

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
PUBLIC MEETING

Regarding:
Certificate of Need Application
for
Relocation and Expansion
of the
Sleep Disorders Center
Applicant: Providence Alaska Medical Center

June 18, 2009
Anchorage, Alaska

Meeting Conducted by:
Karen Lawfer

Reported by:
Valerie Martinez

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1 THURSDAY, JUNE 18, 2009

2 5:40 PM

3 OPENING REMARKS BY KAREN LAWFER

4 KAREN LAWFER: For everyone, my name is Karen
5 Lawfer and I'm with the Certificate of Need program with
6 the Department of Health & Social Services. This
7 evening's public meeting is to take testimony regarding
8 the application from Providence Medical Center,
9 Providence Health Systems, for the relocation and
10 expansion of their Sleep Disorders Center.

11 With that, I am going to allow Lisa Wolf with
12 Providence to begin with the testimony.

13 PRESENTATION BY PROVIDENCE ALASKA MEDICAL CENTER

14 LISA WOLF: Good evening, everyone. Tonight
15 we're going to have several speakers do our presentation
16 for us. Christie Artuso and Dr. Lada will be doing the
17 presentation for us.

18 And so, Christie, why don't you go ahead.

19 CHRISTIE ARTUSO: My name is Christie Artuso.
20 I'm the Director of Neurosciences at Providence Alaska
21 Medical Center. The Sleep Disorders Center does fall
22 under the umbrella of neurosciences, so we'd like to
23 share some of the information we've gathered over the
24 last year and some of the details on the Certificate of
25 Need and why we believe that this would benefit the

1 community.

2 Currently, we have an accredited Sleep
3 Disorders Center. It is accredited by the American
4 Academy of Sleep Medicine.

5 We are located in two locations. We are
6 located in the proper hospital location. We have four
7 beds in that location with no ability to expand because
8 of the geographic location of the sleep center. And so
9 we did expand and added four testing beds into a
10 building that we call the Providence House. It was a
11 building that's been used for multiple purposes on the
12 campus over the past several years. But in proximity,
13 it's close to the hospital and provides an adequate
14 space at this time for temporarily housing patients to
15 test for the sleep center. So we've outfitted those and
16 we do provide testing in those beds.

17 Total capacity is about 4,261 square feet. We
18 do test six nights a week and we currently and have
19 sustained a seven-week waiting list over the past three
20 years consistently.

21 We're proposing a new Sleep Disorders Center
22 that would also maintain the accreditation by the
23 American Academy of Sleep Medicine in one location in a
24 medical office building on the PAMC campus that would be
25 physically connected to the Providence Alaska Medical

1 Center Hospital campus.

2 There would be 10 testing beds with space
3 allowed for expansion to two additional beds in the
4 future, should that need be documented. The total
5 amount of space would 10,360 square feet. The cost for
6 this department is approximately \$3.6 million and it is
7 being paid for by our own operational funds.

8 We anticipate operation somewhere around
9 spring of 2010 barring any unforeseen construction
10 delays, weather delays, supply delays, coming up as the
11 building is being constructed.

12 National healthcare forecaster predicts
13 approximately in Alaska a 60 percent increase in volume
14 between the years 2008 to 2013. And what we believe is
15 going to happen is that there is going to be an
16 increased demand in neurologic cases, an increased
17 demand for preoperative screening and preoperative
18 testing for patients who fall within a specific
19 criteria.

20 There are a number of studies going on right
21 now in the Lower 48 and they are looking at patients
22 preoperatively, screening them appropriately, increasing
23 the observation postoperatively, and then referring for
24 sleep tests if they meet a set of criteria. And so they
25 believe that they're able to decrease postop

1 complications by identifying these patients during the
2 anesthesia preoperative screening process.

3 So that has not happened in Alaska at this
4 point and we believe if we institute this program, it
5 will again increase the volume that we have to see. And
6 we do currently have a seven-week waiting list, so we're
7 a little bit leery about adding patient populations that
8 we have not tested in the past, even evaluating for it,
9 because look at the length of time that we would have to
10 go out to test these patients.

11 Rob, would you like to add some comments about
12 the actual community need and the types of patients that
13 we anticipate testing?

14 DR. ROBERT LADA: Yeah. I mean, I think one
15 aspect if you look at the neurologic cases right now,
16 the majority of the testing that we are doing are really
17 isolated to mainly pulmonary patients, simply because of
18 the culture of the sleep lab up until this point has
19 mainly involved pulmonologists. And so the whole
20 population of neurologic patients has never really
21 entered into a common component in the sleep lab.
22 Rarely you may have some.

23 Another area that has been very underserved is
24 going to be the stroke patients that are present. In
25 upwards of 60 to 80 percent of patients who had a stroke

1 have sleep apnea. Those patients who have sleep apnea
2 and have just had a stroke are at a higher instance to
3 have another stroke and a higher risk of dying in the
4 next 90 days after the stroke. And so right now we
5 don't have the ability to test, evaluate, these patients
6 in an efficient manner in order to prevent problems from
7 taking place in the future.

8 Another category of patients that we don't
9 routinely evaluate are patients with multiple sclerosis.
10 Also, patients with Parkinson's and dementia simply
11 because our facilities are not capable of handling that
12 number of patients. So up until this point, we really
13 haven't consistently and routinely evaluated those
14 patients for sleep disorders.

15 The other avenue that we have not expanded
16 upon, partly because of space issues, is the pediatric
17 population. And that also is an underserved population
18 because we're not really seeing those patients coming
19 through the sleep lab. When we look at the population
20 in Alaska, we should be seeing more of those patients.
21 But probably it's because of manpower issues.

22 But more importantly, we don't have the
23 ability to see those patients. Right now if we do see a
24 pediatric patient, we actually take two beds to do that
25 because we'll close down one bed. And that also further

1 expands out those needs for other patients, so we do
2 have a lack of facility for that.

3 LISA WOLF: Let me speak to the projected need
4 formula that was used. It's a formula based on the
5 current population's use rate. And we included, when we
6 did this, the number of studies that were performed as
7 well as the wait list in this study.

8 The use rate in 2008 was then applied into the
9 future year of 2013 and that created 3,742 studies. And
10 if you look at that number of studies and you divide
11 that by 265 studies per year per bed, you end up with a
12 need of 14.1 beds. Currently in Anchorage there are 10
13 beds, so it's in addition to the four beds.

14 And this need is based on what we're currently
15 seeing. So all the kinds of patients that Dr. Lada just
16 mentioned that we haven't started to see yet aren't in
17 that formula, so that would be an additional demand that
18 we would see.

19 CHRISTIE ARTUSO: And I would just like to add
20 to that. With the stroke patients that he mentioned, we
21 now as of about six months ago have the ability to
22 provide additional interventions for stroke patients in
23 the state of Alaska and we've built that program
24 significantly. We're working collaboratively with six
25 other hospitals in Alaska to deliver a higher level of

1 stroke care, so we also anticipate the number of stroke
2 patients that we identify will increase.

3 And we probably should have introduced
4 Dr. Lada before, but he's a stroke-certified
5 neurologist. And so we've added that clinical capacity
6 to the sleep lab as well. He's also the medical
7 director of our sleep lab, so he has that additional
8 expertise. We had the pulmonary expertise, now we've
9 added the neurology.

10 We've added a level of care for stroke
11 patients, so we're touching on what we anticipate. But
12 with the growth of the programs, we need to be able to
13 meet those patient's needs adequately, especially with
14 the current science that says they have that greater
15 risk.

16 So I think it's important to recognize, too,
17 that we are connected with a number of other
18 organizations throughout the state and we're working
19 with them to deliver this level of care.

20 So, we looked at several alternatives. The
21 first one: Do nothing. Live with what we've got, keep
22 going along the same path, close down a bed when we have
23 a pediatric patient, maintain the seven- to nine-week
24 waiting list depending -- seven weeks is actually the
25 shortest I've ever seen it -- so seven- to nine-week

1 waiting list, not meet the patients' needs. It didn't
2 seem to be the best option. So we pulled that one off
3 the table rather early.

4 We looked at space in our existing medical
5 office buildings. We actually spent quite a bit of time
6 looking at potential space that would have the capacity
7 to expand later on if we needed to, space that would be
8 connected physically to the hospital, space that would
9 provide adequate parking, adequate access for patients,
10 adequate handicapped access, all of those factors that
11 would meet the patients' needs.

12 We also looked at the proximity of some of our
13 buildings and did not find any existing space in the
14 current office buildings that was adequate in size,
15 connected, large enough, and provided some
16 expandability. So that was not a great option. We had
17 some small spaces but they didn't really allow us to
18 create a larger setting.

19 We considered continuing with the split center
20 in two locations. This is very difficult to maintain.
21 It is not as -- I don't feel that it provides us with
22 the ability to provide a solid continuity of care.
23 You've got staff in two locations that don't have the
24 benefit of communicating directly with each other all
25 the time. They communicate certainly remotely with each

1 other.

2 You have to selectively choose which patients
3 are in one location over another location depending --
4 because one is connected, the other is not. And so at
5 times your patient mix may be more difficult to maintain
6 and may not meet all the needs of the patients that need
7 to come in on that day. So it does provide additional
8 challenges. And we're limited to how much we can expand
9 in that space.

10 At this time, we anticipate the Providence
11 House will no longer be available in about one year.
12 And so we would have to move those beds out of
13 Providence House anyway.

14 Leasing space off campus, another potential
15 that we looked at. We costed out the cost, looked at
16 the possibility. One of the challenges is that it's no
17 longer connected. So then we have to still have a
18 second location on campus to provide care to in-patients
19 or patients that might have special needs or pediatric
20 patients where we do provide a little different level of
21 service for those pediatric patients because they need
22 special equipment.

23 So we identified all of the barriers that
24 would occur if we were off campus and not connected with
25 Providence Alaska Medical Center and felt that that was

1 not the best option. It was certainly one that was
2 weighed.

3 And then we looked at leasing space in a new
4 medical office building on the PAMC campus, which is
5 under construction right now. It provided us with the
6 opportunity to maintain connectivity, to design a sleep
7 center that would meet the patients' needs. I think
8 that was a real driver for us, to look at a design that
9 would optimize our ability to provide the service for
10 the patients, that would provide adequate access, that
11 would allow them to be comfortable while they were
12 undergoing their sleep studies, that would provide staff
13 with a central location where they could communicate
14 with each other, perform the sleep studies, and also
15 collaborate with other health care professionals.

16 It allowed us the possibility of developing
17 rooms for specific patient populations. And in the
18 design, we looked at designing rooms specific to the
19 bariatric patient, we were able to design rooms specific
20 for pediatric patients. We were able to look at
21 different elements that would meet needs of those
22 patient populations as well as provide a comfortable
23 environment for them to have their sleep study done
24 under optimal situations.

25 And when we looked at the costs between the

1 two, they were relatively equal between that and leasing
2 space off campus. Leasing space off campus, we had no
3 control really over the type of space. So when we
4 looked at the actual costs of implementing this, it made
5 the most sense to look at space in a new medical office
6 building that we could design to meet patient needs and
7 to meet the current standards at a high level as well as
8 give ourselves the opportunity to expand if that was
9 necessary down the line.

10 So our request is to take our current two
11 sites -- we're proposing that we move to a single
12 location located in a new medical office building on the
13 PAMC campus that is connected to the hospital. We would
14 like to provide 10 testing beds with space for two more
15 in the future. A total of 10,360 square feet which
16 allows us to provide for pediatric testing as well as
17 additional space for patient, family support, bariatric
18 rooms. Total cost of the project is \$3.6 million that
19 is paid for by operational funds. And we anticipate
20 certificate of occupancy by May of 2010.

21 LISA WOLF: That concludes our presentation.

22 KAREN LAWFER: All right. Would anyone else
23 like to speak specifically?

24 For the record, I'd like to note that earlier
25 it was Dr. Lada; right?

1 DR. ROBERT LADA: Yes.

2 KAREN LAWFER: And how do you spell your name?

3 I'm trying to do this for the record.

4 DR. ROBERT LADA: Oh, sure. It's Dr. Robert
5 Lada. And it's L-a-d-a.

6 KAREN LAWFER: I want to make sure we have all
7 the testimony as to who said what.

8 And Mr. Trotter, would you like to --

9 JERRY TRODDEN: Trodden.

10 KAREN LAWFER: Trodden, yes. Would you like
11 to say something as well?

12 PUBLIC COMMENT

13 JERRY TRODDEN: I wasn't prepared to speak,
14 but of course I'm very excited about it. I've been with
15 the sleep center now for 12 years. And the evolution
16 that we've gone through has been pretty amazing and the
17 excitement about seeing a more varied group of patients.

18 It's been difficult to not be able to treat
19 the population that we need to. The preoperative
20 patients that you mentioned, the program, it's important
21 to be able to see those patients so that they can get
22 the surgery they need in a timely manner, and it's very
23 difficult to schedule patients so far out.

24 DR. ROBERT LADA: I think just to kind of
25 reiterate, the whole aspect of once a diagnosis is under

1 suspicion is to be able to attack that problem as fast
2 as possible. And I think that's one of the biggest
3 limiting factors in a lot of folks that we're seeing are
4 coming in from outlying areas. They're driving, they're
5 transferring into here, and we right now don't have the
6 ability to evaluate and institute a treatment in rapid
7 fashion. And a lot of these folks are at risk out in
8 the community waiting for a study to be done that in any
9 other circumstance would be done, if not within a week
10 or so, and decrease that risk.

11 That's the one that always concerns me both as
12 a physician and seeing patients, where I'm seeing them,
13 there's a treatment that's potentially available for
14 them, but I can't get the patient and the treatment
15 together in a timely fashion. So they're going off and
16 I'm hoping the best for them. And I'm putting my
17 license at risk each time I see the patient as well. So
18 this sort of speeds up that process of getting folks in
19 and treated properly.

20 KAREN LAWFER: I want to let everyone know --
21 and you can have a copy of the public notice as well if
22 you'd like to take them along -- written comments can be
23 provided by 4:30 July 2nd, so we do have quite a bit of
24 time period for people to put in written comments. And
25 this is patients, staff. Anyone is allowed to put that

1 in. All the contact information is on there. I can
2 receive it via fax, I can receive it in the mail, and I
3 can also receive it via e-mail. So if you have someone
4 or if someone knows of someone that was not able to come
5 here to provide comments this evening, they're more than
6 welcome to provide them in writing.

7 And if there's nothing else, with that, we'll
8 go off record.

9 (Proceedings adjourned at 5:57 p.m.)

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REPORTER'S CERTIFICATE

I, Valerie Martinez, Notary Public in and for the State of Alaska do hereby certify:

That the proceedings were taken before me at the time set forth; that the proceedings were reported stenographically by me and later transcribed under my direction by computer transcription; that the foregoing is a true record of the 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.

Valerie Martinez
Notary Public for Alaska

My Commission Expires: June 22, 2010