STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
PUBLIC MEETING

Regarding:
Certificate of Need Application
for
Outpatient Surgery and Outpatient Imaging Services
Relocation and Ambulatory Surgery Center
Expansion - Anchorage

Applicant #1:
Alaska Regional Hospital
Applicant #2:
Providence Surgery Centers, LLC,
dba Creekside Surgery Center

March 1, 2011
Anchorage, Alaska

Meeting Conducted by:
Karen Lawfer

Reported by: Valerie Martinez, RPR

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TUESDAY, MARCH 1, 2011
4:30 P.M.

OPENING REMARKS BY KAREN LAWFER

MS. LAWFER: I want to thank everybody for coming. My name is Karen Lawfer and I'm the Certificate of Need coordinator for the State of Alaska. And we are in the process right now of doing what we would call a

concurrent review. And a concurrent review is when we have two Certificate of Need applications in the same area for the same service.

So today is the public comment period. It's what we call the public meeting, according to our regulations. Now, there's a couple of ground rules with this. This is not a meeting from 4:30 to 6:30. If you want to present comments and then leave, I will not take any affront whatsoever. This is a -- we do it for two hours so that people can come in if they want to come in, say what they would like to say, and leave. So that's not an issue, so don't feel that, you know, you need to stay here from 4:30 to 6:30.

The other thing is we are in a public comment period for this concurrent review. And that comment period is until Monday, 4:30 Monday. So if there is someone that you would like to have comments come into the office, et cetera and so on, I have the public

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notice here, which has all the contact information. You can just grab a copy of that or you can grab my card, either one. So feel free if you want someone to put some input.

Additionally -- and this has come up in a couple of other places -- if you are speaking to something and you don't feel like you got the point across and you want to put it in a letter, you'll still have a chance to do that. So even if you give a comment and spoken this evening and you want to add on something that was forgotten, something that has come up later on, you may do that in the comment period as well.

The two applications that we have, the first one is with Alaska Regional Hospital. And Alaska Regional Hospital is -- has put in a Certificate of Need application to relocate its ambulatory surgery center, or ambulatory surgery suites, and its outpatient imaging from the hospital to the VA clinical building. And it's about 32,000 square feet with a cost of $16.28 million. So that is what the first project is.

The second project, or the second application, that came in that will be reviewed at the same time with this application is from Providence Surgery Centers. And they are looking to expand their existing surgery center, which is on the first floor of the Providence

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Park. It's -- they're going to be doing business as Creekside Surgery, and complete in -- about 2500 square feet and house three additional ORs on top of what they have.

I have copies of both applications. So if anyone would like to look at them, feel free. That's quite all right. If you would like a copy of that, you can either e-mail me or you can go on to the web site. But if you're not savvy and you just want a copy, feel free to send me an e-mail and I will send it to you, because we do have it electronically as well.

And so with that, we're going to open up and Alaska Regional is going to give a presentation on their project followed by a presentation by Providence Surgery Centers on their project. And then we will be taking public comment and anybody else that has signed up that would like to speak. If you put down "no" on the list and you do want to say something later on, that's quite

all right. Feel free.
The only thing that I ask you, because we keep a transcribed record of this -- and our transcriptionist will have the sign-in sheet. However, if you would like to just please give your name. And if it's a strange spelling, please spell the last name so that we can get it into the record.

Okay. And I apologize. I tried to set the alarm so that the lights don't shut off at 6:00, but it kept ringing busy. So at about 6:00 the lights will shut off, I have to enter in codes, and we'll turn them back on. So I apologize beforehand.
And with that, I'm guessing, Sam, you are opening up? Annie is? All right.

PRESENTATION BY ANNIE HOLT

MS. HOLT: Thank you, everybody. I'm Annie Holt. I'm the CEO of Alaska Regional Hospital. And our project is to talk about an expansion of our inpatient surgery services and relocation of our outpatient services, which includes some surgical suites that are currently mixed with inpatient and imaging.
The VA building -- you'll hear us refer to VA, VACB, VA clinical building. As many of you know, the VA built a new building out by Elmendorf. They moved their services to that and vacated a very large building that sits right in the center of our hospital campus. And so our proposal is to take advantage of that vacancy central to our campus to expand services, and I'll go into a little bit more detail on that.
So we're requesting again an expansion of inpatient surgery. I'm going to show you some numbers. We've had a dramatic increase in the minutes and the complexity of our inpatient surgeries over the last several years. And our outpatient surgical patients are mixed in with our inpatient surgeries in the same ORs inside the main hospital currently.
We have determined by using the State guidelines for surgical capacity that there is no need for an additional outpatient surgery suite building in Anchorage in this market for the next four years, and that's using the State guideline. So we tried to come up with a solution that would respect those guidelines and projections, and this is what we'd like to propose and what we're requesting for the Certificate of Need.
We want to expand our inpatient surgery services by four dedicated rooms to inpatient surgery. There are currently ten -- we have ten surgical suites and one cardiac suite. And the surgical suites are combined, so we have inpatients and outpatients mixed in together. So the idea -- obviously it's more efficient -- to have complex inpatient cases turning over and following each other and more efficient to have the outpatient cases clustered together, so this enables us to do that.
What we're proposing is to -- and just so you know, our inpatient minutes have increased in the last four and a half years by 28 percent, so that is part of the reason why this demand has increased on the inpatient side.
Once we do this -- we're currently at 100

percent capacity. And, again, that's using the State calculations for standard capacity. So after we do this change, we'll be at 70 percent inpatient and 72 percent outpatient. So our projected surgical minutes by 2014 are going to be 1,136,000, so that's pretty substantial.

The reasons why we need to do this -- why we're proposing this particular solution is we researched what we could do and the obvious thing is to build. I've been in Alaska about 18 months and Alaskans like to build bigger and better.

So we researched that and we found that that would cost $150 million to build a new inpatient tower and add ORs and all of these other things. And we do need some additional capacity for our inpatient services.

And, again, mixing inpatients and outpatients is not very efficient and it's really not fair to the patients because inpatients are more complex and take more time. And outpatients, those surgeries go more quickly and can be done more efficiently. And we don't like to delay our outpatients, which are elective, when we have urgent and emergent inpatients either in our ICU

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or coming in through our emergency department.

So trying to balance the needs of all those types of patients, what we thought would be a much better solution would be to relocate our current outpatient to surgical suites that would be -- we just move those patients and suites into the VA via the clinic building. That would allow to us expand our inpatient services into the ten ORs.

So we're really spreading the mix of in and outpatients between two locations. But that makes us more efficient, that allows to us make our registration process more efficient, and allows us also growth, as you recall on the previous slide. We dropped from 100 percent capacity with everybody lumped together running through one main OR to 72 percent and 70 percent when we just separate the services as we're describing.

So in order to do that -- similarly with outpatient imaging, it's an issue when we've got patients that come in for routine x-rays and other types of imaging and we may have somebody coming -- a trauma patient coming through the emergency department that needs to get to the CT scanner now, our outpatients have to wait. So, again, we're moving, separating, the imaging, in- and outpatients as well for that convenience. So it provides a continuum of a one-stop

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shop and ensures quicker turn around for the outpatients and a better process for managing the inpatients.

Let's see. I think that takes care of that slide.

Most of our patient growth has been in neurological, cardiac, and orthopedic procedures. I'll blow our own horn. We were named by U.S. News & World Report in their 2010 best hospitals issue, we were in the top 50 hospitals in the United States for the quality of our orthopedic services and so -- also neurosurgical and our cardiac outcomes as well.

Alaska Regional, again, has seen 18 to 22 percent in growth. These are the main surgeries driving our growth, as well as -- like our colleagues in

town -- a new surgical robot, which again has increased the demand for those services. And a robot does take up a room. So it's great we can offer that service, but once the robot is in a room, you can't really work around it.

I want to show you our Medicare case mix. Medicare case mix is a calculation that's done by CMS, or Medicare, to show the complexity of services and the intensity of the services. And Alaska Regional has the highest case mix of all the acute care hospitals in the area.

So we have our other colleagues here. And as you can see, this is a reflection -- again, this is using government data and calculations to show that the procedures and the patients that we're caring for are complex and require a higher intensity of services and care.

So this is what the VA building offers to us, its availability central to our campus. It offers 32,000 square feet of covered parking with direct access right into the building. It's got a 20-year -- plus-20-year history of being an outpatient center and it's functioned very successfully that way.

It provides greater convenience to patients and their families. They can either park in the garage underneath or outside. There are walkways that go directly into the VA building and you can then -- would be able to access all the services from those two points.

It lessens the capitalization of a new medical tower. And it's less than $150 million to actually build out inpatient capacity to $17 million. And it supports the mission and vision of Alaska Regional in caring for our patients.

And I being a patient, I'm pretty picky about my health care. And if it's not good enough for me and my family, it's not good enough for our patients. And I'm also a nurse by original training and so I'm very passionate about making sure that we do the best we can for our patients, so we provide our patients and providers with a viable choice that is more efficient. It provides an opportunity. We hope to be able to develop -- better our imaging services for women. We separate, as I've mentioned. It's just a greater impact on being able to focus our care on those two populations.

And this is what I've described for you again. We have ten surgical suites. Currently all in- and outpatients go through those ten. Really our inpatient surgeries are constraining the growth for outpatient surgical services and the inconvenience.

One thing that happens is you may be in our hospital for an outpatient procedure that's elective, you know, a ganglion taken off of your wrist or something, a trauma patient comes in and has to immediately be rushed to the OR, and your case gets bumped. And it may get bumped until the evening. If you haven't eaten all day, that's -- and you're waiting for surgery and you're an outpatient, that's -- it's really not the kind of situation you want to be in or you want your family to be in and we don't want that

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either.
So our minutes have increased 6 percent, I think, year over year in terms of the number. And I think we've summarized all of these. These are our current operational issues; inconvenience, people getting rescheduled. Inpatient registration takes a lot longer. We want to know a lot more about you if you're coming in as an inpatient. And then, again, the service expansion is due to demand for more inpatient surgeries.
So I think we've showed you all the numbers. And then -- Sam, got the wrap-up? I think we've talked about that, the things getting pushed out. We do need ten full ORs for inpatient so that we'll grow our inpatient capacity into those and just shift our outpatients to the ORs in the VA. We are not -- we are serving our current population on the same campus. This will allow to us adapt to future needs.
And, you know, you're going real fast, Sam. I'm not looking at my notes. I think I'm not finishing.
MR. KORSMO: You're doing good.
MS. HOLT: So, anyway, that just summarized the projected population growth that also then feeds in besides our current patient base.
Outpatient is increasing nationwide. The ability to do outpatient procedures has increased

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dramatically. We have specialized professionals on our campus that we really want our people in Anchorage and Alaska to access those professionals. We have advanced technology to provide a higher level of care and by doing it more in an outpatient arena at a lower cost.
So we mentioned this about a combined -- the State guidelines for a combined use OR. Capacity is at 94,250 minutes. We've mentioned about the 72 percent -- once we make this transition -- inpatient and 70 percent outpatient. So that gives us the capacity at a much lower cost than building a new tower.
This is interesting. Well, let's flip to the graph. These are average surgery minutes. Alaska Regional inpatient, our average surgery is 159 minutes. The outpatient average case is 95 minutes. Another local competing hospital is -- they're both less, lower; 122 minutes, 70 minutes. The national average for an inpatient, 130 minutes, and national average for outpatient, 79 minutes. So you can see again this reflects the higher complexity of cases that we're seeing.
We've mentioned the 22 percent, the case mix index, and that summary is that it's 20 percent higher than any other acute care hospital in Alaska.
So our outpatient services center in the VA

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would include the outpatient surgery patients put in suites there, the imaging center, and some lab draw station services.
That just shows the growth rate. Next.
This is the first floor of the VA. Outpatient surgery over here. Other outpatient over there.
And then our campus map. My finger is the pointer. This is the VA building. Our main OR is right there. It's a covered walkway and then we have access to all these points on campus. But as you can see, it's

center to our campus and a very convenient access.
So we need a Certificate of Need to expand inpatient surgery and relocate our outpatient services to the VA to meet the needs of our patients. We are dedicated, as I mentioned, to make sure that we provide the best that we can for our patients and our families. And the expansion of the inpatient surgery and relocation, we ask that you approve and support the Certificate of Need for us to proceed with this.
Any questions? Thank you.
MS. LAWFER: Thank you.
Next -- unless someone has to leave and would like to give comments, I'll defer to Susan for the Providence presentation.

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PRESENTATION BY SUSAN HUMPHREY-BARNETT
MS. HUMPHREY BARNETT: Good afternoon. I'm Susan Humphrey-Barnett. I'm representing the Creekside Surgery Center. And I apologize to all of you and to my fellow Creekside board members. I learned that one of the consequences of Providence having implemented our new Epic IT system over the weekend was that we have so much encryption in so many places I really was not able to download my presentation on to a thumb drive and bring it here today. So I will just -- I do have a copy to leave with Karen and I'll just be speaking from my notes. So I apologize for that.
The Creekside Surgery Center is an ambulatory surgery center, four class C operating rooms, located in the Providence Health Park. It opened in November of 2010. It is accredited by AAAHC and currently serves orthopedic, pain, and podiatry patients and will be adding ENT and spine services in the coming months.
We lease the first floor of the office building, which houses orthopedic and neurological medical practices as well as the sleep center. The floor print of the building is such that it allowed Creekside to shell in space for three additional ORs for future use. And we are now asking the State permission to complete the tenant improvements and purchase

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equipment needed to bring these three shelled-in ORs in to use.
The cost is projected to be $1.82 million for equipment, plus another $118,000 a year in lease costs. The tenant improvements are going to impact 244,000 -- I'm sorry -- 2,444 square feet. And the tenant improvements will cost $978,000. But the cost of those tenant improvements would just be folded into the lease, so the lease goes up. If approved, the tenant improvements and equipment purchases could be completed within eight months.
When Creekside got their CON -- I want to read from it -- the State put a condition on this shelled space. It did say, "A condition of approval is that any shelled-in or other space planned for conversion to additional surgical suites at a later date must go through the Certificate of Need process and be approved by the department, regardless of cost, prior to expending any funds for conversion or operation."
So the State was fully aware of our shelled-in space, but directed us not to go forward even if we were

going to be spending under the CON limit amount without going through the CON process.

As far as community need, we used -- in our calculations, we used the same catchment area as was used in the original CON for the Creekside Surgery Center, so it's broader than just the Anchorage area. It's Anchorage, Mat-Su, Valdez, and Cordova.

So we believe that for ambulatory surgery purposes, it's appropriate to assume that individuals can and do travel to population centers, such as Anchorage, to see the physician of their choice or to receive services which are unavailable in their own community.

We see the trend towards surgeries being performed safely in an out- -- more surgeries being performed safely in an outpatient setting, is one that will continue. We see that technology will continue to decrease the invasiveness of surgeries and the time needed to complete them. Minimally invasive techniques lead to fewer complications and faster recovery. And we believe the population of the service area as a whole will continue to grow, although more slowly than in previous decades.

So to arrive at our -- the population projection that we used for our calculations, we took the State of Alaska population projections for 2007 through 2030 and took their population projection for 2015, added the 2015 population -- and that was for Mat-Su and Anchorage -- added the projection for Cordova and Valdez for that same period, then you had to add a year's worth of growth for the year 2016 because you -- the State wants you to look at five years from the implementation date, so that put us to 2016, and then we subtracted a percentage to account for the Alaska Native population since the Alaska Native population is more than likely to be served by ANMC than one of the other local hospitals.

In the formula the State is now using to calculate, it says, "population times use rate equals caseload." And then you take the caseload, minus the existing capacity, to get the unserved capacity and multiply the result there. Well, you actually divide it by the target use, which is 900 cases for an inpatient room or 1200 cases for an outpatient room.

So using that formula, we arrived at a need of 5.4 surgery suites. But, unfortunately, there is a catch. The use rate that was available to us at the time that we were developing this application last fall was the January '05 use rate document that we got off the State CON web site. We had asked the department for the updated use rate information, but unfortunately we didn't get that until the afternoon before our application was due. So we put our application in using the calculation I just described.

The new use rate data from the State is different than what was used in our application. And if the department concludes using that new use rate data that there is not a need for additional surgery suites, basically in this area, we certainly will abide by that decision. I've tried to run projections using the new

use rate data and it's difficult because we use this larger catchment area, including the Mat-Su, so we didn't really have an apples to apples comparison.

But as far as I was able to get in that projection analysis, it does not appear that it's going to -- that there will be a need for more ORs of any type in this area. But as I say, it's up to the department to look at that and make their determination.

So just to summarize our project, it's a simple, straightforward project that we just build out and equip the three shelled-in operating rooms that we have available to us at Creekside. It's 2,444 square feet at $1.82 million for equipment and additional lease costs of $118,000 a year.

If the department agrees with the need projections that are in our application, then both ARH and Creekside would be able to add operating rooms, which would meet the community's needs for the foreseeable future, at least for the remainder of the

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decade.

Our project is easy, fast, inexpensive to implement, and should be approved if need is found to exist. I'll leave it at that.

MS. LAWFER: Thank you.

Again, unless someone has someplace to go and would like to talk, I'll just go down through the list, if that's all right with everyone.

Lester Lewis. And you can speak from there, you know, as long as our transcriptionist can hear it, and I think we're probably fine. You don't have to get up unless you feel the need to.

PUBLIC COMMENT

DR. LEWIS: I'll get up. I know most people here.

So I'd like to just talk about the imaging services, a portion of the outpatient service project. I'm a radiologist. My name is Lester Lewis. I've been with the campus, Alaska Regional Hospital, since 1992, so I'd just like to give you my perspective of what I've seen since then and where I think we should go. And I'd like to convince you to support the project, the CON.

To roll back the clock to 1992 when I started, there were two MRIs in the state. There was one at Alaska Regional -- what is now Alaska Regional and I

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think one at Prov. Also, Alaska Regional at that time, there was one CT scanner in 1992. By 1995 we got our second CT scanner as a backup, essentially, because for the hospital and for the emergency department, we needed one for backup. Similarly, the imaging devices in the department were in single digits, radiology, the RAD equipment and so on.

If you look at it now, I believe we've been told there's 34 MRIs in the state and 36 CT scanners in the state. At Alaska Regional right now there is still one MRI, just one, and there's still just two CT scanners. So we've been very frugal as far as the imaging devices over this long period of time. And that may be good, but I think there's a cost and it's cost of service. And I think that's why we're going to the service center right now with this project, and I think that's why it's important.

To understand what's happened in the department, I just want to describe just a little bit about the layout of the hospital campus. So the main radiology department right now is in the center of the hospital. It's in the old building. And as time has gone along, there's been expansion projects and so on, but the radiology department has not expanded in that core. Instead, devices have been clipped out into other

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buildings. And so we have ultrasound and mammogram in Building B and we have the MRI scanner that's all the way at the end of the hallway in Building A. And so we don't have a core. We don't have a central physical area where all the devices are.

What happens with that when a patient comes in to get an exam, they'll come to radiology, they'll get registered, and they find out, well, now they've got to go to a different building all the way down the hallway down to the MRI device. And so that may be okay for a lot of us, but for someone that's in a wheelchair or debilitated, then it's more difficult. Or they may have to go over to -- walk across the walkway, find their way over to Building B, and then get a mammogram over there.

Or if they're really unlucky, they might have to register in one place, get a chest x-ray in one place, walk over to another building to get a mammogram, and then walk to another location to go to the laboratory. So essentially, it's logistically difficult for the patients in a hospital setting to get things done in an efficient matter.

The department certainly has an obligation to service inpatients and the emergency department. So the urgent cases that happen -- when there is an urgent case from those two areas, the exam gets done right away. So

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if you're a patient of course waiting in the waiting room for your 1:00 appointment and then there's a car accident and there's three CTs that need to be done, well, you're just going to get bumped and it could be for a period of time. It's very, very difficult to run a schedule when inpatients and the emergency patients take precedence.

So a person takes off for their two hours off of work and they come in for their CT scan and they get bumped, well, they may go home because they're out of time and then have to reschedule if they can. So it's very, very difficult for the patient to be seen in this type of setting without outpatient services being available to run a more efficient schedule.

Access is limited as well, too, because we have limited resources. We have one MRI; one CT scanner. Everything else is in single digits in terms of the radiology devices and ultrasound, too. Pretty -- we have two ultrasound devices, two RAD devices.

So what happens with that is, a patient sees the doctor, has a problem, wants to get that addressed right away, needs a CT scan. So they call up and they hear, well, we can -- it's Tuesday now and we can do Thursday. Well, they don't want to wait until Thursday and so what they do is they call somebody else. Well,

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their last three CT scans have been Alaska Regional comparisons and now they go out to another facility, an

outpatient facility, and they get that done. Well, there's a logistics problem now because some images are here, some images are there, and so there has to be some coordination to get those together to give the patient the best review of the imaging devices.

What is even worse that happens is that they have an outpatient exam done at one location outside of the hospital and then the doctor or the radiologist recommends a biopsy. Now the patient is scheduled for a CT-guided biopsy at our facility, but we don't have the images and so we can't really work up that patient to know what the best thing to do is without those images from that other location. So someone has to get those. They have to get the CD, plus the notes, from the outpatient device, and they're going to have to get it to us in our facility so we can do the biopsy.

Many times that happens. Sometimes however that doesn't happen. So that means the patient or the doctor or the department or someone has to go get that image so we can look at it and we can do the biopsy. Sometimes when you get that CD, it just doesn't work in the computers that we have because it's proprietary software and so you can't even load it up and look at it

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to see what happened with that patient.

So even though the patient has been treated multiple times in our facility and they go out to get something else, there is this problem with coordinating all that. And it just makes it hard. It makes it more difficult for the patient, for the doctor, and for us.

And these are not hypothetical circumstances that I'm describing. This is what happens on a daily basis. This is one of the problems that we deal with. So not having the access for the patients to get their images done all the time, that's a big problem for us and a big problem for the patient.

With outpatient imaging services, those problems go away. And the big thing of it is, is that all the devices are located in one spot. They're in the clinic building that has easy access. So whatever the patient might need for imaging, it's all there. Also, the laboratory is right there and other support services are there. So it's the one-stop-shopping concept that was described before.

But for us, that's a huge difference. Right now we're working on the inpatient ER type of model. Scheduling is very hard. We don't have this outpatient model. So it's not just additional devices that we're adding on, we're actually adding a big, huge concept of

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service that's not there. So it's more than just the individual parts. It's much, much more service to the patient that I believe our patients deserve.

Also what's there is best technology and the specialists to do either the procedures or the imaging that needs to be done. Right now, again, not only the devices are scattered but our radiologists are scattered.

So if a woman comes in for a mammogram over in Building B, it's very difficult to look at the mammogram, make a decision, get in touch with the physician, and decide to do something about that if there's an abnormality. In the imaging center, in the

outpatient center, one of our concepts is a women's center. So a woman comes in with a mammogram that's looked at right away, there's an abnormality, we talk to the doctor, decide what to do, a biopsy might be needed, and that can be done right away or right there because everything is in one spot.

And so we can do that now to a certain extent, but right now it's very, very difficult. What the centralized concept allows us to do is it allows us to do that efficiently and then provide that to many more patients.

So I guess I ask for your support because this

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is a big, huge step for the hospital. This has been a long time. If you look at our history, we have many deficiencies in the department that we can solve with this. And we can provide a much better service to the patient in that imaging center concept.

So I believe our patients deserve that, I believe it's long overdue, and I ask you for your support for this project.

MS. LAWFER: Thank you.

Tom Vilaseff -- Vasileff. I'm sorry. I apologize.

DR. VASILEFF: I'm the orthopedic surgeon and working at Creekside and I'm on the board there.

When people apply for Certificates of Need, there's a process that we under- -- everyone undergoes and there's this statistical analysis of the needs of the State. Well, I'd like to quote Mark Twain who talks about statistics. He says there's lies, there's damned lies, and there's statistics.

So what that means to me is, when you evaluate things like needs, it's very arbitrary. For instance, in the surgery center now, there are many, many cases that we're doing now that two or three years ago were not possible to be done as an outpatient that were done, you know, as an inpatient. For instance, now we do like

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knee surgeries. ACL reconstructions are typically done as outpatient surgery. But several years ago a patient was in the hospital two or three or four days. Simple laminectomies now are done as outpatients and they were, again, in the hospital three or four days. Now the general surgeons are doing gallbladders.

So my crystal ball isn't very good, but I can tell you just using what's -- looking at things that have happened in the past five to ten years, there's been a huge shift to outpatient surgery. And this is for many reasons, not just technology. But these outpatient surgery units are showing that they can do a more efficient job, a better quality job, fewer complications, and the patients like it.

So the way I see things, and again my crystal ball isn't very good, is I see a very large increase in outpatient surgery. And if you use statistics, I think that doesn't really tell us what's really going to happen in the next five to ten years. I think we're going to see -- we're seeing right now an explosion in outpatient services, because it -- not only because of what can be done from a technological standpoint but because of the quality that outpatient surgery offers.

And patients like it. The doctor is more

involved. What's happening in the hospitals now is the
doctors have sort of advocated their responsibilities to the hospitals to let administrators take over. And that's not to say that they're not doing a good job, but in the surgery center environment, the outpatient surgery center, the physicians are much more intimately involved. And I think we can do a better job of managing the care of our patients than the administrator. And I think that has been shown.

And then there's also the efficiency of anesthesia. I think if you had dedicated anesthesia in the surgery center, it's been shown that those anesthesiologists are more attuned to a patient as an outpatient than an inpatient. I think that was pointed out in the Alaska Regional presentation that the care and the quality of services as an outpatient has significantly risen and I think it will continue to rise.

MS. LAWFER: Thank you.

Next I have Dr. Chennault.

DR. CHENNAULT: I guess I have too many notes, so I'll just have to speak very quickly. I am Regina Chennault and I am a general surgeon/trauma surgeon. I'm here supporting the Alaska Regional CON.

I can tell you all my reasons for that. My office is over there, for number one. But I wear many
hats and so I represent the Alaska Regional CON on many different sides.

I'm a mother of four. I'm a hockey mom, so we've been in the ER lots of times with my children. My husband fell and broke his ankle, had a severe fracture through his ankle. He had to wait four hours to get into the OR. And that had to do with a number of cases that were elective and already scheduled and had to get finished before he could get in.

I'm also a trauma surgeon. I'm the American College of Surgeons chair for the State of Alaska committee on trauma, which is the national committee on trauma. And I take a lot of trauma calls at Alaska Regional. Sometimes up to 14 days a month. And when I have a man shot or a woman or anybody shot, I need the OR right now. And on any given day, if we walk over there right now, they're probably all still running. So it's quite a problem having all of those patients that could be out in those other rooms right in the building adjacent to where our inpatient ORs are.

If we pulled all those patients out, we would have space to have this room available for the true emergencies. And the sad part about that is it just doesn't have to be the drug dealers that get shot. It could be any one of us that's in the wrong place at the
wrong time; car wrecks, you know, the moose fell on the trooper's car. You know, there's a lot of strange things that can make each one of us end up there and need those services.

And back to the trauma issue. It's been well published -- and this is from the American College of Surgeons -- that once you're injured, once you're a trauma victim, your morbidity and mortality is lessened by 25 percent if your care is received in a timely

manner. And those come down to minutes. They're talking about minutes of response time for surgeons; minutes of times of getting into the CAT scanners, suppose you have a head injury or a head bleed; minutes if you have intraabdominal or intrathoracic injuries, just getting into the OR, which will make all the difference in saving your life.

And I have five patient testimonials that I can kind of summarize. Go back to December 2008. And this one -- particular one is a 50-year-old woman who had had six months of urinary symptoms. And she had been seen in Soldotna. She's actually a personal friend of mine, a fishing buddy of mine, because I like to fish the Kenai River.

She was treated with us. She had a urine infection and then she noticed she had some blood and

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she came up and saw a primary care doctor based out of an office at Alaska Regional Hospital. She underwent further diagnostic tests, including a CAT scan, but it took many, many, many days to get her in because she wasn't shot, she wasn't in the ER, she was in no extreme pain, she didn't have any -- she didn't meet any of the criteria to bump somebody off the already scheduled CAT scan schedule.

So she waited several days before the CAT scan appointment became available for her. She then ended up seeing a urologist. Looking at the CAT scan, he really thought this was definitely cancer. So her level of anxiety and worry and just her mental anguish and such rang over this situation for her. And she really felt that she really wanted her care at Alaska Regional, so going to some other place or some other place that might accommodate her would not have been okay in her mind.

The CAT scan did confirm that she had a very large kidney cancer. It turned out not to be one -- not a good one, kind of an aggressive one, and so she wanted her surgery to be scheduled as soon as possible.

Well, that's the next thing -- because this is December 2008 that I'm talking about -- is it was impossible for her to get on the schedule. She was just told no by her urologist. The office had called and

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they just couldn't get a spot for her. Well, that wasn't good enough, so I think she ended up calling me or something. I forget what happened. Anyway, she eventually got her surgery scheduled on a Saturday at Alaska Regional and she got told that it would be a time in the middle of the day, 10:00, 11:00.

Well, then emergencies started coming in like head injuries and the neurosurgeon took the room and then somebody got shot and the general surgeon took the room. What turned in to her coming in early in the morning to get an early morning operation, the operation didn't start until 8:00 p.m. that night. I know because I was sitting in the waiting room with her husband.

The operation took two or three hours. I mean, this was just hard on their family. Their family -- it's a big local family, a family that's been here in Anchorage for many years, in the state of Alaska for many years. And this was just wreaking havoc on her, the time that she had to wait.

I know she worried constantly about the spread

and -- the spread of the disease and waiting for -- waiting that long to actually be able to get in. These were delays that added up to weeks actually when she had a very aggressive carcinoma.

So, you know, again, she was concerned about her -- this was -- again, I think somebody mentioned this. I read a study about this last night. But Glenda was very concerned about the possibility of -- as the time got pushed on for her surgery, about how awake is that anesthesia doctor now, how does my surgeon feel now, isn't my surgeon worn out at this time.

And there was just a paper that came out that surgeons are making a lot of mistakes when they've been up all night or they've been working all day or they're very tired for whatever reason, the pager going off or whatever reason.

So she even had a talk that night -- and I was there in the room with her -- where she asked the doctor, did you get enough sleep last night, you know, was he going to be able to function at his optimal level of function. And, again, I just read that in a journal last night that there are many -- with many continuous hours of work or just being awake, that more mistakes are made or the physician, the surgeon in particular, is more slow and more impaired to react to something than they would be otherwise if they had slept all night or not been so exhausted.

So as they were having that conversation before she rolled back to the operating room at 8:00 at night, she was offered the -- because of all -- she was just -- you know, as you imagine, like a cat clinging from the ceiling, she was upset. She asked what her options were. She was offered -- the surgeon said he would operate on Sunday, but that didn't guarantee her just like it didn't on that Saturday that she would get an 8:00 a.m. or a 10:00 start. That's where she'd be listed on the schedule, but the same things could happen when an injury comes in that has to be dealt with, somebody shot or stabbed or somebody is in a car wreck, a child is run over by a car.

So she was offered the Sunday, but because there was no guarantee, the same situation could happen the same day -- that things could play out the same way. But her concerns that she brought forth to me was that she was very upset with how long the cancer had been there during this whole process that it took to work out and her surgical care to actually be accomplished and completed.

The second one was the delay in going and getting the CAT scan. I think that took most of a working week to get her in there just because it was so booked. Then the OR schedule. Giving her such an unconventional time, she was actually very happy. Everybody was very accommodating. But then the fact that she got bumped, she was very concerned about that.

And then she said she couldn't even sleep at night because she had waited longer than that scheduled time. She didn't want to go on to that Sunday because it could delay in getting that very aggressive cancer out of her even more, but she was very concerned about

the late time, the alertness of the OR team.
And here's -- I am a trauma surgeon and it does bother me. I have been working all night and all day today, and I think I feel kind of normal right now because that's usually what I do. But she was worried about, you know, what if my urologist needs the pathologist. Well, it's true. They're usually not there at 8:00 on Saturday night.
So there's some issues that the support staff and just not to mention -- and radiology, too. Sometimes I might need Dr. Lewis to look at a film for me or interpret something for me that I'm trained in and very capable of reading myself, but those ancillary people and all those support services are just not there.
I've got just a few more quick ones. I'll go faster with this one. That one I just -- is a personal one that I knew way too much about.
This one is a -- goes back to just last year. A 50-year-old young woman was driving -- she was driving
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back and forth from Seward and Anchorage with her family. They were getting ready for Christmas. And on their way up, they actually had to pull over so she could throw up. She had a miserable ride up from Seward. And then her belly started hurting and she was in extreme pain.
And she was brought in to Alaska Regional emergency room where she did get a workup and she needed these images. She was not in any extremist state, as we say, not unstable, not meeting admission criteria, those types of things, judged by physical exam and vital signs and the things we use.
But, again, to get her outpatient imaging scheduled, it took quite a while. And it was just booked and it was hard for her to drive all the way back and feeling this way constantly. It turns out to be a gallbladder. I bet lots of people in this room know how bad that can make you feel.
So she was a trooper about it. She would drive to Seward and drive back up here and come to Alaska Regional and get her imaging. I mean, after the ER visit. And she would go back to Seward and then she would come back and get her imaging studies done.
But they always told her, if she could wait, they could try to fit her in, but that gets into the
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issues that I think Annie mentioned that -- maybe Dr. Vasileff mentioned -- that you've already taken some time off work or you've got kids or you've got another obligation and you've got this very short amount of time and you schedule something and you really do think you're going to go there and get it done. She even tried that one day and that didn't work out. So she was a little bit dissatisfied about that because of the expense of driving back and forth from Seward.
She was not able to get on the OR schedule because it was booked. And I have blocked time, but she couldn't fit in there because that was just all blocked in around me by other people that had blocked time. So she was told that she could sit around and get on the schedule past 6:00, 7:00, 8:00 at night.
And, again, if I start a gallbladder surgery,

which has a chapter of things that can go wrong, if I start a case like that at night and I need a radiologist to read my x-ray that I take or if I get in there and I find that this doesn't look like regular gallstones, this looks like cancer, I might need to be taking out pieces of a liver or something, I might need to call in a vascular surgeon. And none of these people are going to be maybe not even available at 8:00. Maybe not even able to come help me. So that is just not the optimum

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patient care.

So she was kind of, you know, miserable during this whole time that this -- she went back and forth between Anchorage and Seward. So we were actually able -- I was more than willing and the OR actually at Alaska Regional accommodated, even though it wasn't an open day, a routine day for surgery -- I took her gallbladder out on Christmas Eve.

But, again, I've just mentioned the dangers of routine cases outside of regular business hours as not being optimum care for the patient because we just may not have everybody we need in-house. I specifically mentioned other surgeons and radiologists and specialty doctors and pathologists, which we always are -- we always strive to do the best care we can.

The next one is -- this is an amazing story. He's a 58-year-old man. The brain surgeon in the room is going to know him. He had an aggressive kidney cancer bout in 2003. It looked like he was going to die from his kidney cancer. He was cared for at Alaska Regional.

He did fine for a couple years until he started having some symptoms and he was worked up and had a CAT scan. And he reported all these delays in getting this CAT scan. Again, because of the scheduling

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issue over at Alaska Regional. And it ends up that he ends up having a craniotomy in 2005 to remove this kidney cancer that spread to his brain. So he's a survivor of two aggressive cancers in two different parts of his body.

And how he meets me is after surviving these two major operations, again, he's passing through town. He actually lives in Moose Pass in a cabin, which is down towards Seward if you don't know that. But he works up north kind of in the Nome area and has a dwelling there and his son lives here in town.

So as he was on his trip back and forth to work, his commute, he was getting very, very sick. Just like this other lady from Seward, he would just suddenly have to pull over and throw up, extreme pain. The driving -- the trip was almost unbearable and he was driving himself. He was by himself. The other lady fortunately had her husband driving her.

And as he was passing through town, he got sick and he came over to the emergency department at Alaska Regional. So I came to see him. And he had developed sort of this fear of eating. If you've ever had gallstones, you know what that is. You know what things are going to make you sick and stay away from. These patients usually lose a lot of weight because they

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just think they're going to be throwing up their

eyeballs and they just don't want to eat anything. And sometimes they get to the point where even water will set that off even though that's not a fatty food.

So he lost a lot of weight. In his job, he's a pretty high-ranking person. I was asked not to give too much -- because of HIPAA violations and things like that -- too much information about him. But it was getting to the point where the weight loss and the weakness that he had was affecting his ability to really function and do his job, so he was having difficulty in those ways.

Because of the situation of his malignancy in both the kidney and the metastatic renal disease to his head, I thought, well, before I just go rushing in there -- it sounds like a gallbladder that needs to come out -- I have to do my due diligence as a surgeon and make sure that while that could be recurrent kidney cancer or a different kind of cancer, it could be something else.

So he's in my office and I actually myself pick up the phone and call over to scheduling, centralized scheduling, because I want a CT of his abdomen. And I'm told, oh, it will be in like a week and a half. But this man, he needs his paycheck, you

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know, so he's traveling around and staying in these different places and his life is very complicated. And he just said, forget it. I'll go down the street to XY facility. So he went to a freestanding facility. And within about an hour, I had the report in my hand from him getting a CAT scan at this facility.

The problem with that, though, is -- and Dr. Lewis touched on this. I'm up in Dr. Lewis's office on a pretty regular basis. I would almost say every day. He's probably getting tired of looking at me. But when I have a patient, especially something that's not straightforward, I want to look at this study with the radiologist. I trained a long time ago so I was trained to look at my CAT scans myself and make my own readings and come up with my own determination, but it's always nice to look at the radiologist -- look at the film with the radiologist because they may see something different or they may see something that you don't see at all because they look at CTs all day.

So the problem was, I had the report but I couldn't get the film. They sent a disc. I couldn't get it to open. And I've had this issue with traumas that come up from the Valley. They put them on a disc and they've already scanned this patient, exposed this patient from head to toe sometimes with that much

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radiation, and we have to do it all over again, which is just a bad, bad deal. There's starting to be lawsuits over exposing patients to too much radiation, specifically leukemia and some different kinds of cancer.

So it was great that I had his report, but it was bad because I couldn't compare it to the films that he had at Alaska Regional before. And this is a huge -- again, we want to take optimum care of the patient. I know that's why we're all here at this hour talking about this. So that's his story.

There's just two more that are shorter.

There's a recent case where a young 59 -- I think 59 is young. I think it's the new 40. A young man comes in to Alaska Regional, seen in the emergency department. He gets a CAT scan because he's in the ER, so that's not such an issue for him, and then he gets the scope he needs and the biopsy he needs. And then he's kind of sick for a day, but then he's ready to be put on the OR schedule.

And I, again, pick up my own phone in my own office -- because I'm just usually doing a lot of things myself unless I'm having staff members do it -- and I was told that the earliest that I could get him on would be a few days. Well, he's not really an emergent case

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at that point, so -- and I don't do that. I don't ever say, yes, this is an emergency just so I can go next. It's just not my -- not the way I roll.

So I was told it would be a few days. And so, again, we have this cancer patient. So remember these two patients I'm talking about now have cancer. A minute, an hour, a day, a week, we don't know, it just depends on the aggressiveness of the tumor, for them to wait, that's just not the best standard of care that we can provide these people. I mean, it would be to get them in the CAT scanner the next day and on the OR schedule the next day. That would be how that should happen.

So I know that if we can serve these people in a more timely manner by getting these outpatient surgeries -- and I do a lot of outpatient surgeries as a general surgery, lumps and bumps and biopsies and things like that -- I know that we would serve all of the patients better.

We just have to focus on patient safety, and that's what medicine has become about all these days. And, again, starting late. I was offered a time like at 8:00 at night and I'm like, no way. This could be grown into his liver. I might need our interventional radiologist who may not even be in town. I don't know,

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you know, if we haven't set those things up ahead of time. So it's just not an ideal situation for the patient, the hospital staff, and the surgeon.

And if you'll allow me just a couple more minutes. This last one is a patient -- this goes back a couple of months. This goes back to last year. This is a terrible situation because I am on the committee on trauma and I am very much involved at the state level and the federal level and the city level in the delivery of trauma care. I serve on the mayor's advisory board for EMS, Mayor Sullivan. I serve on the state trauma committee. I've served under that since Murkowski, so I've served under three governors on that. And I've been on a committee on trauma, the chair, for the State of Alaska since 2008.

So I got called in to Alaska Regional. Somebody had -- a patient came to the ER, had a CAT scan. Because it was an emergency, there was no radiology issue on that one. He did have appendicitis. So I'm standing there waiting.

But because the whole day the board was so jam-packed with cases, they still had a handful of rooms that were still going and they weren't these little

simple outpatient procedures. They were maybe a more complex neurosurgical or orthopedic procedure or something that was just going to take hours and hours and hours.

And so I just sat there because it's not worth me -- I'm not a really good winter driver, so it's not worth me trying to get out on the roads and trying to get home and trying to get back. So I just sat on the couch in the surgeon's lounge and basically watched TV and got to find out what's going on in the world for about three hours, okay, until all of those rooms finished and then they let me have one of those crews.

And what happened there is, you know, once I started the operation -- and it turned out not to be so straightforward because he had this very complex hernia. And I can describe all this to you forever, but it wasn't just like a 30-minute appendectomy. It turned into, you know, more like an hour or so appendectomy.

And the minute I almost just make the incision on the man's abdomen -- but it's too late. He's already asleep. So, you know, I can't leave him. He's my patient and my due diligence is to serve him. The minute I make the incision, my pager goes off.

So when we're operating, the pagers are usually on the table or on the countertop somewhere so usually the circulator nurse will answer that. In this case, the anesthesia doctor did because he was just at wit's end at this point. So they're calling a status one trauma.

This is a young man whose -- Regional is closer to where his wreck was. He was out on the Glenn Highway north of here and he's had -- he's hit his face and has suffered severe craniofacial and neck and airway injuries.

So the ER doctor, the emergency room department doctor, is saying that because the pre-hospital team -- the fire department, the EMS, the people that were working with him -- I better put my pager back on because I'm on call and I don't want to leave it here -- they tried many times to establish an airway for this young man. And so the danger there is that without an airway, the more minutes -- the more seconds and minutes that go on without an airway, the patient is suffering more brain damage.

The ER doctor wanted the surgeon on call, which was me obviously, to be exactly present in the ER when the patient arrived. So the anesthesia doctor said -- he actually involved himself and said, "Divert that patient to another hospital even though we're the closest hospital because she can't be in two places at one time and we've just started this case."

So, you know, my take on this is if I had been able to do my appendectomy three hours ago when I had been called in, I probably would have been finishing up still hanging out in the building. I kind of go around looking for people who need operations because I love what I do and, you know, I would have been there waiting and certainly willing and certainly capable of securing an airway for that young man.

And I've had follow-up on what went on with

him and it didn't turn out so well because he got taken, I guess, to -- yeah, it just took more time to get him to a place where he could be served.
Any questions? No. Okay.
MS. LAWFER: Would you be willing to give those testimonies or do you not want to for confidentiality reasons?
DR. CHENNAULT: Confidentiality reasons would worry me with a couple of them. A couple of them were okay.
MS. LAWFER: Okay. If they would like to -- I mean, we've got what you've presented. But if they would like to go on the record with the testimonial, they can easily just write a letter.
DR. CHENNAULT: Okay. Would that go to you?
MS. LAWFER: Uh-huh. Yes. And if you want to --

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DR. CHENNAULT: Do you have a card?
MS. LAWFER: There's a card up there as well as the public notice. And they can --
DR. CHENNAULT: Okay. I'll do that.
MS. LAWFER: But I just want to make sure that they understand, you know, that I don't want them to think that they would be providing you information and giving names for privacy reasons.
DR. CHENNAULT: They asked me not to and I told them I wouldn't. But if you need the information directly from them --
MS. LAWFER: If they would like.
DR. CHENNAULT: -- what would you do with it?
MS. LAWFER: It would go on the record.
DR. CHENNAULT: Okay. So their name would show up somewhere?
MS. LAWFER: Right. But they are providing their testimony.
DR. CHENNAULT: Okay.
MS. LAWFER: It would be first person as opposed to third person --
DR. CHENNAULT: Right.
MS. LAWFER: -- that type of thing.
Next I have Kevin Barry.
MR. BARRY: Yes, ma'am.

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Good evening. I'm Kevin Barry. I'm the administrator for the Alaska Surgery Center. First, thank you. I appreciate what all of you are doing. This is enlightening. I'll tell you, this is my first one of these I have ever been to. It's pretty impressive.
Obviously, I'm not here supporting either side. I mean, that's -- if we look at what we've done in the city of Anchorage, we include Elmendorf. What I'm doing is I'm including Elmendorf and the new VA with the total ORs that are available, only because the population that is used in most of these include the military, their family, veterans that stay here or retirees. We have the highest population in the United States of military veterans compared to our total population of the state. So that's why I put them in here.
Right now we have -- in November prior to opening eight new procedure rooms, including Elmendorf

and the VA, there were 24 ORs available for folks for outpatient-type services. And obviously they also at the other two centers do the inpatient work. That increased between ORs and procedure rooms to 32, eight rooms in November.

If we go and increase that now, what we're going to do within less than three months, four months, our goal here now is to take -- without Elmendorf, there's 22 ORs. With them, there's 32. We increase seven more, that's another 21 percent increase.

Based on Governor Sean Parnell's Alaska population projections in the Department of Labor going up to 2034, the total increase in population for this state is going to be 170,400. That's a 4 percent growth each year. The non-Native is 27 percent. That's important because the Native growth will be 46 percent based off their numbers and their projections. Those folks don't come to any of our centers for any outpatient-type work. They have their own facility they have to go to. That right there tells you, if somebody needs one, it might be the Native hospitals.

MS. HOLT: Can I just make a clarification? We do take inpatient Native complex surgery patients and they're running in our OR with all of the outpatients as well. That has been part of the increase of our complex inpatient caseloads.

MR. BARRY: Very good. I'm talking about outpatient elective surgery only.

MS. HOLT: I know. But that's why our -- we're constrained, because we have such a growth of inpatients. We just want to move --

MR. BARRY: I understood.

MS. HOLT: Okay. Just to clarify, though.

MR. BARRY: Certainly.

Opening up seven more ORs in this area is going to do one thing only, and that's going to increase a lot of unused capacity. Right now there are three centers, two new ones and one that's been here for a while, none of which are at capacity right now. They're brand new. Haven't even had a full quarter open for projections and we're already saying we need to increase the ORs in this city.

Do I agree there's additional services that are needed? Absolutely. I'm not saying that we don't need to improve some of the other services that these folks need, ancillary services. But as far as ORs, adding seven more based on the projected populations, it doesn't warrant it.

One of the biggest things we're missing, too, that nobody is even mentioning right now is the capability of staff in this city. There is not enough staff right now to fill every OR we have. Adding seven more ORs is going to do nothing but pull these people in every direction and it's going to cause a decrease in health care and not an increase in quality of care. Nobody has even looked at that. Trying to bring people up might be a noble idea, but they are just not here right now for the workforce.

With the Native population growing, the Native hospital looks like they would be the ones that need it.

Mat-Su Valley Regional based on the projected population growth up until 2008, with their numbers from 2000 and 2008, they grew almost exactly the same amount as the city of Anchorage. They might want ORs. But the city of Anchorage doesn't need them right now.

It was mentioned in a previous CON request by one of our judges that the spirit of the CON process needs to be protected. This process of a true need must not be manipulated or circumvented.

I'd just like to say that hospitals have it -- you guys have a tremendous gift for what you do for folks. Adding outpatient ORs is not needed in this city right now. They're not up and running. Two of them are brand new. One of them is struggling. And trying to project that off the population, the population stated by our own state says there won't be enough need here.

Thank you.

MS. LAWFER: Thank you.

And then the last one that I had that said they wanted to testify was Tim Cohen.

DR. COHEN: I'll actually come forward here so

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I'm not speaking to your back.

MS. LAWFER: Oh, thank you.

DR. COHEN: I'm Dr. Tim Cohen. I'm a neurosurgeon and I work at both hospitals, both Providence and Alaska Regional.

And to speak to the Alaska Regional Certificate of Need request, the numbers that they showed indicate that the problem is capacity of the operating room to handle the current caseload. My personal experience confirms this based on trying to schedule patients in a timely manner. And with many neurosurgical procedures, most people don't want to wait the six to eight weeks that it takes to procure an operating room during what I think most of us would agree would be normal hours.

It is difficult -- Dr. Chennault addressed a number of problems associated with the inability to handle elective cases and the fact that it pushes your schedule later into the day thereby lessening your ability to take care of emergent cases, which tend to come in in the evening and at night. I think that speaks . . .

DR. CHENNAULT: That means you're doing a great job.

MS. LAWFER: I have a computer glitch or

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something and it keeps trying to mess with me.

DR. COHEN: You know, I think that speaks to the health of our population from the standpoint that we don't want to hold up emergent cases to take care of elective cases that have been jammed into too small a space.

And it does appear to me that the inpatient need is problematic for the provision of their current outpatient surgery. And that's based on the numbers and also my personal experience. I do few outpatient procedures, predominantly inpatient procedures, with both elective and emergent cases mixed in. And my group of four neurosurgeons, we communicate regularly, usually in positive tones, and the experience indicates that the capacity needs to be increased.

And Alaska Regional has done a good job of providing care to Medicare patients. We actually take care of a number of TRICARE patients, active duty military patients, in the operating room both as inpatients and outpatients who are unable to obtain their services through the military. We provide care to Natives who could obtain their care at ANMC but prefer to be treated in the community or the service is not available at ANMC.

And so the population of patients that are

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treated here are not related to non-Native, non-military patients. And I couldn't quote you facts on this, but it's my experience that there are a number of military patients who are treated outside the military health care system, either for expertise reasons or for scheduling reasons, because it's my understanding that their care has to be provided within a timely manner. And if that manner is not met, then they're allowed to be treated by the civilian population.

I think addressing the needs of the Medicare population, the case index would indicate that the inpatient services that are being provided at Regional are more time consuming and -- so in other words, the population requires more inpatient care. And so by expanding their ability to provide that care, we improve the health of the population.

The time factor is certainly an issue. In 2006 my wife had a complex wrist fracture. We were told at one hospital the case would not start until midnight the next day. And at Regional, she was able to get started at about 6:00 in the evening. So I think addressing the entire need of the city based on personal experience and weekly or daily experience, I think that there is definitely a need to increase the capacity to provide those inpatient services.

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MS. LAWFER: Thank you.

DR. COHEN: Sure.

MS. LAWFER: I have Carol Heyman who would like to speak.

MS. HEYMAN: I think I'll just speak from here.

MS. LAWFER: Feel free.

MS. HEYMAN: I'm Carol Heyman and I'm currently vice chair of the board of trustees of Alaska Regional Hospital. I've lived in Alaska for over 30 years.

And my personal family history with Alaska Regional in the last three years is we've had three outpatient procedures and I had a major orthopedic surgery that was three parts to it and two granddaughters. And I'll say the two granddaughters were the most fun.

But we had -- and I was lucky enough to have doctors who had blocks of time, but I still had to schedule much farther out than I probably would have ordinarily just because of the scheduling problems at Alaska Regional. And even if you have a block of time, you don't always get to accommodate all your patients.

And we had a very good experience at Alaska Regional with a very high level of care and service.

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And our hope would be that Alaska Regional Hospital -- other patients at Alaska Regional Hospital, other patients have that same level care and service. And we also think choice is good. I just have to say my two daughters were actually born at Providence, so there's obviously two hospitals.

From the trustee point of view, we are tasked with ensuring and maintaining the highest level of care and safety required for patients in the hospital and through the community. And choice is important to both patients and doctors and should exist in fairness to the community.

As hospital trustee in a state where -- in a recent ISER study, Mark Foster pointed out that 23 percent of the gross state product actually is spent on health care. And that means that almost 25 cents on every dollar that goes through the economy in Alaska is being spent on health care. And as the board of trustees, we feel that streamlining and trying to maximize the dollars for both the patient and all Alaskans in the health care arena is a good thing. And so we are very supportive obviously of the Certificate of Need for the hospital.

And as part of the community need interface for the hospital, we certainly listen to praise. And

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for that, we say thanks. And then we also listen to concerns from the community. And I think scheduling, waiting, is a primary concern of the community and we'd like to be able to say we meet those needs, that you aren't going to have that problem and that Alaska Regional will be able to serve you in the manner in which you believe it should serve.

And so I would like to thank you for giving me the opportunity to talk and say that I've also written a letter on behalf of the board of trustees supporting the Certificate of Need for Alaska Regional. And I won't read it. I'll just give it to you.

MS. LAWFER: All right. That would be just fine. Thank you.

Is there anyone else who would like to speak? If not, what I normally do is -- because like I said earlier, I will not take any affront if you decided to leave. However, this is a lot of times the only time someone gets to see someone else and so you may want to do some socializing and talking, and that's quite all right.

We will go off the record right now and if I have someone come, we will go back on the record. But in the meantime, if you would like to visit with acquaintances, feel free and thank you very much.

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(Off the record.)

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

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REPORTER'S CERTIFICATE

I, VALERIE MARTINEZ, RPR, and Notary Public in and for the State of Alaska do hereby certify:

That the proceedings were taken before me at the time and place herein 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 _____, 2011.

_____
VALERIE MARTINEZ,
Registered Professional Reporter
Notary Public for Alaska

My Commission Expires: June 22, 2014