



Providence Mat-Su Surgery Center

Ambulatory Surgery Center in Mat-Su

Providence Health & Services Alaska


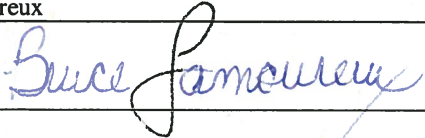
Certificate of Need Application

November 9, 2012

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Section I. General Applicant Information

	CERTIFICATE OF NEED APPLICATION APPLICANT IDENTIFICATION AND CERTIFICATION OF ACCURACY
1. Applicant Identification	
Facility Name Providence Mat-Su Surgery Center	Medicaid Provider Number To be determined
Facility Address (Street/City/State/Zip Code) 1926 S. Woodworth Loop Wasilla, AK, 99654	Medicare Provider Number To be determined
Name and mailing address of organization that operates the facility (if different from above) Providence Health & Services Alaska P.O. Box 196604 Anchorage, AK 99519-6604	
Facility Administrator (Name, title, mailing address, including City/State/Zip Code) To be appointed	Telephone: Facsimile: E-mail:
Applicant (Name, title, mailing address, including City/State/Zip Code) Bruce Lamoureux, CEO Providence Health & Services Alaska P.O. Box 196604 Anchorage, AK 99519-6604	Telephone: 907-212-3055 Facsimile: 907-212-2884 E-mail: bruce.lamoureux@providence.org
Principal Contact Person (Name, title, physical address, mailing address, including City/State/Zip Code) Gretchen Guess, Regional Director of Business Development Providence Health & Services Alaska 3760 Piper St., Suite 3041 Anchorage, AK 99508	Telephone: 907-212-6204 Facsimile: 907-212-2375 E-mail: gretchen.guess@providence.org
2. Ownership Information	
A. Type of Ownership (check applicable category) <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> For profit: individual <input type="checkbox"/> For profit: partnership <input type="checkbox"/> For profit: corporation </div> <div> <input type="checkbox"/> Not for profit: government <input checked="" type="checkbox"/> Not for profit: corporation <input type="checkbox"/> Other (specify): _____ </div> </div>	
B. List of all Owners (Page 2 of application) C. Accreditation Information (Page 2 of application)	
3. Agreement to participate in the Uniform Statewide Reporting System	
I hereby agree to participate in the uniform statewide reporting system required under AS 18.07.101 when requested to do so under 7 AAC 07.105(c).	
4. Certification of Accuracy by Certifying Officer of the Organization	
I hereby certify that the information contained in this application, including all documents that form any part of it, is true, to the best of my knowledge and belief. I agree to provide, within 60 days from receipt of a request from the department under 7 AAC 07.050(b), any additional information needed by the department to make a decision.	
Name Bruce Lamoureux	Title SVP Chief Executive AK Region
Signature 	Date 11-9-12

For Part 2.B. of the application form, provide the following ownership information under each requirement, using as much space as necessary to provide complete information:

- (1) For individual owners and partnerships, list the names, titles, organizational name, mailing and street addresses, and telephone and facsimile numbers of the owner or partners.**
- (2) For corporations, list the names, titles, and addresses of the corporate officers and Board of Directors. If the facility is a subsidiary of another company or has multiple owners, provide the names and addresses of the all of companies that have ownership in the facility.**
- (3) For governmental or other nonprofit owners, list the names and addresses of hospital board members.**

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Board of Directors**

Effective Aug. 1, 2012

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For Part 2.C. of the application form, provide the following information:

Is this facility accredited or certified by a recognized national organization? ☐ Yes ☐ No

If yes, identify the organization, the date of accreditation or certification, and attach as an appendix to this application a copy of the most current accreditation or certification.

Not Applicable.

This facility will be a new facility. The facility will be licensed by the Alaska Department of Health and Social Services (DHSS) as an ambulatory surgery center. It will be certified by the Centers for Medicare and Medicaid Services (CMS) for conditions of participation and coverage. Additionally, the new facility will seek accreditation by The Joint Commission (TJC) or Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

Section II. Summary Project Description

Provide a one-page summary of the proposed project including:

- (1) A brief description of each proposed service, including whether equipment will be purchased or replaced and a list of that equipment.**
- (2) The number of square feet of construction/renovation.**
- (3) The number and type of beds/surgery suites/specialty rooms.**
- (4) Services to be expanded, added, replaced, or reduced.**
- (5) The total cost of the project.**
- (6) How the project will be financed.**
- (7) Estimated completion date.**

Providence Health & Services Alaska (Providence) proposes to lease space for the creation of the Providence Mat-Su Surgery Center, a **new** freestanding ambulatory surgery center (ASC).¹ The proposed facility will have two Class C operating rooms supported by three preoperative rooms, and seven recovery rooms. The project will increase the number of Class C licensed ambulatory surgery suites in Mat-Su area to a total of **two** operating rooms.

Ambulatory surgery centers perform short duration surgeries (no more than 90 minutes of operating time and a total of four hours of expected recovery time²) and allow the patient to go home on the day of surgery. The proposed ASC will focus on meeting community need for both adult and pediatric patients, focusing on surgeries and patients appropriately served in an ASC environment³ including orthopedic; ear, nose and throat; and general surgery services. Both operating rooms will be Class C and will be equipped for providing general anesthesia⁴.

Providence is addressing the problem of unmet community need for operating room along with the lack of a not-for-profit, mission-based surgery provider in the community. Unlike the for-profit providers who have a fiduciary responsibility to their shareholders, Providence, a not-for-profit provider, has an obligation to our mission: *“As people of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.”*

¹ Providence will lease space from its real estate company ensuring the continuation of property taxes to the Borough for the land and building.

² 42 CFR 416.65 - Covered surgical procedures

³ Patient selection criteria will be based on the existing guidelines and recommendations of the physicians associated with the proposed ASC. Example of such guideline is presented in the Appendix A.

⁴ According to American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), procedures that require general anesthesia cannot be provided in Class A or Class B operating rooms, regardless of the specialty (Definition of Facility Classes by AAAASF / <http://www.aaaasf.org/surgicenters.php>). Also, according to American Society of Anesthesiologists, for most children, general anesthesia is the preferred form of ambulatory anesthesia (Anesthesia for Ambulatory Surgery / American Society of Anesthesiologists / <http://old.asahq.org/patientEducation/ambulatoryAnes.pdf>).

This difference is highlighted by the report prepared by Milliman, Inc. for Alaska Health Care Commission in 2011¹. In the report, the Mat-Su Regional Medical Center was identified as the second most profitable hospital in the State of Alaska in 2010, with operating margin at 25.8 percent and the highest Medicare margin in the state at 4.0 percent (margin is defined as operating income divided by net revenues). In the same report, Providence Alaska Medical Center was reported to have operating margin at 13.0 percent or approximately one-half of MSRMC operating margin.

As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured, uninsured, Medicaid, and Medicare populations. According to County Health Ranking, ***24 percent of the Matanuska-Susitna Borough population does not have health insurance²; therefore, the proposed project is also addressing community need of these patients.*** Providence is committed to the Mat-Su surgery center promoting its services to the uninsured and underinsured and reporting to the community on its charity care.

The proposed ASC has a project cost of \$12,255,386 including net present value of the lease of \$7,219,549 (10,800 square feet) and furniture, fixture and equipment costs of \$3,976,886 as indicated in Appendix B. Providence plans to finance the costs of this project with an estimated operational date of May 1, 2014 and a project completion date of May 1, 2015

Providence has provided a modest application based on publically available data to meet the needs of the community, including the uninsured and underinsured, in a responsible manner. Because the state has not responded to Providence's requests to provide the number of surgeries in the Mat-Su Borough, nor the number of Class C operating rooms in this market, Providence requests the right to amend this application, at no penalty to Providence, if the state provides more accurate data. This right includes additional operating rooms if the community need exists.

¹ "Drivers of Health Care Costs in Alaska and Comparison States"/ Page 22 / Table 6B.1 / http://www.hss.state.ak.us/healthcommission/docs/drivers_healthcare_costs.pdf

² 2012 County Health Ranking/Access to Care/ Alaska 2012/ <http://m.countyhealthrankings.org/node/207/85>

Section III. Description of Facilities and Capacity Indicators

A. Proposed changes in service capacity. Provide either the number of beds, surgery suites, rooms, pieces of equipment, or other service.

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	TOTAL PROPOSED CAPACITY
IN-PATIENT ACUTE CARE HOSPITALS			
Med/Surg Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
ICU Beds			
Obstetrics Beds			
Pediatric Beds			
Acute Rehab Beds			
Obstetrics Beds			
Pediatric Beds			
Ancillary Services (list)			
BEHAVIORAL HEALTH CARE			
In-patient Acute Psychiatric Beds			
RPTC Beds			
In-patient Substance Abuse Beds			
LONG-TERM CARE			
Acute Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
Nursing Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
DIAGNOSTIC AND DIAGNOSTIC IMAGING SERVICES			
CT Scanner			
MRI			
PET or PET/CT			
Cardiac Catheterization			
Emerging Med. Tech. (list)			

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	TOTAL PROPOSED CAPACITY
SURGICAL CARE			
Ambulatory Surgery or Dedicated OP Suites	0	2	2
Suites for IP & OP	0	0	0
Endoscopy Suites	0	0	0
Open-Heart Surgery	0	0	0
Organ Transplantation	0	0	0
Other Services (list)			
THERAPEUTIC CARE			
Radiation Therapy			
Lithotripsy			
Renal Dialysis			
Other (List)			
Total Capacity	0	2	2

B. Provide a detailed narrative description of each service identified in "A" above, including the type of change (addition, expansion, conversion, reduction, replacement, elimination). Include, as appropriate, detailed information relative to the scope and level of service.

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Ambulatory surgery centers perform short duration surgeries (no more than 90 minutes of operating time and a total of four hours of expected recovery time²) and allow the patient to go home on the day of surgery. The proposed ASC will focus on meeting community need for both adult and pediatric patients, focusing on surgeries and patients appropriately served in an ASC environment³. Both operating rooms will be Class C and will be equipped for providing general anesthesia⁴.

Given the ASC patient criteria, Providence is planning for adult and pediatric orthopedic; ear, nose and throat; and general surgery services with the capability to provide other surgical services needing Class C operating rooms.

¹ Providence will lease space from its real estate company ensuring the continuation of property taxes to the Borough for the land and building.

² 42 CFR 416.65 - Covered surgical procedures

³ Patient selection criteria will be based on the existing guidelines and recommendations of the physicians associated with the proposed ASC. Example of such guideline is presented in the Appendix A.

⁴ According to American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), procedures that require general anesthesia cannot be provided in Class A or Class B operating rooms, regardless of the specialty (Definition of Facility Classes by AAAASF / <http://www.aaaasf.org/surgicenters.php>). Also, according to American Society of Anesthesiologists, for most children, general anesthesia is the preferred form of ambulatory anesthesia (Anesthesia for Ambulatory Surgery / American Society of Anesthesiologists / <http://old.asahq.org/patientEducation/ambulatoryAnes.pdf>).

As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured and uninsured populations.

C. Provide in the following table information regarding equipment to be purchased.

Please see Appendix B.

D. Provide in the following table information regarding equipment to be replaced or retired.

Not Applicable.

E. Describe replacement or upgrading of utilities including the electrical, heating, ventilation, and air conditioning systems.

Not Applicable.

F. Describe the structural framing, floor system, and number of floors (including the basement).

The building will be constructed by a third party.

- Structural framing: steel frame over concrete foundation.
- Floor system: Primarily consist of concrete floor slab with perimeter and internal grade beams located to support load bearing walls.
- Number of floors: Single floor (no basement)

G. Total square footage in current facility/project.

Not applicable. This application is for a new facility.

H. Total square footage of proposed facility/project.

Total square footage of the proposed facility is 10,800 sq. ft.

I. Area per bed, service unit, or surgery suite (if applicable).

The facility will have two surgery suites. Total facility area per surgery suite is 5,400 sq. ft.

J. Percentage of total floor area used for direct service (non-bed activity).

Approximately 60 percent of the total floor space area in the proposed facility will be used for direct patient care, with the remainder divided among building mechanical and support space, staff support space, family support space, and public reception space.

K. Additional volume of service (non-bed activity) expected.

The proposed surgery center will provide 837 surgeries in the first operational year, which is a partial year. In the fifth year of operations and beyond, surgery case volume is projected to be 2,400 cases per year.

L. Provide a brief history of expansion and construction for the past five years, including new equipment purchases, additional beds, and new services. Describe how this project fits into the facility's long-range plans, including potential projects planned for development within the next five years.

Providence has a long history of serving Alaska, beginning when the Sisters of Providence first brought health care to Nome in 1902 during the Gold Rush. This pioneering, mission-based spirit set the standard for modern health care in Alaska and formed the foundation for Providence's growth as the state's leading health care provider. Since 1902, Providence has served many Alaskan communities by hearing the call to serve the poor and vulnerable, being true to its Catholic heritage and mission, and focusing on community need.

Today, Providence serves Alaskans in the communities of Anchorage, Cordova, Kodiak, Matanuska-Susitna Valley (Mat-Su), Seward, Soldotna, and Valdez. In 2011, Providence hospitals throughout Alaska had over 120,000 patient days and performed over 11,500 inpatient and outpatient surgeries. Providence hospitals and outpatient facilities had over 350,000 outpatient visits, and Providence long term care facilities had over 55,000 patient days.

Providence has been providing healthcare to Mat-Su residents through Providence Matanuska-Susitna Valley Healthcare Center (Providence Mat-Su) since 1999. Providence Mat-Su moved to its current location in Palmer in November 2010. The new building consolidated Providence's existing Mat-Su services (family medicine, behavioral health, and laboratory services) for the convenience of the community. Additionally, Providence's joint venture with radiologists, Imaging Associates of Providence, serves Mat-Su residents at two locations, one in Palmer and another in Wasilla.

The proposed project fits into Providence's long-range plan to keep residents in their community for health care when appropriate and to use our assets to meet and serve community need. Providence is committed to growing to meet community need, providing high-quality health care, and enhancing the access to and affordability of health care for all, especially the uninsured and underinsured.

The following are other expansion and construction projects of Providence Alaska in the Anchorage market in the last five years.

- Modernization and expansion of Providence Alaska Medical Center (PAMC) newborn intensive care unit, maternity areas, surgery, and ancillary support services. The project will be completed in 2014.
- Construction of Emergency Power Supply System in Anchorage to be completed in 2013.
- Construction of Providence Cottages, a 96-bed intermediate care facility in East Anchorage to be completed in 2013.
- Addition of an electrophysiology laboratory at PAMC, completed in 2010.
- Addition of a cardiac catheterization laboratory at PAMC, completed in 2008.
- Expansion of Newborn Intensive Care Unit at PAMC, completed in 2008.
- Expansion and relocation of sports medicine and rehabilitation therapy services in 2007.

Section IV. Narrative Review Questions

A. RELATIONSHIP TO APPLICABLE PLANS AND NATIONAL TRENDS

Indicate how the application relates to any relevant plans, including the applicant's long-range plans, appropriate local, regional, or state government plans, the current *Alaska Certificate of Need Review Standards and Methodologies*, adopted by reference in 7 AAC 07.025, and current planning guidelines of recognized national medical and health care groups. If the proposal is at variance with any of these documents, explain why. (See the department's website for state planning processes and materials and links to federal websites.)

Consistency with National Trends, and Guidelines of National Medical and Health Care Groups

The U.S. Department of Health and Human Services Administration on Aging predicts that between 2010 and 2050 the United States will experience rapid growth in its older population¹, which is mostly attributed to aging of the baby boom generation. For example, the U.S. Center for Disease and Control Prevention (CDCP) projects that the number of persons aged over 65 years is expected to increase from approximately 35 million in 2000 to an estimated 71 million in 2030². Similar to the State of Alaska senior population projections, the Alaska Department of Labor (DOL) projects the senior population (60-plus) of the Mat-Su Borough to grow 30.8 percent by 2015 and 73.8 percent by 2020, from DOL 2011 population estimates³.

Along with being consistent with the needs of a growing aging population, this project is consistent with the national trend of increased outpatient surgery caused by medical improvements that cause more procedures to be performed in an outpatient, rather than inpatient, settings.⁴

This project is also consistent with the Institute for Healthcare Improvement (IHI) Triple Aim initiative, which seeks to accomplish three objectives: improve population health, improve patient experience, and reduce the cost of care. Since their inception more than three decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs⁵. ASCs offer physicians the ability to work more efficiently and are highly regulated to ensure patient safety and quality of care. These regulations include state licensure, Medicare certification, and voluntary accreditation. Not only are ASCs focused on ensuring patients have the best surgical experience possible, the care they provide has been shown to be is also more affordable compared to hospitals for a similar procedure.⁶

¹ "The Next Four Decades. The Older Population in the United States:2010 to 2050"/ U.S. Department of Health and Human Services Administration on Aging, May 2010 / http://www.aoa.gov/aoaroot/aging_statistics/future_growth/DOCS/p25-1138.pdf

² "Public Health and Aging: Trends in Aging: United States and Worldwide" / U.S. Center for Disease and Control Prevention/ February 2003/ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5206a2.htm>

³ DOL Population Estimates and Projections <http://labor.alaska.gov/research/pop/popest.htm>

⁴ What Surgery Centers Should Expect in 2012: 15 ASC Market Trends/ Becker's Healthcare ASC Review/ February 06, 2012/ <http://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/what-surgery-centers-should-expect-in-2012-15-asc-market-trends.html>

⁵ Ambulatory surgery centers: a positive trend in healthcare / ASC Coalition / http://www.precisionsurgicenter.com/docs/ASC_Positive_Trends.pdf

⁶ Ibid.

For example, in 2008, otolaryngologists Dr. Jedidiah Grisel, M.D. and Dr. Ellis Arjmand, M.D. examined 275 ambulatory surgery centers and 211 hospitals, in order to compare quality of outpatient ENT surgeries performed in an ASC and in a hospital. They developed measures for the following categories: safety, patient-centeredness, timeliness, efficiency, and equitability. Upon completion of the research, Dr. Grisel and Dr. Arjmand concluded that performance at the ASCs generally exceeded that at the hospitals, while the total charges for procedures were 12 to 23 percent less at the ASC than at the hospital¹.

Consistency with Local, Regional, and State Governmental Plans

A number of local, regional and state governmental plans discuss lack of comprehensive health care in many Alaskan communities and inadequate access to health care services for uninsured and underinsured Alaskans. The reports emphasize the need to achieve health equity, eliminate disparities and improve the health of all groups. These reports include the following:

- “Transforming Health Care in Alaska,” the 2009 report by Alaska Health Care Commission, identifies inadequate health insurance coverage and logistical challenges in the delivery of and in accessing health care services as major challenges of the health care in Alaska².
- “Achieve health equity, eliminate disparities, and improve the health of all groups” is also one of the overarching goals of “Healthy People 2010,” a publication of the Office of Disease Prevention and Health Promotion, Department of Health and Human Services USA³.
- The Alaska Health Care Strategies Planning Council’s 2007 report⁴ lists accessibility of health care for all Alaskans to meet their health care needs as one of the top priorities of the Alaska’s Health Care Action Plan.
- Also, Chapter 15 of the state plan “Healthy Alaskans 2010. Targets and Strategies for Improved Health,” published by the Alaska Department of Health and Social Services, points out the importance of improving access to comprehensive, high-quality health care services for all Alaska residents⁵.

Further, the report “Drivers of Health Care Costs in Alaska and Comparison States,”⁶ demonstrates the lack of affordability in our communities, including the Mat-Su. This report, prepared by Milliman, Inc. for Alaska Health Care Commission in 2011, states the Mat-Su Regional Medical Center was identified as the second most profitable hospital in the State of Alaska in 2010, with operating margin at 25.8

¹ Grisel J, Arjmand E. “Comparing quality at an ambulatory surgery center and a hospital-based facility: Preliminary findings.” Otolaryngology - Head and Neck Surgery. Dec;141(6):701-709/Abstract at <http://www.ncbi.nlm.nih.gov/pubmed/19932841>

² “Transforming Health Care in Alaska” / <http://hss.state.ak.us/healthcommission/docs/report.pdf>

³ “Healthy People 2020” / http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/hp2020_brochure.pdf

⁴ The Alaska Health Care Strategies Planning Council. Final Report: Summary and Recommendations, 2007/ http://www.hss.state.ak.us/commissioner/legislature/pdf/HCSPC_report.pdf

⁵ “Healthy Alaskans 2010”, Chapter 15, Access to Quality Health Care / <http://www.hss.state.ak.us/dph/targets/ha2010/PDFs/ExecWeb.pdf>

⁶ “Drivers of Health Care Costs in Alaska and Comparison States”/ Page 22 / Table 6B.1 / http://www.hss.state.ak.us/healthcommission/docs/drivers_healthcare_costs.pdf

percent and the highest Medicare margin in the state at 4.0 percent (margin is defined as operating income divided by net revenues).¹ The table of their calculation is below.

Calculation of the Hospital Total Margin and Medicare Margin for Alaska and Comparison States (2010)
(dollar amounts in millions)

Region	FY10 Number of Hospitals	All Payer							Medicare			
		A Total Net Revenue	B Total Expenses	C=A-B Total Income	D=C/A Total Margin	E Contributions	F Investments	G=(C-E-F)/(A-E-F) Approximate Operating Margin	H Operating Revenue	I Operating Expenses	J=H-I Operating Income	K=J/H Operating Margin
Anchrg / Fbns / Mat-Su, AK	4	1,208	1,009	199	16.5%	0	5	16.2%	184	201	(17)	-9.1%
Non-MSA Area, AK	12	463	431	32	6.8%	0	3	6.1%	73	86	(13)	-17.4%
AK	16	1,671	1,440	231	13.8%	1	8	13.4%	257	287	(29)	-11.5%
HI	24	2,826	2,693	132	4.7%	14	24	3.4%	443	454	(12)	-2.7%
ID	40	3,160	2,914	246	7.8%	14	42	6.1%	617	674	(57)	-9.2%
ND	41	2,088	1,976	113	5.4%	3	27	4.0%	510	519	(9)	-1.7%
OR	56	8,478	7,841	637	7.5%	8	120	6.1%	1,440	1,592	(152)	-10.5%
WA	87	15,977	14,908	1,069	6.7%	39	108	5.8%	3,150	3,462	(312)	-9.9%
WY	27	1,380	1,230	151	10.9%	7	17	9.4%	291	322	(31)	-10.8%
Comparison State Average	275	33,908	31,560	2,348	6.9%	85	338	5.7%	6,451	7,023	(572)	-8.9%
Nationwide Average	4,135	667,210	625,210	42,000	6.3%	1,431	5,825	5.3%	153,408	156,671	(3,263)	-2.1%
Anchrg / Fbns / Mat-Su, AK												
Alaska Regional Hospital		207	146	61	29.5%	0	0	29.4%	32	35	(3)	-10.0%
Fairbanks Memorial Hospital		217	206	11	5.0%	0	0	4.8%	33	37	(4)	-13.2%
Mat-Su Regional Medical Center		169	125	44	25.8%	0	0	25.8%	25	24	1	4.0%
Providence Alaska Medical Center		615	531	84	13.7%	0	4	13.0%	95	105	(10)	-10.9%
Non-MSA Area, AK												
Bartlett Regional Hospital		78	72	6	7.3%	0	1	6.5%	10	13	(3)	-26.5%
Central Peninsula General Hospital		98	96	3	2.7%	0	0	2.7%	19	22	(3)	-15.4%
Cordova Community Medical Center		8	8	(0)	-2.9%	0	0	-9.2%	1	1	(0)	-14.6%
Ketchikan General Hospital		65	60	6	8.9%	0	2	6.4%	10	11	(1)	-13.6%
Norton Sound Regional Hospital		77	66	11	13.8%	0	1	13.1%	3	3	0	1.0%
Petersburg Medical Center		10	10	0	2.6%	0	0	2.6%	2	3	(0)	-23.2%
Providence Kodiak Island Medical Ctr		36	35	2	4.8%	0	0	4.8%	6	7	(1)	-16.4%
Providence Seward Hospital		18	16	2	12.2%	0	0	12.2%	2	3	(1)	-27.9%
Providence Valdez Medical Center		11	11	(0)	-0.8%	0	0	-0.8%	3	4	(1)	-32.9%
Sitka Community Hospital		19	18	1	6.2%	0	0	6.2%	5	6	(1)	-18.3%
South Peninsula Hospital		35	33	1	3.9%	0	0	3.6%	9	10	(1)	-9.8%
Wrangell Medical Center		8	8	1	6.2%	0	0	6.2%	2	3	(1)	-26.2%

Notes:

1) Based on Medicare Cost Reports.

2) All Payer Approximate Operating Margin removes investment income and contributions from the All Payer Total Margin.

3) Medicare values based on cost report allocation process and Medicare allowed costs. This typically leads to better margins than if all costs are included and allocated by LOB.

The proposed project is consistent with these reports because it focuses on keeping residents in their community for health care and enhancing access and affordability of care for all, especially the uninsured and underinsured population. Providence is committed to the Mat-Su surgery center promoting its services to the uninsured and underinsured and reporting to the community on its charity care.

Further, with the proposed project, Providence continues our commitment to meet the needs of the uninsured and underinsured, Medicaid and Medicare populations, in a compassionate manner. Providence charity care policy requires providing medically necessary health care services to members of the community who are not able to pay for such services. In concert, the proposed project will fall under Providence's Hospital Guidelines for Financial Assistance and Discounts for uninsured patients. This policy ensures that uninsured patients are offered appropriate discounted pricing to make certain that they are treated fairly and equitably.

Although we all must be responsible for ourselves, we have the obligation to be compassionate to each other. Providence does our best to work with each patient who cannot afford care to meet their health care needs first and work with them on their payment second. As an example, per policy, Providence will not pursue legal action for non-payment against the uninsured that is unemployed and without significant income or assets.

¹ In the same report, Providence Alaska Medical Center (PAMC) was reported to have operating margin at 13.0 percent. Further, in 2011, the amount of charity care provided by PAMC was equal 8.8 percent of the facility's net revenues; and Providence Alaska provided over \$57 million of charity care and community benefit.

Consistency with Providence Long-Range Planning

The foundation of Providence's long-range planning is meeting community need. We determine community need through formal community need assessments, discussions with stakeholders, and gap analyses. Every three years, in each community we serve, we work with the community to develop a formal community needs assessment.

As a current provider in the community, Providence Alaska is participating in the Mat-Su Community Health Needs Assessment (CHNA). Specifically, Providence Alaska is providing the following: \$25,000 of financial support; an employee with experience in community needs assessments on the steering committee; and a commitment to be involved in the steering committee's efforts to address needs identified in the CHNA.

Consistency with the Current Alaska Certificate of Need Review Standards and Methodologies

The Certificate of Need (CON) methodology is based on the number of surgeries in a market area. Further, because the types of services that can be performed in Class A and B versus Class C differ significantly, case law¹ indicates that CON community need differs for Class C operating rooms.

To determine unmet need of Class C surgical services in the Mat-Su, Providence requested the number of surgeries performed in the Mat-Su Borough from the state multiple times². Providence did not receive a reply.³

To test unmet need, Providence examined PAMC data and found that Mat-Su residents still come to Anchorage for outpatient surgery.

Table IV.A.1. PAMC Surgery Volume of Patients from Mat-Su Borough, 2006-2011.

	2006	2007	2008	2009	2010	2011
Outpatient Surgery Cases	662	687	709	744	807	527

Since specific Mat-Su surgery data are not available, to determine unmet need according to CON methodology and standards, Providence applied the following data to determine CON community need.

- The most recent publically available data from the American Hospital Association (AHA) for the years 2005-2010 for the State of Alaska. The AHA publications⁴ report all surgeries in Alaska

¹ In the Matter of the South Anchorage Ambulatory Surgery Center Joint Venture, OAH No. 06-0152-DHS, Decision and Order at pp. 9 (fn 50), 17 (fn 86), 18-19 (ALJ Thurbon); and In the Matter of Alaska Medical Development – Fairbanks, LLC, Kobuk Ventures, LLC and Fairbanks Memorial Hospital, OAH No. 06-0744-DHS, Decision and Order at pp. 14, 31-36 (ALJ Kennedy).

² Email from Sofia Yainova to Alice Rarig, DHSS, of Mon 4/9/2012 11:16 AM and emails from Sofia Yainova to Karen Lawfer, DHSS, of Thu 8/18/2011 9:03 AM, Tue 4/10/2012 1:10 PM, and Tue 7/10/2012 10:41 AM.

³ Further, current information indicates the Mat-Su Regional Medical Center, although required by law, has not provided the state their surgery data since 2008

⁴ 2010 AHA Hospital Statistics / American Hospital Association / Page 53 and 2012 AHA Hospital Statistics / American Hospital Association / Page 53 / www.ahadata.com. See Appendix C.

performed in the hospitals reporting¹. Since Mat-Su residents historically have received care outside of their community, applying the proportion of statewide surgeries to the state population to the Mat-Su population provides community need estimate consistent with the current CON standards.

- Department of Labor forecast for population growth, with 2018 as the fifth year following the implementation of the project.

Because the state has not responded to Providence's requests to provide the number of surgeries in the Mat-Su Borough, nor the number of Class C operating rooms in this market, Providence requests the right to amend this application, at no penalty to Providence, if the state provides more accurate data. This right includes additional operating rooms if the community need exists.

Below are the CON review methodology and standard steps. The complete analysis is presented in the Appendix D.

Step One: Determining Caseload

Caseload fifth year from the project implementation date = Population fifth year from the project implementation date x General Surgery Use Rate over the preceding three years per 1,000

Population. Based on Department of Labor projections² and estimates³, with forecasting methodology in the between years. The population of the Mat-Su Borough is projected as the following.

Table IV.A.2. The Alaska Department of Labor Population Estimates and Projections for Matanuska-Susitna Borough, 2005-2020.

<i>Estimates</i>								
	2005	2006	2007	2008	2009	2010	2011	
	74,871	78,229	81,012	83,691	86,074	88,995	91,697	
<i>Projections*</i>								
2012	2013	2014	2015	2016	2017	2018	2019	2020
94,520	97,273	100,025	103,070	105,530	108,283	111,036	113,788	117,222
<i>*DOL Projections are used for 2015 and 2020; linear forecast is used for 2012 through 2014 and 2016 through 2019.</i>								

¹ Per 2010 AHA Hospital Statistics publication, 14 out of 22 Alaska hospitals were reporting their data (2005 used in this CON) with 12 of 14 hospitals providing surgery data; per 2012 AHA Hospital Statistics publication, 13 out of 22 Alaska hospitals were reporting their data to the AHA (2006-2010 data used in this CON) with 10 of the 13 hospitals providing surgery data (Appendix C). Currently, Providence estimates 14 hospitals in Alaska provide surgery services.

² Alaska Department of Labor and Workforce Development / Population Projections/
<http://labor.alaska.gov/research/pop/popproj.htm>

³ Alaska Department of Labor and Workforce Development / Population Estimates/
<http://labor.alaska.gov/research/pop/popest.htm>

Table IV.A.3. The Alaska Department of Labor Population Estimates and Projections for Alaska, 2005-2020.

Estimates								
	2005	2006	2007	2008	2009	2010	2011	
	667,146	674,583	680,169	686,818	697,828	710,231	722,190	
Projections*								
2012	2013	2014	2015	2016	2017	2018	2019	2020
727,579	736,653	745,728	759,244	763,877	772,952	782,026	791,101	802,762
*DOL Projections are used for 2015 and 2020; linear forecast is used for 2012 through 2014 and 2016 through 2019.								

Based on the population projections of the Alaska Department of Labor, the 2018 Mat-Su Borough population is projected at 111,036 and the 2018 Alaska population is 782,026.

General Surgery Use Rate. Based on publically available data¹, the general surgery use rate for the state of Alaska is as follows.

Table IV.A.4. Total number of hospital surgeries performed in Alaska in 2005-2020².

<i>Actual Data</i>						<i>Projections*</i>	
2005	2006	2007	2008	2009	2010	2011	2012
59,246	61,309	63,117	64,089	70,763	65,416	70,008	71,728
<i>Projections*</i>							
2013	2014	2015	2016	2017	2018	2019	2020
73,447	75,167	76,887	78,606	80,326	82,045	83,765	85,484
<i>*Linear regression is used to project number of surgeries for 2011 and beyond, based on the actual 2005-2010 hospital data from American Hospital Association</i>							

Table IV.A.5. General Surgery Use Rate (GSUR) per 1,000 population, 2005-2020.

<i>Actual Data</i>						<i>Projections**</i>	
2005	2006	2007	2008	2009	2010	2011	2012
89	91	93	93	101	92	97	99
<i>Projections**</i>							
2013	2014	2015	2016	2017	2018	2019	2020
100	101	101	103	104	105	106	106
<i>**For 2011 and beyond, the projected number of hospital surgeries (Table IV.A.3) divided by population (Table IV.A.2).</i>							

¹ American Hospital Association / 2010 AHA Hospital Statistics / Page 53 / Table 6. Appendix C.

² The surgery data from American Hospital Association does not include surgeries performed in Alaska ASCs, which is most likely to explain the recent decline in the number of surgery services. Only the state of Alaska has the authority to gather surgery data from ASCs in Alaska.

Therefore, the **average general surgery use rate for 2009-2011 is 97** for the state of Alaska. Alternatively, based on case law¹, the unmet need could be also calculated by applying the GSUR regression for 2018, which is **105** (see Appendix D for detail).

Caseload. The caseload, therefore, based on both GSUR assumptions is the following.

Table IV.A.6. 2018 Projected Surgery Caseload.

GSUR		2018 Mat-Su Population	Projected Caseload
2009-2011 Average	97	111,036	10,750
2018 Forecast	105	111,036	11,649

Step Two: Operating rooms required

$$\text{General operating rooms required} = \text{projected general surgery cases} / \text{target use rate}$$

The proposed project is an outpatient only facility; **therefore, the target use rate is 1,200 cases** and the community need is calculated as the following.

Table IV.A.7. General Operating Rooms Required.

GSUR		2018 Mat-Su Population	Projected Caseload	ORs Needed
2009-2011 Average	97	111,036	10,750	9.0
2018 Regression	105	111,036	11,649	9.7

Step Three: Unmet need

The unmet need in the Mat-Su community is the difference between the “ORs Needed” in Table IV.A.7 less the number of Class C operating rooms in the community. Similar to the number of surgeries, Providence requested from the state the number of operating rooms in the community but our requests were not answered². Based on our research, we estimate that there are between five and seven Class C operating rooms in Mat-Su: four to five at the Mat-Su Regional Hospital, and one to two at the hospital’s ambulatory center on the hospital campus.

Because the state has provided neither the number of surgeries in the Mat-Su Borough, nor the number of Class C operating rooms in this market, Providence requests the right to amend this

¹ South Anchorage Ambulatory Surgery Center, Appellant, v. State of Alaska, Department of Health & Social Services, Appellee, Case No. 3AN-07-10738 CI, OAH No. 06-0152-DHS, Decision on Appeal at pp. 9-10. (Superior Court Judge Torrissi.)

² Emails from Sofia Yainova to Karen Lawfer, DHSS, of Thu 8/18/2011 9:03 AM, Tue 4/10/2012 1:10 PM, and Tue 7/10/2012 10:41 AM.

application, at no penalty to Providence, if the state provides more accurate data. This right includes additional operating rooms if the community need exists.

As a result, the unmet community need for Class C operating rooms in the Mat-Su is the following.

Table IV.A.8. Unmet Community Need for Class C Operating Rooms in Mat-Su.

GSUR		2018 Mat-Su Population	Projected Caseload	ORs Needed	Existing ORs	Unmet Need
2009-2011 Average	97	111,036	10,750	9.0	5-7	2-4
2018 Regression	105	111,036	11,649	9.7	5-7	3-5

From the 2003 Mat-Su Hospital's CON Application¹ and its CON Certificate, it is unclear exactly how many Class C surgery suites are currently at the hospital or would be considered "CON-approved." With this uncertainty, **the proposed project fits well within the unmet need of the community.**²

B. DEMONSTRATION OF NEED

1. Identify the problems being addressed by the project. For example, identify whether this project is for (a) a new service; (b) an expanded service; or (c) an upgrade of an existing service.

Providence is addressing the problem of unmet community need for operating room along with the lack of a not-for-profit, mission-based surgery provider in the community. Unlike the for-profit providers who have a fiduciary responsibility to their shareholders, Providence, a not-for-profit provider, has an obligation to our mission: *"As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service."*

This difference is highlighted by the report prepared by Milliman, Inc. for Alaska Health Care Commission in 2011³. In the report, the Mat-Su Regional Medical Center was identified as the second most profitable hospital in the State of Alaska in 2010, with operating margin at 25.8 percent and the highest Medicare margin in the state at 4.0 percent (margin is defined as operating income divided by net revenues). In the same report, Providence Alaska Medical Center was reported to have operating margin at 13.0 percent or approximately one-half of MSRMC operating margin.

To address these problems, Providence is proposing a **new** ASC with two Class C operating rooms. ASCs perform short duration surgeries (no more than 90 minutes of operating time and a total of four hours of expected recovery time⁴) and allow the patient to go home on the day of surgery. ASC surgeries can be less expensive patient alternative to the hospital-based outpatient surgeries. For example, according to

¹ Mat-Su Valley Medical Center, LLC CON Application, April 2003.

² Evidence that this methodology, if anything, underestimates unmet need are a public comment made that the hospital performed 8,610 surgeries in 2010 (*Summary Minutes: Medical Care Advisory Committee*, January 20 and 21, 2012, Best Western Lake Lucille, Wasilla, Alaska). Using this one data point (assuming no growth) indicates a similar 97 GSUR.

³ "Drivers of Health Care Costs in Alaska and Comparison States"/ Page 22 / Table 6B.1 /

http://www.hss.state.ak.us/healthcommission/docs/drivers_healthcare_costs.pdf

⁴ 42 CFR 416.65 - Covered surgical procedures.

American Hospital Association's Trend Watch, Medicare beneficiaries often pay lower coinsurance at an ASC than at a hospital outpatient department.¹

The proposed ASC will focus on meeting community need for both adult and pediatric patients, focusing on appropriate surgeries and patients served in an ASC environment. Given the ASC patient criteria², Providence is planning for both adult and pediatric orthopedic; ear, nose and throat; and general surgery services along with being able to provide other surgical services need Class C operating rooms.

As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured, uninsured, Medicaid, and Medicare populations. According to County Health Ranking, ***24 percent of the Matanuska-Susitna Borough population does not have health insurance³; therefore, the proposed project is also addressing community need of these patients.*** Providence is committed to the Mat-Su surgery center promoting its services to the uninsured and underinsured and reporting to the community on its charity care.

2. Describe whether (and how) this project (a) addresses an unmet community need; (b) satisfies an increasing demand for services; (c) follows a national trend in providing this type of service; or (d) meets a higher quality or efficiency standard.

The proposed project addresses all four areas.

- a) **Unmet Community Need.** As discussed in Section A, the proposed project will meet unmet surgical capacity need in the community for adults and pediatrics along with community need for a not-for-profit, mission-based, surgical provider.
- b) **Increasing Demand for Services.** As demonstrated in Section A and Appendix D, the need for surgeries is growing. This proposed project will satisfy some of this outpatient demand.
- c) **National Trends.** As demonstrated in Section A, as more complex and higher-end procedures are expected to move to the outpatient setting⁴, the need for ambulatory surgery services will continue to grow. ASC, since their inception more than three decades ago, have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs⁵, which is crucial for achieving the Triple Aim⁶ in healthcare.

¹ The Migration of Care to Non-hospital Settings / American Hospital Association / Trend Watch / July 2006 / Page 3 / <http://www.aha.org/research/reports/tw/twjuly2006migration.pdf>

² Patient selection criteria will be based on the existing guidelines and recommendations of the physicians associated with the proposed ASC. Example of such guideline is presented in the Appendix A.

³ 2012 County Health Ranking/Access to Care/ Alaska 2012/ <http://m.countyhealthrankings.org/node/207/85>

⁴ What Surgery Centers Should Expect in 2012: 15 ASC Market Trends/ Becker's Healthcare ASC Review/ February 06, 2012/ <http://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/what-surgery-centers-should-expect-in-2012-15-asc-market-trends.html>

⁵ Ambulatory surgery centers: a positive trend in healthcare / ASC Coalition / http://www.precisionsurgicenter.com/docs/ASC_Positive_Trends.pdf

⁶ In 2007 the Institute for Healthcare Improvement (IHI) began the Triple Aim initiative, which seeks to accomplish three objectives: improve population health, improve patient experience, and reduce the cost of care.

- d) **Meet Higher Quality or Efficiency Standard.** ASCs are highly regulated to ensure patient safety and quality of care. The regulations include state licensure, Medicare certification, and voluntary accreditation. The proposed facility will be licensed by the Alaska Department of Health and Social Services (DHSS) as an ambulatory surgery center. It will be certified by the Centers for Medicare and Medicaid Services (CMS) for conditions of participation and coverage. Additionally, the new facility will seek accreditation by The Joint Commission (TJC) or Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) to ensure the highest quality and efficiency standards are met and/or exceeded.

In 2008, otolaryngologists Dr. Jedidiah Grisel, M.D. and Dr. Ellis Arjmand, M.D. examined 275 ambulatory surgery centers and 211 hospitals, in order to compare quality of outpatient ENT surgeries performed in an ASC and in a hospital. They developed measures for the following categories: safety, patient-centeredness, timeliness, efficiency, and equitability. Upon completion of the research, Dr. Grisel and Dr. Arjmand concluded that performance at the ASCs generally exceeded that at the hospitals, while the total charges for procedures were 12 to 23 percent less at the ASC than at the hospital¹.

Also, the members of American Association of Orthopedic Surgeons believe that the ability to perform higher volumes of a narrow range of procedures allows ASCs to maximize operational efficiencies and harvest economies of scale which save money for patients and payers alike. The savings produced from the efficiency gains allow ASCs to continue to provide many valuable services to all patients regardless of payer status and their ability to pay².

3. Describe any internal deficiencies of the facility that will be corrected, and document which of these deficiencies have been noted by regulatory authorities. Note any deficiencies that will not be corrected by this project, what efforts have been taken to correct the deficiencies, and how this project will affect the deficiencies. Attach any pertinent inspection records and other relevant reports as an appendix to the application.

Not applicable to the proposed project.

4. Identify the target population to be served by this project. The "target population" is the population that is or may reasonably be expected to be served by a specific service at a particular site. Explain whether this is a local program, or a program that serves a population outside of the proposed service area. Use the most recent Alaska Department of Labor and Workforce Development statistics for population data and projections. Explain and document any variances from those projections. The population may be defined in one or more ways:

The proposed ASC will focus on meeting the Mat-Su Borough community need for both adult and pediatric patients, focusing on appropriate surgeries and patients served in an ASC environment. Given

¹ Grisel J, Arjmand E. "Comparing quality at an ambulatory surgery center and a hospital-based facility: Preliminary findings." Otolaryngology - Head and Neck Surgery. Dec;141(6):701-709/Abstract at <http://www.ncbi.nlm.nih.gov/pubmed/19932841>

² Ambulatory Surgical Centers Position Statement/ American Association of Orthopedic Surgeons/ <http://www.aaos.org/about/papers/position/1161.asp>

the ASC patient criteria¹, Providence is planning for both adult and pediatric orthopedic; ear, nose and throat; and general surgery services along with being able to provide other surgical services needing Class C operating rooms.

Table IV.B.4. The Alaska Department of Labor Population Estimates and Projections for Matanuska-Susitna Borough, 2005-2020.

<i>Estimates</i>								
	2005	2006	2007	2008	2009	2010	2011	
	74,871	78,229	81,012	83,691	86,074	88,995	91,697	
<i>Projections*</i>								
2012	2013	2014	2015	2016	2017	2018	2019	2020
94,520	97,273	100,025	103,070	105,530	108,283	111,036	113,788	117,222
<i>*DOL Projections are used for 2015 and 2020; linear forecast is used for 2012 through 2014 and 2016 through 2019.</i>								

a. Document the service area by means of a patient origin analysis.

The proposed facility is expected to have patients from the entire Mat-Su Borough. The Mat-Su population is currently distributed as the following². Providence does not expect to provide services outside of the borough population.

Table IV.B.4.a. Mat-Su Borough Communities.

Mat-Su Community	2011 Population	Percent of Borough
Big Lake	3,399	3.7%
Buffalo Soapstone	876	1.0%
Butte	3,274	3.6%
Chase	32	0.0%
Chickaloon	270	0.3%
Eureka Roadhouse	24	0.0%
Farm Loop	1,032	1.1%
Fishhook	4,757	5.2%
Gateway	5,680	6.2%
Glacier View	239	0.3%
Houston city	1,945	2.1%
Knik-Fairview	15,588	17.0%
Knik River	760	0.8%
Lake Louise	51	0.1%
Lakes	8,612	9.4%
Lazy Mountain	1,471	1.6%
Meadow Lakes	7,918	8.6%
Palmer city	6,087	6.6%
Petersville	5	0.0%

¹ Patient selection criteria will be based on the existing guidelines and recommendations of the physicians associated with the proposed ASC. Example of such guideline is presented in the Appendix A.

² Alaska Department of Labor 2011 Population Estimates, Places and Special Areas.

Mat-Su Community	2011 Population	Percent of Borough
Point MacKenzie	632	0.7%
Skwentna	30	0.0%
Susitna	17	0.0%
Susitna North	1,323	1.4%
Sutton-Alpine	1,492	1.6%
Talkeetna	896	1.0%
Tanaina	8,411	9.2%
Trapper Creek	499	0.5%
Wasilla city	8,064	8.8%
Willow	2,156	2.4%
Balance	6,157	6.7%
Total	91,697	100.0%

b. Justify the customary geographical area served by the facility using trade and travel pattern information. Indicate the number and location of individuals using services who live out of the primary service area.

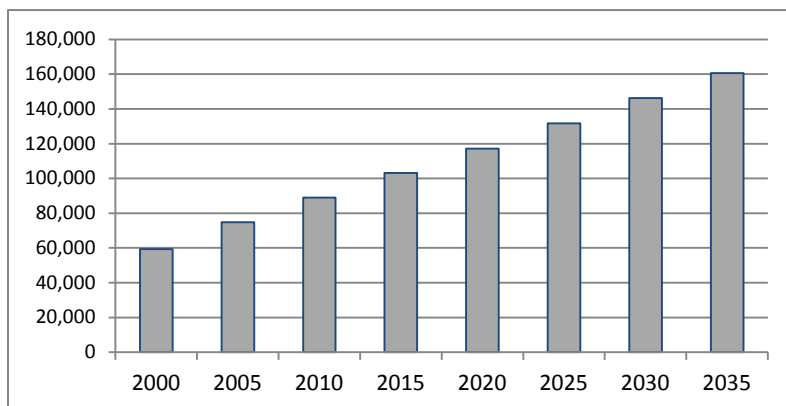
Providence does not expect to provide services outside of the Mat-Su Borough population.

c. Use Alaska Department of Labor and Workforce Development information, including current census data on cities, municipalities, census areas, or census sub-areas, to describe trends, age/sex breakdowns, and other characteristics pertinent to the determination of need.

The Alaska Department of Labor (AK DOL) projects significant growth both in the total population, and an aging of the population, of the Mat-Su Borough in the next 20 years.¹ Further, the proposed facility will provide services to children, another growing population in the Mat-Su Borough. Although gender does not impact need, these trends are similar for both genders.

As the population grows and ages, the need for surgeries will increase.

Figure 1. Mat-Su Total Population Growth Projections, 2000-2035, AK DOL.



¹ DOL Population Estimates and Projections/<http://labor.alaska.gov/research/pop/popest.htm>

Figure 2. Mat-Su Population, Males, by Age Category, with Percent Growth from 2000 to 2020, AK DOL.

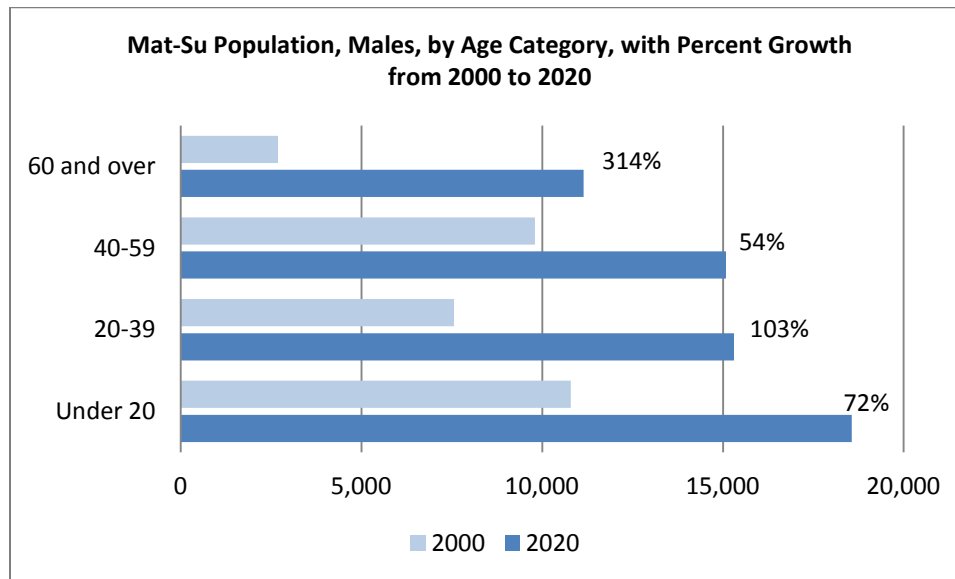
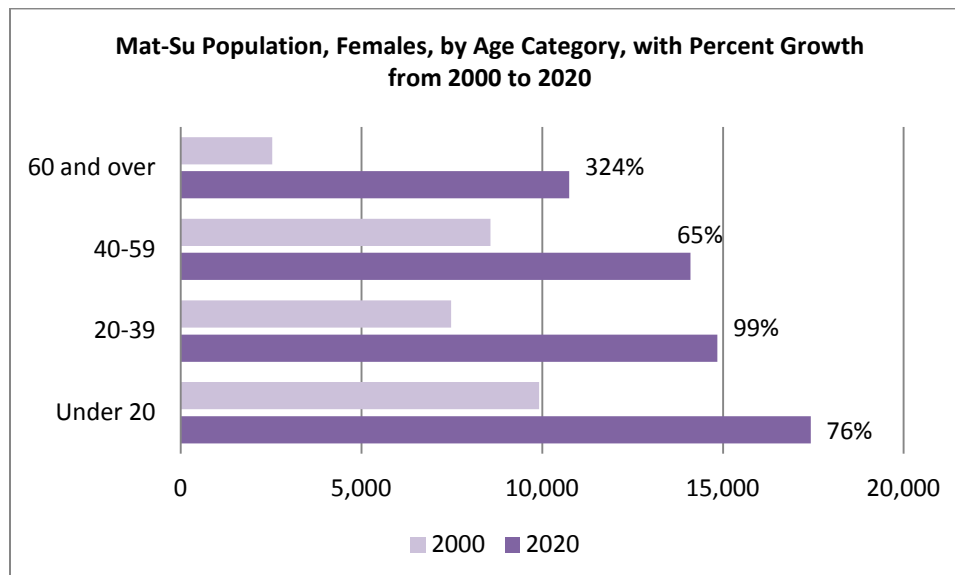


Figure 3. Mat-Su Population, Females, by Age Category, with Percent Growth from 2000 to 2020, AK DOL.



d. The population to be served can be defined according to the unique needs of patients requiring specialized or tertiary care (e.g. heart, cancer, kidney, alcoholism, etc.) or the needs of under-served groups.

The proposed ASC will focus on meeting community need for both adult and pediatric patients, focusing on appropriate surgeries and patients served in an ASC environment. In the proposed ASC, certain criteria will be used to determine whether a patient can undergo a surgery in an ambulatory setting. Patient selection criteria will be based on the existing guidelines¹ and recommended by the physicians associated with the proposed ASC. Examples of such criteria include the following.

- Patient's Body Mass Index (BMI) no greater than 35;
- American Society of Anesthesiologists (ASA) status class I, II, or III.

ASA Physical Status Classification²

Class	Description
I	Normal healthy patient
II	Mild systemic disease (e.g. diet controlled diabetes mellitus, mild hypertension)
III	Severe systemic disease (e.g. insulin dependent diabetic, morbid obesity, moderate to severe chronic obstructive pulmonary disease)
IV	Severe systemic disease that is a constant threat to life
V	Moribund patient who is not expected to survive without an operation
VI	A patient that has been declared brain dead

Given ASC patient selection criteria, Providence is planning to provide adult and pediatric orthopedic; ear, nose and throat; and general surgery services along with other surgical services needing Class C operating room.

As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured and uninsured populations.

We are addressing the problems of unmet community need for operating room and no not-for-profit, mission-based surgical provider in the community. Unlike for-profit providers who have a fiduciary responsibility to their shareholders, as a not-for-profit provider Providence has an obligation to our mission: *"As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service."*

This difference is highlighted by the report prepared by Milliman, Inc. for Alaska Health Care Commission in 2011¹. In the report, the Mat-Su Regional Medical Center was identified as the second

¹ Example of the guideline on patient selection criteria is presented in the Appendix A. *Evidence-based patient safety advisory: patient selection and procedures in ambulatory surgery* / National Guideline Clearinghouse / Agency for Healthcare Research and Quality / U.S. DHHS.

² American Society of anesthesiologists/ <http://www.asahq.org/Home/For-Members/Clinical-Information/ASA-Physical-Status-Classification-System>

most profitable hospital in the State of Alaska in 2010, with operating margin at 25.8 percent and the highest Medicare margin in the state at 4.0 percent (margin is defined as operating income divided by net revenues). In the same report, Providence Alaska Medical Center was reported to have operating margin at 13.0 percent.

To address these problems, Providence is proposing a **new** ASC with two Class C operating rooms. ASCs perform short duration surgeries (no more than 90 minutes of operating time and a total of four hours of expected recovery time²) and allow the patient to go home on the day of surgery. ASC surgeries can be less expensive patient alternative to the hospital-based outpatient surgeries. For example, according to American Hospital Association's Trend Watch, Medicare beneficiaries often pay lower coinsurance at an ASC than at a hospital outpatient department.³

The proposed ASC will focus on meeting community need for both adult and pediatric patients, focusing on appropriate surgeries and patients served in an ASC environment. Given the ASC patient criteria⁴, Providence is planning for both adult and pediatric orthopedic; ear, nose and throat; and general surgery services along with being able to provide other surgical services needing Class C operating rooms.

As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured, uninsured, Medicaid, and Medicare populations. According to County Health Ranking, ***24 percent of the Matanuska-Susitna Borough population does not have health insurance⁵; therefore, the proposed project is also addressing community need of these patients.***

Providence is committed to the Mat-Su surgery center promoting its services to the uninsured and underinsured and reporting to the community on its charity care.

5. Describe the projected utilization of the proposed services and the method by which this projection was derived. Do not annualize utilization data. It must include the last complete year of operation (indicate if it is a calendar year or fiscal year) and as many prior years as is feasible to show trends. If graphs are used to depict this information, and they do not include the actual utilization numbers, numerical charts must be included. In providing this information:

a. Include evidence of the number of persons from the target population who are currently using these services and who are expected to continue to use the service, including individuals served out of the service area or out of state;

¹ "Drivers of Health Care Costs in Alaska and Comparison States"/ Page 22 / Table 6B.1 / http://www.hss.state.ak.us/healthcommission/docs/drivers_healthcare_costs.pdf

² 42 CFR 416.65 - Covered surgical procedures.

³ The Migration of Care to Non-hospital Settings / American Hospital Association / Trend Watch / July 2006 / Page 3 / http://www.aha.org/research/reports/tw/tw_july2006migration.pdf

⁴ Patient selection criteria will be based on the existing guidelines and recommendations of the physicians associated with the proposed ASC. Example of such guideline is presented in the Appendix A.

⁵ 2012 County Health Ranking/Access to Care/ Alaska 2012/ <http://m.countyhealthrankings.org/node/207/85>

Please see Section A for the number of expected need of surgeries in the Mat-Su Borough. Additionally, in Section IV.A, we demonstrate the current outpatient surgery volume at PAMC from Mat-Su. Both demonstrate the target populations that are expected to use the service.

b. Include evidence of the number of persons who will begin to use any new services that are not now available, accessible, or acceptable to the target population.

Currently, no Class C ambulatory surgery center is provided in the Mat-Su Borough. Based on our financial analysis, we expect 837 persons to utilize this service already in the first year of operations. In the fifth year of operations and beyond, surgery case volume is projected to be 2,400 cases per year.

c. Provide annual utilization data and demand trends for the five most recent years and monthly utilization data for the most recent incomplete year prior to the application for each existing facility offering a similar service in the service area. Provide projections for utilization for three years (or the appropriate planning horizon set out in the review standards related to this project) after construction, and show methodology used to determine use, including the math.

Currently, there are no Class C ambulatory surgery centers in the Mat-Su Borough and data are not available for MSRMC outpatient center; therefore, past demand is not available. That said, please see Section IV.A for the number of expected need of surgeries in the Mat-Su Borough and current residents seeking outpatient surgery services at PAMC.

Surgery volumes projected for the five years following implementation of the project are presented below in the *Table IV.B.5.c*. These volumes are based on the number of days open times, the hours of operation, and the number of procedures estimated per day based on ASC criteria. Providence estimates approximately 2.7 cases per day per operating room in Year 1 for the 155 estimated days open (2.7×155) and by year five 4.8 procedures per day per operating room for 250 days open (4.8×250).

Table IV.B.5.c. Projected Volumes for Providence Mat-Su Surgery Center.

	Year 1	Year 2	Year 3	Year 4	Year 5
Projected Number of Surgery Cases	837	1,538	1,825	2,113	2,400

d. If the project is an acquisition of a new piece of major equipment or a new service, provide utilization data for similar services, existing equipment, or older technology. Indicate whether similar existing equipment will continue to be used and the project's effect on utilization of similar services. If this service or equipment was not in place in the service area, compare the expected utilization with other similar communities in Alaska or in other states.

Currently, there are no licensed Class C Ambulatory Surgery Centers in Mat-Su Borough. Further, there are no publically available data regarding current Class C outpatient use.

e. If an increase in utilization is projected, list the factors that will affect the increase. Provide annual utilization projections for three to five years in the future, as applicable, for each specific service in the proposal (in general, equipment projections are for three years, and new beds and facility construction are for five years). Include each of the following data when applicable:

- (1) number of admissions/discharges

- (2) number of patient days
- (3) average length of stay
- (4) percent occupancy
- (5) average daily census
- (6) number of licensed beds
- (7) number of beds set up
- (8) number of inpatient and outpatient surgeries and surgery minutes
- (9) number of existing surgery suites in the service area
- (10) number of procedures
- (11) number of treatment rooms
- (12) number of patients served
- (13) number of outpatient visits
- (14) number of laboratory tests
- (15) number of x-rays
- (16) number of ER visits
- (17) number of CT, MRI, PET or PET/CT scanners

Table IV.B.5.d. Projected Volumes for Providence Mat-Su Surgery Center.

	Year 1	Year 2	Year 3	Year 4	Year 5
Projected Number of Surgery Cases	837	1,538	1,825	2,113	2,400

The following factors are expected to drive the utilization increase during the first five years after the project implementation.

1. **High demand for services.** As demonstrated in Appendix D, the population and need for surgery services is high and growing. These projections are based on the CON Review Standards and Methodology Calculations.
2. **Lack of providers.** There are currently no Class C ambulatory surgery centers in the Mat-Su area.
3. **Case mix.** The proposed ASC will focus on providing adult and pediatric orthopedic, ENT, and general surgery services. While all surgeries performed in ASCs take no more than 90 minutes of operating time, ENT surgeries are especially short in duration. For instance, ear tub insertion, one the most common childhood surgeries performed with anesthesia, lasts less than 15 minutes, with patients quickly awakening after the procedure¹. Performing very short in duration surgeries will allow for serving more patients every day.
4. **Number of procedure and recovery rooms.** The proposed ASC will have two ORs and seven recovery rooms to allow simultaneous recovery of multiple patients. This will allow for greater efficiency when serving patients.

¹ American Academy of Otolaryngology – Head and Neck Surgery / <http://www.entnet.org/HealthInformation/Ear-Tubes.cfm>

f. If any services will be reduced, indicate how the proposed reduction will affect the service area needs and patient access.

The proposed project is for a new services; Providence is not proposing any service reductions.

g. Provide any other information that may be pertinent to establishing the need for this project.

Providence has provided a modest application based on publically available data to meet the needs of the community, including the uninsured and underinsured, in a responsible manner. Because the state has not responded to Providence's requests to provide the number of surgeries in the Mat-Su Borough, nor the number of Class C operating rooms in this market, Providence requests the right to amend this application, at no penalty to Providence, if the state provides more accurate data. This right includes additional operating rooms if the community need exists.

Since the proposed project will lease its space from Providence's Real Estate division, this proposed building and land will continue to pay property taxes in the Mat-Su Borough.

h. Attach letters of support from local and regional agencies, other health care facilities, individuals, governmental bodies, etc.

Providence intends to enter additional information into the record at the public hearing for this CON application.

6. Include your calculations of numerical need for each proposed activity for your service area. If the proposed project is expected to have a larger capacity than that projected by (and available from) the department, explain the rationale and provide documentation to support the larger capacity.

Please see Section A for the proposed calculation of need for the operating rooms; it is the only service in the proposed project.

C. AVAILABILITY OF LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

1. Describe the different alternatives considered in developing this project. Explain why the particular alternative for providing the services proposed by this application was selected. Include as an alternative a discussion of the effect of doing nothing.

The following alternatives had been considered.

Option 1: Status Quo “Do Nothing.” Providence Alaska decided against this option because “doing nothing” does not address the unmet community need, demonstrated through the CON methodology and standards, and evidenced by patient migration to Anchorage; nor does “doing nothing” address the need of a not-for-profit, mission-based provider in the community to provide care to the uninsured and underinsured population.

Option 2: Build a more than two suite ASC. Although the CON methodology indicates a possible greater need than is addressed by the proposed project, Providence decided against this option to avoid overbuilding of medical facilities resulting in increase of undue costs on the community. That said, *because the state has not responded to Providence’s requests to provide the number of surgeries in the Mat-Su Borough, nor the number of Class C operating rooms in this market, Providence requests the right to amend this application, at no penalty to Providence, if the state provides more accurate data. This right includes additional operating rooms if the community need exists.*

Option 3: Build A Hospital. Although the CON methodology and standards indicates a need for both surgical services and acute care beds, Providence decided against building a hospital with operating room suites for two reasons: (1) the community is served by a hospital at present and another would result in overbuilding; (2) an ambulatory surgery center focuses on procedures that can be provided more efficiently in an ASC setting than in a hospital setting.

Option 4: Build two suites ASC. Providence chose this option because (1) it is the most effective and efficient way for us to address the problem of unmet community need for operating rooms, and (2) there is no not-for-profit, mission-based provider of surgery services in Mat-Su Borough.

2. Describe any special needs and circumstances. Special needs may include special training, research, Health Maintenance Organizations (HMOs), managed care, access issues, or other needs.

As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured and uninsured populations.

Providence is addressing the problem of unmet community need for operating room, and no not-for-profit, mission-based surgical provider in the community. Unlike for-profit providers who have a fiduciary responsibility to their shareholders, as a not-for-profit’s provider Providence has an obligation to our mission: *“As people of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.”*

This difference is highlighted by the report prepared by Milliman, Inc. for Alaska Health Care Commission in 2011¹. In the report, the Mat-Su Regional Medical Center was identified as the second most profitable hospital in the State of Alaska in 2010, with operating margin at 25.8 percent and the highest Medicare margin in the state at 4.0 percent (margin is defined as operating income divided by net revenues). In the same report, Providence Alaska Medical Center was reported to have operating margin at 13.0 percent.

The proposed ASC will focus on meeting community need for both adult and pediatric patients, focusing on appropriate surgeries and patients served in an ASC environment. Given the ASC patient criteria², Providence is planning for both adult and pediatric orthopedic; ear, nose and throat; and general surgery services along with being able to provide other surgical services needing Class C operating rooms.

As with all Providence facilities, as a not-for-profit, mission-based organization, we will focus on providing compassionate service to the poor and vulnerable with an emphasis on the underinsured and uninsured, Medicaid, and Medicare populations. According to County Health Ranking, ***24 percent of the Matanuska-Susitna Borough population does not have health insurance³; therefore, the proposed project is also addressing this community need.***

Providence is committed to the Mat-Su surgery center promoting its services to the uninsured and underinsured and reporting to the community on its charity care.

¹ “Drivers of Health Care Costs in Alaska and Comparison States”/ Page 22 / Table 6B.1 / http://www.hss.state.ak.us/healthcommission/docs/drivers_healthcare_costs.pdf

² Patient selection criteria will be based on the existing guidelines and recommendations of the physicians associated with the proposed ASC. Example of such guideline is presented in the Appendix A.

³ 2012 County Health Ranking/Access to Care/ Alaska 2012/ <http://m.countyhealthrankings.org/node/207/85>

D. THE RELATIONSHIP OF THE PROPOSED PROJECT TO EXISTING HEALTH CARE SYSTEM AND TO ANCILLARY OR SUPPORT SERVICES

1. Identify any existing comparable services within the service area and describe any significant differences in population served or service delivery. If there are no existing comparable services in the area, describe the unmet need and how the target population currently accesses the services. Describe significant factors affecting utilization, including cost, accessibility, and acceptability.

The only current provider of Class C operating rooms in Mat-Su is Mat-Su Regional Medical Center (MSRMC), a for-profit corporation 75 percent owned and fully managed by Community Health Services (NYSE: CYH). Mat-Su Regional provides inpatient and outpatient surgery services; however, the available capacity is not sufficient to meet all surgical Class C needs of the Mat-Su residents as indicated in the community need analysis in Section A.

Although MSRMC provides outpatient services, they do these services within a hospital structure. There are no Class C ambulatory surgery centers in the Mat-Su. ASCs perform short duration surgeries (no more than 90 minutes of operating time and a total of four hours of expected recovery time¹) and allow the patient to go home on the day of surgery. ASC surgeries can be a less expensive patient alternative to the hospital-based outpatient surgeries. For example, according to American Hospital Association's Trend Watch, Medicare beneficiaries often pay lower coinsurance at an ASC than at a hospital outpatient department.²

The factors affecting utilization are the projected future demand as indicated in Section A and B. This projected future demand is based on increased population, an aging population, and increased use of outpatient surgeries.

The other factor affecting utilization will be the populations of the uninsured, underinsured, Medicare and Medicaid. As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured, uninsured, Medicaid, and Medicare populations. According to County Health Ranking, ***24 percent of the Matanuska-Susitna Borough population does not have health insurance³; therefore, the proposed project is also addressing community need of these patients.*** Further, the MSRMC, in their 2003 CON application, projected a low charity care of only three percent of their total net patient revenues⁴.

¹ 42 CFR 416.65 - Covered surgical procedures.

² The Migration of Care to Non-hospital Settings / American Hospital Association / Trend Watch / July 2006 / Page 3 / <http://www.aha.org/research/reports/tw/twjuly2006migration.pdf>

³ 2012 County Health Ranking/Access to Care/ Alaska 2012/ <http://m.countyhealthrankings.org/node/207/85>

⁴ Mat-Su Valley Medical Center, LLC CON Application, April 2003, Appendix 11 Facility Income Statement.

2. Describe the probable effect on other community resources, including any anticipated impact on existing facilities offering the same/similar services or alternatives locally or statewide if applicable. Describe how each proposed new or expanded service will:

- a. Complement existing services** – Given the ASC patient criteria¹, Providence is planning for both adult and pediatric orthopedic; ear, nose and throat; and general surgery services along with being able to provide other surgical services. As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured and uninsured population. This proposed project will be a compliment to the only other Class C surgical provider, MSRMC, freeing up surgical space for more hospital-appropriate procedures.
- b. Provide unique service** – Currently there are no licensed Class C ambulatory surgery centers in Mat-Su. The only licensed ASC in Mat-Su is Pioneer Peak Surgery Center², and it focuses on pain management procedures. The proposed Providence Mat-Su ASC will be the only not-for-profit provider of surgery services in the proposed service area, the Mat-Su Borough.

Providence is providing the unique service of not-for-profit, mission-based surgical. Unlike for-profit providers who have a fiduciary responsibility to their shareholders, as a not-for-profit's provider Providence has an obligation to our mission: *"As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service."*

- c. Specific target population** – The proposed ASC will focus on meeting the Mat-Su Borough community need for both adult and pediatric patients, focusing on appropriate surgeries and patients served in an ASC environment. As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including Medicaid, Medicare, and the underinsured and uninsured populations.
- d. Competition** – Currently there are no licensed Class C ambulatory surgery centers in Mat-Su; MSRMC does provide outpatient surgeries in, we assume, Class C surgical suites. Although this proposed project may have an impact on MSRMC, it will free up surgical time for procedures more appropriate for a hospital setting. Further impact will be to the hospitals and Class C ASCs in Anchorage, which are not in the proposed service area.

¹ Patient selection criteria will be based on the existing guidelines and recommendations of the physicians associated with the proposed ASC. Example of such guideline is presented in the Appendix A.

² State of Alaska/ Division of Health care Services/ Health Facilities Licensing Certification/ Facility List/
http://www.hss.state.ak.us/dhcs/hflc/PDF/hflc_facility_list.pdf

3. Identify existing working relationships the applicant has with hospitals, nursing homes, and other resources serving the target population in the service area. Include a discussion of cooperative planning activities, shared services (i.e. agreements assigning services such as emergency or obstetrics), and patient transfer agreements. If other organizations provide ancillary or support services to your facility, describe the relationship. Attach copies of relevant agreements in an appendix in the application. If a service requires support from another agency but does not have an agreement, explain why.

Currently Providence Alaska serves Mat-Su residents at Providence Matanuska-Susitna Valley Healthcare Center, where we offer preventative care, maternity care, pediatrics, chronic disease treatment, and on-site laboratory services. Additionally, Providence Behavioral Medicine Group offers psychiatric and behavioral health care to Mat-Su residents.

As a current provider in the community, Providence Alaska is participating in the Mat-Su Community Health Needs Assessment (CHNA). Specifically, Providence Alaska is providing the following: \$25,000 of financial support; an employee with experience in community needs assessments on the steering committee; and a commitment to be involved in the steering committee's efforts to address needs identified in the CHNA.

Regarding the proposed project, Providence looks forward to working with the providers of the Mat-Su Borough to serve the community and ensure access to services for all residents. We are open to joint venturing with local providers and/or the Mat-Su Health Foundation, whose mission aligns with Providence to serve the community. If such a partnership develops, Providence will require access for Medicaid and Medicare patients, and the adoption of a charity care policy which mirrors Providence's policy.

Providence will look to agreements with local providers for needed physician services along with patient transfer agreements with MSRMC. If these agreements do not come to fruition, Providence will establish any needed agreements with its facilities and affiliations within the Mat-Su Borough and Anchorage.

E. FINANCIAL FEASIBILITY

1. Demonstrate how the project will ensure financial feasibility, including long-term viability, and what the financial effect will be on consumers and the state, region, or community served.

The financial feasibility of the proposed project is demonstrated in the financial statements presented in Section IX. The proposed ASC is projected to operate at loss only during the first three years of operations, mostly due to the large amount of start-up expenses, operating not a full year in 2014 (the ASC is expected to open on May 1, 2014), and operating below full capacity. During the first three operational years, the project will be financially supported by the stable and sustainable operations of Providence Health & Services Alaska. Starting in 2017, the ASC is projected to have revenues in excess over expenditures.

2. Discuss how the project construction and operation is expected to be financed. Demonstrate access to sufficient financial resources and the financial stability to build and operate this project.

The building will be constructed by a third party. The proposed project will lease approximately 10,800 square feet for this program. The project's furniture, fixtures, and equipment of over \$3.9 million and the start-up expenses of over \$1.0 million will be financed through taxable debt. The debt will be taken by issuing a \$5 million bond for 10 years at 6.5 percent.

The financial feasibility of the proposed project is demonstrated in the financial statements presented in Section IX. The proposed ASC is projected to operate at loss only during the first three years of operations, mostly due to the large amount of start-up expenses, operating not a full year in 2014 (the ASC is expected to open on May 1, 2014), and operating below capacity. During the first three operational years, the project will be financially supported by the stable and sustainable operations of Providence Health & Services Alaska. Starting in 2017, the ASC is projected to have revenues in excess over expenditures.

3. Provide a description and estimate of:

a. the probable impact of the proposal on the annual increase on the overall costs of the health services to the target population to be served;

Since their inception more than three decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs¹. ASCs offer physicians the ability to work more efficiently and are highly regulated to ensure patient safety and quality of care. Not only are ASCs focused on ensuring patients have the best surgical experience possible, the care they provide has been shown to be is also more affordable compared to hospitals for a similar procedure.²

¹ Ambulatory surgery centers: a positive trend in healthcare / ASC Coalition / http://www.precisionsurgicenter.com/docs/ASC_Positive_Trends.pdf

² Ibid.

The proposed project will bring these outpatient surgery services (currently not available) to Mat-Su Borough; therefore, the probable impact on overall increased costs to health care services is low. Additionally, the cost of traveling outside of the community for healthcare should be reduced for the Mat-Su residents.

- b. If applying to build a residential psychiatric treatment centers, nursing homes, or additional nursing home beds the annual increase to Medicaid required to support the new project, and the projected cost of and charges for providing the health care services in the first year of operation (per diem rate, scan, surgery etc);**

Not applicable.

- c. The immediate and long-term financial feasibility of continuing operations of the proposal.**

The immediate financial feasibility of the proposed project is demonstrated in the financial statements presented in Section IX. The long-term financial feasibility of the project is expected to be sufficient to maintain continuous operations, as the need for surgeries in the Mat-Su community will continue to grow due to the growth and aging of population.

F. ACCESS TO SERVICE BY THE GENERAL POPULATION AND UNDER-SERVED GROUPS

1. Provide information on service needs and access of under-served groups of people such as low-income persons, racial and ethnic minorities, women, and persons with a disability. Discuss any plans to overcome language and cultural barriers of groups to be served.

Unlike for-profit providers who have a fiduciary responsibility to their shareholders, as a not-for-profit's provider Providence has an obligation to our mission: *"As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service."*

As with all Providence facilities, as a not-for-profit, mission-based organization, we will provide compassionate service to the poor and vulnerable including the underinsured, uninsured, Medicaid, and Medicare populations. Our mission and not-for-profit approach is reflected in the annual amounts of charity care provided by Providence Alaska and the projections for the future charity care as indicated below.

For the patients who are not proficient in English, a third-party vendor interpreter service will be offered via the telephone for those patients who need it.

2. Indicate the annual amount of charity care provided in each of the last five years with projections for the next three years. Include columns for revenue deductions, contractual allowances, and charity care.

The proposed project is a new service to this community; thus, we do not have historical charity care data for this project. Table IV.F.1 reflects the charity care for Providence Alaska; Table IV.F.2 reflects the estimated charity care for the proposed project.

**Table IV.F.1. Providence Health & Services Alaska
Charity Care – Actual 2006-2010**

Year	Charity Care	Contractual Allowances	Bad Debt	Total Deductions from Revenue
2006	\$ 29,483,722	\$ 400,279,279	\$ 34,434,951	\$ 464,197,952
2007	\$ 34,758,350	\$ 441,349,650	\$ 57,116,036	\$ 533,224,037
2008	\$ 51,156,102	\$ 506,589,979	\$ 45,130,568	\$ 602,876,649
2009	\$ 60,737,092	\$ 554,784,277	\$ 48,283,558	\$ 663,804,927
2010	\$ 70,859,297	\$ 668,469,310	\$ 50,071,386	\$ 789,399,993

**Table IV.F.2. Providence Mat-Su Surgery Center
Charity Care – Projections 2014-2016**

Year	Charity Care	Contractual Allowances	Bad Debt	Total Deductions from Revenue
2014	\$ 330,293	\$ 3,286,767	\$ 232,936	\$ 3,849,996
2015	\$ 624,922	\$ 6,237,904	\$ 440,720	\$ 7,303,546
2016	\$ 764,031	\$ 7,649,787	\$ 538,825	\$ 8,952,643

3. Address the following access issues:

- a. transportation and travel time to the facility;**
- b. special architectural provisions for the aged and persons with a disability;**
- c. hours of operation; and**
- d. the institution's policies for nondiscrimination in patient services.**

a. Transportation and travel time to facilities.

The new proposed facility will be conveniently located on the Providence Mat-Su medical campus, in the central location between Palmer and Wasilla. Transportation to the facility can be provided by private vehicles, public transportation, and medical transport.

b. Special architectural provisions for the handicapped and aged.

Providence will comply with the rules and regulations of the Federal Register Nondiscrimination on the Basis of Disability in Public Accommodations and Commercial Facilities and Alaska Department of Health & Social Services, which oversees licensing and certification. The proposed project will comply with the standards set forth in the Americans with Disabilities Act (ADA).

c. Service hours of operations.

The proposed ASC will operate five days a week, Monday through Friday, 7 a.m. to 4 p.m., for surgeries and open until 7 p.m. (or later if needed) to ensure proper recovery time. Providence may consider Saturday hours to meet the needs of special-needs populations (e.g., pediatrics).

d. Institutional Policies for non-discrimination in patient services

Providence provides care without regard for patients' ability to pay, consistent with Providence's not-for-profit status and mission. Providence does not discriminate against a patient because of race, creed, color, national origin, or payer source.

Section V. Consideration of Quality, Effectiveness, Efficiency, and Benefits of the Applicant's Services

Please discuss the following in narrative form:

1. Accreditation and Licensure: Following receipt of a Certificate of Need and during the construction period, Providence will apply for a license as an ambulatory surgery center with the State of Alaska Department of Health and Social Services. Providence Mat-Su Surgery Center will also seek certification by the Centers for Medicare and Medicaid Services (CMS) for conditions of participation and coverage. Additionally, the proposed facility will seek accreditation by The Joint Commission (TJC) or Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

2. Quality Control: Providence will develop a quality control program to address requirements defined in TJC or AAAHC certification standards, by CMS and by the State of Alaska Health Facilities Certification and Licensing regulations. The proposed facility will be designed by an architectural firm experienced in the development of health care facilities, specifically ambulatory surgery centers, with substantial input and engagement from the ambulatory care experts at Providence.

The focus of the design is safety, efficiency, and optimum patient care. All equipment will be newly acquired and selected to meet all federally required quality and safety standards and will undergo a thorough inspection for defects, safety standards and functionality prior to commissioning for use in patient care. The proposed facility will be entering into a bio-medical services contract with a third party, whose staff will work side-by-side with the staff at the proposed facility during the inspection and commissioning of equipment.

Infrastructure equipment such as HVAC, generators, boilers, medical gas and vacuum systems will be certified and maintained by certified technicians as required by CMS and the accrediting agency (TJC or AAAHC). Clinical and business staff will be trained for job-specific competencies and complete mandatory annual retraining. Clinical staff will be provided training on new equipment prior to its implementation.

3. Personnel:

The proposed facility plans to employ approximately 23.0 FTEs with some staff will be cross-trained to maximize efficiencies and staff availability for specific services. An organization chart is in Appendix E.

Physicians: The proposed facility will establish Medical Staff Bylaws and, Rules and Regulations to establish standards for physicians and allied health personnel. Physicians' education, training and skills are evaluated through a credentialing process, and only qualified physicians will be recommended for privileges. The Providence Mat-Su Surgery Center Medical Executive Committee and the Providence Alaska Region Community Ministry Board are accountable for approving entry to the credentialed medical staff. Members of the medical staff stay current with new developments in their respective specialties through training and continuing education as required by the Medical Staff Bylaws, Alaska medical licensing and the individual physician's membership in specialty medical organizations.

Clinical: The proposed facility will establish job descriptions for all job types, compliant with the national and state standards for positions such as Registered Nurse and Operating Room Technologist. All personnel will be required to meet professionally accepted job requirements at hiring, and periodically meet professional competency standards as required by TJC or AAAHC.

Non-Clinical Personnel: The proposed facility will employ non-clinical employees in positions such as materials management, business office and medical records. These staff must also meet professional hiring standards and perform commensurate with accreditation and regulatory requirements. All employees' performance will be regularly evaluated and plans for improvement and career growth will be implemented

Continuing Education: Providence will provide for continuing education opportunities and will ensure that all personnel receive training provided by equipment vendors, professional societies, and attend selected special educational meetings both in and out of the state.

4. Appropriate Utilization: The proposed facility will ensure appropriate patient selection to comply with current standard operating procedures. Careful patient screening by the surgeon and anesthesia team will ensure patients are medically stable with few to no co-morbid conditions, with the patient Body Mass Index (BMI) within acceptable range, and that any other disease processes are well managed. Patients who do not meet these criteria and are deemed higher-risk will not be cared for at the proposed facility, as they will likely require services regularly provided in a hospital inpatient environment. Patient selection criteria will be based on the existing or future guidelines¹ and recommended by the physicians associated with the proposed ASC. Examples of such criteria include the following.

- Patient's Body Mass Index (BMI) no greater than 35;
- American Society of Anesthesiologists (ASA) status class I, II, or III.

ASA Physical Status Classification²

Class	Description
I	Normal healthy patient
II	Mild systemic disease (e.g. diet controlled diabetes mellitus, mild hypertension)
III	Severe systemic disease (e.g. insulin dependent diabetic, morbid obesity, moderate to severe chronic obstructive pulmonary disease)
IV	Severe systemic disease that is a constant threat to life
V	Moribund patient who is not expected to survive without an operation
VI	A patient that has been declared brain dead

The proposed facility has also been developed to support the shift in procedures from the inpatient to the outpatient setting. The shift from inpatient to ambulatory settings in surgical services will continue as

¹ Example of the guideline on patient selection criteria is presented in the Appendix A. *Evidence-based patient safety advisory: patient selection and procedures in ambulatory surgery* / National Guideline Clearinghouse / Agency for Healthcare Research and Quality / U.S. DHHS.

² American Society of anesthesiologists/ <http://www.asahq.org/Home/For-Members/Clinical-Information/ASA-Physical-Status-Classification-System>

technological advances provide for the expansion of minimally invasive surgery and as CMS expands the types and numbers of procedures deemed appropriate for an ambulatory surgical environment.

5. New Technology and Treatment Modes: The proposed facility is being designed by architects experienced in the design of health care facilities and familiar with the ambulatory service environment. Through the direction of Providence leaders, consideration is given to creating an environment that facilitates the delivery of quality care in an efficient manner. Consideration is given to the needs of the ambulatory patient and the surgeons who will be performing the procedures. The Medical Executive Committee (MEC) will serve as the approval body for the selection of equipment and instrumentation. Supported by the Administrator, the Director of Nursing and Quality and the materials management specialist, the MEC assures the surgeons have adequate types and amounts of instruments, supplies, disposable items, and implants to meet the needs of each patient.

Technological advancement in equipment allows for minimally invasive procedures, reducing risk to the patient through limited disruption to healthy tissues and a more prompt recovery and rehabilitation. This results in a decrease of anesthesia time and a decrease in total operating room time, which decreases risk to the patient and decreases costs to the payers.

6. Labor Saving Devices and Efficiency: Freestanding ambulatory surgery centers use labor saving equipment and processes to achieve the best operating economies, while maintaining high-quality care. Surgical cases are carefully scheduled to a specific operating room, to provide the optimum match of surgeon, patient, nursing team, and equipment. Support staff is scheduled to provide faster cleaning of rooms and equipment between cases (“turn-around time”) that is not possible in a hospital surgery department.

7. Program Evaluation: Future plans for evaluation of the proposed activity to ensure that it fulfills present expectations and benefits. The proposed facility, as an entity of Providence Health & Services, will follow the health system’s Quality Strategic Plan. A specific quality plan for the proposed facility will be developed, utilizing national benchmarks and standards of care, in compliance with either TJC or AAAHC accreditation standards. Key performance indicators will be developed and results will be reported to the proposed facility’s medical staff and the appropriate Providence management.

8. Organizational Structure: Include an organizational chart, descriptions of major position requirements and board representation; show representation from community economic and ethnic groups.

The organizational chart for the proposed facility is located in the Appendix E. Rosters for the Providence Health & Services Board of Directors, Corporate Officers, and the Providence Alaska Region Community Ministry Board are located in Section I. Our Community Ministry Board always includes members from each of the communities we serve, including the Mat-Su.

9. Staff Skills: Provide descriptions of major position requirements, appropriate staff-to-patient ratios to maintain quality, and the minimal level of utilization that must be maintained to ensure that staff skills are maintained. Provide a source for the staffing standards. Positions include

Administrator, Director of Nursing/Quality, Medical Director, and clinical and support staff positions.

Job descriptions for the Administrator, Director of Nursing and Quality, Medical Director, Registered Nurse, Operating Room Tech, and Sterile Processing Tech are located in Appendix F. The staffing plan is based upon the size of the center (two operating rooms), and the anticipated volume of surgical cases. TJC and AAAHC do not prescribe specific levels of staffing. AAAHC standards, Chapter 10, Surgical and Related Services, Subchapter 1. H. reads, “Registered nurse(s) and other personnel assisting in the provision of surgical services are appropriately trained and supervised, and are available in sufficient numbers for the surgical and emergency care provided.” In addition, AAAHC standard I.H.MS (1)/CMS 416.46 Condition: Nursing Service reads, “The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met. AAAHC standard I.H.MS(2)/CMS 416.46(a) Standard: Organizing and Staffing reads, “Patient care responsibilities must be delineated for all nursing services personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC.” The Association of Operating Room Nurses (AORN) addresses staffing in Position Statements and other publications. The AORN Position Statement, Operating Room Staffing Skill Mix for Direct Caregivers, states, “Although there is no consensus among perioperative nursing managers related to OR skill mix ratios, a survey conducted by AORN indicates a 2:1 RN/surgical technologist/LPN ratio. AORN’s findings are consistent with current literature” (Appendix G). The AORN Position Statement, One Perioperative Registered Nurse Circulator Dedicated to Every Patient Undergoing A Surgical or Other Invasive Procedure states, “At a minimum, one perioperative registered nurse circulator should be dedicated to each patient undergoing a surgical or other invasive procedure and be present during that patient’s entire intraoperative experience”(Appendix G). The AORN Position Statement Orientation of the Registered Nurse and Certified Surgical Technologist to the Perioperative Setting (Appendix G) addresses the periods of training and experience recommended to achieve competency. The minimum experience periods are exceeded in the Job Descriptions. The size of the center, anticipated surgical volumes and staffing plan will assure adequate practice to maintain competencies

10. Economies of Scale: The minimum and maximum size of facility or unit required to ensure optimum efficiency. If the planned project is significantly smaller or larger, explain the effect and why the size was chosen.

The facility size (two operating rooms and support space) has been determined based on community need. The staffing plan provides for efficient operation of both operating rooms. The building, as designed, meets the volume and specialty needs, and is integrated into the staffing and equipment plans.

Section VI. Narrative Description of How Project Meets Applicable Review Standards

Describe in this section of the application how the proposed project meets each review standard applicable to all activities, and each specific review standard applicable to the proposed activity. *Some of this information will duplicate information required elsewhere in the application packet; that duplication is intentional.*

General Review Standards for Certificate of Need

1. **Application Documents Need for the Population Served.** Section IV.A and Appendix D provide the unmet need for surgical facilities in Mat-Su Borough along with the growing and aging population that will need increased services closer to home. Additionally, no not-for-profit surgical provider exists in the proposed service area with a population of 24 percent uninsured. **The proposed project meets this standard.**
2. **Application Documents Relevant Planning.** Section IV.A provides the consistency with current national and state plans. **The proposed project meets this standard.**
3. **Application Documents Stakeholder participation.** Providence developed this project with internal experts, including individuals who currently work in, live in and/or serve the Mat-Su community. Because the current CON regulations give a preference to the first applicant, Providence was not able to work directly with all of the stakeholders in the community before submitting this application. Once the public notice of the CON application has been posted, Providence will increase our stakeholder participation and intends to enter additional information into the record at the public hearing for this CON application.
4. **Application Documents Alternative Methodologies.** Section IV.C describes the four alternatives Providence considered, including “do nothing.” The most suitable alternative to meet community need in an efficient and effective manner, and focused on the uninsured and underinsured, is the proposed solution. **The proposed project meets this standard.**
5. **Application Documents Impact on Existing Local and Statewide Health Systems.** Section IV.D describes the impact to Mat-Su and Anchorage providers. The proposed project, providing a Class C ambulatory surgery center that will see all payers, is a compliment to the existing services in the Mat-Su Borough. **The proposed project meets this standard.**
6. **Application Documents Accessibility.** Section IV.D describes the accessibility of the proposed facility. Located on the Providence Mat-Su campus, it is easily accessible. **The proposed project meets this standard.**

Concurrent Review Standards for Certificate of Need

In case there is a concurrent Certificate of Need, the following are the additional review standards.

1. **Application documents quality consistent or better than existing services.** No Class C ACSs currently exist in the community; research, however, indicates that, compared to alternate venues (e.g. hospital surgery department) ASCs offer more efficient clinical operations, saving time and money in delivering services¹.

In 2008, otolaryngologists Dr. Jedidiah Grisel, M.D. and Dr. Ellis Arjmand, M.D. examined 275 ambulatory surgery centers and 211 hospitals, in order to compare quality of outpatient ENT surgeries performed in an ASC and in a hospital. They developed measures for the following categories: safety, patient-centeredness, timeliness, efficiency, and equitability. Upon completion of the research, Dr. Grisel and Dr. Arjmand concluded that performance at the ASCs generally exceeded that at the hospitals, while the total charges for procedures were 12 to 23 percent less at the ASC than at the hospital².

Also, the members of American Association of Orthopedic Surgeons believe that the ability to perform higher volumes of a narrow range of procedures allows ASCs to maximize operational efficiencies and achieve economies of scale which save money for patients and payers alike. The savings produced from the efficiency gains allow ASCs to continue to provide many valuable services to all patients regardless of payer status and their ability to pay³.

2. **Application documents a pattern of licensure and accreditation.** The facility will be licensed by the Alaska Department of Health and Social Services (DHSS) as an ambulatory surgery center. It will be certified by the Centers for Medicare and Medicaid Services (CMS) for conditions of participation and coverage. Additionally, the new facility will seek accreditation by The Joint Commission (TJC) or Accreditation Association for Ambulatory Health Care, Inc. (AAAHHC).

Providence Alaska does not currently manage or wholly own any ambulatory surgery centers. However, with all our facilities, we ensure that the highest quality and efficiency standards are met and/or exceeded, which is confirmed by the accreditation and certification granted to the facilities.

Providence Owned or Managed Facility	Licensed by State as	Accredited by	Enrolled by CMS
Providence Alaska Medical Center	General Acute Care Hospital	The Joint Commission (TJC)	Yes
Providence Extended Care Center	Nursing Facility	N/A	Yes

¹ Ambulatory Surgical Centers Position Statement/ American Association of Orthopedic Surgeons/
<http://www.aaos.org/about/papers/position/1161.asp>

² Grisel J, Arjmand E. "Comparing quality at an ambulatory surgery center and a hospital-based facility: Preliminary findings." Otolaryngology - Head and Neck Surgery. Dec;141(6):701-709/Abstract at <http://www.ncbi.nlm.nih.gov/pubmed/19932841>

³ Ambulatory Surgical Centers Position Statement/ American Association of Orthopedic Surgeons/
<http://www.aaos.org/about/papers/position/1161.asp>

Providence Owned or Managed Facility	Licensed by State as	Accredited by	Enrolled by CMS
Providence Kodiak Island Medical Center (leased facility)	General Acute Care Hospital	TJC	Yes (Medicare Certified CAH)
Providence Kodiak Island Medical Center (leased facility)	Nursing Facility	TJC	Yes
Providence Seward Medical Center (managed facility)	Rural Primary Care Hospital	N/A	Yes (Medicare Certified CAH)
Providence Seward Mountain Haven (managed facility)	Nursing Facility	N/A	Yes
Providence Valdez Medical Center (managed facility)	Critical Access Hospital	N/A	Yes (Medicare Certified CAH)
Providence Valdez Extended Care Center (managed facility)	Nursing Facility	N/A	Yes
Providence Imaging Center (Joint Venture – Providence managed)	IDTF	ACR	Yes

3. **Application documents high levels of care to low-income and uninsured.** Sections II, III, and IV demonstrate Providence's commitment to serve low-income and uninsured persons with the proposed project.

Section VII. Construction Data

A. Please check appropriate boxes:

- | | | | |
|----------------------|-------------------------------|------------------------------------|-------------------------------------|
| 1. Construction type | <input type="checkbox"/> New | <input type="checkbox"/> Expansion | <input type="checkbox"/> Renovation |
| 2. Basement | <input type="checkbox"/> Full | <input type="checkbox"/> Partial | <input type="checkbox"/> None |

Not applicable.

The building is being constructed by a third party. The proposed project will lease approximately 10,800 square feet for this program. The space will include two operating rooms, three pre-operative and seven post-operative stations, service support space, administrative space, staff lounge, locker rooms, waiting area, and public toilets.

B. Project Development Schedule

Date

- | | |
|--|------------------------|
| 1. Estimated completion of final drawings and specifications | <u>April 1, 2013</u> |
| 2. Estimated construction begun by | <u>May 1, 2013</u> |
| 3. Estimated construction complete by | <u>January 1, 2014</u> |
| 4. Estimated opening of proposed services | <u>May 1, 2014</u> |

Funds will be encumbered through May 1, 2015, the completion date of the project.

C. Facility site data: Provide the following as attachments (referenced by the subsection and item number):

The proposed ambulatory surgery center will lease space in a building constructed by a third party. The location plan and the conceptual drawings of the facility are in Appendix H.

1. Legal description and area of the proposed site: Township 17N Range 1E Section 15 LOT D7. The site is owned by Legacy, LLC, a real estate entity of Providence Health & Services – Washington.
2. Diagrammatic plan showing dimensions and location of structures, parking facilities, and service roads and walkways.

See Appendix H.

3. Document clearances regarding zone restrictions, fire protection, sewage, and other waste disposal arrangements (under special circumstances, it is acceptable to present evidence of conditional approvals from local government and regulatory agencies).

Not applicable as the proposed project will lease space in a building constructed by a third party.

4. An architectural master plan including long-range concept and development of total facility.

Not applicable as the proposed project will lease space in a building constructed by a third party.

5. Schematic floor plan drawings (or conceptual drawings) of proposed activity, including functional use of various rooms.

See Appendix H.

D. Describe the plan for completing construction and the effect (disruption) construction activities will have on existing services.

As this is a new facility, there will be no disruption to health care services either during construction or tenant improvements.

Section VIIIA. Financial Data - Acquisitions

1. Acquisition type: (Please check applicable boxes)

☒ Lease ☐ Rent ☐ Donation ☐ Purchase ☐ Stock Transaction

2. Cost data

(Omit cents)

a. Total acquisition cost*	\$ 7,219,549
b. Amount to be financed	\$ 0

c. Difference between items (a) and (b) (list available resources to be used, e.g. available cash, investments, grants, etc.)	\$ 7,219,549
---	--------------

The building for the proposed project will be constructed by a third party. The project will lease approximately 10,800 square feet of space to provide surgery services. The NPV of the lease is estimated at \$7,219,549. The lease payments will be an operating expense of the proposed surgery center.

d. Anticipated interest rate <u>N/A</u> % , term <u>N/A</u> years.	
e. Total anticipated interest amount	\$ 0
f. Total of (a) and (e)	\$ 7,219,549
g. Estimated annual debt service requirements	\$ 0

3. Describe how you expect to finance the project.

The building will be constructed by a third party. The proposed project will lease approximately 10,800 square feet for this program. The NPV of the lease is estimated at \$7,219,549. The lease payments will be an operating expense of the proposed surgery center.

Note: Acquisition costs must include (as appropriate):

- Total purchase price of land and improvements (if donated, the fair market value)
- "Goodwill" or "purchase of business" costs
- The net present value of the lease calculated on the total lease payments over the useful life of the asset as set out in the 2004 version of *Estimated Useful Lives of Depreciable Hospital Assets*, published by the American Hospital Association.
- Consultant or brokers fees paid by person acquiring the facility
- Other pre-development costs to date.

* Includes the net present value of the lease payments (\$7,219,549).

Section VIII.B. Financial Data – Construction Only

1. Construction Method (Please check)

- a. ☐ Conventional bid ☐ Contract management ☐ Design and build
 b. ☐ Phased ☒ Single project ☐ Fast Track

None applicable. The building will be constructed by a third party. The proposed project will lease approximately 10,800 square feet for this program. The NPV of the lease is estimated at \$7,219,549.

2. Construction Cost (New Activity)

	(Omit cents)
a. Site acquisition (Section VIIIA.2.f)	\$ 7,219,549
b. Estimated general construction	\$ 0
c. Fixed equipment, not included in (a)	\$ 0
d. Total construction costs (sum of items a, b, and c)	\$ 7,219,549
e. Major movable equipment	\$ 3,976,886
f. Other cost:	\$ 1,058,950
(1) Administration expense	\$ 788,950
(2) Site survey, soils investigation, and materials testing	\$ 0
(3) Architects and engineering fees	\$ 0
(4) Other consultation fees (preparation of application included)	\$ 150,000
(5) Legal fees	\$ 100,000
(6) Land development and landscaping	\$ 0
(7) Building permits and utility assessments	\$ 0
(8) Additional inspection fees (clerk of the works)	\$ 20,000
(9) Insurance (required during construction period)	\$ 0
g. Total project cost (sum of items d, e, f)	\$12,255,386
h. Amount to be financed*	\$ 5,000,000
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.)	\$ 7,255,386
j. Anticipated long-term interest rate	<u>6.5 %</u>
k. Anticipated interim (construction) interest rate	<u>N/A%</u>
l. Anticipated long-term interest amount	\$ 1,955,235
m. Anticipated interim interest amount	\$ 0
n. Total items g, l, and m	\$14,210,620
o. Estimated annual debt service requirement	\$ 695,523
p. Construction cost per sq. ft.	N/A
q. Construction cost per bed	N/A
r. Project cost per sq. ft. (10,800sq.ft.)	\$ 1,316
s. Project cost per bed (if applicable)	N/A

* The project FFE of approximately \$3.98 million and the start-up expenses of approximately \$1.1 million will be financed through taxable debt. The debt will be taken by issuing a \$5 million bond for 10 years at 6.5 percent. The principal of the bond and interest on the debt will be paid off as result of the operations.

** The difference between items 2(g) and 2(h) contains the NPV of the lease, which is estimated at \$7,219,549. The lease payments will be an operating expense of the proposed surgery center.

Section IX. Financial Data – All Proposed Activities

Provide an accompanying narrative explanation for each of the schedules below if there are any significant trends or significant changes in any item or group of items from year to year.

Note: Indicate whether you are using a calendar year or other fiscal year period.

A. Attach Schedule I - Facility Income Statement

1. For the most recent five prior full fiscal or calendar years
2. Projections during construction or implementation period (if applicable)
3. Projection for three years following completion of construction, or implementation of the proposed activity.

B. Attach Schedule II - Facility Balance Sheet

1. For the most recent five prior fiscal or calendar years.
2. Current fiscal or calendar year to date

C. Attach Schedule III - Average Patient Cost Per Day (Per Diem Rate if applicable) and Revenue Amounts

Provide revenue and expense data FOR EACH SERVICE THAT IS IDENTIFIED AS CHANGING.

1. For the most recent five prior full fiscal or calendar years (information may be obtained on total patient load, directly from your respective years' Medicare Cost Reports)
2. Current fiscal or calendar year to date
3. Projection for five years following completion of construction or implementation.

D. Attach Schedule IV – Operating Budget

Current and projected line item capital and operating budgets for the proposed activity. Describe what alternative plans have been made if deficits occur.

E. Attach Schedule V – A. Debt Service Summary, and B. New Project Debt Service Summary

A debt service cash flow schedule over the life of the debt, if applicable, for all long-term debt of the facility. Identify each debt, including the proposed activity, and break out interest, principal, and other costs.

F. Attach Schedule VI - Reimbursement Sources

Showing reimbursement sources for the facility for the previous five full years and projected for three years after implementation.

G. Attach Schedule VII – Depreciation Schedule

Showing a depreciation schedule for all items acquired through the proposed project. Note that the straight-line method must be used. Indicate on the depreciation schedule or separately which major movable equipment is being purchased for the project (see Section VIIB, Item 2e). Also, on a separate page, include a list of all equipment to be purchased through this project and the costs.

Schedule I. Facility Income Statement					
<i>in \$000s</i>					
	2014	2015	2016	2017	2018
Gross Patient Revenue:					
Inpatient Routine	-	-	-	-	-
Inpatient Ancillary	-	-	-	-	-
Outpatient	7,212	13,645	16,682	19,889	23,274
Long-Term Care	-	-	-	-	-
Swing Beds	-	-	-	-	-
Other	-	-	-	-	-
Total Patient Revenue	7,212	13,645	16,682	19,889	23,274
Less Deductions:					
Charity Care	330	625	764	911	1,066
Bad Debts	233	441	539	642	752
Medicare & Medicaid	1,683	3,199	3,930	4,707	5,534
Contractual Allowances	1,604	3,039	3,720	4,441	5,203
Other	-	-	-	-	-
Total Deductions	3,850	7,304	8,953	10,701	12,554
Net Operating Revenues	3,362	6,341	7,729	9,188	10,719
All Other Revenues					
EXPENSES:					
Salaries	1,613	2,003	2,063	2,135	2,210
Benefits	469	593	614	639	664
Professional Fees	155	110	113	117	120
Supplies	1,030	1,912	2,335	2,784	3,261
Purchased Services	1,156	1,296	1,347	1,404	1,464
Utilities	-	-	-	-	-
Property Tax	-	-	-	-	-
Rent	-	-	-	-	-
Lease	518	534	550	566	583
Other Expenses	1,121	92	106	122	138
Depreciation	674	674	674	633	592
Interest	325	301	275	248	219
Total Expenses	7,061	7,515	8,079	8,648	9,251
Excess (Shortage) of Revenue Over Expenditures	(3,700)	(1,174)	(350)	539	1,469

Schedule II. Facility Balance Sheet					
<i>in \$000s</i>					
	2014	2015	2016	2017	2018
Current Assets					
Cash & Cash Equivalent	-	-	-	-	-
Net Patient Accounts Receivable	371	701	851	1,014	1,184
Other Accounts Receivable	-	-	-	-	-
Inventories	254	472	574	687	804
Prepaid Expenses	-	-	-	-	-
Other	-	-	-	-	-
Total Current Assets	625	1,172	1,425	1,701	1,988
Property and Equipment	3,649	3,749	3,849	3,949	4,049
Land & Improvements	-	-	-	-	-
Building/Fixed Equipment	-	-	-	-	-
Major Movable Equipment	-	-	-	-	-
Accumulated Depreciation	(674)	(1,349)	(2,023)	(2,656)	(3,249)
Net Property & Equipment	2,975	2,401	1,826	1,293	800
Other Assets	-	-	-	-	-
Total Assets	3,600	3,572	3,252	2,994	2,788
Liabilities/Fund Balance					
Current Liabilities					
Accounts Payable	392	398	438	483	530
Affiliates Payable	1,867	3,377	3,759	3,335	2,060
Accrued Compensation	40	42	43	45	46
Current Portion of Long-Term Debt	371	395	420	448	477
Other Accruals	-	-	-	-	-
Total Current Liabilities	2,670	4,211	4,660	4,311	3,113
Long Term Liabilities					
Long Term Debt	4,629	4,235	3,815	3,367	2,890
Other	-	-	-	-	-
Total Long Term Liabilities	4,629	4,235	3,815	3,367	2,890
Fund Balance	(3,700)	(4,874)	(5,223)	(4,684)	(3,215)
Total Liabilities & Fund Balance	3,600	3,572	3,252	2,994	2,788

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and Revenue Amounts					
	<i>in \$000s</i>				
	2014	2015	2016	2017	2018
Gross Revenues	7,212	13,645	16,682	19,889	23,274
Expenses	7,061	7,515	8,079	8,648	9,251
Patient Days	N/A	N/A	N/A	N/A	N/A
Revenue Per Patient Day	N/A	N/A	N/A	N/A	N/A
Operating & Capital Budget Summary:					
Gross Revenues	7,212	13,645	16,682	19,889	23,274
Deductions from Revenue	3,850	7,304	8,953	10,701	12,554
Net Revenue	3,362	6,341	7,729	9,188	10,719
Direct Expense	4,423	5,914	6,473	7,079	7,719
Indirect Expense	2,638	1,601	1,605	1,569	1,532
Net Income Projected	(3,700)	(1,174)	(350)	539	1,469
Rate Computation	N/A	N/A	N/A	N/A	N/A
Annual Medicaid Rate	N/A	N/A	N/A	N/A	N/A
Base Year Cost	N/A	N/A	N/A	N/A	N/A
Less Ancillary	N/A	N/A	N/A	N/A	N/A
Plus Admin. Overhead	N/A	N/A	N/A	N/A	N/A
Cost Basis for Rate	N/A	N/A	N/A	N/A	N/A
Base Year Patient Days	N/A	N/A	N/A	N/A	N/A
Cost per Patient Day	N/A	N/A	N/A	N/A	N/A

Patient Days, Revenue per Patient Day, and Medicaid Rate Computation do not apply as the proposed project is an outpatient facility.

Schedule IV. Operating Budget			
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion			
<i>in \$000s</i>			
Description:	2014	2015	2016
Number of Beds	N/A	N/A	N/A
Days in a year	365	365	366
Number of cases	837	1,538	1,825
Available bed days	N/A	N/A	N/A
Resident bed days	N/A	N/A	N/A
Percent growth	N/A	N/A	N/A
Occupancy	N/A	N/A	N/A
Average length of stay	N/A	N/A	N/A
Patient Bed Days	N/A	N/A	N/A
Number of Residents	N/A	N/A	N/A
Daily Room and Board Rate*	N/A	N/A	N/A
Nursing Revenue	N/A	N/A	N/A
Nursing Services	N/A	N/A	N/A
Payer Mix:	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A
Medicare	N/A	N/A	N/A
Other	N/A	N/A	N/A
Ancillary Revenue	N/A	N/A	N/A
Total Revenue	7,212	13,645	16,682
Rate Computation	N/A	N/A	N/A
Annual Medicaid Rate	N/A	N/A	N/A
Base Year Cost	N/A	N/A	N/A
Less Ancillary	N/A	N/A	N/A
Plus Admin. Overhead	N/A	N/A	N/A
Cost Basis for Rate	N/A	N/A	N/A
Base Year Patient Days	N/A	N/A	N/A
Cost per Patient Day	N/A	N/A	N/A

Most of the line items of the Schedule IV are not applicable to the proposed project.

Projected revenues and expenses for the first five years of operations are presented in the Schedule I.

Schedule V-A. Debt Service Summary					
Provide Current Debt Data and Projections For the Next Three Years					
Existing Debt:	2014	2015	2016	2017	2018
(Identify)	-	-	-	-	-
Principal	-	-	-	-	-
Interest	-	-	-	-	-
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
(Identify)					
Principal					
Interest					
Total Existing Debt					
Principal					
Interest					
Estimated Debt – New Project					
Principal					
Interest					

There is no **current** debt associated with the project.

Schedule V-B. New Project Debt Service Summary					
Year	Item	Principal	Interest	Other	Total
2014	Scheduled Payment	\$ 370,523	\$ 325,000	-	695,523
2015	Scheduled Payment	394,607	300,916	-	695,523
2016	Scheduled Payment	420,257	275,266	-	695,523
2017	Scheduled Payment	447,574	247,950	-	695,523
2018	Scheduled Payment	476,666	218,857	-	695,523
2019	Scheduled Payment	507,649	187,874	-	695,523
2020	Scheduled Payment	540,646	154,877	-	695,523
2021	Scheduled Payment	575,788	119,735	-	695,523
2022	Scheduled Payment	613,215	82,309	-	695,523
2023	Scheduled Payment	653,074	42,450	-	695,523
	Total	5,000,000	1,955,235	-	6,955,235

Schedule VI. Reimbursement Sources

Show reimbursement sources for the previous five years and projections for three years after the new project opens.

Since the proposed project is a new facility, historical information is not available. Tables below demonstrate our projections for the first three years of operations.

Fiscal Year 2014				
<i>in \$000s</i>				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	168	1,445	963	482
Medicare	112	963	719	244
Private Insurance	367	3,165	1,001	2,164
Self Pay	72	619	146	474
Charity	38	330	330	-
Bad Debt	0	-	233	(233)
Other	80	688	457	231
Total	837	7,212	3,850	3,362

Fiscal Year 2015				
<i>in \$000s</i>				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions**	Net Patient Revenues
Medicaid	308	2,734	1,832	902
Medicare	205	1,823	1,366	456
Private Insurance	675	5,989	1,894	4,095
Self Pay	132	1,172	276	896
Charity	70	625	625	-
Bad Debt	0	-	441	(441)
Other	147	1,302	869	433
Total	1538	13,645	7,304	6,341

Fiscal Year 2016				
<i>in \$000s</i>				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions**	Net Patient Revenues
Medicaid	366	3,343	2,253	1,090
Medicare	244	2,229	1,677	552
Private Insurance	801	7,322	2,316	5,006
Self Pay	157	1,433	337	1,096
Charity	84	764	764	-
Bad Debt	0	-	539	(539)
Other	174	1,592	1,067	525
Total	1825	16,682	8,953	7,729

Schedule VII. Depreciation Schedule			
Use the straight-line method.			
Provide a separate schedule for any pieces of major moveable equipment.			
Equipment Description	Cost	AHA Life	Depreciation Per Year
Computer, Laptop	\$ 2,500	3.00	\$ 833
Chair, Clinical, Recliner, Treatment	7,947	15.00	530
Monitor, Physiologic, Vital Signs, w/Stand	5,310	8.00	664
Chair, Interiors, Lounge, Bariatric	2,686	10.00	269
Refrigerator, Laboratory, w/ Freezer	2,882	10.00	288
Sink, Utility, 1-Compartment	2,996	20.00	150
Cart, Procedure, Malignant Hyperthermia	3,065	10.00	307
Desk, Office, Executive	3,069	20.00	153
Cart, Procedure, Resuscitation	6,298	10.00	630
Compression Unit, Extremity Pump, Intermittent	6,400	10.00	640
Cart, Medication, Large	3,339	10.00	334
Casework, Base/Wall Combo	3,435	15.00	229
Scale, Clinical, Adult, Wheelchair	3,571	10.00	357
Shield, Lead, Mobile	3,622	15.00	241
Stretcher, Transport	7,274	15.00	485
Cabinet, OR Console, Supply	22,524	15.00	1,502
Smoke Evacuation, Surgical	7,900	10.00	790
Pump, Infusion, PCA	8,250	10.00	825
Pump, Infusion, Dual	4,250	10.00	425
Cart, Case, Medium (40-49in wide)	8,798	10.00	880
Oximeter, Pulse	9,000	10.00	900
Oximeter, Pulse	4,500	10.00	450
Cart, Case, Medium (40-49in wide)	4,905	10.00	491
Cart, Case, Medium (40-49in wide)	24,525	10.00	2,453
Allowance, Furniture	5,000	15.00	333
Monitor, Video, LCD, Display	5,000	8.00	625
Allowance, Furniture	5,000	15.00	333
Casework, Base Cabinet w/Sink	10,070	15.00	671
Casework, Base Cabinet w/Sink	5,035	15.00	336
Casework, Base Cabinet w/Sink	5,035	15.00	336
Monitor, Physiologic, Portable	16,275	8.00	2,034
Monitor, Physiologic, Portable	21,700	8.00	2,713
Pump, Infusion, Syringe	5,695	10.00	570
Stretcher, Procedure / Recovery	17,544	7.00	2,506
Stretcher, Procedure / Recovery	23,392	7.00	3,342
Seating, Lounge, 5-Seat	24,224	15.00	1,615
Safe, Lead Lined	6,500	20.00	325
Freezer, Laboratory, 1 door	7,086	7.00	1,012
Artwork, Illuminated, Virtual Skylight	22,080	8.00	2,760
Headlight, w/ Light Source	14,890	10.00	1,489
Allowance, Furniture	7,500	15.00	500
Pass-thru, Window Assembly	7,501	10.00	750
Pass-thru, Window Assembly	7,501	10.00	750
Refrigerator, Blood Bank, 1 door	7,628	10.00	763

Schedule VII. Depreciation Schedule			
Use the straight-line method.			
Provide a separate schedule for any pieces of major moveable equipment.			
Equipment Description	Cost	AHA Life	Depreciation Per Year
Ice Machine, Modular w/Bin, Flaker	\$ 7,681	10.00	\$ 768
Ice Machine, Dispenser, Flaker, Countertop	7,702	10.00	770
Sink, Clean-up Workstation (2-sink)	9,199	20.00	460
Artwork, Digital/Video, Allowance	10,000	8.00	1,250
Artwork, Digital/Video, Allowance	10,000	8.00	1,250
Artwork, Digital/Video, Allowance	20,000	8.00	2,500
Warmer, Fluid/ Blood, Portable	20,000	7.00	2,857
Artwork, Digital/Video, Allowance	10,000	8.00	1,250
Artwork, Digital/Video, Allowance	10,000	8.00	1,250
Warmer, Fluid/ Blood, Portable	10,000	7.00	1,429
Analyzer, Lab, Blood Gas, Point-of-Care	20,900	7.00	2,986
Defibrillator, Manual	10,545	5.00	2,109
Cabinet, Warming, Dual, Freestanding	21,456	10.00	2,146
Sink, Scrub, 2-Bay, Stainless Steel	24,324	20.00	1,216
Hypo-Hyperthermia Unit, General	12,640	10.00	1,264
Insufflator, CO2	13,394	5.00	2,679
Electrosurgical Unit, Bipolar	31,616	7.00	4,517
Monitor, Physiologic, Transcutaneous, O2 / CO2	38,854	8.00	4,857
Tourniquet System, General	19,490	7.00	2,784
Boom, Equipment, Dual Arm	45,000	10.00	4,500
Waste Disposal, Surgical Fluid Collection	51,858	5.00	10,372
Boom, Anesthesia	52,000	10.00	5,200
Signage, Digital, Allowance	28,000	10.00	2,800
Monitor, Physiologic, Anesthesia	72,000	8.00	9,000
Monitor, Physiologic, Anesthesia	36,000	8.00	4,500
Light, Surgical, Dual, Ceiling	100,254	15.00	6,684
Integration System, Surgical, Allowance	120,000	5.00	24,000
Anesthesia Machine, General	150,000	7.00	21,429
Anesthesia Machine, General	75,000	7.00	10,714
Sterilizer, Steam (Electric), Cabinet	81,055	12.00	6,755
Sterilizer, Steam (Electric), Cabinet	81,055	12.00	6,755
Table, Surgical, Major	163,076	15.00	10,872
Navigation System, Surgical, Image Guided	233,400	5.00	46,680
Laser, Surgical, CO2	132,650	5.00	26,530
Table, Surgical, Spinal	148,815	10.00	14,882
CCTV Allowance	150,000	10.00	15,000
X-Ray Unit, C-Arm, Mobile	194,000	7.00	27,714
Nurse Call, Allowance	200,000	10.00	20,000
Instruments, Surgical, Orthopedics, Allowance	543,558	3.00	181,186
Software, Asset Management, Instrument Tracking	300,000	5.00	60,000
Network Provisioning	22,500	4.00	5,625.00
Desktop PCs	52,038	4.00	13,009.43
Signature pads	6,365	4.00	1,591.31
Medication barcode scanner	10,901	4.00	2,725.33

Schedule VII. Depreciation Schedule			
Use the straight-line method.			
Provide a separate schedule for any pieces of major moveable equipment.			
Equipment Description	Cost	AHA Life	Depreciation Per Year
Power Mic for Dragon	\$ 2,300	4.00	\$ 575.00
Document scanners	3,477	4.00	869.36
Multifunction printers	8,754	4.00	2,188.50
Radiology Reading Workstation (1 outside Ors)	15,550	4.00	3,887.50
Radiology Reading workstation	11,550	4.00	2,887.50
Pyxis MedStation	2,000	4.00	500.00
Pyxis Supply Station	2,000	4.00	500.00
Server for the Medstation	7,900	4.00	1,975.00
Server for Supply station	7,900	4.00	1,975.00
30 station phone switch	23,711	4.00	5,927.71
Estimated cost for 22 phones	3,801	4.00	950.13
File server plus storage	31,050	4.00	7,762.50
Computer room equipment rack	1,500	4.00	375.00
Server Set-up	4,000	4.00	1,000.00
Storage Set-up	2,400	4.00	600.00
DHCP server	6,900	4.00	1,725.00
UPS for Server network and storage equipment	2,990	4.00	747.50
50 MB circuit	1,000	4.00	250.00
50 MB circuit	1,000	4.00	250.00
Network equipment set-up	4,000	4.00	1,000.00
Network Router at ASC location	14,375	4.00	3,593.75
Network Router at PAMC location	57,000	4.00	14,250.00
Network Switches	20,700	4.00	5,175.00
Total	\$3,976,886		\$674,414.10

APPLICATION FEE – DETERMINATION AND CERTIFICATION OF AMOUNT

How to Determine the Amount of the Application Fee Required Under 7 AAC 07.079

(1) For a project that does not include a lease of a facility or equipment, the value of the project is:

A. the amount listed under Section VIIIA,
Financial Data – Acquisitions, subsection (2), item “a” (total
acquisition cost of land and buildings): \$ 7,219,549

plus

B. the amount listed under Section VIIIB,
Financial Data – Construction Only, item “g” (total project cost,
which is the sum of items d, e, and f)*: \$ 5,035,837

Estimated Value of the Activity for (1) sum of A & B above) \$ 12,255,386

(2) For a project that has a component that is leased, the fair market value of the leased equipment, facility, or land must be considered in addition to the acquisition cost. See the form on page 31 of this packet for how to determine fair market value.**

Estimated Fair Market Value for (2): \$ N/A

Estimated Value for (1) from above: \$ N/A

Total Estimated Value of the Activity
(sum of (1) and (2)): \$ 12,255,386

Amount of Application Fee submitted with this application
(see 7 AAC 07.079 to calculate amount due): \$ 12,256

* Excludes NPV of the lease included in the (A) of this section.

** Net present value of the lease component is included in the (A) of this section.

Certification of Individual Determining Application Fee

I certify that, to the best of my knowledge, as of this date, the estimated value and fee for this certificate of need activity are accurate.

Date: 11-9-12

Facility Name and Address: Providence Health & Services Alaska, P.O. Box 196604 Anchorage, AK 99519

Name and Title of Person Determining Application Fee: Bruce Lamoureux, CEO

Bruce Lamoureux
Signature of Certifying Officer of the Organization

Appendix A
Patient Selection Guidelines



Guideline Summary NGC-7526

Guideline Title

Evidence-based patient safety advisory: patient selection and procedures in ambulatory surgery.

Bibliographic Source(s)

Haeck PC, Swanson JA, Iverson RE, Schechter LS, Singer R, Basu CB, Damitz LA, Glasberg SB, Glassman LS, McGuire MF, ASPS Patient Safety Committee. Evidence-based patient safety advisory: patient selection and procedures in ambulatory surgery. *Plast Reconstr Surg* 2009 Oct;124(4 Suppl):6S-27S. [101 references]

Guideline Status

This is the current release of the guideline.

This guideline updates two previous versions: Iverson RE. Patient safety in office-based surgery facilities: I. Procedures in the office-based surgery setting. *Plast Reconstr Surg* 2002 Oct;110(5):1337-42. [14 references]

Iverson RE, Lynch DJ. Patient safety in office-based surgery facilities: II. Patient selection. *Plast Reconstr Surg* 2002 Dec;110(7):1785-90. [4 references]

Scope

Disease/Condition(s)

- Any condition which may be treated by ambulatory surgery
- Complications associated with ambulatory surgery

Guideline Category

Evaluation

Management

Prevention

Risk Assessment

Clinical Specialty

Anesthesiology

Plastic Surgery

Surgery

Intended Users

Advanced Practice Nurses

Health Care Providers

Physician Assistants

Physicians

Guideline Objective(s)

- To provide an overview of the preoperative steps that should be completed to ensure appropriate patient selection for ambulatory surgery settings
- To identify several physiologic stresses commonly associated with surgical procedures, in addition to potential postoperative recovery problems, and to provide recommendations for how best to minimize these complications
- To update, combine, and expand on two prior practice advisories issued by the American Society of Plastic Surgeons in 2002: one detailing patient selection in the office-based surgery setting and another detailing procedures in the office-based surgery setting

Target Population

Any patient undergoing plastic surgery in the ambulatory surgery setting

Interventions and Practices Considered

Risk Assessment/Evaluation

1. Patient selection
 - Preoperative patient history including assessment of risk factors
 - Physical examination, including body mass index determination, respiratory status, American Society of Anesthesiologists (ASA) physical classification status, cardiovascular status assessment (including electrocardiogram and evaluation and treatment of active cardiac conditions)
 - Complete blood count/blood chemistries
 - Additional tests as appropriate
2. Assessment of risk of thrombosis or embolism
3. Assessment of ASA physical classification status

Management/Prevention

1. Cardiovascular monitoring
 - Noninvasive blood pressure measurement
 - Heart rate
 - Electrocardiography
 - Pulse oximetry
 - Respiratory rate
 - Additional specialized monitoring as needed
2. Management of specific patient populations
 - Obese patients (including obese patients with respiratory abnormalities and other comorbid conditions)
 - Patients with obstructive sleep apnea
 - Patients with cardiac conditions
3. Thromboprophylaxis (implemented according to risk rating)
 - Patient education
 - Early and frequent ambulation (continued at home)
 - Flexion/extension of ankles (continued at home)
 - Graduated compression stockings (may be used at home)
 - Intermittent pneumatic compression (IPC)
 - Low-molecular-weight heparin (LMWH)
 - Venous foot pumps
 - Longer term prophylaxis with warfarin
 - Patient positioning on the operating room table
4. Chemoprophylaxis (LMWH, fondaparinux, idraparinux, direct thrombin inhibitors) as indicated
5. Management of physiologic stresses associated with surgical procedures
 - Strategies for hypothermia
 - Strategies for anticipated intraoperative blood loss
 - Choice of anesthesia type and monitoring anesthesia
 - Duration of procedure
 - Combining multiple procedures
 - Preventing unanticipated admission

Major Outcomes Considered

Morbidity and mortality associated with surgery and anesthesia

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

PubMed and the Cochrane Library were searched. The search terms used were: *patient selection, preoperative assessment, ambulatory surgery, outpatient surgery, office-based surgery, surgical procedures, physical examination,*

medical history, risk factors, comorbidity, age, deep vein thrombosis (DVT), pulmonary embolus (PE), body mass index (BMI), obesity, obstructive sleep apnea (OSA), heart disease, stroke, hypertension, American Society of Anesthesiologists (ASA) Status, hypothermia, anesthesia, malignant hyperthermia, multiple procedures, duration of operation/procedure/surgery, unanticipated admission. No limits were set on publication dates in the searches. The searches included all types of published articles. However, articles that were critically appraised and rated for level of evidence were limited to systematic reviews, meta-analyses, randomized controlled trials (RCTs), clinical trials, comparative studies, case series and case reports.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Level of Evidence	Qualifying Studies
I	High-quality, multi-centered or single-centered, randomized controlled trial with adequate power; or a systematic review of these studies
II	Lesser-quality, randomized controlled trial; prospective cohort study; or a systematic review of these studies
III	Retrospective comparative study; case-control study; or a systematic review of these studies
IV	Case series
V	Expert opinion; case report or clinical example; or evidence based on physiology, bench research, or "first principles"

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

The supporting literature was critically appraised for study quality according to criteria referenced in key publications on evidence-based medicine. Depending on study design and quality, each reference was assigned a corresponding level of evidence (I through V) with the American Society of Plastic Surgeons (ASPS) Evidence Rating Scales, and the evidence was synthesized into practice recommendations. (see "Rating Scheme for the Strength of the Evidence").

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Not stated

Rating Scheme for the Strength of the Recommendations

Grade	Descriptor	Qualifying Evidence	Implications for Practice
A	Strong Recommendation	Level I evidence or consistent findings from multiple studies of levels II, III, or IV	Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
B	Recommendation	Levels II, III, or IV evidence and findings are generally consistent	Generally, clinicians should follow a recommendation but should remain alert to new information and sensitive to patient preference.
C	Option	Levels II, III, or IV evidence, but findings are inconsistent	Clinicians should be flexible in their decision-making regarding appropriate practice, although they may set bounds on alternatives; patient preference should have a substantial influencing role.
D	Option	Level V; little or no systematic empirical evidence	Clinicians should consider all options in their decision-making and be alert to new published evidence that clarifies the balance of benefit versus harm; patient preference should have a substantial influencing role.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

The guideline was approved by the American Society of Plastic Surgeons Executive Committee on January 10, 2009.

Recommendations

Major Recommendations

Definitions for the levels of evidence (I–V) and the grades of the recommendations (A–D) are provided at the end of the "Major Recommendations" field.

Recommendations	Supporting Evidence	Grade
Patient Selection		
Preoperative tests		
<ul style="list-style-type: none"> Order pertinent tests based on the patient's preoperative history and physical examination results: <ul style="list-style-type: none"> Electrocardiogram in patients older than 45 years Electrocardiogram at any age when known cardiac conditions are present Complete blood count/blood chemistries, as needed, for detailed evaluation of specific diagnosis Additional tests as appropriate 	Expert opinion	D
Age		
<ul style="list-style-type: none"> Patients older than 60 years can be considered for ambulatory surgery but may be at increased risk for cardiac events, other complications, and unanticipated admissions. Cardiovascular monitoring is important; however, the level of monitoring depends on the patient's overall health, the presence and severity of cardiovascular disease, and the nature of the surgical procedure. Standard monitoring should include <ul style="list-style-type: none"> Noninvasive blood pressure Heart rate Electrocardiography Pulse oximetry Respiratory rate Additional specialized monitoring may be needed (see Fleisher et al., 2007) 	Custer & Trinkaus, 2002; Mandal et al., 2005; Aldwinckle & Montgomery, 2004; George et al., 2004; Fleisher et al., 2007; Chung, Mezei, & Tong, "Adverse events," 1999	B
Body mass index (BMI)		
<ul style="list-style-type: none"> Ambulatory surgery can be considered for patients with: <ul style="list-style-type: none"> BMI 18.5–24.9 (normal weight) BMI 25–29.9 (overweight) BMI 30–34.9 (moderately obese) A hospital setting should be considered for patients with: <ul style="list-style-type: none"> BMI 35–39.9 (severely obese) A hospital setting is recommended for patients with: <ul style="list-style-type: none"> BMI ≥40 (morbidly obese) 	Mandal et al., 2005; Kempers, Foote, & DiFlorio-Brennan, 2000; Atkins, White, & Ahmed, 2002; Chacon, Viehweg, & Ganzberg, 2004	D
<ul style="list-style-type: none"> General management of obese patients: <ul style="list-style-type: none"> Consider histories/comorbidities that may complicate patient management. Consider prophylaxis against deep vein thrombosis (DVT) (i.e., with low-dose heparin, sequential compression devices, and postoperative ambulation). 	Nielsen et al., 2005; Samama, 2000; Chacon, Viehweg, & Ganzberg, 2004; Friedman, Chung, & Wong, 2004	B
<ul style="list-style-type: none"> Management of obese patients with respiratory abnormalities: <ul style="list-style-type: none"> Ensure proper patient positioning and monitoring. Use a semiupright position in a chair for patients under sedation. 	Chung, Mezei, & Tong, "Pre-existing," 1999; Myles et al., 2002; Chacon, Viehweg, & Ganzberg, 2004	B
<ul style="list-style-type: none"> Consider supplemental oxygen. Carefully sized airway adjuncts (e.g., oral/nasal pharyngeal airways, endotracheal tubes, laryngeal mask airways) should be immediately available for patients under moderate sedation or general anesthesia. Consider intravascular monitoring of arterial pressure (or other 	Chacon, Viehweg, & Ganzberg, 2004	D

<p>approaches) if blood pressure measurements and auscultation of the heart and lungs is difficult to obtain.</p> <ul style="list-style-type: none"> Pharmacologic approaches to sedation and pain management in obese patients: <ul style="list-style-type: none"> Use a catheter-over-needle system to prevent loss of intravenous access. Short operation times and lighter levels of sedation are recommended. Consider a hospital setting if deeper anesthesia is required. Calculate initial doses of pharmacologic agents based on ideal body weight (as a reflection of lean body mass) rather than actual body weight. Consider possible drug interactions. <ul style="list-style-type: none"> Exercise caution for patients taking appetite suppressants or other medications. Consider avoiding opioids, especially in patients with diagnosed or suspected obstructed sleep apnea (OSA); consider nonopioid analgesics and moderate sedation with reversible agents. 		
OSA		
<ul style="list-style-type: none"> Patients with OSA can be considered for ambulatory surgery; however, careful patient assessment is necessary. For patients <i>without</i> a prior diagnosis of OSA, inquire about the following symptoms: <ul style="list-style-type: none"> Airway obstruction during sleep Loud and frequent snoring Frequent arousal from sleep, especially with choking sensation Daytime somnolence or fatigue Falling asleep in nonstimulating environments (e.g., watching television, reading, driving) Also consider interviewing family members as to whether they have seen telltale OSA symptoms in the patient (e.g., apneic events, restless sleep, vocalizations) The physical examination should include an evaluation of the following: <ul style="list-style-type: none"> The airway Nasopharyngeal characteristics Tonsil and tongue size Neck circumference BMI For patients <i>with</i> suspected OSA, consider referring the patient for additional tests (e.g., sleep studies, more extensive airway assessment) and OSA treatment prior to surgery. Factors to be considered in determining whether outpatient surgery is appropriate for patients with OSA: <ul style="list-style-type: none"> Sleep apnea status Anatomical and physiologic abnormalities The status of coexisting diseases The nature of the surgery The type of anesthesia The need for postoperative opioids Patient age Adequacy of postdischarge observation Capabilities of the outpatient facility (availability of emergency difficult airway equipment, respiratory care equipment, radiology facilities, clinical laboratory facilities, and a transfer agreement with an inpatient facility) Discharge criteria for patients with OSA: <ul style="list-style-type: none"> Patients can be discharged from the recovery area to an unmonitored setting (i.e., the home, unmonitored hospital bed) when they are no longer at risk for postoperative respiratory depression. Because of the propensity to develop airway obstruction or central respiratory depression, OSA patients may require a longer stay as 	<p>Friedman, Chung, & Wong, 2004; Sabers et al., 2003; "Practice guidelines," 2006</p>	D

<p>compared with non-OSA patients undergoing similar procedures.</p> <ul style="list-style-type: none"> Document the adequacy of postoperative respiratory function by observing patients in an unstimulated environment (preferably while asleep) to establish that they are able to maintain their baseline oxygen saturation while breathing room air. 		
Cardiovascular conditions		
<ul style="list-style-type: none"> Patients with a history of cardiovascular conditions can be considered for ambulatory surgery; however, the surgery location depends on the severity of disease. Patients with moderate to severe cardiovascular disease may not be appropriate candidates for surgery outside of the hospital setting. 	Custer & Trinkaus, 2002; George et al., 2004; Friedman, Chung, & Wong, 2004	D
<ul style="list-style-type: none"> General management of patients with cardiovascular conditions: <ul style="list-style-type: none"> Evaluate the risk of bleeding and thromboembolism. Adjust medications such as aspirin, warfarin, or clopidogrel bisulfate accordingly. Refer patients to their cardiologist, hematologist, or internist for preoperative evaluation and treatment. 	Custer & Trinkaus, 2002; George et al., 2004; Kirkorian et al., 2007; Broad et al., 2007; Ardekian et al., 2000; Dhiwakar, Khan, & McClymont, 2006; Bartlett, 1999; Partridge, Campbell, & Alvarado, 2008; Chassot, Delabays, & Spahn, 2007; Burger et al., 2005; Szalat, Erez, & Leitersdorf, 2007; Inman, Michla & Partington, 2007	B
Risk for thrombosis or embolism		
<ul style="list-style-type: none"> Assess risk factors: <ul style="list-style-type: none"> Patient history, including the use of contraceptives and hormone replacement, stillbirth, preterm delivery, and possibly recurrent miscarriage Family history, including past episodes of thrombosis or embolism Genetic disposition to clotting disorders (e.g., factor V Leiden, prothrombin G20210A) Edema, swelling, or other signs of venous insufficiency in the lower extremities 	Samama, 2000; Reinisch et al., 2001; Spring & Gutowski; 2006; Keyes et al., 2008; Wu et al., 2006; Wu et al., "Oral contraceptives," 2005; Kocher et al., 2007; Sottolotta et al., 2006; Jauniaux et al., 2006; Wu et al., "Thrombophilia," 2005	B
Thromboprophylaxis		
<p>Implement thromboprophylaxis according to risk rating:</p> <ul style="list-style-type: none"> Low risk <ul style="list-style-type: none"> Patient education Early and frequent ambulation (continue at home) Flexion/extension of ankles (continue at home) Optional: graduated compression stockings (GCS) (may be used at home) 	Reinisch et al., 2001; Young & Watson, "The need for," 2006; Michot et al., 2002	D
<ul style="list-style-type: none"> Moderate risk <ul style="list-style-type: none"> Same as low risk, <i>plus</i> Intermittent pneumatic compression (IPC) if anticoagulation is not an option (continue until good ambulation) Low -molecular-weight heparin (LMWH) (30–40 mg subcutaneously [SQ] once daily [qd]; initial dose 2 hr before surgery or 12 hr after; continue until patient is fully ambulatory and evaluate need for longer prophylaxis) <i>or</i> low-dose unfractionated heparin (LDUH) (every [q] 12h until patient is fully ambulatory) 	Handoll et al., 2002; Wille-Jørgensen et al., 2003; Urbankova et al., 2005	A
<ul style="list-style-type: none"> High risk <ul style="list-style-type: none"> Same as low risk, <i>plus</i> IPC and/or GCS (until good ambulation) LMWH (40 mg SQ qd; initial dose 2 hr before surgery or 12 hr after; continue for 5–10 days) <i>or</i> fondaparinux (2.5 mg SQ qd; initial dose 6–8 hr after surgery; do not give <6 hr postoperatively; continue for 5–10 days) 	Handoll et al., 2002; Urbankova et al., 2005; Amaragiri & Lees 2000; Turpie et al., 2002; Turpie et al., 2007	A
<ul style="list-style-type: none"> Very high risk <ul style="list-style-type: none"> Same as low risk, <i>plus</i> IPC and/or GCS (until good ambulation) LMWH (40 mg SQ qd; initial dose 2 hr before surgery or 12 hr after; continue for 7–12 days and seriously consider longer prophylaxis) <i>or</i> fondaparinux (2.5 mg SQ qd; initial dose 6–8 hr after surgery; do not give 	Handoll et al., 2002; Urbankova et al., 2005; Amaragiri & Lees 2000; Turpie et al., 2002; Turpie et al., 2007	A

<p><6 hr postoperatively; continue for 7–12 days and evaluate need for longer prophylaxis)</p> <ul style="list-style-type: none"> • Longer term prophylaxis with warfarin <i>or</i> convert to warfarin at international normalized ratio (INR) 2–3 (if patient risk factors indicate the need for other vitamin K antagonist long-term prophylaxis) 		
Mechanical prophylaxis		
<ul style="list-style-type: none"> • Methods recommended for patients with a high risk of bleeding or as an adjunct to chemoprophylaxis: <ul style="list-style-type: none"> • GCS • IPC devices • Venous foot pumps (VFP) • IPC devices or VFP are recommended for any procedure that lasts >1 hr, and for all patients receiving general anesthesia; begin 30–60 min before surgery. • Also consider patient positioning on the operating room table. <ul style="list-style-type: none"> • Flex the patient's knees at 5 degrees <i>or</i> • Reposition the patient's legs at regular intervals throughout a procedure. 	Reinisch et al., 2001; Young & Watson, "The need for," 2006; Michot et al., 2002	D
Chemoprophylaxis		
<ul style="list-style-type: none"> • Use chemoprophylaxis (e.g., LMWH, fondaparinux, idraparinux, direct thrombin inhibitors) in patients undergoing: <ul style="list-style-type: none"> • Abdominoplasty • Circumferential body contouring • Thighplasty • Combined procedures • Procedures lasting >4 hr • Surgery requiring open-space dissection • Transverse rectus abdominus musculocutaneous (TRAM) flap procedures • Surgical procedures likely to contribute to venous stasis or compression • Recognize the increased risk of bruising or hematoma and the possible need for blood transfusion when using chemoprophylaxis; bleeding incidence is strongly associated with dosage. 	Reinisch et al., 2001; Young & Watson, "The need for," 2006; Michot et al., 2002	D
American Society of Anesthesiologists (ASA) status		
<ul style="list-style-type: none"> • Patients categorized as ASA class 1–3 can be considered for ambulatory surgery; however, the setting should be determined by the ASA class, the type of procedure, and the type of anesthesia. 	George et al., 2004; Friedman, Chung, & Wong, 2004; Fortier, Chung, & Su, 1998; Ansell & Montgomery, 2004	B
<ul style="list-style-type: none"> • ASA class 4 patients can be considered for ambulatory surgery; however, the setting is dependent on the type of procedure and type of anesthesia. • Office-based procedures: <ul style="list-style-type: none"> • ASA class 1 and 2 patients are generally considered the best candidates for ambulatory surgery and reasonable candidates for the office-based surgery setting. 	Expert opinion	D
<ul style="list-style-type: none"> • ASA class 3 patients may also be reasonable candidates for office-based surgery facilities when local anesthesia, with or without sedation, is planned and the facility is accredited. • ASA class 4 patients are appropriate candidates for the office-based surgery setting only when local anesthesia without sedation is planned. 	Expert opinion	D
If a free-standing ASC or office-based setting is chosen, it should be accredited with appropriate hospital transfer arrangements.	Expert opinion	D
Management of Physiologic Stresses Associated with Surgical Procedures		
Hypothermia		
<ul style="list-style-type: none"> • General strategies: 	Fossum, Hays, & Henson, 2001; Smith et al., 1998; Agrawal	B

<ul style="list-style-type: none"> • Equip the ambulatory surgery suite so that temperatures can be adequately monitored and adjusted. • Have equipment available (e.g., Bair Huggers [Arizant Healthcare, Inc., Eden Prairie, Minn.]), forced-air warming blankets, intravenous fluid warmers] to warm the patient, as necessary, especially during more extensive procedures. • When no hypothermia prevention measures are available, the procedures performed should be of short duration (1–2 hr) and limited to no more than 20% of the body surface area. • Recommended protocol for hypothermia prevention during general or regional anesthesia: <ul style="list-style-type: none"> • Actively prewarm patients. • Monitor core temperature throughout administration of general and regional anesthesia. • Cover as much body surface area as possible with blankets or drapes to reduce radiant and convective heat loss through the skin. • Actively warm patients intraoperatively with a forced-air heater or resistive-heating blanket to prevent heat loss and add heat content; rearrange covers every time the patient is repositioned to warm as much surface area as possible. • Minimize repositioning time as much as possible so that the active warming method can be quickly continued. • Warm intravenous fluids and/or infiltration fluids if large volumes are used. • Warm incision irrigation fluids. • Aggressively treat postoperative shivering with a forced-air heater or resistive-heating blanket and consider pharmacologic intervention. 	<p>et al., 2003; Cavallini, Baruffaldi Preis, & Casati, 2005; Negishi et al., 2003; Robles-Cervantes, Martinez-Molina, & Cárdenas-Camarena, 2005; Vanni et al., 2003; Ng et al., 2003; Young & Watson, "Prevention," 2006</p>	
Intraoperative blood loss		
<ul style="list-style-type: none"> • Procedures performed on the average-size adult patient in which blood loss >500 cc is anticipated should be performed only in facilities where adequate blood and blood components are readily available. 	Junger et al., 2001	D
Type of anesthesia		
<ul style="list-style-type: none"> • General anesthesia, moderate sedation, and local anesthesia can be used safely in the ambulatory setting. The type of anesthesia administered depends on the invasiveness of the procedure, the health status of the patient, and the preference of the physician and patient. The physician should discuss anesthetic options with the patient and determine the most appropriate regimen. 	George et al., 2004; Fleisher et al., 2007; Perrott et al., 2003; Hoefflin, Bornstein, & Gordon, 2001; Bitar et al., 2003; Ersek, 2004; Shirakami, Teratani, & Fukuda, 2006; Shirakami et al., 2005; Liu, 2004; Marcus et al., 1999; Sungurtekin, Sungurtekin, & Erdem, 2003; Cinnella et al., 2007	B
<ul style="list-style-type: none"> • The ASA and American Association of Oral and Maxillofacial Surgeons (AAOMS) recommends the following measures for patients undergoing deep sedation/general anesthesia: <ul style="list-style-type: none"> • Continuous use of pulse oximetry • Recording of blood pressure every 5 min • Continuous cardiovascular monitoring with an electrocardioscope • Use of supplemental oxygen throughout the anesthesia period • Ventilatory monitoring should include auscultation of breath sounds and <ul style="list-style-type: none"> • ≥1 of the following: <ul style="list-style-type: none"> • Observation of the chest wall • Observation of the reservoir bag • Monitoring the color of skin, nails, mucosa, and the surgical site • Capnography • Additional monitoring should include either auscultation of heart sounds or palpation of peripheral pulses. • Capnography—end tidal carbon dioxide when endotracheal anesthesia or laryngeal mask airway (LMA) is inserted. 	Perrott et al., 2003; American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists, 2002	D
Multiple procedures		
<ul style="list-style-type: none"> • The presumed benefits of combining procedures, particularly liposuction, must be weighed against the possibility of adverse events. 	Stevens, Vath, & Stoker, 2004; Stevens et al., 2006; Kim & Stevenson, 2006; Simon, Thaller, & Nathan, 2006; Stokes &	B

<ul style="list-style-type: none"> Liposuction can be performed safely in the ambulatory setting when performed in accordance with American Society of Plastic Surgeons (ASPS) recommendations to limit the total aspirant (supernatant fat and fluid) to ≤ 5000 cc. Combining large-volume liposuction with certain other procedures (e.g., abdominoplasty) should be avoided because of the possibility of serious complications. 	Williams, 2007; Cárdenas-Camarena, 2005; Cárdenas-Camarena & Paillet, 2007; Stevens et al., 2005	
Duration of procedures		
<ul style="list-style-type: none"> Long procedures should be scheduled sufficiently early in the day to allow for adequate recovery time before discharge. If possible, surgery should be completed by 3 pm to allow adequate time for recovery and discharge. The overall duration of the procedure(s) should ideally be completed within 6 hr. Attention to patient selection, intraoperative management, and postoperative care is of particular importance when procedures of longer duration are to be performed in the ambulatory setting. 	Fleisher, Pasternak, & Lyles, 2007; Mandal et al., 2005; Fortier, Chung, & Su, 1998; Shirakami et al., 2005; Mattila et al., 2005; Gordon & Koch, 2006	B
Preventing unanticipated admission		
<ul style="list-style-type: none"> Control of pain, nausea/vomiting, dizziness, and postoperative bleeding is essential to postoperative recovery and discharge. Pain management should be correlated to BMI and the procedure being performed, and the patient should be sent home with sufficient medication to control pain and with adequate instructions on the use of this medication. Recommendations regarding the duration of procedure(s) also apply. 	Mandal et al., 2005; Fortier, Chung, & Su, 1998; Shirakami et al., 2005; Tham & Koh, 2002	B

Definitions:

Evidence Rating Scale for Studies Reviewed

Level of Evidence	Qualifying Studies
I	High-quality, multi-centered or single-centered, randomized controlled trial with adequate power; or a systematic review of these studies
II	Lesser-quality, randomized controlled trial; prospective cohort study; or a systematic review of these studies
III	Retrospective comparative study; case-control study; or a systematic review of these studies
IV	Case series
V	Expert opinion; case report or clinical example; or evidence based on physiology, bench research, or "first principles"

Scale for Grading Recommendations

Grade	Descriptor	Qualifying Evidence	Implications for Practice
A	Strong Recommendation	Level I evidence or consistent findings from multiple studies of levels II, III, or IV	Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
B	Recommendation	Levels II, III, or IV evidence and findings are generally consistent	Generally, clinicians should follow a recommendation but should remain alert to new information and sensitive to patient preference.
C	Option	Levels II, III, or IV evidence, but findings are inconsistent	Clinicians should be flexible in their decision-making regarding appropriate practice, although they may set bounds on alternatives; patient preference should have a substantial influencing role.
D	Option	Level V; little or no systematic empirical evidence	Clinicians should consider all options in their decision-making and be alert to new published evidence that clarifies the balance of benefit versus harm; patient preference should have a substantial influencing role.

Clinical Algorithm(s)

None provided


Evidence Supporting the Recommendations

References Supporting the Recommendations


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
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Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate patient selection and improved patient safety in the ambulatory surgery setting

Potential Harms

Risks inherent with ambulatory surgery, which can be minimized through appropriate patient selection and adherence to recommended practices

Qualifying Statements

Qualifying Statements

- Practice advisories are strategies for patient management, developed to assist physicians in clinical decision-making. This practice advisory, based on a thorough evaluation of the present scientific literature and relevant clinical experience, describes a range of generally acceptable approaches to diagnosis, management, or prevention of specific diseases or conditions. This practice advisory attempts to define principles of practice that should generally meet the needs of most patients in most circumstances. However, this practice advisory should not be construed as a rule, nor should it be deemed inclusive of all proper methods of care or exclusive of other methods of care reasonably directed at obtaining the appropriate results. It is anticipated that it will be necessary to approach some patients' needs in different ways. The ultimate judgment regarding the care of a particular patient must be made by the physician in light of all the circumstances presented by the patient, the diagnostic and treatment options available, and available resources.
- This practice advisory is not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all the facts or circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance, and as practice patterns evolve. This practice advisory reflects the state of knowledge current at the time of publication. Given the inevitable changes in the state of scientific information and technology, periodic review and revision will be necessary.

Appendix B
Equipment List

#	Description	Manufacturer	Model	ItemQty	Unit Cost	Ext. Cost
1	50 MB circuit	GCI	TBD	1	\$ 1,000	\$ 1,000
2	50 MB circuit	ACS	TBD	1	\$ 1,000	\$ 1,000
3	Allowance, Furniture	To Be Determined	TBD	1	\$ 5,000	\$ 5,000
4	Allowance, Furniture	To Be Determined	TBD	1	\$ 7,500	\$ 7,500
5	Allowance, Furniture	To Be Determined	TBD	1	\$ 5,000	\$ 5,000
6	Analyzer, Lab, Blood Gas, Point-of-Care	Abbott Point of Care Inc	I-STAT 1	2	\$ 10,450	\$ 20,900
7	Anesthesia Machine, General	GE Healthcare - Datex-Ohmeda	Aisys Carestation	2	\$ 75,000	\$ 150,000
8	Anesthesia Machine, General	GE Healthcare - Datex-Ohmeda	Aisys Carestation	1	\$ 75,000	\$ 75,000
9	Artwork, Digital/Video, Allowance	Unspecified	TBD	1	\$ 10,000	\$ 10,000
10	Artwork, Digital/Video, Allowance	Unspecified	TBD	1	\$ 10,000	\$ 10,000
11	Artwork, Digital/Video, Allowance	Unspecified	TBD	2	\$ 10,000	\$ 20,000
12	Artwork, Digital/Video, Allowance	Unspecified	TBD	1	\$ 10,000	\$ 10,000
13	Artwork, Digital/Video, Allowance	Unspecified	TBD	1	\$ 10,000	\$ 10,000
14	Artwork, Illuminated, Virtual Skylight	Unspecified	TBD	3	\$ 7,360	\$ 22,080
15	Boom, Anesthesia	Stryker Communications	1000/1000mm Fixed w/600mm Service Head	2	\$ 26,000	\$ 52,000
16	Boom, Equipment, Dual Arm	Unspecified	TBD	2	\$ 22,500	\$ 45,000
17	Cabinet, OR Console, Supply	InnerSpace - Datel	514818DAS Stainless Steel	6	\$ 3,754	\$ 22,524
18	Cabinet, Warming, Dual, Freestanding	Blickman Inc.	7924TG (Glass Door)	2	\$ 10,728	\$ 21,456
19	Cart, Case, Medium (40-49in wide)	Pedigo Products	TBD	2	\$ 4,399	\$ 8,798
20	Cart, Case, Medium (40-49in wide)	Pedigo Products	Surgical case cart (Tall 2 door, 2 shelf)	1	\$ 4,905	\$ 4,905
21	Cart, Case, Medium (40-49in wide)	Pedigo Products	Surgical case cart (Tall 2 door, 2 shelf)	5	\$ 4,905	\$ 24,525
22	Cart, Medication, Large	Harloff Company, Inc.	SL294BOX	1	\$ 3,339	\$ 3,339
23	Cart, Procedure, Malignant Hyperthermia	Harloff Company, Inc.	6641 Specialty Pkg	1	\$ 3,065	\$ 3,065
24	Cart, Procedure, Resuscitation	Harloff Company, Inc.	6411 Super-Stat	2	\$ 3,149	\$ 6,298
25	Casework, Base Cabinet w/Sink	Unspecified	TBD	2	\$ 5,035	\$ 10,070
26	Casework, Base Cabinet w/Sink	Unspecified	TBD	1	\$ 5,035	\$ 5,035
27	Casework, Base Cabinet w/Sink	Unspecified	TBD	1	\$ 5,035	\$ 5,035
28	Casework, Base/Wall Combo	Unspecified	TBD	1	\$ 3,435	\$ 3,435
29	CCTV Allowance	Unspecified	TBD	1	\$ 150,000	\$ 150,000
30	Chair, Clinical, Recliner, Treatment	Stryker Medical	Symmetry Plus	3	\$ 2,649	\$ 7,947
31	Chair, Interiors, Lounge, Bariatric	Unspecified	TBD	1	\$ 2,686	\$ 2,686
32	Compression Unit, Extremity Pump, Intermittent	Covidien - Kendall Products	SCD Express	2	\$ 3,200	\$ 6,400
33	Computer room equipment rack	Unspecified	TBD	1	\$ 1,500	\$ 1,500
34	Computer, Laptop	Hewlett-Packard	TBD	1	\$ 2,500	\$ 2,500
35	Defibrillator, Manual	Zoll Medical Corporation	M Series - Basic	1	\$ 10,545	\$ 10,545
36	Desk, Office, Executive	Unspecified	TBD	1	\$ 3,069	\$ 3,069
37	Desktop PCs	HP	TBD	22	\$ 2,365	\$ 52,038
38	DHCP server	HP	TBD	1	\$ 6,900	\$ 6,900
39	Document scanners	Fujitsu	TBD	3	\$ 1,159	\$ 3,477
40	Electrosurgical Unit, Bipolar	Covidien - Valleylab Div	Force FX C	2	\$ 15,808	\$ 31,616
41	Estimated cost for phones	Unspecified	TBD	1	\$ 3,801	\$ 3,801
42	File server plus storage	HP	TBD	1	\$ 31,050	\$ 31,050
43	Freezer, Laboratory, 1 door	Helmer, Inc.	Horizon HLF125	1	\$ 7,086	\$ 7,086
44	Headlight, w/ Light Source	Welch Allyn, Inc. - Med Division	ProXenon 350 System(8 ft fiber, CoolVent Headbar)	2	\$ 7,445	\$ 14,890
45	Hypo-Hyperthermia Unit, General	Cincinnati Sub-Zero Products Inc.	Blanketrol III	1	\$ 12,640	\$ 12,640
46	Ice Machine, Dispenser, Flaker, Countertop	Scotsman Ice Systems	MDT4F12	1	\$ 7,702	\$ 7,702
47	Ice Machine, Modular w/Bin, Flaker	Scotsman Ice Systems	F0522A-1A/ B222S	1	\$ 7,681	\$ 7,681
48	Instruments, Surgical, Orthopedics, Allowance	Unspecified	TBD	2	\$ 271,779	\$ 543,558
49	Insufflator, CO2	Unspecified	TBD	1	\$ 13,394	\$ 13,394
50	Integration System, Surgical, Allowance	Unspecified	TBD	2	\$ 60,000	\$ 120,000
51	Laser, Surgical, CO2	Unspecified	TBD	1	\$ 132,650	\$ 132,650
52	Light, Surgical, Dual, Ceiling	Stryker Communications	Visum LED (Camera Ready)	2	\$ 50,127	\$ 100,254
53	Medication barcode scanner	Unspecified	TBD	15	\$ 727	\$ 10,901
54	Monitor, Physiologic, Anesthesia	GE Healthcare - Datex-Ohmeda	S/5 Anesthesia Monitor	2	\$ 36,000	\$ 72,000
55	Monitor, Physiologic, Anesthesia	GE Healthcare - Datex-Ohmeda	S/5 Anesthesia Monitor	1	\$ 36,000	\$ 36,000
56	Monitor, Physiologic, Portable	GE Healthcare - Monitoring Systems	DASH 2000 Pro	3	\$ 5,425	\$ 16,275
57	Monitor, Physiologic, Portable	GE Healthcare - Monitoring Systems	DASH 2000 Pro	4	\$ 5,425	\$ 21,700
58	Monitor, Physiologic, Transcutaneous, O2 / CO2	Radiometer America Inc	TCM4	2	\$ 19,427	\$ 38,854
59	Monitor, Physiologic, Vital Signs, w/Stand	Welch Allyn, Inc. - Med Division	Spot 42NTB-E1-M (NIBP, SpO2, Temp, Stand)	2	\$ 2,655	\$ 5,310
60	Monitor, Video, LCD, Display	TBD	TBD	1	\$ 5,000	\$ 5,000
61	Multifunction printers	Xerox	TBD	3	\$ 2,918	\$ 8,754
62	Navigation System, Surgical, Image Guided	Unspecified	TBD	2	\$ 116,700	\$ 233,400
63	Network equipment set-up	Unspecified	TBD	1	\$ 4,000	\$ 4,000
64	Network Provisioning	Unspecified	TBD	1	\$ 22,500	\$ 22,500
65	Network Router at ASC location	Unspecified	TBD	1	\$ 14,375	\$ 14,375
66	Network Routers at PAMC location and Port Adapters	Unspecified	TBD	1	\$ 57,000	\$ 57,000
67	Network Switches, WS-C3750V2-48PS-S, GLC-T	Unspecified	TBD	4	\$ 5,175	\$ 20,700
68	Nurse Call, Allowance	Unspecified	TBD	1	\$ 200,000	\$ 200,000
69	Oximeter, Pulse	Covidien - Nellcor Division	OxiMax N-600 w/Durasensor Sensor	2	\$ 4,500	\$ 9,000
70	Oximeter, Pulse	Covidien - Nellcor Division	OxiMax N-600 w/Durasensor Sensor	1	\$ 4,500	\$ 4,500
71	Pass-thru, Window Assembly	STERIS Corporation	444 Rack Return Passthrough [FD241]	1	\$ 7,501	\$ 7,501
72	Pass-thru, Window Assembly	STERIS Corporation	444 Rack Return Passthrough [FD241]	1	\$ 7,501	\$ 7,501
73	Power Mic for Dragon	Unspecified	TBD	4	\$ 575	\$ 2,300
74	Pump, Infusion, Dual	CareFusion - Alaris	Alaris SE Dual	1	\$ 4,250	\$ 4,250
75	Pump, Infusion, PCA	Hospira, Inc.	TBD	2	\$ 4,125	\$ 8,250
76	Pump, Infusion, Syringe	Smiths Medical	Medfusion 3500	1	\$ 5,695	\$ 5,695
77	Pyxis MedStation	Unspecified	TBD	1	\$ 2,000	\$ 2,000
78	Pyxis Supply Station	Unspecified	TBD	1	\$ 2,000	\$ 2,000
79	Radiology Reading Workstation with PACS & monitor	Unspecified	TBD	1	\$ 15,550	\$ 15,550
80	Radiology Reading workstation with PC/24" & monitor	Unspecified	TBD	2	\$ 5,775	\$ 11,550

#	Description	Manufacturer	Model	ItemQty	Unit Cost	Ext. Cost
81	Refrigerator, Blood Bank, 1 door	Helmer, Inc.	Horizon HB125	1	\$ 7,628	\$ 7,628
82	Refrigerator, Laboratory, w/ Freezer	Fisher Scientific Company	Isotemp Value 18.2 cuft (13-986-106A)	1	\$ 2,882	\$ 2,882
83	Safe, Lead Lined	Unspecified	TBD	1	\$ 6,500	\$ 6,500
84	Scale, Clinical, Adult, Wheelchair	Detecto Scale- Div.Cardinal Scale Mfg	6550 Folding (w/ AC adapter)	1	\$ 3,571	\$ 3,571
85	Seating, Lounge, 5-Seat	Unspecified	TBD	4	\$ 6,056	\$ 24,224
86	Server for Supply station	Unspecified	TBD	1	\$ 7,900	\$ 7,900
87	Server for the Medstation	Unspecified	TBD	1	\$ 7,900	\$ 7,900
88	Server Set-up	Unspecified	TBD	1	\$ 4,000	\$ 4,000
89	Shield, Lead, Mobile	Infab Corporation	683460 Standard	1	\$ 3,622	\$ 3,622
90	Signage, Digital, Allowance	Unspecified	TBD	1	\$ 28,000	\$ 28,000
91	Signature pads (15)	Unspecified	TBD	15	\$ 424	\$ 6,365
92	Sink, Clean-up Workstation (2-sink)	STERIS Corporation	2-Sink (96", L-R, No Ends, Painted Base)	1	\$ 9,199	\$ 9,199
93	Sink, Scrub, 2-Bay, Stainless Steel	STERIS Corporation	Flexmatic w/Infrared Sensor	2	\$ 12,162	\$ 24,324
94	Sink, Utility, 1-Compartment	Unspecified	TBD	1	\$ 2,996	\$ 2,996
95	Smoke Evacuation, Surgical	Covidien - Valleylab Div	RapidVac	2	\$ 3,950	\$ 7,900
96	Software, Asset Management, Instrument Tracking	Unspecified	TBD	1	\$ 300,000	\$ 300,000
97	station phone switch	Cerium	TBD	1	\$ 23,711	\$ 23,711
98	Sterilizer, Steam (Electric), Cabinet	STERIS Corporation	Amsco 400 20x20x38 Cabinet 480V	1	\$ 81,055	\$ 81,055
99	Sterilizer, Steam (Electric), Cabinet	STERIS Corporation	Amsco 400 20x20x38 Cabinet 480V	1	\$ 81,055	\$ 81,055
100	Storage Set-up	Unspecified	TBD	1	\$ 2,400	\$ 2,400
101	Stretcher, Procedure / Recovery	Stryker Medical	Prime w/Big Wheel 1115 (26" Litter)	3	\$ 5,848	\$ 17,544
102	Stretcher, Procedure / Recovery	Stryker Medical	Prime w/Big Wheel 1115 (26" Litter)	4	\$ 5,848	\$ 23,392
103	Stretcher, Transport	Stryker Medical	Transport 738 (30" Litter) ST104	2	\$ 3,637	\$ 7,274
104	Table, Surgical, Major	STERIS Corporation	Steris 5085 SRT	2	\$ 81,538	\$ 163,076
105	Table, Surgical, Spinal	Mizuho OSI	Axis Jackson System	1	\$ 148,815	\$ 148,815
106	Tourniquet System, General	Stryker Instruments	SmartPump Dual Channel w/ Stand	1	\$ 19,490	\$ 19,490
107	UPS for Server network and storage equipment	Unspecified	TBD	1	\$ 2,990	\$ 2,990
108	Warmer, Fluid/ Blood, Portable	Smiths Medical - Level 1 Inc.	H-1200 Fast Flow w/ Air Detector Clamp	2	\$ 10,000	\$ 20,000
109	Warmer, Fluid/ Blood, Portable	Smiths Medical - Level 1 Inc.	H-1200 Fast Flow w/ Air Detector Clamp	1	\$ 10,000	\$ 10,000
110	Waste Disposal, Surgical Fluid Collection	Stryker Instruments	Neptune 2 Ultra Rover	2	\$ 25,929	\$ 51,858
111	X-Ray Unit, C-Arm, Mobile	GE Healthcare Surgery OEC	OEC 9900 PMCare 8fps (Super C-Arm)	1	\$ 194,000	\$ 194,000
	Total					\$ 3,976,886

Appendix C
AHA Hospital Statistics



American Hospital
Association

2010
E D I T I O N

The comprehensive
reference source for
analysis and comparison
of hospital trends

AHA Hospital StatisticsTM

TABLE 6

ALASKA

U.S. Registered Community Hospitals
(Nonfederal, short-term general and other special hospitals)

Overview 2004–2008

	2008	2007	2006	2005	2004
Total Community Hospitals in Alaska	22	22	22	22	19
Bed Size Category					
6-24	6	6	7	7	5
25-49	7	7	7	8	8
50-99	4	4	4	3	2
100-199	3	3	2	3	2
200-299	1	1	1	0	1
300-399	1	1	1	1	1
400-499	0	0	0	0	0
500 +	0	0	0	0	0
Location					
Hospitals Urban	5	5	5	5	3
Hospitals Rural	17	17	17	17	16
Control					
State and Local Government	7	7	7	7	7
Not for Profit	13	13	13	13	10
Investor owned	2	2	2	2	2
Physician Models					
Independent Practice Association	0	2	2	1	2
Group Practice without Walls	0	0	1	1	3
Open Physician-Hospital Organization	2	3	2	1	1
Closed Physician-Hospital Organization	0	0	0	1	0
Management Service Organization	0	0	0	0	0
Integrated Salary Model	4	4	6	6	2
Equity Model	0	0	0	0	0
Foundation	0	0	1	1	0
Insurance Products					
Health Maintenance Organization	0	0	0	0	0
Preferred Provider Organization	2	3	2	3	1
Indemnity Fee for Service	1	0	0	0	0
Managed Care Contracts					
Health Maintenance Organization	0	0	0	0	0
Preferred Provider Organization	8	9	8	6	4
Affiliations					
Hospitals in a System	8	8	8	8	12
Hospitals in a Network	3	4	4	4	4
Hospitals in a Group Purchasing Organization ..	11	11	13	11	6

TABLE 6

ALASKA

U.S. Registered Community Hospitals
(Nonfederal, short-term general and other special hospitals)

Utilization, Personnel, Revenue and Expenses, Community Health Indicators 2004–2008

	2008	2007	2006	2005	2004
TOTAL FACILITY (Includes Hospital and Nursing Home Units)					
Utilization - Inpatient					
Beds	1,553	1,554	1,551	1,393	1,427
Admissions	58,204	56,584	52,357	51,022	45,359
Inpatient Days	346,837	337,028	304,978	306,027	285,999
Average Length of Stay	6.0	6.0	5.8	6.0	6.3
Inpatient Surgeries	20,522	18,924	26,787	18,091	27,473
Births	8,882	9,047	9,128	8,554	7,366
Utilization - Outpatient					
Emergency Outpatient Visits	328,164	328,947	610,324	326,528	253,405
Other Outpatient Visits	1,365,178	1,455,616	1,165,596	1,340,089	1,077,327
Total Outpatient Visits	1,693,342	1,784,563	1,775,920	1,666,617	1,330,732
Outpatient Surgeries	43,567	44,193	34,522	41,155	44,071
Personnel					
Full Time RNs	2,090	2,091	2,071	2,135	1,583
Full Time LPNs	163	197	191	222	184
Part Time RNs	848	512	826	702	509
Part Time LPNs	48	45	56	55	58
Total Full Time	8,809	8,712	8,668	8,299	6,191
Total Part Time	2,435	1,661	2,304	2,031	1,532
Revenue - Inpatient					
Gross Inpatient Revenue	\$2,045,394,009	\$1,688,213,313	\$1,619,128,443	\$1,503,737,136	\$1,338,181,466
Revenue - Outpatient					
Gross Outpatient Revenue	\$1,623,182,947	\$1,379,909,276	\$1,283,765,424	\$1,156,015,492	\$971,620,399
Revenue and Expenses - Totals (Includes Inpatient and Outpatient)					
Total Gross Revenue	\$3,668,576,956	\$3,068,122,589	\$2,902,893,867	\$2,659,752,628	\$2,309,801,865
Deductions from Revenue	2,054,343,109	1,623,832,318	1,529,429,013	1,433,497,046	1,302,835,817
Net Patient Revenue	1,614,233,847	1,444,290,271	1,373,464,854	1,226,255,582	1,006,966,048
Other Operating Revenue	66,832,290	78,687,582	73,602,633	53,752,321	43,170,801
Other Nonoperating Revenue	16,635,452	41,367,990	27,681,282	18,810,420	13,685,375
Total Net Revenue	1,697,701,589	1,564,345,843	1,474,748,769	1,298,818,323	1,063,822,224
Total Expenses	1,570,873,845	1,458,281,758	1,424,479,572	1,281,505,051	1,053,847,164
HOSPITAL UNIT (Excludes Separate Nursing Home Units)					
Utilization - Inpatient					
Beds	1,381	1,280	1,359	1,268	1,344
Admissions	58,081	56,310	51,957	50,773	45,140
Inpatient Days	293,939	252,315	242,591	270,302	261,976
Average Length of Stay	5.1	4.5	4.7	5.3	5.8
Personnel					
Total Full Time	8,712	8,469	8,483	8,182	6,115
Total Part Time	2,350	1,546	2,203	1,969	1,486
Revenue and Expenses - Totals (Includes Inpatient and Outpatient)					
Total Net Revenue	\$1,678,203,874	\$1,502,363,012	\$1,446,879,893	\$1,283,490,046	\$1,055,506,617
Total Expenses	1,560,050,288	1,432,798,379	1,402,317,116	1,272,419,936	1,048,048,983
COMMUNITY HEALTH INDICATORS PER 1000 POPULATION					
Total Population (in thousands)	686	681	676	669	661
Inpatient					
Beds	2.3	2.3	2.3	2.1	2.2
Admissions	84.8	83.1	77.4	76.3	68.6
Inpatient Days	505.4	494.8	451.0	457.7	432.7
Inpatient Surgeries	29.9	27.8	39.6	27.1	41.6
Births	12.9	13.3	13.5	12.8	11.1
Outpatient					
Emergency Outpatient Visits	478.2	483.0	902.4	488.4	383.4
Other Outpatient Visits	1,989.2	2,137.1	1,723.5	2,004.2	1,629.9
Total Outpatient Visits	2,467.4	2,620.1	2,625.9	2,492.6	2,013.3
Outpatient Surgeries	63.5	64.9	51.0	61.6	66.7
Expense per Capita (per person)	\$2,288.9	\$2,141.0	\$2,106.3	\$1,916.6	\$1,594.4

2008 Facilities and Services in the U.S. Census Divisions and States

These data include only hospital-based facilities and services as reported by responding hospitals in Section C of the 2008 AHA Annual Survey, beginning on page 215. All hospitals are represented with Community Hospitals listed separately under United States. No estimates have been made for nonresponding hospitals. Definitions of facilities and services are listed in the Glossary, page 201.

Table

7

CLASSIFICATION	HOSPITALS REPORTING	GENERAL MEDICAL SURGICAL CARE				OBSTETRICS INPATIENT CARE		NEONATAL INTERMEDIATE CARE		INTENSIVE CARE									
		ADULT		PEDIATRIC						NEONATAL		PEDIATRIC		CARDIAC		MEDICAL SURGICAL		OTHER	
		UNITS		UNITS		UNITS		UNITS		UNITS		UNITS		UNITS		UNITS		UNITS	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
UNITED STATES	4,862	4,158	85.5	2,136	43.9	2,751	56.6	733	15.1	963	19.8	466	9.6	1,449	29.8	3,064	63.0	530	10.9
COMMUNITY HOSPITALS	4,186	3,905	93.3	2,084	49.8	2,714	64.8	724	17.3	948	22.6	458	10.9	1,397	33.4	2,941	70.3	511	12.2
CENSUS DIVISION 1, NEW ENGLAND	210	175	83.3	115	54.8	136	64.8	28	13.3	38	18.1	18	8.6	65	31.0	160	76.2	15	7.1
Connecticut	33	27	81.8	20	60.6	26	78.8	4	12.1	13	39.4	2	6.1	15	45.5	28	78.8	0	0.0
Maine	38	33	86.8	4	10.5	27	71.1	4	10.5	4	10.5	4	10.5	6	15.8	30	78.9	6	15.8
Massachusetts	81	64	79.0	47	58.0	44	54.3	15	18.5	15	18.5	7	8.6	28	34.6	58	71.6	4	4.9
New Hampshire	30	26	86.7	18	60.0	23	76.7	2	6.7	4	13.3	3	10.0	7	23.3	25	83.3	3	10.0
Rhode Island	13	11	84.6	5	38.5	6	46.2	1	7.7	1	7.7	1	7.7	4	30.8	10	76.9	2	15.4
Vermont	15	14	93.3	7	46.7	10	66.7	2	13.3	1	6.7	1	6.7	5	33.3	11	73.3	0	0.0
CENSUS DIVISION 2, MIDDLE ATLANTIC	398	343	86.2	217	54.5	252	63.3	120	30.2	116	29.1	58	14.6	188	47.2	311	78.1	60	15.1
New Jersey	73	61	83.6	49	67.1	51	69.9	43	58.9	25	34.2	17	23.3	43	58.9	61	83.6	10	13.7
New York	157	143	91.1	97	61.8	106	67.5	52	33.1	50	31.8	34	21.7	82	52.2	128	81.5	26	16.6
Pennsylvania	168	139	82.7	71	42.3	95	56.5	25	14.9	41	24.4	7	4.2	63	37.5	122	72.6	24	14.3
CENSUS DIVISION 3, SOUTH ATLANTIC	678	582	85.8	310	45.7	391	57.7	142	20.9	154	22.7	73	10.8	230	33.9	499	73.6	109	16.1
Delaware	8	5	62.5	4	50.0	5	62.5	2	25.0	3	37.5	3	37.5	4	50.0	5	62.5	2	25.0
District of Columbia	13	8	61.5	4	30.8	7	53.8	3	23.1	6	46.2	3	23.1	7	53.8	8	61.5	1	7.7
Florida	142	128	90.1	58	40.8	82	57.7	23	16.2	44	31.0	25	17.6	58	40.8	119	83.8	16	11.3
Georgia	122	105	86.1	44	36.1	64	52.5	35	28.7	28	23.0	7	5.7	32	26.2	80	65.6	18	14.8
Maryland	59	49	83.1	36	61.0	34	57.6	8	13.6	15	25.4	6	10.2	25	42.4	47	79.7	7	11.9
North Carolina	121	110	90.9	59	48.8	81	66.9	34	28.1	27	22.3	15	12.4	37	30.6	91	75.2	20	16.5
South Carolina	80	62	77.5	47	58.8	43	53.8	26	32.5	8	10.0	6	7.5	28	35.0	53	66.3	33	41.3
Virginia	70	62	88.6	31	44.3	46	65.7	9	12.9	19	27.1	5	7.1	19	27.1	61	87.1	8	11.4
West Virginia	63	53	84.1	27	42.9	29	46.0	2	3.2	4	6.3	3	4.8	20	31.7	35	55.6	4	6.3
CENSUS DIVISION 4, EAST NORTH CENTRAL	753	662	87.9	408	54.2	482	64.0	93	12.4	134	17.8	85	11.3	261	34.7	526	69.9	126	16.7
Illinois	173	155	89.6	103	59.5	112	64.7	35	20.2	30	17.3	21	12.1	47	27.2	123	71.1	11	6.4
Indiana	121	106	87.6	60	49.6	86	71.1	14	11.6	21	17.4	9	7.4	32	26.4	89	73.6	9	7.4
Michigan	158	136	86.1	77	48.7	88	55.7	14	8.9	23	14.6	11	7.0	48	30.4	102	64.6	13	8.2
Ohio	159	144	90.6	68	42.8	104	65.4	30	18.9	35	22.0	14	8.8	61	38.4	129	81.1	22	13.8
Wisconsin	142	121	85.2	100	70.4	92	64.8	0	0.0	25	17.6	30	21.1	73	51.4	83	58.5	71	50.0
CENSUS DIVISION 5, EAST SOUTH CENTRAL	424	374	88.2	177	41.7	190	44.8	67	15.8	62	14.6	39	9.2	127	30.0	239	56.4	45	10.6
Alabama	104	92	88.5	32	30.8	50	48.1	7	6.7	16	15.4	8	7.7	30	28.8	67	64.4	15	14.4
Kentucky	100	85	85.0	39	39.0	46	46.0	18	18.0	13	13.0	5	5.0	28	28.0	60	60.0	23	23.0
Mississippi	109	102	93.6	72	66.1	44	40.4	28	25.7	14	12.8	16	14.7	42	38.5	46	42.2	4	3.7
Tennessee	111	95	85.6	34	30.6	50	45.0	14	12.6	19	17.1	10	9.0	27	24.3	66	59.5	15	13.5
CENSUS DIVISION 6, WEST NORTH CENTRAL	683	624	91.3	300	43.9	380	55.8	76	11.0	85	12.3	48	6.9	149	21.5	352	51.5	48	6.9
Iowa	125	120	96.0	62	49.6	80	64.0	13	10.4	19	15.2	12	9.6	24	19.2	78	60.8	9	7.2
Kansas	153	139	90.8	45	29.4	71	46.4	13	8.5	13	8.5	7	4.6	14	9.2	52	34.0	5	3.3
Minnesota	116	101	87.1	62	53.4	84	72.4	7	6.0	14	12.1	10	8.6	31	26.7	66	56.9	7	6.0
Missouri	149	119	79.9	78	52.3	74	49.7	29	19.5	20	13.4	8	5.4	41	27.5	89	59.7	15	10.1
Nebraska	65	62	95.4	23	35.4	37	56.9	5	7.7	8	12.3	2	3.1	18	27.7	27	41.5	5	7.7
North Dakota	31	30	96.8	14	45.2	13	41.9	5	16.1	6	19.4	4	12.9	10	32.3	18	58.1	3	9.7
South Dakota	54	53	98.1	16	29.6	21	38.9	4	7.4	5	9.3	5	9.3	11	20.4	24	44.4	4	7.4
CENSUS DIVISION 7, WEST SOUTH CENTRAL	852	642	75.4	269	31.6	370	43.4	99	11.6	147	17.3	62	7.3	182	19.0	406	47.7	51	6.0
Arkansas	98	74	75.5	29	29.6	45	45.9	10	10.2	10	10.2	3	3.1	29	29.6	46	46.9	4	4.1
Louisiana	96	78	81.3	42	43.8	44	45.8	11	11.5	30	31.3	14	14.6	24	25.0	60	62.5	5	5.2
Oklahoma	116	101	87.1	30	25.9	53	45.7	3	2.6	9	7.8	5	4.3	18	15.5	47	40.5	7	6.0
Texas	542	389	71.8	168	31.0	228	42.1	75	13.8	98	18.1	40	7.4	91	16.8	253	46.7	35	6.5
CENSUS DIVISION 8, MOUNTAIN	347	307	88.5	140	40.3	212	61.1	47	13.5	71	20.5	33	9.5	82	23.6	197	56.8	28	8.1
Arizona	59	49	83.1	24	40.7	36	61.0	12	20.3	12	20.3	7	11.9	26	44.1	41	69.5	3	5.1
Colorado	66	62	93.9	32	48.5	46	69.7	10	15.2	23	34.8	6	9.1	15	22.7	44	66.7	8	12.1
Idaho	34	31	91.2	13	38.2	20	58.8	2	5.9	5	14.7	3	8.8	7	20.6	15	44.1	3	8.8
Montana	59	57	96.6	21	35.6	28	47.5	4	6.8	7	11.9	4	6.8	12	20.3	22	37.3	3	5.1
Nevada	29	21	72.4	9	31.0	15	51.7	4	13.8	6	20.7	4	13.8	6	20.7	16	55.2	4	13.8
New Mexico	36	29	80.6	13	36.1	21	58.3	5	13.9	2	5.6	2	5.6	5	13.9	20	55.6	2	5.6
Utah	33	29	87.9	18	54.5	26	78.8	8	24.2	16	48.5	6	18.2	11	33.3	19	57.6	4	12.1
Wyoming	31	29	93.5	10	32.3	20	64.5	2	6.5	0	0.0	1	3.2	0	0.0	20	64.5	1	3.2
CENSUS DIVISION 9, PACIFIC	507	449	88.6	200	39.4	338	66.7	61	12.0	156	30.8	50	9.9	185	36.5	374	73.8	48	9.5
Alaska	14	12	85.7	5	35.7	9	64.3	2	14.3	3	21.4	2	14.3	2	14.3	10	71.4	0	0.0
California	334	291	87.1	132	39.5	214	64.1	38	11.4	131	39.2	40	12.0	139	41.6	252	75.4	35	10.5
Hawaii	20	16	80.0	2	10.0	10	50.0	1	5.0	0	0.0	0	0.0	5	25.0	13	65.0	0	0.0
Oregon	57	57	100.0	24	42.1	52	91.2	6	10.5	8	14.0	2	3.5	18	31.6	49	86.0	4	7.0
Washington	82	73	89.0	37	45.1	53	64.6	14	17.1	14	17.1	6	7.3	21	25.6	50	61.0	9	11.0



American Hospital
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2012
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AHA Hospital StatisticsTM



**The comprehensive reference for analysis and
comparison of hospital trends**

TABLE 6

ALASKA

*U.S. Registered Community Hospitals
(Nonfederal, short-term general and other special hospitals)*

Overview 2006–2010

	2010	2009	2008	2007	2006
Total Community Hospitals in Alaska	22	22	22	22	22
Bed Size Category					
6-24	6	6	6	6	7
25-49	7	8	7	7	7
50-99	4	3	4	4	4
100-199	3	3	3	3	2
200-299	1	1	1	1	1
300-399	1	1	1	1	1
400-499	0	0	0	0	0
500 +	0	0	0	0	0
Location					
Hospitals Urban	5	5	5	5	3
Hospitals Rural	17	17	17	17	19
Control					
State and Local Government	7	6	7	7	7
Not for Profit	13	14	13	13	13
Investor owned	2	2	2	2	2
Physician Models					
Independent Practice Association	1	0	0	2	2
Group Practice without Walls	0	0	0	0	1
Open Physician-Hospital Organization	2	2	2	3	2
Closed Physician-Hospital Organization	1	1	0	0	0
Management Service Organization	0	1	0	0	0
Integrated Salary Model	4	3	4	4	6
Equity Model	0	0	0	0	0
Foundation	0	0	0	0	1
Insurance Products					
Health Maintenance Organization	0	0	0	0	0
Preferred Provider Organization	1	2	2	3	2
Indemnity Fee for Service	0	0	1	0	0
Managed Care Contracts					
Health Maintenance Organization	0	0	0	0	0
Preferred Provider Organization	5	7	8	9	8
Affiliations					
Hospitals in a System	9	8	8	8	8
Hospitals in a Network	3	5	3	4	4
Hospitals in a Group Purchasing Organization ..	8	12	11	11	13

TABLE 6

ALASKA

U.S. Registered Community Hospitals
(Nonfederal, short-term general and other special hospitals)

Utilization, Personnel, Revenue and Expenses, Community Health Indicators 2006–2010

	2010	2009	2008	2007	2006
TOTAL FACILITY (Includes Hospital and Nursing Home Units)					
Utilization - Inpatient					
Beds	1,543	1,532	1,553	1,554	1,551
Admissions	57,005	57,227	58,204	56,584	52,357
Inpatient Days	342,960	338,547	346,837	337,028	304,978
Average Length of Stay	6.0	5.9	6.0	6.0	5.8
Inpatient Surgeries	17,999	20,294	20,522	18,924	26,787
Births	8,919	9,358	8,882	9,047	9,128
Utilization - Outpatient					
Emergency Outpatient Visits	296,573	296,524	328,164	328,947	610,324
Other Outpatient Visits	1,486,369	1,470,894	1,365,178	1,455,616	1,165,596
Total Outpatient Visits	1,782,942	1,767,418	1,693,342	1,784,563	1,775,920
Outpatient Surgeries	47,417	50,469	43,567	44,193	34,522
Personnel					
Full Time RNs	2,238	2,348	2,090	2,091	2,071
Full Time LPNs	178	163	163	197	191
Part Time RNs	906	816	848	512	826
Part Time LPNs	28	27	48	45	56
Total Full Time	9,608	9,421	8,809	8,712	8,668
Total Part Time	2,584	2,125	2,435	1,661	2,304
Revenue - Inpatient					
Gross Inpatient Revenue	\$2,340,223,028	\$1,920,419,380	\$2,045,394,009	\$1,688,213,313	\$1,619,128,443
Revenue - Outpatient					
Gross Outpatient Revenue	\$2,263,620,240	\$1,956,296,065	\$1,623,182,947	\$1,379,909,276	\$1,283,765,424
Revenue and Expenses - Totals (Includes Inpatient and Outpatient)					
Total Gross Revenue	\$4,603,843,268	\$3,876,715,445	\$3,668,576,956	\$3,068,122,589	\$2,902,893,867
Deductions from Revenue	2,836,623,088	2,198,399,661	2,054,343,109	1,623,832,318	1,529,429,013
Net Patient Revenue	1,767,220,180	1,678,315,784	1,614,233,847	1,444,290,271	1,373,464,854
Other Operating Revenue	146,570,128	65,784,620	66,832,290	78,687,582	73,602,633
Other Nonoperating Revenue	21,027,327	18,948,295	16,635,452	41,367,990	27,681,282
Total Net Revenue	1,934,817,635	1,763,048,699	1,697,701,589	1,564,345,843	1,474,748,769
Total Expenses	1,590,214,704	1,753,736,940	1,570,873,845	1,458,281,758	1,424,479,572
HOSPITAL UNIT (Excludes Separate Nursing Home Units)					
Utilization - Inpatient					
Beds	1,334	1,300	1,381	1,280	1,359
Admissions	56,797	56,918	58,081	56,310	51,957
Inpatient Days	275,518	263,515	293,939	252,315	242,591
Average Length of Stay	4.9	4.6	5.1	4.5	4.7
Personnel					
Total Full Time	9,428	9,174	8,712	8,469	8,483
Total Part Time	2,443	1,990	2,350	1,546	2,203
Revenue and Expenses - Totals (Includes Inpatient and Outpatient)					
Total Net Revenue	\$1,900,578,038	\$1,724,497,539	\$1,678,203,874	\$1,502,363,012	\$1,446,879,893
Total Expenses	1,564,596,210	1,726,965,040	1,560,050,288	1,432,798,379	1,402,317,116
COMMUNITY HEALTH INDICATORS PER 1000 POPULATION					
Total Population (in thousands)	709	698	688	682	677
Inpatient					
Beds	2.2	2.2	2.3	2.3	2.3
Admissions	80.4	81.9	84.6	82.9	77.3
Inpatient Days	483.8	484.7	504.0	494.0	450.3
Inpatient Surgeries	25.4	29.1	29.8	27.7	39.5
Births	12.6	13.4	12.9	13.3	13.5
Outpatient					
Emergency Outpatient Visits	418.4	424.5	476.9	482.1	901.1
Other Outpatient Visits	2,096.8	2,105.9	1,983.9	2,133.4	1,720.9
Total Outpatient Visits	2,515.2	2,530.4	2,460.8	2,615.5	2,622.0
Outpatient Surgeries	66.9	72.3	63.3	64.8	51.0
Expense per Capita (per person)	\$2,243.3	\$2,510.8	\$2,282.8	\$2,137.3	\$2,103.1

Table 7 (Continued)

These data include only hospital-based facilities and services as reported by responding hospitals in Section C of the 2010 AHA Annual Survey, beginning on page 215. All hospitals are represented with Community Hospitals listed separately under United States. No estimates have been made for nonresponding hospitals. Definitions of facilities and services are listed in the Glossary, page 201.

CLASSIFICATION	HOSPITALS REPORTING	GENERAL MEDICAL SURGICAL CARE						INTENSIVE CARE UNITS								LONG-TERM CARE UNITS							
		ADULT UNITS		PEDIATRIC UNITS		CARDIAC UNITS		MEDICAL SURGICAL UNITS		NEONATAL UNITS		OTHER UNITS		PEDIATRIC UNITS		ACUTE LONG-TERM CARE UNITS		SKILLED NURSING CARE UNITS		INTERMEDIATE NURSING CARE UNITS		OTHER LONG-TERM CARE UNITS	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
UNITED STATES	4,782	4,014	83.9	2,020	42.2	1,351	28.3	2,964	62.0	938	19.6	484	10.1	423	8.8	336	7.0	1,148	24.0	371	7.8	232	4.9
COMMUNITY HOSPITALS	4,079	3,756	92.1	1,971	48.3	1,316	32.3	2,829	69.4	923	22.6	465	11.4	415	10.2	215	5.3	1,055	25.9	328	8.0	191	4.7
CENSUS DIVISION 1, NEW ENGLAND	198	164	82.8	107	54.0	55	27.8	152	76.8	36	18.2	14	7.1	15	7.5	11	5.6	34	17.2	18	9.1	6	3.0
Connecticut	32	25	78.1	18	56.3	13	40.6	25	78.1	15	46.9	1	3.1	3	9.4	2	6.3	3	9.4	1	3.1	0	0.0
Maine	40	35	87.5	21	52.5	5	12.5	32	80.0	3	7.5	5	12.5	3	7.5	2	5.0	10	25.0	8	20.0	4	10.0
Massachusetts	74	57	77.0	43	58.1	25	33.8	53	71.6	13	17.6	4	5.4	6	8.1	6	8.1	8	10.8	1	1.4	2	2.7
New Hampshire	28	24	85.7	15	53.6	6	21.4	22	78.6	3	10.7	2	7.1	1	3.6	1	3.6	9	32.1	7	25.0	0	0.0
Rhode Island	12	11	91.7	6	50.0	4	33.3	10	83.3	1	8.3	2	16.7	1	8.3	0	0.0	0	0.0	0	0.0	0	0.0
Vermont	12	12	100.0	4	33.3	2	16.7	10	83.3	1	8.3	0	0.0	1	8.3	0	0.0	4	33.3	1	8.3	0	0.0
CENSUS DIVISION 2, MIDDLE ATLANTIC	414	349	84.3	206	49.8	186	44.9	318	76.8	118	28.5	46	11.1	55	13.3	16	3.9	105	25.4	10	2.4	23	5.6
New Jersey	73	58	79.5	43	58.9	36	49.3	58	79.5	23	31.5	6	8.2	16	21.9	4	5.5	15	20.5	5	6.8	7	9.6
New York	158	153	91.1	98	58.3	88	52.4	137	81.5	57	33.9	21	12.5	32	19.0	10	6.0	46	27.4	4	2.4	14	8.3
Pennsylvania	173	138	79.8	65	37.6	62	35.8	123	71.1	38	22.0	19	11.0	7	4.0	2	1.2	44	25.4	1	0.6	2	1.2
CENSUS DIVISION 3, SOUTH ATLANTIC	715	590	82.5	304	42.5	230	32.2	505	70.6	155	21.7	100	14.0	69	9.7	63	8.8	193	27.0	64	9.0	43	6.0
Delaware	11	6	54.5	6	54.5	7	63.6	6	54.5	5	45.5	2	18.2	4	36.4	1	9.1	2	18.2	2	18.2	2	18.2
District of Columbia	12	6	50.0	3	25.0	6	50.0	7	58.3	5	41.7	1	8.3	2	16.7	2	16.7	3	25.0	2	16.7	1	8.3
Florida	160	132	82.5	56	35.0	64	40.0	123	76.9	43	26.9	18	11.3	24	15.0	8	5.0	15	9.4	7	4.4	4	2.5
Georgia	128	112	87.5	44	34.4	29	22.7	81	63.3	27	21.1	15	11.7	6	4.7	9	7.0	38	29.7	13	10.2	4	3.1
Maryland	58	46	79.3	34	58.6	22	37.9	45	77.6	17	29.3	9	15.5	5	8.6	4	6.9	15	25.9	3	5.2	2	3.4
North Carolina	115	101	87.8	53	46.1	32	27.8	85	73.9	22	19.1	14	12.2	12	10.4	6	5.2	39	33.9	14	12.2	1	0.9
South Carolina	79	60	75.9	46	58.2	27	34.2	52	65.8	10	12.7	30	38.0	7	8.9	29	36.7	33	41.8	8	10.1	25	31.6
Virginia	89	74	83.1	35	39.3	25	28.1	70	78.7	22	24.7	7	7.9	6	6.7	2	2.2	19	21.3	9	10.1	2	2.2
West Virginia	63	53	84.1	27	42.9	18	28.6	36	57.1	4	6.3	4	6.3	3	4.8	2	3.2	29	46.0	6	9.5	2	3.2
CENSUS DIVISION 4, EAST NORTH CENTRAL	721	636	88.2	383	53.1	249	34.5	501	69.5	128	17.8	129	17.9	80	11.1	40	5.5	165	22.9	43	6.0	38	5.3
Illinois	173	154	89.0	95	54.9	48	27.7	124	71.7	31	17.9	12	6.9	19	11.0	7	4.0	53	30.6	7	4.0	8	4.6
Indiana	108	95	88.0	54	50.0	27	25.0	74	68.5	19	17.6	11	10.2	9	8.3	4	3.7	20	18.5	9	8.3	5	4.6
Michigan	147	128	87.1	72	49.0	48	32.7	101	68.7	23	15.6	16	10.9	12	8.2	9	6.1	31	21.1	8	5.4	8	5.4
Ohio	152	139	91.4	60	39.5	55	36.2	122	80.3	29	19.1	18	11.8	11	7.2	7	4.6	36	23.7	10	6.8	12	7.9
Wisconsin	141	120	85.1	102	72.3	71	50.4	80	56.7	26	18.4	72	51.1	29	20.6	13	9.2	25	17.7	9	6.4	5	3.5
CENSUS DIVISION 5, EAST SOUTH CENTRAL	419	358	85.4	172	41.1	116	27.7	227	54.2	65	15.5	41	9.8	32	7.6	16	3.8	83	19.8	21	5.0	29	6.9
Alabama	120	94	78.3	34	28.3	29	24.2	67	55.8	17	14.2	14	11.7	8	6.7	4	3.3	13	10.8	8	6.7	3	2.5
Kentucky	98	80	81.6	36	36.7	25	25.5	60	61.2	15	15.3	7	7.1	4	4.1	8	8.2	25	25.5	5	5.1	5	5.1
Mississippi	110	105	95.5	73	66.4	39	35.5	45	40.9	16	14.5	7	6.4	13	11.8	0	0.0	25	22.7	0	0.0	19	17.3
Tennessee	91	79	86.8	29	31.9	23	25.3	55	60.4	17	18.7	13	14.3	7	7.7	3	3.3	20	22.0	8	8.8	2	2.2
CENSUS DIVISION 6, WEST NORTH CENTRAL	649	585	90.1	283	43.6	139	21.4	326	50.2	84	12.9	40	6.2	45	6.9	39	6.0	261	40.2	124	19.1	54	8.3
Iowa	125	119	95.2	58	46.4	23	18.4	72	57.6	17	13.6	7	5.6	10	8.0	6	4.8	56	44.8	42	33.6	14	11.2
Kansas	153	137	89.5	47	30.7	15	9.8	54	35.3	16	10.5	7	4.6	9	5.9	12	7.8	65	42.5	44	28.8	15	9.8
Minnesota	102	96	94.1	54	52.9	28	27.5	62	60.8	10	9.8	4	3.9	7	6.9	3	2.9	42	41.2	6	5.9	2	2.0
Missouri	149	118	79.2	79	53.0	41	27.5	86	57.7	20	13.4	16	10.7	8	5.4	12	8.1	36	24.2	15	10.1	9	6.0
Nebraska	52	49	94.2	18	34.6	14	26.9	20	38.5	11	21.2	3	5.8	3	5.8	1	1.9	25	48.1	5	9.6	6	11.5
North Dakota	24	23	95.8	11	45.8	9	37.5	12	50.0	7	29.2	2	8.3	5	20.8	3	12.5	12	50.0	4	16.7	2	8.3
South Dakota	44	43	97.7	16	36.4	9	20.5	20	45.5	3	6.8	1	2.3	3	6.8	2	4.5	25	56.8	8	18.2	6	13.6
CENSUS DIVISION 7, WEST SOUTH CENTRAL	883	647	73.3	264	29.9	148	16.8	410	46.4	150	17.0	60	6.8	56	6.3	111	12.6	99	11.2	21	2.4	12	1.4
Arkansas	91	69	75.8	25	27.5	26	28.6	42	46.2	10	11.0	5	5.5	2	2.2	9	9.9	15	16.5	1	1.1	0	0.0
Louisiana	102	78	76.5	46	45.1	18	17.6	59	57.8	28	27.5	8	7.8	12	11.8	8	7.8	19	18.6	4	3.9	3	2.9
Oklahoma	123	101	82.1	32	26.0	21	17.1	50	40.7	11	8.9	8	6.5	5	4.1	10	8.1	22	17.9	4	3.3	2	1.6
Texas	567	399	70.4	161	28.4	83	14.8	259	45.7	101	17.8	39	6.9	37	6.5	84	14.8	43	7.6	12	2.1	7	1.2
CENSUS DIVISION 8, MOUNTAIN	335	287	85.7	134	40.0	70	20.9	202	60.3	70	20.9	21	6.3	28	8.7	19	5.7	91	27.2	39	11.6	16	4.8
Arizona	59	50	84.7	18	30.5	17	28.8	43	72.9	13	22.0	4	6.8	8	13.6	2	3.4	3	5.1	2	3.4	0	0.0
Colorado	71	65	91.5	32	45.1	15	21.1	45	63.4	24	33.8	4	5.6	6	8.5	3	4.2	14	19.7	6	8.5	3	4.2
Idaho	30	30	100.0	13	43.3	6	20.0	17	56.7	5	16.7	1	3.3	2	6.7	1	3.3	12	40.0	5	16.7	0	0.0
Montana	53	51	96.2	21	39.6	11	20.8	23	43.4	7	13.2	2	3.8	3	5.7	5	9.4	34	64.2	9	17.0	6	11.3
Nevada	27	19	70.4	6	22.2	6	22.2	17	63.0	6	22.2	4	14.8	4	14.8	4	14.8	1	3.7	1	3.7	1	3.7
New Mexico	36	30	83.3	15	41.7	4	11.1	22	61.1	4	11.1	2	5.6	2	5.6	2	5.6	5	13.9	4	11.1	2	

Appendix D

Review Standards and Methodology

Review Standards and Methodology for Surgical Care
Ambulatory Surgery Services in Mat-Su

STEP ONE: Determine the projected general surgery caseload

Caseload $C = P * OSUR$, where

C (caseload) = number of general surgery cases projected for the fifth year from the project implementation date.

P (projected population) = the official state projected population in the fifth year following implementation of the project

GSUR (use rate) = the average number of general surgery cases provided over the preceding three years per 1,000 (persons).

P (projected population)

Mat-Su Population Estimates and Projections, Alaska Department of Labor (DOL)

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
74,871	78,229	81,012	83,691	86,074	88,995	91,697	94,520	97,273	100,025	103,070	105,530	108,283	111,036	113,788	117,222
DOL Estimates							Projections*								

*DOL Projections are used for 2015 and 2020; linear forecast is used for 2012 through 2014 and for 2016 through 2019

State of Alaska Population Estimates and Projections

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
667,146	674,583	680,169	686,818	697,828	710,231	722,190	727,579	736,653	745,728	759,244	763,877	772,952	782,026	791,101	802,762
DOL Estimates							Projections**								

**DOL Projections are used for 2015 and 2020; linear forecast is used for 2012 through 2014 and for 2016 through 2019

GSUR (use rate)

Alaska Total Hospital Surgeries from American Hospital Association (AHA)

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
59,246	61,309	63,117	64,089	70,763	65,416	70,008	71,728	73,447	75,167	76,887	78,606	80,326	82,045	83,765	85,484
Actual Data from AHA							Projections***								

***Linear forecast is used to project number of surgeries for 2011 and beyond, based on the actual 2005-2010 hospital data from American Hospital Association

General Surgery Use Rate per 1,000 population

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
88.81	90.88	92.80	93.31	101.40	92.11	96.94	98.58	99.70	100.80	101.27	102.90	103.92	104.91	105.88	106.49
Actual Data							Projections								

C (caseload)

1. Projected caseload based on the average number of general surgery cases provided over the three preceding years (2009-2011)

CON Mat-Su OR Need for 2018

2009-2011 AVG GSUR	Mat-Su Population in 2018	2018 Caseload
96.82	111,036	10,750

2. Projected caseload based on the GSUR projected for 2018****

CON Mat-Su OR Need for 2018

2018 Projected GSUR	Mat-Su Population in 2018	2018 Caseload
104.91	111,036	11,649

****South Anchorage Ambulatory Surgery Center, Appellant , v. State of Alaska, Department of Health & Social Services, Appellee, Case No. 3AN-07-10738 CI, OAH No. 06-0152-DHS, Decision on Appeal at pp. 9-10. (Superior Court Judge Torrissi.)

STEP TWO: Determine the projected number of operating rooms required to meet the projected demand

$GORR = C / TU$

GORR = general operating rooms required

C (caseload) = number of general surgery cases projected for the fifth year from the project implementation date

TU (target use rate) = defined as **1200** surgical cases (for operating rooms dedicated to outpatient surgery use)

	2018 Caseload	OR Needed
2009-2011 AVG GSUR	10,750	9.0
2018 Projected GSUR	11,649	9.7

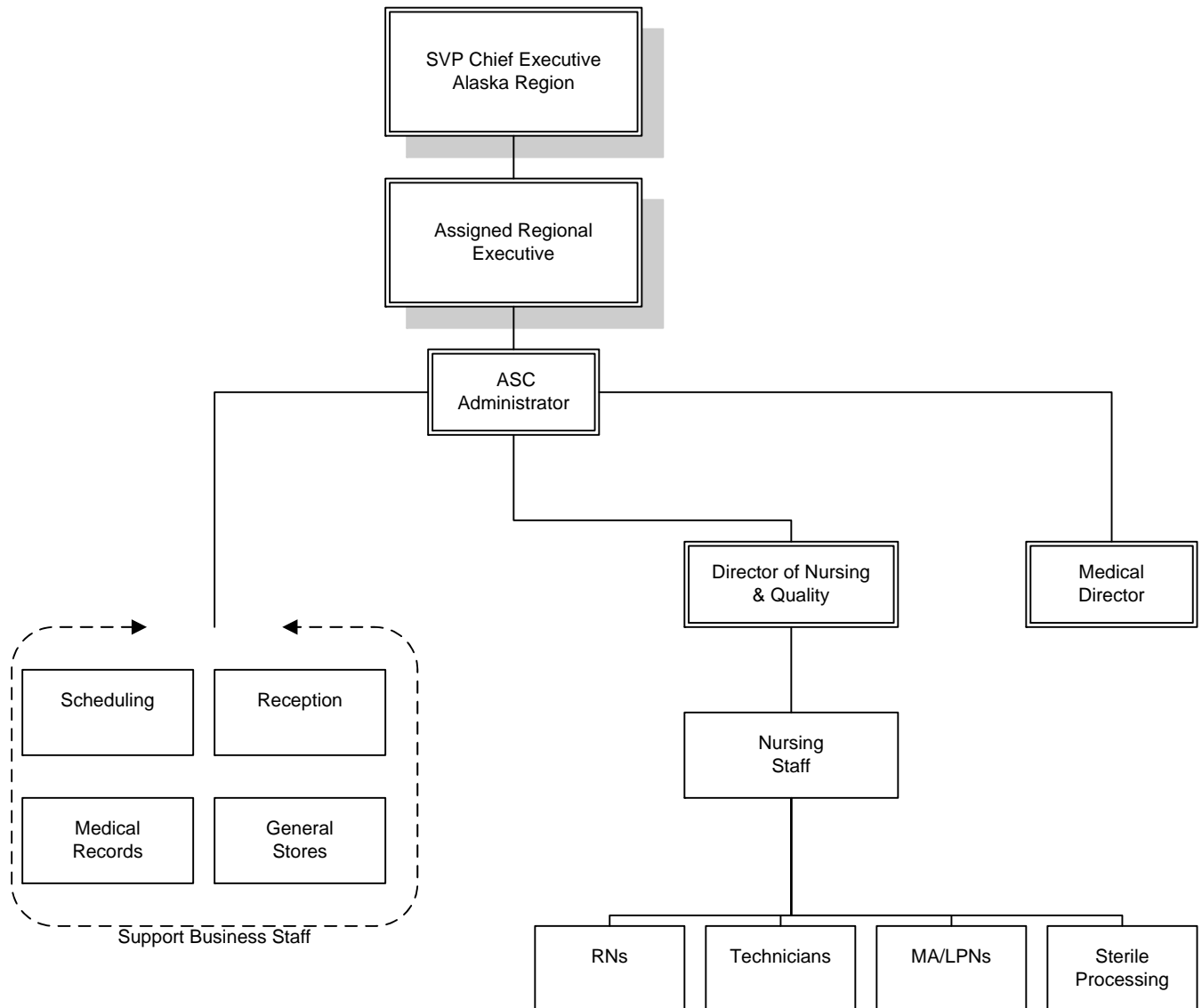
STEP THREE: Determine unmet need for general purpose operating rooms by subtracting number of currently existing and CON-approved ORs from the projected to be needed

	2018 Caseload	OR Needed	Existing Class C ORs	Additional ORs Needed
2009-2011 AVG GSUR	10,750	9.0	5 to 7	2 to 4
2018 Projected GSUR	11,649	9.7	5 to 7	3 to 5

Appendix E
Organizational Chart

Providence Mat-Su Surgery Center

Organizational Chart



Appendix F
Job Descriptions

PROVIDENCE HEALTH & SERVICES ALASKA

JOB DESCRIPTION

JOB CODE:**JOB TITLE:** ADMINISTRATOR**PROCESS LEVEL:** Providence Mat-Su Surgery Center**REPORTS TO:** Assigned Providence Executive, Alaska Region**COLLABORATES WITH:** Medical Director**SUPERVISES:** Nurse Manager and other assigned supervisory staff**DESCRIPTION STATUS:**

POSITION SUMMARY:

Under the direction of the Providence executive, the Administrator is responsible for development and implementation of plans resulting in the smooth and efficient operation of Providence Mat-Su Surgery Center ("PMSSC"), in accordance with Providence policies and standards. The Administrator leads all activities related to the ambulatory surgery center and is responsible for planning, organizing, delegating, budgeting, and controlling the services of the ASC in an efficient and cost effective manner. The Administrator supervises the Director of Nursing and, ultimately, the staff of the operating rooms and recovery rooms, the business office, and all additional employees and/or contractors.

ESSENTIAL JOB FUNCTIONS: (Responsibilities, accountabilities, and competencies. May not include all duties of this job)

A. JOB DUTIES:

1. **LEADERSHIP/SUPERVISION:** In collaboration with the Medical Director, Administrator provides overall direction and guidance to entire organization through the Director of Nursing and other leaders; assists Director of Nursing and staff in developing and achieving goals. Implements employee engagement plans which result in high levels of employee satisfaction and retention. Encourages staff input, and is receptive to suggestions of staff members, and provides prompt feedback to employees. Administrator models open communication throughout the organization and displays professionalism at work and in the community. Provides for the orientation of newly credentialed physicians.

2. **COMMUNICATION:** Demonstrates professional interpersonal and verbal skills when communicating with a wide variety of people from differing literacy levels, languages and cultures. Communicates effectively in a compassionate manner to patients, families, visitors and other staff members. Exhibits the necessary written skills for effective communication and documentation.

3. **TEAMWORK:** Exhibits the necessary skills to build effective teams by coaching, building trust, and training staff to work collaboratively and cohesively with other staff and/or team members in a variety of settings. Encourages positive interaction and, if necessary, directs staff to work directly with other team members when resolving issues. Monitors key processes to identify and enhance the effectiveness of the team.

4. **PLANNING:** Identifies and participates in short and long term goal development and periodically reports performance as defined by Providence's strategic plans. Prepares annual budgets in accordance with established timelines. Prepares monthly analysis of performance. Participates in the development of three-year long range financial plan and three-year strategic plan in accordance with established timelines. Facilitates process for annual updating of the plans.

Develops plans for increased volume, additional specialties and/or other changes to surgical volumes. Works collaboratively with physicians and other health care team members to influence sound decision-making in selection of equipment and supplies. Assists Director of Nursing to implement, evaluate, and revise nursing standards.

5. **MANAGEMENT:** Provides for the establishment of Human Resources functions and services. Works with direct reports to hire qualified staff for all positions. Ensures that all employees are oriented to department and job role, and maintains position-specific competencies. Ensures all employees receive annual performance evaluation. Assists Director of Nursing and other supervisors with employee evaluations, coaching, and counseling. Develops performance indicators and metrics, and provides periodic reports. Assists direct reports to develop staffing plans that ensure efficiency and productivity. Maintains thorough knowledge of all functions in the ASC, to include regulatory and licensing standards, national trends and changes in reimbursements. In collaboration with the Medical Director, provides feedback to contracted anesthesia staff. Engages anesthesia staff as appropriate in planning and communication activities. Negotiates contracts with vendors and continually evaluates their performance. Obtains guidance from assigned Providence executive and/or Providence legal counsel as directed. Facilitates meetings of Medical Executive committee, Quality Management committee, Medical Advisory committee, staff meetings and other work teams as needed. Provides for the development and implementation of Fire and Disaster plan, Risk Management program, and ensure staff education and competency. Provides for the medical staff services in accordance with the Providence standards, state license and national standards. Manages medical staff credentialing process. Promotes and facilitates competent care of the patient in the ASC. Ensures that policies and procedures are developed, followed, annually reviewed, and updated as needed. Ensures clinical policies and procedures are fully reviewed by the Nurse Manager and Medical Director as appropriate. Ensures that documentation of care is complete, accurate and timely. Communicates information to all healthcare team members regarding patient care and outcomes.

Administrator oversees the development and implementation of plans for continuous improvement of patient care; works with physicians to evaluate and enhance the patient experience at PMSSC. Develops and implements methods to measure patient satisfaction.

6. **COMPLIANCE:** Provides for the implementation of the Providence Compliance Plan. Ensures adherence to all Federal and State regulations and standards. Directs the implementation of adequate privacy and data security policies. Directs the implementation of the Providence Quality Strategic Plan, and provides for periodic reporting on performance.

7. **FISCAL MANAGEMENT:** Collaborates and cooperates with Providence Revenue Cycle staff to ensure accurate and timely billing. Measures the cost per procedure and per physician, and provides periodic reports. Implements procedures to monitor inventory, including supplies and drugs. Implements processes to monitor utilization of staffing resources, to ensure efficient operations and adequate staffing levels.

B. QUALIFICATIONS AND EXPERIENCE:

1. Bachelor's degree in a health profession, business administration, or public administration. Masters degree preferred.
2. Minimum of five (5) years experience in health care management.
3. Leadership experience in licensed ambulatory surgery center strongly preferred.
4. Registered Nurse preferred. Must hold current license to practice nursing in the State of Alaska.
5. Demonstrates executive level organizational and communication skills required to interact with physicians, staff, and the public. Possesses expansive knowledge of current health care trends, issues and concerns.
6. Must be able to read, write and speak fluent English.
7. Must be able to utilize technology appropriate for this position, including but not limited to mobile communications devices, medical and business computer applications, intranet and internet features.
8. Regular attendance is a requirement of this position
- 9 Possesses excellent physical and mental health. There are no special physical requirements for this position.

IN AN 8 HOUR WORKDAY, THIS JOB REQUIRES:

N = NEVER	(0 hours per day)
R = RARELY	(less than 1/2 hours per day)
O = OCCASIONALLY	(1/2 to 2.5 hours per day)
F = FREQUENTLY	(2.5 to 5.5 hours per day)
C = CONTINUALLY	(5.5 to 8 hours per day)

WORKING CONDITIONS/ENVIRONMENT

I. LIFTING/CARRYING (Amount of force exerted to lift and/or carry)	
1 - 10 lbs.	R
11 - 20 lbs.	R
21 - 35 lbs.	N
36 - 50 lbs.	N
51 - 75 lbs.	N
76 - 100 lbs.	N
II. PUSHING/PULLING (Amount of force exerted to push and/or pull)	
1 - 10 lbs.	R
11 - 20 lbs.	R
21 - 35 lbs.	N
36 - 50 lbs.	N
51 - 75 lbs.	N
76 - 100 lbs.	N
III. POSTURES/MOVEMENTS	
Sitting	C
Standing	O
Walking	O
Stooping, kneeling, crouching or crawling	R
Reaching and /or grasping	O
Hand/finger dexterity	O
Climbing and/or balancing	R
Carrying, pushing and/or pulling	R

IV. COGNITIVE/SENSITIVE

Talking	F
Hearing	C
Sight (acuity, color blindness)	C
Smelling/tasting	R

OCCUPATIONAL ASPECTS

A. WORK ENVIRONMENT

Working Inside	C
Working Outside	N
Changing Temperatures	R
Wet/Humid Conditions	R
Areas of dust, odors, mist, gases or other airborne matter	R
Mechanical, electrical and/or other hazards	R
Confined Spaces	N

B. OTHER ASPECTS

Infectious Agents	O
Chemicals	R

C. Special Equipment/Clothing	O
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The above is intended to describe the general content of, and requirements for, the performance of this job. It is not intended to be construed as an exhaustive statement of duties, responsibilities or requirements.

PROVIDENCE HEALTH & SERVICES ALASKA

JOB DESCRIPTION

JOB CODE:

JOB TITLE: DIRECTOR OF NURSING AND QUALITY

PROCESS LEVEL: Providence Mat-Su Surgery Center

REPORTS TO: Administrator, Providence Mat-Su Surgery Center

SUPERVISES: Staff in Nursing, Quality Improvement, Employee Health/Infection, and Sterile Processing

DESCRIPTION STATUS:

POSITION SUMMARY

The Director of Nursing and Quality is responsible for planning, coordinating and direct supervising of the activities of the nursing staff, including those assigned to Quality, Employee Health, Infection Control, and Sterile Processing services, in accordance with Providence philosophy, objectives, policies, procedures, and standards. Director of Nursing fosters change and teamwork and is primarily responsible for the quality improvement program.

ESSENTIAL JOB FUNCTIONS: (Responsibilities, accountabilities, and competencies. May not include all duties of this job)

A. JOB DUTIES:

1. **LEADERSHIP/SUPERVISION:** Demonstrates ability to provide leadership and create positive work environment. Provides guidance and support to staff members to ensure that they are able to perform their work effectively and efficiently. Directs the activities of the department to ensure that continuous quality and cost effective services are provided. Demonstrates the ability to make decisions, delegate tasks and encourage staff to use their talents to achieve the desired outcomes. Appropriately credits staff and/or other team members for their effort and accomplishment.
2. **CLINICAL EXPERTISE:** Demonstrates expertise and current clinical competencies in all aspects of ambulatory surgery operations. Possesses clinical knowledge, judgment, and critical-thinking skills based on scientific principles. Works collaboratively with medical director, surgeons, and staff to select equipment, instruments and supplies, appropriate to ambulatory surgery needs. Supervises care of the equipment and facility to ensure cleanliness, sterility and the operational ability of all equipment and supplies. Functions as a staff RN when necessary. Ensures that documentation of care is complete and

accurate. Promotes a safe environment for staff and patients. Works with medical director to evaluate and enhance the patient experience.

3. **COMMUNICATION:** Demonstrates professional interpersonal and verbal skills when communicating with a wide variety of people from differing literacy levels, languages and cultures. Communicates effectively and in a compassionate manner with patients, families, visitors, and staff members. Exhibits the necessary written skills for effective communication and documentation.
4. **TEAMWORK:** Exhibits the necessary skills to build effective teams by coaching, building trust, and training staff to work collaboratively and cohesively with other staff and/or team members in a variety of settings. Encourages positive interaction and, if necessary, directs staff to work directly with other team members when resolving issues. Monitors key processes to identify and enhance the effectiveness of the team.
5. **DEVELOPMENT AND ORGANIZING:** Develops and implements staffing plans, work schedules and work assignments in a manner consistent with benchmarks, and assures adequate staffing to deliver quality, efficient, and cost effective patient care. Develops, implements, and maintains department policies and procedures in accordance with the requirements of accrediting bodies, Federal, State and Municipal requirements to ensure safe and effective services. Participates in personnel functions including hiring, evaluations, disciplinary actions and terminations. Anticipates and prioritizes workflow and adjusts work assignments to meet work flow demands and prevent delays. Utilizes available resources to recognize errors/problems and takes corrective action and assists with problem resolutions.
6. **FINANCIAL RESOURCE/STEWARDSHIP:** Participates in the annual development of departmental operating and capital budgets. Anticipates and adjusts operating plans to meet facility goals. Regularly monitors performance against budgeted benchmarks.
7. **QUALITY IMPROVEMENT:** In collaboration with the Medical Director, develops and maintains quality control and quality assurance programs by establishing indicators to measure, monitor, and report performance to other team members. Engages staff to implement process improvements to impact quality outcomes. Oversees development of data collection, statistical data analysis, appropriate action planning and reporting. Directs and manages education programs related to quality and patient safety, and use of statistical analysis and improvement tools. Facilitates teamwork and leads operational excellence initiatives. Develops performance indicators and measurable outcomes collaboratively with medical director and staff, in coordination with Providence Health and Services goals and initiatives.
8. Implement care/services that recognize specific needs/issues of diverse customers served.
9. Performs other related duties as required.

B. IDENTIFIED COMPETENCIES

Completes Competency Plan for assigned job and department.

C. CORE VALUES

Demonstrates personal and interpersonal qualities that support the Core Values of Providence Health & Services.

D. ESSENTIAL JOB QUALIFICATIONS:

1. **Education:** Bachelor's Degree in Nursing; Master's degree preferred.
2. **Experience:** Minimum of five (5) years of experience in the operating room and recovery room nursing required. Three years experience in nursing management preferred and PerioOperative management preferred, within last 5 years. Experience in Quality Improvement and performing to standards of accreditation body preferred.
3. **Licensure/Certification:** Licensure as a Registered Nurse in the State of Alaska required. Certification as a Healthcare Quality Professional preferred. Basic Life Support (BLS) required. Advanced Cardiac Life Support (ACLS) preferred.
4. **Other Qualifications:** Must have excellent verbal and written communication skills. Must be thorough, accurate and objective in carrying out review and investigative responsibilities.
5. **Attendance:** Regular attendance is a requirement of this position.
6. **English Language:** Must be able to read, write, and speak English.

This Job Description reflects Providence Health & Services Alaska's best effort to describe the essential functions and qualifications of the job described. It is not an exhaustive statement of all the duties, responsibilities or qualifications of the job. This document is not intended to exclude an opportunity for modifications consistent with providing reasonable accommodation. This is not intended to be a contract. Your signature indicates you have read this Job Description and understand the essential functions and essential qualifications of the job.

Employee Printed Name: _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

IN AN 8 HOUR WORKDAY, THIS JOB REQUIRES:

N = NEVER	(0 hours per day)
R = RARELY	(less than 1/2 hours per day)
O = OCCASIONALLY	(1/2 to 2.5 hours per day)
F = FREQUENTLY	(2.5 to 5.5 hours per day)
C = CONTINUALLY	(5.5 to 8 hours per day)

WORKING CONDITIONS/ENVIRONMENT

I. LIFTING/CARRYING (Amount of force exerted to lift and/or carry)	
1 - 10 lbs.	O
11 - 20 lbs.	O
21 - 35 lbs.	O
36 - 50 lbs.	R
51 - 75 lbs.	R
76 - 100 lbs.	N
II. PUSHING/PULLING (Amount of force exerted to push and/or pull)	
1 - 10 lbs.	F
11 - 20 lbs.	F
21 - 35 lbs.	F
36 - 50 lbs.	R
51 - 75 lbs.	R
76 - 100 lbs.	N
III. POSTURES/MOVEMENTS	
Sitting	O
Standing	F
Walking	F
Stooping, kneeling, crouching and/or crawling	R
Reaching and /or grasping	O
Hand/finger dexterity	C
Climbing and/or balancing	N
Carrying, pushing and/or pulling	O

IV. COGNITIVE/SENSITIVE

Talking	C
Hearing	C
Sight (Addendum: acuity, color blindness)	C
Smelling/tasting	R

OCCUPATIONAL ASPECTS

A. WORK ENVIRONMENT

Working inside	C
Working outside	N
Changing Temperatures	O
Wet/Humid Conditions	O
Areas of dust, odors, mist, gases or other airborne matter	N
Mechanical, electrical and/or other hazards	N
Confined Spaces	N

B. OTHER ASPECTS

Infectious Agents	F
Chemicals	R

C. Special Equipment/Clothing

Special Equipment or Clothing	C
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The above is intended to describe the general content of, and requirements for, the performance of this job. It is not intended to be construed as an exhaustive statement of duties, responsibilities or requirements.

PROVIDENCE HEALTH & SERVICES ALASKA

JOB DESCRIPTION

JOB CODE:

JOB TITLE: MEDICAL DIRECTOR

PROCESS LEVEL: Providence Mat-Su Surgery Center (PMSSC)

REPORTS TO: Administrator

SUPERVISES: N/A

DESCRIPTION STATUS:

POSITION SUMMARY

Develop and assist the Surgery Center's Management in implementing policies and procedures for safe and effective patient care;

Develop and assist the Surgery Center's Management in implementing programs for quality assurance/quality improvement and achievement and maintenance of accreditation by certifying bodies; and

Provide physician expertise in clinical oversight; work with the Surgery Center's Management in scheduling and effective use of services.

ESSENTIAL JOB FUNCTIONS: (Responsibilities, accountabilities, and competencies. May not include all duties of this job)

A. JOB DUTIES

1. **LEADERSHIP AND SUPERVISION:** Assist PMSSC Management and Director of Nursing in the development, implementation, promotion and supervision of policies and procedures for safe, effective, and efficient patient care; programs for achievement and maintenance of licensure by the State of Alaska, and accreditation by Medicare/Medicaid, applicable accrediting bodies, and fulfillment of selected managed care contractual requirements.

2. **QUALITY:** Collaborate with the PMSSC leadership to develop programs for Quality Assurance/Quality Improvement of anesthesia, surgery, pre- and post-operative care, by physicians, nursing staff, and other personnel; Physician Peer Review; Utilization Review; Continuing Medical Education for ASC patient care employees. Collaborate with the PMSSC management when planning

schemes for scheduling, staffing, equipment procurement, budget, and system improvements; participate on a regular basis in financial analysis and budget development for anesthesia.

3. **PROFESSIONAL OVERSIGHT:** Review clinical performance by physicians at the ASC facility. Review ASC Medical Staff membership and privileges and work with PMSSC management so it can review and act regarding the same. Make recommendations to the Surgery Center regarding any inappropriate actions or failures to act, or untoward results at the ASC. In collaboration with PMSSC management, oversee and direct the Quality Assurance/Quality Improvement for physicians and all anesthesia personnel, Peer Reviews, and Utilization Reviews.

4. **ORGANIZATIONAL PARTICIPATION:** Participate in the promotion of the ASC at community and civic events and help maintain professional relations with referring agencies and physicians. Provide a substitute in the event of absence. Provide consistent staffing for anesthesia services. Oversee emergency plans for ASC and emergency situations as they occur. Assist with third party payer contract negotiations. As necessary, devote time to the administration of the ASC, in accordance with patient safety and needs. Submit any forms required by Medicare for documentation of work and attesting to administrative duties.

B. IDENTIFIED COMPETENCIES

Completes Competency Plan for assigned job and department

C. CORE VALUES

Demonstrates personal and interpersonal qualities that support the Core Values of Providence Health & Services

D. ESSENTIAL JOB QUALIFICATION

1. QUALIFICATIONS:

- a. Licensure as a physician in the State of Alaska;
- b. Federal DEA number;
- c. Medical Staff membership and appropriate clinical privileges at an acute care Hospital;
- d. Certification by Board(s) of Anesthesiology;
- e. Participating provider status with the Medicare and Medicaid programs.

2. **EXPERIENCE:** Minimum of four (4) years experience as anesthesiologist in acute and/or ambulatory surgery setting. Medical Director experience is strongly preferred. Medical Director experience in a licensed ambulatory surgery center is strongly preferred.

3. **OTHER QUALIFICATIONS:** must have excellent verbal and written communication skills. Must have excellent analytical skills. Must be thorough, objective and accurate while carrying out responsibilities.

4. **ATTENDANCE:** Regular attendance is a requirement of this position.

5. **ENGLISH LANGUAGE:** must be able to read, write, and speak fluent English.

IN AN 8 HOUR WORKDAY, THIS JOB REQUIRES:

N = NEVER	(0 hours per day)
R = RARELY	(less than 1/2 hours per day)
O = OCCASIONALLY	(1/2 to 2.5 hours per day)
F = FREQUENTLY	(2.5 to 5.5 hours per day)
C = CONTINUALLY	(5.5 to 8 hours per day)

WORKING CONDITIONS/ENVIRONMENT

I. LIFTING/CARRYING (Amount of force exerted to lift and/or carry)

1 - 10 lbs.	R
11 - 20 lbs.	R
21 - 35 lbs.	N
36 - 50 lbs.	N
51 - 75 lbs.	N
76 - 100 lbs.	N

II. PUSHING/PULLING (Amount of force exerted to push and/or pull)

1 - 10 lbs.	R
11 - 20 lbs.	R
21 - 35 lbs.	N
36 - 50 lbs.	N
51 - 75 lbs.	N
76 - 100 lbs.	N

III. POSTURES/MOVEMENTS

Sitting	C
Standing	O
Walking	O
Stooping, kneeling, crouching or crawling	R
Reaching and /or grasping	O
Hand/finger dexterity	O
Climbing and/or balancing	R
Carrying, pushing and/or pulling	R

IV. COGNITIVE/SENSITIVE

Talking	F
Hearing	C
Sight (acuity, color blindness)	C
Smelling/tasting	R

OCCUPATIONAL ASPECTS

A. WORK ENVIRONMENT

Working inside	C
Working outside	N
Changing Temperatures	R
Wet/Humid Conditions	R
Areas of dust, odors, mist, gases or other airborne matter	R
Mechanical, electrical and/or other hazards	R
Confined Spaces	N

B. OTHER ASPECTS

Infectious Agents	O
Chemicals	R
C. Special Equipment/Clothing	O

The above is intended to describe the general content of, and requirements for, the performance of this job. It is not intended to be construed as an exhaustive statement of duties, responsibilities or requirements.

PROVIDENCE HEALTH & SERVICES ALASKA

JOB DESCRIPTION

JOB CODE:**JOB TITLE:** STAFF REGISTERED NURSE (RN)**PROCESS LEVEL:** Providence Mat-Su Surgery Center**REPORTS TO:** Director of Nursing and Quality**SUPERVISES:** N/A**DESCRIPTION STATUS:**

POSITION SUMMARY

The registered nurse is accountable for the delivery and supervision of safe, quality care that is individualized for their assigned patients and follows the nursing process in accordance with the Nurse Practice Act (assessment, planning implementation, evaluation). RN is responsible for the assessment, treatment and care of patients in populations and ages as assigned. The registered nurse accepts and promotes professional development as an integral part of nursing practice. RN will access, analyze, customize, coordinate and communicate the patient's plan of care and activities collaboratively with other members of the healthcare team. Families and or significant others will be included within the plan of care as appropriate. She/He will direct, delegate and manage the care delivered by colleagues and subordinates. The registered nurse performs all duties in a manner that respects and supports the family centered care model. Collegial and collaborative care will reflect the philosophy of the Division of Nursing, the Mission and Core Values of the Sisters of Providence, and National Patient Safety Standards.

ESSENTIAL JOB FUNCTIONS: (Responsibilities, accountabilities, and competencies. May not include all duties of this job)

A. JOB DUTIES

1. Possesses knowledge of developmental needs and competent in the assessment and treatment as it relates to the age of the patient population served. Conducts and documents a comprehensive patient assessment upon admission. Continually reassesses and applies appropriate advocacy and interventions as indicated. Competent in the interpretation of a patient's self-assessment and behavior. This information must be interpreted with an understanding of the cognitive, physical emotional, psychosocial and chronological maturation process. Actively involves patient and family in the collaborative development of a plan of care.

2. Consistently demonstrates and promotes safe patient care practices: (i.e. hand washing, patient identification, communication, reduction of infection risks, medication safety & reconciliation, falls

prevention, death/injury prevention, inclusion of patients/families concerns and access to healthcare team).

3. Collaborates with the patients, families, and members of the healthcare team; develops, documents, implements, and monitors individualized plans of care which reflect a standard of care based on best practice and evidence-based medicine. Provides, documents, and consults to ensure necessary patient and family education in support of the treatment plan. Adapts to change and updated patient care practices within an evolving healthcare environment.

4. Collaborates with team members, patients, the patients' families and others, as appropriate, in the development of a proactive discharge plans.

5. Performs procedures and treatments according to accepted department/unit protocols, guidelines, standards and the Nurse Practice Act.

6. Legibly and electronically documents patient care activities and information in an accurate, concise, and timely manner. Competent in the input and retrieval of information within the various forms of written and electronic documentation.

7. Provides safe quality care in an efficient and cost effective manner.

8. Supports and assists with orientation of new staff and students. Acquires necessary training and skills to competently perform the preceptor and charge nurse function when selected.

9. Demonstrates advancement of professional nursing practice through continuing education, required training, certification, and participation in department and unit activities. Ensures all competencies, certifications, safety information and courses are completed as required.

10. Identifies concerns and takes appropriate actions to involve colleagues and management in the development and promotion of a safe patient care environment. Actively engages in positive communication, feedback, and the ongoing development of self and team. Takes an active role in building and maintaining an environment that fosters open communication, patient and family-centered care, and healthy collegial relationships. Demonstrates adaptive/timely communication based on individual patient/family needs. Attends and participates in a minimum of 50 percent of scheduled staff meetings or reads the minutes and signs off on them, and is responsible for meeting content regardless of attendance.

11. Promotes and models collaborative practice and relationships with other healthcare professionals. Recognizes the cultural diversity of patients and their families, employees, medical staff, volunteers and community members plays in achieving productive and positive relationships. Rounds with physicians and other team members to promote continuity of care and patient's confidence in their care delivery team.

12. Monitors patient's condition, notes changes in status, utilizes judgment and takes appropriate action. Communicates patient status to colleagues and physicians to include: situation, background, assessment, and recommendations (S.B.A.R). Utilizes tools adopted through quality and safety initiatives when communicating patient status change and at the time of patient handoff. Uses the Providence Early Assessment Team (P.E.A.T.) when indicated by changes in patient's conditions or concerns.

13. Promotes and routinely offers comfort and pain management measures. Documentation reflects assessment, treatment and re-assessment, as required, to meet patient's goals.

14. Consistently demonstrates and incorporates principles and policies of safety and infection control as defined by policy and procedure, National Patient Safety Goals and Emergency Response procedures. Complies with surgery center standards to ensure continued compliance and regulatory requirements are met. Examples include but are not limited to: The Joint Commission, Occupational Safety and Health Administration, State and Federal requirements.

15. Actively participates in department and unit based activities, including quality improvement programs and processes. Participates in departmental activities that improve patient care and process systems, participates in Tracer Rounds and actively assists others in transitioning and applying knowledge to the clinical and operational setting

16. Performs other related duties as required.

17. Safeguards all forms (electronic, written and oral) of confidential information as it relates to patients, their families, medical staff, and employees. Is aware of and compliant with organizational policies regarding Fraud and Abuse, Conflict of Interest and the Code of Conduct.

18. Adheres to all policies and procedures of the surgery center.

B. IDENTIFIED COMPETENCIES

Completes initial and annual Competency Plan for assigned job and department. Competencies include mandatory surgical competencies and basic life support (BLS) training, and may include other competencies as designated.

C. CORE VALUES

Demonstrates personal and interpersonal qualities that support the Core Values of Providence Health & Services.

D. ESSENTIAL JOB QUALIFICATIONS (Any equivalent combination of knowledge, skills, abilities, education, and experience)

1. **EDUCATION:** Graduate of an accredited/approved School of Nursing.

2. **EXPERIENCE:** Minimum of one year RN experience in an acute care hospital operating room or an ambulatory surgery center.

3. **LICENSURE/CERTIFICATION:** Licensed as a Registered Nurse in the State of Alaska.

4. **OTHER QUALIFICATIONS:** Schedule varies to meet department needs. Must be able to prioritize multiple tasks, and work with a variety of health unit teams.

5. **ENGLISH LANGUAGE:** Must be able to read, write, and speak English.

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Employee Printed Name: _____ Date: _____
Employee Signature: _____ SSN _____

The above is intended to describe the general content of, and requirements for, the performance of this job. It is not intended to be construed as an exhaustive statement of duties, responsibilities or requirements.

IN AN 8 HOUR WORKDAY, THIS JOB REQUIRES:

N = NEVER	(0 hours per day)
R = RARELY	(less than 1/2 hours per day)
O = OCCASIONALLY	(1/2 to 2.5 hours per day)
F = FREQUENTLY	(2.5 to 5.5 hours per day)
C = CONTINUALLY	(5.5 to 8 hours per day)

WORKING CONDITIONS/ENVIRONMENT

I. LIFTING/CARRYING (Amount of force exerted to lift and/or carry)	
1 - 10 lbs.	C
11 - 20 lbs.	F
21 - 35 lbs.	O
36 - 50 lbs.	O
51 - 75 lbs.	N
76 - 100 lbs.	N
II. PUSHING/PULLING (Amount of force exerted to push and/or pull)	
1 - 10 lbs.	F
11 - 20 lbs.	F
21 - 35 lbs.	O
36 - 50 lbs.	O
51 - 75 lbs.	N
76 - 100 lbs.	N
III. POSTURES/MOVEMENTS	
Sitting	O
Standing	C
Walking	C
Stooping, kneeling, crouching,	F
Reaching and /or grasping	F
Hand/finger dexterity	F
Climbing and/or balancing	R
Carrying, pushing and/or pulling	F

IV. COGNITIVE/SENSITIVE

Talking	F
Hearing	F
Sight (Acuity, color blindness)	F
Smelling	F

OCCUPATIONAL ASPECTS

A. WORK ENVIRONMENT

Working inside	C
Working outside	R
Changing Temperatures	O
Wet/Humid Conditions	R
Areas of dust, odors, mist, gases or other airborne matter	O
Mechanical, electrical and/or other hazards	F
Confined Spaces	N

B. OTHER ASPECTS

Infectious Agents	O
Chemicals	O

C. Special Equipment/Clothing

Special Equipment or Clothing	O
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The above is intended to describe the general content of, and requirements for, the performance of this job. It is not intended to be construed as an exhaustive statement of duties, responsibilities or requirements.

For Ergonomic Questions – Please contact Providence Employee Health services at 907-261-4837

** Reference: The Dictionary of Occupational Titles defines force exerted and frequency of work.

PROVIDENCE HEALTH & SERVICES ALASKA

JOB DESCRIPTION

JOB CODE:

JOB TITLE: OPERATING ROOM TECHNICIAN

PROCESS LEVEL: Providence Mat-Su Surgery Center

REPORTS TO: Director of Nursing and Quality

SUPERVISES: N/A

DESCRIPTION STATUS:

POSITION SUMMARY

Operating room technician (OR Tech) works with surgeons, anesthesiologists, nurses, and other surgical personnel in delivering patient care during surgery. Handles instruments, supplies, and equipment necessary during the surgical procedure, anticipates the needs of the surgeon in providing these and maintains a sterile environment.

ESSENTIAL JOB FUNCTIONS: (Responsibilities, accountabilities, and competencies. May not include all duties of this job)

A. JOB DUTIES

1. Anticipates the needs of the surgeon, as well as emergency and unusual circumstances, acts accordingly to expedite the surgery, and initiates corrective actions.
2. Provides for the comfort and safety of the patient during the operation. Anticipates the need for supplies, identifies developing emergency situations, and initiates actions to assist in the care of the patient. Operates all equipment, including the preparation of hemeostatic, and blood replacement products and devices.
3. Demonstrates appropriate review of patient chart and intervenes as necessary to assure chart is complete prior to surgery. Appropriately identifies and safely transports patients to and from operating rooms.
4. Sets up surgical equipment. Selects and prepares appropriate equipment, suture, and stapling devices for procedures. Cleans and sterilizes equipment.
5. Implements care/services that recognize age/diversity specific needs/issues of customers served.
6. Performs other related duties as required.

B. IDENTIFIED COMPETENCIES

Completes initial and annual Competency Plan for assigned job and department.

C. CORE VALUES

Demonstrates personal and interpersonal qualities that support the Core Values of Providence Health & Services.

D. ESSENTIAL JOB QUALIFICATIONS (Any equivalent combination of knowledge, skills, abilities, education, and experience)

1. **EDUCATION:** High School diploma or equivalent required. Graduation from a Surgical Technology Program accredited by the Committee on Allied Health Education and Accreditation (CAAHEP) or other program accredited by the Liaison Council on Certification for the Surgical Technologist or completion of a Surgical Technician Military Training program is required.

2. **EXPERIENCE:** Operating Room experience for candidates who have graduated from an accredited Surgical Technology Program or have completed other accredited programs by the Liaison Council on Certification for the Surgical Technologist or completion of a Surgical Technician Military Training program. Candidates with equivalent other or at least six months of on the job clinical training must have minimum one year operating room experience scrubbing on surgical procedures.

3. **LICENSURE/CERTIFICATION:** Certified Surgical Technologist (CST) is required.

4. **OTHER QUALIFICATIONS:** Experience scrubbing independently in at least three surgical specialties; e.g. general surgery, orthopedics, urology, cardiac/vascular, ENT, ophthalmology, neurosurgery, etc.

5. **ATTENDANCE:** Regular attendance is a requirement of this position.

6. **ENGLISH LANGUAGE:** Must be able to read, write, and speak English.

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Employee Printed Name: _____ Date: _____

Employee Signature: _____ Emp No: _____

IN AN 8 HOUR WORKDAY, THIS JOB REQUIRES:

N = NEVER	(0 hours per day)
R = RARELY	(less than 1/2 hours per day)
O = OCCASIONALLY	(1/2 to 2.5 hours per day)
F = FREQUENTLY	(2.5 to 5.5 hours per day)
C = CONTINUALLY	(5.5 to 8 hours per day)

WORKING CONDITIONS/ENVIRONMENT

I. LIFTING/CARRYING (Amount of force exerted to lift and/or carry)

1 - 10 lbs.	F
11 - 20 lbs.	F
21 - 35 lbs.	O
36 - 50 lbs.	O
51 - 75 lbs.	O
76 - 100 lbs.	

II. PUSHING/PULLING (Amount of force exerted to push and/or pull)

1 - 10 lbs.	F
11 - 20 lbs.	F
21 - 35 lbs.	F
36 - 50 lbs.	F
51 - 75 lbs.	F
76 - 100 lbs.	O

III. POSTURES/MOVEMENTS

Sitting	O
Standing	C
Walking	C
Stooping, kneeling, crouching and/or crawling	O
Reaching and /or grasping	C
Hand/finger dexterity	C
Climbing and/or balancing	O
Carrying, pushing and/or pulling	F

IV. COGNITIVE/SENSITIVE

Talking	F
Hearing	C
Sight (Addendum: acuity, color blindness)	C
Smelling/tasting	O

OCCUPATIONAL ASPECTS

A. WORK ENVIRONMENT

Working inside	C
Working outside	N
Changing Temperatures	F
Wet/Humid Conditions	R
Areas of dust, odors, mist, gases or other airborne matter	C
Mechanical, electrical and/or other hazards	F
Confined Spaces	O

B. OTHER ASPECTS

Infectious Agents	O
Chemicals	O

C. Special Equipment/Clothing

Special Equipment or Clothing	F
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PROVIDENCE HEALTH & SERVICES ALASKA

JOB DESCRIPTION

JOB CODE:

JOB TITLE: STERILE PROCESSING TECHNICIAN

PROCESS LEVEL: Providence Mat-Su Surgery Center

REPORTS TO: Director of Nursing and Quality

SUPERVISES: N/A

DESCRIPTION STATUS:

POSITION SUMMARY

Sterile Processing (SP) technician is responsible for cleaning, inspection, assembling, sterilization, and distribution of instruments and equipment. SP technician prepares operating room (OR) case carts and functions as preceptor and resource to new SP staff.

ESSENTIAL JOB FUNCTIONS: (Responsibilities, accountabilities, and competencies. May not include all duties of this job)

A. JOB DUTIES:

1. Technical: Transports and receives soiled instruments and equipment. Cleans and decontaminates instruments and equipment according to the surgery center's protocols and device manufacturers' guidelines. Inspects and assembles instruments and instrument sets; tags and removes from service damaged and or defective instruments and equipment. Prepares and packages instruments and instrument sets for sterilization. Sterilizes instruments and instrument sets according to manufacturers' guidelines. Performs sterilization and testing and takes appropriate action, including load recall, in the event of a sterilization failure. Stocks and stores instruments according to the surgery center's protocols; distributes items as requested by customers. Prepares OR case carts in an accurate and timely manner; utilizes resource map system. Assists inventory coordinator as needed.
2. Documentation: Responsible for accurate maintaining of sterilization records.
3. Communication/Teamwork: Uses positive interpersonal skills when interacts with customers and team members. Communicates in a manner that facilitates teamwork and collaboration in order to ensure patient safety and excellence in patient care.

4. Quality: Participates in department quality improvement initiatives, including peer review and tray accuracy audits.
5. Safety: Complies with all safety protocols of the facility.
6. Problem Solving/Critical Thinking: Identifies real or potential issues that may affect accuracy and timeliness of instrument processing and distribution; solves issues within area of knowledge, and refers complex issues to the appropriate team member.
7. Implement care/services that recognize age/diversity specific needs/issues of customers served.
8. Performs other related duties as required.

B. IDENTIFIED COMPETENCIES

Completes initial and annual Competency Plan for assigned job and department. Competencies include mandatory surgical competencies and BLS and may include other competencies as designated.

C. CORE VALUES

Demonstrates personal and interpersonal qualities that support the Core Values of Providence Health System.

D. ESSENTIAL JOB QUALIFICATIONS (Any equivalent combination of knowledge, skills, abilities, education, and experience)

1. EDUCATION: High school diploma or equivalent.
2. EXPERIENCE: One year experience as a sterile processing technician.
3. LICENSURE/CERTIFICATION: CRCST or CBSPDT certification required.
4. OTHER QUALIFICATIONS: Must be able to visually distinguish colors. Must be able to follow written instructions and perform multiple tasks, and have a basic working knowledge of computers.
5. ATTENDANCE: Regular attendance is a requirement of this position. Must be able to flex schedule in order to meet customer needs.
6. ENGLISH LANGUAGE: Must be able to read, write, and speak English.

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O = OCCASIONALLY	(1/2 to 2.5 hours per day)
F = FREQUENTLY	(2.5 to 5.5 hours per day)
C = CONTINUALLY	(5.5 to 8 hours per day)

WORKING CONDITIONS/ENVIRONMENT

I. LIFTING/CARRYING (Amount of force exerted to lift and/or carry)

1 - 10 lbs.	C
11 - 20 lbs.	C
21 - 35 lbs.	O
36 - 50 lbs.	R
51 - 75 lbs.	R
76 - 100 lbs.	N

II. PUSHING/PULLING (Amount of force exerted to push and/or pull)

1 - 10 lbs.	F
11 - 20 lbs.	F
21 - 35 lbs.	O
36 - 50 lbs.	O
51 - 75 lbs.	R
76 - 100 lbs.	N

III. POSTURES/MOVEMENTS

Sitting	R
Standing	F
Walking	O
Stooping, kneeling, crouching and/or crawling	O
Reaching and /or grasping	F
Hand/finger dexterity	F
Climbing and/or balancing	R
Carrying, pushing and/or pulling	F

IV. COGNITIVE/SENSITIVE

Talking	F
Hearing	F
Sight (Acuity, color blindness)	F
Smelling/tasting	R

OCCUPATIONAL ASPECTS

A. WORK ENVIRONMENT

Working inside	C
Working outside	N
Changing Temperatures	R
Wet/Humid Conditions	R
Areas of dust, odors, mist, gases or other airborne matter	N
Mechanical, electrical and/or other hazards	R
Confined Spaces	N

B. OTHER ASPECTS

Infectious Agents	R
Chemicals	R

C. Special Equipment/Clothing

Special Equipment or Clothing	R
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Appendix G
AORN Position Statements



POSITION STATEMENT

Operating Room Staffing Skill Mix for Direct Caregivers

PREAMBLE

A primary responsibility of perioperative nursing managers is to create an environment in which the safe care of the patient is the priority. Developing a staffing plan in which adequate numbers of competent perioperative registered nurses are available to care for patients and their family members is a critical component. Health care market forces (eg, lower reimbursement, a competitive health care environment) have compelled health care administrators to place pressure on perioperative nursing managers to reduce labor costs associated with staffing salaries. It is imperative that perioperative nursing managers understand factors influencing staffing patterns to maximize staffing resources. Perioperative nursing managers need to clearly articulate staffing ratio recommendations and provide justification to support them.

An important step in providing safe patient care is the development of a perioperative staffing ratio that provides the skill level necessary to promote optimum patient outcomes and efficient patient flow; is fiscally responsible; and satisfies federal, state, and local regulations. Some studies have demonstrated an association between lower RN staffing levels and adverse patient outcomes.¹⁻⁴

The perioperative registered nurse is accountable for patient outcomes resulting from the nursing care provided during the perioperative experience. A perioperative registered nurse functioning in the circulating role must plan and direct the nursing care of every patient undergoing surgical and other invasive procedures, thus requiring a 1:1 perioperative RN:patient ratio.^{5,6} The scrub role may be filled by an RN or a surgical technologist (ST)/licensed practical nurse (LPN). To this end, perioperative nursing managers must develop a staffing plan that integrates the perioperative registered nurse into the circulating role and accommodates for skill diversity in the scrub role. Sufficient numbers of perioperative registered nurses are necessary to meet this objective.

Although there is no consensus among perioperative nursing managers related to OR skill mix ratios, a survey conducted by AORN indicates a 2:1 (67:33) RN:ST/LPN ratio. AORN's findings are consistent with current literature.⁷⁻¹¹

POSITION STATEMENT

AORN believes that perioperative nursing managers in acute care and ambulatory facilities should maintain a minimum RN:ST/LPN ratio of 67:33 (two RNs to one ST/LPN) to provide two circulating nurses on nonanesthetist provider sedation procedures and procedures requiring a second circulating nurse and to provide additional RN resources when necessary.

AORN believes that OR staffing skill mix ratios must ensure that every patient undergoing a surgical or invasive procedure has a perioperative registered nurse in the role of circulator.⁶

AORN believes that OR staffing skill mix ratios must ensure that the core activities of perioperative nursing care (ie, assessment, diagnosis, outcome identification, planning implementation, evaluation) are completed by a perioperative registered nurse.⁵

AORN believes that OR staffing skill mix ratios should support the perioperative registered nurse functioning in both the scrub and circulating roles.

AORN believes that direct caregivers who are in orientation should not be included when calculating OR skill mix ratios.

GLOSSARY

Direct staff caregivers. The direct caregivers in the OR are defined as those directly involved in providing care to patients undergoing surgical or other invasive procedures. For the purpose of this document, individuals providing direct patient care include perioperative registered nurses and STs/LPNs. Staffing policies for the OR should state the minimum number of personnel that will be provided for different types of surgical procedures. Procedure complexity and patient acuity may necessitate more than the minimum number of personnel identified.

Skill mix. Ratio of RNs to STs/LPNs providing direct patient care in the department.

REFERENCES

1. Agency for Healthcare Research and Quality, "Hospital nurse staffing and quality of care," in *Research in Action* (Rockville, Md: Agency for Healthcare Research and Quality, March 2004) 1-9.
2. Institute of Medicine, "Maximizing workforce capability," in *Keeping Patients Safe: Transforming the Work Environment of Nurses* (Washington, DC: National Academies Press, 2004) 171.
3. M A Blegen, C J Goode, L Reed, "Nurse staffing and patient outcomes," *Nursing Research* 47 (January/February 1998) 43-50.
4. A J Hartz et al, "Hospital characteristics and mortality rates," *The New England Journal of Medicine* 321 (Dec 21, 1989) 1720-1725.
5. "AORN official statement on unlicensed assistive personnel" in *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2004) 167.
6. "AORN statement on nurse-to-patient ratios," in *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2004) 157-158.
7. F Koch, "Staffing outcomes: Skill mix changes," *Seminars in Perioperative Nursing* 5 (January 1996) 32-35.
8. J Shamian, "Skill mix and clinical outcomes," *Canadian Operating Room Nursing Journal* 16 (June 1998) 36-41.
9. B Fernsebner, S Beyea, "Survey provides a snapshot of staffing challenges in the OR," *OR Manager* 17 (June 2001) 1, 10-13.
10. "Salary/career survey," *OR Manager* 19 (October 2003) 13.
11. "Salary/career survey," *OR Manager* 20 (October 2004) 15.



*Original approved by the House of Delegates, New Orleans, April 2005.
Reaffirmed by the Board of Directors: October 2011
Sunset review: October 2012*



POSITION STATEMENT

One Perioperative Registered Nurse Circulator Dedicated to Every Patient Undergoing A Surgical or Other Invasive Procedure

PREAMBLE

The perioperative nurse is a registered nurse who plans, coordinates, delivers, and evaluates nursing care to patients whose protective reflexes or self-care abilities are potentially compromised during surgical or other invasive procedures. Although the perioperative registered nurse works collaboratively with other perioperative professionals (eg, surgeons, anesthesia care providers, surgical technologists) to meet patient needs, the perioperative registered nurse is accountable for the patient outcomes resulting from the nursing care provided during the surgical or invasive procedure. Possessing clinical knowledge, judgment, and critical-thinking skills based on scientific principles, the perioperative nurse plans and implements nursing care to address the physical, psychological, and spiritual responses of the patient having a surgical or invasive procedure. The goal of perioperative nursing practice is to assist patients, their families, and significant others to achieve a level of wellness equal to or greater than that which they had before the procedure. The perioperative registered nurse may delegate certain patient care tasks to suitably trained and competent allied health providers and assistive personnel, but retains accountability for the outcome of perioperative nursing care. Core nursing activities that, by licensure, may not be delegated are assessment, diagnosis, outcome identification, planning, and evaluation.¹

In conjunction with the escalating changes in health care, there is a continuous need to provide optimal care that is high quality, safe, accessible, cost-effective, and affordable for patients undergoing invasive procedures in any setting. Evolving models of health care delivery are affecting perioperative nursing practice across diverse settings where surgical or other invasive procedures are performed. Past staff reengineering attempts that were part of cost-savings initiatives have not demonstrated improvement, and may in fact have a deleterious effect on patient care outcomes. Health care systems have unsuccessfully attempted to replace registered nurses with allied health providers and assistive personnel who lack the education and critical-thinking skills to provide quality patient outcomes. Studies have demonstrated that patient-centered outcome measures are more positive when there are higher numbers of registered nurses to care for patients. Better outcomes are inversely proportional to cost. In other words, better outcomes equals lower cost for the health care system.²

The aging of the population has resulted in patients who are more acutely ill upon admission to health care facilities. Despite the decreased lengths of stay in acute care facilities, patients continually require more sophisticated care to maintain their health. This situation has been further complicated by an absence of standardized, mandatory public reporting of data that could objectively quantify the effects of altered staffing configurations. National use of the AORN Perioperative Nursing Data Set (PNDS) will provide perioperative leaders with a standardized means of gathering reliable and valid data to make informed decisions regarding staffing, scheduling, and purchasing.³

Registered nurses are familiar with anecdotal reports of health care errors resulting in patient injuries and even death. The media has continued to fuel the health care controversy with many of these stories. In 1999, the Institute of Medicine (IOM) published its report *To Err Is Human: Building a Safer Health System*, which opened the issue of medical errors to public debate and identified national, state, and local policy directions for a safer health care system capable of reducing medical errors and improving patient safety.⁴ To improve patient safety, the provision of one perioperative registered nurse circulator dedicated to every patient undergoing a surgical or other invasive procedure must include awareness of community needs and the needs of the population served and must provide for appropriate perioperative nursing staff to meet those needs. The economic situation of the provider organization should not serve as the sole basis for determining services offered. At no time should economic concerns supersede the priority for patient safety.

Since its 1999 report, the IOM's Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes has begun to illustrate the relationship between nurse staffing, patient outcomes, and cost of care.⁵ This report acknowledges that patient care provided by a registered nurse does affect patient outcomes and has a positive impact on cost of care.⁵ The Code of Federal Regulations "Conditions of participation for hospitals" (42 CFR §482) sets forth national staffing standards for hospitals receiving Medicare reimbursement. Under these regulations, the health care organization must have adequate numbers of qualified registered nurses to provide nursing care, which includes circulating duties.⁶ The Centers for Medicare and Medicaid Services interpretive guidelines in §482.51(a)(3) state, "The circulating nurse must be an RN." If a licensed practical nurse or surgical technologist assists with delegated circulating duties, in accordance with local, state, and federal regulations, they must be supervised by a registered nurse who is physically present in the operating room for the entire procedure.⁷ Several states have legislation requiring a registered nurse as circulator.⁸ Perioperative registered nurses should know their individual state statutes regarding the role of the registered nurse as the circulator in the perioperative setting.

Administrators, directors, and managers responsible for providing staff for perioperative services should refer to the "AORN position statement: Operating room staffing skill mix for direct caregivers"⁹ and "AORN guidance statement: Perioperative staffing."¹⁰

POSITION STATEMENT

AORN is committed to the provision of safe perioperative nursing care by ensuring that every patient undergoing a surgical or other invasive procedure is at a minimum cared for by a registered nurse in the circulating role, regardless of the setting.⁹ To this end, AORN believes the following:

- At a minimum, one perioperative registered nurse circulator should be dedicated to each patient undergoing a surgical or other invasive procedure and present during that patient's entire intraoperative experience.¹⁰
- Patient care in the perioperative setting is dynamic in nature and depends on the clinical knowledge, judgment, and critical-thinking skills possessed by the perioperative registered nurse.
- The foundation of perioperative nursing practice is based on both the art and science of nursing, including evidence-based practice and patient advocacy.
- A practice environment that acknowledges the unique education of a registered nurse supports perioperative nurses to provide the highest quality of patient care in the surgical arena.

Scientific research and the identification of nursing quality indicators, such as those found in the language of the PNDS, are the best means to monitor the relationship between appropriate nurse staffing and patient outcomes in the surgical setting.

- Having a practice environment with one perioperative registered nurse circulator dedicated to each patient undergoing a surgical or other invasive procedure will provide for safe, quality patient care in the surgical arena.
- Administrative and collegial support, as well as effective relationships with physicians and surgeons, contributes to the perioperative nurse's ability to provide safe, quality patient care.

Furthermore, AORN affirms

- Support for ongoing research to determine proper nurse staffing to sustain safe quality patient outcomes,
- Continued collaboration with all organizations endeavoring to reduce and eliminate health care errors, and
- Adequate staffing as an essential element of error prevention.

REFERENCES

1. Perioperative patient focused model. In: Standards, Recommended Practices, and Guidelines. Denver, Colo: AORN, Inc; 2006:13-16.
2. Needleman J, Buerhaus P, Mattke S, Stewart M, Zelevinsky K. Nurse-staffing levels and the quality of care in hospitals. *N Engl J Med*. 2002;346:1715-1722.
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Sunset review: March 2012



POSITION STATEMENT

Orientation of the Registered Nurse and Certified Surgical Technologist to the Perioperative Setting

POSITION STATEMENT

1. AORN believes there are certain basic components that must be incorporated into the orientation of perioperative registered nurses (RNs) and certified surgical technologists (CSTs) and met consistently to ensure optimal patient outcomes.^{3-5, 7,8,18}

This position statement on orientation does not apply to registered nurses or surgical technologists who are contracted travelers.

NOTE: In collaboration with the perioperative RN in the circulating role, the CST* functions as a member of the team to maintain an environment that facilitates a safe patient outcome.

2. AORN supports the use of an outcomes-focused orientation process that incorporates the outcomes defined in the Perioperative Nursing Data Set.¹⁰ The following topics should be developed by the organization and incorporated into the orientation of perioperative RNs and CSTs* as applicable..

Domain 1: Safety. The patient will be free of signs and symptoms of acquired physical injury. (Patient-specific outcomes are in parentheses.)

- Prevention of retained surgical items (O.20)
- Electrosurgical safety (O.10, O.70)
- Laser safety (O.90)
- Medication safety (O.130)
- Positioning (O.80)
- Radiation safety (O.110)
- Smoke evacuation (O.90)
- Specimen handling (O.40)
- Universal Protocol (O.30)
- Pneumatic Tourniquets (O.60)
- Equipment/instrumentation/supplies\
 - Minimally invasive (ie, endoscopic) equipment (O.60)
 - Powered equipment (O.10)
 - Basic instrumentation (O.10)
 - Basic OR equipment (eg, tables, lights, electrosurgical unit, suction) (O.80, O.60)
- Implants (ie, documentation/tracking)

Domain 2: Physiologic response. The patient's physiologic responses to surgery are as expected. (Patient-specific outcomes are in parentheses.).

- Individualized plan of care (O.730)
- Normothermia (O.290)
- Basic life support/code response – cardiac and respiratory status (O.320, O.310)
- Latex allergy (O.100)
- Malignant hyperthermia (O.280)
- Monitoring and sedation (O.310, O.320, O.330)
- Prevention of infection (O.280)
 - Infection control
 - Surgical attire
 - Wound management
 - Instrument processing (ie, care and handling)
 - Sterilization/disinfection
 - Skin preps
 - Scrubbing, gowning, and gloving
- Respiratory status (eg, airway maintenance, assisting with intubation/extubation) (O.310)
- Surgical Implants – Synthetic and Biologic (O.280)

Domain 3A: Behavioral response. The patient and family are knowledgeable regarding the perioperative process.

- Advance directives (O31)
- Informed consent (O31)
- Preoperative teaching (includes postoperative self-care) (O18 - O23)

Domain 3B: Behavioral response. The patient and his or her family member's rights and ethics are supported. (O26)

- Advocacy (O.23, O.24, O.26)
- Age-specific policies (O.21, O.24)
- Cultural/population-specific policies (O.28)
- Documentation (O24)
- Health Insurance Portability and Accountability Act compliance (O.25).
- Patient privacy policies (O.25)
- Patient self-determination act (O.23)

Domain 4: Health system concerns. The perioperative RN and CST* have knowledge regarding the perioperative and health system environment.

- Career advancement
- Certification
- Code of conduct
- Committee participation
- Communication
- Critical thinking
- Disaster planning
- Employee rights
- Employee safety
- Environmental responsibility (eg, hazardous waste, sustainability)
- Fire safety

- Legal issues/documentation
- Organizational structure
- Performance improvement projects
- Professional associations
- Regulatory issues
- Scope of practice
- Team roles
- Terminology
- Vendor policies

3. The recommended duration for orientation of a novice perioperative RN should be six to twelve months.
4. Orientation for a novice perioperative RN should include both a didactic and clinical component.
5. The recommended duration for orientation of a novice CST* should be up to six months.
6. Entry into practice for a CST* must follow graduation from an accredited surgical technology program.
7. The recommended duration for orientation of an experienced perioperative RN or CST* should be a minimum of three months.
8. Completion of an individualized orientation for both novice and experienced RNs and CSTs* should be measured by successful competency assessment that is role and scope specific.
9. Orientation programs should be customized to meet the individual needs of the orientee and incorporate the facility required learning experiences and the orientee's baseline knowledge and preferred learning method.
10. The scope of responsibility of the perioperative RN includes the scrub role as it relates to patient outcomes.² Therefore, the perioperative RN should be oriented to both the scrub and circulating roles during the orientation period.
11. The perioperative RN should be oriented to his or her responsibilities in the coordination of care and delegation of specific duties of the scrub role.^{3,8}
12. The orientation process should include orientation to off shifts, weekends, and on-call situations^{4-6,8,10,14}
13. A basic orientation for a novice perioperative RN or CST* also should include at least 40 hours for every clinical specialty within his or her defined practice area.^{4,8,14}
14. A skills assessment should be completed to accurately assess competency levels in all specialties for the novice and experienced perioperative RN and CST*.
15. Orientation should be accomplished using a preceptor system (ie, an experienced RN or CST serves as an immediately available resource for the orientee). The orientee should not be included in the staffing numbers ratio.

RATIONALE

- **Orientation Programs**

Facilities vary and one orientation program may not adequately address every need. Orientation timelines and their effect on the budget varies depending on the capacity of the facility.^{6,11,14} Facilities should consider developing an advisory committee that incorporates both experienced perioperative RNs and CSTs* to work with the orientation coordinator to design and implement both the orientation program and the preceptor development program.

Before a new perioperative RN or CST* begins to function in his or her environment, the orientation coordinator assesses the ability of the health care system to accommodate the required learning experiences and the orientee's baseline knowledge and preferred learning method. Teamwork is an essential element in a successful orientation program.

- **Scrub Role**

AORN believes that the perioperative RN performing in the role of the scrub person is practicing nursing.^{1,7,8,10,11,14} Maintaining these skills can present a challenge in some facilities; however, performance in the scrub role enhances the overall competence of the nurse in the circulating role. The perioperative RN's presence in the scrub role does not negate the need for a perioperative nurse in the circulator role. AORN acknowledges the long and rich history of the perioperative RN performing in the role of scrub person¹.

The perioperative RN maintains an active presence when performing the scrub role to ensure the appropriate delegation and supervision of scrub duties to new orientees and to maintain an integral link between the scrubbed team members and the circulator, which contributes to achieving optimal patient outcomes. The perioperative RN's presence in the scrub role enhances the perioperative RN's ability to assess and implement a plan of care, including the appropriate delegation of duties to orientees.

Perioperative nursing practice incorporates cognitive, behavioral, and technical components. When performing in the scrub role, the perioperative RN augments his or her ability to anticipate, plan for, and respond to the needs of the patient, surgeon, and other team members. The perioperative RN is cognizant of patient responses to both planned and unplanned surgical events. He or she contributes to the overall well-being of a patient by being vigilant in assessing the patient's condition.

Delegation

The perioperative RN is responsible for coordinating care, including delegating technical functions under his or her direct supervision to individuals who are not licensed to practice as an RN based on the individual's level of training and competency.

- **Off Shift Orientation**

Off shifts, weekends, and on-call situations present challenges to the new perioperative RN or CST*. Providing adequate support during these new situations

helps to ensure both employee and physician satisfaction and patient safety. It is critical that orientation to these situations is accomplished using a preceptor system (ie. an experienced nurse or certified* surgical technologist serves as an immediate resource for the orientee).

* AORN recognizes that different standards exist across the country with regard to educational preparation and certification of surgical technologists. The Association of Surgical Technologists (AST) supports the certification exam as the outcome indicator for graduation from accredited surgical technology programs. Beginning in August 2011, the CST exam will become the only outcome indicator for accredited programs.

GLOSSARY

Novice perioperative RN: any registered nurse who has not worked in the perioperative environment before, including a new graduate, an experienced nurse from another area of nursing, or a nurse with previous OR experience who has not maintained basic competency.

Novice certified surgical technologist:* an entry-level practitioner who has recently graduated from an accredited surgical technology program and who has been employed for one year or less. Experienced CSTs* with previous OR experience who have not maintained basic competency also are included in this category.

Experienced perioperative RN: a registered nurse with recent perioperative experience. This nurse should have a minimum of two years of experience in a facility of similar size and patient acuity as the hiring facility. A skills assessment should be completed to accurately assess competency levels in all specialties.

Experienced certified surgical technologist:* a technologist with recent perioperative experience. This technologist should have a minimum of two years of experience in a facility of similar size and patient acuity as the hiring facility. A skills assessment should be completed to accurately assess competency levels in all specialties.

Orientation coordinator: a nurse educator or designated experienced perioperative registered nurse, clinical nurse specialist, and/or nurse manager who is a registered professional nurse.

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Appendix H

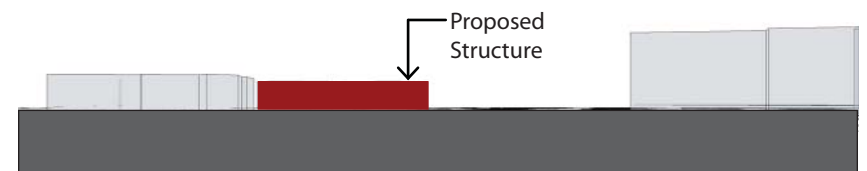
Site Plan



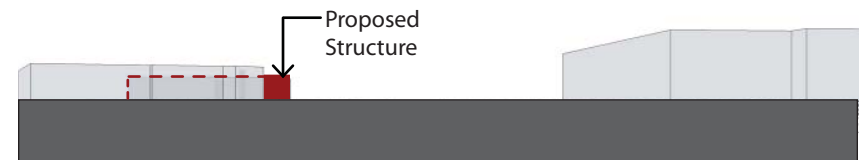
Site Plan



Aerial Overlay with View Locations from the Parks Highway



View 1 from the Parks Highway



View 2 from the Parks Highway



Floor Plan