Cape Cod Healthcare, Inc.
DoN # CCHC-25120121-RE

DoN QUESTIONS

Responses should be sent to DoN staff at **DPH.DON@State.MA.US by 2.25.26**

While you may submit each answer as available, please

- List question number and question for each answer you provide
- Submit responses as a separate word document, using the above application title and number as a running header and page numbers in the footer
- When providing the answer to the final question, submit all questions and answers in one final document
- Submit responses in WORD or EXCEL; only use PDF's if absolutely necessary. If "cutting and pasting" charts, provide them in a PDF so they can be clearly seen
- **Whenever possible, include a table with the response**
- **For HIPAA compliance Do not include numbers <11.**

1. Factor 1(a) page 12, you state that the units are operating above the "target utilization of 80%". Why is 80% the target utilization?

The industry standard for high-functioning MRI utilization is generally considered between 70% to 80% of available operating hours. Effective utilization, ensuring optimal efficiency without causing excessive, unsustainable bottlenecks, often targets around 65% to 75% for fixed scanners.

The Hospital's operational experience also shows 75–85% utilization as the efficiency peak because it allows time for, emergencies, equipment maintenance, patient no-shows, and turnover time, including cleaning, between patients. As a result, the Hospital holds 80% to be the most sustainable threshold target for it's MRI utilization.

2. You have touched on the number holiday visitors to the Cape. Have you been able to calculate the impact of that surge in terms of patient volume for the ED visits, and how that translates to increases in stroke, trauma, and MRI volume as this may further support the need for redundancy of MRI services by re-instating the dormant unit?

Patient volume data for CCH ED visits over the past 33 months shows an average increase of 25.4% in the summer months over non-summer months. This increase in ED patient volume has a direct impact on demand for stroke and trauma care, including the need for MRI to diagnose and treat.

Average Monthly ED Volume at Cape Cod Hospital

Non-Summer	**6,364**
Summer	**7,978**
Difference	**1,614**
% Different	**25.4%**

Summer visitors not only bring more volume but also participate in specific activities that drive demand for MRI including water sports, heat-related illnesses, and traffic accidents. The summer surge on Cape Cod underscore the need for immediate diagnostic imaging.

3. Factor 1(a) page 12 of the Narrative you state the following:
" As a result of high utilization, wait times have increased for all patients. In FY25, inpatient and observation patients waited an average of 22 hours for MRI, a 13% increase from FY24. Similarly, emergency department (ED) patients waited 15.5 hours in FY25 for MRI, a 15% increase from FY24. These delays in receiving MRI negatively impact hospital throughput, including longer inpatient stays and increased ED boarding."

    a) Are you able to quantify the impact of what you describe as the longer ED boarding and inpatient stays at CCH. For example, can you provide the number of patients who remained in the ED for longer periods and the cost to patients and the CCHC of delayed discharges?

In 2025, CCH's ED had 80,516 visits. Of those encounters, more than 5,000 patients boarded in the ED for more than 12 hours for a total of 173,101 hours. Moreover, 21% of ED encounters resulted in the patient being admitted to an inpatient bed at the Hospital (17,230 admissions). The total number of inpatient admissions at CCH in 2025 was 17,755.

Delaying inpatient MRIs by 22 hours may require longer inpatient admissions than otherwise necessary. The additional day of a patient's inpatient stay increases costs and prevents the bed from being available for a patient boarding in the ED. [1] As a result, the cost and care delivery impact of delaying MRI is two-fold.

    b) In F1c you state there are delays and rescheduling that often occur when emergency cases take priority over scheduled imaging. How often do such delays occur? How many patients were impacted by these delays?

The Hospital does not have a way to track delayed or rescheduled MRIs due to emergent need for the MRI. However, the Hospital notes that accommodating one emergency patient interrupts not only the outpatient scheduled for that slot, but potentially every patient scheduled for the remainder of the day.

4. How old is the MRI unit that is dormant/ out of service? What is the projected useful life of the unit? Is this unit able to operate efficiently, without the need for frequent downtime?

The unit opened in June 2010 and will be 16 years old this summer. Downtime is controlled with all quality measures, maintenance, and physicist testing being performed while the unit is out of service. Notably, the manufacturer is still providing parts and services for necessary maintenance and repairs. There is nothing at this time to indicate that the unit will not be useful for years to come.

[1] "Daily ED boarding costs were nearly two times higher than daily inpatient costs for stroke patients, the study found. The daily total cost for medical/surgical boarding was $1,856, compared to $993 for medical/surgical inpatient care. Dr. Canellas attributed the higher cost of boardings to three key drivers: the overhead of using a more expensive ED bed, higher nurse staffing costs and higher physician costs due to redundant care." https://www.beckershospitalreview.com/finance/the-costs-of-ed-boarding-4-takeaways/#:~:text=1.,4. See also, "Independent of the cause of delayed discharge, an extra bed day can have serious repercussions, including a 30.7% increase in daily expenses." https://www.cureus.com/articles/247476-exploring-the-ramifications-of-delayed-hospital-discharges-impacts-on-patients-physicians-and-healthcare-systems#!/ .