STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
PUBLIC MEETING

Regarding:
Certificate of Need Application
for
Providence Alaska Medical Center
Catheterization Labs
and
Alaska Regional Hospital
Interventional Neuroradiology Suite

February 22, 2007
Anchorage, Alaska

Meeting Conducted by:
David Pierce

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THURSDAY, FEBRUARY 22, 2007

5:00 P.M.

OPENING REMARKS BY DAVID PIERCE

MR. PIERCE: Okay. We are here tonight to have public comment on two catheterization projects that are in the works and have submitted Certificate of Need Applications. And what we're going to do is have the two applicants give short presentations about the projects, and then we'll open it up for public comment.

If you do supply public comment, or if you are speaking, please give your name and who you represent before you give us your comments.

And I am going to turn it over now to Jordan Herget. He is representing Alaska Regional Hospital, and he will have his presentation first.

PRESENTATION BY JORDAN HERGET

ALASKA REGIONAL HOSPITAL

MR. HERGET: Okay. Thank you, David.

I won't stand up, if that's okay, since I

am attached to a mouse here. I'm Jordan Herget from Alaska Regional Hospital. We're here today to present and to comment at this public hearing on two applications. Our application is titled "Interventional Neuroradiology Suite," and we have in parenthesis on the screen "Endovascular Service," just as a tie-in to the service a little here.

A concurrent review -- we are here today to talk about both applications. Alaska Regional Hospital has applied for an Interventional Neuroradiology Suite. Providence has applied for the two catheterization labs. In terms of brief descriptions and basis for need, our suite that we are proposing is dedicated to neuroradiology endovascular interventions, excluding cardiac catheter -- catheterization services. Providence's application declares that they will be able to perform interventional radiology and cardiac catheterizations.

The basis for the need of our application is, this is a new service to Alaska. It is currently available at Regional, but it's limited by the existing equipment and by the demand for space, potentially, for that program. The basis for need of Providence's application is that the current labs

at Providence are operating above the capacity for the state use methodology.

So the applicable review standards that we are going to address today -- both applicants are under the general review standards. The additional considerations for concurrent review both fall into that. And then of course, with cardiac catheterization services, those review standards would apply for Providence's application, where they would not apply to ours.

Based on that, we would propose that the two applications be reviewed independently. We will continue our presentation as if it is a concurrent review, but we would like to offer that up, that that independent review take place.

We will tackle this in two parts. One, we will talk about our project, and part two of our position is that we do oppose the cardiac catheterization labs at Providence.

Just briefly, our project is to add one suite where we focus on neuroradiology, endovascular, and radiology interventions, and cardiac caths are excluded from that -- from the services in this suite. The expensive piece of the project is that we are going to purchase the

Phillips biplane flat detector system. It is a neuro system dedicated to neurointerventions, and we will also renovate the space that the equipment will go into.

The specific services are endovascular coiling and stenting, which are treatment for stroke. And the project is critical to Alaska Regional Hospital's long-range plans and also ties into both the state and federal forecasts for stroke, which is the fourth leading cause of death in Alaska. So the development of this program will ensure Alaskans can receive the highest quality care without leaving state, and that is really what we are here about today.

We have two changes to the application I just wanted to highlight before we went on. One is an addition to the equipment. It's a feature called "Expert CT," and this would allow the physician or the provider to basically provide a CT function on a patient that is on the table at the time without stopping the procedure and taking them down the hall to the CT scanner and getting them back, then, on the catheterization table.

As well, we have changed the location of the cath lab with Pax being added at Alaska Regional

Hospital. That's going to free up our film library, which there is about 917 square feet that we're going to dedicate to that.

So, demonstration of need in Alaska -- why is this service important? Essentially, with all the work the state has done forecasting the need for stroke treatments -- these various publications generally talk about the need for treatment for stroke. And this treatment that we're talking about is the most advanced treatment available for stroke which, up until recently, was not available in this state.

The project also addresses the specific portion of the regs which says that the Commissioner will consider, for these projects, community access to healthcare, including provision of a continuum of care in close proximity to family and community.

What's happening now, or prior to this new service, was that people were being flown to Seattle to receive care, and that, of course, disrupts family connections and continuum of care and availability of care in this state.

The next slide demonstrates that, for the past five or six years, you can see the two different treatments for aneurisms, surgical

clipping and coiling. In 2003, 2004, and 2005, we did a total of 24, 25 treatments in Seattle for coiling -- 3, 11, and 11. And then, in the first half of '06, we did another 5. And those are patients that are being flown down to Seattle where they can be treated for aneurisms, get that procedure done there. And you can see the average charges.

Once Dr. Tolbert, who I will introduce here in a minute, came to Alaska in August of '06, we started doing those procedures here. And in five months, from August to December of '06, we did 14 coilings in Alaska. And to our knowledge -- the data isn't available yet -- very few patients have been flown to Seattle for the treatment. One or two from Native have been flown there, but most referrals are now being kept in the state.

The other advantage of having the service here is that early detection can be -- an emergency treatment can be handled. I think the window -- and maybe Dr. Tolbert will talk about this in a minute -- for treatment is six hours from the first detection. So getting on a plane and flying out of state to get this treatment sometimes compromises the patient, and potentially the treatment isn't

undertaken. So this will allow for that to happen here.

So the need for the specific equipment, I think -- and the application goes into a lot more detail about the need for the service. Then the question is: Why do we need this equipment? And we're doing it at Alaska Regional now. Why do you need this new equipment, and why can't you just upgrade your existing equipment?

Essentially, the scope and the level of treatment for the procedures are limited by our equipment. We have a biplane cath lab with image intensifiers that are large drums. David was over at the hospital today, and I was showing him that these large things prohibit some viewing of these aneurisms.

So the first thing is location of the aneurisms. The biplane drums have a hard time catching these aneurisms, which are sometimes deep in the head of the patient. So the closer they get to the head, I guess -- and Marshall is involved with this. He's rolling his eyes a little bit. But the closer they get to the head, the harder it is to see the aneurism. And I have a couple slides here that I'll show about that. As well, the

magnification and 3-D imaging capability is limited, so you get fuzzy or pixilated images.

And the third reason that we include it in our application is that the equipment is also used for a bunch of physiology studies as well as cardiac catheterizations, so that compromises the availability of the equipment. At times, these long studies, EP studies, six-to-eight-hour studies -- if an emergent case shows up in our room, we might not be able to provide the service to the stroke patient.

The fourth reason, which is not in our application -- but it's new -- is that our current equipment has inadequate image processing memory and realtime measurements. So for what Dr. Tolbert needs to do, he is sometimes limited by the software that is involved.

I mentioned the CT treatment. Basically, these limitations pose risks to the patients, and the risks are unclear diagnoses, additional time on the table, and unnecessary additional coils.

Before I turn a little bit of time over to Dr. Tolbert, I wanted to show one example of this. This was an image taken of a patient, and this is the aneurism right here with our current

imaging equipment. And there are several coils in this aneurism. And at that point in the procedure, Dr. Tolbert, based on what he could see here, had to decide whether to go on with more coils to complete his treatment of the aneurism, or if he needed to stop. And based on the image quality, he, I think, had to go on.

And maybe you'll recall this case, Marshall, but this is an example where, if we had that top-of-the-line, latest equipment, the patient's time on the table would have been limited. Patient risk -- every time you do more coils, it adds risk to the patient. So that's one example.

And, Dr. Tolbert, if you have -- maybe if you have a few minutes to say a few things, maybe I'll turn the time over to you, if that's okay.

DR. TOLBERT: Sure. I see you have some other pictures here too.

MR. HERGET: I included some other pictures --

DR. TOLBERT: Well, the equipment that is --

MR. PIERCE: Oh, by the way, if you're going to speak, you need to stand over there.

DR. TOLBERT: I am Marshall Tolbert, and I'm an interventional neurosurgeon. I did my neurosurgery training at UNC and Chapel Hill, North

Carolina, and a two-year fellowship in endovascular neuroradiology at Duke University in Durham, North Carolina.

And I came up here to kind of provide two roles. One, there was a need for neurosurgery in the state of Alaska. There is also the complete absence of any interventional endovascular treatment in the state of Alaska. I can provide both of those services, and so it was a perfect fit.

Alaska Regional has a biplane angiography unit, which is pretty much required for navigating these cranial vasculatures. It is very tortuous. The vessels twist around on themselves. They make 360-degree loops. The anatomy can be very, very difficult to navigate and to interpret.

The modern angiography machines are past the level of the current machine that is available, both in terms of modification resolution and aids in navigation, such as what is known as road-mapping, which allows you to rotate your blood vessels on the screen and watch yourself as you are moving the wires and the catheters through the blood vessels.

These are very important for a number of factors: For safety, obviously, so you know where you are. For optimizing treatment, we need to be

able to resolve items as small as an eight-thousandth-of-an-inch wire going through a blood vessel. And if you can't do that, you can't perform these functions safely.

The existing equipment is -- it can do it, but it's difficult. You have to sometimes try alternate methods to get optimal performance out of the machine. It's a couple of years old, and it doesn't have the modern technology, just as most of us probably drive something newer than a 1950 Chevy. But there is a big difference if you sit in a new Buick or a new Cadillac versus a car from the '50s or '60's -- not that the angio machine is that old, but it is one of the kind of base-line models, a couple of years old.

In this case, I think that Jordan was showing, or not, in that one -- that was actually a good one right there -- I can't see some of the stents in that one. But in that case, there was a small arterial branch originating off the neck of the aneurism which was not resolved by the existing angiography equipment, and we couldn't get a high enough resolution, three-dimensional image off the existing equipment because of the complex anatomy.

The equipment works fine if it's a very

straightforward, simple, five-millimeter bubble sticking off of a vessel. But when we get into highly complex lesions, it's difficult. Again, there is a lot of tweaking of the system to get it to give good results. There was a little bit of coil that ended up including one of the small arteries. It was fine. She's asymptomatic from it.

The important thing was, the aneurism was treated. But it was difficult, and it took a lot longer than it would have otherwise, and a lot more contrast was used to get better working views during the case.

I think in that other case, you can't even see the stents because the resolution is a little bit -- again, you have to get the monitor right up close to see some of what we are doing, but there are actually stents extending out, that straight segment -- I'm going out this way. If you look at the far right, straight this way, and then two stents, one going up and one going down, to reconstruct the neck of the aneurism. That kind of big fuzzy area is the coil mass preventing blood from entering the aneurism and treating the aneurism.

So again, a resolution in imaging issue.

We can work with this, obviously. I mean, you can try to work on a bicycle or whatever else you want, but if we want to optimize and provide the best possible care -- for the simple cases, it's fine, but as we are getting more and more complex cases, it gets more and more difficult.

One of the big things we want to bring to the state of Alaska -- and I mean "we" in the term of healthcare providers in general -- is a very aggressive stroke program. All the hospitals in the state are kind of enrolling in this. It is going to be a major joint effort just to raise stroke awareness to bring neurologists in line with stroke treatment and to provide interventions for the stroke patient.

Your typical standard stroke intervention that is not interventional has a three-hour window. Interventional techniques extend that window upwards of six to eight hours, and in certain cases indefinitely, given the right circumstance. Again, the ability to navigate blood vessels which can be very tortuous, very small -- the resolution required to see the wires and make sure that you are in the artery when you put something in -- because the artery is closed off with this stroke -- it gets a

little more tricky. It really requires a more modern technology.

The need for these procedures is going to grow in this state. We just started this -- well, in August I did my first case, somewhere, I think, the first week or two of August. It kind of fluctuates up and down, but there are more and more referrals coming in because we are keeping the patients now in state for the first time.

Alaskans are being treated in the state of Alaska, instead of a two-hour-or-whatever plane flight, three-hour plane flight to Seattle. So the cost, obviously, is much, much better to keep them in-house, in-state, and keeping people near their family. And as this becomes more well known, I definitely anticipate an increase in the number of the procedures.

With stroke intervention going on and more and more public awareness of strokes, there is going to be an increased number of stroke interventions. Stroke prevention is another issue which is going to be addressed, again, on a statewide level, and I'm just looking at a local level here. And as the third leading cause of death in the United States is stroke, there are a lot of

people that we can help by preventing them from having a stroke. And in Alaska, it's the fourth leading cause.

And so as we get more of the family physicians, primary care physicians in line with looking for stroke risk factors, there are things that we can intervene -- obviously, from the medical side -- as well as intracranial stenosis, carotid stenosis -- those issues, which again, particularly in the intracranial stenosis, which may be responsible for 20 percent or more of strokes, is something that requires the more advanced angiography equipment.

So, I think we are starting a really good program for the state of Alaska. We're really taking a step upwards with these techniques, being able to keep people here in state, even, at this point, having some of the patients from the Native Medical Center being treated locally, avoiding, again, a major transfer. These are people who live out in Bethel and places. Getting to Anchorage is difficult for them. If you can imagine getting out to Seattle, it's almost overwhelming. So the ability to keep patients here in Alaska is a very important issue.

But to keep developing the program, it really does need to have more advanced technology, because there has been major rapid advances in the past two to three years in the quality of image and the resolution and the size of the equipment. So now you can move these large IIs, the image intensifiers, the X-ray projectors around the head. And you put them in really funny positions sometimes, and the larger this piece of equipment is, it limits you how far you can move. So if you have to put a tube under the patient's chin, the smaller it is, the more you can tuck it in.

The image resolution is markedly better. The computing power -- you can just imagine the computer you use today versus six, seven years ago. It's so much quicker. With any computer option, program that you use, the ability to generate three-dimensional reconstructions of the blood vessels now occurs within a matter of seconds versus many, many minutes. And the new equipment now offers options where -- it is known as three-dimensional road-mapping -- you inject a little contrast in the blood vessel, and instead of the old days where it may take 30 or 40 cc's of contrast, which potentially can damage your kidneys

at high levels, you are now using 3 cc's.

So there is a major advantage just from that standpoint of protecting the patient. These road maps will rotate with the fluoroheads as you are moving the angiography equipment around, getting new projections. The new equipment, with the new computers, will move your image with it so you are not reinjecting contrast all the time, again making things safer and more efficient.

So I think it is a good move to build a new unit, to bring it in, because it offers a lot more than what is available right now. And this is a program that is going to be developing. It's the need for the entire state, not just for the local region, that we are going to be addressing.

So anyway, I am biased, I admit, but I do see this as a major step forward. I think there is a lot of major pluses that we will see in the very near and very definitely in the distant future from this.

So that's my say, so . . .

MR. HERGET: Thank you, Dr. Tolbert.

The next thing I wanted to address was, in the event of a concurrent review, there are additional considerations the department will take

into consideration. Those are quality of licensure and accreditation surveys, and high levels of care for low income and uninsured patients. And we feel both facilities demonstrate all three of those. And just as a note, we wanted to mention a couple of things about Regional.

Right now -- this week, actually -- today was the closing day of a quality review survey, which is similar to JCAHO, but also takes into account state, OSHA, and other regulations. And it's sponsored by HCA, and it was a pretty intensive review of our quality process. So we just finished that this week. That represents our commitment. As well, in the past two or three years, we have been a pilot site for JCAHO's unannounced surveys.

Moving on to part two, addressing the Providence project, our position is to oppose the application for two catheterization labs. Specifically, we feel the application fails to follow and/or meet the two regs that are up on the screen.

The first is the specific review standards that are adopted by reference, and the second is the service area question, where we feel Providence's application doesn't take into

consideration all the cath labs in this market, those cath labs being their four, Alaska Regional's two, the one diagnostic lab at AHI, the new diagnostic lab down in Mat-Su, and then any future labs in Fairbanks.

The reason that that impacts this application is because volumes from all of those areas, even though they may be outside of the immediate Anchorage market, have been in play over the past two or three years, and so any volume numbers that we look at will include the effects of those labs.

In the application, Providence states that this market right now, with just considering their four labs and Regional's two labs, is at 88 percent. What that doesn't take into account is the diagnostic capacity at AHI and Mat-Su. So maybe there is a factor there of .5 or.75 for those labs that should be considered, that some of the work that we could be doing at our labs and have been doing at our labs in the past is now being done at those diagnostic labs.

The last thing we want to point out is that Providence, in their application, departs from the review standards and suggests a higher rate of

growth, I guess, for the projection. The review standards that have been adopted talk about utilizing the three-year historical trends, and the application from Providence focuses on the growth that they had in 2005 which, with all these other labs that opened up, there's got to be a mix in there that I think the state should look at.

So our proposal is that the state uses the methodology in the regs, using 2004 to 2006 volumes -- which 2006 is now available. So we now have three good years of volume -- and consider the impact of AHI and Mat-Su as well as any Fairbanks volumes that have come down to Anchorage, to do a needs assessment and determine exactly how many cath labs are or are not needed in the area. But based on the application as it stands, we would feel like it does not demonstrate the need for the two additional labs.

I think that's all we have, unless my colleague, Rick Davis, has additional comments.

MR. DAVIS: I think that's good for now.

MR. HERGET: Okay. So that's it.

MR. PIERCE: Thank you very much. And I'll -- Lisa, if you'd like to -- are you going to be presenting?

MR. GILBERTSON: I'll do it.

MR. PIERCE: Oh, okay. Good.

MR. GILBERTSON: Give them -- I don't know if they have copies.

MS. WOLF: We only have just a couple there -- copies.

MR. GILBERTSON: Here you go.

MS. WOLF: Looks good. Thank you.

PRESENTATION BY JOEL GILBERTSON
PROVIDENCE ALASKA MEDICAL CENTER

MR. GILBERTSON: For the record, my name is Joel Gilbertson. I'm the Regional Director of Strategic Development and Administration at Providence Health System in Alaska. I'm here speaking on behalf of Providence Alaska Medical Center and the Certificate for Need request for two catheterization labs for the AMC.

First, I would like to thank the state for the opportunity to participate tonight for Providence. The proposal that is before the state right now is the addition of two catheterization labs for our Providence Heart Center. The proposals will bring one of the labs on line in 2007, and the

second one would come on line during the first part of 2008. The total project cost is slightly over $5 million, and Providence intends to pay for this capital project through internal funds.

I think there has already been some testimony about how these projects differ, but just let me emphasize a few pieces of how the Alaska Regional Hospital proposal differs from the Providence proposal.

At Providence, 90 percent of the procedures done at the Providence Heart Center are currently focused on cardiac care, 10 percent of the procedures are focused on other parts of the body, and no neuroradiology work is currently being done in our catheterization labs.

Providence Alaska Medical Center -- our four current existing labs that have been spoken about thus far this evening provide multiple procedure types. This includes diagnostic cardiac catheterizations, interventional cardiac catheterizations, electrophysiology procedures, and interventional radiology procedures. And not every lab is the same, and they are not equally suited to all procedures. Both do provide inpatient/outpatient services, and they serve both

adult and pediatric patients.

PAMC, for virtually all of our service lines, including our heart program, serves all of Alaska. Currently 56 percent of the patients seen are from Anchorage, 26 percent come from the gulf coast and Mat-Su regions, 15 percent from other parts in Alaska, and 3 percent are coming in from out of state.

Only one cardiologist in the state is currently located outside of Anchorage, and the complex cases come to Anchorage for care. The Anchorage labs will see more complex procedures due to the availability of open-heart surgery. Attempts to include the Mat-Su lab or AHI's diagnostic lab and the Fairbanks proposed labs, which don't even exist at this point, sort of fail to acknowledge that the majority of the procedures, including the more complex procedures, are being done in Anchorage. And more specifically, those labs do not offer the full complement of services offered in the Anchorage labs.

PAMC's Heart Center is at capacity right now. All four labs are operating at capacity and are currently 40 percent over the state's targeted capacity per lab. Our labs serve more than 20

physicians, including cardiologists and radiologists. Scheduling, as you see, is very tight. This is resulting in overtime, inconvenience to the patients, physicians, and staff, and right now we are experiencing a three-month wait list for cardiac ablations.

I want to talk a little bit about the trends that are being seen in the marketplace, and I think that is important as you look at what standards and methodologies will be used to analyze the laboratories.

First, there have been tremendous advancements in technology, allowing more procedures to be done in catheterization labs. We're seeing increasing volumes. It's not just that the population is growing; it's that that population is aging as well.

Also, the length of procedures -- more complex procedures take longer to complete. This is impacting the capacity and throughput in the labs. Some procedures are taking four to eight hours.

So why two laboratories? Well, one laboratory simply addresses overcrowding and capacity issues within the existing four labs and will allow us to improve operations and make sure

that we can deal with the overtime issues, the rescheduling, the waiting lists. And the second lab allows us, really, to respond to the growing and continuing demand for services, which is shown both in volume increases experiences within the labs and the addition of new physicians in the Anchorage market.

There is a community-wide need. There are six catheterization labs, full-service catheterization labs in the Anchorage marketplace -- four at PAMC and two at Alaska Regional Hospital. Both facilities are experiencing the impact of longer procedures, serving more physicians, and doing new types of procedures. Together, looking at these six labs, the current capacity is 85 percent, which is a little above the state's target capacity for a lab of 75 percent.

When you look at the state's methodology to calculate community need, it's based on average use rates. So there are some things that are not being included, and they're worth noting and worth examining.

One is that this formula doesn't account for an aging population, so while there is some reflection of population growth, there really is no

inclusion of the changing demographic of an aging population that will require more services. It also does not accommodate the increase in number and new types of procedures that are being done, and doesn't acknowledge the growing number of physicians able to do procedures in Anchorage.

If you look simply at the combined volume between Providence Alaska Medical Center and Alaska Regional Hospital -- and Providence has not been able to receive or have access to the 2003 volume data at Alaska Regional Hospital -- you will always get, at a time in which volume is increasing -- so volume increases. Take any three periods of time, years of time in any service, anything that is increasing, even incrementally over a three-year period. Using this methodology and formula will always project into the future a reduction in volume because it simply adds the three years and divides by three and takes an average.

And so an increasing trend in volume fundamentally always produces an outcome that volume will decrease in out years, and that is inconsistent with what is being experienced in the market and inconsistent with what is being experienced in healthcare.

So when you apply the methodology -- even seeing tremendous growth in volume between 2004 and 2005 -- you project forward four years. You add an aging population, an increasing number of procedures, and a growing supply of physicians into the state, and you come up with an inconsistent conclusion, which is that volume is going to drop. And for that reason, Providence respectfully requests that the state consider using a more appropriate methodology.

We put forward alternative methodologies. One we feel that is fair methodology in examining lab capacity simply looks at the growth that is actually being experienced from 2003 to 2005. When you look at simply the volume growth at PAMC, where we have access to actuals for 2003, 2004, and 2005 -- and I'm on the bottom half of this slide right now -- what you'll see is that there is essentially a 7.7 percent compounded growth rate, based on PAMC's volumes during those years.

Projecting that forward, we're experiencing volume at the combined facilities of 7,000 procedures, almost 7,500 in 2009. Looking at the use rate per 1,000 population, you're looking at a use rate of about 10.7, and when you look at

current capacity, using the state's targeted level of 750 patients per lab, with six labs we're projecting forward to be at 165 percent of capacity.

When you look at this in terms of labs, applying the state's methodology, you produce a realistic number of 9.8 labs needed in the marketplace, versus 7.

I wanted to wrap up with just a couple of thoughts. One is that in the Alaska Regional Hospital application, it includes a proposal for neuroradiology as well as interventional radiology procedures. Many of the cath labs that are already in the marketplace, including cath labs at PAMC, also perform interventional radiology procedures.

Alaska Regional Hospital's volumes project that 75 percent of the procedures done in the new lab will be interventional radiology, and only 25 percent will be neuroradiology. However, their application chooses not to use the state methodology for interventional radiology for projecting volumes, and thus falls under the same standards that are used for cardiac cath labs, and I think that's worth noting.

And finally, in conclusion, sort of to share the reason why we move forward in this, the

Sisters of Providence came to the state in 1902, and we've continued to look at ways in which we, as an organization, can continue to increase and improve the services we provide the state.

Our mission remains committed to high-quality care, making it accessible and affordable across the state. But we are having a difficult time delivering that, based on the volume that we are experiencing and the limited capacity in the marketplace. As a result, what we see is that there is a need for at least the two labs that Providence is proposing, and that we are going to have to assume that there is a capacity issue going into the future.

And with that, I'll stop. Thank you.

MR. PIERCE: I think the sign-up sheet is down here.

DR. LEWIS: Thanks.

MR. PIERCE: Well, we don't have anyone signed up to comment, so I'll just throw this open. If any of you change your mind -- have changed your mind and would like to comment, now is the time.

So is there anyone here that would like to say a few words regarding either of these proposals? Okay. Come on up. If you would sit at

the table here and just introduce yourself.

PUBLIC TESTIMONY BY LESTER LEWIS

DR. LEWIS: My name is Lester Lewis. I am a radiologist. I'm a member of Alaska Imaging Associates. We provide radiology services at Alaska Regional Hospital.

I was involved in the preparation and planning for the catheterization lab -- we call it a vascular interventional suite -- that Dr. Tolbert was talking about that now exists at Alaska Regional Hospital. It's the one multifunction room that's in the facility. The other catheterization lab is a specialized cardiac catheterization lab, so they are completely separate.

So in the one big room, we do cardiac procedures, the AP procedure. We do our own body procedures, which are vascular procedures, angiography, and Dr. Tolbert is using that room now for the neuroradiology procedures.

When the room was designed and planned, Dr. Tolbert was not here. And I, as a radiologist, and my colleague radiologists don't do the studies and the exams that Dr. Tolbert does. And so his

specialty was excluded in the planning for that room.

The big thing I would like to point out is, knowing how all the rooms are designed, I would like to emphasize that the room that is being considered for Alaska Regional Hospital is a very specialized room. Just as a cardiac cath lab is very specialized for the heart, this is very specialized for the brain and the arteries and so on. So this room, with the big imaging devices and the table and essentially the more cumbersome devices to use, was not designed for what he needs to do.

In working with patients, not having the best or the right equipment is a significant deficit to the patient, because what happens is that you can't see things perfectly the way you want to. Dr. Tolbert is used to using other equipment, so he knows what is -- what can be done and what is better and now is forced to use this other less-easily-used tool.

What that does is, it increases the risk for the patient, so two things can happen. If you can't see things as well, you might not get the best picture that you want, and also the procedures take

longer. And so when the procedure time goes out, the risk for something unwarranted or unwanted can happen.

So the point I'd like to make is that this room is very specialized. It's for neurosurgical work. The room that we have now wasn't designed for that, and that's the big issue, and I think that's why.

What I see, too, in looking at the two things -- I see a specialized neurosurgical suite and specialized cardiac suites. They are completely different. And I don't know the whole process, but I guess I'm a little bit confused why they are thrown in together into one consideration.

So that's the other point I'd like to make. This is a very specialized room, and I think it should be evaluated on the merits of that program and that room, completely separate from a cardiac catheterization evaluation. It looks to me, as a radiologist and a physician, they're completely separate entities. And I am not sure how the process works, but I would also suggest that that evaluation be separated.

MR. PIERCE: Thank you very much.

Is there anyone else who would like to

speak?

MR. HERGET: I just have a comment, if I could.

MR. PIERCE: Sure. Yes.

MR. HERGET: Jordan Herget again from Alaska Regional.

A couple of things I just wanted to state for the record, that we did look at the review standards that are there for the state, and we felt the ones that applied for this particular application are the general review standards and then the concurrent review standards.

The reasons we felt that cardiac cath standards weren't applicable is because we're excluding cardiac cath services from this new room. And looking through the review standards, we didn't see any specific interventional radiology standards, review standards. So I just wanted to put that on the record.

And then the second question I have is for Providence. The volumes that we looked at earlier, did those include patients that could be done in the diagnostic lab at AHI and/or Mat-Su and/or any Fairbanks labs that get built in the future? And did those include patients that might

be from the Mat-Su area that previously had come into Anchorage, and would that inflate the volumes going forward?

MR. HUGHES: My name is Bob Hughes. I'm the Director of Cardiovascular Services at Providence.

Actually, there's a lot of similarities with these applications, because they are both specialized. I mean, there is very little neurodiagnostic work available in Anchorage, and it's highly specialized, and it needs to be provided.

By the same token, the work that we are doing and that we are applying for is highly specialized also. And you are correct, there are other labs, and they have affected the volume. Providence has seen a significant drop over the last two years in diagnostic cases because they are being done out at Mat-Su or at AHI.

That being said, and with that drop in diagnostic cases, we've still seen an increase in overall volume. And the diagnostic cases are being replaced by longer, more complex, and more involved interventional cases that are being discovered in the diagnostic labs and that are coming to us.

So in addition to the increase in the

volume and the predicted increases in volumes, the complexity and the length of time that it takes to do these cases is increasing. The need is getting greater, on a daily basis, because of the complexities of what's being done.

MR. HERGET: Thank you.

MR. PIERCE: Are there any other comments that would like to be made?

Usually, at the end, if we don't have any comments, we ask if anybody has any questions regarding -- that they would like to ask to any of the applicants.

And regarding the applicants, feel free to -- you don't have to answer a question if it's asked to you. Okay? Don't feel like you're on the spot because, you know, you may choose to answer it at a future time, not answer it all, or if you have an answer you would like to give now, that would be fine too.

So just let me open it up here, if anyone has any questions that they would like to ask either of the applicants.

Well, if not, I would say our meeting is over. Thank you all for coming. I appreciate the comments, and I appreciate the efforts that have

been put in in these applications.

(Public hearing adjourned at 6:00 p.m.)

C E R T I F I C A T E

SUPERIOR COURT)
) ss.
STATE OF ALASKA)

I, LYNDA BATCHELOR BARKER, Registered Diplomate Reporter and certified for transcript services by the United States Courts and the Alaska State Courts, hereby certify:

That the foregoing pages contain a full, true and correct transcript of proceedings in the above-referenced matter, transcribed by me to the best of my knowledge and ability, or at my direction, from the electronic sound recording.

DATED at Juneau, Alaska, this 3rd day of March, 2007.

SIGNED AND CERTIFIED TO BY:

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LYNDA BATCHELOR BARKER, RDR, Notary Public for the State of Alaska. My commission expires: 5/6/08