these substantial benefits, as described in subsection (i) above, the impact to the UVM Medical Center is very minor, less than 1% of its budgeted gross outpatient revenues for 2015. And any potential impact to other area hospitals who lie outside of the Center's primary service area is expected to be small.

The cost-benefit calculus of incorporating multispecialty ASCs into the health care system is perhaps best reflected by the pervasiveness of ASCs elsewhere in the United States. According to 2014 CMS data, neighboring New Hampshire has 29 licensed ASCs and Maine has 17.⁹⁰ Massachusetts has 59 and New York has 116.⁹¹ Maryland, a state that Vermont often looks to for health care reform inspiration, has 325.⁹² States which, like Vermont, have populations of under 1,000,000 average approximately 16 ASCs.⁹³ Among the fifty states, the states tied for the second fewest licensed ASCs are Rhode Island and West Virginia, with nine each.⁹⁴ Vermont is truly an outlier, with only one ASC.

(C) less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate;

Please see our response to CON STANDARD 1.11, where we addressed this issue in detail. Briefly, ACTD worked with a real estate consultant, an architect who has experience in ASC construction and remodeling, and its ASC consultant to select the proposed site. ACTD has concluded that it is less expensive and will result in a superior ASC to fit up and lease a unit in a new building rather than retrofit an existing, imperfect office space. ACTD and its consultants looked at several Chittenden County properties and went so far as to order a construction budget prepared for one such existing property. But the costs associated with remodeling existing space

⁸⁹ ASCA, *supra* note 7, at 1.

⁹⁰ Gordon, *supra* note 8.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *See id.* Wyoming has 18, North Dakota 12, Alaska 15, South Dakota 19 and Delaware 17. *Id.*

⁹⁴ *Id.*

exceeded by over \$25/square foot the costs of an ASC build-out.

Additionally, it was tricky to retrofit any of the existing spaces into a surgery center due to the public access already in place. It would be necessary to design labyrinthine routes to preserve the restricted access and infection control infrastructure necessary in an FGI compliant surgery center, while still retaining the existing public access points for the rest of the tenants, if we were to renovate existing office space. As we analyzed alternatives, it became clear that the proposed ASC would have not have been satisfactory or appropriate to us, or our staff and patients, if we were design an expensive and navigationally complicated ASC.

In addition, the only alternative to ASCs in Vermont are hospital outpatient departments. As discussed elsewhere in this Application, hospital outpatient departments are a *more* expensive alternative than ASCs, in terms of costs to the health system.

(3) there is an identifiable, existing, or reasonably anticipated need for the proposed project which is appropriate for the applicant to provide;

Vermonters need lower health care costs. The lack of development of lower-cost alternative settings of care in Vermont may contribute to our relatively high overall health care costs compared to other states, despite the state's focus and laudable progress in addressing the high costs of health care and checking its growth. Vermont is consistently ranked as one of the top one or two healthiest states in the country.⁹⁵ According to American's Health Rankings, Vermonters have ranked in the top 1 or 2 healthiest states in the nation for the past seven years with comparatively low rates of obesity, inactivity, and diabetes.⁹⁶ Yet, paradoxically, its per capital health care costs are higher than the national average, and have been growing at a faster rate than the national average.⁹⁷ And Vermont has among the highest commercial health insurance premiums in the nation.⁹⁸ For instance, the premium cost of a benchmark silver-plan for a 40 year-old individual making \$30,000 a year is \$436 in Vermont, compared to \$282 in Maine, \$247 in New Hampshire, \$257 in Massachusetts, and \$260 in Rhode Island.⁹⁹ This year, the Shumlin administration proposed important health reforms aimed at controlling health care

⁹⁵ *State Data: Vermont*, AMERICA'S HEALTH RANKING (last visited June 6, 2015), <http://www.americashealthrankings.org/VT>; *Vermont Once Again Tops Healthiest State Rankings*, AMERICAN ACADEMY OF PEDIATRICS (last visited June 6, 2015), <http://www.aapvt.org/news/vermont-once-again-tops-healthiest-state-rankings>; *Vermont Once Again Tops Healthiest State Rankings*, AMERICAN ACADEMY OF PEDIATRICS (last visited June 6, 2015), <http://www.aapvt.org/news/vermont-once-again-tops-healthiest-state-rankings>.

⁹⁶ *State Data: Vermont*, *supra* note 93; *How Healthy Are We? Vermont Ranked #2 Healthiest State after the New #1, Hawaii*, VERMONT DEPARTMENT OF HEALTH (Dec. 11, 2013), http://healthvermont.gov/news/2013/121113_ahr.aspx.

⁹⁷ GMCB, *supra* note 2, at 7.

⁹⁸ *Monthly Silver Premiums for a 40 Year Old Non-Smoker Making \$30,000/Year* (2014-15), KAISER FAMILY FOUNDATION (last visited June 6, 2015), <http://kff.org/other/state-indicator/monthly-silver-premiums-for-a-40-year-old-non-smoker-making-30000year/>.

⁹⁹ *Id.*

costs, but those reforms were met with considerable political resistance due in large part due to the price tag. In short, Vermont faces a crisis of already high health care costs that are growing at a fast rate, and has had difficulty finding a political solution.

The ASC proposed in this Application is offered as an alternative so that in the future the State does not have to rely exclusively on expanding the current higher-cost, hospital-based healthcare infrastructure. Once open, the ASC will immediately reduce the financial burden borne directly by Vermonters and the State's health care system as a whole.

While the proposed ASC is not the silver bullet for all of Vermont's health care challenges, it is a simple and cost-effective solution for reducing a portion of health care costs in the state and should be an important component to the State's reform efforts. ASCs perform services relating to outpatient surgeries at a fraction of the cost of hospitals.¹⁰⁰ Recent data indicates that ASCs are reimbursed by Medicare at a rate of 56% of that of hospitals.¹⁰¹

The need for our proposed project is also supported by the prevalence of ASCs throughout the country. As has been mentioned elsewhere, Vermont is an outlier with respect to the number of ASCs within its borders, with only one. The states with the next smallest total are Rhode Island and West Virginia, each of which has nine licensed ASCs.¹⁰² New Hampshire, the state to which Vermont is often compared due to its similar size, location and demographics, has 29 licensed ASCs.¹⁰³ Viewing the nation as a whole, and excluding the low and high outliers (Vermont and California, respectively), the average number of ASCs per state is approximately 109.¹⁰⁴ For states having a population of less than 1,000,000 (excluding Vermont), the average is approximately 16.¹⁰⁵ Among states with a certificate of need process to ensure the appropriate allocation of health care resources, the average number of ASCs is approximately 95 and the median number is 60.5.¹⁰⁶ The bottom line is that ASCs play an important role in the health care systems of *every other state*, providing a low-cost, high quality alternative for outpatient surgery. We cannot identify any rational explanation to justify Vermont's extreme outlier status.

The proposed project is also needed due to the demographic shifts occurring in Chittenden County. Based on 2000 U.S. Census data, Vermont's population is projected to increase by 83,040 from 628,827 in 2000 to 711,867 in 2030, or 13.2%.¹⁰⁷ And, Economic & Policy

¹⁰⁰ Munnich & Parente, *supra* note 10, at 765.

¹⁰¹ Szabad et al., *supra* note 32, at 3.

¹⁰² Gordon, *supra* note 8.

¹⁰³ *Id.*

¹⁰⁴ *See id.*

¹⁰⁵ *See id.*

¹⁰⁶ *See id.*

¹⁰⁷ U.S. CENSUS BUREAU, POPULATION DIVISION, INTERIM PROJECTIONS OF THE TOTAL POPULATION FOR THE UNITED STATES AND STATES: APRIL 1, 2000 TO JULY 1, 2030 (2005).

Resources, Inc. projects that the population of Chittenden County will increase by 102,503, from 148,295 to 250,798, or 69%.¹⁰⁸ Thus, while the rest of Vermont's population is expected to shrink in the aggregate, Chittenden County projects strong growth, which will place further strain on existing health care resources in the area.

At the same time, the population of Vermont is graying. In 2000, Vermont was ranked as the 26th oldest state, based on percentage of population age 65 and older.¹⁰⁹ By 2010, it had become the 11th oldest state. And it projects to be the 8th oldest state by 2030.¹¹⁰ Between 2000 and 2030, the percentage of Vermont age 65 and older is expected to increase from 12.7 percent of the population to 24.4 percent of the population.¹¹¹ The percentage of Vermonters age 45 and older is expected to grow from 37.5 percent to 48.5 percent.¹¹² Because an aging population is more likely to utilize outpatient surgical services, this demographic shift will require additional outpatient surgical capacity in the State.

UVM Medical Center has recently indicated that its Ambulatory Care Center is stretched for capacity, stating that "Clinical capacity in the Ambulatory Care Center has been reached (and in many areas exceeded)."¹¹³ Anecdotal evidence that we have collected supports this conclusion. For instance, primary care physicians practicing in Chittenden County and the surrounding areas have reported significant difficulties getting their patients in for timely appointments with area specialists at the UVM Medical Center. Our discussions with an independent gastroenterology practice indicate that current wait times for patients wishing to schedule a screening colonoscopy with an independent gastroenterologist operating at the hospital range from 2.5 months to 3.5 months. This independent practice would like to add another gastroenterologist to reduce wait times and better meet the needs of its patients, however the hospital has indicated that the time allocated to the practice to perform procedures at UVM Medical Center has been maxed out. In addition, another physician has indicated that UVM Medical Center limits his practice of interventional pain procedures at the hospital, notwithstanding his patient's desire for such treatments and evidence that the treatments can prevent or delay costly surgeries, particularly in elderly patients. As the demographic shifts described above grow, this pressure on the health care system will only worsen. The proposed ASC will help alleviate some of the present and projected future undersupply of outpatient surgical services by offering an affordable, high-quality alternative to Vermont's hospital-based system.

The present difficulties in scheduling timely appointments with specialists at the hospital have

¹⁰⁸ Economic & Policy Resources, Inc., *supra* note 36, at 33.

¹⁰⁹ U.S. Census Bureau, *supra* note 37.

¹¹⁰ *Id.*

¹¹¹ U.S. CENSUS BUREAU, POPULATION DIVISION, INTERIM STATE POPULATION PROJECTIONS, VERMONT POPULATION PROJECTIONS: APRIL 1, 2000 TO JULY 1, 2030 (BY AGE GROUP) (2005).

¹¹² *See id.*

¹¹³ CON Application by Fletcher Allen Healthcare, Inc. to Acquire Real Estate in South Burlington, Dated June 2, 2014.

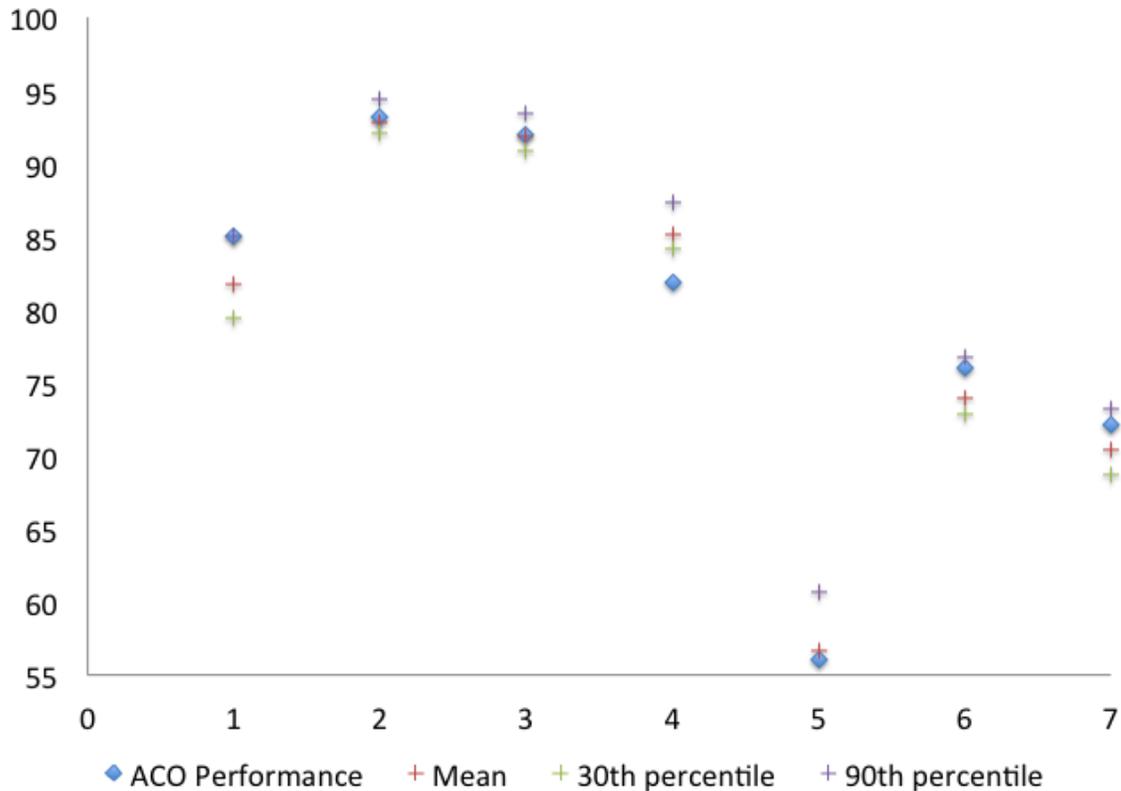
resulted in additional negative consequences to the health care system. In many cases, primary care physicians seeking to refer their patients to specialists at UVM Medical Center have been told by hospital-employed specialists that in order to get a timely appointment, they should send their patients to the hospital emergency room for a work-up, and the patient will be able to get on the specialists' schedule if an urgent referral is made from the hospital's emergency room. This care pathway is expensive, inefficient, and in many instances duplicative, as the primary care physician has often already done the work-up. From the patient's perspective, this is inconvenient and a very poor health care experience.

Quality data from the first year of the Accountable Care Coalition of the Green Mountains Medicare ACO supports the conclusion that efficient outpatient surgical capacity is needed in Chittenden County in order to improve patient access to specialists. As shown on **Figure 5**, patients attributed to the Accountable Care Coalition of the Green Mountains, whose primary care physicians are located primarily in Chittenden County, and who were surveyed as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, rated their experience receiving care at, or above, the national average on six out of the seven Patient/Caregiver Experience quality measures. The *only* measure where patients reported an experience well below the national average, and in fact well below the national 30th percentile, was on ACO- measure 4: Access to Specialists.¹¹⁴ By expanding consumer access to specialists, the Green Mountain Surgery Center would reduce these inefficiencies in the health care system, while improving the overall patient experience.

¹¹⁴ X-axis on **Figure 5** consists of: (ACO-1) Getting Timely Care, Appointments, and Information, (ACO-2) How Well Your Doctors Communicate, (ACO-3) Patient's Rating of Doctor, (ACO-4) Access to Specialists, (ACO-5) Health Promotion and Education, (ACO-6) Shared Decision Making and (ACO-7) Health Status/Functional Status.

Figure 5

**ACO Score on the following Patient Experience
Summary Survey Measures form the CAHPS Survey**



Accountable Care Organization (ACO) 2012 Quality Performance Report
Prepared for: Accountable Care Coalition of the Green Mountains, LLC
ACO ID: A1272
Source: CMS

The present hospital-based surgery system is also inefficient in that it necessary results in physician idle time while the physician waits to use a hospital operating room. For instance, in a hospital setting, an eye surgeon may be able to perform eight cataract surgeries in a day. The surgery itself takes less than thirty minutes, but there are often delays in the hospital that cause the surgeon to have to spend the whole day in the hospital. These delays regularly result, for instance, when trauma cases arise and take precedence over the eye surgery. Surgeons also spent time waiting for equipment change-overs after a totally unrelated procedure, and must cope with delays that occur when nurses who are inexperienced with the particular surgery being performed are staffing the ORs. By contrast, in the ASC setting, all surgeries are pre-scheduled, the facility and equipment are designed to minimize room change-over time, and the nurses are trained on a specific set of procedures performed in the ASC. In the ASC setting, the same ophthalmologist can perform 16 surgeries in a day, which frees up at least one more day during the week for him/her to spend in the office evaluating patients. This in turn reduces wait times for patients to see specialists and improves the patient experience of care.

(4) the project will improve the quality of health care in the state or provide greater access to health care for Vermont's residents, or both;

The proposed project will both improve the quality of health care and provide greater access to outpatient services for Vermonters. ASCs have a strong track record of providing high quality care, so much so that studies have shown that ASCs on average have very high levels of patient satisfaction with respect to both the care and the service they receive from ASCs.¹¹⁵ Empirical evidence indicates that on balance, ASCs have relatively low infection rates.¹¹⁶ These low rates may be attributable to smaller scale, facility design, low risk patients, better patient flow and strong infection control policies. Some studies have concluded that ASCs outperform hospital outpatient departments with respect to quality of care and efficiency.¹¹⁷

In addition to adding high-quality outpatient surgical capacity to Vermont's health care system, the proposed ASC will increase access. First, by offering a lower-cost health care alternative to hospital outpatient departments, outpatient surgery services will become more affordable to low and middle income Vermonters. Our best estimate is that for privately insured patients, the cost of a procedure at a free-standing ambulatory surgery center is typically 45-60% less than in a hospital setting, but sometimes as high as 80-90% less. The cost of services will also be predictable and available to patients in advance of the procedure, removing the element of price uncertainty that may keep patients from utilizing health care services. Second, by adding outpatient capacity to the system, the proposed ASC will alleviate existing and future pressures on hospital outpatient departments, and reduce backlogs and wait times. Third, the ASC will adopt a generous charity care policy in line with hospital policies, which will enable low income Vermonters to access ASC services for free or discounted costs. In addition, the proposed ASC will offer a smaller-scale, patient-friendly environment. Many patients prefer this to the larger, more institutional hospital environment, which may result in more patients seeking care who need it.

(5) the project will not have an undue adverse impact on any other existing services provided by the applicant;

The Applicant does not provide any other existing health care services.

(6) the project will serve the public good;

¹¹⁵ ASCA, *supra* note 7, at 3.

¹¹⁶ Owens et al., *supra* note 66.

¹¹⁷ See, e.g., Munnich & Parente, *supra* note 10, at 766, 768 (concluding that “the findings in this article indicate that ASCs are a high-quality, lower-cost substitute for hospitals as venues for outpatient surgery” and finding that ASCs were more efficient than hospital outpatient departments); Grisel & Arjmand, *supra* note 11 (comparing performance at an ASC with a hospital based facility and concluding that the ASC generally outperformed the hospital based facility).

There is no doubt that the project will serve the public good. The proposed ASC will:

- Lower the cost of outpatient procedures to patients, payers and the health care system;
- Expand access to critical health care services, including diagnostic and screening procedures such as colonoscopies, which have been shown to improve population health;
- Offer a smaller-scale, more personal alternative to hospital-based care, which will facilitate access to health care for a segment of the population;
- Enable patients to schedule procedures quickly and with minimal administrative headache;
- Enable physicians to perform simple procedures efficiently;
- Offer high quality, efficient health care in a patient-friendly setting;

More detailed discussion as to how the project serves the public good is included below:

The Board may consider the following factors in determining whether a project will serve the public good under 18 V.S.A. § 9437(6):

(a) Whether the project will help meet the needs of medically underserved groups and the goals of universal access to health services.

The ASC will be a valuable health care resource for the state by offering high quality health care to all Vermonters regardless of ability to pay. The ASC will adopt a charity care policy, a draft of which is attached as **Exhibit 2**, which is in line with, or even more generous than, those offered by Vermont hospitals. In addition, unlike a hospital, the ASC will offer transparent pricing, removing the element of price uncertainty that may prevent some from seeking care who need it. Third, the ASC will be the State's only alternative to hospital-based routine surgical procedures. As described elsewhere, while there are undoubtedly patients who prefer a hospital environment, there are also patients who find hospitals institutional, overwhelming, imposing and difficult to navigate. Vermonters who fit within this rubric do not presently have an alternative site of care to hospital-based surgery. The ASC will offer a smaller, more intimate and accessible site of care, which will enable more Vermonters to access health care without unnecessary stress. And finally, as has been discussed at length elsewhere in this Application, ASCs on the whole are markedly less expensive than hospital owned outpatient departments.

(b) Whether the project will help facilitate the implementation of the Blueprint.

A stated goal of the Blueprint is to lower the total cost of care by focusing on preventative health. It is anticipated that GI procedures will constitute the highest volume of procedures performed at the ASC. Within Vermont, there is a particular need to add operating capacity for affordable GI procedures (i.e., screening and diagnostic colonoscopies) because screening colonoscopies are a quality measure for the state's Commercial and Medicaid shared-savings programs and Medicare's shared-savings program. We understand that currently patients are

putting off needed medical procedures due to their current high-cost and slow scheduling times. In the future, the state's ACO provider organizations will find it more difficult to meet their goals of meeting or exceeding quality measure targets unless new lower-cost, more efficient settings are developed for these procedures to be performed.

Furthermore, as part of the Center's credentialing process, all of the specialists operating at the center will sign a 'Collaborative Care Agreement' to function as part of an effective care delivery network. Based on Blueprint and national Patient Center Medical Home guidelines, this agreement was developed by practicing physician and outlines the protocols for effective communication among primary care and specialty physicians. The protocols outlined in the agreement enhance the effectiveness of the patient centered medical home and contribute directly to greater continuity of care for all patients. The principles agreed to by all the specialty physicians who will operate at the center, as outlined in the Collaborative Care Agreement, are: (i) timely access to care, (ii) communication, (iii) adherence to widely-accepted evidence-based principles of care, and (iv) support of the primary care practice (PCP) as the Medical Home for most patients. Per the 'Collaborative Care Agreement,' after a specialist performs a procedure at the center, he or she will provide the patient's PCP with guidelines and instructions for follow-up care, including parameters for additional consultation.

(c) Whether the applicant has demonstrated it has analyzed the impact of the project on the Vermont health care system and the project furthers effective integration and coordination of health care services.

It is our intention that the ASC will fill an important role within an integrated, coordinated health care system. First, the ASC will fill an essential niche in the health care system by offering a lower cost alternative to hospital-based care for routine cases that do not require extensive resources and do not justify high expenses. The ASC will provide simple surgical services for a cost that is commensurate with complexity. The ASC will not host complicated surgeries or procedures on patients with complex health conditions, both of which would be more appropriately suited for the State's academic medical center or a local hospital.

Having a multi-specialty ASC in Vermont will enhance effective coordination and integration of health care services because the ASC will be a valuable low-cost, high-value site of care for the state's Accountable Care Organizations (ACOs). Part of the work of an ACO is to transform care processes to emphasize more cost effective pathways that produce similar or better outcomes. A care pathway that leads through the ASC will allow the ACO to take advantage of these cost-savings to help it hit its financial targets, while providing its attributed population with a high-quality care experience. ACOs must also offer convenient and readily available access to surgical care. In the event that there are longer than necessary wait times for important preventative health or other procedures at local hospitals, ACOs may take advantage of the ASC for providing ready access to these procedures. The local physician-owners of the Green Mountain Surgery Center are all members of HealthFirst and affiliated participants in its ACO programs. The owners would also welcome entering into formal or informal partnership arrangements with the state's other two currently existing ACOs, OneCare Vermont and Community Health Accountable Care.

Also, as described elsewhere in this Application, ACTD intends to enter into a transfer

agreement with UVM Medical Center to coordinate the smooth transfer of patients whose health needs require hospital care to a more appropriate setting. At the same time, we hope that the ASC will provide value to the UVM Medical Center by offering physicians (both hospital-based and independent) an alternative site of care for simple procedures, which will be particularly valuable when the hospital's resources are stressed or when the hospital is experiencing significant backlogs. And as discussed elsewhere in this Application, the ASC intends to utilize local hospitals pharmacy, laboratory, and radiology services to meet the needs of our shared patient population.

(d) Whether the project is consistent with current health care reform initiatives, at the state and federal level.

Federal and state health reform efforts are primarily concerned with lowering the cost of and expanding access to health care, while at the same time maintaining or improving the quality of health care and improving population health. As has been discussed elsewhere in this Application, our proposed ASC addresses all of these concerns. ASCs provide a lower cost option to hospitals for simple surgical procedures. By offering lower costs, transparent pricing knowable in advance, and a generous charity care policy, the project will expand access to healthcare to those with modest financial means. The proposed ASC will offer a smaller scale, more intimate health care setting, which will be an attractive health care option for those patients who are uncomfortable in a hospital environment. ASCs are associated with high quality health care and high patient satisfaction scores.¹¹⁸ And the proposed ASC will offer several important screening and diagnostic services, such as colonoscopies, which have been shown to improve population health by detecting and enabling treatment of serious health conditions early on.

In addition, as discussed in the previous section, the ASC will provide a valuable low-cost, high-value site of care for the state's ACOs, which are widely viewed as one of the State's most promising health reform tools. For ACOs to succeed, they must have access to convenient, low cost and readily available sites of surgical care. Thus, we anticipate that ACOs would benefit from the Green Mountain Surgery Center, which will facilitate meeting ACO goals. As noted above, the local physician-owners of the Green Mountain Surgery Center are all members of HealthFirst and affiliated participants in its ACO programs. In addition, the owners would welcome collaborative arrangements with the state's other two currently existing ACOs, so that the Center may contribute even more to Vermont's health reform efforts.

Finally, the Green Mountain Surgery Center plans to work with the Vermont Program for Quality in Healthcare (VPQHC) and, with its support, will submit data on surgical outcomes to the ACS-NSQIP clinical database. The goal is to improve surgical outcomes, enhance patient safety, and reduce costs. VPQHC received a \$900,000 SIM grant to develop new statewide infrastructure to support the collection, submission and reporting of surgical clinical data. Our new center intends to join the Statewide Surgical Services Collaborative and submit data alongside the Vermont hospitals. <http://www.vpqhc.org/NSQIP-VT>

(e) Except where circumstances support approval of an emergency Certificate of

¹¹⁸ See, e.g., Grisel & Arjmand, *supra* note 11, at 701 (noting the ASC's "quality advantage"), 706 (noting that patient satisfaction surveys for ASC were positive).

Need, whether the project was identified prospectively as needed at least two years prior to the time of filing in the hospital's four-year capital plan.

Not applicable

(f) Whether, and if so to what extent, the project will have an adverse impact on the ability of existing facilities to provide medically necessary services to all in need, regardless of ability to pay or location of residence.

As described in Section 2(B)(i) above, this Project will have the most direct impact on the UVM Medical Center. We fully expect that this impact will be immaterial, however, and certainly should not have any effect on the medical center's ability to provide medically necessary services to all in need, regardless of ability to pay. As an initial matter, UVM Medical Center is by far the largest health care provider in Vermont, with an annual budget that exceeds that of all other Vermont hospitals combined.¹¹⁹ In fact, the Medical Center is consistently ranked among the largest handful of employers in the State. There is simply no likelihood that an ASC of the size and scope that we propose here would have any material impact on the medical center's bottom line and its ability to support a charity care policy.

In addition, to the extent that the ASC will draw patients from the hospital, thereby reducing somewhat the volume of simple, outpatient procedures performed at the UVM Medical Center, we anticipate that the cross section of patients who visit the ASC to look very similar to those of the hospital. That is, the ASC anticipates a patient mix that includes Medicare, Medicaid, commercial payer, self-pay, and charity care patients, all in similar proportions to those of the hospital. The ASC will not select patients based on insurance status, and we project that twenty-five percent of our patients will be self-pay, Medicaid or charity care/bad debt. These projections are based on the actual payer mix for patients of the physicians who have expressed interest in utilizing the ASC. Thus, the ASC should not have any impact on the proportion of financially needy patients accessing hospital services.

(7) the applicant has adequately considered the availability of affordable, accessible patient transportation services to the facility; and

The location for the proposed ASC was selected with accessibility in mind. The facility will be located at 535 Hercules Drive in Colchester, Vermont, which is proximate to several other health care providers and resources including the OneCare Vermont ACO, certain medical offices of the UVM Medical Center, the Vermont Interventional Spine Center, and the Albany College of Pharmacy. The location is easily accessed, just off of the interstate, and is a ten minute drive from the center of Burlington and only 5 minutes from Winooski. The location will have ample, free and easily accessible parking, including dedicated handicapped spaces. In addition, the Chittenden County Transportation Authority's (CCTA) Milton Commuter bus stops at nearby Mountain View Drive.¹²⁰ And patients who are eligible for Special Services Transportation

¹¹⁹ The Medical Center's 2015 budget projects \$2,425,019,304 in gross patient revenue. GMCB, *supra* note 48 The aggregate projected gross patient revenue for the remaining 13 community hospitals (including Central Vermont Medical Center, which is affiliated with the UVM Medical Center) is \$2,310,975,244. See Fiscal Year 2015 budget analyses for Vermont community hospitals.

¹²⁰ *Route 56: Milton Commuter Stop List*, CHITTENDEN COUNTY TRANSPORTATION AUTHORITY (last visited June 8,

Agency (SSTA) may also access the ASC via SSTA transportation.

(8) if the application is for the purchase or lease of new health care information technology, it conforms with the health information technology plan established under section 9351 of this title.

This CON application is not for the purchase or lease of new health care IT.

IV. LETTERS OF SUPPORT

In connection with our Application for a Certificate of Need, we submit herewith the following letters in support of the proposed Green Mountain Surgery Center:

1. AARP Vermont
2. Burton Snowboards
3. Vermont Campaign for Healthcare Security
4. Vermont State Employees Association
5. Vermont Education Health Initiative
6. Vermont State Troopers Association

June 9, 2015

Mr. Alfred Gobeille
Chair, Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Dear Mr. Gobeille,

I write on behalf AARP-VT, an organization dedicated to enhancing quality of life for all as we age. Representing approximately 140,000 Vermonters we work for positive social change and to deliver value to our members through information, advocacy and service.

I am writing to support the effort to build an outpatient ambulatory surgery center in Chittenden County. For our members, having a lower cost, high quality outpatient surgery option is something which makes sense and should be available.

AARP believes that health care spending should be more rational and support the goals of more efficient planning, budgeting, and resource coordination. We believe that cost containment should be an explicit consideration in decisions relating to the distribution and allocation of health care resources, capital, technology, and personnel, whereby innovation, efficiency, cost effectiveness and reasonable access to services are all encouraged.

Outpatient surgery has become an increasingly important part of medical care in the United States in the past 30 years, with the number of outpatient procedures rising dramatically since 1981. In 2011, more than 60 percent of all U.S. surgeries were outpatient procedures compared to 19 percent in 1981. This is due in part because they're more convenient for patients than hospitals, getting them back home more quickly as well as being less costly. According to a [2014 study published in Health Affairs](#), ambulatory surgery centers (ASCs) offer a lower-cost alternative to hospitals as venues for outpatient surgeries. By analyzing survey data from the CDC, the study found that, on average, procedures performed in ASCs took about 25 percent less time than the same procedures performed at a hospital and with equal levels of patient satisfaction. The study's findings suggest that ASCs provide an efficient way to meet future growth in demand for outpatient surgeries and can help fulfill the Affordable Care Act's goals of reducing costs while improving the quality of health care delivery.

In my opinion AARP-VT members, and in fact all Vermonters, will be well served by having a non-hospital based surgical option in our state.

Sincerely,



Greg Marchildon
Executive Director, AARP-VT

Mr. Al Gobeille
Chair, Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Dear Chairman Gobeille,

I am writing this letter to share our strong support for granting a Certificate of Need to build an ambulatory care center in the greater Burlington area. Based on our discussions with the applicant's management team, and our experience and research into the success of ambulatory care centers in other states, we believe that a facility like this will generate significant financial savings for Burton and our 400 Burlington-based employees, and this center will be able to provide equally or more efficient and effective health care outcomes as compared to the current outpatient surgery options in the local Burlington area.

Besides the 400 employees working out of our Burlington headquarters, we have another 200 employees throughout the United States, many of whom regularly take advantage of these types of facilities. Our experience is that these centers are able to expedite the scheduling process, reduce the time spent waiting/prepping/recovering by both staff and patients, and significantly reduce the costs of procedures performed in the facilities. I recently spoke to an employee who had a routine outpatient procedure at an ambulatory care center, and paid less than half of what it would have cost at a local hospital. We have fully embraced consumer-driven approaches to our health plans, and therefore these savings will be shared equally by the company, and by our employees.

We also believe that the independent physicians proposing to open the Green Mountain Surgery Center are part of a well-managed network, with the staff and expertise to support a project like this and bring it online successfully. Many of our employees have long-standing and very positive relationships with independent physicians from the HealthFirst provider network, and therefore we are very supportive of their plans regarding this ambulatory care center.

In addition to our direct experience with our employees in other states, and in Vermont with members of the HealthFirst network, we have reviewed a lot of data regarding the success of ambulatory care centers and believe this is a solid approach that aligns very well with Vermont's current focus on improving health care delivery and reducing costs. In fact I'm a bit baffled why it's taken this long to get a solid proposal on the table...

For these reasons, we are fully backing the Green Mountain Surgery Center's plans and requesting your support in embracing their proposal and expediting the approval process to the full extent possible. I would be happy to discuss Burton's perspective with you in more detail and you can reach me anytime at justinw@burton.com, 802-651-0499 (office) or 802-922-0713 (mobile).

Best regards,



Justin Worthley
Vice President – Human Resources

Vermont Campaign for Health Care Security Education Fund

Working to make health care affordable for every Vermonter.

Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Dear Members of the Green Mountain Care Board:

I write on behalf of the Campaign for Health Care Security a non-partisan organization committed to creating and supporting outreach initiatives that facilitate popular understanding of and expand accessibility to health care.

I would like to express strong support for the CON application for an Ambulatory Surgery Center in Chittenden County. As we look at Vermont's goals of expanding access to health care for all our citizens our state must be open to a mix of providers that are going to give patients a variety of treatment setting options. We as a state should be supporting our hospitals but we should also understand and embrace the important role that non-hospital based providers, e.g. our FQHCs and independent physicians, play in our system. Authorizing a locally owned outpatient surgical center where independent doctors can treat their patients outside the hospital center makes sense as a consumer option and should be available. Furthermore, we should acknowledge what every other state has acknowledged, that such non-hospital based surgical centers provide consumers a affordable, high-quality, convenient option that can also play a role to bend the cost curve of our health care system.

Thank you for your consideration of this important issue and I encourage you to support the effort to allow this important consumer option to Vermonters.

Sincerely,



Peter Sterling, Director
Campaign for Health Care Security



Vermont State Employees' Association

155 State Street, Montpelier, VT 05602;

Phone: (802) 223-5247

Fax: (802) 223-4035 E-mail: vsea@vsea.org

Website: www.vsea.org

Al Gobeille
Chair, Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Dear Mr. Gobeille,

On behalf of the Vermont State Employees Association, an organization that represents approximately 25,000 consumers of health care in Vermont, we are writing in support of the Certificate Of Need application to establish a freestanding ambulatory surgery center in Chittenden County owned and operated by local independent physicians.

As good stewards of our members benefits, with acute awareness of the pressures on health care costs, and with a strong commitment to quality health care for our members, we are convinced that establishing an ambulatory surgery center would provide a lower cost, high quality consumer option for our members. Currently, Vermont is last in the nation in terms of access to non-hospital based alternatives for outpatient surgical procedures. This fact exists despite the trend toward lower cost, high quality surgical centers across the country and in our region. As we look at controlling costs associated with health care, the lack of such options is something that Vermont must begin to change.

VSEA values our community hospitals and understands the important role they play. However, we are convinced that there is room for more outpatient care options in Chittenden County than solely those offered by the University of Vermont Medical Center, and that the benefits of establishing such a center are compelling for our members and Vermonters more broadly.

Thank you for your consideration of this matter and we look forward to having this option available to our members and their families.

On Behalf of the Board of Trustees
and Members of VSEA,

A handwritten signature in black ink that reads "Shelley Martin". The signature is written in a cursive, flowing style.

Shelley Martin
President

On Behalf of the Benefit Advisory
Committee,

A handwritten signature in black ink that reads "Dave Bellini". The signature is written in a cursive, flowing style.

Dave Bellini
Chair

Dear Members of the Green Mountain Care Board:

The Vermont Education Health Initiative (VEHI) provides comprehensive health benefit plans for nearly 43,000 active and retired Vermont education employees and their dependents. This self-funded purchasing trust is managed jointly by the Vermont School Boards Insurance Trust (VSBIT) and the Vermont-National Education Association (Vermont-NEA).

On behalf of VEHI, we are writing to express our support for a recent Certificate of Need Application, which, if approved, would establish an independent **Ambulatory Surgical Center** in Chittenden County.

As fiduciaries for VEHI and its members, it is incumbent upon us to advocate for health care options that are of high quality and can deliver medical services at a lower cost. We understand that ASCs are operating effectively and safely across the nation, and throughout our region, and are providing cost savings.

We are convinced that an outpatient surgical option in Chittenden County would be an affordable and convenient option for the school district members of VEHI and their employees, for retirees in the Vermont State Teachers' Retirement System, and, more generally, for the people of Vermont. Further, being able to deliver excellent health care more affordably to our members and subscribers would strengthen VEHI fiscally and, thus, help us to control premium growth, which in turn would contribute to reducing budgetary pressures on local tax payers.

Establishing an ASC in Chittenden County makes sense, medically and financially. It is an idea whose time has come for Vermont.

Sincerely,



Laura Soares
VSBIT/VEHI



Mark Hage
Vermont-NEA/VEHI



VERMONT TROOPERS' ASSOCIATION, INC.

7 Baldwin Street | P.O. Box 1474 | Montpelier, VT 05601

Executive Board

Michael O'Neil, President

Matt Denis, Vice-President

Todd Wilkins, Treasurer

Darren Annis, Secretary

March 18, 2015

Al Gobeille
Chair, Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Dear Mr. Gobeille,

On behalf of the Vermont Troopers association, an organization that represents approximately 600 consumers of health care in Vermont, Troopers and their families, we would like to express our support for the establishment of a freestanding ambulatory surgery center in Chittenden County owned and operated by local physicians.

Many of our members living throughout Vermont can access such lower cost, high quality sites of care in other states. For our members, concerned about both cost and quality, it only makes sense that such a surgical center is available in the Chittenden County region. We think the establishment of this center is good for our members, their families and for Vermonters, and is a common sense option that can provide both excellent care in a more cost effective setting.

Sincerely,

Michael O'Neil
President, Vermont Troopers Association

CONCLUSION

ASCs have served an important role in health reform efforts outside of Vermont for many years, and have established an impressive track record of success by offering high quality care at a reduced cost. Vermont is unusual in that it did not have a single ASC within its borders until 2008, when the state's only ASC, devoted exclusively to eye surgery, opened its doors. It is now time for Vermont to embrace the ASC, as every other state has done, as an alternative model for delivering surgical care to compliment the State's robust hospital system. Our State has been left behind, as more than 5,000 licensed ASCs have opened nationally, which have given those states a competitive advantage over Vermont in reducing healthcare costs. Our community hospitals provide invaluable services to Vermonters, and are a critical health resource that should be supported. But given the health care challenges that we now face, we cannot rely exclusively on hospital-based surgical care, particularly when many of the same procedures can be performed by the same doctors in an alternative setting for a lower cost, without sacrificing quality or patient satisfaction.

In proposing the Green Mountain Care Surgery Center, we seek not to supplant hospital-based care, but rather to complement it by offering a smaller-scale and more efficient site of care for relatively simple surgical procedures, for a cost that is commensurate with the acuity of the patient. The Center will be an integrated part of Vermont's health care system. It will offer hospitals an alternative to relieve pressure on their surgery rooms during times of peak demand, enabling hospitals to reduce patient wait times and increase the satisfaction of their patients. We hope to pursue collaboration opportunities with community hospitals, such as by offering joint training opportunities and by ordering medical services from the hospitals. And the Center will also serve as an important resource for Vermont's ACOs, by enabling patients to be seen faster, in a more efficient manner, and for a lower cost, furthering health reform efforts aimed at improving patient satisfaction and health outcomes, while reducing system costs.

We recognize that the ASC concept is relatively new to, and not well understood within, the State of Vermont, notwithstanding the prevalence of ASCs outside our borders. We anticipate that this proposal will generate robust discussion and look forward to the opportunity to engage in that discussion with the Green Mountain Care Board and the stakeholders of the State's health care system. We are confident that as this discussion plays out, it will become clear that ASCs embody the triple aim of health care reform by offering an effective means of controlling surgical health care costs, improving patient experience and improving the health of our community.

INDEX OF TABLES REQUIRED BY GREEN MOUNTAIN CARE BOARD

<u>TABLE</u>	<u>DESCRIPTION</u>
1	Project Costs
2	Debt Financing Arrangement: Sources & Uses of Funds
3	Income Statement
4	Balance Sheet
5	Statement of Cash Flows
6	Revenue Source Projections
7	Utilization Projections
8	<i>Omitted</i>
9	Staffing Projections

Note that because ACTD, LLC was formed exclusively to develop and operate a free-standing ambulatory surgery center, and does not conduct or propose to conduct any other business, “without project” financial tables do not appear to apply and “project only” and “with project” financial tables appear to be identical. Thus, for each of Tables 3 through 6 we are not submitting separate Tables A through C, and we are omitting Table 8.

INDEX OF EXHIBITS

<u>EXHIBIT</u>	<u>DOCUMENT(S)</u>
1	Floor Plan of Green Mountain Surgery Center
2	Sample Draft Policies and Procedures <ol style="list-style-type: none">a. Charity Careb. Quality Improvement Planc. Continuous Quality Improvement Flowchartd. Infection Controle. Cooperationf. Facility Plan for Patient Care
3	Initial List of Procedures to be Performed at Center
4	Applicable 2014 FGI Guidelines

INDEX OF SELECTED CITATIONS

1. John Bian & Michael A. Morrissey, *Free-Standing Ambulatory Surgery Centers and Hospital Surgery Volume*, 44(2) INQUIRY 200 (Summer 2007).
2. Charles Courtemanche & Michael Plotzke, *Does Competition from Ambulatory Surgery Centers Affect Hospital Surgical Output?*, 29(5) J. HEALTH ECON. 765 (Jul. 15 2010).
3. Atul Gawande, *Overkill: An Avalanche of Unnecessary Medical Care is Harming Patients Physically and Financially*, THE NEW YORKER (May 11, 2015).
4. Jed Grisel & Ellis Arjmand, *Comparing Quality at an Ambulatory Surgery Center and a Hospital Based Facility: Preliminary Findings*, 141(6) OTOLARYNGOLOGY-HEAD AND NECK SURG. 701 (Dec. 2009).
5. Gabor Mezei & Frances Chung, *Return Hospital Visits and Hospital Readmissions After Ambulatory Surgery*, 230(5) ANNALS OF SURGERY 721, 726 (Nov. 1999).
6. Elizabeth L. Munnich & Stephen T. Parente, *Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up*, 33(5) HEALTH AFF. 764, 765 (May, 2014).
7. Elizabeth L. Munnich & Stephen T. Parente, *Returns to Specialization: Evidence from the Outpatient Surgery Market*, 24 (Apr. 2014) (unpublished paper).
8. Nishihara, Reiko, et al., *Long-Term Colorectal-Cancer Incidence and Mortality after Lower Endoscopy*, 369(12) NEW ENG. J. MED. 1095 (Sept. 19, 2013).
9. Pamela L. Owens, Marguerite L. Barrett, Susan Raetzman, Melinda Maggard-Gibbons, & Claudia A. Steiner, *Surgical Site Infections Following Ambulatory Surgery Procedures*, 311(7) J. AM. MED. ASS. 709 (Feb. 19, 2014).
10. Melissa Szabad, Melesa Freerks & Meggan Michelle Bushee, *Reverse Migration?: A Trend of ASC Conversion to HOPD 3* (McGuire Woods, White Paper, 2013).

TABLES REQUIRED
BY
GREEN MOUNTAIN CARE
BOARD

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER
 TABLE 1
 PROJECT COSTS

Construction Costs		Comments
1 New Construction	\$0	
2 Renovation	\$0	
3 Site Work	\$0	
4 Fixed Equipment	\$1,609,875	Fixed Equip. is the interior build-out cost for the ASC. A detailed 'Interior
5 Design/Bidding Contingency	\$0	Improvements - Construction Costs' Budget is included with the application
6 Construction Contingency	\$0	
7 Construction Manager Fee	\$0	
8 Other (please specify):	\$4,000,570	This is the remaining portion of the Capitalized Lease Payments
Subtotal	\$ 5,610,445.46	Total Capitalized Lease
Related Project Costs		
1 Major Moveable Equipment	\$0	
2 Furnishings, Fixtures & Other Equip.	\$330,000	Includes Initial Furniture/Fixtures and Initial Inventory
3 Architectural/Engineering Fees	\$0	
4 Land Acquisition	\$0	
5 Purchase of Buildings	\$0	
6 Administrative Expenses & Permits	\$0	
7 <i>Total Debt Financing Expenses (see below)</i>	\$0	
8 Debt Service Reserve Fund	\$0	
9 Working Capital	\$681,540	
10 Other (please specify)	\$801,298	Other Start-Up Costs include cost of the obtaining CON, cost of Medicare and
Subtotal	\$1,812,838	private accreditation, cost of consultants for operations/legal, cost of hiring staff,
Total Project Costs	\$ 7,423,283.46	
Debt Financing Expenses		
1 Capital Interest	\$0	There are no debt financing costs related to construction
2 Bond Discount or Placement Fee	\$0	Debt financing for Related Project Costs are shown in Table 2
3 Misc. Financing Fees & Exp. (issuance costs)	\$0	
4 Other (specify):	\$0	
Subtotal	\$0	
Less Interest Earnings on Funds		
Debt Service Reserve Funds	\$0	
Capitalized Interest Account	\$0	
Construction Fund	\$0	
Other (specify):	\$0	
Subtotal	\$0	
Total Debt Financing Expenses	\$0	
<i>feeds to Debt Financing Expenses above</i>		

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER

TABLE 2
DEBT FINANCING ARRANGEMENT, SOURCES & USES OF FUNDS

Sources of Funds		Comments
1 Financing Instrument	Debt	
a Interest Rate		7.00%
b Loan Period	20 years	
c Amount Financed		\$680,000
2 Equity Contribution		\$1,132,838
3 Other Sources		
a Working Capital		\$0
b Fundraising		\$0
c Grants		\$0
d Other		\$0
Total Required Funds	\$	1,812,838

Uses of Funds		Comments
1 New Construction		\$0
2 Renovation		\$0
3 Site Work		\$0
4 Fixed Equipment		\$0
5 Design/Bidding Contingency		\$0
6 Construction Contingency		\$0
7 Construction Manager Fee		\$0
8 Major Moveable Equipment		\$0
9 Furnishings, Fixtures & Other Equip.		\$330,000
10 Architectural/Engineering Fees		\$0
11 Land Acquisition		\$0
12 Purchase of Buildings		\$0
13 Administrative Expenses & Permits		\$0
14 Debt Financing Expenses		\$0
15 Debt Service Reserve Fund		\$0
16 Working Capital		\$681,540
17 Other (please specify)		\$801,298
Total Uses of Funds	\$	1,812,838

Comments

The developer is financing new construction, not ACTD. ACTD will lease the new building developed for the ASC. Therefore, ACTD does not intend to raise funds for these construction purposes.

Includes Initial Furniture/Fixtures and Initial Inventory

Other Start-Up Costs include cost of the obtaining CON, cost of Medicare and private accreditation, cost of consultants for operations/legal, cost of hiring staff, etc.

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER
TABLE 3*
INCOME STATEMENT

**Because ACTD was formed exclusively for the development and operation of the proposed ASC, it has no other existing or proposed lines of business. Accordingly, we are not submitting separate subtables A-C*

	Year 1	Year 2	Year 3	Year 4
Revenues				
Patient Revenues	\$ 5,848,706	\$ 6,852,344	\$ 7,024,680	\$ 7,201,351
Deductions from Revenue:				
Bad Debt	\$ (94,693)	\$ (137,047)	\$ (140,494)	\$ (144,027)
Charity Care	\$ (94,693)	\$ (137,047)	\$ (140,494)	\$ (144,027)
Total Deductions from Revenue	\$ (189,387)	\$ (274,094)	\$ (280,987)	\$ (288,054)
Net Patient Revenue	\$ 5,659,319	\$ 6,578,250	\$ 6,743,693	\$ 6,913,297
Expenses				
Clinical Personnel Costs	\$ 1,991,808	\$ 2,031,644	\$ 2,072,277	\$ 2,113,723
Clinical Expenses (Non Personnel)	1,786,547	2,124,135	2,229,807	2,340,749
Administrative Expenses	803,847	925,321	955,715	990,249
Lease Expense	489,402	504,084	519,207	534,783
Equipment Expense	638,843	638,843	638,843	579,559
Interest Expense	47,088	45,918	44,664	43,320
Depreciation Expense	28,571	28,571	28,571	28,571
Total Expenses	\$ 5,786,106	\$ 6,298,517	\$ 6,489,084	\$ 6,630,954
Income Before Taxes	\$ (126,787)	\$ 279,733	\$ 254,609	\$ 282,343

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER
TABLE 4*
BALANCE SHEET

**Because ACTD was formed exclusively for the development and operation of the proposed ASC, it has no other existing or proposed lines of business. Accordingly, we are not submitting separate subtables A-C*

	Start-Up	Year 1	Year 2	Year 3	Year 4
Assets					
Current Assets:					
Cash		\$ 607	\$ 271,566	\$ 526,145	817,115
Supplies Inventory	130,000	130,000	150,000	160,000	160,000
Total Current Assets	130,000	130,607	421,566	686,145	977,115
Fixed Assets:					
Land and Building	-	-	-	-	-
Furniture, Fixtures and Equipment	200,000	200,000	200,000	200,000	200,000
Total Fixed Assets	200,000	200,000	200,000	200,000	200,000
Less: Accumulated Depreciation/Amort		(28,571)	(57,143)	(85,714)	(114,286)
Net Fixed Assets	200,000	171,429	142,857	114,286	85,714
Total Assets	\$ 330,000	\$ 302,036	\$ 564,423	\$ 800,431	\$ 1,062,829
Liabilities and Equity					
Current Liabilities					
Current Portion of LTD (Working Capital)	16,177	17,346	18,600	19,945	21,387
Total Current Liabilities	16,177	17,346	18,600	19,945	21,387
Long Term Debt					
Non Current Portion (Working Capital)	663,823	646,477	627,877	607,932	586,545
Total Long Term Debt	663,823	646,477	627,877	607,932	586,545
Total Liabilities	680,000	663,823	646,477	627,877	607,932
Equity					
Capital Contribution	1,132,838	1,247,838	1,247,838	1,247,838	1,247,838
Retained Earnings	(1,482,838)	(1,609,625)	(1,329,892)	(1,075,283)	(792,941)
Closing Equity	(350,000)	(361,787)	(82,054)	172,555	454,897
Total Liabilities and Equity	\$ 330,000	\$ 302,036	\$ 564,423	\$ 800,431	\$ 1,062,829

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER
TABLE 5*

STATEMENT OF CASH FLOWS

**Because ACTD was formed exclusively for the development and operation of the proposed ASC, it has no other existing or proposed lines of business. Accordingly, we are not submit*

	Start-Up	Year 1	Year 2	Year 3	Year 4
Cash flows from operating activities:					
Income (loss) before income taxes	\$(1,482,838)	\$ (126,787)	\$ 279,733	\$ 254,609	\$ 282,343
Non cash adjustment to income (loss)					
Depreciation and amortization		28,571	28,571	28,571	28,571
(Increase) decrease in inventory	(130,000)	-	(20,000)	(10,000)	-
Net cash provided (used) by operating activities	<u>(1,612,838)</u>	<u>(98,216)</u>	<u>288,304</u>	<u>273,180</u>	<u>310,914</u>
Cash flow from investing activities:					
Furniture, fixtures and equipment	(200,000)	-			
Net cash provided (used) by investing activities	<u>(200,000)</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Cash flow from financing activities:					
Proceeds from issuance of long-term debt	680,000	-	-	-	-
Principal payments on long-term debt		(16,177)	(17,346)	(18,600)	(19,945)
Proceeds from issuance of shares	1,132,838	115,000			
Net cash provided (used) by financing activities	<u>1,812,838</u>	<u>98,823</u>	<u>(17,346)</u>	<u>(18,600)</u>	<u>(19,945)</u>
Increase (decrease) in cash	-	607	270,958	254,580	290,969
Cash (Loan), beginning of period	-	-	607	271,566	526,145
Cash (Loan), end of year before distributions to Members	-	607	271,566	526,145	817,115
Cash Available for Distributions	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Cash (Loan), end of period after distributions	\$ -	\$ 607	\$ 271,566	\$ 526,145	\$ 817,115

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER
TABLE 6*
REVENUE SOURCE PROJECTIONS

**Because ACTD was formed exclusively for the development and operation of the proposed ASC, it has no other existing or proposed lines of business. Accordingly, we are not submitting separate subtables A-C*

	Latest Actual	Budget	Proposed Year 1	Proposed Year 2	Proposed Year 3	Proposed Year 4
Gross Inpatient Revenue						
Medicare	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A	N/A	N/A
Commercial	N/A	N/A	N/A	N/A	N/A	N/A
Self Pay	N/A	N/A	N/A	N/A	N/A	N/A
Free Care/Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A	N/A	N/A
Gross Outpatient Revenue						
Medicare	N/A	N/A	\$2,221,818	\$2,604,440	\$2,668,195	\$2,736,866
Medicaid	N/A	N/A	\$566,720	\$664,074	\$681,023	\$697,878
Commercial	N/A	N/A	\$2,435,229	\$2,852,448	\$2,925,109	\$2,998,647
Self Pay	N/A	N/A	\$624,939	\$731,382	\$750,354	\$767,960
Free Care/Bad Debt	N/A	N/A	(\$189,387)	(\$274,094)	(\$280,987)	(\$288,054)
Other	N/A	N/A	\$0	\$0	\$0	\$0
Gross Other Revenue						
Medicare	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A	N/A	N/A
Commercial	N/A	N/A	N/A	N/A	N/A	N/A
Self Pay	N/A	N/A	N/A	N/A	N/A	N/A
Free Care/Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A	N/A	N/A
Gross Patient Revenue						
Medicare	N/A	N/A	\$2,221,818	\$2,604,440	\$2,668,195	\$2,736,866
Medicaid	N/A	N/A	\$566,720	\$664,074	\$681,023	\$697,878
Commercial	N/A	N/A	\$2,435,229	\$2,852,448	\$2,925,109	\$2,998,647
Self Pay	N/A	N/A	\$624,939	\$731,382	\$750,354	\$767,960
Free Care/Bad Debt	N/A	N/A	(\$189,387)	(\$274,094)	(\$280,987)	(\$288,054)
Other	N/A	N/A	\$0	\$0	\$0	\$0

(Please see Tables in Section I.H of the Application for additional data on revenue source projections)

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER
TABLE 7*
UTILIZATION PROJECTIONS

**Because ACTD was formed exclusively for the development and operation of the proposed ASC, it has no other existing or proposed lines of business. Accordingly, we are not submitting separate subtables A-C*

	Latest Actual	Budget	Proposed Year 1	Proposed Year 2	Proposed Year 3	Proposed Year 4
Inpatient Utilization						
Staffed Beds	N/A	N/A	N/A	N/A	N/A	N/A
Admissions	N/A	N/A	N/A	N/A	N/A	N/A
Patient Days	N/A	N/A	N/A	N/A	N/A	N/A
Average Length of Stay	N/A	N/A	N/A	N/A	N/A	N/A
Outpatient Utilization						
All Outpatient Visits	N/A	N/A	N/A	N/A	N/A	N/A
OR Procedures	N/A	N/A	5132	5924	5983	6043
Observation Units	N/A	N/A	N/A	N/A	N/A	N/A
Physician Office Visits	N/A	N/A	N/A	N/A	N/A	N/A
Ancillary						
All OR Procedures	N/A	N/A	N/A	N/A	N/A	N/A
Emergency Room Visits	N/A	N/A	N/A	N/A	N/A	N/A
Adjusted Statistics						
Adjusted Admissions	N/A	N/A	N/A	N/A	N/A	N/A
Adjusted Patient Days	N/A	N/A	N/A	N/A	N/A	N/A

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER
TABLE 8
UTILIZATION PROJECTIONS
PROJECT SPECIFIC

Please see Table 7, which includes all information required for this Table. Because ACTD was formed exclusively for the development and operation of the proposed ASC, it has no other existing or proposed lines of business. Accordingly, we are not submitting a separate Table 8.

ACTD LLC
GREEN MOUNTAIN SURGERY CENTER
TABLE 9*
STAFFING PROJECTIONS

**Because ACTD was formed exclusively for the development and operation of the proposed ASC, it has no other existing or proposed lines of business. Accordingly, we are not submitting separate subtables A-C*

	Latest Actual	Budget	Start-Up	Proposed Year 1	Proposed Year 2	Proposed Year 3	Proposed Year 4
Surgical Tech	0	N/A	0.5	3	3	3	3
Instrument Tech	0	N/A	0	1	1	1	1
RN Manager	0	N/A	1	1	1	1	1
Receptionist	0	N/A	0	1	1	1	1
Scheduler	0	N/A	0	1	1	1	1
Business Office Manager	0	N/A	0.5	1	1	1	1
Total Non-MD FTEs	0	N/A	2	8	8	8	8
Physician FTEs	0	N/A	0	0	0	0	0
Surgical RN	0	N/A	0	3	3	3	3
Pre-Op RN	0	N/A	0	3	3	3	3
PACU RN	0	N/A	0	4	4	4	4
GI/ Pain RN	0	N/A	0	4	4	4	4
Direct Service Nurse FTEs	0	N/A	0	14	14	14	14
Total FTEs	0	N/A	2	22	22	22	22

EXHIBITS

EXHIBIT 1



1 PROPOSED FLOOR PLAN
 1/8" = 1'-0"

2014 FEB	2014 FEB
(2) O.R.'S	PRE-OP 1 O.R. = 2
PHASE 1 130K.R. = 3	(4) S/P PRE-OP 1 S/P = 3
POST 1 S/P = 4	POST 1 S/P = 4
TOTAL = 4	TOTAL = 4
	(14) PROVIDED

- NOTES:
 1. DRESS / T.I.T. TO HAVE ADA ACCESSIBLE FOLD DOWN BENCH.
 2. ONE DRESS / T.I.T. IN THE RECOVERY AREA SHALL BE EQUIPPED W/ A BED PAN WASHING DEVICE.
 3. PRE-OP & POST-OP CUBICLES ARE 80 S.F. CLEAR.

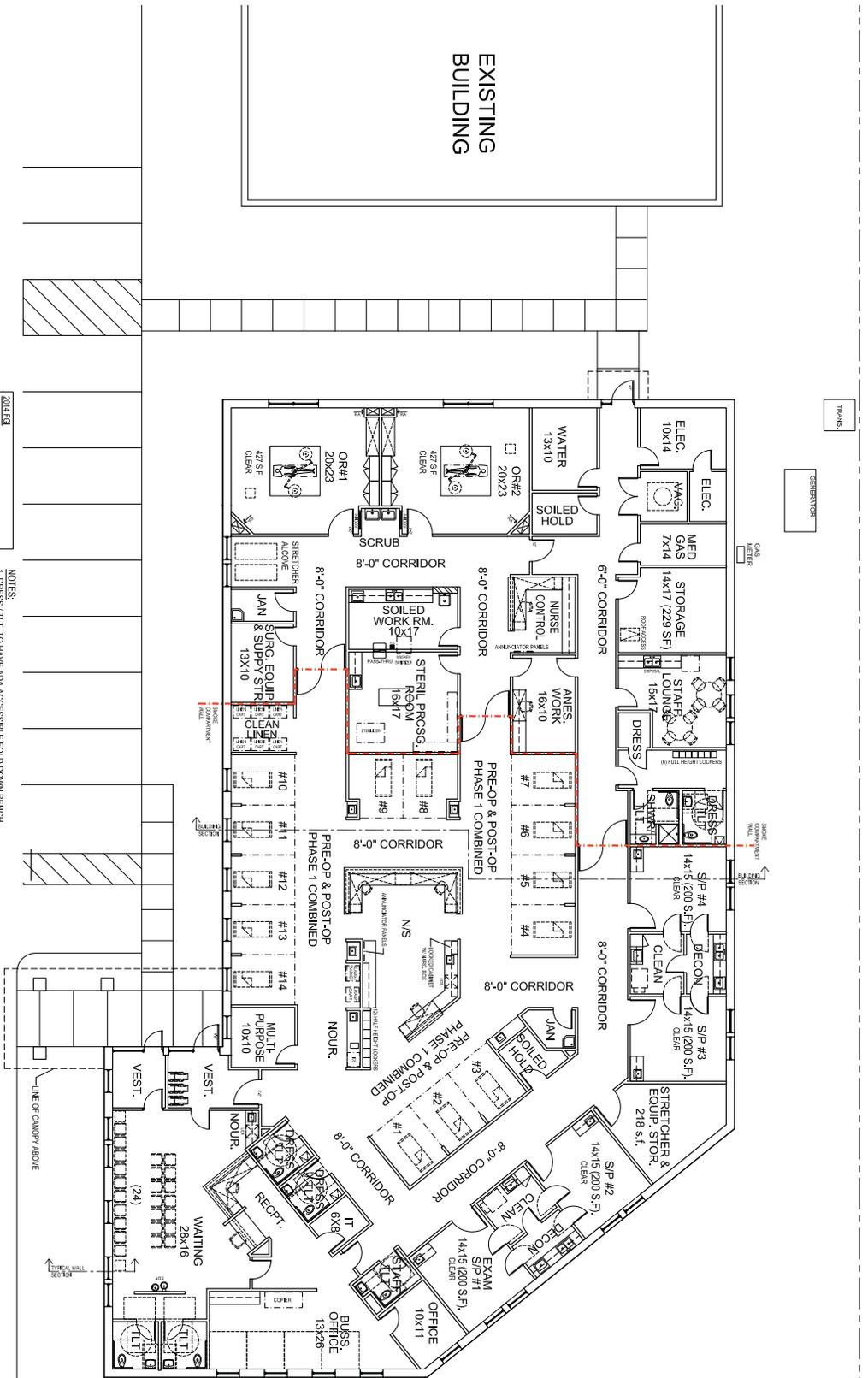


EXHIBIT 2.a

Charity Care Policy

PURPOSE:

To establish a process for providing financial assistance for patients unable to pay for outpatient surgery, and who meet the criteria for charity care.

POLICY:

The Green Mountain Surgery Center (the "Center") is committed to ensuring that all Vermonters have access to quality health care, regardless of their ability to pay. The Green Mountain Surgery Center accordingly offers to qualifying individuals free and discounted care for services performed by the Center in connection with medically necessary procedures performed at the Center. Eligibility for the financial assistance program will be determined based upon the patient's demonstrated financial need and without regard to the patient's race, religion, sex, age, gender identity, sexual orientation or national origin.

PROCEDURE:

In order to be considered for financial assistance, individuals must submit a complete Application for Free or Discounted Care. An application is considered complete if all questions are answered fully, the application is signed and dated by applicant(s), and all required supporting documentation is attached. Documentation required to be submitted along with the completed application will include:

- *Most recently filed federal income tax return for all members of the household* (including all forms and schedules): Individuals to be included in household size must be a spouse or dependent of the applicant, as reflected on the federal income tax return(s) provided.
- *Proof of household income:* Type of documentation of household income will depend upon the sources of household income, but may include, without limitation, pay stubs, written verification of wages from employer, W-2 withholding form, social security or disability benefit statements, unemployment or pension/annuity benefits, supplemental security income statements, and written verification from a governmental agency attesting to household income.
- *Proof of monetary assets:* Type of documentation of monetary assets will depend on the nature of the monetary assets, but may include, without limitation, copies of recent bank or broker statements relating to checking accounts, savings accounts, stocks, bonds, mutual funds, money market accounts, certificates of deposit, trusts, or annuities. The following assets are not considered monetary assets and are not included in the determination of eligibility: primary residence, vehicles, personal property, retirement assets,

cash surrender value of life insurance policies, and burial funds.

- *Statement of Zero Income* (if applicable): An applicant whose income is documented as "\$0", must complete and submit a "Statement of Zero Income."
- *Evidence Relating to Health Insurance*: The applicant shall provide evidence that all possible third party payers have been exhausted and that the balance is due from the applicant. If the applicant is ineligible for government insurance program(s), the applicant shall provide a copy of the letter or notice received from such government insurance program(s) documenting such ineligibility.

Upon receipt of an application, patient accounts related to all members of the applicant's household with outstanding balances in good standing (less than 120 days outstanding) will be placed on hold during the application review process. If the application is found to be incomplete, the applicant will be notified by telephone, in addition to a written notice in the mail, to communicate what required elements are missing. The applicant must submit the required information within 10 business days or the account hold will be released. Upon receipt of a complete application, a determination of eligibility for or denial of financial assistance will be communicated to the applicant in writing within 15 business days of receipt of the complete application.

All Applications for Free or Discounted Care and supporting documentation will be reviewed and approved by the Center's Business Manager. Applications for eligible recipients whose awarded assistance will be greater than \$2,500 will also be reviewed and approved by the Center's Administrator.

The Green Mountain Surgery Center will work with the applicant to identify other potential sources of payment for their medical bills. If the Center identifies a potential alternative payment source, such as one of Vermont's Green Mountain Care programs, the applicant will be expected to cooperate with the Center to determine eligibility for that program. Failure to cooperate with applying for alternative sources of payment will be considered a voluntary withdrawal of the application for assistance from the Green Mountain Surgery Center.

ELIGIBILITY:

The following criteria must be met to be eligible for free or discounted care at the Green Mountain Surgery Center:

Residency:

The applicant must be a full-time resident of Vermont or must have resided in Vermont for more than the last 6 consecutive months.

Eligible Services:

Free and discounted care is available for all services offered by the Green Mountain Surgery Center in conjunction with medically necessary procedures. Determination

of medical necessity may require the input from the attending physician to take into account all the relevant facts and circumstances. Services offered in connection with elective procedures are not included under this Free and Discounted Care Policy.

Services that have been denied by insurance due to the patient's non-compliance with the requirements of the patient's plan are not considered eligible for financial assistance. In addition, Services reimbursed directly to the patient/guarantor by the insurance carrier or covered by another third party are not eligible for financial assistance.

Financial:

To be eligible for financial assistance under this Free and Discounted Care Policy, the applicant's household income and monetary assets should be at or below the following guidelines.

- *Monetary Assets:* The applicant's monetary assets must be below \$5,000 (or, if married, \$7,500). Monetary assets include cash, checking accounts, savings accounts, stocks, bonds, mutual funds, money market accounts, certificates of deposit, trusts, annuities, and non-home real property. The following assets are not considered monetary assets and are excluded from the determination of monetary assets: the applicant's primary residence, vehicles, personal property, retirement assets, cash surrender value of life insurance policies, and burial funds.
- *Income:* Household income must be at or below 400% of the Federal Poverty Level Guidelines (FPLG), as adjusted for household size. The level of assistance is granted on a sliding scale based on the FPLG as follows:

Federal Poverty Level	Up to 250%	251% - 300%	301% - 350%	351% - 400%
Discount	100%	75%	50%	25%
	100%			

Household income includes gross earnings, unemployment compensation, workers compensation, social security benefits, supplemental security income, public assistance, veteran's benefits, survivor benefits, pension or retirement, interest, dividends, rents, royalties, estate income, trusts, educational assistance, alimony, annuities, and child support for a household. Household income does not include capital gains, liquid assets (including withdrawals from a bank or proceeds from the sale of property), tax refunds, gifts, loans, lump-sum inheritances, or non-cash benefits such as food stamps and housing subsidies.

Term of Financial Assistance:

Each eligibility determination for financial assistance, whether approved or denied, is effective for a period of 6 months following the date of the determination letter, referred to as the termination date.

The awarded level of financial assistance for first-time recipients will be applied to eligible services, as described above, that were provided to the recipient during the 6 months preceding the date of receipt of a complete application and will be automatically applied to any eligible medical services received up through the termination date communicated in the determination letter sent to the recipient.

Subsequent to the termination of the initial determination for financial assistance, a recipient may re-apply for assistance if s/he continues to claim financial hardship by submitting a complete application with updated information and supporting documentation. If approved, the awarded level of financial assistance will be applied to eligible services received since the termination of the last award, up to a maximum of 6 months preceding the date of receipt of the complete re-application.

Communication of Policy for Free or Discounted Care

Notification of this Policy for Free or Discounted Care will be distributed by posting notices in prominent patient locations within the Center and placing information regarding the policy on patient statements. The Center will also include a copy of the policy on its website and in brochures available in patient access areas. Such notices and summary information will be provided in the primary languages spoken by the population served by the Center and will include a contact number for inquiries regarding the policy.

Confidentiality and Records Retention

All information relating to financial assistance applications will be kept strictly confidential. Applications for Free or Discounted Care will be kept for a minimum of 7 years following the date of application.

Regulatory Requirements

In implementing this policy, the Green Mountain Surgery Center will comply with all other federal, state, and local laws and regulations that may apply to activities conducted pursuant to this policy.

Policy reviewed with:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input type="checkbox"/> Business Office Manager | | |

EXHIBIT 2.b

Quality Improvement Plan

Policy Statement

The Green Mountain Surgery Center maintains an active, integrated, organized, peer-based continuous quality improvement program. The facility utilizes a systematic approach for Performance Improvement through multi-disciplinary cooperation, both internal and external. Quality improvement activities demonstrate the systematic, "closing the QI loop" process. This process incorporates an improvement model that includes (design), (identification) of problems/concerns in the care of patients; (evaluation) of the frequency, severity and source of these problems/concerns; (resolution measures); (re-evaluation); (reporting). The plan will address clinical, administrative, cost-of-care issues and patient outcomes. The focus will be activities that affect the majority of patients serviced and consider high-risk, high-volume, and problem-prone patients. The following plan is an integral part of the Center's overall goal of continually improving organizational performance.

Procedures

I. Mission:

- A. The Center recognizes ambulatory surgical services as an integral part of the healthcare continuum and that healthcare improvement is a component of utmost importance in the delivery of patient care. The facility's staff understands and demonstrates that in order to improve existing processes, healthcare providers must constantly examine and monitor clinical outcomes with a systematic, concurrent approach. Facility staff is dedicated to providing all patients with the highest quality and efficiency of clinical services with utilization of the most cost-effective measures.

II. Objectives:

- A. Ambulatory care quality improvement activities must be designed to evaluate several parameters of quality. Continuous quality improvement (CQI), when properly performed, should meet a few main objectives:
 - 1. Prompt attention to high-priority access of clinical care
 - 2. An increased likelihood of desired health outcomes through the facility's participation in performance measurement and quality improvement activities
 - 3. Stimulate analysis of the appropriateness and effectiveness of clinical care
 - 4. Findings of CQI activities are incorporated into the organization's educational process
 - 5. Mechanisms are in place for designing, measuring, assessing, improving, and redesigning organizational functions – knowing that performance can be improved even when high standards appear to be met
 - 6. Leaders of the organization are held accountable for setting priorities and providing needed resources to achieve the highest quality of care possible
 - 7. Patient and organizational focused functions are maintained in the process

8. Dimension of performance aspects are considered:
 - a. efficiency
 - b. availability
 - c. timeliness
 - d. efficacy safety
 - e. respect and caring
 - f. continuity
9. Consideration is given to the needs of patients, surgeons, vendors, payers, and staff in the process
10. Design improvement functions which affect the majority of patients serviced and consider high-risk, high-volume, and problem-prone patients
11. Consideration is given to the mission, philosophy, and scope of service of the organization
12. Results of peer review information are used as part of the basis for granting continuation of clinical privileges.
13. The implementation of a consistent process for the identification, reporting, analysis, and prevention of adverse incidents/occurrences.

III. Process:

- A. The Center utilizes the systematic "closing the QI loop" process to promote continuous quality improvement throughout the facility.
- B. This process provides for a planned, systematic, organization-wide, prioritized, approach that is inter-disciplinary and uniform.
- C. QI activities conducted by specific clinical disciplines within the organization are consistent with the characteristics of the overall CQI program.
- D. The improvement activities are on-going and part of the Center's planning process.
- E. The improvement activities take into consideration patient, surgeon, and staff needs and expectations as well as others; i.e. payers, community.
- F. The improvement activities take into consideration patient and organizational functions as well as dimensions of performance.
- G. Improvement activities consider:
 1. Scope of service
 2. Mission and philosophy
 3. Important aspects of care
 4. High-volume, high-risk, problem-prone patients
 5. Contracted services, if appropriate
 6. Patient, surgeon, staff satisfaction
 7. Incident reports
 8. Standards of practice
 9. Identifying unacceptable or unexpected trends that influence patient outcomes
- H. Improvement activities are re-designed as appropriate.
- I. Individual performance is addressed as necessary and appropriate.

IV. Characteristics:

- A. Quality improvement activities have the following characteristics:
 - 1. Important problems or concerns in the care of patients are identified. Sources of identifiable problems include, but are not limited to:
 - a. Unacceptable or unexpected results of on-going monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal test results, radiology film re-takes, prescribing errors for medications, specific diagnoses, and so forth
 - b. The clinical performance and practice patterns of health care practitioners
 - c. Medical record review for quality of care and completeness of entries
 - d. Quality controls for and use of diagnostic imaging, pathology, medical laboratory, and pharmaceutical services
 - e. Other professional and technical services provided
 - f. Assessment of patient satisfaction
 - g. Direct observation
 - h. Staff concerns
 - i. Accessibility
 - j. Medical/legal issues
 - k. Wasteful practices
 - l. Over-utilization and under-utilization
 - m. Prevalent diseases, including chronic conditions
 - 2. The frequency, severity, and source of suspected problems or concerns are evaluated. Healthcare practitioners participate in the evaluation of identified problems or concerns.
 - 3. Measures are implemented to resolve important problems or concerns that have been identified. Healthcare practitioners, as well as administrative staff, participate in the resolution of the problems or concerns that are identified.
 - 4. The problems or concerns are re-evaluated to determine objectively whether the corrective measures have achieved and sustained the desired result. If the problem remains, alternative corrective actions are taken as needed to achieve and sustain improvement.
 - 5. Through the organization's designated mechanisms, quality improvement activities are reported, as appropriate, to the proper personnel, the chief executive officer, and the governing body.
 - 6. The facility has a process in place to review key indicators in comparison with other similar organizations.
 - 7. Benchmarks used will be based on state, local, or national standards.

V. Quality Committees:

- A. Quality Improvement Committee (QIC)
 - 1. The Quality Improvement Committee (QIC) is established as a mechanism by which the CQI plan may be implemented. The QIC will generally meet monthly
 - 2. The QIC may be composed of one or more representatives from the Center's operations, such as:
 - a. Administration

- b. Business office
 - c. Pre-op and admitting
 - d. OR nursing staff
 - e. Scrub technicians
 - f. Anesthetists
 - g. Recovery room nursing staff
 - h. Medical Director, etc.
3. Members (other than *ex-officio* members) will serve for one year.
 4. The QIC will generally meet monthly, and subject to call of such special meetings as may be necessary to review particular problems or issues that may arise during the period between scheduled meetings.
 5. The purpose of the QIC is to monitor important aspects of care and to encourage communication about Center operations which will provide maximum opportunities to implement continuous quality improvement and to aid in quality assurance. The committee will review at least the following at each meeting:
 - a. All incident/occurrence reports related to patient and employee safety.
 - b. All patient evaluation cards and surveys.
 - c. All direct hospital admissions and transfers.
 - d. All complication data generated by chart review.
 - e. Medical chart audit studies (at least one per quarter).
 6. A permanent record will be kept of each meeting and these minutes will be submitted to the MEC.

B. Medical Executive Committee (MEC)

1. The Medical executive committee (MEC) will monitor and continuously review the CQI plan.
2. The MEC shall be a permanently organized committee and shall consist of the Medical Director and a representative of each medical and surgical specialty at the Center. Additional members of the MEC may be appointed as necessary. Administrator or designee may participate in the MEC and serve as a liaison between the MEC and Board, but has no voting privileges.
3. The MEC will meet at least quarterly on a regular basis, but may occasionally meet more often, if required. Members of the MEC will serve for two years and may be reappointed.
4. The responsibilities of the MEC are as follows:
 - a. To represent and act on behalf of the Medical Staff subject to such limitations as may be imposed by these By-Laws.
 - b. To receive and act upon committee reports and make necessary recommendations to the Board of Directors.

- c. To implement policies, both clinical and administrative, of the Medical Staff.
- d. To review applications for initial appointment and reappointment to Medical Staff membership and delineation of or changes to clinical privileges.
- e. To review all information available regarding the performance and clinical competence of Medical Staff members, using the results of such reviews to make recommendations for reappointments, renewal and changes in clinical privileges.
- f. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance.
- g. Insofar as it relates to the Medical Staff, to monitor and assure compliance with applicable accreditation standards.
- h. To promulgate such policies and procedures or rules and regulations as deemed necessary and appropriate for the effective provision of patient care and/or operation of the Medical Staff.
- i. To oversee the performance of the Patient Care Committee and any ad hoc committees; including, but not limited to, oversight of all quality improvement activities.

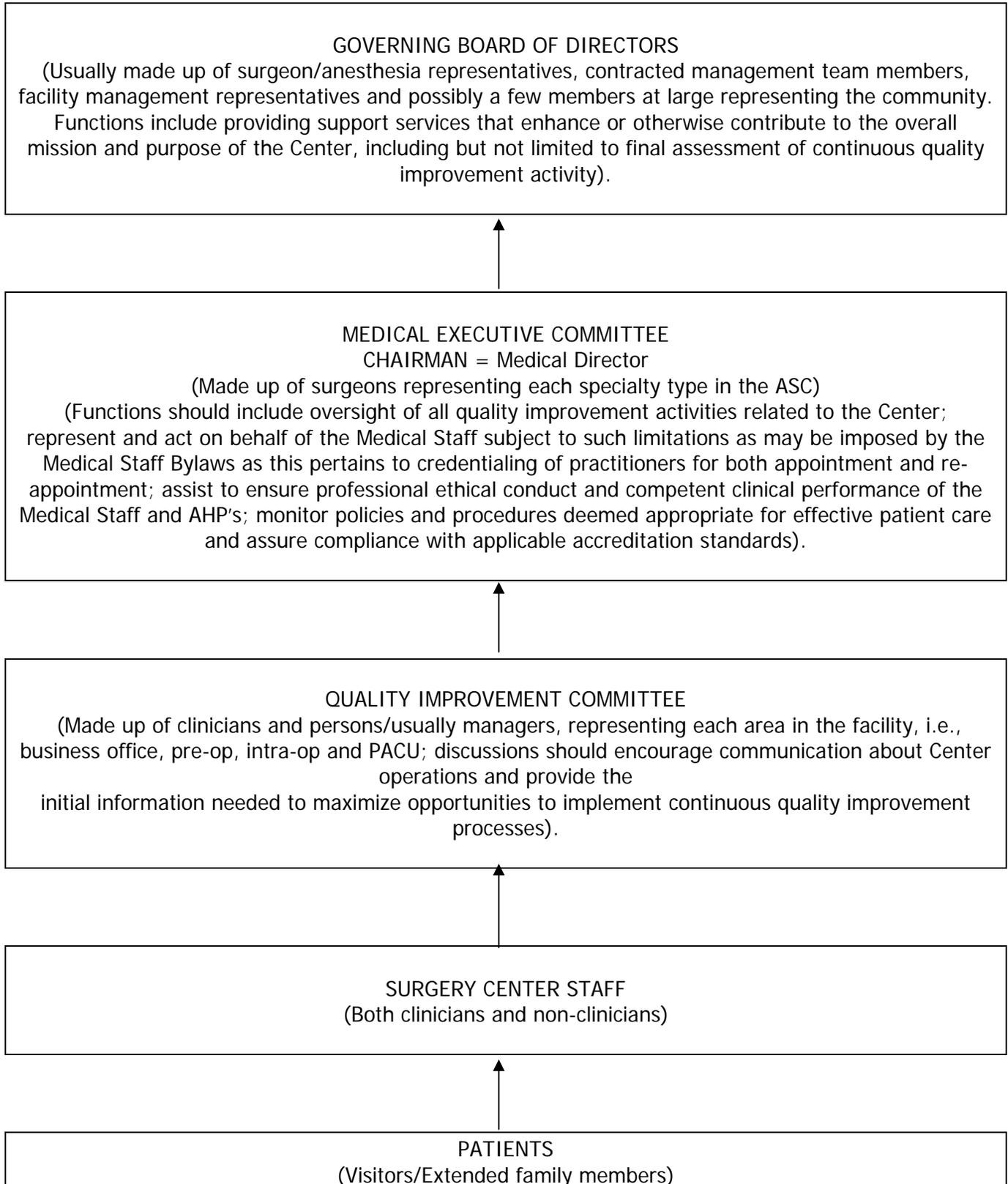
Please see attached CQI Flowchart and CQI Worksheet

Policy reviewed with:

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|--|--|--|
| <input type="checkbox"/> Pre-Op Staff | <input type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Post-Op Staff | <input checked="" type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input type="checkbox"/> Business Office Manager | | |

EXHIBIT 2.c

Continuous Quality Improvement Flowchart



Green Mountain Surgery Center

Continuous Quality Improvement
Worksheet

DATE: _____
STUDY #: _____

TYPE OF ISSUE:

CLINICAL	_____	ADMINISTRATIVE	_____
COST-OF-CARE	_____	PATIENT OUTCOME	_____

I. Problem Identified:

II. Evaluation of Problem: (address frequency, severity, and source)

III. Measures Implemented to Resolve Problem:

EXHIBIT 2.d

Communicable Disease Reporting Policy

Policy Statement

To comply with Public Health Department in reporting of communicable disease.

POLICY:

The Center's administrator or designee will notify the local and/or state Public Health Department when a patient or employee is diagnosed or suspected to have a reportable communicable disease.

PROCEDURE:

1. The states list of reportable diseases will be used for this policy.
2. The report will be filed with the local and/or state Health Department within 48 hours.
3. Forms will be provided by the Health Department.
4. The report should be initiated with a phone call to the County Health Department and followed up with completion of the reporting form.

Policy reviewed With:

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| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input type="checkbox"/> Business Office Manager | | |

Infection Control – Education and Training Policy

Policy Statement

Specific infection prevention and safety training will be provided to all medical staff members, allied health practitioners, volunteers and others as determined by management.

- Training will be required within 30-days of initial hire as part of the overall employee orientation program
- Additional training will be provided annually or more often as deemed required by management.
- Training programs will be relevant to the organization and the patient population served.
- Training programs will include risk management issues that may differ based on services offered and patients served,
- Training may be in the form of online webinars or organization-conducted in-services.
- Documentation of completed training will be maintained in the employee personnel or education file.

Refer to policy 7.07, Injury Prevention and Safety Training

Policy reviewed With:

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| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input type="checkbox"/> Business Office Manager | | |

Infection Prevention and Control and Safety Program Policy

Policy Statement

To implement and monitor a comprehensive safety / environmental control program relative to safety and sanitation that involves staff, equipment operation, and maintenance in order to provide a functional and environmentally safe atmosphere for patients, personnel, and visitors.

POLICY:

The Green Mountain Surgery Center Governing Board has designated _____ as the center's designated safety officer.

All employees will participate in implementing the safety and environmental control program of the Green Mountain Surgery Center ("Center").

1. All employees will collaborate with the Safety Officer as needs are identified.
2. There will be an annual group meeting to address safety issues.
3. The Safety Officer will be responsible for conducting the business of the Safety meeting.
4. All employees are expected to:
 - a. Implement and review policies and procedures concerning functional safety and environmental control annually.
 - b. Maintain communication with the Safety and Infection Control Officers.
 - c. Participate in the conduction of hazard surveillance including all accidents or near accidents.
 - d. Investigate all accidents and evaluate findings and recommend action. Follow up is essential to make certain that corrective action has been implemented and is appropriate.

- e. Participate in the in-service education and orientation program as they apply to new and existing employees.
 - f. Be familiar with community safety oriented agencies, especially those involved with fire and other disasters.
5. Findings of the safety meeting and recommended action will be reported to the Performance Improvement Committee.

Policy reviewed With:

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| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input type="checkbox"/> Business Office Manager | | |

Infection Control – Guidelines Policy

Policy Statement

Center practices reflect the promotion of wellness and assist in the prevention and containment of infection among patients.

Procedures

I. Employee practices:

- A. Employees must wear the approved uniform (i.e. scrub attire and should wear a lab coat when exiting the building).
- B. Employees with active infections should not have patient contact. Employees with a fever (100°F) should not report to work.
- C. Employees should wash their hands before and after patient contact, since hand washing is one of the most important methods of preventing infections.
- D. Employees may not eat or drink within the patient care areas. There is no smoking within the Surgery Center facility.

II. Infection control practices:

- A. Precautions detailed in the policy titled “Standard Precautions” should be followed. (These are in compliance with OSHA and the Bloodborne Pathogen Standards.)
- B. If a nosocomial infection is suspected following patient discharge, the patient’s physician will follow-up with patient and the Center. The Center, when notified, will take necessary action to correct potential source(s) of infection.

III. Patient precautions:

- A. Patients with known or suspected communicable diseases will not be scheduled for surgery. These patients will be rescheduled for surgery at a later date. Only the Medical Director may make exceptions.

IV. Environmental requirements:

- A. Departmental cleaning is done according to Surgery Center routine.
- B. All horizontal surfaces, except the ceiling, are cleaned daily with a facility-approved disinfecting agent. Gross soilage on the walls must be washed off immediately.
- C. Stretchers are stripped and cleaned with a facility-approved disinfecting agent between patients and washed down thoroughly each week.
- D. Freshly laundered linens are provided for each patient.

V. Supplies:

- A. Sterile supplies are furnished by the Center. Prior to using sealed sterile products, an inspection of the item for package integrity and sterility is essential. Any outdated or compromised items are considered contaminated and are not to be used.
- B. If disposable supplies are used, they are discarded after use.

VI. Surveillance of the system:

- A. The Nurse Manager will identify deficiencies through quarterly Infection Control audits and will involve a "team concept" to develop plans for corrective action.
- B. If persistent problems occur, the utilization of external resources may be required at the discretion of the Medical Director, Nurse Manager, and/or Medical Executive Committee.

Policy reviewed With:

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|--|--|--|
| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input type="checkbox"/> Business Office Manager | | |

Infection Control – General Policy Statement

Policy Statement

To reduce the probability of Center personnel transmitting communicable diseases.

Procedures

- I. Any Green Mountain Surgery Center personnel with infections must report them to the Administrator and/or Nurse Manager.
 - II. All preparation of sterile parenteral and irrigation solutions will be performed utilizing acceptable aseptic technique. Only nurses properly trained are authorized to prepare sterile products. Clinical staff will be familiar with policies regarding multiple-dose vial usage and medication outdates monitoring.
 - III. Clinical personnel shall wash their hands with soap and water following visits to patient rooms and preparing parenteral medications.
 - IV. All utensils/instruments shall be cleaned after each usage with a facility-approved agent and sterilized, if applicable.
 - V. The routine cleaning of the Surgery Center will be performed by the contracted cleaning service. The sinks and countertops will be cleaned daily. The floors will be vacuumed daily and shampooed as needed to remove spills and stains.
 - VI. Medication refrigerator temperatures throughout the Center will be checked and documented by Center personnel. Refrigerator temperature should fall within the 37-42°F range.
-

Policy reviewed With:

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| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input type="checkbox"/> Business Office Manager | | |

EXHIBIT 2.e

Cooperation with Public and Private Review Organizations Policy

PURPOSE:

Green Mountain Surgery Center (the "Center") will cooperate with all public and private review organizations.

POLICY:

The Center is committed to comply with all appropriate public and private reviews.

The Center will cooperate with all public and private review organizations, including survey preparation, entrance activities, information gathering, exit conferences and any post survey activities. The Center will designate a Team Coordinator to assist with the survey when the survey team consists of more than one surveyor.

In the event that a review organization identifies any deficiencies, the Center shall implement any needed corrections as soon as possible and shall maintain records of noted deficiencies and steps taken to correct them.

Policy reviewed with:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input type="checkbox"/> Business Office Manager | | |

EXHIBIT 2.f

Facility Plan for Patient Care Policy

Policy Statement

Green Mountain Surgery Center (the "Center") philosophy is that the Center can best maintain a community-based, family-oriented, consistently high level of service through a customer focus where we continually strive to understand and exceed the expectations of our customers. This focus is enabled through instituting best practices protocols, effective communication systems, staff education, team building, process improvement, work design and an empowered work force.

POLICY:

I. PHILOSOPHY OF PATIENT CARE SERVICES:

As a premier provider of community-based, family-oriented healthcare, this organization believes it can best maintain this level of service through a customer focus where we continually strive to understand and exceed the expectations of our customers. This focus is enabled through instituting best practices protocols, effective communication systems, staff education, team building, process improvement, work design and an empowered work force.

- A. In collaboration with the community, this organization will provide customer-focused care and service through:
1. A mission statement, which serves as a foundation for planning.
 2. Long-range strategic planning with facility leadership.
 3. Establishment of core values which guide employee behavior. The organization will support personnel relations, which foster growth, encourage innovation and support teamwork. The facility recognizes the relationship between positive personnel relations and its ability to achieve the organization's objectives and will pursue the means to strengthen and enhance this association.
 4. Provision of services that are appropriate to the scope and level required by the patient population to be served.
 5. Ongoing evaluation of services provided, through performance improvement activities.
 6. Integration of services through a variety of mechanisms (i.e., Performance Improvement Committee, informational meetings, staff meetings, and employee education).
 7. Priority focus on patient relations, their interests, needs and expectations.
 8. Recognition of the need to be a responsible member of the community through contribution toward the quality of life by means of activities, services and involvement with the community. This organization is committed to supporting or initiating efforts concerned with the health of the community.

II. DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT:

Patient services at this organization are provided through an organized and systematic process designed to ensure the delivery of safe, effective and timely care and treatment in an atmosphere that promotes respect and caring. The provision of patient care delivery requires specialized knowledge, judgment and skill derived from the principles of physical, biological, behavioral, psychosocial and mental sciences. As such, patient services will be planned, coordinated and provided, delegated and supervised by professional healthcare providers. A registered nurse will assess each patient's need for nursing care in all settings in which nursing care is to be provided. Patient care encompasses the recognition of disease and health, patient education and advocacy, recognizing the unique physical, emotional and spiritual needs of each person. A cohesive unit is formed with the facility's administrative leaders, medical staff, nursing staff and other healthcare professionals functioning collaboratively as a multidisciplinary team to achieve positive patient outcomes.

- A. Patient Services - Limited to those that have direct contact with patients.
- B. Patient Care - Provided by those professionals who are also charged with patient assessment and planning.
- C. Patient Support - Provided by a variety of individuals who may not have direct contact with the patients, but who support the individuals providing direct patient care through their collaboration and interaction with direct patient care providers.
- D. Patient Service Departments:
 - Registration
 - Business Office
 - Central Services
 - Data Processing
 - Infection Control
 - Materials Management
 - Medical Record
 - Plant Services

III. STANDARDS OF PATIENT CARE:

The patients at this organization can expect to receive the following:

- A. The appropriate procedures, treatments, interventions and care will be provided according to the established policies, procedures and protocols which have been developed to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions and care provided will be demonstrated based on patient assessments/reassessments, practice and desired outcomes, with respect to patient rights and confidentiality.
- B. Systems and services for care delivery (assessments, procedures, treatments and interventions), which will be designed, implemented and evaluated consistent with a customer focused philosophy, that will be demonstrated through:
 - 1. An attitude of compassion, respect and dignity for each individual without bias;

2. A manner that best meets the individualized needs of the patient population;
3. Efficiency based on the individualized needs of the patients;
4. Coordination through multidisciplinary team collaboration, to ensure continuity and seamless delivery of care to the greatest extent possible;
5. Efficient use of the facility's financial and human resources.

IV. SCOPE OF SERVICES PROVIDED:

The population utilizing healthcare services of this organization consists primarily of adults and is limited to non-emergent surgeries and procedures that allow for patient discharge within 23 hours of admission.

V. STAFFING PLANS:

Staffing plans for patient care service department will be developed based on the level and scope of care that needs to be provided, the frequency of the care to be provided and a determination of the level of staff who can most appropriately provide the type of care needed. Staffing plans are specific and developed to address the needs of the organization's patient population.

VI. QUALITY CONTROL and PERFORMANCE IMPROVEMENT COMMITTEE ACTIVITIES:

All staff members will be responsible for participating in the facility's Performance Improvement program. Components of this program are:

- A. Quality Control
- B. Performance Improvement

VII. SUPPORT SERVICES:

Other facility services will be available and provided to ensure that direct patient care and services are maintained in an uninterrupted and continuous manner by coordinated, identified organizational functions such as leadership/management, information systems, environmental care, infection control and performance improvement. These services support the comfort and safety of the patient and the efficiency of services available and are fully integrated with the patient service departments of the facility.

VIII. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES:

- A. The importance of a collaborative multidisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. Open lines of communication exist between all departments providing patient care, patient services and support services within the facility and, as appropriate, with community agencies, to ensure provision of patient care that is effective, efficient and rendered at the same level to the entire patient population.

- B. To facilitate effective departmental relationships, problem-solving is encouraged at every level of the organization. Organizational administration maintains an “open-door” policy which serves as a model for all personnel to openly and constructively discuss issues and seek mutually acceptable solutions. Administrators and Managers have the authority to mutually solve problems and seek solutions within their sphere of influence. Positive interdepartmental communications are a strong part of the customer focus philosophy.

IX. LEADERSHIP RESPONSIBILITIES:

Organizational leadership is defined as the Governing Board, MEC, Administrator, administrative staff, departmental leaders and medical staff, in appointed or designated leadership positions, and is responsible for:

- A. Providing a framework for planning healthcare services provided by the facility, based on the organization's mission, and for developing and implementing an effective planning process. The planning process includes an assessment of customer and community needs, defining a strategic plan, establishing annual operating and capital budgets and an ongoing evaluation of each. The planning process minimally addresses:
 - 1. Patient care functions:
 - a. Access
 - b. Treatment
 - c. Patient rights
 - d. Patient teaching
 - e. Discharge planning
 - f. Assessment
 - g. Pain management
 - 2. Organizational support functions:
 - a. Information systems
 - b. Infection control
 - c. Safety management
 - d. Environment
 - e. Quality Assessment Performance Improvement program
- B. Ensuring collaboration with community leaders and organizations to design services to be provided by the facility which are appropriate to the scope and level of care required by the patients served.
- C. Ensuring communication of the facility's mission, vision and values across the organization.
- D. Ensuring uniform delivery of patient care services provided throughout the organization.
- E. Providing appropriate personnel development and continuing education opportunities, which serve to promote retention of staff and foster excellence in care delivery and support services. Encouraging personnel to take an active part in responsibility for their own growth and educational development.
- F. Ensuring appropriate direction, management and leadership of all services and departments.

- G. Ensuring that systems are in place, which promotes the integration of services, to support the patient's continuum of care needs.
- H. Ensuring staffing resources are available to appropriately meet the needs of the patients served.
- I. Ensuring staffing resources and the physical environment fosters the provision of patient safety.
- J. Appointing appropriate committees, task forces and other forums to ensure collaboration on issues of mutual concern, which would benefit from a multidisciplinary effort.
- K. Involving clinical managers in evaluating, planning and recommending annual expense and capital objectives and expense budgets based on the expected resource needs of their departments. Clinical managers are held accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to, identifying, investigating and budgeting for new technologies which can be expected to improve the delivery of patient care and services.

X. STAFF COMPETENCY:

Requirements for staff will vary in each area, based on the scope of service and will include:

- A. Legal requirements
- B. Facility requirements for proof of competency
- C. Educational requirements

XI. ASSESSMENT:

As early as possible in the care of the patient, the needs of the patient are identified. Identifying the needs of the patient and the system of communication used, to see that the proper staff is assigned to provide proper treatment, will be outlined in each department's written performance improvement plan.

XII. ANNUAL REVIEW:

Annual review of the plan for care will be conducted with revisions as necessary. Ongoing reviews will be made to:

- A. Meet changing patient care needs or findings;
- B. Consider the department and facility's ability to attract and develop appropriate staff;
- C. React to relevant information from staffing variance reports;
- D. React to performance improvement, risk management, information needs and other evaluation activities;
- E. Assure a comparable level of care as provided to patients no matter where they are in the facility;
- F. Improve care through education and innovation of new systems.

Policy reviewed with:

Pre-Op Staff

Post-Op Staff

PACU Staff

Business Office Manager

All Employees

All Clinical Staff

All Business Office Staff

Nurse Manager

Medical Director

Administrator

EXHIBIT 3

INITIAL PROCEDURE LIST

Anesthesia

Anesthesia, General Inhalation

Anesthesia, General Intravenous

Anesthesia, Local

Anesthesia, Regional Anesthesia

 Spinal

 Caudal

 Epidural

 Intravenous

Anesthesia, Topical

Monitored Anesthesia Care (MAC)

Nerve Blocks

 Axillary

 Bier

 Interscalene

 Femoral

 Sciatic

 Popliteal Fossa

Supervision of Anesthesia

INITIAL PROCEDURE LIST (continued)

Gastro-Intestinal (Highest level of anesthesia: General)

Anesthesia, Local
Anesthesia, Topical
Colonoscopy
Colonoscopy with biopsy
Colonoscopy with dilatation
Colonoscopy with polypectomy
Conscious Sedation
Duodenal or gastric biopsy
Duodenoscopy
Esophagogastroduodenoscopy with or without biopsy, with or without dilation.
Endoscopic sphincterotomy
Esophageal Biopsy
Esophageal Polypectomy
Esophagoscopy
Gastrosocopy
Gastrosocopy tube insertion/removal
PEG tube insertion/removal
Paracentesis
Polypectomy
Proctoscopy
Sigmoidoscopy flexible or rigid
Sigmoidoscopy with or without biopsy or polypectomy
Small Intestine biopsy via endoscope
Supervision of Anesthesia

INITIAL PROCEDURE LIST (continued)

Orthopedics (Highest level of Anesthesia for all procedures: General)

Amputations- toes, fingers, thumb
Anesthesia, Local
Anesthesia, Topical
Anterior Cruciate Ligament (repair or replacement)
Arthrocentesis
Arthrodosis-wrist, hand, ankle, foot
Arthroscopic Surgery (diagnostic, therapeutic)
 Ankle
 Elbow
 Hip
 Knee
 Shoulder
 Wrist
Arthrotomy, Meniscectomy
Bone Cyst Excision
Bone fusion
Bone Graft
Bursectomy
Callus Excision
Carpal Tunnel decompression- Open
Carpal Tunnel decompression- Endoscopic
Cast Application
Cast Change w/wo manipulation
Cast Removal
Closed Reduction w/wo x-ray
Closed reduction of fractures-phalanges, toes, clavicle, ribs, upper and lower extremities
Condylectomy
Conscious Sedation
Corn Excision
Debridement soft tissue
DeQuervain's release
Excision of Mass/Skin lesions
Exostosis Excision
Fasciotomy/Fasciectomy
Finger joint replacement
Fusion of joints, hand, foot, ankle, wrist
Flexor tendon repairs
Ganglion excision, excision of synovial cyst or tissue
Grafts-split and full thickness skin graft
 Tendon
Hammer toe
Hand Surgery
Injection of tendon sheath, ligaments, trigger points, or bursa
Insertion of prosthetic replacement of bones or joints, (hands and feet only)
Joint Manipulation
Joint Resection
Metatarsal Head Excision
Morton's Neuroma

Muscle Biopsy, Bone Marrow

Nail Removal

Nerve Blocks:

 Caudal

 Celiac

 Epidural

 Intercostal

 Lumbar

 Stellate

Nerve Decompression

Nerve Repair

Neurolysis

Orthopedic Hardware Placement, Removal

Osteotomy, arthroplasty

Reconstruction of hand

Release of joint contracture

Removal foreign body

Repair congenital lesions of foot and fingers

Repair of tendon

Rotator cuff repair

Supervision of Anesthesia

Tendon graft, Tendon slide procedure

Tenotomy/tenolysis-upper and lower extremities

Trigger finger/thumb release

Open Fractures and Dislocations

 Ankle fractures-ORIF

 Calcaneous-pinning

 Clavicle, shoulder, upper extremities

 Elbow

 Forearm

 Lower extremity fractures

 Metacarpal and phalanges

 Metatarsal and Phalanges-ORIF and pinning

 Navicular-pinning

 Patella dislocations and fractures-ORIF

 Reconstruction of AC Joint

 Shoulder dislocations and fractures-ORIF

 Talus pinning

 Tibial and fibular dislocations and fractures (casting)

INITIAL PROCEDURE LIST (continued)

General Surgery (Highest level of Anesthesia for all procedures: General)

Anesthesia, Local
Anesthesia, Topical
Appendectomy
Axillary node aspiration, biopsy or excision
Biopsy of peritoneum or omentum
Bone Marrow Biopsy
Breast Biopsy
Bronchoscopy
Chest tube insertion
Colon resection or biopsy of
Colonoscopy with or without biopsy
Conscious Sedation
Cryohemorrhoidectomy, anal condylomata cryo-surgery
Debridements
EGD with or without biopsy
Electrocautery anal condylomata
Exam under anesthesia
Excision Gynecomastia
Excision, I & D, repair mouth, tongue, lips, nose, throat, auricle
Excisional Biopsy, tumor, mass lesion, cyst, lymph node, verruca, lipoma
Fistulotomy/Fissurectomy/Fistulectomy
Foreign body Excision with or without z-ray
Frenotomy, frenectomy
Ganglion Excision
Grafts-split thickness skin graft
Hematoma drainage
Hemorrhoidectomy
Herniorrhaphy adult or pediatric, femoral, umbilical, ventral, inguinal
Incision and drainage of abscess
Laparoscopic cholecystectomy
Laparoscopic hernia repair
Laser assisted procedures
Liver biopsy
Muscle biopsy
Parotidectomy
 Pedicule
PEG tube insertion or replacement
Peritoneal Lavage, Paracentesis
Pilonidal Cystectomy
Porta Cath insertion
Rectal dilation
Rectal Polypectomy
Sigmoidoscopy, rigid or flexible
Simple Mastectomy
Sinus Tract Excision
Stump Revision
Supervision of Anesthesia
Temporal artery biopsy

Thoracentesis
Thyroidectomy
Tracheotomy,
Varicocelectomy
Varicose vein ligation w/without stripping
Vein sclerotherapy
Wound closure, secondary

INITIAL PROCEDURE LIST (continued)

Gynecology (Highest level of Anesthesia for all procedures: General)

Amniocentesis
Anesthesia, Local
Anesthesia, Topical
Appendectomy
Biopsy of ovary
Biopsy of perineum
Cervical Cerclage
Cervical Conization (cold knife, Laser, Leetz)
Colposcopy
Colpotomy
Conscious Sedation
Cryotherapy
Culdocentesis
Cyst excision, perineum
Cystocele Repair
Destruction of condylomata
Dilation and Curettage
Drainage pelvic abscess
Endometrial ablation
Endometrial biopsy
Episiotomy revision
Examination under Anesthesia
Excision of cervical stump
Excision of Lesion vulva, vagina or perineum
Exploratory Laparotomy
Hymenectomy/Hymenotomy
Hysterosalpingogram
Hysteroscopy
Incision and Drainage Abscess
Laparoscopy assisted vaginal hysterectomy
Laparoscopy Diagnostic
Laparoscopy with fulguration of endometriosis
Laparoscopy with lysis of adhesions
Laparoscopy with removal of adnexa
Laparoscopy with treatment of ectopic
LEEP
Marsupialization of Bartholin's gland or cyst Revision of
Mini Laprotomy
Oophorectomy/Salpingectomy
Polypectomy
Rectocele Repair
Suction Dilation and Curettage
Supervision of Anesthesia
Uterine suspension
Vaginal Biopsy
Vaginal Hysterectomy
Vaginal or Uterine Packing
Vaginal Stenosis, Release
Vaginal Suturing

Vaginal Web Excision

Vaginoplasty

Vulvar Biopsy

Vulvar Lesion Excision

Lap tubal Ligation/Fulguration

Tubal Re-anastomosis

All hysteroscopic procedures including hysteroscopic placement of tubal occlusion device

INITIAL PROCEDURE LIST (continued)

Pain Management

Nerve block: peripheral, nerves without catheters, neurolytic, facet, selective nerve, intravenous regional sympathetic nerve

Neurolysis: epidural, subarachnoid, peripheral

Percutaneous caudal decompression

Flouro and CT-guidance with or without contrast injection

Facet blocks

Spinal Cord Stimulation Trial

Epidural injection: cervical, thoracic, lumbar, caudal, transforaminal

EXHIBIT 4

This checklist summarizes and references the applicable requirements from the 2014 Edition of the FGI Guidelines for Design and Construction of Hospitals and Outpatient Facilities.

In addition, the ASC will comply with the following regulations and codes as applicable:

- NFPA 101 Life Safety Code (2000)
- Joint Commission on the Accreditation of Health Care Organizations
- CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities
- Accessibility Guidelines of the Americans with Disabilities Act (ADA)

'Y' signifies that the requirements have been met

OUTPATIENT SURGICAL FACILITIES

Ref.	Architectural Requirements	Building Systems Requirements	Table
3.1-1.2.2	PATIENT PRIVACY:		
	<u>Y</u> Each facility design ensures appropriate levels of patient acoustic & visual privacy & dignity throughout care process		
3.1-1.2.3	SHARED/PURCHASED SERVICES: NOT IN PROJECT		
3.7-1.3.2	PARKING		
3.7-1.3.2.1	<u>Y</u> At least 4 parking spaces for each room routinely used for surgical procedures <u>Y</u> At least 1 space for each staff member		
3.7-1.3.2.2	<u>Y</u> Parking space designated for pickup of patients after recovery		
3.1-1.3.3	ENTRANCE:		
	<u>Y</u> At grade level <u>Y</u> Clearly marked <u>Y</u> Located so patients need not go through other activity areas (public lobbies may be shared)		
3.7-1.3.3	LOCATION & LAYOUT		
3.7-1.3.3.1	<u>Y</u> Surgical suite located & arranged to prevent unrelated traffic through suite		
3.7-1.3.3.2	<u>Y</u> Patient care area designed to facilitate movement of patients & personnel into, through & out of defined areas in surgical suite		
3.7-1.3.3.3	<u>Y</u> Signs clearly indicate where surgical attire is required at all entrances to semi-restricted areas		
3.7-1.3.3.4	<u>Y</u> Outpatient surgical facility divided into three designated areas unrestricted, semi-restricted & restricted		
3.7-3	DIAGNOSTIC & TREATMENT AREAS		
3.7-3.2	___ Procedure room (formerly Class "A" Operating Room) NOT PROVIDED		
3.7-3.3	<u>Y</u> Outpatient operating rooms (formerly Class "B" & "C" Operating Rooms)		
3.7-3.3.1	Space Requirements:	Ventilation:	
3.7-3.3.1.1	<u>Y</u> min. clear floor area 250 sf <u>Y</u> min. clear dimension 15'-0" between fixed cabinets & built-in shelves	<u>Y</u> Min. 20 air changes per hour <u>Y</u> No recirculating room units <u>Y</u> Positive pressure to all adjoining spaces	Table 7.1 4/7.4.1
3.7-3.3.3 3.7-3.3.4	<u>Y</u> documentation area <u>Y</u> image viewer access from each operating room	<u>Y</u> Airflow unidirectional, downwards & average velocity of diffusers 25-35 cfm/ft ² <u>Y</u> Diffusers concentrated to provide airflow pattern over patient & surgical team <u>Y</u> Area of primary supply diffuser	

Ref.	Architectural Requirements	Building Systems Requirements	Table
		array extends min. 12” beyond footprint of surgical table on each side <u>Y</u> No more than 30% of primary supply diffuser array area used for ceiling mounted equipment	
		<u>Y</u> At least 2 low sidewall return or exhaust grilles on opposite corners or as far apart as possible, with bottom of these grilles installed approximately 8” above floor	
		Power: <u>Y</u> 18 receptacles <u>Y</u> 12 receptacles convenient to operating table <u>Y</u> 2 receptacles on each wall	Table 3.1-1
		Nurse Call System: <u>Y</u> Emergency staff assistance station	Table 3.1-2
		Medical Gases: <u>Y</u> 2 OX, 3 VAC <u>Y</u> 1 MA	Table 3.1-3
3.7-3.4.2	PREOPERATIVE PATIENT CARE AREA		
3.7-3.4.2.1 (1) (2) (a)(c) (b) (3)	Application: <u>Y</u> accommodates patients on stretchers <u>Y</u> accommodates seating space for patients & visitors Location: <u>Y</u> unrestricted area (may be part of Phase II recovery area) <u>Y</u> under direct visual control of nursing staff <u>Y</u> min. one patient care station per operating room		
3.7-3.4.2.2	Space Requirements: <u>Y</u> patient cubicles		
	<u>Y</u> min. clear floor area 80 sf <u>Y</u> min. clearance 3’-0” between sides & foot of lounge chairs/stretchers & adjacent walls or partitions		
3.7-3.4.2.4	<u>Y</u> Provisions for patient privacy such as cubicle curtains		
3.7-3.4.2.5	Handwashing stations:		
3.1-3.6.5.1	___ located in each room where hands-on patient care is provided NOT PROVIDED		
3.1-3.6.5.3	Handwashing Stations Serving Multiple Patient Care Stations:		
(1)	<u>Y</u> min. 1 handwashing station for every 4 patient care stations or fewer & for each major fraction thereof		

Ref.	Architectural Requirements	Building Systems Requirements	Table
(2)	<u>Y</u> evenly distributed & provide uniform distance from two patient care stations farthest from handwashing station		
3.7-3.4.3	POSTOPERATIVE RECOVERY AREAS		
3.7-3.4.3.1 (1) (a)	<u>Y</u> Phase I post-anesthesia recovery room Location: <u>Y</u> unrestricted area <u>Y</u> at least one door to the recovery room provides access directly from the semi-restricted area the surgical suite without crossing a public corridor		
(b)	Size: <u>Y</u> min. ratio 1.5 recovery patient care stations per operating room		
(2) (a) (b)	Space Requirements: <u>Y</u> min. clear floor area 80 sf for each patient bay or cubicle <u>Y</u> min. clearance 5'-0" between patient stretchers or beds <u>Y</u> min. clearance 4'-0" between patient stretchers or beds & adjacent walls or other fixed elements (at sides & foot) <u>Y</u> min. clearance 3'-0" from the foot of the stretcher or bed to curtain	Ventilation: <u>Y</u> Min. 6 air changes per hour <u>Y</u> No recirculating room units Power: <u>Y</u> 8 receptacles convenient to head of stretcher Nurse Call System: <u>Y</u> Emergency staff assistance station <u>Y</u> Code call station Medical Gases: <u>Y</u> 1 OX, 1 VAC	Table 7.1 Table 3.1-1 Table 3.1-2
(4)	<u>Y</u> provisions for patient privacy such as cubicle curtains		Table 3.1-3
(5)	<u>Y</u> handwashing stations		
3.1-3.6.5.1	<u> </u> located in each room where hands-on patient care is provided NOT PROVIDED		
3.1-3.6.5.3	Handwashing Stations Serving Multiple Patient Care Stations:		
(1)	<u>Y</u> min. 1 handwashing station for every 4 patient care stations or fewer & for each major fraction thereof		
(2)	<u>Y</u> evenly distributed & provide uniform distance from two patient care stations farthest from handwashing station		
3.7-3.4.3.2	<u> </u> Phase II recovery area NOT PROVIDED		
3.7-3.5.2	SUPPORT AREAS FOR PREOPERATIVE & POSTOPERATIVE PATIENT CARE AREAS		
3.7-3.5.2.1	<u>Y</u> Directly accessible to patient care areas served		
3.7-3.5.2.3 (1) (2)	<u>Y</u> Nurse station with documentation space <u>Y</u> Clinical sink (may be located in soiled workroom if directly accessible to recovery areas)		

Ref.	Architectural Requirements	Building Systems Requirements	Table
(3)	<u>Y</u> Nourishment facilities		
3.1-3.6.7 (1)	<u>Y</u> handwashing station located in or directly accessible	Ventilation: <u>Y</u> Min. 2 air changes per hour	Table 7.1
(2) (3)(4)(5)	<u> </u> food preparation (meals are not prepared in nourishment area)		
3.7-3.5.2.3(4)	<u>Y</u> Provisions for soiled linen & waste holding		
3.7-3.5.3	SUPPORT AREAS FOR STAFF		
	<u>Y</u> Staff toilet located within recovery areas	Ventilation: <u>Y</u> Min. 10 air changes per hour <u>Y</u> Exhaust	Table 7.1
3.7-3.5.4	SUPPORT AREAS FOR PATIENTS		
3.7-3.5.4.1	<u>Y</u> Dedicated patient toilet room accessible from preoperative & recovery areas without entering public spaces	Ventilation: <u>Y</u> Min. 10 air changes per hour <u>Y</u> Exhaust	Table 7.1
3.7-3.6	SUPPORT AREAS FOR SURGICAL SUITE		
3.7-3.6.1	<u>Y</u> Nurse or control Station		
3.7-3.6.1.1	<u>Y</u> located at point of primary ingress (in unrestricted or semi-restricted area)		
3.7-3.6.1.2	<u>Y</u> direct visual observation of all traffic into suite <u>Y</u> Controlled access through all other entries		
3.7-3.6.5	<u>Y</u> Hand scrub facilities		
3.1-3.3.1	<u>Y</u> at least one hand scrub position located next to entrance to each operating or procedure room		
3.1-3.3.2	<u>Y</u> one hand scrub station consisting of 2 scrub positions permitted to serve 2 procedure or operating rooms if located next to entrance of each procedure or operating room		
3.1-3.3.3	<u>Y</u> placement of scrub station does not restrict minimum required corridor width		
3.7-3.6.6	<u>Y</u> Medication safety zones		
3.1-3.6.6.1 (2)	<u>Y</u> self-contained medication dispensing units		
(a)	<u>Y</u> located at nurse station, in clean workroom or in an alcove <u>Y</u> lockable unit to secure controlled drugs		
(b)	<u>Y</u> handwashing station or hand sanitation located next to stationary medication-dispensing units		
3.7-3.6.8	<u>Y</u> Ice-making equipment		
	<u>Y</u> located in unrestricted area		
3.7-3.6.9	<u>Y</u> Clean supply room		
3.7-3.6.9.1	<u>Y</u> storage space for sterile & clean supplies		
3.7-3.6.9.2 (1)	<u>Y</u> separate from soiled storage rooms	Ventilation: <u>Y</u> Min. 4 air changes per hour	Table 7.1

Ref.	Architectural Requirements	Building Systems Requirements	Table
(2)	<u>Y</u> entrance from semi-restricted area	<u>Y</u> Positive pressure	
3.7-3.6.10	<u>Y</u> Soiled workroom or soiled holding room		
3.7-3.6.10.1			
(3)	<u>Y</u> directly accessible to semi-restricted area surgical suite (may also be accessible from unrestricted area)		
(4)			
(5)	<u>Y</u> no direct connection with operating rooms or other sterile activity rooms		
3.7-3.6.10.2	<u>Y</u> soiled workroom	Ventilation:	
(1)	<u>Y</u> flushing-rim clinical sink or equivalent flushing-rim fixture	<u>Y</u> Min. 10 air changes per hour	Table 7.1
(2)	<u>Y</u> handwashing station	<u>Y</u> Exhaust	
(3)	<u>Y</u> work counter	<u>Y</u> Negative pressure	
(4)	<u>Y</u> space for waste receptacles		
(5)	<u>Y</u> space for soiled linen receptacles		
3.7-3.6.10.3	<u>Y</u> storage for supplies		
	___ soiled holding room NOT PROVIDED		
	___ handwashing station	Ventilation:	Table 7.1
	___ space for waste receptacles	___ Min. 10 air changes per hour	
	___ space for soiled linen receptacles	___ Exhaust	
	___ storage for supplies	___ Negative pressure	
	___ provisions for disposal of liquid waste		
3.7-3.6.11.2	<u>Y</u> Surgical equipment & supply storage		
(1)	<u>Y</u> combined area equipment & clean clinical supply storage rooms min. floor area 50 sf for each OR up to two OR's + 25 sf per additional OR		
(2)			
(a)	<u>Y</u> located in semi-restricted area (may be part of clean assembly/workroom)		
(b)			
3.7-3.6.11.3(1)	<u>Y</u> Stretcher storage area for at least one stretcher		
3.7-3.6.11.3(2)	<u>Y</u> Wheelchair storage space		
	<u>Y</u> immediately accessible to areas of high use		
3.1-3.6.11.3(1)	<u>Y</u> located out of required corridor width		
3.1-3.6.11.3(2)	<u>Y</u> Designated area for wheelchair parking		
	<u>Y</u> located in non-public area		
	<u>Y</u> located out of any required egress width or other required clearance		
3.7-3.6.11.4	<u>Y</u> Emergency equipment storage in surgical suite (may be a portion of surgical equipment & supply storage)		
	<u>Y</u> Emergency equipment storage in recovery areas		
3.1-3.6.11.4(2)	<u>Y</u> readily accessible		
	<u>Y</u> under staff control		
3.7-3.6.11.5	<u>Y</u> Medical gas storage (including space for reserve cylinders)		
3.7-3.6.12	<u>Y</u> Environmental services room		
3.7-3.6.12.1	<u>Y</u> located in surgery suite & not shared		

Ref.	Architectural Requirements	Building Systems Requirements	Table
	with other areas		
3.7-3.6.12.2	<u>Y</u> accessed from semi-restricted corridor		
3.1-5.5.1.2 (1) (2) (3)	<u>Y</u> service sink or floor-mounted mop sink <u>Y</u> provisions for storage of supplies & housekeeping equipment <u>Y</u> handwashing station or hand sanitation dispenser	Ventilation: <u>Y</u> Min. 10 air changes per hour <u>Y</u> Exhaust <u>Y</u> Negative pressure	Table 7.1
3.7-3.6.14	<u>Y</u> Fluid waste disposal facilities		
3.7-3.6.14.1	<u>Y</u> clinical sink or equivalent equipment in soiled workroom serving operating rooms		
3.7-3.6.14.2	<u>Y</u> toilet equipped with bedpan-cleaning device or separate clinical sink in recovery area		
3.7-3.6.15	___ Storage for blood, organs & pathological specimens NOT PROVIDED		
3.7-3.7	SUPPORT AREAS FOR STAFF		
3.7-3.7.1	<u>Y</u> Staff lounge		
3.7-3.7.2	<u>Y</u> Staff changing area & toilet facilities		
3.7-3.7.2.1 (1) (2) (3) (4) (5)	<u>Y</u> lockers <u>Y</u> toilets <u>Y</u> handwashing stations <u>Y</u> space for donning surgical attire <u>Y</u> provision for separate storage for clean & soiled surgical attire		
3.7-3.7.2.2	<u>Y</u> located in/unrestricted area		
3.7-3.7.3	<u>Y</u> Staff shower		
	<u>Y</u> readily accessible to surgical suite & recovery areas	Ventilation: <u>Y</u> Min. 10 air changes per hour <u>Y</u> Exhaust	Table 7.1
3.7-3.8	SUPPORT AREAS FOR PATIENTS		
3.7-3.8.1	<u>Y</u> Patient changing & preparation area (may be combined with preop patient care area)		
3.7-3.8.1.1 (3) (a) (b) (c) (d)	<u>Y</u> Space for patients to change from street clothing into hospital gowns & to prepare for surgery <u>Y</u> place or method of storage for patient clothing <u>Y</u> access to toilet room without passing through public space <u>Y</u> clothing change or gowning area <u>Y</u> space for administering medications		
3.7-3.8.1.2	<u>Y</u> Provisions made for securing patients' personal effects		
3.7-3.8.2	<u>Y</u> Patient toilet room		

Ref.	Architectural Requirements	Building Systems Requirements	Table
3.7-3.8.2.1	<u>Y</u> separate from public use toilet <u>Y</u> located for access from pre-operative & post-operative patient care areas	Ventilation: <u>Y</u> Min. 10 air changes per hour <u>Y</u> Exhaust	Table 7.1
3.7-5	GENERAL SUPPORT FACILITIES		
3.7-5.1	<u>Y</u> Sterilization facilities - on-site sterile processing room		
3.7-3.6.13	On-Site Sterile Processing Room:		
3.7-3.6.13.1 (1)	<u>Y</u> consists of decontamination area & clean work area		
(2)	Location: <u>Y</u> designed to provide one-way traffic pattern of contaminated materials/instruments to clean materials/instruments to sterilizer equipment		
(a)	<u>Y</u> entrance to contaminated side of sterile processing room from semi-restricted area		
(b)	<u>Y</u> exit from clean side of sterile processing room to semi-restricted area or to operating room (may be shared between two or more OR's)		
(3)			
3.7-3.6.13.2 (1)	<u>Y</u> decontamination area	Ventilation: <u>Y</u> Min. 6 air changes per hour	Table 7.1
(a)	<u>Y</u> countertop	<u>Y</u> Negative pressure	
(b)	<u>Y</u> handwashing station <u>Y</u> separate from instrument-washing sink	<u>Y</u> Exhaust <u>Y</u> No room recirculating units	
(c)	<u>Y</u> sink for washing instruments		
(d)	<u>Y</u> storage for supplies		
(2)	<u>Y</u> min. 4'-0" distance from edge of decontamination sink to clean work area		
3.7-3.6.13.3 (1)	<u>Y</u> clean work area <u>Y</u> countertop	Ventilation: <u>Y</u> Min. 4 air changes per hour	Table 7.1
(2)	<u>Y</u> sterilizer	<u>Y</u> Positive pressure	
(3)	<u>Y</u> handwashing station	<u>Y</u> No room recirculating units	
(4)	<u>Y</u> built-in storage for supplies		
3.7-5.2	<u>Y</u> Linen services		
3.7-5.2.1	<u>Y</u> clean linen storage		
3.7-5.2.2	<u>Y</u> soiled linen holding		
3.7-5.5	<u>Y</u> Environmental services room		
3.1-5.5.1.1	<u>Y</u> min. one ES room per floor		
3.1-5.5.1.2 (1)	<u>Y</u> service sink or floor-mounted mop sink	Ventilation: <u>Y</u> Min. 10 air changes per hour	Table 7.1
(2)	<u>Y</u> provisions for storage of supplies & housekeeping equipment	<u>Y</u> Exhaust	
(3)	<u>Y</u> handwashing station or hand sanitation dispenser	<u>Y</u> Negative pressure	
3.7-5.5.1.2	<u> </u> Fluid waste management system NOT PROVIDED		

Ref.	Architectural Requirements	Building Systems Requirements	Table
3.7-6.2	PUBLIC AREAS		
3.1-6.2.1	<u>Y</u> Vehicular drop-off & pedestrian entrance		
3.7-6.2.1	<u>Y</u> Min. one drop-off area or entrance reachable from grade level		
3.1-6.2.2	<u>Y</u> Reception & information counter, desk, or kiosk		
3.1-6.2.3	<u>Y</u> Waiting space		
3.1-6.2.4	<u>Y</u> Public toilets (may be located off public corridor in multi-tenant building)		
3.1-6.2.4.1	<u>Y</u> readily accessible from waiting area without passing through patient care or staff work areas	Ventilation: <u>Y</u> Min. 10 air changes per hour <u>Y</u> Exhaust	Table 7.1
	<u>Y</u> Local telephone access		
3.1-6.2.5	<u>Y</u> Provisions for drinking water		
3.1-6.2.6	<u>Y</u> Wheelchair storage		
3.7-6.3	ADMINISTRATIVE AREAS		
3.7-6.3.2	<u>Y</u> Interview space for private interviews relating to admission (may be shared with office, multipurpose, or consultation room)		
	<u>Y</u> separate from public & patient care areas		
3.7-6.3.3	<u>Y</u> Office space		
3.7-6.3.4	<u>Y</u> Multipurpose or consultation room		
3.7-6.3.4.1	<u>Y</u> located in unrestricted area		
3.7-6.3.5	<u>Y</u> Medical records		
3.1-6.3.5.1	<u>Y</u> restricted to staff access		
3.1-3.6.11.3 (1)	Wheelchair Storage & Parking Space: <u>Y</u> designated for at least one facility-owned wheelchair		
(2)	<u>Y</u> located out of required corridor width <u>Y</u> designated area for wheelchair parking <u>Y</u> located in non-public area <u>Y</u> located out of any required egress width or other required clearance		
3.7-6.4	SUPPORT AREAS FOR STAFF		
3.1-6.4.2	<u>Y</u> Storage for staff personal effects (locking drawers, cabinets, or lockers) <u>Y</u> readily accessible to individual work areas		

ENDOSCOPY FACILITIES

Ref.	Architectural Requirements	Building Systems Requirements	Table
3.1-1.2.2	PATIENT PRIVACY		
	<u>Y</u> Each facility design ensures appropriate levels of patient acoustic & visual privacy & dignity throughout care process		
3.1-1.3.2	PARKING		
1.3-3.3.1.1	<u>Y</u> Parking capacity sufficient to satisfy needs of patients, personnel & public		
3.1-1.3.3	ENTRANCE		
	<u>Y</u> At grade level <u>Y</u> Clearly marked <u>Y</u> Located so patients need not go through other activity areas (public lobbies may be shared)		
3.1-1.4	FACILITY LAYOUT		
	<u>Y</u> Precludes unrelated traffic in facility		
3.9-1.3.4.1	Endoscopy procedure suite divided into minimum of 3 major functional areas: (1) <u>Y</u> procedure room (2) <u>Y</u> instrument processing room (3) <u>Y</u> patient holding/preparation & recovery room or area		
3.9-1.3.4.2	<u>Y</u> Endoscopy procedure suite designed to facilitate movement of patients & personnel into, through & out of defined areas in suite		
3.9-3	DIAGNOSTIC & TREATMENT AREAS		
3.9-3.1	<u>Y</u> Examination/consultation room		
3.1-3.2.1	<u>Y</u> provision made to preserve patient privacy from observation from outside exam room through open door		
3.1-3.2.2.2	Space Requirements: (1) <u>Y</u> min. clear floor area 80 sf	Ventilation: <u>Y</u> Min. 6 air changes per hour	
(2)(a)	<u>Y</u> min. clearance 2'-8" at each side & at foot of exam table, recliner, or chair <u>Y</u> exam table, recliner, or chair shown with clearance zone	Power: <u>Y</u> Min. 8 receptacles <u>Y</u> Min. 4 receptacles convenient to head of exam table	
3.1-3.2.2.3	<u>Y</u> handwashing station		
3.1-3.2.2.4	<u>Y</u> documentation area for written or electronic documentation		
3.9-3.2.2	<u>Y</u> Endoscopy procedure room		
3.9-3.2.2.2	Space Requirements: (1) <u>Y</u> min. clear floor area 200 sf (2) <u>Y</u> min. clearance 3'-6" at each side,	Ventilation: <u>Y</u> Min. 6 air changes per hour <u>Y</u> No recirculating room units	Table 7.1

Ref.	Architectural Requirements	Building Systems Requirements	Table
	head & foot of stretcher/table		
3.9-3.2.2.4 3.9-3.2.2.5	<u>Y</u> provisions made for patient privacy <u>Y</u> handwashing station	Power: <u>Y</u> 8 receptacles Nurse Call System: <u>Y</u> Emergency staff assistance station Medical Gases: <u>Y</u> 1 OX, 3 VAC	Table 3.1-1 Table 3.1-2 Table 3.1-3
3.9-3.2.2.6	<u>Y</u> Patient toilet room <u>Y</u> separate from public use toilet <u>Y</u> directly accessible from pre-procedure & recovery patient care areas	Ventilation: <u>Y</u> Min. 10 air changes per hour	Table 7.1
3.9-3.3.2	<u>Y</u> Pre-procedure patient care area		
3.9-3.3.2.1 (1) (2) (3)	<u>Y</u> accommodates stretcher patients and/or seating for patients <u>Y</u> under observation of nursing staff <u>Y</u> at least one pre-procedure patient care station per procedure room		
3.9-3.3.2.2	Space Requirements: <u>Y</u> patient cubicles		
	<u>Y</u> min. clear floor area 80 sf <u>Y</u> min. clearance 3'-0" between sides & foot of lounge chairs/stretchers & adjacent walls or partitions		
3.9-3.3.2.4	<u>Y</u> Provisions made for patient privacy		
3.9-3.3.2.5	Handwashing Stations:		
3.1-3.6.5.3	Handwashing Stations Serving Multiple Patient Care Stations:		
(1) (2)	<u>Y</u> min. 1 handwashing station for every 4 patient care stations or fewer & for each major fraction thereof <u>Y</u> evenly distributed & provide uniform distance from 2 patient care stations farthest from handwash station		
3.9-3.2.2.6	<u>Y</u> Patient toilet room <u>Y</u> separate from public use toilet <u>Y</u> directly accessible from pre-procedure patient care areas	Ventilation: <u>Y</u> Min. 10 air changes per hour	Table 7.1
3.9-3.3.3	<u>Y</u> Post-procedure recovery area		
3.9-3.3.3.1	<u>Y</u> at least one patient care station per procedure room for recovery		
3.9-3.3.3.2 (1)	Space Requirements: <u>Y</u> min. clear floor area 80 sf for each bay or cubicle	Medical Gases: <u>Y</u> 1 OX, 1 VAC (portable equipment immediately	Table 3.1-3

Ref.	Architectural Requirements	Building Systems Requirements	Table
(2) (a) (b) (c)	<u>Y</u> min. clearance 5'-0" between patient stretchers or beds <u>Y</u> min. clearance 4'-0" between stretchers or beds & adjacent walls or other fixed elements at stretcher/bed sides & foot <u>Y</u> min. clearance 3'-0" from foot of stretcher or bed to closed privacy curtain	accessible)	
3.9-3.3.3.4	<u>Y</u> provisions made for patient privacy		
3.9-3.3.3.5	Handwashing Stations:		
3.1-3.6.5.3	Handwashing Stations Serving Multiple Patient Care Stations:		
(1) (2)	<u>Y</u> min. 1 handwashing station for every 4 patient care stations or fewer & for each major fraction thereof <u>Y</u> evenly distributed & provide uniform distance from two patient care stations farthest from handwashing station		
3.9-3.2.2.6	<u>Y</u> Patient toilet room <u>Y</u> separate from public use toilet <u>Y</u> directly accessible from recovery patient care areas	Ventilation: <u>Y</u> Min. 10 air changes per hour	Table 7.1
3.9-3.6	SUPPORT AREAS FOR ENDOSCOPY PROCEDURE SUITE		
3.9-3.6.1	<u>Y</u> Nurse or control station		
	<u>Y</u> located to permit visual observation of all traffic entering diagnostic & treatment areas		
3.9-3.6.2	<u>Y</u> Documentation area		
	<u>Y</u> accommodations for written or electronic documentation in procedure room & in pre-procedure & recovery patient care areas		
3.9-3.6.6	<u> </u> Medication safety zone		
3.1-3.6.6.1(2)	Self-contained medication dispensing unit		
(a) (b)	<u>Y</u> located at nurse station, in clean workroom or in an alcove <u>Y</u> lockable unit to secure controlled drugs <u>Y</u> handwashing station or hand sanitation located next to stationary medication-dispensing units		
3.9-3.6.10	<u> </u> Soiled workroom NOT PROVIDED		
3.9-3.6.11.2	<u>Y</u> General equipment & supply storage <u>Y</u> min. 25 sf per procedure room		

Ref.	Architectural Requirements	Building Systems Requirements	Table
3.9-3.6.11.3 (1)	<u>Y</u> Stretcher storage area		
3.1-3.6.11.3 (1)	Wheelchair Storage & Parking Space: <u>Y</u> designated for at least one facility-owned wheelchair		
(2)	<u>Y</u> located out of required corridor width <u>Y</u> designated area for wheelchair parking <u>Y</u> located in non-public area <u>Y</u> located out of any required egress width or other required clearance		
3.9-3.6.11.4	<u>Y</u> emergency equipment storage <u>Y</u> located at both procedure & recovery areas		
3.1-3.6.11.4	<u>Y</u> readily accessible <u>Y</u> under staff control		
3.9-3.6.11.5	<u>Y</u> Anesthesia equipment & supply storage <u>Y</u> space for cleaning, testing & storing anesthesia equipment & supplies		
3.9-3.6.11.6 (1)	<u>Y</u> Medical gas storage <u>Y</u> adequate space for supply & storage, including space for reserve cylinders		
(2)	<u>Y</u> medical gas storage location protected as required in NFPA 99		
3.9-3.6.12	<u>Y</u> Environmental services room		
	<u>Y</u> exclusively for endoscopy procedure suite		
3.1-5.5.1.2 (1)	<u>Y</u> service sink or floor-mounted mop sink	Ventilation: <u>Y</u> Min. 10 air changes per hour	Table 7.1
(2)	<u>Y</u> provisions for storage of supplies & housekeeping equipment	<u>Y</u> Exhaust	
(3)	<u>Y</u> handwashing station or hand sanitation dispenser	<u>Y</u> Negative pressure	
3.9-3.6.15	<u>Y</u> Fluid waste disposal facilities in recovery area		
3.9-3.6.15.2	<u>Y</u> toilet equipped with bedpan washer in patient toilet room		
3.9-3.7	SUPPORT AREAS FOR NURSING STAFF		
3.9-3.7.1	<u>Y</u> Staff changing areas (may be unisex)		
3.9-3.7.1.2 (1)	<u>Y</u> lockers		
(2)	<u>Y</u> toilets		
(3)	<u>Y</u> handwashing stations		
(4)	<u>Y</u> space for changing clothes		
3.9-3.7.2	<u>Y</u> Staff lounge & toilet facilities		
3.1-6.4.1	<u>Y</u> Staff lounge		
	<u>Y</u> handwashing station		
3.9-3.8	SUPPORT AREAS FOR PATIENTS		

Ref.	Architectural Requirements	Building Systems Requirements	Table
3.9-3.8.1	<u>Y</u> Patient changing area		
3.9-3.8.1.1 (1) (2) (3) (4)	<u>Y</u> lockers <u>Y</u> toilet <u>Y</u> clothing change or gowning area <u>Y</u> space for administering medications		
3.9-3.8.1.2	<u>Y</u> provisions for securing patients personal effects		
3.9-4	PATIENT SUPPORT FACILITIES		
3.9-4.1	<u> </u> Laboratory services NOT PROVIDED		
3.9-5	GENERAL SUPPORT FACILITIES		
3.9-5.1	<u>Y</u> Instrument processing room		
3.9-5.1.1.4 (1) (2)	Layout: <u>Y</u> allows for flow of instruments from decontamination area to clean work area & then to storage in separate location <u>Y</u> min. clearance 3'-0" between decontamination area & clean work area		
3.9-5.1.2 3.9-5.1.2.1 3.9-5.1.2.2 3.9-5.1.2.3	<u>Y</u> decontamination area <u>Y</u> work counter <u>Y</u> access to handwashing station within instrument processing room <u>Y</u> utility sink	Ventilation: <u>Y</u> Min. 6 air changes per hour <u>Y</u> Negative pressure <u>Y</u> Exhaust <u>Y</u> No room recirculating units	Table 7.1
3.9-5.1.3	<u>Y</u> clean work area		
3.9-5.1.3.1 (1) (2) (3)	<u>Y</u> countertop with space for equipment used <u>Y</u> handwashing station <u>Y</u> storage for supplies	Ventilation: <u>Y</u> Min. 4 air changes per hour <u>Y</u> Positive pressure <u>Y</u> No room recirculating units	Table 7.1
3.9-5.1.3.3 (2)	<u>Y</u> Storage for clean endoscopes <u>Y</u> enclosed storage separate from instrument processing room		
3.9-5.5.1	<u>Y</u> Environmental services room		
3.1-5.5.1.1	<u>Y</u> min. one ES room per floor		
3.1-5.5.1.2 (1) (2) (3)	<u>Y</u> service sink or floor-mounted mop sink <u>Y</u> provisions for storage of supplies & housekeeping equipment <u>Y</u> handwashing station or hand sanitation dispenser	Ventilation: <u>Y</u> Min. 10 air changes per hour <u>Y</u> Exhaust <u>Y</u> Negative pressure	Table 7.1
3.9-6.2	PUBLIC AREAS		
3.9-6.2.1	<u>Y</u> Vehicular drop-off and pedestrian entrance		
3.9-6.2.2.1	<u>Y</u> Reception		
3.9-6.2.2.2	<u>Y</u> Waiting space		

Ref.	Architectural Requirements	Building Systems Requirements	Table
3.9-6.2.2.3	<u>Y</u> Public toilets		
3.9-6.2.2.4	<u>Y</u> Public telephones		
3.9-6.2.2.5	<u>Y</u> Provisions for drinking water		
3.9-6.3	ADMINISTRATIVE AREAS		
3.9-6.3.2	<u>Y</u> Interview space for private interviews relating to admission (may be combined with multipurpose room)		
3.9-6.3.2.2	<u>Y</u> separate from public & patient areas		
3.9-6.3.3	<u>Y</u> Offices for business transactions		
3.9-6.3.4	<u>Y</u> Multipurpose room or consultation room		
3.9-6.3.5	<u>Y</u> Medical records		
3.1-6.3.5.1	<u>Y</u> restricted to staff access		
3.9-6.4	SUPPORT AREAS FOR ADMINISTRATIVE STAFF		
3.9-6.4.1	<u>Y</u> Staff storage facilities		
	<u>Y</u> locking drawers and/or cabinets for personal effects of staff		

ARCHITECTURAL DETAILS

3.7-7.2.2.1	Corridor Width:
(1)	<u>Y</u> Public corridors min. width 5'-0"
(2)	<u>Y</u> At least one corridor that connects surgical suite & PACU to exit min. width 6'-0"
(3)	<u>Y</u> Corridor connecting surgical suite & PACU min. width 8'-0" for transport of patients between pre-operative, procedure & PACU
(4)	<u>Y</u> Staff-only corridors min. width 3'-8"
3.1-7.2.2.2	Ceiling Height:
(1)	<u>Y</u> Min. 7'-10" (except in spaces listed below in this section)
	<u>Y</u> Min. 7'-6" in corridors
	<u>Y</u> Min. 7'-6" in normally unoccupied spaces
(2)	<u>Y</u> Min. height 7'-0" from lowest protruding element of equipment in procedure & operating rooms
3.1-7.2.2.3	Doors & Door Hardware:
(1)	Door Type:
(a)	<u>Y</u> all doors between corridors, rooms, or spaces subject to occupancy of swing type or sliding doors
(b)	<u> </u> sliding doors NOT PROVIDED
(3)	<u>Y</u> door do not swing into corridors except doors to non-occupiable spaces
(4)	<u>Y</u> lever hardware
(b)	<u>Y</u> doors to patient use toilets in patient care & treatment areas have hardware that allows staff emergency access
3.7-7.2.2.3(1)	
(a)	<u>Y</u> Door openings serving occupiable spaces min. clear width 2'-10"
(b)	<u>Y</u> Door openings for stretcher access min. clear width 3'-8"
(2)	Patient Toilet Rooms In Surgery & Recovery Areas:
(a)	<u>Y</u> equipped with doors & hardware that permit access from outside in emergencies
(b)	<u>Y</u> doors shall open outward
3.1-7.2.2.8	Handwashing Stations:
(3)	<u>Y</u> Anchored to support vertical or horizontal force of 250 lbs.
(4)	Counter-Mounted Sinks:
(a)	<u> </u> countertops made of porcelain, stainless steel, or solid surface materials
(b)	<u>Y</u> plastic laminate countertops
	<u>Y</u> at minimum substrate marine-grade plywood with impervious seal
(5)	<u>Y</u> no storage casework beneath sink
(6)	<u>Y</u> provisions for drying hands at all handwashing stations except hand scrub facilities
(a)	<u>Y</u> hand-drying device does not require hand contact
(b)	<u>Y</u> hand-drying provisions enclosed to protect against dust or soil
(7)	<u>Y</u> liquid or foam soap dispensers
3.1-7.2.2.9	Grab Bars:
(2)	<u>Y</u> anchored for concentrated load of 250 lbs.
3.1-7.2.3	SURFACES
3.1-7.2.3.1	Flooring & Wall Bases:

(1)	<u>Y</u> Selected flooring surfaces cleanable & wear-resistant for location
(2)	<u>Y</u> Smooth transitions between different flooring materials
(3)	<u>Y</u> Flooring surfaces, including those on stairways, stable, firm & slip-resistant
(4)	<u>Y</u> Carpet provides stable & firm surface
	<u>Y</u> Floors & wall bases materials in all areas subject to frequent wet cleaning are not affected by germicidal cleaning solutions
3.7-7.2.3.2	
(1)	<u>Y</u> Floor finishes cleanable
(2)	<u>Y</u> Floor finishes in areas such as clean corridors, central sterile supply spaces, specialized radiographic rooms & procedure rooms washable & smooth
(3)	<u>Y</u> Floor finishes in operating rooms scrubable, able to withstand chemical cleaning
(4)	<u>Y</u> All floor surfaces in clinical areas allow easy movement of all required wheeled equipment
3.1-7.2.3.1(5)	<u>Y</u> Monolithic floors & wall bases in operating rooms & procedure rooms
	<u>Y</u> integral coved base min. 6" high
3.1-7.2.3.2	Walls & Wall Protection:
(1)	
(a)	<u>Y</u> Wall finishes washable
(b)	<u>Y</u> Wall finishes in vicinity of plumbing fixtures smooth, scrubable & water-resistant
(2)	<u>Y</u> Wall surfaces in areas routinely subjected to wet spray or splatter are monolithic or have sealed seams
(4)	<u>Y</u> No sharp protruding corners
(5)	<u>Y</u> Corner guards durable & scrubable
3.7-7.2.3.3	
(2)	<u>Y</u> Wall finishes in areas such as clean corridors, central sterile supply spaces, & procedure rooms washable & smooth
(3)	<u>Y</u> Wall finishes in operating rooms are scrubable & monolithic
3.7-7.2.3.4	Ceilings:
(1)	
(a)	<u>Y</u> Ceiling finishes in semi-restricted areas such as clean corridors, central sterile supply spaces, & procedure rooms smooth, scrubable, non-absorptive & non-perforated
(b)	<u>Y</u> no perforated, tegular, serrated, or highly textured tiles
(2)	
(a)	<u>Y</u> Ceilings in operating rooms monolithic & scrubable
(b)	<u>Y</u> all access openings are gasketed
3.1-8.2	HVAC SYSTEMS
4/6.1	Utilities:
4/6.1.1	<u>Y</u> Space ventilation & pressure relationship requirements of Table 7.1 be maintained in event of loss of normal electrical power in operating rooms
4/6.3.1	Outdoor Air Intakes:
4/6.3.1.1	<u>Y</u> Located min. 25 feet from cooling towers & all exhaust & vent discharges
	<u>Y</u> Bottom of air intake is at least 6'-0" above grade
	<u>Y</u> Roof Mounted Air Intakes: bottom min. 3'-0" above roof level
4/6.4	Filtration:
	<u>Y</u> Filter banks conform to Table 6.4
4/6.4.1	<u>Y</u> Filter Bank #1 placed upstream of heating & cooling coils

4/6.4.2	<u>Y</u> Filter Bank No. 2 installed downstream of cooling coils & supply fan
4/6.7	Air Distribution Systems:
4/6.7.1	<u>Y</u> Ducted return or exhaust systems in spaces listed in Table 7.1 with required pressure relationships <u>Y</u> Ducted return or exhaust systems in recovery rooms
4/6.9	Duct Lining: <u>Y</u> No duct lining in ductwork located downstream of Filter Bank #2
4/7	Space Ventilation:
4/7.1	<u>Y</u> Spaces ventilated per Table 7.1
	<u>Y</u> Air movement from clean areas to less clean areas
	<u>Y</u> Min. number of total air changes indicated either supplied for positive pressure rooms or exhausted for negative pressure rooms
	<u>Y</u> Recirculating room HVAC units NOT INCLUDED IN PROJECT
3.1-8.2.1.1(5)	Acoustical Considerations: <u>Y</u> Equipment location or acoustic provisions limit noise associated with outdoor mechanical equipment to 65 dBA at building façade
3.1-8.2.1.2	Ventilation & Space-Conditioning:
(1)	<u>Y</u> All rooms & areas used for patient care have provisions for ventilation
	<u>Y</u> Natural ventilation only allowed for non sensitive areas via operable windows
(2)	<u>Y</u> Mechanical ventilation provided for all rooms & areas in facility in accordance with Table 7.1 of Part 4
3.1-8.2.3.1	Exhaust Systems:
(1)	<u>Y</u> Room routinely used for administering inhalation anesthesia & inhalation analgesia
(a)	<u> </u> anesthesia scavenging system with air supply at or near ceiling & exhaust air inlets near floor level NOT PROVIDED
(b)	<u>Y</u> gas-collecting system arranged so as not to disturb patients respiratory systems
(c)	<u>Y</u> gases from scavenging system exhausted directly to outside
3.1-8.3.2	ELECTRICAL DISTRIBUTION & TRANSMISSION
3.1-8.3.2.1(1)	Switchboards Locations:
(a)	<u>Y</u> located in areas separate from piping & plumbing equipment <u>Y</u> not located in rooms they support
(b)	<u>Y</u> accessible to authorized persons only
(c)	<u>Y</u> easily accessible
(d)	<u>Y</u> located in dry, ventilated space free of corrosive gases or flammable material
3.1-8.3.3.1	<u>Y</u> Emergency electrical service conforms with NFPA 70, NFPA 99, NFPA 101, NFPA 110 & NFPA 111
3.1-8.3.4	LIGHTING
3.1-8.3.4.3(2)	<u>Y</u> Operating rooms have general lighting in addition to special lighting units at surgical table <u>Y</u> general lighting & special lighting on separate circuits
3.1-8.3.6	ELECTRICAL RECEPTACLES
3.1-8.3.6.2	<u>Y</u> Receptacles in patient care areas conform to Table 3.1-1
3.1-8.3.7	CALL SYSTEMS
	<u>Y</u> Nurse call stations conform to Table 3.1-2
3.1-8.4	PLUMBING SYSTEMS
3.1-8.4.2.5	Heated Potable Water Distribution Systems:

(2)	<u>Y</u> Systems serving patient care areas are under constant recirculation
	<u>Y</u> Non-recirculated fixture branch piping does not exceed 25'-0" in length
(3)	<u>Y</u> No dead-end piping
(4)	<u>Y</u> Water-heating system has supply capacity at minimum temperatures & amounts indicated in Table 2.1-3
(5)	<u>Y</u> Handwashing stations supplied as required above
3.1-8.4.3	PLUMBING FIXTURES
3.1-8.4.3.1(1)	<u>Y</u> Materials material used for plumbing fixtures non-absorptive & acid resistant
3.1-8.4.3.2	Handwashing Station Sinks:
(1)	<u>Y</u> Basins reduce risk of splashing to areas where direct patient care is provided, sterile procedures are performed & medications are prepared
(2)	<u>Y</u> Basin min. 144 square inches
(3)	<u>Y</u> Min. dimension 9 inches
(5)	<u>Y</u> Made of porcelain, stainless steel, or solid-surface materials
(7)	<u>Y</u> Water discharge point of faucets at least 10 inches above bottom of basin
(8)	<u>Y</u> Anchoring for sinks withstands min. vertical or horizontal force of 250 lbs
	<u>Y</u> Fittings operated without using hands for sinks used by staff, patients & public
(a)	<u>Y</u> blade handles or single lever
	<u>Y</u> min. 4 inches long
	<u>Y</u> provide clearance required for operation
(b)	<u> </u> sensor-regulated water fixtures NOT PROVIDED
3.1-8.4.3.4	Ice-Making Equipment: <u>Y</u> copper tubing provided for supply connections
3.1-8.4.3.5	Clinical Sinks:
	<u>Y</u> Trimmed with valves that can be operated without hands
(1)	<u>Y</u> Handles min. 6 inches long
(2)	<u>Y</u> Integral trap wherein upper portion of water trap provides visible seal
3.1-8.4.3.6	Scrub Sinks:
(1)	<u>Y</u> Freestanding scrub sinks trimmed with foot, knee, or electronic sensor controls
3.1-8.4.4	MEDICAL GAS & VACUUM SYSTEMS
	<u>Y</u> Station outlets provided as indicated in Table 3.1-3
3.7-8.4.1	<u>Y</u> no flammable anesthetics in outpatient surgical facilities
3.7-8.5	COMMUNICATIONS SYSTEMS
3.7-8.5.2	Emergency Communication System:
	<u>Y</u> OR's & PACU equipped with emergency communication system designed to summon additional staff support with push activation of emergency call switch
3.1-8.7.2	ELEVATORS
3.1-8.7.2.1	<u>Y</u> Outpatient facility located on entrance floor at grade level