

**CERTIFICATE OF NEED
APPLICATION REVIEW**

**ALASKA REGIONAL
HOSPITAL BASED EMERGENCY DEPARTMENT**

November 2024

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Governor**

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Commissioner**

**State of Alaska
Department of Health
Office of Rate Review
Healthcare Access and Services Development
Certificate of Need Program**

Table of Contents

BACKGROUND.....	3
PROJECT DESCRIPTION.....	3
PROJECT COSTS.....	4
REVIEW.....	4
General Review Standards.....	5
General Review Standard #1- Documented Need:.....	5
General Review Standard #2 – Relationship to Applicable Plans:	13
General Review Standard #3 – Stakeholder Participation:	16
General Review Standard #4 – Alternatives Considered:	17
General Review Standard #5 – Impact on the Existing System:	17
General Review Standard #6 – Access:.....	21
Service-Specific Review Standards.....	22
VII. Diagnostic Imaging Services	24
FINANCIAL FEASIBILITY.....	26
PUBLIC COMMENTS.....	30
Oral Public Comments.....	30
Written Public Comments	34
RECOMMENDATION.....	37
APPENDIX A - Estimated Impact to Medicaid.....	41
APPENDIX B - General Review Standards.....	43
APPENDIX C – Service Specific Review Standards.....	45
APPENDIX D - ARH -Annual CON Data 2021-2023.....	47
APPENDIX E - PAMC - Annual CON Data 2021-23.....	56

BACKGROUND

This is a review of a certificate of need (CON) Application for a hospital-based emergency department (HBED), submitted July 1, 2024, by Alaska Regional Hospital (ARH). ARH is an acute care hospital with 250 licensed, acute care beds located at 2801 DeBarr Road, Anchorage, Alaska. ARH is owned by HCA Healthcare, Inc. a publicly traded corporation that owns approximately 182 hospitals, in 20 states. See *CON Application* at 4.

PROJECT DESCRIPTION

The proposed project will create 5 additional emergency department (ED) treatment rooms to its existing ARH ED by building one (1) hospital-based emergency department (HBED) on the Old Seward Highway, in south Anchorage. The proposed facility will be an off campus, stand-alone building and consist of 10,860 square feet.

ARH currently operates 16 ED treatment rooms at its hospital, located on DeBarr Road in Anchorage, in what is universally referred to as the “U-Med” district.

The HBED will be completely self-contained. “As a satellite facility, the proposed HBED will be an extension of Alaska Regional and will offer hospital-level care for the conditions most commonly seen in emergency departments, including broken bones, chest pain, symptoms of stroke, gastrointestinal issues, head trauma, concussions, and psychiatric emergencies.” See *CON Application* at 6.

Per ARH, “Alaska Regional’s proposed HBED in south Anchorage will include five (5) treatment rooms and have the following equipment onsite: a GE Definium Tempo Plus diagnostic X-ray machine; a GE Logiq S8 ultrasound; a GE MACVU 360 EKG machine; five GE B450 patient monitors; a Panda infant warmer; Zoll Defibrillators; and a GE Revolution Maxima 64 slice CT scanner. The HBED will also be equipped with Tele-Stroke capabilities connected to Alaska Regional, the State of Alaska’s only accredited Comprehensive Stroke Center.” See *CON Application* at 9.

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	TOTAL PROPOSED CAPACITY
DIAGNOSTIC AND DIAGNOSTIC IMAGING SERVICES			
CT Scanner	0	1	1
Diagnostic X-ray	0	1	1
Ultra Sound	0	1	1
Cardiac Monitoring	0	5	5

Portable X-Ray	0	1	1
Portable C-Arm X-ray	0	1	1
THERAPEUTIC CARE			
Radiation Therapy			
Lithotripsy			
Renal Dialysis			
Other (List) Emergency Treatment Rooms	0	5	5
Total Capacity	0	5	5

ARH states that the HBED will be operated under the license of ARH. “The HBED will be staffed with qualified doctors and nurses and all staff will be trained and have the same qualifications as the staff working at the ARH campus; to include all radiology staff and adhere to all existing EMTALA standards and Medical Screening Exam requirements.” *Id.*

ARH anticipates that upon approval of the proposed project it will take approximately a year to complete.

PROJECT COSTS

ARH HBED: \$17,421,000

\$13,826,000 Construction Costs

\$ 2,655,000 Movable Equipment

\$ 940,000 Other Costs

REVIEW

ARH is a licensed health care facility under AS 18.07.111(8), and the proposed project consists of an “expenditure” that is over the \$1.5 million threshold for “construction” of a health care facility or “alteration” of a health care facility’s capacity. Therefore, the project will receive general review and service-specific review for Hospital Emergency Department Services and Radiological Services.

To perform this review, the entire project will first be subject to the General Review Standards. Then, “[a]fter determining whether an applicant has met the general review standards in Section I of this document, the department will apply the . . . service-specific review standards, as applicable, in its evaluation of an application for a certificate of need.” See *Appendix C and D*.

General Review Standards

General Review Standard #1- Documented Need:

The applicant documents need for the project by the population served, or to be served, including, but not limited to, the needs of rural populations in areas having distinct or unique geographic, socioeconomic, cultural, transportation, and other barriers to care.

ARH states that there is a critical shortage of ED beds in Anchorage and adding a HBED facility in south Anchorage would help address this need. ARH says their current ED is operating above capacity and has been doing so over the last seven years. See *CON Application* at 19.

Thru its application, ARH provides that between years 2017 and 2023 they have experienced the following volume at their current hospital ED, with a complement of 16 treatment rooms and the volume is indicative of a projected need of an additional 27.2 ED beds to accommodate present demand.

Year	Total Visits	Number of rooms needed at 1,500 visits per room	Number of patients currently seen in each room per year
2017	31,031	20.7	1,939
2018	29,917	19.9	1,870
2019	31,963	21.3	1,998
2020	29,511	19.7	1,844
2021	33,547	22.4	2,097
2022	38,876	25.9	2,430
2023	40,848	27.2	2,553

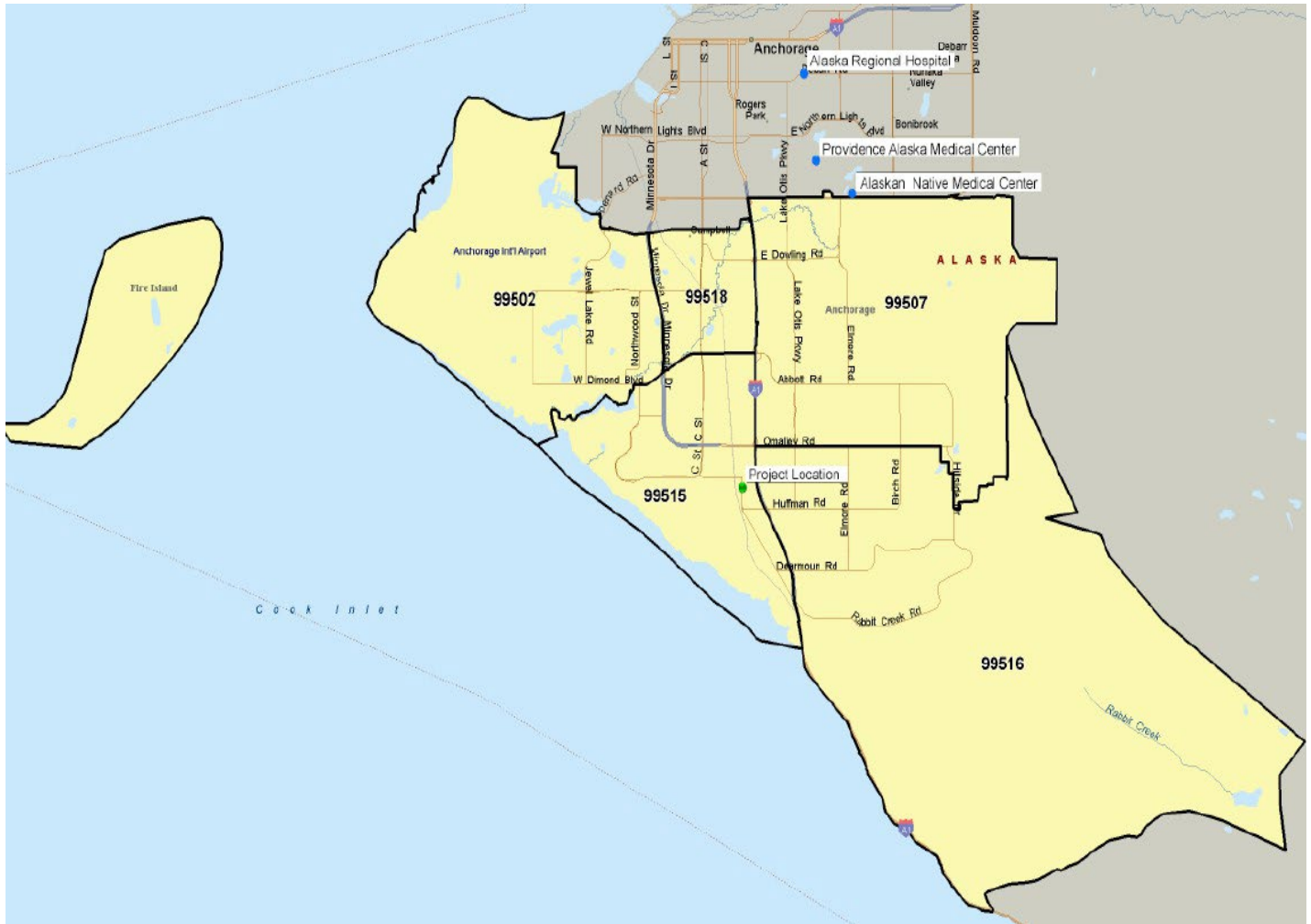
See *CON Application* at 20.

ARH states the current, perceived shortage of ED beds in Anchorage is a crisis, one which ultimately results in increasing patient care costs, lengthened patient stays, and adverse patient health outcomes, as patients must be diverted to another ED as staffing and space allows, “[o]vercrowding causes hospital ED’s to go into “recovery mode”, which means they cannot accept new patients and must divert them to other hospitals.

Currently, Alaska Regional often bears the brunt of other ED closures. As one of only two EDs open to the general public, Alaska Regional must accept and be ready to receive diverted patient traffic from limited-access hospitals like Alaska Native Medical Center (ANMC) and Joint Base Elmendorf-Richardson (JBER) but cannot divert *its* patients to those hospitals in times of high demand. The proposed HBED will be open to the public 24-hours a day, 7-days a week, 365 days a

year, and will provide an additional destination for ambulance traffic and residents regardless of their demographics or ability to pay.” See *CON Application* at 20.

ARH states the service area for the proposed HBED is the entire Municipality of Anchorage, however, it will primarily serve the south Anchorage community, comprised of five zip codes 99502, 99518, 99515, 99507, and 99516, though it will be the closest ED to several other zip codes. ARH further asserts the HBED will also be ideally situated for those commuting to and from the greater Anchorage area, as well as those coming to and from Kincaid Park, the Ted Stevens International Airport, the Hillside Trail System, and Girdwood. See *CON Application* at 22.



Zip Code	Alaska Native Medical Center	Alaska Regional Hospital	Providence Alaska Medical Center	All Other	Total
99502	2,545	1,812	3,693	195	8,245
99507	4,855	2,883	6,520	368	14,626
99515	1,871	1,372	3,436	175	6,854
99516	685	782	2,197	133	3,797
99518	1,021	817	1,734	94	3,666
Total	10,977	7,666	17,580	965	37,188

ARH states that there is a large patient base located within the south Anchorage community, and in 2023, 37,188 ED visits originated from these five zip codes, including ANMC patient origination data (which is exempt for purposes of CON). See *CON Application* at 23.

ARH states the HBED will address four overarching issues with its proposed project.

1. **Critical shortage of available ED treatment rooms**, specifically the shortage of ED treatment rooms at ARH's main campus.
2. **Overcrowding caused by hospital ED's going on diversion status**, citing overcrowding is a serious issue and cites studies supporting the theory that consistent overcrowding increases the cost of patient care, increased length of patient visits or stays, and results in poor patient health outcomes.
3. **Lack of ED treatment rooms outside of the U-Med district**, which is where all of Anchorage's current supply resides.
4. **Unnecessary ED utilization**, which can be attributed to the overcrowding of EDs and the need felt by providers to treat the patient but forgo valuable counseling and messaging that could have possibly prevented the visit in the first place. "Moreover, by being closer to (and better integrated with) the population it serves, Alaska Regional's HBED will be able to better educate patients about non-emergency options close to them. See *CON Application* at 21.

ARH states that they will serve all patients, regardless of their ability to pay, and all patients will have access to services offered on their main campus hospital emergency department. ARH states that the primary conditions treated at their main campus hospital emergency department include chest pain, stroke, gastrointestinal issues, orthopedic injury, trauma related injury, psychiatric and

other general medical conditions; all which will be treated at the proposed HBED. Those that cannot be treated at the HBED will be transported to a hospital of their choice, via emergency transport at no cost to the patient. See *CON Application* at 25.

ARH believes most of their ED patients are not candidates for an urgent care facility. “The vast majority of patients presenting to Alaska Regional’s main-campus ED require emergency department care and could not be appropriately diverted to an urgent care. Last year, 80% of patients presenting to the main-campus ED were identified as being at an acuity level between 1 and 3 [Alaska Regional uses a standard acuity index, which scores patients on a scale of 1-5, with 1 being the most severe and 5 being the least severe] and Alaska Regional projects a similar level of acuity at the proposed south Anchorage HBED. Moreover, the availability of a local ED acts as an important safety net, as it is obligated under federal law (EMTALA) to provide treatment regardless of a patient’s ability to pay, and (unlike urgent care facilities) remains open 24 hours/day.” See *CON Application* at 26.

To further provide justification for the additional ED treatment rooms, ARH, states it anticipates the population 65 years of age and older will only increase, and considers anticipated increase in tourism in its request for five additional ED treatment rooms.

Anchorage Municipality Historical Population Trend

	2020	2021	2022	2023
Total Population	291,247	290,440	289,972	289,653
Population Age 65+	36,134	38,793	40,724	41,577
65+ Percent of Total	12.4%	13.4%	14.0%	14.4%

To support this theory, ARH cites the AK State Plan for Senior Services 2024-2027, which states that there was a 73% increase in Alaska residents 65 years of age and older from the year 2010 thru 2020. Additionally, per ARH, “[A]laska’s population 65 years of age and older (which are more frequently in need of emergency services will increase by 30.4% between 2021 and 2030 while residents under age 65 will decline by 4.0%.” See *CON Application* at 17.

In terms of documenting need for the purposes of General Review Standard #1, ARH states it understands the service specific ED treatment room review standard methodology that the department applies, based on service area, to project need. The department considers the Municipality of Anchorage as the service area, not south Anchorage. ARH attempts to demonstrate that the concentration of emergency department patients primarily come from the five specific zip codes in a self-identified “service area” [south Anchorage] and uses the origin status data of patients from these zip codes to support its claim for a south Anchorage HBED noting that in year 2023, 37,188 ED visits originated from these five zip codes. *Id.*

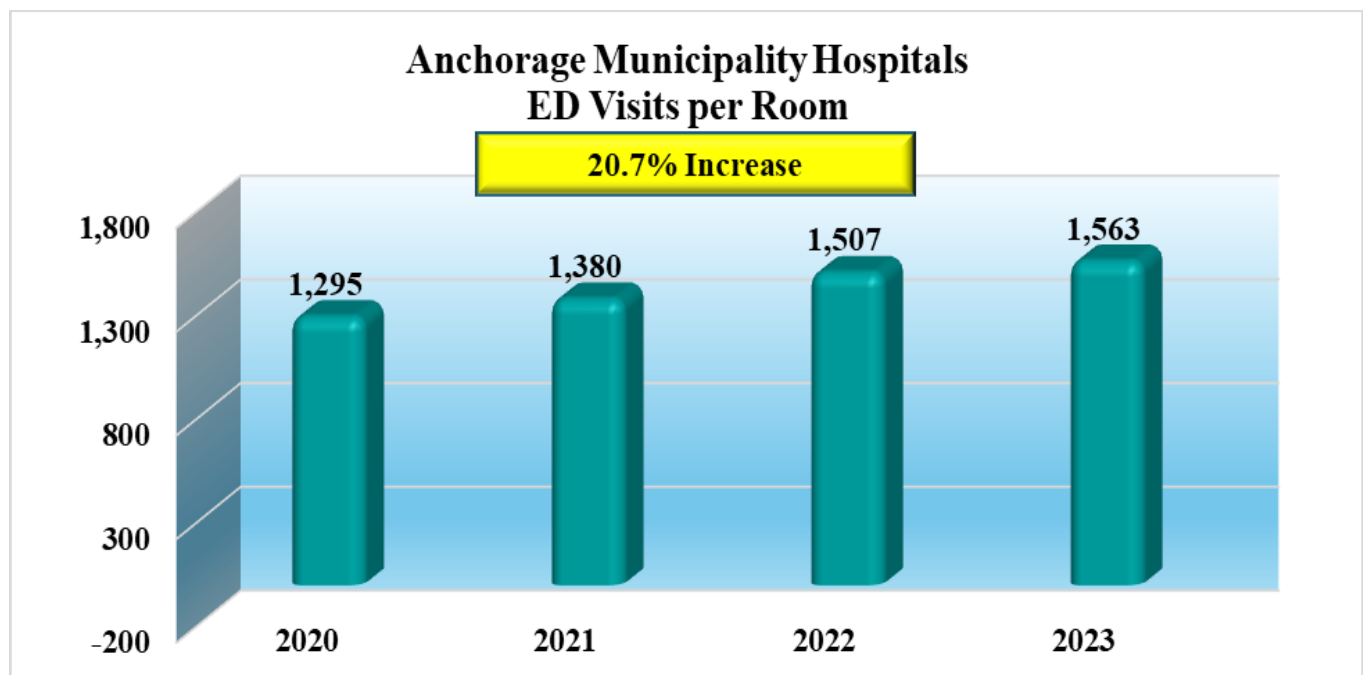
“We anticipate additional patients from outside the primary service areas will also use the south Anchorage HBED, including patients from Girdwood, Kincaid Park, the Hillside Trail System, the Ted Stevens International Airport, and all residents in south Anchorage. Further, the proposed

project location for the south Anchorage HBED is conveniently located near to the Old and New Seward Highways, which serve as primary traffic corridors for Anchorage and its surrounding communities.” See *CON Application* at 23.

ED Visits at Anchorage Municipality Community Hospitals Per Year

	2020	2021	2022	2023
Alaska Regional Hospital	29,511	33,547	38,876	40,848
Providence Alaska Medical Center	54,634	56,134	59,103	60,748
Total ED Visits	84,145	89,681	97,979	101,596
% Change from Prior Year		6.6%	9.3%	3.7%

ARH provides the preceding graph to demonstrate the percentage of change in ED visits for ARH and PAMC for the years 2020-2023. There is no explanation provided for the overall ED visit percentage drop (significant) from year 2022 to year 2023 for both hospitals, except to state, “[A]laska Regional in particular has seen dramatic growth in ED visits since 2020, which was the first year of the pandemic. Over that period, Alaska Regional’s ED visits per ED room grew by 38.4%.” See *CON Application* at 14.



Both hospitals (ARH and PAMC) saw overall increases in volume, however, volume increase percentages did drop from the year 2020 to 2024. See Appendix D and E.

ARH states its plan to develop a HBED in south Anchorage is consistent with its overall long-term goal, which is to provide care and facilities to meet the healthcare needs of all the patients it serves.

ARH believes the expanded ED service option in south Anchorage will allow patients access to services that are comprehensive, not necessarily found in other urgent care facilities, and states that to simply expand its existing hospital campus ED department footprint would be too costly, disruptive of current service delivery at that location and "[w]ould yield at most four additional ED treatment rooms. Moreover, expanding capacity at Alaska Regional will not improve geographic access to ED services for residents of south Anchorage." See *CON Application* at 15.

General Review Standard #1 specifically requests that the applicant *document a need for the additional, proposed services for the population served*.

ARH states that their application of the service specific review standard methodology for ED treatment rooms *excludes* the twelve ED treatment rooms that PAMC added to their complement in 2016 (PAMC was awarded thirteen beds; ten of which were to be used or designated to treat pediatric patients but could also be used as ED treatment rooms for all patients when, or if, necessary). "Given the lack of more specific data, and for the sake of simplicity, this application excludes Providence's pediatric ED visits from current utilization statistics, given the exclusion of pediatric beds from the total count of existing ED beds." See *CON Application* at 7.

Specifically, ARH believes the PAMC's self-designated (or named) ED treatment rooms are and should be considered "specialized".

"When PAMC's specialized pediatric rooms are excluded from the calculation, the Department's methodology shows a current need for 13 beds, based on Anchorage's average ED utilization over the past three years.¹ Even if PAMC's pediatric ED visits are excluded from the calculation as well,² there is a need for **five additional beds** – which is the number that ARH seeks approval to build."

¹ *Excluding pediatric rooms further comports with the Department's own practice of excluding ED rooms that serve only specific population groups. Alaska Regional notes that the Department's 2023 analysis emphasized that ED rooms at ANMC could not be included in the existing count because "ANMC (and JBER) only serve certain populations. Therefore, it is not correct to consider ANMC and JBER in utilization because ANMC and JBER cannot serve the general population."*

² *Given the lack of more specific data, and for the sake of simplicity, this application excludes Providence's pediatric ED visits from current utilization statistics, given the exclusion of pediatric beds from the total count of existing ED beds. Alaska Regional notes that this approach likely **under-**estimates the existing need, as it excludes pediatric patients seen in Providence's general ED rooms as well." *Id.**

“Currently, there are 52 non-specialized emergency department treatment rooms in Anchorage. Alaska Regional notes that this number reflects a correction the 65 rooms assumed by the Department in its analysis of Alaska Regional’s 2023 application. The Department’s prior assumption regarding bed count appears to have been based on the inclusion of a 13-room specialized pediatric treatment area at PAMC, which neither treats the same volume of patients per room as the main ED, nor is appropriately included in the total ED bed count given the review standards’ instruction to exclude “specialized rooms.” See *CON Application* at 53.

However, the CON program does not distinguish one type of ED treatment bed, from the other, regardless of how a hospital facility chooses to designate their beds. The CON does exclude “specialized rooms” in an ED; these are ones used exclusively for cast/x-ray service, observation, secure, and visiting physician clinic rooms only. See *Appendix C*.

The Municipality of Anchorage currently has 65 ED treatment beds on-line as of 2023. See *Appendix D and E*.

Recommendation General Review Std #1:

ARH supplied an array of data, tables and matrices’, along with a convincing narrative for additional ED treatment rooms in Anchorage, (specifically, south Anchorage), however this argument is not factually supported as ARH incorrectly applied the departments service specific review standard methodology for ED treatment rooms.

The Municipality of Anchorage currently has 65 ED treatment rooms. The department does not exclude PAMC’s 12 self-identified, or self-designated pediatric ED treatment rooms for the purposes of calculating projected need for the service area of the Municipality of Anchorage. The department does not consider pediatric ED treatment rooms as specialized. For the purposes of calculating need and applying applicable CON methodology, an ED treatment room can be utilized for all emergency care, by any population, regardless of age-related demographic assignation.

It appears ARH confused the total count of ED treatment rooms in the Municipality of Anchorage, subject to CON, due to circumstances surrounding the awarding of a CON in 2016 to PAMC, for the construction of 13 ED treatment rooms.

In 2016 a CON was awarded to PAMC to construct the addition of 13 ED treatment rooms, to their existing complement of 37 ED treatment rooms. The following CON public notice was issued to the public:

A Notice of Decision to Issue a Certificate of Need from the Department of Health and Social Services

In accordance with the decision in Office of Administrative Hearings Case 15-1084-CTN, a Certificate of Need has been issued as follows:

Summary of Decision: On February 29, 2016, the proposed decision in Office of Administrative Hearings Case Number 15-1084-CTN was adopted in its entirety. The decision states:

“Alaska Regional Hospital’s application for a certificate of need to construct a freestanding emergency room in Eagle River is denied. **Providence Alaska Medical Center’s application for a certificate of need to construct 13 additional emergency department treatment rooms, 10 of which will be designed to treat pediatric patients, while convertible to treat adults, if necessary, is granted.** Providence will submit a revised budget and timeline for this project no later than 60 days after the date of this decision. The revised project budget cannot exceed the original proposed project cost of \$12,853,311[.]

DATE: May 20, 2016

Please note the highlighted language in the ruling; the CON was issued with the specific caveat that any self-designated pediatric ED treatment rooms were convertible to other ED treatment rooms (adult) if necessary.

ARH incorrectly applied the CON methodology when considering the service area, and instead, applied the methodology to a geographical subsection of the Municipality of Anchorage, defined by five zip codes of their choosing. ARH also then applied the methodology as directed, however in this exercise they excluded the ED treatment rooms PAMC was awarded in 2016, stating they were to be considered “specialized” and therefore exempt for the purposes of establishing an existing ED treatment room count for purposes of CON.

In their effort to document population and service area share for their proposed facility in south Anchorage, ARH provided a service area that they considered most likely to be served by the HBED, broken out by zip code. This method would be acceptable if south Anchorage was considered a distinct and separate community from the Municipality of Anchorage, however, it is not.

“South Anchorage” is not universally defined by zip code(s), and any identification as such is up to interpretation, depending on who you ask. It is certainly not a defined service area recognized by the department for the purposes of calculating need for services. ARH defines “south Anchorage” in terms of five zip codes, which encompass residential addresses and P.O. Box addresses from the Cook Inlet (west) to the Chugach foothills (east), from Tudor Road to Girdwood and surrounding communities, with the exemption of Spenard Road. This radius, defined by ARH, and specific to zip code patient origination, means potential recipients of ED care would literally drive past PAMC (and ANMC) to reach ARH’s proposed HBED. Essentially, meaning that most of the patients originating from 99502,

99518, and 99507 zip codes would be *moving away* from the U-Med district; to be seen at ARH's proposed HBED.

ARH fails to document the correct total capacity of ED treatment rooms, subject to CON, in the Municipality of Anchorage. ARH also failed to apply the CON service specific ED treatment department review standards correctly; assuming PAMC's ED beds are excluded because they are "specialized", which they are not.

General Review Standard #1 is not satisfied.

General Review Standard #2 – Relationship to Applicable Plans:

The applicant demonstrates that the project, including the applicant's long-range development plans, augments and integrates with relevant community, regional, state, and federal health planning, and incorporates or reflects evidence-based planning and service delivery. A demonstration under this standard should show that the applicant has checked with the department regarding any relevant state plan, with appropriate federal agencies for relevant federal plans, and with appropriate communities regarding community or regional plans.

Per its application, ARH states its project is aligned with several state and local emergency services plans. "This project is consonant with state and local emergency services plans and was developed with consideration for (among others) the State of Alaska's 2024 Emergency Operations Plan, the Municipality of Anchorage's Comprehensive Emergency Operations Plan (2022 update), the Healthy Alaskans 2030 and State Health Improvement Plan, the Alaska State Plan for Senior Services 2024-2027, and the Healthy and Equitable Communities Strategic Plan (2022-2025). Specific notes with regard to these plans include:

State and Local Emergency Operations Plans

Both the State of Alaska's 2024 Emergency Operations Plan and the Municipality of Anchorage's Comprehensive Emergency Operations Plan emphasize the difficulties associated with medical surge capacity (*i.e.*, the ability to rapidly expand the capability and capacity of the existing healthcare system services during emergencies) and discuss the Anchorage population's reliance on existing hospital infrastructure, including Alaska Regional and PAMC. As discussed herein, Anchorage's existing Emergency Departments are unfortunately already at (or frequently above) capacity – even without a major public emergency or crisis event. Expanding Anchorage's existing capacities and distributing ED capacity to underserved parts of the Anchorage bowl is fully consistent with these plans and would improve Alaska Regional's ability to provide timely emergency services as expected.

Healthy Alaskans 2030 and State Health Improvement Plan

Although the Healthy Alaskans initiative is largely focused on environmental and community health needs and interventions that don't relate directly to the availability of emergency department care, the Healthy Alaskans initiative notes the importance (and frequent lack) of healthcare access for populations of all economic and racial backgrounds. In keeping with this important goal, services at the south Anchorage HBED will be provided to all patients regardless of income, race, creed, gender,

national origin or disability. The HBED will also be subject to EMTALA requirements, which require an appropriate medical screening of all patients regardless of ability to pay.” See *CON Application* at 15.

ARH states it engaged in multiple discussions with the department’s Section of Rural and Community Health Systems staff regarding emergency management and training, exercise and outreach as well as the Anchorage Health Department’s Coordinator for Emergency Preparedness. See *CON Application* at 16.

Note, while ARH states discussions were held and its HBED project presented to stakeholders and members of the community; there seemingly is little direct reference to what the outcome of those discussions were, nor any other demonstration of support in ARH’s *CON Application*. “The proposed HBED would provide emergency responders a low acuity option allowing more critical patients to benefit from primary hospital facilities. Additionally, state officials recognized the challenges Alaska faces due to limited current capacity with few alternatives due to geographic location.”. *Id.*

ARH demonstrates that it considered national trends and reviewed data relating to emergency treatment departments that are separate from hospitals (but operates under same licensure as they propose) and states that their proposal is in line with what is happening on a national level. ARH also shared that its parent company, HCA, is the largest operator of HBED’s in the country, operating approximately 128 facilities. See *CON Application* at 19.

ARH attempts to allay any doubt when it comes to HBEDs, and associated delays, if a patient must be transferred to an actual hospital facility because their emergency healthcare status requires advanced medical care/systems only available at a hospital, meaning inability to be treated effectively at an HBED. “While concerns are sometimes raised about whether patients presenting to freestanding EDs will experience delays in treatment that could impact their outcomes, these concerns are unfounded based on HCA’s experience.

- As a starting point, Alaska Regional will work closely with local EMS to establish protocols regarding the types of patients appropriate for transport to the south Anchorage HBED. Typically, only 3% to 5% of HBED patients require transport to a hospital.
- The emergency medicine physicians at the south Anchorage HBED will have the same training as those working at the main-campus EDs. These physicians can stabilize and treat a wide range of conditions in a freestanding environment.
- The south Anchorage HBED will have procedures in place for the rapid transfer of patients to hospitals, when necessary, at no additional cost to patients.”

ARH states that current ED overcrowding is supported by the fact they are seeing an increase of diverted patients from other EDs in the Municipality of Anchorage, and they expect this increase in traffic to continue. To support this fact, ARH states they “[e]xperienced a 28% growth in ambulance traffic between 2022 and 2023, which has continued into 2024.” *Id.*

Patient Transports from AFD to Alaska Regional Hospital

2022						2023					
Grand Tot	Transports	Hospitals				Grand Total	Transports	Hospitals			
	Months	ANMC	ARH	JBER	PROV		Months	ANMC	ARH	JBER	PROV
1st Q	Jan	390	548	37	1037	1st Q	Jan	457	628	10	824
	Feb	399	445	45	824		Feb	246	662	21	779
4354	Mar	370	440	21	805	5361	Mar	386	652	27	812
2nd Q	Apr	329	542	21	811	2nd Q	Apr	346	662	28	832
	May	429	484	21	731		May	440	536	25	788
4668	Jun	410	515	17	706	5016	Jun	445	573	29	785
3rd Q	Jul	465	485	20	718	3rd Q	Jul	421	681	23	702
	Aug	473	544	23	710		Aug	501	693	25	698
5052	Sep	515	437	28	771	5189	Sep	388	537	19	805
4th Q	Oct	534	439	23	735	4th Q	Oct	395	672	19	853
	Nov	476	582	42	832		Nov	466	678	27	846
5208	Dec	542	441	25	950	5621	Dec	443	612	28	917
19282	Total	5332	5902	323	9630	21187	Total	4934	7586	281	9641
2022						2023					
<p>■ ANMC ■ ARH ■ JBER ■ PROV</p>						<p>■ ANMC ■ ARH ■ JBER ■ PROV</p>					

Recommendation General Review Std #2:

While ARH’s proposal demonstrates they consulted with state and community providers and stakeholders, and reviewed state and other, various and relevant health plans, there was not significant evidence of how these discussions and review of plan(s) support the establishment of the proposed HBED, and the projected increased volume of EMS traffic as a result.

ARH did not articulate or provide any data regarding impact to existing EMS services, other than current patient transports by AFD to its ED currently (above). It did not provide any plan or strategy regarding how they will manage increased, and anticipated emergency transport volume and its impact on an already limited and stressed resource. Diverting critical EMS services to transport patients again, from the HBED to a hospital, would divert and slow the response time of existing EMS providers. Instead, ARH states, “[i]f a patient at the proposed HBED subsequently needs to be admitted as an in-patient to Alaska Regional, there will be no additional transportation cost. Rather, the hospital – not the patient – will be billed for any transportation costs incurred.” This fact is not

supported by any corroborating EMS statement in ARH's application, or any other agreements with EMS services or providers in the service area. In addition, ARH provides little insight or information regarding EMS transfer times and associated impact to overall EMS service delivery, only stating that they have begun "coordination efforts" with EMS as it relates to the proposed project and will continue to do so. See *CON Application* at 22.

Lastly, and significantly, ARH does not mention cost implications to the patient (payor) if the patient requires transfer its hospital ED or any other ED in the service area.

General Review Standard #2 is not satisfied.

General Review Standard #3 – Stakeholder Participation:

The applicant demonstrates evidence of stakeholder participation in planning for the project and in the design and execution of services.

ARH states it met, in addition to the officials referenced in General Review Standard #2, with payors, union representatives and a variety of community councils, those of which are in south Anchorage, primarily.

"Payors: The facility has discussed the plan with numerous payors throughout the community including Aetna, the Pacific Health Coalition (PHC) and Moda. The PHC from a health planning perspective has come out in support for prior and current CON request.

Union Representatives: The Labors Union 341, which represents the local trades has come out in support for the HBED for its members. After reviewing the data and feedback from their represented members they felt the project would be a value add to the community.

Community Councils and Neighborhoods: Alaska Regional leadership has met with the local community councils represented in this area including, Bayshore Klatt Community Council, Old Seward/Oceanview Community Council, Rabbit Creek Community Council and Huffman O'Malley Community Council." See *CON Application* at 50.

In addition, ARH commissioned a poll to be conducted by Cooley Public Strategies in June of 2024, stating, "[r]esults from that poll showed broad support for a south Anchorage ED. Specifically, Anchorage residents supported a south Anchorage ED by more than a 2:1 margin, and 79% agreed that "new emergency room in south Anchorage would provide resources needed for quick medical care in case of natural disasters, or workplace / large scale disasters." Fewer than half of residents (43%) thought that "there is no need for a new ER in south Anchorage because other nearby medical centers are easily accessible and have adequate capacity to treat patients." *Id.*

Recommendation General Review Std #3:

There is evidence in ARH's application of stakeholder participation in the planning, design or execution of services.

General Review Standard #3 is satisfied.

General Review Standard #4 – Alternatives Considered:

The applicant demonstrates that they have assessed alternative methods of providing the proposed services and demonstrates that the proposed services are the most suitable approach.

Per its CON application, ARH demonstrates that it considered options when considering the proposed services.

The first option ARH considered was to add capacity at its existing hospital ED department location on DeBarr Road. However, after analysis of a study conducted in 2020, ARH determined this option was not feasible due to cost and the ability of the existing hospital ED to accommodate a reduced and limited amount of additional ED treatment beds.

“Because of space limitations, Alaska Regional’s main campus can only accommodate 4 additional ED beds without significant disruption to its facilities and operations. As a result, expansion of Alaska Regional’s existing ED is not a feasible alternative, and foregoing additional ED capacity entirely would fail to address the overcrowding witnessed in recent years.” See CON Application at 51.

Recommendation General Review Std #4:

ARH's consideration of alternatives was adequate. ARH demonstrates it considered alternatives for its proposed HBED.

General Review Standard #4 is satisfied.

General Review Standard #5 – Impact on the Existing System:

The applicant briefly describes the anticipated impact on existing health care systems within the project's service area that serve the target population in the service area, and the anticipated impact on the statewide health care system.

Per its CON application, ARH provides that the new HBED will initially redirect patients from existing providers but given the anticipated rise in ED utilization, the impact on existing providers will eventually be absorbed. And the immediate benefits realized will address the overcrowding currently experienced at ARH's main ED, reduce the necessity of all ED providers to go on “divert” status, and

provide much needed, and geographically accessible, ED services in south Anchorage. See *CON Application* at 51.

ARH states they anticipate full utilization of its proposed five beds within five years, and “[a]nticipates the HBED will help to alleviate the pressure of its increasing share of ambulance traffic, by receiving appropriate patient transports that originate in the primary ZIP Codes served by the HBED.” See *CON Application* at 30.

ARH provides three tables projecting utilization and impact of its proposed HBED on existing ED systems thru 2030, as follows:

Alaska Regional HBED Utilization and Market Share in Surrounding Five ZIP Code Area

	2026	2027	2028	2029	2030
Total ED Visits*	39,464	40,253	41,059	41,880	42,717
Projected ED Visits from Five ZIP Code Area	14,661	15,432	16,245	17,100	18,000
% from Five ZIP Code Area	70%	70%	70%	70%	70%
Visits from Five ZIP Code Area	10,263	10,802	11,372	11,970	12,600
Five ZIP Code Area Market Share	26.0%	26.8%	27.7%	28.6%	29.5%

*Total Nearby Area ED visits projected to increase at 2% annually from 2023 based on historical trend

The next step was to estimate the shift of patients from existing providers serving the five ZIP Codes area to the south Anchorage ED. An initial assumption was that patients would shift from the community hospitals serving the area, and not ANMC, which serves a specialized population. It was assumed that patients already utilizing Alaska Regional for emergency services would be more likely to seek care at the new facility than those using PAMC. Projections for south Anchorage ED visits under these assumptions are presented.

Projected Shift of HBED on Existing Providers from the Five ZIP Code Area

	2026	2027	2028	2029	2030
HBED ED Visits from Five ZIP Code Area	5,498	5,787	6,092	6,413	6,750
% Shifted from:					
Alaska Regional Hospital	80%	80%	80%	80%	80%
Providence Alaska	20%	20%	20%	20%	20%
Patients Shifted from:					
Alaska Regional Hospital	4,398	4,630	4,874	5,130	5,400

Providence Alaska	1,100	1,157	1,218	1,283	1,350
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The final step was to consider the patients from outside the five ZIP Codes area that would be served by the new facility. These patients would include residents of other portions of the Anchorage Municipality as well as in-migration from the many tourists who visit the area. This in-migration was estimated to be 10% of the total visits, as reflected...[T]he south Anchorage ED is projected to serve 7,500 visits in 2030, or 1,500 visits per room annually.

South Anchorage ED total Projected Utilization

	2026	2027	2028	2029	2030
Patients from Shift	5,498	5,787	6,092	6,413	6,750
In-migration (10%)	611	643	677	713	750
Total Projected ED Visits	6,109	6,430	6,769	7,125	7,500

See *CON Application* at 30.

ARH states that it received 33% of all ambulance traffic that originated in Anchorage in the year 2023. “Alaska Regional actively participates in the Mayor’s Advisory Board (MAB) meetings, which helps provide medical care guidance for and destination decisions for Anchorage Fire Department. Alaska Regional will also ensure that the HBED is incorporated into the Anchorage Fire Department’s Hospital Specialty Designation Chart ...which will allow the HBED to receive EMS patient transports in a manner that improves system-wide efficiency and limits secondary transports of patients after admission.” See *CON Application* at 52.

Anchorage Area Hospital Specialty Destination Chart

	PAMC	ANMC	ARH	JBER
OB*				
Routine Deliveries > 36 weeks				
Routine Deliveries 32 - 36 weeks				
Unstable Medical Condition/Trauma Alert > 32 weeks				
Imminent Deliveries < 32 weeks				
Unstable Medical Condition/Trauma Alert < 32 weeks				
PSYCHIATRIC				
Pure behavioral, emotional, psychiatric problems including apparent psychosis, mania or delusions unrelated to acute substance abuse				
STEMI				
ALL STEMI Patients				
C99 with ROSC and likely or demonstrated STEMI				
PEDIATRIC				
Status 1 or 2 Peds including trauma. ANMC is the primary destination for their beneficiary patients.				
TRAUMA (ADULT)				
Trauma Alert meeting YES to any Anchorage EMS Trauma Alert Conditions				
STROKE				
All Patients with acutely positive ministroke scale (chance that lytics may be given)				
DIALYSIS				
All dialysis patients with any potentially significant medical or traumatic complaint will be transported to one of the three dialysis hospitals				
Notes				
*PAMC has the highest level of neonatal care and is the destination hospital for all patients in which a combined obstetric-neonatal team may be required for best care.	KEY	Accepts these patients	Does NOT accept these patients	

Recommendation General Review Std #5:

ARH describes a perceived positive impact of a HBED on Anchorage's existing health care system. More specifically, ARH asserts that a HBED will complement existing services, provide relief to existing ED providers by alleviating overcrowding and relieve the pressure of its increasing share of ambulance traffic by receiving appropriate patient transports originating in the primary zip codes that ARH believes will most benefit by its HBED in south Anchorage.

However, while there was an abundance of statistics shared on projected utilization of services and perceived, associated impact to existing healthcare providers, little was shared or provided in terms of

actual impact to emergency transportation services and how the proposed project will address inevitable challenges and changes in emergency transport of patients when established.

Other than a vague reference to participating in the Mayor's Advisory Board, and providing medical care guidance on destination decisions for Anchorage Fire Department and associated system wide efficiencies that could be realized, including the limitation of secondary transports of patients after admission there was no evidence to support these alleged discussions or parameters of any agreements with stakeholders and partners.

General Review Standard #5 is partially satisfied.

General Review Standard #6 – Access:

The applicant demonstrates that the project's location is accessible to patients and clients, their immediate and extended families and community members, and to ancillary services. This includes the relocation of existing services or facilities.

ARH proposes no relocation of services; but essentially offers a "hybrid" ED service in south Anchorage. ARH provides the following, "As discussed throughout this application, ED services in the Anchorage Municipality are concentrated in a small area. This project will significantly improve access to the south Anchorage community, thereby reducing travel time to receive care. The proposed HBED will offer all necessary ancillary services for patients presenting for emergency treatment." See *CON Application* at 51.

Recommendation General Review Std #6:

ARH posits that the proposed HBED will be more readily accessible to potential patients located in south Anchorage. However, this is not a realistic accessibility option for many other residents in the Municipality of Anchorage. Further, a hybrid model of a hospital ED, aka HBED, located off campus, significantly distanced from its hospital, and services, poses multiple challenges and associated constructs; to include transportation should the patient require more advanced or skilled healthcare to treat the emergency. Situations often associated with emergency healthcare and medical practices, and ones which would be vastly easier, and more cost efficient if accessed, are in a co-located hospital.

ARH did not provide sufficient evidence or support that their HBED would alleviate accessibility issues; other than a possibility, with determinants, that it would be a potential option for some residents of the Municipality of Anchorage.

General Review Standard #6 is not satisfied.

Service-Specific Review Standards

After determining whether a project has met the general review standards, the department must apply service-specific review standards for services designated in the *Alaska Certificate of Need Review Standards and Methodologies*. For purposes of this application, Hospital Emergency Department Services require this additional review.

Hospital Emergency Department Review Standards

- 1. The applicant demonstrates that the project promotes, or otherwise helps ensure, the maintenance of a stable and efficient emergency medical system.**

ARH does not adequately identify the need for additional ED services based on population and fails to demonstrate that its proposal will promote and ensure the maintenance of a stable and efficient emergency medical system. HBEDs cannot offer trauma services (i.e., surgery and other treatment). Even in cases of disaster, HBEDs are limited because they are not equipped for, or capable of, providing surgery services and acute trauma care.

- 2. For the addition or expansion of general emergency services, a proposal will not be approved unless each emergency department treatment room will provide a minimum of 1,500 visits annually. . . . The department may approve additional space if the applicant documents use patterns and submits data and analysis that show seasonal high peak use rates warranting additional treatment rooms.**

The department uses the following formula to determine the need for emergency department treatment room services:

$$\text{EDTR} = \text{C5} / 1500$$

$$\text{C5} = \text{P5} \times \text{SAS} \times \text{UR}$$

EDTR emergency department treatment rooms needed

C5 caseload: ED visits projected for the fifth year after project completion

UR current utilization rate: average of number of ED visits per year for last three years divided by population, based on the service area

P5 projected population for the fifth year after project completion

SAS service area share: the proposed service area's current share of the population to be served, as of the most recent geographic population estimates

The following shows the department's (DOH) application of the CON service specific methodology for Emergency Departments, compared to ARH's application of the methodology:

Projected Population

DOH P5 = 290,948

ARH P5=285,931

The department utilizes the Department of Labor and Workforce Development's population projection for 2030. (<https://live.laborstats.alaska.gov/pop/projections.html>)

Service Area Share

DOH SAS = 100%

ARH SAS = 100%

Both the Department and ARH utilize 100%.

Utilization Rate

3 year look back average 2021,2022, 2023

DOH UR=0.33288

ARH UR=0.3325

Caseload

$C5 = P5 \times SAS \times UR$

DOH C5=95,080

ARH C5 = 96,769

Emergency Department Treatment Rooms (Bed Need)

$EDTR = C5 / 1500$

EDTR = 63.3867

Since there is no such thing as a .3867 of a treatment room, the decimal must be rounded up to the nearest whole number, which is 64 emergency department treatment rooms.

DOH EDTR=64

ARH EDTR = 65

Summary:

Anchorage currently has 65 beds. Based on the CON Program's EDTR calculation, there is no demonstrated need for additional emergency treatment rooms in the Municipality of Anchorage.

Recommendation Service-Specific Review Std #1:

Service-Specific Review Standard #1 is not satisfied.

Recommendation Service-Specific Review Std #2:

For the addition or expansion of fast-track emergency services within a facility.. . .

This review standard is not applicable as there are no fast-track services proposed.

Recommendation Service-Specific Review Std #3:

Service-specific review standard #3 is not applicable.

3. For a proposal for additional space in the hospital emergency department, the applicant must perform a size-by-functional-need survey and analysis for additional space that demonstrates efficient use of the space.

This review standard is not applicable because ARH does not seek to add space to an existing structure.

Recommendation Service-Specific Review Std #4:

Service-Specific Review Standard #4 is not applicable.

VII. Diagnostic Imaging Services

ARH's proposal seeks to establish a new emergency department. Its new emergency department will need diagnostic equipment to provide emergency treatment services. The proposed HBED will provide lab and radiology services and include one CT scanner, 1 X-ray machine, 1 ultrasound machine, 5 cardiac monitoring machines, 1 portable X-ray machine and 1 portable C-Arm X-ray machine.

These imaging services will not be open to the general community and will not support other services, other than those at the proposed HBED. Rather, the CT scanners will solely be dedicated to emergency department services to patients using the HBED.

Again, this component is unique in that unlike other hospital or imaging projects, ARH is seeking to establish emergency diagnostic imaging services only. Doing so will not create an outpatient service that is available by referral. It will not establish an independent diagnostic testing facility. It also will not free up capacity on any equipment that will allow ARH to compete for general outpatient imaging services.

Given that these imaging services are truly limited to emergency department services and given the specific circumstance and use of the equipment, the true service-specific review standards for the Diagnostic Imaging Services are for general emergency department treatment room services and therefore do not apply.

Recommendation Diagnostic Imaging Services:

Service-Specific Review Standards for Diagnostic Imaging Services are not applicable.

FINANCIAL FEASIBILITY

2. Construction Cost (New Activity) (Omit cents)

a. Site acquisition (Section VIIIA.2.f)	\$ 1,450,000
b. Estimated general construction**	\$ 10,244,000
c. Fixed equipment, not included in a**	\$ 2,132,000
d. Total construction costs (sum of items a, b, and c)**	\$ 13,826,000
e. Major movable equipment**	\$ 2,655,000
f. Other cost:**	
(1) Administration expense	\$ 50,000
(2) Site survey, soils investigation, and materials testing	\$ 156,000
(3) Architects and engineering fees	\$ 400,000
(4) Other consultation fees (preparation of application included)	\$ 75,000
(5) Legal fees	\$ 50,000
(6) Land development and landscaping	Included in Construction
(7) Building permits and utility assessments (including water, sewer, electrical, phones, etc.)	\$ 159,000
(8) Additional inspection fees (clerk of the works)	\$ 20,000
(9) Insurance (required during construction period) <input type="checkbox"/>	\$ 30,000
g. Total project cost (sum of items d, e, f)	\$ 17,421,000
h. Amount to be financed	\$ -
i. Difference between 2.g and 2.h (list, as Schedule 1, available resources to be used, e.g., available cash, investments, grants funds, community contributions, etc.)	\$ 17,421,000
j. Anticipated long-term interest rate	N/A
k. Anticipated interim (construction) interest rate	N/A
l. Anticipated long-term interest amount	\$ -
m. Anticipated interim interest amount	N/A
n. Total items g, l, and m	\$ 17,421,000
o. Estimated annual debt service requirement	N/A
p. Construction cost per sq. ft.	\$ 943
q. Construction cost per bed	\$ 931,273
r. Project cost per sq. ft.	\$ 1,623
s. Project cost per bed (if applicable)	\$ 1,601,909

Schedule I. Alaska Regional Facility Income Statement 2018-2023

Schedule I. Facility Income Statement						
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion						
Gross Patient Revenue:	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Inpatient Routine	165,671,379	204,777,608	221,191,095	265,101,678	304,232,478	306,382,145
Inpatient Ancillary	619,375,298	778,409,036	810,167,062	911,595,477	979,552,847	1,032,953,783
Outpatient	350,714,800	418,831,620	443,333,258	572,330,010	672,016,132	722,903,902
Total Patient Revenue	1,135,761,477	1,402,018,264	1,474,691,415	1,749,027,165	1,955,801,457	2,062,239,830
Charity Care	11,166,927	16,191,631	14,552,807	14,734,539	22,095,463	34,779,869
Contractual Allowances	846,918,903	1,074,410,984	1,139,663,079	1,361,722,242	1,563,955,534	2,518,179,865
Bad Debts	17,459,247	2,302,614	(3,310,422)	8,758,769	14,529,951	(2,823,577)
Total Deductions	875,545,077	1,092,905,229	1,150,905,464	1,385,215,550	1,600,580,948	1,697,155,084
Net Operating Revenues	260,216,400	309,113,035	323,785,951	363,811,615	355,220,509	355,220,488
All Other Revenues	530,506	551,592	536,313	465,813	716,441	609,590
EXPENSES:						
Salaries	77,915,446	89,283,361	84,102,446	87,886,775	95,699,955	93,465,434
Benefits	16,009,748	15,345,491	15,513,365	18,256,068	19,734,266	20,268,715
Supplies	46,955,866	52,397,180	51,515,672	58,589,015	54,656,040	55,266,746
Utilities	3,133,737	2,957,377	2,906,085	2,713,854	2,410,407	3,121,556
Property Tax	2,292,084	2,017,767	2,104,487	2,189,474	2,277,946	1,880,702
Rent	1,973,657	824,983	2,523,085	2,582,747	1,914,927	2,108,586
Lease						
Other Expenses	56,609,604	37,960,018	54,994,267	56,303,020	55,918,823	51,827,402
Depreciation	12,910,907	13,090,199	11,078,729	10,798,196	10,723,731	12,146,620

Interest	507,034	(4,258,974)	(11,011,034)	(12,270,830)	(28,262,021)	(62,014,442)
Total Expenses	218,308,083	209,617,402	213,727,102	227,048,319	215,074,074	228,520,931
Excess (Shortage) of Revenue	42,438,823	100,047,225	110,595,162	137,229,109	140,862,876	127,415,998
Note: Use one copy of this form for the previous five years, another for the construction or development period, and five years after the project opens						

Schedule II. Alaska Regional Balance Sheet 2023-2028

Schedule II. Facility Balance Sheet					
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion					
CURRENT ASSETS	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
Cash & Cash Equivalent	6,202	6,202	6,202	6,202	6,202
Net Patient Accounts Receivable	1,592,188	3,639,188	3,856,188	4,095,188	4,357,188
Other Accounts Receivable	310,532	310,532	310,532	310,532	310,532
Inventories	19,065,911	19,333,911	19,361,911	19,392,911	19,425,911
Prepaid Expenses	858,969	858,969	858,969	858,969	858,969
Other					
Total Current Assets	21,833,802	24,148,802	24,393,802	24,663,802	24,958,802
Property and Equipment					
	5,572,657	5,572,657	5,572,657	5,572,657	5,572,657
Land & Improvements					
Building/Fixed Equipment	161,050,958	177,576,958	193,384,958	208,475,958	222,847,958
Major Movable Equipment	171,786,068	171,347,068	170,906,068	170,466,068	170,024,068
Accumulated Depreciation	(223,321,024)	(224,039,024)	(224,757,024)	(225,475,024)	(226,193,024)
Net Property & Equipment	115,088,659	130,457,659	145,106,659	159,039,659	172,251,659
Other Assets	1,209,779	1,209,779	1,209,779	1,209,779	1,209,779
TOTAL ASSETS	138,132,240	155,816,240	170,710,240	184,913,240	198,420,240

LIABILITIES/FUND BALANCE					
Current Liabilities					
Accounts Payable	12,122,690	12,122,690	12,339,690	12,362,690	12,386,690
Accrued Expenses	1,986,373	1,986,373	1,986,373	1,986,373	1,986,373
Accrued Compensation	7,595,012	7,595,012	7,595,012	7,595,012	7,595,012
Other Accruals	676,726	1,415,726	1,494,726	1,580,726	1,674,726
Total Current Liabilities	22,380,801	23,336,801	23,438,801	23,548,801	23,669,801
Long Term Liabilities					
Long Term Debt	(663,011,662)	(669,031,260)	(673,044,637)	(701,926,978)	(738,882,989)
Other	1,600,116	1,817,116	2,301,116	2,537,116	2,623,116
Total Long Term Liabilities	(661,411,546)	(667,214,144)	(670,743,521)	(699,389,862)	(736,259,873)
Fund Balance	801,321,198	840,224,428	858,799,156	999,156,308	1,062,128,285
Total Liabilities & Fund Balance	112,854,897	162,290,453	196,347,085	211,494,436	323,315,247
<p>Note: Use one copy of this form for the previous five years, another for the construction or development period, and five years after the project opens</p>					

PUBLIC COMMENTS

Oral Public Comments

A public meeting was held telephonically on August 27, 2024. Approximately 120 individuals attended the meeting, and about 27 individuals provided verbal comment. Of those in attendance, there were a combination of private citizens, Providence Health System employees, Alaska Regional Hospital employees, and community health care providers.

ARH Representatives, Jennifer Opsut, CEO, and Hank Grinold, COO, gave a presentation on ARH's proposed construction of a HBED in south Anchorage. The presentation outlined ARH's corporate structure and holdings, gave an overview of the proposed south Anchorage facility, and explained the need for HSED versus urgent care clinic and traditional hospital-based emergency department service in the Municipality of Anchorage. Ms. Opsut stated, *"The three acute care hospitals in Anchorage spent a cumulative total of 6,617 hours last year diverting EMS drop-off because of capacity."* While Mr. Grinold spoke to the location, building size, services provided and the funding of the proposed ER in South Anchorage.

Of the approximately 27 comments made at the public meeting, 3 were affiliated with ARH, 3 were affiliated with Providence, 8 were affiliated with other Medical Providers and 13 comments from private citizens. The comments were both positive and negative for the HSED.

Notable Excerpts/In Favor of:

Blaine Norton an Emergency Medicine physician at ARH stated, *A hospital based emergency room, as an extension of the hospital, in a location where about 22% of our patients come from at present, is something that's worth while to do. I think that our colleagues at Prov will agree with us. What makes an emergency room is board certified emergency room doctors and we plan on staffing our emergency room with exactly that. Those highly trained emergency room physicians that can treat emergent conditions, with access to ultrasound, CTs, x-ray, 24/7. And these are things that urgent cares just don't have. Urgent cares are not built to take care of heart attack and stroke patient. "I think broadening access to care is only a good thing."*

Maya Wolf told of a personal antidote regarding emergency mental health care. *She has seen in the ER that a lot of the staff are overworked or they simply do not have enough people to go around to help. There are just not enough places for people to go. If the space is filled up, there is no help and they will not refer to another place because there is nowhere to refer to. Mental health professionals are overworked and overrun with cases, and there are not enough places for them to work. If the Psych ER is filled, they will put you in the regular ER if there is a bed available. If there are no beds available, and someone you love has attempted suicide, there is nowhere to go and no one to help. In support of the freestanding ED because of her own family, but also because urgent cares are not open 24/7. We need this to happen.*

Another statement of support came from Charlie Grimm, CEO and founder of AK Medical Transport. *Some of the wait times hold up patient transport from one hospital to another or*

taken to an ALF. Have had to take employees to the hospital (to the ER, not taken in their emergency vehicles) and have had long wait times. Wait times are 2-4 hours because ERs take the most emergent people first. It would be nice to have another place to take their patients or employees or loved ones to. His family and employees own homes on the South side of Anchorage and a lot of them have kids. Sometimes with the weather it is treacherous to get down to midtown/East side to get to the hospitals. "We would be in full support of a hospital being over in the South Anchorage area, even having one down towards close to Girdwood would be awesome too." There is a lot of room for expansion for "all of us" and we should all work as one team together.

Many of the supportive comments included personal antidotes and the message that the time and distance to the ER from South Anchorage, Indian, Girdwood etc. is too long and can be more than doubled in the winter weather.

C Hunt - South Anchorage residents deserve to have an ER nearby to effectively treat life threatening emergencies....

B Norton- Doesn't disagree with the problems other commenters brought up...A hospital based emergency room, as an extension of the hospital, in a location where about 22% of our patients come from at present, is something that's worthwhile to do. ... "I think broadening access to care is only a good thing."

Tyler B - Disappointed as a taxpayer and citizen to hear economic and political arguments from entities that are for-profit in this industry. We can all find studies that can either back or go against this kind of thing. The biggest thing is that every one of the ERs are very crowded day in and day out. Seen numerous instances of divert, and patients not able to go to the ER that they choose to go to or see a doctor that they may prefer to go to, due to the length of time that it takes. It is an access issue that we can work over time to improve but this is one step along the way to a number of other things.

Van S. - The area is currently under served when it comes to emergency care. Son fell and hit is head. Went to a small walk in urgent care on Huffman, they didn't try to stop the bleeding or help in anyway and redirected them to Providence ER in midtown. Son was bleeding from the back of his head and the extra time it took to get to the ER in midtown was worrisome as parents. "Every minute matters to a parent when your child is in pain and in need of medical help." South Anchorage has many similar families that would prefer closer, vital, emergency care. All of Anchorage would benefit from more emergency room capacity. It would take some of the burden off of current ER providers in midtown. If there was a freestanding ER he would go to urgent care to make sure he will not pay more than he needs to, but it would provide the option for specific circumstances that are critical emergencies. An ER is open 24/7, staffed with emergency physicians, with a much higher level of care than walk in urgent care clinics. Residents in "this" community deserve these resources in South Anchorage, closer to their homes.

Notable Excerpts/In Opposition:

In opposition, there was also a clear message of increased costs, confusion, and delay in definitive care.

Ella Goss a RN and CEO of Providence Alaska stated she has served as a flight nurse and emergency department nurse during a 29-year career in Alaska healthcare. Sharing three reasons why the proposed emergency department is not appropriate for our community: 1) A freestanding emergency department will increase the cost of care for lower acuity patients who visit the facility and for Alaska's entire healthcare system. It does not make sense in the Anchorage market. The application for CON advocates for one of the most expensive forms of healthcare. It would charge patients more for care, that in many cases could be treated in a less expensive setting, without increasing the systematic cost of care in Alaska. Freestanding emergency departments are more expensive than other care options because they charge hospital level prices. However, unlike regular hospitals, freestanding emergency departments don't have most of the advanced services available onsite, such as, trauma care, specialists, operating rooms, cardiac catheterization, and inpatient care. 2) A freestanding emergency department can not only result in additional costs for patients, but it can delay care for those that require immediate emergency interventions that are only available at a hospital. Patients experiencing stroke often present with atypical symptoms. When appropriate hospital based medical care is minutes away a stop at a freestanding ED, that is not adequately equipped with a cardiac cath lab or operating room, can result in a devastating outcome. Additional time in transfer creates a delay in care and increases the burden on our EMS system. The applicant does not address the increased transportation costs for patients who require trauma services at another facility or requests to be transferred to a different local hospital. 3) As a community our shared focus should be on more accessible, affordable, preventative settings of care that keep Alaskans out of emergency departments. Provides other options for expanded medical care underway in Alaska that can further relieve hospital EDs.

Dr Tim Soloff spoke about the confusion around entity being proposed. Describing as hospital-based emergency room, freestanding emergency department is different. Feels for the community member on the call that wants a hospital and lifesaving treatment in South Anchorage. The South Anchorage residents' personal stories all identify the need for an emergency department with operational capacity such as an operating room, cath lab, blood bank, interventional radiology, specialty services. Those are not available at a freestanding ED. That confusion makes it hard for the public to understand what is being proposed. What is being proposed is a physician with 5 beds, and imaging studies, who is unable to care for major emergencies that require definitive care. The definitive care requires a hospital, and the transfer from the freestanding ED to the hospital will cause delay. Delay is the problem. A freestanding ED without hospital services will lead to delay which will result in bad care and bad outcomes. Will add a huge cost to the community. The care of our loved ones would be negatively impacted.

Dr Helen Adams stated as Lifelong Alaska resident, and Southwest Anchorage resident since 2000. Address misconceptions that she's heard on the call. They are using language such as "hospital-based ER" which is far from the truth. It is a hospital "affiliated" ER. It is not a place

where one should seek care for an emergency that comes down to minutes and seconds. ER docs had said that emergency medicine is where an emergency medicine physician is, and she agrees. She fully believes that they can provide good care but will admit that we are only as strong as the system in which we operate and knowing our limits. She knows that if one of our family members goes into a freestanding ED with a gunshot wound, they are not going to get "our city's best". Wants to highlight what appears to be a misconception from the residents of South Anchorage, that are her neighbors, friends, elderly parents, that this is not a hospital in South Anchorage. "In fact, I would love a hospital in South Anchorage. If this application was for a hospital in South Anchorage that had surgical suites, obstetric care, a cath lab, endoscopies, stroke center, sign me up, I would advocate for that." This is not what is being promoted. The idea that the physicians testifying today in opposition are somehow breaking they're Hippocratic oath by doing so, is hurtful. She is not only charged with doing no harm and helping the person in front of her but is also charged with the task of looking at our community from a public health perspective and what is being proposed is not aligned with the long-term goals of Anchorage and the health of the people who live here. This type of facility has been shown through evidence to increase costs, dilute care, and delay diagnosis. Freestanding ERs are not right for Anchorage. She would love to see full-service hospitals in place in South Anchorage to help residents where she lives and all the way down the inlet, but that is not what is on the table.

The final speaker did not definitively state if he was for or opposed to the project. [His name was undistinguishable.] The man spoke of the EMS mayors advisory board, who review EMS data, wait times, and which ERs are open/diverting. *The important thing for people to know is that in a true-life threatening emergency, the place you need to be is at a full-service hospital where there is access to specialty services, and the specialists that can manage that care. Referring to a previous caller, if a child had a head injury, they would need to be at a hospital and not a freestanding South Anchorage location. The specialists that are on call to the ERs in town are limited. Adding another location where they would need to be available could be very untenable for them. In regard to psychiatric care, the South Anchorage location would not be a good place for psychiatric patients to go because they won't have mental health clinicians or psychiatrists. Two facilities are being developed through Providence and South-Central Foundation that will be specifically available for psychiatric emergencies and be open 24/7. If a patient needs acute trauma care, they need to be at one of the level 2 trauma centers, Providence or ANMC. That's where trauma surgeons are located, and neurosurgery is readily available. It's not that no type of patient would benefit from this type of facility, but those that need the most urgent, emergent care would have laze in their care. We need to do the right thing for the patients and that is not the delayed care.*

Written Public Comments

A written public comment period was open from July 31, 2024 – September 16, 2024. A total of 286 written comments were received. Of the written comments received 16 were duplicate entries (either written or verbal), 251 were in favor and 35 were opposed.

In Favor:

Of the 251 in favor; 245 letters (generic, solicited, gathered and submitted by Holland & Hart LLP, legal counsel and representative of ARH for the purposes of their CON Application). Of the remaining 6 letters submitted in favor, 1 was a duplicate, 1 was a medical professional, 1 a business owner, 1 a union representative, and 2 private residents.

Of the 245 that were submitted by Holland & Hart LLP; most of them carried the message of distance and time to the underserved community in South Anchorage.

Notable Excerpts:

A. Woolrich Services in South Anchorage are completely inadequate in distance and availability.

A. Ryan I support FSED in South Anchorage and believe it will improve the area's safety.

A Preis I'd like ER services closer to home.

A Bauer, Director of Therapy Services ARH as a Resident of Rabbit Creek neighborhood, having ems close to home would make me feel safer. Director of Therapy Services at ARH, every minute saved in diagnosis and treatment of patients experiencing stroke or heart attack symptoms improves chances of positive outcome exponentially.

B.Hopkins support of ARH FSED in S Anc. Travel time from S Anc across town is over 20 min, this is unacceptable considering the timely treatment during life-threatening medical events...

A letter from an EMS professional, N McLeod, in support of this CON application states; Anchorage needs a lower acuity facility to allow the major hospitals in Anchorage to treat higher acuity, sicker patients. ER wait times are rising and the volume of patients being seen exceeds the capabilities of the hospitals... hospital staff will have less strain and be able to focus on higher acuity patients and prevent burnout from high patient volumes.

Another support letter submitted by Holland & Hart LLP for Timothy Kelley states; Most primary care providers in Anchorage do not accept patients if they are signed up for Medicare. So, the only option Medicare recipients have is often the ER. It shouldn't be this way. Primary care should accept Medicare, and especially if people just want to pay cash. But until laws are changed, the ER is the go-to for Medicare recipients. Because of this, more ER capacity in Anchorage is very much needed.
M Weston, Fire Chief of Girdwood Fire and Rescue stated Girdwood Fire and Rescue (GF&R) support the ER in South Anchorage. GF&R provides EMS, rescue and fire services to Turnagain Arm,

from Bird Creek to Hope cut off, occasionally Whittier and patients from the AK Railroad. The Girdwood Clinic is open Monday thru Friday 9am - 6pm, leaving GF&R as the only medical provider for 15 hours Monday thru Friday and 24 hours on the weekend. Having a closer ER would expand accessibility to care ...

Opposed:

The independently submitted opposition letters presented similar ideas; increased cost of care, increased time for definitive care, increase strain on EMS transport, and will not fix the issue of wait times or on-boarding. Another common theme is the lack of preventative and post-acute services are driving the increased usage of ERs.

Notable Excerpts:

Dr. J Miss states An actual hospital based Emergency Department can care for any medical emergency due the hospital, operating rooms, specialists and specialty services attached to it; its why we have designated trauma, stroke, heart attack and pediatric centers in Anchorage. ...FSED's provide inadequate care for critically ill patients and excessively expensive care for the "less sick", all while further burdening our EMS infrastructure with unnecessary extra transports.

Ella Goss from PAMC has a different approach. As a substantially affected party (7 AAC 07.900.27.C) ... "Providence" exercises its right to comment on the Certificate of Need (CON) application submitted by Alaska Regional Hospital (ARH) on July 1, 2024... Providence believes the intent of AS 18.07 is to maintain a balance between community need and available capacity to ensure access to health care services without costly overbuilding of capacity, all within the context of current state and federal health care strategic goals and initiatives. This letter describes how the ARH application does not meet the intent of AS 18.07 or the requirements of 7 AAC 07 CON regulations. Specifically, the applicant does not meet several of the general review standards required to approve additional emergency department beds in the Anchorage community ...Providence believes approving the ARH CON application would conflict with the intent of AS 18.07 and its regulations and standards and methodology, expanding emergency department services beyond what is justified by community need.

Dr Helen Adams submitted an email attaching her comments from last year. She stated Essentially, all references and points I made at that time are pertinent. The proposal this year is only weakened further by reducing the number of beds to 5. I truly believe that the creation of this facility will do nothing to reduce wait times at the definitive care centers, delay timely and lifesaving care to Alaskans, and will inevitably increase costs to our system.

Dr Helen Adams' attachment has over 72 physicians listed in agreement with the following statement. The utilization of FSEDs in the lower 48 have not improved ED congestion, rather they deliver inadequate emergency care in true critical situations, while simultaneously

delivering expensive care in less emergent cases. FSEDs are not equipped to definitively manage true emergencies such as trauma cases, heart attacks, strokes, etc.. They typically do not have on-call specialists or surgical capabilities, whereas a traditional ED will have trauma surgeons, critical care physicians, OB/GYNs, anesthesiologists, internal medicine specialists, in house nearly 24 hrs a day. In addition, FSED lack specialty equipment - operating rooms, endoscopy suites, cath labs, ICU, pediatric ICU, and NICU. The reality is that this is an expensive and well equipped urgent care masquerading as something it's not. FSEDs deliver the wrong care in the wrong place.

Dr Helen Adams also submitted a statement previously submitted in 2023; a comment from AEMA, Alaska Emergency Medicine Associates. In this document she has several references; NY Dept of Health, The American Journal of Emergency Medicine, Annals of emergency medicine, Kaiser Family Foundation, to name a few. Dr Adams discusses the original intent of FSEDs, increasing access in rural areas. She also discusses the level of care served in the wrong place, driving up the costs. And she focuses on what the solution for Anchorage's long wait times, boarding and backups. She suggests the increase of discharge placements, primary care for Medicare recipients, and support for education and retainment of nursing and support staff.

Dr A Funary of NorthStar Cardiothoracic Surgery writes As lead surgeon for the only locally based, full-time team of cardiothoracic surgeons in Alaska...my strong opposition to AKRH's FSED application. 'Time is Muscle'. There is an urgency of properly treating heart attacks and other cardiothoracic life-threatening emergencies. The longer the delay in treatment the more heart muscle is likely to be damaged. Time is critical... patients should not stop at an FSED...

Dr B Sweeney, The Alaska Landmine, Explosive Alaska News; suggests this should not be about for or against, it should be about evidence. It should be rejected., Op Ed Column 8/29/2023 No studies showing FSEDs improve health care system.

RECOMMENDATION

The CON Program recommends full denial of ARH's application.

- ARH failed General Review Standards #1, #2 and #6.
- ARH satisfied General Review Standard #4 and satisfied, in part, #5.
- ARH failed Service Specific Review Standard #1, and #2 for Hospital Emergency Department Services, #3 and #4 were not applicable.

As it pertains to Service Specific Review Standard #1, ARH incorrectly interpreted and applied population data (source, identified and provided by the department) incorrectly in its self-identified service area when calculating projected need. ARH's application of the methodology was, and is, wholly incorrect. The CON or "CASU" methodology is specific to the issue at hand; and provided for the sole purpose of calculating projected need for services proposed, i.e. existing ED treatment beds.

ARH's incorrect interpretation of applicable, reviewable and accessible data is unfortunate. As noted throughout this analysis, when applying the correct assumptions extrapolated from applicable population and utilization data, and considering the entire service area, there is a projected *negative* ED treatment bed need in five years. On this premise alone, denial of the CON is warranted in full.

It is known and well documented that HBEDs are expensive settings for care and are inefficient compared to traditional EDs that are physically attached to hospitals due to their inability to provide trauma care and other critical emergency services for this exact reason. Most cases that would present at an HBED can and should, when possible, be handled in less expensive, more appropriate settings for care, like urgent care clinics and physicians' primary care offices and include new facility types or healthcare settings such as a "Crisis Rehabilitation Center" (CRC), a facility type that is currently being developed in the Municipality, by PAMC.

Per ARH, transfer of patients needing trauma or other critical ED services not provided in the proposed HBED will be transferred to a hospital at no cost to the patient.

ARH provided no evidence of agreements, explanation or corroboration of their statement in its application that there will be no cost to the patient if additional EMS transport is necessary to move the patient to a hospital. It is unclear how ARH draws its conclusion that no cost will be incurred by the patient, based on information shared in their application. Who will bear the responsibility of additional transports, regardless of the hospital ED location? It is assumed that not all patients necessitating hospital-based ED services will elect to go to ARH's hospital ED.

Even if every patient was being re-transported, after being seen at ARH's HBED, to ARH's hospital ED, ARH fails to describe how the cost will be deflected, or absorbed by ARH, and not the responsibility of the patient, EMS or other payor. Nor, how (or who) the cost of transport of the emergency patient is delegated if they need specific trauma care, or request care at a facility other than ARH's.

ED care, regardless of whether it is provided in a hospital ED or HBED is expensive because under Medicaid and Medicare, both the physicians and professional staff providing the care, and *the hospital entity* all receive reimbursement.

In an urgent care setting, crisis rehabilitation center or a physician's office, the professional staff are reimbursed for services, and no facility fee is passed on to the patient. This is not the case in a free standing or hospital-based ED, one co-located with its hospital.

ARH's proposed HBED will be reimbursed at the *facility rate*, that covers all hospital services at its existing hospital, located across town on DeBarr Road. This hospital fee is significantly higher than the fee associated with care provided at an urgent care clinic, crisis rehabilitation center or primary physician office.

From a planning perspective, the department supports improving care and the efficient delivery of services. Increasing access points to emergency room services may improve convenience for some, but it does not necessarily improve care or efficient delivery of care, nor is it in any way a cost containment measure. In fact, just the opposite. ARH's HBED stands to be reimbursed at a significantly higher rate; consistent with existing billing and reimbursement schemes that were designed to be applied to hospital EDs only.

As far as efficient and effective delivery of ED services, consider the following scenario. In its application, ARH states it is proposing five (5) ED treatment rooms, a x-ray machine, a CT machine and five (5) cardiac monitors. The 5 cardiac monitors are for the purposes of managing ischemic stroke interventions via "Tele-Scope" capabilities connected, virtually, to its hospital ED.

This means that ARH's HBED based emergency physicians can monitor a cardiac event but cannot administer essential cardiac trauma services as those need to be supported by a hospital based cardiac cathartic (cath) lab. These patients would then have to be immediately transferred to a hospital ED. This scenario does not improve delivery of care or make it more efficient. In fact, a potentially life-threatening scenario becomes even more so because the patient must be loaded back into a transport vehicle and taken to a hospital ED.

Efficient, effective healthcare, resulting in improved health outcomes for its population, is a priority for Alaska Medicaid services. Specifically, Alaska is dedicated to developing and providing state of the art health care to all who reside or visit the state that is cost effective. To do this, it is imperative careful consideration be given to managing the cost, without forfeiting quality or access to healthcare. Unfortunately, like many states, Alaska has what is considered "super utilizers" of emergency room services. This term refers to an ED patient who does not routinely utilize or have access to preventative or other healthcare services. Essentially, super utilizers are

those patients that resort to receiving primary and non-emergency care at an ED because they do not have a primary physician or access to an urgent care clinic.

Note that Alaska Medicaid strives to reduce emergency room visits by creating access and realizing improvements in the use of preventative services, including lower, less expensive levels of care, *e.g.*, urgent care clinics and crisis stabilization centers.

An example of these less expensive, lower level of care efforts currently underway in the Municipality, and supported at the state and federal level, is the establishment of the new Crisis Stabilization Center (CSC) or CRC by PAMC, currently under development in Anchorage. This center is part of the state's "crisis now" model. The \$11 million dollar facility is on track to provide a less expensive, better option for people experiencing behavioral and substance abuse health crises than an ED would. The PAMC CSC is currently on track to be fully developed in the Summer of 2025.

Establishing multiple, more convenient access points for emergency room services contradicts the department's priority and long-term planning to contain costs by curbing unnecessary use of emergency departments.

The CON program does not believe that the proposed HBED will have a desirable impact on the existing health care system. One particularly concerning issue is the fact that there is no statutory or regulatory framework in place concerning Free Standing Emergency Departments (FSED), or HBED's in Alaska. The CON program questions whether a statute change will be necessary if ARH's application receives a CON.

Per 7 AAC 07.070(b)(7)(A), in granting or denying a CON, the Commissioner must consider "any other special or extraordinary circumstances related to . . . community access to health care[.]"

Ultimately, ARH did not demonstrate that any extraordinary benefit would be realized for the Municipality of Anchorage should it's proposed HBED be approved. It applied a misinterpretation of data sources, and high-lighted a self-defined service area of five zip codes called "south Anchorage" as a large population center, assuming on these facts, in part, there was a valid and reasonable argument for additional ED services in south Anchorage.

As stated throughout this analysis, there is no such service area as south Anchorage, and the service area that needs to be considered for purposes of this analysis is the Municipality of Anchorage. ARH's argument for locating ED services across town from a hospital is not acceptable because simply peeling off ED services and locating a freestanding building (HBED) in south Anchorage does not address comprehensive access needs that represent an actual service area. For example, it is inconsistent to consider South Anchorage as standalone service areas when their residents must leave these areas to access nearly all other health care services (i.e. hospital services, trauma services, surgery services, etc., which are all located in the downtown and midtown areas of Anchorage).

In addition, ARH failed to identify the correct, existing number of true ED treatment rooms thus arrived at an incorrect number of projected and needed ED treatment rooms in five years. ARH failed in their attempt because they calculated need based on incorrect assumption that P ED treatment rooms that are “self-designated” as pediatric are specialized. By doing so, ARH fails to demonstrate any exception that would warrant waiving the available capacity for its project on the part of the Commissioner and Department of Health.

In issuing her final decision, the Commissioner of the Department of Health must consider how ARH’s proposal will affect the entire health care system and the community’s access to that health care system and whether the community’s access to emergency department treatment services is best accomplished by establishing a HBED in south Anchorage.

Throughout this Analysis there is sufficient evidence that the establishment of an HBED in south Anchorage is not going to meaningfully increase access to healthcare, that it’s not an efficient and an effective use of resources and will not improve health outcomes for patients in or residing in the Municipality of Anchorage.

Accordingly, the CON Program recommends that the Commissioner deny ARH’s application in FULL.

APPENDIX A - Estimated Impact to Medicaid



THE STATE
of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

OFFICE OF RATE REVIEW

3601 C Street, Suite 978
Anchorage, Alaska 99503-5932
Main: 907.334.2464

MEMORANDUM

To: Alexandria Hicks
Certificate of Need Coordinator

From: Christine Goetz
Audit & Review Analyst III

CG

Date: July 23, 2024

Subject: Alaska Regional Hospital HBED Certificate of Need Staff Analysis

Alaska Regional Hospital, located in Anchorage, Alaska, is requesting a Certificate of Need (CON) for a Hospital Based Emergency Department (HBED) in South Anchorage. The facility's purpose is to offer hospital-level care for conditions most seen in emergency rooms and will be capable of receiving ambulance traffic and providing pediatric, OB/GYN, isolation, bariatric, secure holding, and trauma care. In addition to square footage and new beds, the project will have the following on site: CT Scanner, diagnostic X-ray, Ultrasound, Cardiac Monitoring, Portable X-ray, and a Portable C-arm X-ray. The HSED will also be equipped with Tele-Stroke capabilities connected to Alaska Regional, the State of Alaska's only accredited Comprehensive Stroke Center. Upon project completion, Alaska Regional's HSED will have twelve (12) treatment rooms and will be open to the public 24/7.

Using Alaska Regional Hospital's 2017, 2018, and 2019 pre-pandemic volumes and 2021 and 2022 post-pandemic volumes, patient visits per room averaged about 1,800 patients per room. Based off this knowledge and the 2023 estimated average of patients per day, Alaska Regional Hospital would need 12 additional general treatment rooms to meet the CON methodology standard of 1,500 visits per ED room.

The costs are projected to be \$17,621,000. The project will be 100% funded from existing HCA reserves. The facility estimates the HSED will be operational for patient care by January 1, 2025, and anticipates to immediately utilize all 12 beds.

The services provided through this project are on an outpatient basis only. CON rate add-ons are calculated for inpatient services and long-term care services. Outpatient rates are paid as a percentage of charges and facilities are immediately reimbursed for cost. Therefore, no CON add-on adjustment is necessary.

The total projection of Medicaid program costs from the January 1, 2026, implementation and the following full three State Fiscal years of operations is \$9,967,900 as outlined below. The first year is a partial State Fiscal year.

Alaska Regional Hospital Based Emergency Department (HBED)

	<u>2026</u>	<u>2027</u>	<u>2028</u>
Net Emergency Department (ED) Revenue Per Visit*	\$ 1,973	\$ 2,450	\$ 2,931
HSED Expansion Visit Threshold&	7,500	7,500	7,500
Estimated HBED Visit Threshold Revenue	\$ 14,797,500	\$ 18,375,000	\$ 21,982,500
Ancillary HBED Revenue^	\$ 13,583,000	\$ 15,027,000	\$ 16,611,000
Total Estimated HBED Revenue	\$ 28,380,500	\$ 33,402,000	\$ 38,593,500
Medicaid Utilization@	33.00%	33.00%	33.00%
HBED Medicaid Revenues	\$ 9,365,565	\$ 11,022,660	\$ 12,735,855
Outpatient Medicaid Payment Rate#	8.37%	8.37%	8.37%
HSED Total Cost to Medicaid Program	\$ 783,897.79	\$ 922,596.64	\$ 1,065,991.06

* Data provided in CON application 70/171

& 5 beds * 1,500 CON standard of visits per ED room

^ Data provided in CON application 72/171

@ Medicaid Utilization taken from CON application 75/171

Payment rates for FY 2026-2028 are estimated based on the facility's 2024 outpatient % of charges

Please note, all calculations in this memorandum are estimates only and are based on the assumptions set forth in the CON application. The Department is not bound by these estimates or assumptions. Also, please note 7 AAC 07.070(i):

Approval of a certificate of need does not imply any guarantee of federal, state, or private money, including Medicaid payments or grant awards, and does not imply any guarantee of profitability.

Should you have any questions please contact Christine Goetz at 907-334-2476.

APPENDIX B - General Review Standards

I. General Review Standards Applicable to all Certificate of Need Applications

Review Standards

The department will apply the following general review standards, the applicable service-specific review standards set out in this document, the standards set out in AS 18.07.043, and the requirements of 7 AAC 07 in its evaluation of each certificate of need application:

1. The applicant documents need for the project by the population served, or to be served, including, but not limited to, the needs of rural populations in areas having distinct or unique geographic, socioeconomic, cultural, transportation, and other barriers to care.
2. The applicant demonstrates that the project, including the applicant's long-range development plans, augments and integrates with relevant community, regional, state, and federal health planning, and incorporates or reflects evidence-based planning and service delivery. A demonstration under this standard should show that the applicant has checked with the department regarding any relevant state plan, with appropriate federal agencies for relevant federal plans, and with appropriate communities regarding community or regional plans.
3. The applicant demonstrates evidence of stakeholder participation in planning for the project and in the design and execution of services.
4. The applicant demonstrates that PAMC has assessed alternative methods of providing the proposed services and demonstrates that the proposed services are the most suitable approach.
5. The applicant briefly describes the anticipated impact on existing health care systems within the project's service area that serve the target population in the service area, and the anticipated impact on the statewide health care system.
6. The applicant demonstrates that the project's location is accessible to patients and clients, their immediate and extended families and community members, and to ancillary services. This includes the relocation of existing services or facilities.

Additional Considerations for Concurrent Review of More than one Application

In completing a concurrent review of two or more applications under 7 AAC 07.060, in addition to applying the standards set out above, the department will compare the extent to which each applicant, including any parent organization of the applicant,

1. Demonstrates a commitment to quality that is consistent with, or better than, that of existing services, if any;
2. Demonstrates a pattern of licensure and accreditation surveys with few deficiencies and a consistent history of few verified complaints; and
3. Demonstrates that the applicant has consistently provided, or has a policy to provide, high levels of care to low-income and uninsured persons.

APPENDIX C – Service Specific Review Standards

B. Hospital Emergency Department Services Review Standards

After determining whether an applicant has met the general review standards in Section I of this document, the department will apply the following service-specific review standards, as applicable, in its evaluation of an application for a certificate of need that involves the expansion of an emergency department:

1. The applicant demonstrates that the project promotes, or otherwise helps ensure, the maintenance of a stable and efficient emergency medical system.
2. For the addition or expansion of general emergency services, a proposal will not be approved unless each emergency department treatment room will provide a minimum of 1,500 visits annually. The total number of emergency department treatment rooms (excluding specialized rooms such as cast/x-ray rooms, observation rooms, secure rooms and space for visiting physician clinics) approved will not exceed one room per 1,500 visits annually, based on utilization projections in the fifth year of operation. The department may approve additional space if the applicant documents use patterns, and submits data and analysis that show seasonal high peak use rates warranting additional treatment rooms.
3. For the addition or expansion of fast track emergency services within a facility, a proposal will not be approved unless the applicant demonstrates that:
 - a. the fast track space will have at least one physician, advanced nurse practitioner, or physicians' assistant assigned full-time to the service; and
 - b. a minimum of two fast track rooms are needed, each anticipated to accommodate at least 1,500 visits per room per year by the fifth year of operation; and
 - c. remaining general emergency service rooms will continue to handle a minimum of 1500 visits annually.
4. For a proposal for additional space in the hospital emergency department, the applicant must perform a size-by-functional-need survey and analysis for additional space that demonstrates efficient use of the space.

Review Methodology

The department will use the following formula to determine the need for emergency department treatment room services:

$$EDTR = C5/1500$$

$$C5 = P5 \times SAS \times UR$$

EDTR = emergency department treatment rooms needed

C5 = caseload (emergency department visits) projected for the fifth year after project completion

UR = current utilization rate (average number of emergency department visits per year for the last three years, divided by population), to be determined on a service area basis

P5 = projected population for the fifth year after project completion

SAS (service area share) = the proposed service area's current share of the population to be served, as of the most recent geographic population estimates. If there is public information about service area population changes expected over the planning horizon, such as a military base closing, or a major economic project such as a new mine, the service area share estimate may be modified with an explanation to reflect the expected change.

APPENDIX D - ARH -Annual CON Data 2021-2023

Part 1. Capacity & Utilization Reporting Form - Data Elements - State of Alaska Certificate of Need Program		
Facility Name: Alaska Regional Hospital		
Person Completing Form: Rob Stantus	Contact Information robert.stantus@hcahealthcare.com	
A. In-Patient Acute Care Capacity		
	Calendar Year 2023	
Type of Service	Number of Beds	Billable Patient Days
Licensed Beds Total:	250	45877
If facility designates beds according to service please report accordingly - If not, report as Med/Surg beds		
Med/Surg Beds	122	13170
# licensed as swing beds^	0	0
Intensive Care Unit Beds	14	3424
Cardiac Care Beds	13	2346
Obstetrics Beds*	14	1338
Pediatric Beds	2	33
NICU Bassinets**	10	332
Acute Rehabilitation Beds	10	2994
Other -- specify type, and if counted as licensed (Yes or No):	65 Internal Med	22151
^ Report Swing Bed Patient Days according to their use (acute med/surg care or long term care)		
* Includes LDRP - Labor, delivery, recovery, postpartum, birthing rooms, observation beds. "Day use only" beds not counted as licensed beds should be reported under "other."		
B. Long-Term Care		
(1) Capacity by Calendar Year, and July 1 Census		
Calendar Year	Calendar Year 2023	
	Number of Beds	July 1 Census
Intermediate Care Facility	0	N/A
Skilled Nursing Facility	0	N/A
Assisted Living Facility	0	N/A
Hospice Facility	0	N/A
(2) Bed Days for Calendar Year By Age Group for Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF)		
	SNF Bed Days	ICF Bed Days
Age 0-64	0	N/A
Age 65-74	0	N/A
Age 75-84	0	N/A
Age 85+	0	N/A
Total	0	N/A
C. Surgical Care		
Calendar Year	Calendar Year 2023	
	Number of Suites	Number of Patients***
Suites for In-Pt or Out-Pt Surgery	11	8,039
Day Surgery or Dedicated Outpatient Suites	0	0
Endoscopy Suites	2	2396
Open-Heart Surgery Suites	1	102
Organ Transplantation Suites	0	0
Cardiac Catheterization Suites	2	5006
Cardiac Electrophysiology Suites	1	263
Other Suites (list) Proced Room	2 L&D Ors	143
***"Patient" refers to an individual served on a particular day regardless of the number of procedures performed.		

D. Behavioral Health Care		
Calendar Year	Calendar Year 2023	
	Beds	Patient Days
In-patient Acute Psychiatric Beds		
Adult	0	N/A
Youth	0	N/A
RPTC - Level 5		
Adult	0	N/A
Youth	0	N/A
In-patient Substance Abuse Beds		
Adult	0	N/A
Youth	0	N/A
Please specify age criteria in facility:		
E. Emergency Department		
Calendar Year	Calendar Year 2023	
Type of Service	Rooms	Visits
	16 Rooms with 4 fast track bays, 4 recliners in the hallways and 6 stretchers in the hallways for surg	40848

Part 2. Service Capacity Data Reporting Form - Data Elements - State of Alaska Certificate of Need Program							
Facility Name:		Alaska Regional Hospital					
Person Completing Form:		Rob Stantus		robert.stantus@hcahealthcare.com			
Diagnostic Imaging Services							Number of Scans per Calendar Year
CT Scanner	Slice Speed	Make/Model	Service	Other*	Scanner?	Use?***	2023
	32	GE Optima 660	Apr-19			Yes	
	64	GE Revolution HD 60 HVY CTM	Sep-19			Yes	
Total							18,424
MRI	Tesla	Make/Model	Service	Other*	Scanner?	Use?***	2023
	1.5	GE Artist	Oct-19			Yes	3,648
PET or PET/CT		Make/Model	First Year in Service	Full Body or Other*			2023
		N/A	N/A	N/A		N/A	
Ultrasound							
GE Logiq E10	N/A	5935000 E10	Jun-19			Yes	
GE Logiq S8	N/A	Logiq S8 R4	Mar-19			Yes	
GE Logiq E9	N/A	5205000-3	Feb-14			Yes	
GE Logiq P5	N/A	5329654	Apr-10			Yes	
GE Logiq E9	N/A	5205000-8	Sep-15			Yes	
Total							5497
Mammography							
Hologic	N/A	Selenia Dimensions	Feb-22			Yes	
Hologic	N/A	Selenia Dimensions	Aug-17			Yes	
Total							5237
Other							
XR 1	GE	GE Discovery XR656 G2	Mar-17			Yes	
XR 2						Yes	
XR 3	GE	GE P500	Mar-13			Yes	
XR 4	GE	GE ADVNTH DRS	Nov-00			Yes	
Total							53,053
Nuc Med	GE	GE 850 Spec CT	Dec-23			Yes	
Nuc Med	GE	Discovery NM	Jan-17			Yes	
Total							600
Ancillary Services			First year of Service			Exclusive Use?***	Number of tests/treatments per calendar year
Radiation Therapy							2023
Internal Radiation Therapy		N/A	N/A			N/A	
External Radiation Therapy		N/A	N/A			N/A	
Systemic Radiation Therapy		N/A	N/A			N/A	
Other*:		N/A	N/A			N/A	
Lithotripsy		N/A	N/A			N/A	
Renal Dialysis		N/A	N/A			N/A	
Sleep Studies		N/A	N/A			N/A	
Other*:		N/A	N/A			N/A	
*If OTHER, please list each service							
**If YES, please explain:							

Part 1. Capacity & Utilization Reporting Form - Data Elements - State of Alaska Certificate of Need Program		
Facility Name: Alaska Regional Hospital		
Person Completing Form: Rob Stantus	Contact Information: robert.stantus@hcahealthcare.com	
A. In-Patient Acute Care Capacity		
	Calendar Year 2022	
Type of Service	Number of Beds	Billable Patient Days
Licensed Beds Total:	250	47512
If facility designates beds according to service please report accordingly - if not, report as Med/Surg beds		
Med/Surg Beds	113	16128
# licensed as swing beds^	0	
Intensive Care Unit Beds	14	5761
Cardiac Care Beds	13	4185
Obstetrics Beds*	24	1647
Pediatric Beds	4	203
NICU Bassinets**	10	852
Acute Rehabilitation Beds	10	3143
Other -- specify type, and if counted as licensed (Yes or No):	65 internal med	15593
^ Report Swing Bed Patient Days according to their use (acute med/surg care or long term care)		
* Includes LDRP - Labor, delivery, recovery, postpartum, birthing rooms, observation beds. "Day use only" beds not counted as licensed beds should be reported under "other."		
B. Long-Term Care		
(1) Capacity by Calendar Year, and July 1 Census		
Calendar Year	Calendar Year 2022	
	Number of Beds	July 1 Census
Intermediate Care Facility	0	N/A
Skilled Nursing Facility	0	N/A
Assisted Living Facility	0	N/A
Hospice Facility	0	N/A
(2) Bed Days for Calendar Year By Age Group for Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF)		
	SNF Bed Days	ICF Bed Days
Age 0-64	0	N/A
Age 65-74	0	N/A
Age 75-84	0	N/A
Age 85+	0	N/A
Total	0	N/A
C. Surgical Care		
	N/C. Surgical C	
Calendar Year	Calendar Year 2022	
	Number of Suites	Number of Patients***
Suites for In-Pt or Out-Pt Surgery	11	3408
Day Surgery or Dedicated Outpatient Suites	11	5164
Endoscopy Suites	2	2651
Open-Heart Surgery Suites	1	96
Organ Transplantation Suites	0	0
Cardiac Catheterization Suites	2	1315
Cardiac Electrophysiology Suites	1	258
Other Suites (list) Proced Room	2 L&D Ors	153
***"Patient" refers to an individual served on a particular day regardless of the number of procedures performed.		

D. Behavioral Health Care		
Calendar Year	Calendar Year 2022	
	Beds	Patient Days
In-patient Acute Psychiatric Beds		
Adult	0	N/A
Youth	0	N/A
RPTC - Level 5		
Adult	0	N/A
Youth	0	N/A
In-patient Substance Abuse Beds		
Adult	0	N/A
Youth	0	N/A
Please specify age criteria in facility:		
E. Emergency Department		
Calendar Year	Calendar Year 2022	
Type of Service	Rooms	Visits
	16 Rooms with 4 fast track bays, 4 recliners in the hallways and 6 stretchers in the hallways for surg	38876

Part 2. Service Capacity Data Reporting Form - Data Elements - State of Alaska Certificate of Need Program							
Facility Name: <u>Alaska Regional Hospital</u>							
Person Completing Form: <u>Rob Stantus</u> robert.stantus@hcahealthcare.com							
Diagnostic Imaging Services							Number of Scans per Calendar Year
CT Scanner	Slice Speed	Make/Model	Service	Other*	Scanner?	Use?***	2022
	32	GE Optima 660	Apr-19			Yes	
	64	GE Revolution HD 60 HVY CTM	Sep-19			Yes	
Total							18,760
MRI	Tesla	Make/Model	Service	Other*	Scanner?	Use?***	2022
	1.5	GE Artist	Oct-19			Yes	4318
PET or PET/CT		Make/Model	First Year in Service	Full Body or Other*			2022
		N/A	N/A	N/A		N/A	
Ultrasound							
GE Logiq E10	N/A	5935000 E10	Jun-19			Yes	
GE Logiq S8	N/A	Logiq S8 R4	Mar-19			Yes	
GE Logiq E9	N/A	5205000-3	Feb-14			Yes	
GE Logiq P5	N/A	5329654	Apr-10			Yes	
GE Logiq E9	N/A	5205000-8	Sep-15			Yes	
							5140
Mammography							
Hologic	N/A	Selenia Dimensions	Feb-22			Yes	
Hologic	N/A	Selenia Dimensions	Aug-17			Yes	
Total							6344
Other							
XR 1	GE	GE Discovery XR656 G2	Mar-17			Yes	
XR 2						Yes	
XR 3	GE	GE P500	Mar-13			Yes	
XR 4	GE	GE ADVNTH DRS	Nov-00			Yes	
						Total	50,614
Nuc Med	Phillips	Brightview	Dec-18			Yes	
Nuc Med	GE	Discovery NM	Jan-17			Yes	
						Total	631
Radiation Therapy							2022
Internal Radiation Therapy		N/A	N/A			N/A	
External Radiation Therapy		N/A	N/A			N/A	
Systemic Radiation Therapy		N/A	N/A			N/A	
Other*:		N/A	N/A			N/A	
Lithotripsy		N/A	N/A			N/A	
Renal Dialysis		N/A	N/A			N/A	
Sleep Studies		N/A	N/A			N/A	
Other*:		N/A	N/A			N/A	

***If YES, please explain:

Part 1. Capacity & Utilization Reporting Form - Data Elements - State of Alaska Certificate of Need Program		
Facility Name: <i>Alaska Regional Hospital</i>		
Person Completing Form: <i>Jennifer Opsut, CEO</i> Contact Information: <i>jennifer.opsut@hcahealthcare.com</i>		
A. In-Patient Acute Care Capacity		
	Calendar Year 2021	
Type of Service	Number of Beds	Billable Patient Days
Licensed Beds Total:	250	45,387
If facility designates beds according to service please report accordingly - if not, report as Med/Surg beds		
Med/Surg Beds	113	16,881
# licensed as swing beds^	0	N/A
Intensive Care Unit Beds	14 (20 during high surge for COVID)	3,233
Cardiac Care Beds	13	4,263
Obstetrics Beds*	21	1,326
Pediatric Beds	4	22
NICU Bassinets**	10	268
Acute Rehabilitation Beds	10	3,283
Other -- specify type, and if counted as licensed (Yes or No):	65 Internal Med	16,111
^ Report Swing Bed Patient Days according to their use (acute med/surg care or long term care)		
* Includes LDRP - Labor, delivery, recovery, postpartum, birthing rooms, observation beds. "Day use only" beds not counted as licensed beds should be reported under "other."		
B. Long-Term Care		
(1) Capacity by Calendar Year, and July 1 Census		
Calendar Year	Calendar Year 2021	
	Number of Beds	July 1 Census
Intermediate Care Facility	0	N/A
Skilled Nursing Facility	0	N/A
Assisted Living Facility	0	N/A
Hospice Facility	0	N/A
(2) Bed Days for Calendar Year By Age Group for Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF)		
	SNF Bed Days	ICF Bed Days
Age 0-64	0	N/A
Age 65-74	0	N/A
Age 75-84	0	N/A
Age 85+	0	N/A
Total	0	N/A
C. Surgical Care		
Calendar Year	Calendar Year 2021	
	Number of Suites	Number of Patients***
Suites for In-Pt or Out-Pt Surgery	11	8,669
Day Surgery or Dedicated Outpatient Suites	11	5,235
Endoscopy Suites	2	2,769
Open-Heart Surgery Suites	1	150
Organ Transplantation Suites	0	-
Cardiac Catheterization Suites	2	1438
Cardiac Electrophysiology Suites	1	220
Other Suites (list) Proced Room	2 L&D ORS	140
***"Patient" refers to an individual served on a particular day regardless of the number of procedures performed.		

D. Behavioral Health Care		
Calendar Year	Calendar Year 2021	
	Beds	Patient Days
In-patient Acute Psychiatric Beds		
Adult	0	N/A
Youth	0	N/A
RPTC - Level 5		
Adult	0	N/A
Youth	0	N/A
In-patient Substance Abuse Beds		
Adult	0	N/A
Youth	0	N/A
Please specify age criteria in facility:		
E. Emergency Department		
Calendar Year	Calendar Year 2021	
Type of Service	Rooms	Visits
	16 ED With 4 Fast track and 4 hallway chairs for surg	33,547

Part 2. Service Capacity Data Reporting Form - Data Elements - State of Alaska Certificate of Need Program						
Facility Name: Alaska Regional Hospital						
Person Completing Form: Jennifer Opsut, CEO						
Contact Information: jennifer.opsut@hcahealthcare.com						
Diagnostic Imaging Services						Number of Scans per Calendar Year
CT Scanner	Slice Speed	Make/Model	First	Full Body	Exclusive	2021
	32	GE Optima 660	Apr-19		Yes	
	64	GE Revolution HD 60 HVY CTM	Sep-19		Yes	
					Total	14,273
MRI	Tesla	Make/Model	First	Full Body	Exclusive	2021
GE	1.5	GE Artist	Oct-19		Yes	3,135
PET or PET/CT		Make/Model	First	Full Body or Other*		2021
N/A		N/A	N/A	N/A		N/A
Ultrasound						2021
GE Logiq E10	N/A	S935000 E10	Jun-19		Yes	
GE Logiq S8	N/A	Logiq S8 R4	Mar-19		Yes	
GE Logiq E9	N/A	S205000-3	Feb-14		Yes	
GE Logiq P5	N/A	S329654	Apr-10		Yes	
GE Logiq E9	N/A	S205000-8	Sep-15		Yes	
					Total	7,175
Mammography						2021
Hologic	N/A	Selenia Dimensions	Feb-22		Yes	
Hologic	N/A	Selenia Dimensions	Aug-17		Yes	
					Total	3,378
Other						2021
XR 1	GE	GE Discovery XR656 G2	Mar-17			
XR 2						
XR 3	GE	GE P500	Mar-13			
XR 4	GE	GE ADVNXT DRS	Nov-00			
					Total	30,589
Nuc Med	Phillips	Brightview	Dec-18			
Nuc Med	GE	Discovery NM	Jan-17			
					Total	1,095
Ancillary Services			First year of Service		Exclusive Use?*	
Radiation Therapy						
Internal Radiation Therapy		N/A	N/A	N/A	N/A	N/A
External Radiation Therapy		N/A	N/A	N/A	N/A	N/A
Systemic Radiation Therapy		N/A	N/A	N/A	N/A	N/A
Other*:		N/A	N/A	N/A	N/A	N/A
Lithotripsy		N/A	N/A	N/A	N/A	N/A
Renal Dialysis		N/A	N/A	N/A	N/A	N/A
Sleep Studies		N/A	N/A	N/A	N/A	N/A
Other*:						
*If OTHER, please list each service						
**If YES, please explain:						

APPENDIX E - PAMC - Annual CON Data 2021-23

Part 1. Capacity & Utilization Reporting Form - Data Elements - State of Alaska Certificate of Need Program		
Facility Name: Providence Alaska medical Center		
Person Completing Form: Nick Zubach	Contact Information:	
A. In-Patient Acute Care Capacity		
	Calendar Year 2023	
Type of Service	Number of Beds	Billable Patient Days
Licensed Beds Total:	401	109,177
If facility designates beds according to service please report accordingly - if not, report as Med/Surg beds		
Med/Surg Beds	194	66,959
# licensed as swing beds^		
Intensive Care Unit Beds	28	7,829
Cardiac Care Beds	9	2,957
Obstetrics Beds*	38	8,117
Pediatric Beds	32	5,585
NICU Bassinets**	66	12,892
Acute Rehabilitation Beds		
Other -- specify type, and if counted as licensed (Yes or No):	34	4,838
^ Report Swing Bed Patient Days according to their use {acute med/surg care or long term care}		
* Includes LDRP - Labor, delivery, recovery, postpartum, birthing rooms, observation beds. "Day use only" beds not counted as licensed beds should be reported under "other."		
B. Long-Term Care		
(1) Capacity by Calendar Year, and July 1 Census		
Calendar Year	Calendar Year 2023	
	Number of Beds	July 1 Census
Intermediate Care Facility		
Skilled Nursing Facility		
Assisted Living Facility		
Hospice Facility		
(2) Bed Days for Calendar Year By Age Group for Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF)		
	SNF Bed Days	ICF Bed Days
Age 0-64		
Age 65-74		
Age 75-84		
Age 85+		
Total		
C. Surgical Care		
Calendar Year	Calendar Year 2023	
	Number of Suites	Number of Patients***
Suites for In-Pt or Out-Pt Surgery	15	8,683
Day Surgery or Dedicated Outpatient Suites	6	2,759
Endoscopy Suites	5	3,771
Open-Heart Surgery Suites	2	636
Organ Transplantation Suites		
Cardiac Catheterization Suites	4	3,747
Cardiac Electrophysiology Suites	2	1,120
Other Suites (list) Proced Room		
***"Patient" refers to an individual served on a particular day regardless of the number of procedures performed.		

D. Behavioral Health Care		
Calendar Year	Calendar Year 2023	
	Beds	Patient Days
In-patient Acute Psychiatric Beds	34	4,838
Adult	19	1,984
Youth	15	2,854
RPTC - Level 5		
Adult		
Youth		
In-patient Substance Abuse Beds		
Adult		
Youth		
Please specify age criteria in facility:		
E. Emergency Department		
Calendar Year	Calendar Year 2023	
Type of Service	Rooms	Visits
	49	60,748

Part 2. Service Capacity Data Reporting Form - Data Elements - State of Alaska Certificate of Need Program							
Facility Name: PAMC							
Person Completing Form: Chad Hicks chad.hicks@providence.org							
Diagnostic Imaging Services							Number of Scans per Calendar Year
CT Scanner	Size Speed	Make/Model	Service	Full Body or Other*	Scanner?	Use?***	2023
	128	Siemens	2019	Full Body			23,359 total for both CT
	64	Siemens	2012	Full Body			
MRI	Tesla	Make/Model	Service	Full Body or Other*	Scanner?	Use?***	2023
	1.5	Siemens Espree	2005	Full Body			4441
PET or PET/CT		Make/Model	First Year in Service	Full Body or Other*			2023
	4	GE Infinia Hawkeye	2016				1428 total for both NM
	8	GE 850	2022				
Ultrasound		Make/Model		Full Body or Other*			2023
		Philips Epic Elite	2019				9365 total for 5 US units
		Philips Epic Elite	2019				
		Philips Epic Elite	2019				
		Philips Epic Elite	2019				
		Parks Flow Lab	2021				
Ultrasound		Make/Model		Full Body or Other*			2023
		Siemens s2000	2014	breast			775
Mammography		Make/Model		Full Body or Other*			2023
		Hologic Affirm biopsy table	2017	breast			265
Other							
Ancillary Services			First year of Service			Exclusive Use?***	Number of tests/treatments per calendar year
Radiation Therapy							2022
Internal Radiation Therapy							
External Radiation Therapy							
Systemic Radiation Therapy							
Other*:							
Lithotripsy							
Renal Dialysis							
Sleep Studies							
Other*:							
**If OTHER, please list each service							
***If YES, please explain:							

**Also includes exams performed in MRI Trailer (Siemens Espree 1.5T)

Breast Center Data

Breast Center Data

Part 1. Capacity & Utilization Reporting Form - Data Elements - State of Alaska Certificate of Need Program		
Facility Name: Alaska Medical Center		
Person Completing Form: Nicholas Zubach		Contact Information: 916-769-0474
A. In-Patient Acute Care Capacity		
	Calendar Year 2022	
Type of Service	Number of Beds	Billable Patient Days
Licensed Beds Total:	401	106,284
If facility designates beds according to service please report accordingly - if not, report as Med/Surg beds		
Med/Surg Beds	184	60,130
# licensed as swing beds^		
Intensive Care Unit Beds	28	8,150
Cardiac Care Beds	9	2,420
Obstetrics Beds*	38	6,364
Pediatric Beds	32	5,974
NICU Bassinets**	66	14,161
Acute Rehabilitation Beds	10	3,356
Other -- specify type, and if counted as licensed (Yes or No): Adult and Adolescent	34	5,729
^ Report Swing Bed Patient Days according to their use (acute med/surg care or long term care)		
* Includes LDRP - Labor, delivery, recovery, postpartum, birthing rooms, observation beds. "Day use only" beds not counted as licensed beds should be reported under "other."		
B. Long-Term Care		
(1) Capacity by Calendar Year, and July 1 Census		
Calendar Year	Calendar Year 2022	
	Number of Beds	July 1 Census
Intermediate Care Facility		
Skilled Nursing Facility		
Assisted Living Facility		
Hospice Facility		
(2) Bed Days for Calendar Year By Age Group for Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF)		
	SNF Bed Days	ICF Bed Days
Age 0-64		
Age 65-74		
Age 75-84		
Age 85+		
Total		
C. Surgical Care		
Calendar Year	Calendar Year 2022	
	Number of Suites	Number of Patients***
Suites for In-Pt or Out-Pt Surgery	16	9,460
Day Surgery or Dedicated Outpatient Suites		
Endoscopy Suites	3	3,271
Open-Heart Surgery Suites	2	518
Organ Transplantation Suites		
Cardiac Catheterization Suites	4	3,949
Cardiac Electrophysiology Suites	2	1,026
Other Suites (list) Proced Room		
****Patient** refers to an individual served on a particular day regardless of the number of procedures performed.		

D. Behavioral Health Care		
Calendar Year	Calendar Year 2022	
	Beds	Patient Days
In-patient Acute Psychiatric Beds	34	5,729
Adult	19	3,809
Youth	15	1,920
RPTC - Level 5		
Adult		
Youth		
In-patient Substance Abuse Beds		
Adult		
Youth		
Please specify age criteria in facility:		
E. Emergency Department		
Calendar Year	Calendar Year 2022	
Type of Service	Rooms	Visits
	49	59,103

<<< Excludes: 2,115 Acute Days, 5.9 ADC

295 ED IP Acute Days
130 Psych IP Acute Days
141 CDU IP Acute Days
1,507 L&D IP Acute Days
17 OR Acute Days
4 PACU Acute Days
18 Cath Lab Acute Days
3 Endoscopy Acute Days

Please note that these counts of acute days are not counted in the total as they are IP Days that occurred in non-licensed IP bed locations throughout the Hospital.

Part 2. Service Capacity Data Reporting Form - Data Elements - State of Alaska Certificate of Need Program							
Facility Name: PAMC							
Person Completing Form: Chad Hicks				chad.hicks@providence.org			
Diagnostic Imaging Services							Number of Scans per Calendar Year
CT Scanner	Slice Speed	Make/Model	Service	Other*	Scanner?	Use?*	2022
	128	Siemens	2019	full body			21,145 total for both CT
	64	Siemens	2012	full body			
MRI	Tesla	Make/Model	Service	Other*	Scanner?	Use?*	2022
	1.5	Siemens Espree	2005	Full Body			4192
NM		Make/Model	First Year in Service	Full Body or Other*			2022
	4	GE Infinia Hawkeye	2016				1503 total for both NM
	8	GE 850	2022				
Ultrasound		Make/Model	First Year in Service	Full Body or Other*			2022
		Philips Epic Elite	2019				9334 total for 5 US units
		Philips Epic Elite	2019				
		Philips Epic Elite	2019				
		Philips Epic Elite	2019				
		Unetix	2006				
Ultrasound		Make/Model	First Year in Service	Full Body or Other*			2022
		Siemens s2000	2014	breast		N	376
Mammography		Make/Model	First Year in Service	Full Body or Other*			2022
		Hologic affirm biopsy table	2017	breast		N	263
Other							
Ancillary Services			First year of Service			Exclusive Use?*	Number of tests/treatments per calendar year
Radiation Therapy							2022
Internal Radiation Therapy							
External Radiation Therapy							
Systemic Radiation Therapy							
Other*:							
Lithotripsy							
Renal Dialysis							
Sleep Studies							
Other*:							
*If OTHER, please list each service							
**If YES, please explain:							

Breast Center Data

Breast Center Data

Part 1. Capacity & Utilization Reporting Form - Data Elements - State of Alaska Certificate of Need Program		
Facility Name: Providence Alaska Medical Center		
Person Completing Form: Carissa Silva		Contact Information: 907-212-2356
A. In-Patient Acute Care Capacity		
	Calendar Year 2021	
Type of Service	Number of Beds	Billable Patient Days
Licensed Beds Total:	401	110,495
If facility designates beds according to service please report accordingly - if not, report as Med/Surg beds		
Med/Surg Beds	184	64,790
# licensed as swing beds^		
Intensive Care Unit Beds	28	8,354
Cardiac Care Beds	9	2,278
Obstetrics Beds*	38	7,999
Pediatric Beds	32	4,661
NICU Bassinets**	66	15,016
Acute Rehabilitation Beds	10	
Other -- specify type, and if counted as licensed (Yes or No):	34	
^ Report Swing Bed Patient Days according to their use (acute med/surg care or long term care)		
* Includes LDRP - Labor, delivery, recovery, postpartum, birthing rooms, observation beds. "Day use only" beds not counted as licensed beds should be reported under "other."		
B. Long-Term Care		
(1) Capacity by Calendar Year, and July 1 Census		
Calendar Year	Calendar Year 2021	
	Number of Beds	July 1 Census
Intermediate Care Facility		
Skilled Nursing Facility		
Assisted Living Facility		
Hospice Facility		
(2) Bed Days for Calendar Year By Age Group for Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF)		
	SNF Bed Days	ICF Bed Days
Age 0-64		
Age 65-74		
Age 75-84		
Age 85+		
Total		
C. Surgical Care		
Calendar Year	Calendar Year 2021	
	Number of Suites	Number of Patients***
Suites for In-Pt or Out-Pt Surgery	16	8111
Day Surgery or Dedicated Outpatient Suites		
Endoscopy Suites	3	3462
Open-Heart Surgery Suites	2	506
Organ Transplantation Suites		
Cardiac Catheterization Suites	4	3701
Cardiac Electrophysiology Suites	2	1062
Other Suites (list) Proced Room		
***"Patient" refers to an individual served on a particular day regardless of the number of procedures performed.		

D. Behavioral Health Care		
Calendar Year	Calendar Year 2021	
	Beds	Patient Days
In-patient Acute Psychiatric Beds	34	6,132
Adult	19	2,745
Youth	15	3,387
RPTC - Level 5		
Adult		
Youth		
In-patient Substance Abuse Beds		
Adult		
Youth		
Please specify age criteria in facility:		
E. Emergency Department		
Calendar Year	Calendar Year 2021	
Type of Service	Rooms	Visits
	49	56,134

Part 2. Service Capacity Data Reporting Form - Data Elements - State of Alaska Certificate of Need Program							
Facility Name: PAMC							
Person Completing Form: Laura McDonough				Contact Information: laura.mcdonough@providence.org			
Diagnostic Imaging Services							Number of Scans per Calendar Year
CT Scanner	Slice Speed	Make/Model	First Year in Service	Full Body or Other*	Open Bore Scanner?	Exclusive Use?***	2021
	128	Siemens	2019				15616
	64	Siemens	2012				7000
MRI	Tesla	Make/Model	Service	Other*	Scanner?	Use?***	2021
	1.5	Siemens Espree	2005				4178
NM		Make/Model	First Year in Service	Full Body or Other*			2021
	4	GE Infinia Hawkeye	2016				800
	1	GE infinia	2005				658
Ultrasound							
		Philips Epic Elite	2019				2500
		Philips Epic Elite	2019				2500
		Philips Epic Elite	2019				2500
		Philips Epic Elite	2019				2200
		Unetixs	2006				85
Ultrasound		Make/Model	First Year in Service	Full Body or Other*			
		Siemens S2000	2014	breast	NA	N	581
mammography		Make/Model	First Year in Service	Full Body or Other*			
		Hologic affirm biopsy table	2017	breast	NA	N	277
Other							
Ancillary Services			First year of Service			Exclusive Use?***	Number of tests/treatments per calendar year
Radiation Therapy							
Internal Radiation Therapy							
External Radiation Therapy							
Systemic Radiation Therapy							
Other*:							
Lithotripsy							
Renal Dialysis							
Sleep Studies							
Other*:							
*If OTHER, please list each service							
**If YES, please explain:							

Breast Center Data