

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
PUBLIC MEETING

Regarding:
Certificate of Need Application
for
Renovation and Expansion
of the
Electrophysiology Laboratory

Applicant: Providence Alaska Medical Center

August 4, 2009
Anchorage, Alaska

Meeting conducted by:
Karen Lawfer

Reported by: Susan J. Warnick, RPR

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1 Tudesday, August 4, 2009

2 5:00 P.M.

3 OPENING REMARKS BY KAREN LAWFER

4 KAREN LAWFER: I'm Karen Lawfer, and I'm the
5 certificate of need coordinator with the state department
6 of Health and Social Services.

7 The purpose of this meeting tonight is to take
8 public input on certificate of need application that
9 Providence Alaska Medical Center has submitted to increase
10 or to relocate their electrophysiology catheterization lab
11 -- I take that back -- they are going to actually build in
12 an existing space to build an electrophysiology
13 catheterization lab in approximately 6,000 square feet of
14 existing space in the medical center at a cost of seven
15 million and 30 thousand dollars.

16 The purpose of this meeting is we will be on
17 record. There will be a transcript of the meeting.
18 Anything that is said in this meeting I can use as far as
19 my review as well as what is in the application as well.
20 So if there is something that you think is more timely
21 than when the original application went in in June, you
22 may add that, and that may be considered as part of the
23 review.

24 Public comments are still being taken and they
25 can be taken written or people can e-mail me and they can

1 be taken until -- I can tell you exactly -- August 17,
2 4:30 P.M. So if you have someone that would like to
3 submit written comments, I can receive them by letter; I
4 can receive them by fax; and I can receive them by e-mail,
5 either way is acceptable to me, as long as they are
6 received by 4:30 on the 17th.

7 And if you would like all the contact
8 information that I have, I have extra copies of the public
9 notice right here, so feel free to grab one.

10 And with that, I would like to bring up our
11 first speaker, Mr. Dale Webb.

12 PUBLIC COMMENT

13 DR. DALE WEBB: I'm a physician, and I have been
14 in town for 38 years. I'm an oncologist, and I guess you
15 all know that medicine has gotten so complicated that
16 cardiologists don't know what oncologists do and
17 oncologists don't know what cardiologists do.

18 So I'm a patient advocate testifier of the sense
19 of extending the electrophysiology lab.

20 When I was about 30, I flipped into AF and was
21 in it for a while in the army. Then I was in and out, but
22 it never bothered me, and so I stayed skinny and ran
23 marathons, did all of that stuff. It kind of ran in my
24 family. It got worse and worse.

25 Two years ago, I flipped into it and didn't come

1 out. Did shocks, beta blockers and Coumadin, and that
2 stuff is bad. Beta blockers make you feel crummy. The
3 shocks didn't work, so I just wasn't pleased.

4 So I had a cardiologist friend down in the Bay
5 area look, and he said, come on down here, you need an
6 ablation procedure. I had been hearing about those.

7 It was successful, and now I'm a happy camper.
8 I don't have to take beta blockers, and I'm sort of
9 thinking about a marathon, but I'm not sure.

10 So if any of you have any questions of somebody
11 whose been through it -- and I have a video of the inside
12 of my left atrium, but I can't bring myself to look at it.
13 I just despise being ill with the arrhythmia and I'm sure
14 glad it could be fixed.

15 So this whole field from the people I talked to
16 is exploding. There is zillions of people around the
17 world that have, like me, have AF, and the procedure is
18 not simple but it works and, it's not open heart stuff,
19 and so if you have any questions of somebody who been
20 through the program, can I answer anything?

21 DR. STEVE COMPTON: Come you explain a little
22 bit more about what your procedure was like on your end?

23 DR. DALE WEBB: It was difficult. The
24 anesthesia, they stick a probe down your esophagus and
25 make sure you don't have clots in your left atrium. They

1 worry about that flipping off. That's the reason your
2 blood has to be pretty thin. That's a big deal. I have
3 actually had patients in the past who have dealt with
4 strokes with arrhythmias, and then they put me to sleep,
5 and I was asleep a long time. When I woke up, I was in
6 normal sinus rhythm. I didn't have that quivering atrial
7 fibrillation feeling in my chest.

8 Then I -- you have a cardiomyopathy, and I
9 wasn't right. In fact, I'm just right now kind of -- I'm
10 a year and a half since the ablation, and I'm just now
11 kind of getting back to what I like. So whatever, normal
12 sinus rhythm beats atrial fibrillation any day of the
13 week.

14 ROBERT HUGHES: You said you are no longer
15 taking beta blockers?

16 MR. DALE WEBB: Right.

17 ROBERT HUGHES: Are you still taking the
18 Coumaden?

19 MR. DALE WEBB: No. I take Aspirin; I watch my
20 blood pressure and all that stuff and look forward to
21 doing more exercise.

22 Any other questions?

23 Well, I sure appreciate you letting me in. I'm
24 very much for it.

25 KAREN LAWFER: Thank you.

1 LISA WOLF: Thanks, Dr. Webb.

2 KAREN LAWFER: So for purposes of the record,
3 that was Dale, D-a-l-e. Last name Webb, W-e-b-b.

4 This hearing or this meeting will go until 6:30.
5 I want to you to understand, though, that do you not have
6 to stay until 6:30. We have a time period so that people
7 can come and go. I will not take any exception for
8 someone to say what they would like to say and leave, so
9 please feel free, just like in the case of Dr. Webb, say
10 what you would like to say and leave. That would be just
11 fine.

12 And with that, we will have Dr. Steven Compton
13 -- is it Steven?

14 DR. STEVEN COMPTON: Uh-huh.

15 KAREN LAWFER: I'm sorry, I added an "N" on
16 that. C-o-m-p-t-o-n. And he is going to give a
17 presentation on the electrophysiology catheterization lab.

18 PRESENTATION BY PROVIDENCE ALASKA MEDICAL CENTER

19 MR. STEVE COMPTON: So I represent the Alaska
20 Heart Institute. We're a group of 24 cardiologists, and
21 I'm one of three electrophysiologists who have devoted our
22 practice to heart rhythm management. So that is myself
23 with Dr. Strobel and Balaban.

24 We treat all the arrhythmias out there, and the
25 focus today is in atrial fibrillation, because that

1 therapy is the one that is growing the fastest, and I'll
2 explain why. The most important reason is that it is the
3 most common human arrhythmia by far. Of all of the
4 arrhythmia disturbances that we see, this one is very,
5 very popular. And, for instance, in men, if you make it
6 past age 40, the odds of developing atrial fibrillation
7 before you die is about 26 percent. Around 17 percent for
8 women. So very common rhythm disorder.

9 The main issue with atrial fibrillation is that
10 you developed a rapid chaotic rhythm in the top of the
11 heart, the atrium. And as we put electrodes inside the
12 heart and record, typically they'll clock in around 350 or
13 400 beats per minute. Now, thankfully, the bottom of the
14 heart doesn't go quite as fast, but the top of the heart
15 is firing so quickly it just quivers and doesn't pump
16 blood very effectively. The bottom of the heart then
17 becomes irregular and doesn't pump as effectively either.

18 So as a consequence you have reduced output of
19 the heart; it doesn't pump as well, that may result in
20 feeling okay at rest, but typically there is a lot of
21 exertional fatigue, and people have reduced stamina and
22 reduced exertional tolerance. Often they are short of
23 breath and fatigued whenever they try to exert themselves,
24 and then the fast rhythm in the top of the heart leads to
25 stasis, where blood didn't moving very well, and the

1 bloods job is keep moving through your body. If it ever
2 stops, it can clot. So clots forming in the atrium are
3 bad news. If a clot washes out of your heart, it can go
4 somewhere like your spleen where you never really care
5 about that, but if the same clot goes to your brain, it
6 could cause a disabling stroke, and it does.

7 And so we know that atrial fibrillation is bad
8 for people because it leads to stroke, and it leads to
9 congestive heart failure. It weakens the heart. As a
10 matter of fact, the mortality risk with atrial
11 fibrillation is more than twice that of age managed
12 controls with similar heart function. It doubles your
13 risk of dying, and so besides feeling lousy, you know that
14 you have a higher risk of death.

15 The cost of treating atrial fibrillation in the
16 United States, last figure out was close to seven billion
17 dollars per year, just for medical expenses, not counting
18 lost productivity.

19 There are published international treatment
20 guidelines for management of atrial fibrillation. This is
21 a little scheme from the American College of Cardiology
22 and American Heart Association, and European Society of
23 Cardiology have ganged up, and this is just one little
24 view from almost a hundred-page-long document what we know
25 about atrial fibrillation and what we think about the

1 proper way to manage it.

2 And depending whether there is underlying heart
3 disease, we do have different medications that can be used
4 to treat atrial fibrillation. The problem is that the
5 medicines we have don't work very well, and they can kill
6 you, and so the success rate in various trials for a given
7 anti-arrhythmic drug is typically around 40 percent in
8 terms of controlling arrhythmia for a year, and if you
9 follow people out for more than a year, the success drops
10 further, and then typically, even if you achieve
11 successful control of your arrhythmia with a drug, within
12 five years most people are having break through arrhythmia
13 discontinue the drug. So for most people, drug management is
14 just a temporizing way to maintain a normal arrhythmia.

15 Then, the other part of these drugs is that they
16 act by changing the way that electrical transmission
17 occurs in your heart. That can be very helpful in the
18 atrium, but in the bottom of the heart, the ventricle,
19 these drugs can actually irritate and cause life
20 threatening arrhythmias. So a number of these drugs have
21 been shown to increase mortality risk in patients who use
22 them compared to placebo. So if you're ever in a drug
23 versus placebo study for an anti-arrhythmic, placebo is
24 the good way to go.

25 So the advent of catheter ablation for atrial

1 fibrillation has become important, and you can see that no
2 matter whether or not you have structural heart disease,
3 heart failure, high blood pressure, catheter ablation has
4 become part of how we treat atrial fibrillation.

5 And the history is that we have been able to
6 treat certain simple arrhythmias with surgery starting in
7 the early 1980s, and once it became clear that some of
8 these arrhythmias could be solved, the big question is
9 whether that could be done without opening up the chest.
10 So by the the late 80s, early '90s, it became possible to
11 move catheters around inside the heart, map an arrhythmia
12 source from within the heart, and then cauterize the
13 tissue that's causing the problem. If we cauterize muscle
14 tissue, it stops firing electrically and scar tissue
15 doesn't fire, and so we can interrupt any kind of a
16 re-entrance circuit that way.

17 So that is the basic idea. We started out in
18 the early '90s with very simple arrhythmias. I was there
19 for the beginning of this, and in the last -- especially
20 the last five years we have been able to tackle the most
21 difficult and common arrhythmia, which is atrial
22 fibrillation.

23 So this is -- we have a new procedure which we
24 think is likely curative. The reason I say likely is that
25 there is nobody on the plant that is 20 years out from AF

1 ablations. It's that new. So we have to wait and see
2 what the long-term results are, but I do have patients
3 running around Alaska who are eight or nine years out and
4 still in sinus rhythm, and we have high hopes these are
5 truly curative.

6 The demand is high. Atrial fibrillation is a
7 disease of aging and becomes more common as we get older.
8 The natural history of this disorder is that you start out
9 with little episodes and over the years they become more
10 frequent, more sustained, and likely you lock into atrial
11 fibrillation, just the way Dr. Webb described. That would
12 be a pretty typical course.

13 And so because it's a disease of aging, it's far
14 more common once you're over the age of 60, 65 than it
15 would be in your 30s or 40s. And so as a population ages,
16 expect to see more atrial fibrillation, and as I'll show
17 you, that is a bigger deal here in Alaska because our
18 population is aging more quickly than the general
19 population in the Lower 48.

20 I'm showing you here a picture of one of the
21 electrophysiology laboratories at Providence. We have a
22 patient laying on the x-ray table with two x-ray cameras
23 giving us views of the heart as we move a catheter around
24 inside the heart. We can put in an ultrasound probe
25 inside the heart and also see what's going on, and we can

1 also use a newer three-dimensional mapping system to see
2 our catheters moving in the heart in real time and also
3 keep track of where we have been and to show where
4 arrhythmia lives, and so we can take newer kind of
5 imaging. This is a CT image of the heart. We can take
6 three-dimensional images of the heart, and here is just
7 different views of the same heart.

8 And you can take an image like that off the CT
9 scanner or MR scanner, either way, and put it on a plain
10 old disk, a CD. We can download the data into our mapping
11 system, and I'm showing the raw data here and we can
12 reconstruct a three-dimensional heart from that and then
13 electronically dissect our way down and remove the
14 different heart chambers until we peel our way down to, in
15 this case, the left atrium. In this case, the left atrium
16 is the chamber of interest. We can take that
17 three-dimensional reconstruction of the left atrium and
18 use that as our template as we map around and map the
19 arrhythmia in real time.

20 LISA WOLF: Is that what you were using in one
21 picture today -- is that what you were doing --

22 DR. STEVEN COMPTON: No. That was different.
23 We weren't using a CT image. We were just using a
24 straight map. We don't always have the image. For atrial
25 fibrillation, that is a better way to go because it's the

1 anatomic-based approach.

2 I'm showing the kind of view that we have as
3 we're working our way through the heart. We can see our
4 ablation catheters moving in space, and we can leave a
5 little bread crumb trail behind as we ablate to show where
6 we have been. In this example, we ablating -- in this
7 example it's called an isthmus (ph) line, just to divide and
8 interrupt a re-entrant rhythm pathway.

9 And so this is the image that Dr. Webb -- I knew
10 he was coming. I thought he would want to see it, but
11 apparently not. This is actually Dr. Webb's left atrium,
12 and so here what we have is a cut-away view, a
13 three-dimensional view of his heart. Cut away where the
14 mitral valve is. We see the pulmonary veins heading up,
15 and it turns out the pulmonary veins drain blood from the
16 lungs back to the heart. We used to think of it as
17 passive little pipes, but they have muscle tissue that is
18 electrically active. That's where this particular
19 arrhythmia usually comes from.

20 If we can go into the heart and cauterize our
21 way around and electrically isolate the pulmonary veins
22 from the left atrium, then we can take that arrhythmia and
23 bottle it up in the pulmonary veins, so that that rapid
24 firing no longer gets out into the heart.

25 And so these red dots represent ablation lesions

1 as we have worked our way around through here, and as I
2 paint my way along with the catheter, there is a
3 technician who is leaving a little trail behind so I know
4 where I have been, and so on this image, it looks a little
5 discontinuous because the software will pop the dots on
6 either side of the shell, but these actually continue all
7 the way around.

8 So when we're done, the electrical activity
9 inside the heart, inside the left atrium no longer
10 conducts in the pulmonary veins, and if it repeats in the
11 pulmonary veins, it no longer gets in the heart.
12 Sometimes you'll actually be able to see pulmonary veins
13 fibrillate when you're done with the patient in a
14 rock-steady rhythm. So, all of a sudden, we don't have to
15 worry about the risk of heart failure or stroke because we
16 don't care if the pulmonary veins fibrillate.

17 So I'm showing a plot -- actually a double plot
18 looking at the age distribution with atrial fibrillation
19 as a bar graph, and the main point is that you really
20 don't see anybody with atrial fibrillation that is less
21 than 40, and the median age for an atrial fibrillation
22 patient is 75. So it's really a disease of the elderly.
23 Then, things trail off below that. So between 45 and 75
24 is when we see a lot of atrial fibrillation.

25 And then the second plot here is just an age

1 distribution of the American population as of 1995, and
2 there is a big lump where the baby boomers are. And as
3 the American population ages, the entire -- this entire
4 line moves its way to the right, and when the lump hits
5 this peak, that means the baby boomers are fibrillating,
6 and this is what we're starting to worry about as the
7 population. It's not just atrial fibrillation. All these
8 medical issues we deal with in elderly will really become
9 big, big problems, because we will have a much bigger
10 overall medical burden.

11 The prevalence of atrial fibrillation varies
12 with age and sex, and interestingly, it's more common in
13 men than in women, and what I wanted to show with this
14 plot is just to compare of prevalence of atrial
15 fibrillation versus all the other arrhythmias that we have
16 been ablating for the last 15 years. Super ventricular
17 tachycardias, atrial flutters, the percentage of those is
18 2.3 percent of the population roughly, and so -- but by
19 the time you get up into your 70s, the prevalence of
20 atrial fibrillation in 75-year-old men is around 6
21 percent, and so we're talking about the number of cases of
22 arrhythmias that we actually see. All of sudden the
23 infrastructure that was built for ablating those less
24 common arrhythmias isn't even remotely enough to manage
25 the atrial fibrillation burden of the population.

1 And so the overall number of patients with
2 atrial fibrillation is expected to grow as the baby
3 boomers age and grow, so the slope will start to increase
4 substantially in the next decade or so. It already has.

5 And Alaska has a very special situation because
6 the Alaska population has been pretty young for a long
7 time. When I was kid in the '70s, I remember being
8 surprised to learn that the average age of Alaska at the
9 time was something like 27, you know, back in the pipeline
10 days. People would grow up and they would leave the
11 state. Once they turned 65, it was just unthinkable that
12 you would actually stay here and be an older person. And
13 now we see patients actually come here to retire.

14 And so as a consequence of that, the Alaskan
15 population is aging, and we haven't traditionally had a
16 lot of elderly patients, but the 65-and-older crowd is
17 growing faster in Alaska than the country at large. If
18 you actually compare the growth of the senior population
19 in Alaska versus the rest of the United States, it's about
20 four or five times here, and I think we're only matched by
21 Arizona in terms of the growth of that population. These
22 are data from UAA ISER.

23 And so as a consequence, the volume of atrial
24 fibrillation ablations has just shot up in the last few
25 years. This is the local volume, and we're wrestling with

1 scheduling patients and getting them in there, and the
2 limiting factor to treating our patients is becoming
3 cardiac catheterization laboratory space. We can't run
4 those labs 24 hours a day or staff will all quit on us,
5 and so if we want to do these elective cases what we need
6 is more space. We need to have a higher through-put
7 during workers hours.

8 So for now, atrial fibrillation ablation
9 typically takes anywhere from two to five hours, depending
10 on the complexity of the case. We hope to see the
11 procedure improve in terms of safety and efficacy and
12 timing. One idea is that we ultimately may be inflating
13 balloons in the pulmonary veins, and here's an idea where
14 we inflate a balloon in a pulmonary vein and apply cold
15 and freeze the opening of the vein to once again
16 electrically disconnect it, and this system is being
17 tested in Europe as we speak and may be available in the
18 United States before too long.

19 And there is a lot of effort being expended on
20 finding ways to make these procedure safer and faster. No
21 matter how safe and fast the procedure becomes, we still
22 have to the face the fact that we have an awful lot of
23 patients with atrial fib and we will need a fair amount of
24 specialized equipment in order to manage these arrhythmias
25 with catheterization ablation, even with newer technology,

1 and so we have had very good support from Providence, but
2 at the point, we're kind of running out of time in the
3 labs and a new lab at Providence would make a big
4 difference for our patients and help us treat them better.

5 So we're facing a tsunami of aging population in
6 the United States, even more rapidly in Alaska, and just
7 overall greater local population problem of heart disease.
8 So despite the cost of living, it remains popular. Atrial
9 fibrillation isn't going to go away, and we may as well
10 just plan ahead and be ready to go with it as the problem
11 increases.

12 Thank you for your attention.

13 KAREN LAWFER: Anyone else who would like to
14 speak?

15 ROBERT HUGHES: I do.

16 KAREN LAWFER: Oh, yes. Mr. Hughes.

17 ROBERT HUGHES: I'll leave you a copy of my
18 slides, and I don't need to go through those. You saw
19 today that we have five labs, two of those labs are busy
20 during the day doing angioplasties and stenting and the
21 normal cardiac stuff. One of them is an interventional
22 radiology lab, which is very busy. We only have one lab
23 dedicated to intervention radiology, and there is a lot of
24 dialysis work and fistalgrams and so on being done, so
25 it's a very busy lab. We have one lab which you are

1 looking at today which is dedicated to electrophysiology.
2 The fifth lab is a swing lab. It's whatever you want to
3 call it. It's the overflow, so it gets whatever is the
4 busiest for today. So being that it's, as the term goes,
5 a jack of all trades and a master of none, it's not
6 perfect for cardiac work, it's not perfect for
7 interventional radiology work, it's not perfect -- it's
8 not even close to perfect for electrophysiology work.

9 We do schedule some electrophysiology cases in
10 there. The doctors always come and tell me how unhappy
11 they are that day, because it's just a very difficult lab
12 to work around in.

13 Despite that, there is -- Dr. Compton has looked
14 at the list several times, and we just schedule what the
15 doctors' offices call us and schedule, so we don't keep a
16 waiting list in the hospital.

17 So we went to AHI and we went to the doctors and
18 said, you know, how many patients out there do you need to
19 do atrial fibrillation ablations on or some some type of
20 ablation. As you said, they are not emergent. They are
21 things that we can plan. The list varies. The best
22 situation is that there is three months, the reality is
23 it's probably four and a half months of wait time.

24 We've made this calculation that, you know, our
25 CFO wants to have numbers in order to do this. So we

1 tried to figure out how many of these procedures we can do
2 in a day. So after a lot of work, we figured that we can
3 do two and a quarter a day. Well, you know, you can't do
4 a quarter of a procedure, but sometimes we can get three
5 done. Dr. Compton is excellent, and I'm not sure how he
6 does it, but he can, you know, he will put on three
7 ablation cases, and we will call him up and tell him no
8 way, you can't do that. He'll say, oh, yeah, this one is
9 going to be easy, and sure enough, they're in and out of
10 there in hour and a half and it's no big deal. That
11 doesn't happen very often. So we normally get two
12 scheduled in a day, with the occasional day that gets a
13 third case.

14 This will be a big help to have another lab that
15 we can schedule more cases on a daily basis. AHI has been
16 talking with physicians for quite a while now about
17 getting another electrophysiologist, and they just don't
18 because there is no place for them to work. So this will
19 address the need that is in the community. It's an unmet
20 need. If you look at the calculations that the state
21 recommends, if you look at cath lab volume and increases
22 in volume, they are not predictive of what this is at all.
23 Because this cannot escalate because there is no place for
24 it to go. It's an unmet need that we're addressing to be
25 able to bring these patients in and take care of them.

1 I think that's the big issue, the big thing that
2 needs to be understood is that these are not emergent, so
3 you don't have those people coming in at 2:00 at the
4 morning where you can see that, okay, there is pressure
5 because the patients are coming in. These are patients
6 that can wait; although they are not particularly really
7 happy about it. So we're trying to meet that need.

8 KAREN LAWFER: For the record, that was Robert
9 Hughes, H-u-g-h-e-s.

10 Do I have anyone else who would like to speak to
11 the project?

12 With that, I will close public record, in case
13 someone else shows, then we will go back on record, but in
14 the meantime, as I said earlier, I will not take offense
15 if you need to leave. I'll totally understand. Sue and I
16 will continue to talk about family things, because we
17 don't get to see each other very often.

18 If you want to grab one of the public notices
19 with all the contact information for a patient or someone
20 who would like to provide a written comment, either by
21 letter, fax or e-mail, grab one of those. Like I said
22 earlier, they are due no later than 4:30 on the 17th of
23 August.

24 Off record.

25 (Off record.)

1 KAREN LAWFER: It is now 6:30 and we're closing
2 this public meeting for the evening.

3 (Proceedings adjourned at 6:30 p.m.)

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REPORTER'S CERTIFICATE

I, SUSAN J. WARNICK, RPR, and Notary Public in
and for the State of Alaska do hereby certify:

That the proceedings were then taken before me at
the time and place herein set forth; that the testimony
and proceedings were reported stenographically by me and
later transcribed under my direction by computer
transcription; that the foregoing is a true record of the
testimony and proceedings taken at that time; and that I
am not a party to nor have I any interest in the outcome
of the action herein contained.

IN WITNESS WHEREOF, I have hereunto subscribed my
hand and affixed my seal this _____ day of _____,
2009.

SUSAN J. WARNICK,
Registered Professional Reporter
Notary Public for Alaska

My Commission Expires: April 8, 2010

A		B	C	
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