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

1 TABLE OF CONTENTS

2

3 PAGE

4 OPENING REMARKS BY DAVID PIERCE 3

5 PRESENTATION BY JORDAN HERGET 3

6 ALASKA REGIONAL HOSPITAL

7

8 PRESENTATION BY JOEL GILBERTSON 23

9 PROVIDENCE ALASKA MEDICAL CENTER

10

11

12 PUBLIC COMMENT:

13 DR. LESTER LEWIS 32

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3 THURSDAY, FEBRUARY 22, 2007
4 5:00 P.M.
5 OPENING REMARKS BY DAVID PIERCE
6
7 MR. PIERCE: Okay. We are here tonight to
8 have public comment on two catheterization projects
9 that are in the works and have submitted Certificate
10 of Need Applications. And what we're going to do is
11 have the two applicants give short presentations
12 about the projects, and then we'll open it up for
13 public comment.
14 If you do supply public comment, or if
15 you are speaking, please give your name and who you
16 represent before you give us your comments.
17 And I am going to turn it over now to
18 Jordan Herget. He is representing Alaska Regional
19 Hospital, and he will have his presentation first.
20
21 PRESENTATION BY JORDAN HERGET
22 ALASKA REGIONAL HOSPITAL
23
24 MR. HERGET: Okay. Thank you, David.
25 I won't stand up, if that's okay, since I

1 am attached to a mouse here. I'm Jordan Herget from
2 Alaska Regional Hospital. We're here today to
3 present and to comment at this public hearing on two
4 applications. Our application is titled
5 "Interventional Neuroradiology Suite," and we have
6 in parenthesis on the screen "Endovascular Service,"
7 just as a tie-in to the service a little here.
8 A concurrent review -- we are here today
9 to talk about both applications. Alaska Regional
10 Hospital has applied for an Interventional
11 Neuroradiology Suite. Providence has applied for
12 the two catheterization labs. In terms of brief
13 descriptions and basis for need, our suite that we
14 are proposing is dedicated to neuroradiology
15 endovascular interventions, excluding cardiac
16 catheter -- catheterization services. Providence's
17 application declares that they will be able to
18 perform interventional radiology and cardiac
19 catheterizations.
20 The basis for the need of our application
21 is, this is a new service to Alaska. It is
22 currently available at Regional, but it's limited by
23 the existing equipment and by the demand for space,
24 potentially, for that program. The basis for need
25 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

1 Phillips biplane flat detector system. It is a
2 neuro system dedicated to neurointerventions, and we
3 will also renovate the space that the equipment will
4 go into.
5 The specific services are endovascular
6 coiling and stenting, which are treatment for
7 stroke. And the project is critical to Alaska
8 Regional Hospital's long-range plans and also ties
9 into both the state and federal forecasts for
10 stroke, which is the fourth leading cause of death
11 in Alaska. So the development of this program will
12 ensure Alaskans can receive the highest quality care
13 without leaving state, and that is really what we
14 are here about today.
15 We have two changes to the application I
16 just wanted to highlight before we went on. One is
17 an addition to the equipment. It's a feature called
18 "Expert CT," and this would allow the physician or
19 the provider to basically provide a CT function on a
20 patient that is on the table at the time without
21 stopping the procedure and taking them down the hall
22 to the CT scanner and getting them back, then, on
23 the catheterization table.
24 As well, we have changed the location of
25 the cath lab with Pax being added at Alaska Regional

1 Hospital. That's going to free up our film library,
2 which there is about 917 square feet that we're
3 going to dedicate to that.
4 So, demonstration of need in Alaska --
5 why is this service important? Essentially, with
6 all the work the state has done forecasting the need
7 for stroke treatments -- these various publications
8 generally talk about the need for treatment for
9 stroke. And this treatment that we're talking about
10 is the most advanced treatment available for stroke
11 which, up until recently, was not available in this
12 state.
13 The project also addresses the specific
14 portion of the regs which says that the Commissioner
15 will consider, for these projects, community access
16 to healthcare, including provision of a continuum of
17 care in close proximity to family and community.
18 What's happening now, or prior to this
19 new service, was that people were being flown to
20 Seattle to receive care, and that, of course,
21 disrupts family connections and continuum of care
22 and availability of care in this state.
23 The next slide demonstrates that, for the
24 past five or six years, you can see the two
25 different treatments for aneurisms, surgical

1 clipping and coiling. In 2003, 2004, and 2005, we
2 did a total of 24, 25 treatments in Seattle for
3 coiling -- 3, 11, and 11. And then, in the first
4 half of '06, we did another 5. And those are
5 patients that are being flown down to Seattle where
6 they can be treated for aneurisms, get that
7 procedure done there. And you can see the average
8 charges.
9 Once Dr. Tolbert, who I will introduce
10 here in a minute, came to Alaska in August of '06,
11 we started doing those procedures here. And in five
12 months, from August to December of '06, we did 14
13 coilings in Alaska. And to our knowledge -- the
14 data isn't available yet -- very few patients have
15 been flown to Seattle for the treatment. One or two
16 from Native have been flown there, but most
17 referrals are now being kept in the state.
18 The other advantage of having the service
19 here is that early detection can be -- an emergency
20 treatment can be handled. I think the window -- and
21 maybe Dr. Tolbert will talk about this in a
22 minute -- for treatment is six hours from the first
23 detection. So getting on a plane and flying out of
24 state to get this treatment sometimes compromises
25 the patient, and potentially the treatment isn't

1 undertaken. So this will allow for that to happen
2 here.
3 So the need for the specific equipment, I
4 think -- and the application goes into a lot more
5 detail about the need for the service. Then the
6 question is: Why do we need this equipment? And
7 we're doing it at Alaska Regional now. Why do you
8 need this new equipment, and why can't you just
9 upgrade your existing equipment?
10 Essentially, the scope and the level of
11 treatment for the procedures are limited by our
12 equipment. We have a biplane cath lab with image
13 intensifiers that are large drums. David was over
14 at the hospital today, and I was showing him that
15 these large things prohibit some viewing of these
16 aneurisms.
17 So the first thing is location of the
18 aneurisms. The biplane drums have a hard time
19 catching these aneurisms, which are sometimes deep
20 in the head of the patient. So the closer they get
21 to the head, I guess -- and Marshall is involved
22 with this. He's rolling his eyes a little bit. But
23 the closer they get to the head, the harder it is to
24 see the aneurism. And I have a couple slides here
25 that I'll show about that. As well, the

1 magnification and 3-D imaging capability is limited,
2 so you get fuzzy or pixilated images.
3 And the third reason that we include it
4 in our application is that the equipment is also
5 used for a bunch of physiology studies as well as
6 cardiac catheterizations, so that compromises the
7 availability of the equipment. At times, these long
8 studies, EP studies, six-to-eight-hour studies -- if
9 an emergent case shows up in our room, we might not
10 be able to provide the service to the stroke
11 patient.
12 The fourth reason, which is not in our
13 application -- but it's new -- is that our current
14 equipment has inadequate image processing memory and
15 realtime measurements. So for what Dr. Tolbert
16 needs to do, he is sometimes limited by the software
17 that is involved.
18 I mentioned the CT treatment. Basically,
19 these limitations pose risks to the patients, and
20 the risks are unclear diagnoses, additional time on
21 the table, and unnecessary additional coils.
22 Before I turn a little bit of time over
23 to Dr. Tolbert, I wanted to show one example of
24 this. This was an image taken of a patient, and
25 this is the aneurism right here with our current

1 imaging equipment. And there are several coils in
2 this aneurism. And at that point in the procedure,
3 Dr. Tolbert, based on what he could see here, had to
4 decide whether to go on with more coils to complete
5 his treatment of the aneurism, or if he needed to
6 stop. And based on the image quality, he, I think,
7 had to go on.
8 And maybe you'll recall this case,
9 Marshall, but this is an example where, if we had
10 that top-of-the-line, latest equipment, the
11 patient's time on the table would have been limited.
12 Patient risk -- every time you do more coils, it
13 adds risk to the patient. So that's one example.
14 And, Dr. Tolbert, if you have -- maybe if
15 you have a few minutes to say a few things, maybe
16 I'll turn the time over to you, if that's okay.
17 DR. TOLBERT: Sure. I see you have some other
18 pictures here too.
19 MR. HERGET: I included some other pictures --
20 DR. TOLBERT: Well, the equipment that is --
21 MR. PIERCE: Oh, by the way, if you're going
22 to speak, you need to stand over there.
23 DR. TOLBERT: I am Marshall Tolbert, and I'm
24 an interventional neurosurgeon. I did my
25 neurosurgery training at UNC and Chapel Hill, North

1 Carolina, and a two-year fellowship in endovascular
2 neuroradiology at Duke University in Durham, North
3 Carolina.
4 And I came up here to kind of provide two
5 roles. One, there was a need for neurosurgery in
6 the state of Alaska. There is also the complete
7 absence of any interventional endovascular treatment
8 in the state of Alaska. I can provide both of those
9 services, and so it was a perfect fit.
10 Alaska Regional has a biplane angiography
11 unit, which is pretty much required for navigating
12 these cranial vasculatures. It is very tortuous.
13 The vessels twist around on themselves. They make
14 360-degree loops. The anatomy can be very, very
15 difficult to navigate and to interpret.
16 The modern angiography machines are past
17 the level of the current machine that is available,
18 both in terms of modification resolution and aids in
19 navigation, such as what is known as road-mapping,
20 which allows you to rotate your blood vessels on the
21 screen and watch yourself as you are moving the
22 wires and the catheters through the blood vessels.
23 These are very important for a number of
24 factors: For safety, obviously, so you know where
25 you are. For optimizing treatment, we need to be

1 able to resolve items as small as an
2 eight-thousandth-of-an-inch wire going through a
3 blood vessel. And if you can't do that, you can't
4 perform these functions safely.
5 The existing equipment is -- it can do
6 it, but it's difficult. You have to sometimes try
7 alternate methods to get optimal performance out of
8 the machine. It's a couple of years old, and it
9 doesn't have the modern technology, just as most of
10 us probably drive something newer than a 1950 Chevy.
11 But there is a big difference if you sit in a new
12 Buick or a new Cadillac versus a car from the '50s
13 or '60's -- not that the angio machine is that old,
14 but it is one of the kind of base-line models, a
15 couple of years old.
16 In this case, I think that Jordan was
17 showing, or not, in that one -- that was actually a
18 good one right there -- I can't see some of the
19 stents in that one. But in that case, there was a
20 small arterial branch originating off the neck of
21 the aneurism which was not resolved by the existing
22 angiography equipment, and we couldn't get a high
23 enough resolution, three-dimensional image off the
24 existing equipment because of the complex anatomy.
25 The equipment works fine if it's a very

1 straightforward, simple, five-millimeter bubble
2 sticking off of a vessel. But when we get into
3 highly complex lesions, it's difficult. Again,
4 there is a lot of tweaking of the system to get it
5 to give good results. There was a little bit of
6 coil that ended up including one of the small
7 arteries. It was fine. She's asymptomatic from it.
8 The important thing was, the aneurism was
9 treated. But it was difficult, and it took a lot
10 longer than it would have otherwise, and a lot more
11 contrast was used to get better working views during
12 the case.
13 I think in that other case, you can't
14 even see the stents because the resolution is a
15 little bit -- again, you have to get the monitor
16 right up close to see some of what we are doing, but
17 there are actually stents extending out, that
18 straight segment -- I'm going out this way. If you
19 look at the far right, straight this way, and then
20 two stents, one going up and one going down, to
21 reconstruct the neck of the aneurism. That kind of
22 big fuzzy area is the coil mass preventing blood
23 from entering the aneurism and treating the
24 aneurism.
25 So again, a resolution in imaging issue.

1 We can work with this, obviously. I mean, you can
2 try to work on a bicycle or whatever else you want,
3 but if we want to optimize and provide the best
4 possible care -- for the simple cases, it's fine,
5 but as we are getting more and more complex cases,
6 it gets more and more difficult.
7 One of the big things we want to bring to
8 the state of Alaska -- and I mean "we" in the term
9 of healthcare providers in general -- is a very
10 aggressive stroke program. All the hospitals in the
11 state are kind of enrolling in this. It is going to
12 be a major joint effort just to raise stroke
13 awareness to bring neurologists in line with stroke
14 treatment and to provide interventions for the
15 stroke patient.
16 Your typical standard stroke intervention
17 that is not interventional has a three-hour window.
18 Interventional techniques extend that window upwards
19 of six to eight hours, and in certain cases
20 indefinitely, given the right circumstance. Again,
21 the ability to navigate blood vessels which can be
22 very tortuous, very small -- the resolution required
23 to see the wires and make sure that you are in the
24 artery when you put something in -- because the
25 artery is closed off with this stroke -- it gets a

1 little more tricky. It really requires a more
2 modern technology.
3 The need for these procedures is going to
4 grow in this state. We just started this -- well,
5 in August I did my first case, somewhere, I think,
6 the first week or two of August. It kind of
7 fluctuates up and down, but there are more and more
8 referrals coming in because we are keeping the
9 patients now in state for the first time.
10 Alaskans are being treated in the state
11 of Alaska, instead of a two-hour-or-whatever plane
12 flight, three-hour plane flight to Seattle. So the
13 cost, obviously, is much, much better to keep them
14 in-house, in-state, and keeping people near their
15 family. And as this becomes more well known, I
16 definitely anticipate an increase in the number of
17 the procedures.
18 With stroke intervention going on and
19 more and more public awareness of strokes, there is
20 going to be an increased number of stroke
21 interventions. Stroke prevention is another issue
22 which is going to be addressed, again, on a
23 statewide level, and I'm just looking at a local
24 level here. And as the third leading cause of death
25 in the United States is stroke, there are a lot of

1 people that we can help by preventing them from
2 having a stroke. And in Alaska, it's the fourth
3 leading cause.
4 And so as we get more of the family
5 physicians, primary care physicians in line with
6 looking for stroke risk factors, there are things
7 that we can intervene -- obviously, from the medical
8 side -- as well as intracranial stenosis, carotid
9 stenosis -- those issues, which again, particularly
10 in the intracranial stenosis, which may be
11 responsible for 20 percent or more of strokes, is
12 something that requires the more advanced
13 angiography equipment.
14 So, I think we are starting a really good
15 program for the state of Alaska. We're really
16 taking a step upwards with these techniques, being
17 able to keep people here in state, even, at this
18 point, having some of the patients from the Native
19 Medical Center being treated locally, avoiding,
20 again, a major transfer. These are people who live
21 out in Bethel and places. Getting to Anchorage is
22 difficult for them. If you can imagine getting out
23 to Seattle, it's almost overwhelming. So the
24 ability to keep patients here in Alaska is a very
25 important issue.

1 But to keep developing the program, it
2 really does need to have more advanced technology,
3 because there has been major rapid advances in the
4 past two to three years in the quality of image and
5 the resolution and the size of the equipment. So
6 now you can move these large IIs, the image
7 intensifiers, the X-ray projectors around the head.
8 And you put them in really funny positions
9 sometimes, and the larger this piece of equipment
10 is, it limits you how far you can move. So if you
11 have to put a tube under the patient's chin, the
12 smaller it is, the more you can tuck it in.
13 The image resolution is markedly better.
14 The computing power -- you can just imagine the
15 computer you use today versus six, seven years ago.
16 It's so much quicker. With any computer option,
17 program that you use, the ability to generate
18 three-dimensional reconstructions of the blood
19 vessels now occurs within a matter of seconds versus
20 many, many minutes. And the new equipment now
21 offers options where -- it is known as
22 three-dimensional road-mapping -- you inject a
23 little contrast in the blood vessel, and instead of
24 the old days where it may take 30 or 40 cc's of
25 contrast, which potentially can damage your kidneys

1 at high levels, you are now using 3 cc's.
2 So there is a major advantage just from
3 that standpoint of protecting the patient. These
4 road maps will rotate with the fluoroheads as you
5 are moving the angiography equipment around, getting
6 new projections. The new equipment, with the new
7 computers, will move your image with it so you are
8 not reinjecting contrast all the time, again making
9 things safer and more efficient.
10 So I think it is a good move to build a
11 new unit, to bring it in, because it offers a lot
12 more than what is available right now. And this is
13 a program that is going to be developing. It's the
14 need for the entire state, not just for the local
15 region, that we are going to be addressing.
16 So anyway, I am biased, I admit, but I do
17 see this as a major step forward. I think there is
18 a lot of major pluses that we will see in the very
19 near and very definitely in the distant future from
20 this.
21 So that's my say, so . . .
22 MR. HERGET: Thank you, Dr. Tolbert.
23 The next thing I wanted to address was,
24 in the event of a concurrent review, there are
25 additional considerations the department will take

1 into consideration. Those are quality of licensure
2 and accreditation surveys, and high levels of care
3 for low income and uninsured patients. And we feel
4 both facilities demonstrate all three of those. And
5 just as a note, we wanted to mention a couple of
6 things about Regional.
7 Right now -- this week, actually -- today
8 was the closing day of a quality review survey,
9 which is similar to JCAHO, but also takes into
10 account state, OSHA, and other regulations. And
11 it's sponsored by HCA, and it was a pretty intensive
12 review of our quality process. So we just finished
13 that this week. That represents our commitment. As
14 well, in the past two or three years, we have been a
15 pilot site for JCAHO's unannounced surveys.
16 Moving on to part two, addressing the
17 Providence project, our position is to oppose the
18 application for two catheterization labs.
19 Specifically, we feel the application fails to
20 follow and/or meet the two regs that are up on the
21 screen.
22 The first is the specific review
23 standards that are adopted by reference, and the
24 second is the service area question, where we feel
25 Providence's application doesn't take into

1 consideration all the cath labs in this market,
2 those cath labs being their four, Alaska Regional's
3 two, the one diagnostic lab at AHI, the new
4 diagnostic lab down in Mat-Su, and then any future
5 labs in Fairbanks.
6 The reason that that impacts this
7 application is because volumes from all of those
8 areas, even though they may be outside of the
9 immediate Anchorage market, have been in play over
10 the past two or three years, and so any volume
11 numbers that we look at will include the effects of
12 those labs.
13 In the application, Providence states
14 that this market right now, with just considering
15 their four labs and Regional's two labs, is at 88
16 percent. What that doesn't take into account is the
17 diagnostic capacity at AHI and Mat-Su. So maybe
18 there is a factor there of .5 or.75 for those labs
19 that should be considered, that some of the work
20 that we could be doing at our labs and have been
21 doing at our labs in the past is now being done at
22 those diagnostic labs.
23 The last thing we want to point out is
24 that Providence, in their application, departs from
25 the review standards and suggests a higher rate of

1 growth, I guess, for the projection. The review
2 standards that have been adopted talk about
3 utilizing the three-year historical trends, and the
4 application from Providence focuses on the growth
5 that they had in 2005 which, with all these other
6 labs that opened up, there's got to be a mix in
7 there that I think the state should look at.
8 So our proposal is that the state uses
9 the methodology in the regs, using 2004 to 2006
10 volumes -- which 2006 is now available. So we now
11 have three good years of volume -- and consider the
12 impact of AHI and Mat-Su as well as any Fairbanks
13 volumes that have come down to Anchorage, to do a
14 needs assessment and determine exactly how many cath
15 labs are or are not needed in the area. But based
16 on the application as it stands, we would feel like
17 it does not demonstrate the need for the two
18 additional labs.
19 I think that's all we have, unless my
20 colleague, Rick Davis, has additional comments.
21 MR. DAVIS: I think that's good for now.
22 MR. HERGET: Okay. So that's it.
23 MR. PIERCE: Thank you very much. And I'll --
24 Lisa, if you'd like to -- are you going to be
25 presenting?

1 MR. GILBERTSON: I'll do it.
2 MR. PIERCE: Oh, okay. Good.
3 MR. GILBERTSON: Give them -- I don't know if
4 they have copies.
5 MS. WOLF: We only have just a couple there --
6 copies.
7 MR. GILBERTSON: Here you go.
8 MS. WOLF: Looks good. Thank you.
9
10 PRESENTATION BY JOEL GILBERTSON
11 PROVIDENCE ALASKA MEDICAL CENTER
12
13 MR. GILBERTSON: For the record, my name is
14 Joel Gilbertson. I'm the Regional Director of
15 Strategic Development and Administration at
16 Providence Health System in Alaska. I'm here
17 speaking on behalf of Providence Alaska Medical
18 Center and the Certificate for Need request for two
19 catheterization labs for the AMC.
20 First, I would like to thank the state
21 for the opportunity to participate tonight for
22 Providence. The proposal that is before the state
23 right now is the addition of two catheterization
24 labs for our Providence Heart Center. The proposals
25 will bring one of the labs on line in 2007, and the

1 second one would come on line during the first part
2 of 2008. The total project cost is slightly over
3 $5 million, and Providence intends to pay for this
4 capital project through internal funds.
5 I think there has already been some
6 testimony about how these projects differ, but just
7 let me emphasize a few pieces of how the Alaska
8 Regional Hospital proposal differs from the
9 Providence proposal.
10 At Providence, 90 percent of the
11 procedures done at the Providence Heart Center are
12 currently focused on cardiac care, 10 percent of the
13 procedures are focused on other parts of the body,
14 and no neuroradiology work is currently being done
15 in our catheterization labs.
16 Providence Alaska Medical Center -- our
17 four current existing labs that have been spoken
18 about thus far this evening provide multiple
19 procedure types. This includes diagnostic cardiac
20 catheterizations, interventional cardiac
21 catheterizations, electrophysiology procedures, and
22 interventional radiology procedures. And not every
23 lab is the same, and they are not equally suited to
24 all procedures. Both do provide
25 inpatient/outpatient services, and they serve both

1 adult and pediatric patients.
2 PAMC, for virtually all of our service
3 lines, including our heart program, serves all of
4 Alaska. Currently 56 percent of the patients seen
5 are from Anchorage, 26 percent come from the gulf
6 coast and Mat-Su regions, 15 percent from other
7 parts in Alaska, and 3 percent are coming in from
8 out of state.
9 Only one cardiologist in the state is
10 currently located outside of Anchorage, and the
11 complex cases come to Anchorage for care. The
12 Anchorage labs will see more complex procedures due
13 to the availability of open-heart surgery. Attempts
14 to include the Mat-Su lab or AHI's diagnostic lab
15 and the Fairbanks proposed labs, which don't even
16 exist at this point, sort of fail to acknowledge
17 that the majority of the procedures, including the
18 more complex procedures, are being done in
19 Anchorage. And more specifically, those labs do not
20 offer the full complement of services offered in the
21 Anchorage labs.
22 PAMC's Heart Center is at capacity right
23 now. All four labs are operating at capacity and
24 are currently 40 percent over the state's targeted
25 capacity per lab. Our labs serve more than 20

1 physicians, including cardiologists and
2 radiologists. Scheduling, as you see, is very
3 tight. This is resulting in overtime, inconvenience
4 to the patients, physicians, and staff, and right
5 now we are experiencing a three-month wait list for
6 cardiac ablations.
7 I want to talk a little bit about the
8 trends that are being seen in the marketplace, and I
9 think that is important as you look at what
10 standards and methodologies will be used to analyze
11 the laboratories.
12 First, there have been tremendous
13 advancements in technology, allowing more procedures
14 to be done in catheterization labs. We're seeing
15 increasing volumes. It's not just that the
16 population is growing; it's that that population is
17 aging as well.
18 Also, the length of procedures -- more
19 complex procedures take longer to complete. This is
20 impacting the capacity and throughput in the labs.
21 Some procedures are taking four to eight hours.
22 So why two laboratories? Well, one
23 laboratory simply addresses overcrowding and
24 capacity issues within the existing four labs and
25 will allow us to improve operations and make sure

1 that we can deal with the overtime issues, the
2 rescheduling, the waiting lists. And the second lab
3 allows us, really, to respond to the growing and
4 continuing demand for services, which is shown both
5 in volume increases experiences within the labs and
6 the addition of new physicians in the Anchorage
7 market.
8 There is a community-wide need. There
9 are six catheterization labs, full-service
10 catheterization labs in the Anchorage marketplace --
11 four at PAMC and two at Alaska Regional Hospital.
12 Both facilities are experiencing the impact of
13 longer procedures, serving more physicians, and
14 doing new types of procedures. Together, looking at
15 these six labs, the current capacity is 85 percent,
16 which is a little above the state's target capacity
17 for a lab of 75 percent.
18 When you look at the state's methodology
19 to calculate community need, it's based on average
20 use rates. So there are some things that are not
21 being included, and they're worth noting and worth
22 examining.
23 One is that this formula doesn't account
24 for an aging population, so while there is some
25 reflection of population growth, there really is no

1 inclusion of the changing demographic of an aging
2 population that will require more services. It also
3 does not accommodate the increase in number and new
4 types of procedures that are being done, and doesn't
5 acknowledge the growing number of physicians able to
6 do procedures in Anchorage.
7 If you look simply at the combined volume
8 between Providence Alaska Medical Center and Alaska
9 Regional Hospital -- and Providence has not been
10 able to receive or have access to the 2003 volume
11 data at Alaska Regional Hospital -- you will always
12 get, at a time in which volume is increasing -- so
13 volume increases. Take any three periods of time,
14 years of time in any service, anything that is
15 increasing, even incrementally over a three-year
16 period. Using this methodology and formula will
17 always project into the future a reduction in volume
18 because it simply adds the three years and divides
19 by three and takes an average.
20 And so an increasing trend in volume
21 fundamentally always produces an outcome that volume
22 will decrease in out years, and that is inconsistent
23 with what is being experienced in the market and
24 inconsistent with what is being experienced in
25 healthcare.

1 So when you apply the methodology -- even
2 seeing tremendous growth in volume between 2004 and
3 2005 -- you project forward four years. You add an
4 aging population, an increasing number of
5 procedures, and a growing supply of physicians into
6 the state, and you come up with an inconsistent
7 conclusion, which is that volume is going to drop.
8 And for that reason, Providence respectfully
9 requests that the state consider using a more
10 appropriate methodology.
11 We put forward alternative methodologies.
12 One we feel that is fair methodology in examining
13 lab capacity simply looks at the growth that is
14 actually being experienced from 2003 to 2005. When
15 you look at simply the volume growth at PAMC, where
16 we have access to actuals for 2003, 2004, and
17 2005 -- and I'm on the bottom half of this slide
18 right now -- what you'll see is that there is
19 essentially a 7.7 percent compounded growth rate,
20 based on PAMC's volumes during those years.
21 Projecting that forward, we're
22 experiencing volume at the combined facilities of
23 7,000 procedures, almost 7,500 in 2009. Looking at
24 the use rate per 1,000 population, you're looking at
25 a use rate of about 10.7, and when you look at

1 current capacity, using the state's targeted level
2 of 750 patients per lab, with six labs we're
3 projecting forward to be at 165 percent of capacity.
4 When you look at this in terms of labs,
5 applying the state's methodology, you produce a
6 realistic number of 9.8 labs needed in the
7 marketplace, versus 7.
8 I wanted to wrap up with just a couple of
9 thoughts. One is that in the Alaska Regional
10 Hospital application, it includes a proposal for
11 neuroradiology as well as interventional radiology
12 procedures. Many of the cath labs that are already
13 in the marketplace, including cath labs at PAMC,
14 also perform interventional radiology procedures.
15 Alaska Regional Hospital's volumes
16 project that 75 percent of the procedures done in
17 the new lab will be interventional radiology, and
18 only 25 percent will be neuroradiology. However,
19 their application chooses not to use the state
20 methodology for interventional radiology for
21 projecting volumes, and thus falls under the same
22 standards that are used for cardiac cath labs, and I
23 think that's worth noting.
24 And finally, in conclusion, sort of to
25 share the reason why we move forward in this, the

1 Sisters of Providence came to the state in 1902, and
2 we've continued to look at ways in which we, as an
3 organization, can continue to increase and improve
4 the services we provide the state.
5 Our mission remains committed to
6 high-quality care, making it accessible and
7 affordable across the state. But we are having a
8 difficult time delivering that, based on the volume
9 that we are experiencing and the limited capacity in
10 the marketplace. As a result, what we see is that
11 there is a need for at least the two labs that
12 Providence is proposing, and that we are going to
13 have to assume that there is a capacity issue going
14 into the future.
15 And with that, I'll stop. Thank you.
16 MR. PIERCE: I think the sign-up sheet is down
17 here.
18 DR. LEWIS: Thanks.
19 MR. PIERCE: Well, we don't have anyone signed
20 up to comment, so I'll just throw this open. If any
21 of you change your mind -- have changed your mind
22 and would like to comment, now is the time.
23 So is there anyone here that would like
24 to say a few words regarding either of these
25 proposals? Okay. Come on up. If you would sit at

1 the table here and just introduce yourself.
2
3 PUBLIC TESTIMONY BY LESTER LEWIS
4
5 DR. LEWIS: My name is Lester Lewis. I am a
6 radiologist. I'm a member of Alaska Imaging
7 Associates. We provide radiology services at Alaska
8 Regional Hospital.
9 I was involved in the preparation and
10 planning for the catheterization lab -- we call it a
11 vascular interventional suite -- that Dr. Tolbert
12 was talking about that now exists at Alaska Regional
13 Hospital. It's the one multifunction room that's in
14 the facility. The other catheterization lab is a
15 specialized cardiac catheterization lab, so they are
16 completely separate.
17 So in the one big room, we do cardiac
18 procedures, the AP procedure. We do our own body
19 procedures, which are vascular procedures,
20 angiography, and Dr. Tolbert is using that room now
21 for the neuroradiology procedures.
22 When the room was designed and planned,
23 Dr. Tolbert was not here. And I, as a radiologist,
24 and my colleague radiologists don't do the studies
25 and the exams that Dr. Tolbert does. And so his

1 specialty was excluded in the planning for that
2 room.
3 The big thing I would like to point out
4 is, knowing how all the rooms are designed, I would
5 like to emphasize that the room that is being
6 considered for Alaska Regional Hospital is a very
7 specialized room. Just as a cardiac cath lab is
8 very specialized for the heart, this is very
9 specialized for the brain and the arteries and so
10 on. So this room, with the big imaging devices and
11 the table and essentially the more cumbersome
12 devices to use, was not designed for what he needs
13 to do.
14 In working with patients, not having the
15 best or the right equipment is a significant deficit
16 to the patient, because what happens is that you
17 can't see things perfectly the way you want to.
18 Dr. Tolbert is used to using other equipment, so he
19 knows what is -- what can be done and what is better
20 and now is forced to use this other less-easily-used
21 tool.
22 What that does is, it increases the risk
23 for the patient, so two things can happen. If you
24 can't see things as well, you might not get the best
25 picture that you want, and also the procedures take

1 longer. And so when the procedure time goes out,
2 the risk for something unwarranted or unwanted can
3 happen.
4 So the point I'd like to make is that
5 this room is very specialized. It's for
6 neurosurgical work. The room that we have now
7 wasn't designed for that, and that's the big issue,
8 and I think that's why.
9 What I see, too, in looking at the two
10 things -- I see a specialized neurosurgical suite
11 and specialized cardiac suites. They are completely
12 different. And I don't know the whole process, but
13 I guess I'm a little bit confused why they are
14 thrown in together into one consideration.
15 So that's the other point I'd like to
16 make. This is a very specialized room, and I think
17 it should be evaluated on the merits of that program
18 and that room, completely separate from a cardiac
19 catheterization evaluation. It looks to me, as a
20 radiologist and a physician, they're completely
21 separate entities. And I am not sure how the
22 process works, but I would also suggest that that
23 evaluation be separated.
24 MR. PIERCE: Thank you very much.
25 Is there anyone else who would like to

1 speak?
2 MR. HERGET: I just have a comment, if I
3 could.
4 MR. PIERCE: Sure. Yes.
5 MR. HERGET: Jordan Herget again from Alaska
6 Regional.
7 A couple of things I just wanted to state
8 for the record, that we did look at the review
9 standards that are there for the state, and we felt
10 the ones that applied for this particular
11 application are the general review standards and
12 then the concurrent review standards.
13 The reasons we felt that cardiac cath
14 standards weren't applicable is because we're
15 excluding cardiac cath services from this new room.
16 And looking through the review standards, we didn't
17 see any specific interventional radiology standards,
18 review standards. So I just wanted to put that on
19 the record.
20 And then the second question I have is
21 for Providence. The volumes that we looked at
22 earlier, did those include patients that could be
23 done in the diagnostic lab at AHI and/or Mat-Su
24 and/or any Fairbanks labs that get built in the
25 future? And did those include patients that might

1 be from the Mat-Su area that previously had come
2 into Anchorage, and would that inflate the volumes
3 going forward?
4 MR. HUGHES: My name is Bob Hughes. I'm the
5 Director of Cardiovascular Services at Providence.
6 Actually, there's a lot of similarities
7 with these applications, because they are both
8 specialized. I mean, there is very little
9 neurodiagnostic work available in Anchorage, and
10 it's highly specialized, and it needs to be
11 provided.
12 By the same token, the work that we are
13 doing and that we are applying for is highly
14 specialized also. And you are correct, there are
15 other labs, and they have affected the volume.
16 Providence has seen a significant drop over the last
17 two years in diagnostic cases because they are being
18 done out at Mat-Su or at AHI.
19 That being said, and with that drop in
20 diagnostic cases, we've still seen an increase in
21 overall volume. And the diagnostic cases are being
22 replaced by longer, more complex, and more involved
23 interventional cases that are being discovered in
24 the diagnostic labs and that are coming to us.
25 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

1 been put in in these applications.
2 (Public hearing adjourned at 6:00 p.m.)
3 C E R T I F I C A T E
4
5 SUPERIOR COURT)
6) ss.
7 STATE OF ALASKA)
8
9 I, LYNDA BATCHELOR BARKER, Registered
10 Diplomate Reporter and certified for transcript
11 services by the United States Courts and the Alaska
12 State Courts, hereby certify:
13
14 That the foregoing pages contain a full,
15 true and correct transcript of proceedings in the
16 above-referenced matter, transcribed by me to the
17 best of my knowledge and ability, or at my
18 direction, from the electronic sound recording.
19
20 DATED at Juneau, Alaska, this 3rd day of
21 March, 2007.
22
23 SIGNED AND CERTIFIED TO BY:
24
25 _____

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