

**APPLICATION FOR CERTIFICATE OF NEED**  
**Health Care Facility Projects**  
*(excluding nursing home, hospital, or CCRC related projects)*

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

<p>Signature and Title of Responsible Officer</p> <p>Beth Marker          Director of Finance          Evergreen Eye Center</p> <p>Signature: <i>Beth Marker</i></p>	<p>Date: 1 Aug 2018</p> <p>Telephone Number: 800.340.3595</p>
<p>Legal Name of Applicant</p> <p>Evergreen Eye Center, Inc PS</p> <p>Address of Applicant</p> <p>Evergreen Eye Center          716 South 348th St          Federal Way, WA 98003</p>	<p>Type of Application:  <input checked="" type="checkbox"/> Ambulatory Surgical Facility  <input type="checkbox"/> Kidney Disease Treatment Center</p> <p>Type of Project (check all that apply)</p> <p><input checked="" type="checkbox"/> New Health Care Facility  <input type="checkbox"/> Capital expenditure over expenditure minimum  <input type="checkbox"/> Pre-development Expenditure  <input type="checkbox"/> Increase in the number of dialysis stations in a kidney disease center</p>
<p>Intended date of incurring contractual obligation to construct, acquire, lease or finance capital asset:</p> <p>Estimated capital expenditure: \$ <u>0</u></p>	<p>Intended date of undertaking project:</p> <p>Proposed project is CON approval of existing exempt facility; thus, commencement will be upon CON approval.</p> <p>Intended date for beginning to offer services or operate completed project:</p> <p>Project completion upon CON approval; Anticipated date of 15 Dec 2018</p> <p>Project Summary:</p> <p>CON approval to convert existing exempt one-operating room ambulatory surgical facility (ASF) into a CON approved ASF in Federal Way, WA.</p>

**AMBULATORY SURGERY CENTER**  
**FEE REQUIRED**

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

Ambulatory Surgery Center:           \$20,427

Applicant Name:                        Evergreen Eye Center (EEC Seattle)

Date of Submission:                   \_\_\_\_\_

Check Number:                         \_\_\_\_\_

### ***Application Instructions***

The department will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. (RCW 78.38.115, WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, WAC 246-310-240. For kidney disease treatment centers-WAC 246-310-280 thru 289, and for ambulatory surgery centers- WAC 246-310-270.

#### **General Instructions:**

- Include a Table of contents for major application sections and appendices
- Number **all** pages consecutively
- **Do not** bind or 3-hole punch the application.
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- Provide detailed descriptions of assumptions used for all projections.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.

#### **Submission Instructions:**

- Number of Copies-Initial application:
  - original,
  - one copy,
  - one electronic (pdf) version
- Number of Copies-all other submissions:
  - Original
  - one copy
  - one electronic (pdf) version

#### **To be accepted, the application must include:**

- A completed and signed Certificate of Need application face sheet
- The review fee of:
  - **\$20,427** for Ambulatory Surgical Centers. Make check payable to **Department of Health**
  - **\$25,054** for Kidney Disease Treatment Centers. Make check payable to **Department of Health**
- Send application to:

#### **Mailing Address:**

Department of Health  
Certificate of Need Program  
P O Box 47852  
Olympia, Washington 98504-7852

#### **Other Than by Mail:**

Department of Health  
Certificate of Need Program  
111 Israel Road SE  
Tumwater, Washington 98501

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- Exhibit 5. EEC Seattle License and Accreditation
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- Exhibit 7. EEC Seattle Historic Services; Identified by Top 30 CPT Codes
- Exhibit 8. EEC Seattle Patient Admission, Assessment and Discharge Policy
- Exhibit 9. EEC Seattle Patient Rights and Responsibilities
- Exhibit 10. EEC Seattle Non-Discrimination Policy
- Exhibit 11. EEC Seattle 1.23 Charity Care and Community Service Plan Policy
- Exhibit 12. EEC Seattle Single Line Drawing
- Exhibit 13. EEC Seattle Lease Agreement
- Exhibit 14. EEC Seattle Construction Review
- Exhibit 15. Central King County Planning Area Methodology Calculation Worksheet
- Exhibit 16. EEC Seattle Pro Forma
- Exhibit 17. EEC Income Statement for 2016 and 2017
- Exhibit 18. National Health Statistics Reports; Number 11, January 28, 2009 – Revised September 4, 2009
- Exhibit 19. National Health Statistics Reports; Number 102, February 28, 2017
- Exhibit 20. Ambulatory Surgery Center Association “A Positive Trend in Health Care”
- Exhibit 21. American Academy of Ophthalmology “Rising Cataract Surgery Rates: Demand and Supply”
- Exhibit 22. Ophthalmology Times “The Future of Cataract Surgery”
- Exhibit 23. Michigan Medicine University of Michigan “Increased Use of Ambulatory Surgery Centers for Cataract Surgery”
- Exhibit 24. Washington State 2015 Charity Care Report
- Exhibit 25. WAC 246-310-270
- Exhibit 26. Health Affairs “Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up.”

## **PROJECT OVERVIEW:**

### **Evergreen Eye Surgeons, Inc PS (EEC)**

Evergreen Eye Surgeons, Inc PS (EEC) is a for-profit Washington State professional service organization professionally owned by four doctors, consisting of four MD's. Evergreen Eye Center began as the practice of John S. Jarstad, MD. The Evergreen Eye Center- Federal Way was established on October 2, 1989 in the Medical Office Building of The St. Francis Community Hospital in Federal Way, Washington. The suite was designed to include four examination lanes, two offices, a reception office and waiting room space for ten chairs. The practice began with Dr. Jarstad, one technician and one front desk staff.

During 1993 plans for a new eye center and ambulatory surgery center were developed to meet the increased demand for services. Upon completion of construction drawings in 1994 and review by the Washington State Department of Health, ground was broken in October for an ophthalmic clinic and surgery center.

On January 1, 1994, an optometrist was added to the practice in and a contract with Franciscan Family Care for ophthalmic services was concluded for the Tacoma area. In 1995 two additional ophthalmic technicians were added and surgery volumes increased to the maximum allowed by St. Francis Hospital and average patient visits increased to 40.7 per day in the clinic. As Evergreen Eye Center and Dr. Jarstad reached the saturation point in present facilities the new structure was taking shape and was completed in December 1995.

In November 1995 Evergreen Eye Center, Inc. purchased both the Rockey Eye Clinic and The Rainier Eye Clinic in Auburn, Washington, opening the Auburn/Central King County area for Evergreen Eye patient convenience. Dean M. Rockey, M.D. became the second ophthalmologist on staff.

The new building was occupied on December 15, 1995 and the patient per day ratio increased by 23%, and with the inclusion of Rainier Eye Clinic, The Rockey Eye Clinic and the Tacoma Franciscan facility. In March 1996 a registered nurse was hired to develop the surgery center and in July Medicare certified the surgery center for surgery.

In 1996, the ASC received initial CMS certification and began operations, with the addition of an RN to the staff. In 1997, Evergreen purchased another local practice and added a third MD, Dr. Thomas Roe. Shortly thereafter, Dr. Roe retired and Dr. Aaron Weingeist joined the practice. In the years that followed, the organization purchased the practices of several local ophthalmologists as they retired, but opened no new locations. Dr. Charles Birnbach, a fellowship-trained retina surgeon, joined the practice in 2000. A short time later, in 2002, Dr. Linda Day joined the practice part-time, providing medical retina services, as well as comprehensive ophthalmology.

In 2004, Evergreen purchased two practices in the Burien area and opened an Evergreen Eye Center clinic in that location. That same year, Dr. Robert Tester joined the practice directly from residency. The next year, Dr. Gary Chung also joined the practice directly from residency. That same year, both Dr. Weingeist and Dr. Birnbach left the practice and sold their shares in Evergreen Eye Center. As of the end of 2005, Evergreen Eye Center had five MDs and one OD on staff, operated three clinic locations and one ASC.

In 2015, Dr. Jarstad sold his interest in the practice to Dr. Tester and Dr. Chung, who became the sole owners of Evergreen Eye Center. The shareholders and administrator conducted the first strategic planning session the practice had done in a number of years. They created a new vision for the practice, along with guiding principles by which the shareholders and leadership would organization and through which every employee could govern their own behavior and performance as Evergreen employees.

This new vision focused on “leading-edge, patient-centered care” and becoming an “employer of choice” within ophthalmology regionally, a practice where patients would experience exceptional outcomes and have all treatment options made available to them, including cutting edge, advanced technologies. It focused on becoming a practice with an exceptional corporate culture, where the best employees would seek employment, a thought-leader within ophthalmology in the Puget Sound region. The shareholders also laid out some ambitious goals for their new administrator: in the first year or two, his focus would be assessing the practice, making changes as necessary, building a new administrative team, and laying the groundwork for growth – after which it was their intent to seek aggressive growth, in locations, physicians, and sub-specialties.

In August 2016, Dr. Day left the practice. Rather than fill her position, the practice decided to create a full-time medical retina/comprehensive ophthalmology position and hired Dr. Kelly Bui. Later that same year, after two years as an associate, the shareholders began the process of having Dr. Nicholson buy into the practice as an equal shareholder. Just a short time later, in early 2017, talks began with Dr. John Whitehead, sole owner and physician at Northwest Glaucoma and Cataract Surgery to acquire his practice through a merger that would establish him as an equal shareholder. The shareholders are on schedule to sign documents on both these transactions by the end of April 2018, with an execution date for the merger set as August 1, 2018.

Growth prospects for the Seattle location are very promising. Northwest Glaucoma and Cataract Surgery was the first new ophthalmology practice to open in Seattle proper in over 20 years, and while the conventional wisdom is that the area is oversaturated, our market research shows that it is actually underserved.

**Applicant – Evergreen Eye Center located in Federal Way (EEC Seattle)**

Evergreen Eye Centers located at the Federal Way location (referred to as EEC Seattle) is located within the Central King County secondary planning area. EEC Seattle owns and operates a two-operating room Certificate of Need exempt ambulatory surgery facility, only allowing access to this facility to members and employees of the practice. Northwest Glaucoma and Cataract was established in 2016, with the current lease agreement starting in 2016. EEC Seattle is licensed by the Washington State Department of Health and is Medicare and Medicaid certified. EEC Seattle received a determination of non-reviewability from the Certificate of Need program to perform specialized ophthalmic surgery in August 2018, within Central King County secondary planning area.

With this application, EEC Seattle proposes to establish a Certificate of Need ambulatory surgical facility located within Central King County secondary planning area. After Certificate of Need approval, EEC Seattle would continue to operate at the current location of 1229 Madison St, Ste 1250 Seattle, WA 98104.

For the purposes of this application, EEC Seattle is a dual operating room for specialized ophthalmic surgical services. One operating room is for traditional ophthalmic surgery procedures and the other is for laser-based, invasive ophthalmic procedures. This reasoning is based on definitions provided in WAC 246-330-010. An operating room "means a room intended for invasive procedures." An invasive procedure is a "procedure involving puncture or incision of the skin or insertion of an instrument or foreign material into the body including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations. Excluded are venipuncture and intravenous therapy."

EEC Seattle serves patients 18 years and older that meet EEC Seattle surgical admission guidelines. The specialized ophthalmic surgical services performed can be done appropriately in an outpatient setting.

Our CON exempt status requires us to become a CON approved ASF to extend privileges of using the ASF to physicians not part of EEC practice. Because the additional ophthalmic surgeons will not be employees, this action requires prior Certificate of Need review and approval before opening up additional operating minutes used by non-EEC surgeons in the area. Each interested surgeon will be required to become credentialed and maintain the standards EEC sets for privileges. There is no capital expenditure associated with this project, as there is no project-associated construction or equipment purchase. EEC Seattle is a fully equipped two-operating room ASF and with approval of the Certificate of Need will be increasing the operating minutes available within the Central King County secondary planning area. The costs associated with the increased minutes will be treated as operating expenses, rather than capital expenditure.

With an approval of the Certificate of Need application, EEC Seattle will begin to operate immediately as a Certificate of Need facility as soon as the Certificate of Need is granted. In accordance with the timeline and upon approval, EEC Seattle expects this to be within this year 2018. 2019 will be the first full year of operation as a Certificate of Need facility and will be used within this proposal as such.

## **I. APPLICANT DESCRIPTION:**

### **Legal name(s) of applicant(s)**

Evergreen Eye Center, Inc PS

Please see Letter of Intent for the requested project in Exhibit 1.

For the project purpose, Evergreen Eye Center will be referred to as EEC.

Name and address of the proposed/existing facility.

Evergreen Eye Center  
1229 Madison St, Ste 1250  
Seattle, WA 98104

For the project purpose, Evergreen Eye Center location will be referred as EEC Seattle.

Type of ownership (public/private/corporation, etc.).

EEC is a private for-profit physician owned Professional Service Corporation.

EEC was formed on October 2, 1989 and is currently owned by 4 doctors.

Please refer to Table 4 – to identify the Partners of EEC.

Name and address of owning entity at completion of project (unless same as applicant).

Evergreen Eye Surgeons, Inc PS  
716 South 348th St  
Federal Way, WA 98003

Name, title, address, and telephone number of the person to whom questions regarding this application should be directed.

Lance Baldwin, CoN Consultant  
2103 143rd PL SW  
Lynnwood, WA 98087  
lance@m-exec.com  
(509)818-0787

Beth Marker  
Director of Finance  
Evergreen Eye Center  
716 South 348th St  
Federal Way, WA 98003  
Beth@evergreeneye.com  
(800)343595

Corporate structure and related parties. Attach chart showing organizational relationship to related parties.

Please see Appendix

Name and address of operating entity at completion of project (unless same as applicant).

1229 Madison St, Ste 1250  
Seattle, WA 98104

General description and address of each facility owned and/or operated by applicant

**Table 1 – Name, CON license, and general description of N.W. Eye Surgeons Facilities**

<b>Ambulatory Surgery Centers/DBA</b>	<b>Exempt CON License</b>	<b>Physical Address</b>	<b>Description</b>
<b>Federal Way</b>	July 1996	34719 6th Ave.S Federal Way, WA 98003	Clinic with adjoining exempt CON two-operating room ASF.
<b>Auburn</b>	N/A	700 M St. NE Auburn, WA 98002	Clinic without an adjoining ASF.
<b>Burien</b>	N/A	15153 5th Ave SW Burien, WA 98166	Clinic without an adjoining ASF.
<b>Seattle</b>	July 2018	1229 Madison St, STE 1250 Seattle, WA 98104	Clinic with adjoining exempt CON two-operating room ASF.
<b>Federal Way-Administration Office</b>	N/A	716 South 348th St Federal Way, WA 98003	Administrative Offices

Source: EEC

Facility licensure/accreditation status.

EEC Seattle has active licenses from the Washington State Department of Health as well as Centers for Medicare and Medicaid Services certification.

Medicare CCN Number: 50C0001095

NPI Number: 1811445018

ASF License: ASF.FS. 60685668; expires on 07/01/2021

Is applicant reimbursed for services under Titles V, XVIII, and XIX of Social Security Act?

Yes, EEC Seattle is reimbursed for services under Titles V, XVIII, and XIX of Social Security Act. Please review the Table below for historical reimbursed numbers and projected reimbursed numbers.

**Table 2 – EEC Seattle Historical and Projected Reimbursed Numbers for Medicare and Medicaid**

	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
<b>Medicare</b>	\$677,564	\$695,858	\$714,647	\$733,942	\$753,758
<b>Medicaid</b>	\$169,391	\$173,965	\$183,486	\$183,486	\$188,440

Source: EEC Seattle pro forma and 2017 financials

Geographic identification of primary service area.

For the purposes of quantitative ambulatory surgery need analysis, the Central King County Secondary Health Services Planning area (“Central King planning area”) will be used to define in WAC 246-310-270 (3).

**Table 3 – Central King County  
Secondary Health Services Planning Area**

<b>Zip Codes for South East King County</b>	<b>Cities within the Zip Code</b>
98101	Seattle
98102	Seattle
98104	Seattle
98108	Seattle
98109	Seattle
98112	Seattle
98118	Seattle
98119	Seattle
98121	Seattle
98122	Seattle
98134	Seattle
98144	Seattle
98178	Seattle
98199	Seattle

Source: Washington State Department of Health, Department of Need Division

List physician specialties represented on active medical staff and indicate number of active staff per specialty.

**Table 4 – List of Partners and Employed Surgeons  
credentialed, with privileges and in good standing with EEC**

<b>Name</b>	<b>Partner or Employed</b>	<b>Specialty</b>	<b>License</b>	<b>Recorded Sanctions</b>
<b>Kelly Bui</b>	Employed	Cataract and Lens Implant Surgery, Medical Retina	MD60470169	No
<b>Gary Chung</b>	Partner	Cataract and Lens Implant Surgery, Cornea, Refractive	MD00045207	No
<b>Brice Nicholson</b>	Partner	Cataract and Lens Implant Surgery, Refractive	OP60251025	No
<b>Robert Tester</b>	Partner	Cataract and Lens Implant Surgery, Medical Retina	MD00043755	No
<b>Laura Periman</b>	Employed	Ocular Surface Disease Specialist	MD0003796	No
<b>John Whitehead</b>	Partner	Cataract and Lens Implant Surgery, Glaucoma	MD60070926	No

Source: EEC

EEC also employs optometrist who work within the clinic area of the facility. They are not identified within this proposal as they do not work within the ASF environment. Please refer to [www.evergreeneye.com](http://www.evergreeneye.com) for a list of current EEC optometrists.

List all other generally similar providers currently operating in the primary service area.

Similar providers are Hospital's with capacity to include inpatient, mixed use and outpatient operating rooms within the Central King planning area. ASF's within the Central King planning area are also considered similar providers.

**Table 5 – Hospitals and ASF's within the  
Central King County Secondary Health Services Planning Area**

<b>Facility</b>	<b>Certificate of Need</b>
Harborview Medical Center	Yes
Kaiser Central Hospital	Yes
Swedish Medical Center- First Hill	Yes
Swedish Medical Center - Cherry Hill	Yes
Virgina Mason medical Center	Yes
Pacmed Ambulatory Surgical Clinic	No
The Polyclinic Surgery Endoscopy Centers	No

Seattle Facial Plastic Surgery Center	No
Seattle Hand Surgery Group PC	No
Seattle Surgery Center	Yes
Seattle Plastic Surgery Center	No
Seattle Spine Institute	No
Pacific Northwest Center for Facial Plastic Surgery	No
Seattle Reproductive Surgery Center	Yes
The Polyclinic - Plastic Surgery Center	No
Kaiser Permanente Capitol Hill Procedure center	Yes
Minor and James Surgery Center	No
Minor and James Endoscopy Center	No
First Hill Surgery Center	Yes
Northwest Glaucoma and Cataract	No

Source: Washington State Department of Health Facility Search. List includes current (01/01/2018) active facilities.

For existing facilities, provide applicant's overall utilization for the last five years, as appropriate.

**Table 6 – Number of operations of the Eye performed at EEC Seattle for the past 5 years**

Year	Surgeries Performed
2016	151
2017	972
2018 YTD	633

Source: EEC Seattle EMR Data

Describe the history of applicant entity with respect to criminal convictions related to ownership/operation of health care facility, license revocations, and other sanctions described in WAC 246-310-230 (5)(a). If there have been no such convictions or sanctions, please state.

EEC has no history of convictions or sanctions as described in WAC 246-310-230 (5) (a)

The office of the Inspector General's (OIG) List of Excluded individual/Entities (LEIE) provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs. EEC Providers, Corporate Officers and Billing Personnel are not on the OIG exclusion list.

## II. PROJECT DESCRIPTION:

Include the following elements in the project description. Be aware that an amendment to a Certificate of Need is required for certain project modifications as described in WAC 246-310-100 (1).

Describe the project for which Certificate of Need approval is sought.

EEC Seattle is currently an exempt CON facility as a two-operating room ASF and operates in the Central King planning area.

EEC Seattle is requesting CON approval to expand services (operating minutes) to the Central King planning area. A non-exempt ASF is an integral step allowing EEC Seattle to expand their current offerings of local, affordable, and quality ophthalmic ambulatory surgery options to the Central King planning area residents. CON approval will open the ASF to all surgeons in the community who are able to become credentialed and privileged with EEC. This will ultimately increase the operating minutes within EEC Seattle single-operating room ASF and thus improve the Central King planning area residents' ability to receive a full range of surgical eye specialties. *EEC Seattle will remain a two-operating room entity and the type of services will continue to be ophthalmic only.*

Please review Appendix for Credentialing and Privileging policy.

Total estimated capital expenditures.

The proposed project does not require any construction or change in physical property. As such, there are no associated capital expenditures for the proposed project. EEC Seattle will remain a one-operating room entity and the type of services will continue to be ophthalmic only.

Total estimated operating expense for the first and second years of operation (*please show separately*).

**Table 7 – Estimated operating expense for the first and second years of operation**

Year	Projected Operating Expenses
2019	\$949,645
2020	\$976,426

Source: EEC Seattle pro forma

New services/changes in services represented by this project.

EEC Seattle is currently a two operating room ASF. The intention of the project is to be able to increase the utilization of minutes in the operating room by allowing non-EEC ophthalmic physicians to perform ophthalmic surgery in the facility.

EEC Surgeons perform Operations of the Eye which includes eye, the orbit, and the tissue and musculature surrounding the Eye. As a projection of services, this list in Exhibit 9 may be incomplete because procedures are continually being created as well as new techniques and devices that can be used to care for the Eye.

Please see Appendix for details of the type of historical services offered at EEC Seattle. It is measured by the top 30 CPT codes performed at EEC Seattle from years 2016-2017.

General description of types of patients to be served by the project.

EEC Seattle will continue to provide ophthalmic surgical care within its scope of service in which it is currently licensed. The patients are persons from the age of 18 and older who require ophthalmic surgery and are not expected to require hospitalization and can be served appropriately in an outpatient surgical setting. EEC Seattle’s operating rooms are equipped to provide ophthalmic surgeries for high-quality, safe, and state-of-the-art patient care. Surgeries performed in the ASF will be supported by moderate sedation/analgesia (conscious sedation).

**Table 8 – Average of 2014, 2015, 2016 Hospital Charity Care; EEC Seattle projected charity care**

	<b>% of Total Revenue (Three Year Average)</b>	<b>% of Adjusted Revenue (Three Year Average)</b>
<b>Hospitals in Central King County planning area</b>	1.84%	4.49%
<b>Hospitals in Central King County (excluding Harborview)</b>	0.82%	1.90%
<b>Hospitals in King County</b>	1.02%	2.25%
<b>EEC Seattle 2017</b>	0.0%	0.0%
<b>EEC Seattle 2019 Projected</b>	1.02%	3.40%

Source: Washington State Department of Health, Summary of charity care amounts provided by hospitals in Washington, 2015-2006 (Excel), Zip codes in King County; see also EEC Seattle pro forma.

Projected utilization of service(s) for the first and second year of operation following project completion (please show separately). This should be expressed in appropriate workload unit measures.

**Table 9 – Utilization of service(s) for the first and second year of operation**

<b>Year</b>	<b>Projected Number of Operations of the Eye</b>
2019	1,025
2020	1,053

Source: EEC Seattle pro forma

A copy of the letter of intent, per WAC 246-310-080.

Please refer to Appendix

Sources of patient revenue (Medicare, etc.) with anticipated percentage of revenue from each source. Estimate the percentage of change for each of the courses of revenue by payer that will result from this project.

**Table 10 – Sources of patient revenue with anticipated percentages**

<b>Payer</b>	<b>% Patients</b>	<b>% Payer Source</b>
<b>Medicare</b>	56%	24%
<b>Medicaid</b>	14%	6%
<b>Commercial/Health Care Contractor</b>	27%	67%
<b>Self-Pay</b>	3%	3%
<b>Total</b>	100%*	100%*

Source: EEC Seattle pro forma

\*Percentages may not equal 100 because of rounding.

**Source(s) of financing.**

The proposed project does not require any construction or change in physical property. EEC Seattle is a fully equipped single-operating room ASF and with approval of the CON will be increasing the operating minutes available within the Central King planning area. The costs associated with the increased minutes will be treated as operating expenses, rather than capital expenditure. Our estimated capital expenditure is \$0.

**Equipment proposed:**

Description of equipment proposed.

Description of equipment to be replaced, including cost of the equipment, and salvage value (if any) or disposal, or use of the equipment to be replaced.

The EEC Seattle operating room is currently equipped to provide ophthalmic surgeries for high-quality, safe, and state-of-the-art patient care. Additional equipment will not be purchased and equipment will not be replaced for the purpose of this proposal.

**Drawings:**

Single line drawings, *at least approximately to scale*, of current locations which identify current department and services.

Please see Appendix

**Total net and gross square feet of project.**

Total building square feet is 5,076 useable sq. ft.

Anticipated dates of both commencement and completion of project.

**Table 11 – Anticipated Timeline of CON submission, review and approval**

Action	Timeline	Actual/Anticipated Date
<b>Letter of Intent Submitted</b>		Received in CON Department 21 May 2018
<b>Application Submitted</b>	30 days after LOI submitted	1 August 2018
<b>Department's pre-review activities</b> <b>a) DOH 1st Screening Letter</b> <b>b) Applicant's Responses Received</b>	15 days for response from DON*; 45 days for applicant response	15 September 2018
<b>Beginning of Review</b>	45 days	
<b>Public Hearing Conducted</b>	Within the first 35 days of 45-day review	
<b>Public Comments accepted through end of public comment</b>	Within the first 35 days of 45-day review	
<b>Rebuttal Comments Due</b>	Last 10 days of 45-day review	
<b>Department's Anticipated Decision Date</b>	45 days	15 December 2018

Source: EEC Directors Discussion

\*Department of Need

Describe the relationship of this project to the applicant's long-range plan and long-range financial plan (if any).

EEC goal is to be the premier provider of outpatient ophthalmic surgery services in Washington State.

With the approval of a CON, EEC Seattle will be able to offer more operating minutes in the Central King planning area that will not only engage non-EEC surgeons, but it will also provide more access to specialized ophthalmic surgeries. This will work toward the goal that EEC has set.

Describe any of the following which would currently restrict usage of the proposed site and/or alternate site for the proposed project: (a) mortgages; (b) liens; (c) assessments; (d) mineral or mining rights; (e) restrictive clauses in the instrument of conveyance; (f) easements and right-of-ways; (g) building restrictions; (h) water and sewer access; (i) probability of flooding; (j) special use restrictions; (k) existence of access roads; (l) access to power and/or electricity sources; (m) shoreline management/environmental impact; (n) others (please explain).

EEC Seattle is currently an operational facility, and has been since June 2016. There are no issues that would prevent the continued usage of the site by the proposed project. Construction review available in Appendix.

Provide documentation that the proposed site may be used for the proposed project. Documentation may include, but not limited to a letter from any appropriate municipal authority, zoning information, and signed letter from leasing agent or realtor attesting to appropriate usage.

EEC Seattle is located in the Elmer J Nordstrom Medical Tower. The combined office/ASF facility is approximately 5,076sq. ft. of useable space.

Please also see Appendix for a copy of the lease agreement.

Provide documentation that the applicant has sufficient interest in the site or facility proposed. "Sufficient interest" includes but not limited to one of the following:

a lease for at least one year with, options to renew for not less than a total of five years

Please refer to Appendix for a copy of the lease agreement. EEC Seattle is currently within the original lease period of 10 years. The original lease expires December 2026.

### **III. PROJECT RATIONALE:**

Provide documentation to establish conformance of this project with applicable review criteria.

#### ***A. Need (WAC 246-310-210)***

Identify and analyze the unmet health services needs and/or other problems toward which this project is directed.

#### **Overview of Project Rationale**

EEC is requesting CON approval to convert an existing, two-operating room ambulatory surgical facility into a CON approved facility. This facility has been operational since June 2016 and received a determination of non-reviewability in August 2018. As no construction is needed for this project, the project will be completed upon CON approval.

Currently, only employed surgeons of EEC are providing services through the EEC Seattle. By becoming CON approved, EEC will open up the facility to surrounding area ophthalmic surgeons, which will better enhance access to ophthalmology services within the Central King planning area.

We are confident that CON approval will improve the access and the available operating minutes available to other physicians and their patients in the planning area. As demonstrated through the needs analysis below, there is a projected net need for additional outpatient surgery rooms in the Central King planning area; our project will help address this need.

The service opportunities gained by EEC Seattle will result in increased cost savings for patients' due to the efficiency and cost-effectiveness of an ASF in comparison to hospital outpatient surgery departments. As evidenced in the National Health Statistics Reports (NHSR)<sup>1</sup>, the efficiency of an ASF can be measured by the time spent for the procedure to include the operating room, the actual surgery time and the postoperative care. Table 12 outlines the findings within the report.

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<sup>1</sup> NHSR report is Exhibit 32.

**Table 12 – Distribution of times for surgical visits,  
by ambulatory surgery facility type; United States, 2010**

Calculated time of ambulatory surgical visit	<u>Hospital</u>		<u>ASF</u>		<u>All Facilities</u>	
	Average Time (minutes)	Standard Error	Average Time (minutes)	Standard Error	Average Time (minutes)	Standard Error
Operating Room	63	2	50	4	57	2
Surgical	37	2	29	3	33	2
Postoperative Care	89	3	51	4	70	3
<b>Total Time</b>	<b>189</b>		<b>130</b>		<b>160</b>	

Source: “Ambulatory Surgery Data from Hospitals and Ambulatory Surgery Centers: United States, 2010”, U.S. Department of Health and Human Services, National Center for Health Statistics, Report Number 102, February 28, 2017. Table C, page 6.

In an article in the Ambulatory Surgery Center Association (ASCA) a publication titled “A Positive Trend in Health Care” identifies that the increase and rise of Ambulatory Care Facilities can be attributed to physicians, high-quality, cost-effective alternative to the inpatient hospital setting and the value an ASF adds to the economy.<sup>2</sup>

An article published in the Ophthalmology Times “The future of cataract surgery” identifies the growing need for ophthalmologist.<sup>3</sup> Based on the fact that the formation of cataracts is directly proportional with age and the life expectancy is increasing, the number of cataract surgeries will also increase. In 2015, there were 9,000 ophthalmologists doing 3.6 million cataract surgeries. Extending those numbers out it is estimated that there will be a need for 125,000 surgeons worldwide to treat 50 million cataracts. This number rises to 250,000 surgeons worldwide in 2025.

“A Positive Trend in Healthcare” identifies the cost savings within an ASF compared to a hospital setting is substantial. The recent trend in how Medicare reimburses a procedure done in a hospital outpatient setting compared to reimbursement of that same procedure in an ASF has widened. In 2003 the difference in reimbursement was only 16%, at the time of the article’s publication there was a difference of 72% in reimbursement. In an article titled “Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up”<sup>4</sup>, explained that in 2003, the Medicare Prescription Drug, Improvement, and modernization Act froze ASF’s payment updates. For the next couple of years, they phased in a new ASF’s prospective payment based on the outpatient prospective payment system. This ASF fee schedule set rates for procedures done in an ASF to no more than 59% of payments to hospitals who provided the same procedure. This went into full effect in 2012.

<sup>2</sup> ASCA “A Positive Trend in Health Care” is Exhibit 33.

<sup>3</sup> Ophthalmology Times “The Future of Cataract Surgery” is Exhibit 35.

<sup>4</sup> Health Affairs article “Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down and Ability To Meet Demand Up” is found in Exhibit 39.

**Table 13 – Cost Comparison:  
ASC v. Hospital Outpatient Department**

	Patient Cost		Medicare Cost	
	ASF Co-pay	HOPD Co-pay	Total Procedure Cost ASF	Total Procedure Cost HOPD
Cataract	\$193.00	\$490.00	\$964.00	\$1,670.00
Upper Gi Endoscopy	\$68.00	\$139.00	\$341.00	\$591.00
Colonoscopy	\$76.00	\$186.00	\$378.00	\$655.00

Source: “ASCs: A Positive Trend in Health Care”, Ambulatory Surgery Center Association, Page 2.

In an article published in “Michigan Medicine; University of Michigan”<sup>5</sup>, the authors evaluated the national data that shows the shift in eye surgeries from hospitals to an ASF because of the lower cost to the patients and insurers. The rise of cataract surgeries performed in an ASF has gone from 43.6% in 2001 to 73% in 2014. This cost savings to Medicare equated to a savings of over \$829 million in 2011. The article suggests that the rate of increase for ambulatory surgery use for cataract surgery is 2.34% per year, which is similar to the rate increase for strabismus and retina surgeries; the study further found that the rate of increase of glaucoma surgeries was even faster.

The economic growth that ASFs have added to our economy has been considerable. The following Table illustrates the impact witnessed in 2009.

**Table 14 – Total Nationwide Impact ASFs had on the economy;  
United States, 2009**

Year 2009	
<b>Total Tax Payments</b>	\$5.8 Billion
<b>Total FTE</b>	117,700
<b>Total Nationwide Economic Impact</b>	\$90 Billion

Source: “ASCs: A Positive Trend in Health Care”, Ambulatory Surgery Center Association, Page 1.

“A Positive Trend in Healthcare” also identifies the top “Medicare Case Volume by Specialty” that was derived from analyzing CMS claim data in 2010. The three main specialty services that are performed in an ASF are gastroenterology (31%), ophthalmology (28%) and pain management (22%). The article also provides the results of a survey that was taken on the satisfaction rate of patients having their procedures performed within an ASF coming in at 92% favorable.

Based on the analysis of physician preference, cost effectiveness, efficiency and quality of care, EEC, as an ophthalmic specialty surgical facility, will be in a position to continue to meet the current needs of the residents of Central King planning area with an approved CON. AS the population ages and demand for ophthalmic surgery rises, EEC Seattle is preparing to be able to meet the future need by seeking CON approval.

<sup>5</sup> Michigan Medicine; University of Michigan article is in Exhibit 36.

In conclusion, an approved CON application is a crucial part of (1) increasing emphasis on local, cost-effective care in outpatient settings, (2) meeting the commitment of EEC to create access when and where people need it and (3) meeting the need for additional ORs minutes in the Central King planning area.

The Interpretive Statement issued on January 19, 2018, instructs applicants that cannot show a need to utilize WAC 246-310-270(4). "This regulation provides discretion for the CN Program to approve operating rooms that would not ordinarily be approved. For example, the CN Program can issue a CN without a showing of numeric need if the applicant can show that through existing volumes the facility will have no impact on market share, the facility is necessary to provide access to specific surgical types, or the existing healthcare system supports continued operation of the facility." EEC Seattle's application can satisfy each of these criteria:

1. *No Impact on Market Share.* This ASF has been in operation since 2016 and continues to provide high quality outpatient surgical services to its patients. NWES Seattle performs over 900 surgeries per year. EEC Seattle is the only free-standing ASF in the planning area capable that focuses on outpatient ophthalmic surgeries. Allowing EEC Seattle to operate as a CON-approved facility will not detrimentally impact the other providers of outpatient surgeries in the planning area.
2. *Facility is Necessary to Provide Access to Specific Surgical Types.* As noted above, EEC Seattle is the only outpatient ASF in the planning area providing these types of surgeries. EEC Seattle has the necessary equipment to serve these patients in an outpatient setting. With the continued push by Medicare and private payers to free standing ambulatory surgery centers, EEC Seattle's facility is necessary to provide lower cost and high quality ophthalmic surgeries.
3. *Existing Healthcare System Supports Continued Operation of the Facility.* Without the continued operation of EEC Seattle, patients requiring cataracts, glaucoma, and other eye related surgeries would have no other option but to have the surgeries performed at a hospital or outside of the planning area. The existence of EEC Seattle as a free-standing ASF open to all surgeons is necessary to continue to provide patients access to care and choice of providers.

## **Population Overview and Summary of Need**

Unmet health services need of the defined populations should be differentiated from physical plant and operating (*service delivery*) deficiencies that are related to present arrangements.

Physical plant deficiencies are non-existent with regards to this project. The facility itself is capable of handling increased operating room minutes.

The ability to deliver the service of increased operating minutes is only limited to staffing availability, in which EEC Seattle has not had trouble of finding, hiring and employing qualified staff.

The negative impact and consequences of unmet needs and deficiencies should be identified.

Application of WAC 246-310-270 to the Central King planning area demonstrates need for additional ambulatory surgery suites. Without the project, the available operating minutes will remain where it is today which is insufficient to meet the projected demand resulting in limited access to affordable outpatient care.

Define the population that is expected to be served by the project. The specific manner of definition is of necessity based on the specific project proposed, and may require definitions for different elements of the project.

**Table 15 – Central King Secondary Health Planning Area Population**

	2010	Pct of Tot Pop	2018 Est	Pct of Tot Pop	Pct Chg 2010- 2018	2022 Proj.	Pct of Tot Pop	Pct Chg 2018- 2022
Total Pop.	<b>285,872</b>	<b>100.0%</b>	<b>334,630</b>	<b>100.0%</b>	<b>15.5%</b>	<b>359,258</b>	<b>100.0%</b>	<b>7.1%</b>
Pop. By Age								
<b>0-17</b>	42,140	13.1%	50,967	13.6%	18.5%	55,308	13.8%	8.1%
<b>18-44</b>	139,668	51.0%	153,158	47.8%	9.9%	150,137	43.6%	2.1%
<b>45-64</b>	71,592	24.6%	84,558	25.1%	16.9%	97,180	27.2%	14.3%
<b>Tot. 65+</b>	32,472	11.2%	45,947	13.5%	29.5%	56,633	15.5%	19.1%

Claritas 2018

Patient population served are adults who have been thoroughly evaluated by the operating surgeon for their emotional maturity, ability to comply with instructions and understand of what will be required of them.

In addition, because of the nature of the specialization that EEC Seattle provides, the age of our patient demographic falls into the senior category. Because of this our highest volume of patients are Medicare, consisting of 56%<sup>6</sup> of total population. In contrast, Medicaid is low at 14%.<sup>7</sup>

Source: EEC Seattle EMR Data

\*Percentages may not equal 100 because of rounding.

Below is a summary of our patient origin for the year of 2017.

**Table 16 – Summary of Patient Origin for EEC Seattle**

	%
Central King Planning Area	23.1%
Remaining Areas of Washington	76.9%
<b>Total</b>	<b>100%*</b>

Source: EEC Seattle EMR Data

\*Percentages may not equal 100 because of rounding.

<sup>7</sup> VMG Health's Intellimarker Ambulatory Surgical Centers Financial & Operational Benchmarking Study 2017 report. The study includes an analysis of more than 278 licensed freestanding ASC covering more than 1.3 million cases. The payer mix for an ASC was identified and recorded as a mean, median, 25%, 75% and 90%. Medicare median was 24% and Medicaid median was 5%.

The patient origin of EEC Seattle shows that the ASF serves patients from all over the area, with only 23.1% coming from the actual Central King planning area.

The population expected to be served can be defined according to specific needs and circumstances of patients (e.g., alcoholism treatment, renal dialysis), or by the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.

Provide utilization forecasts for each service included in the project. Include the following:  
 Utilization forecasts for at least five years following project completion.  
 The complete quantitative methodology used to construct each utilization forecast.

**Need Methodology:**

The utilization forecast was created using the National Health Statistics Report (NHSR)<sup>8</sup> utilization rate, the projected population for Central King planning area and EEC Seattle patient demographics in Y2017. The NHSR identified the utilization rate for operation of the eye to be 237.6/10,000. Due to our senior patient population (Table 16), we will use the forecasted population, the rate that corresponds to the specific age group along with EEC Seattle Y2017 patient data broken down into the percentage of age to provide a more accurate number for this project.

**Table 17 - Rate for the rate of ambulatory surgery procedures;  
 United States, 2006**

Procedure Category	.08-16 ICD-9- CM code	SEX			AGE			
		Total	Male	Female	Under 15 years	15-44 years	45-64 years	65+years
<b>Rate per 10,000 population</b>								
<b>Operations of the eyelid</b>	0.08	12.9	9.4	16.4	4.7	3.1	20.9	43.55
<b>Extraction of lens</b>	13.1- 13.6	102.5	78.8	125.5		3	81.6	646.7
<b>Insertion of prosthetic lens (pseudophakos)</b>	13.7	86.6	67.4	105.2		2.6	70.1	543.5
<b>Other</b>		35.6	35.7	35.2	12.3	12.5	48.2	127.9
<b>TOTAL</b>		<b>237.6</b>	<b>191.3</b>	<b>282.3</b>	<b>17</b>	<b>21.2</b>	<b>220.8</b>	<b>1361.5</b>

Source: "Ambulatory Surgery in the United States, 2006", U.S. Department of Health and Human Services, National Center for Health Statistics, Report Number 11, January 28, 2009, revised September 4, 2009. Table 7, page 18.

The following outlines how EEC Seattle calculated their projections for surgical cases by year.

The expected ophthalmic surgical case frequencies for various populations (rate per 10,000 capita by gender and age) were then calculated with the following explanation.

Ages were grouped as follows

- o

<sup>8</sup> NHSR report found in Exhibit 31.

- Under 15 years old (< 15) 17 Surgeries on the eye per 10,000
- Between 15 and 44 years old (15 – 44) 21.2 “”
- Between 45 and 64 years old (45 – 64) 220.8 “”
- 65 and older 1361 “”

**Calculation**

Assume the projected 45 – 64-year-old population for year X is 20,000.

To preserve generality, let the surgical case frequency amongst the specified population be Y.

Let our projected population be Z.

Then, we would calculate the associated projected number of surgeries (PS) on 45 to 64-year-olds in year X as follows

$$PS(X) = (Z / 10,000) * Y$$

$$PS(X) = (20,000 / 10,000) * 220.8$$

$$PS(X) = (2) * 220.8$$

$$PS(X) = 441.6$$

**Table 18 – Operations of the Eye**

Operations of the Eye by Age Group for Central Planning Area						
		2018	2019	2020	2021	2022
<b>Pop. By Age</b>	<b>Utilization rate</b>					
<b>Total Population 18 and older</b>		243,732	248,096	262,220	277,149	303,950
<b>18-44</b>		139,668	142,285	144,903	147,520	150,137
<b>45-65</b>		60,041	61,129	62,179	63,305	64,393
<b>65+</b>		32,254	32,839	33,423	34,008	34,592
<b>Operations of the Eye 18-44 Years</b>	0.00212	296	302	307	313	318
<b>Operations of the Eye 45-65 Years</b>	0.02208	1,326	1,350	1,374	1,398	1,422
<b>Operations of the Eye 65+ Years</b>	0.13615	4,391	4,471	4,551	4,630	4,710

WAC (246-310-270) describes how to take current surgical capacity, hospital and ambulatory surgery utilization figures and population estimates and forecasts to prepare a planning area need forecast to determine if there is need for additional inpatient/mixed use and/or outpatient ORs.

After identifying planning area inpatient/mixed use and outpatient surgical capacity, surgery volumes by active licensed surgery centers were obtained from the data from the Washington State Certificate of Need Program 2017 Annual Operating Room Use Survey. This is specific for surgical procedures performed during CY2016. Not all facilities had responded in 2017, therefore the CON Program indicated that using the 2015 data for unresponsive facilities was appropriate. Operating rooms identified in the methodology were used only from CON approved facilities with an active license on 01/01/2018.<sup>9</sup>

**Table 19 – Need Methodology Assumption  
Data Summary**

<b>Need Methodology Assumptions and Data</b>	
<b>Assumption</b>	<b>Data Used</b>
<b>Planning Area</b>  (zip codes identified in Table 3, facilities identified in Table 5)	Central King County
<b>Population Forecasts</b>  (Table 15)	Age Group: 0-75+ Year 2016 – 606,892 Year 2021 – 652,104
<b>Use Rate</b>  (Exhibit 24)	Divided calculated surgical cases by 2017 population results in the service area use rate of 309.4/1,000 population
<b>OR Annual capacity in minutes</b>  (Exhibit 38)	68,850 outpatient surgery minutes; 94,250 inpatient or mixed-use surgery minutes (per methodology in rule)
<b>Existing providers/OR's</b>  (Exhibit 24, based on survey information)	Based on listing of Central King County Providers that are CON approved; 99 – dedicated mixed use ORs 21 – dedicated outpatient ORs
<b>Methodology Results</b>	<b>Numeric Surplus of 4.21 outpatient ORs</b>

\*Not all facilities turned in a 2016 survey in 2017. We were instructed by CON to use facilities 2015 data if 2016 was unavailable.

Using WAC (246-310-270) regulations as a guide, **the methodology shows that there is a net surplus of 4.21 outpatient ORs** in the Central King planning area in 2022.

The Interpretive Statement issued on January 19, 2018, instructs applicants that cannot show a need to utilize WAC 246-310-270(4). “This regulation provides discretion for the CN Program to approve operating rooms that would not ordinarily be approved. For example, the CN Program can issue a CN without a showing of numeric need if the applicant can show that through existing volumes the facility will have no impact on market share, the facility is necessary to provide access to specific surgical types, or the

<sup>9</sup> <https://fortress.wa.gov/doh/facilitysearch/>

existing healthcare system supports continued operation of the facility.” EEC Seattle's application can satisfy each of these criteria:

1. *No Impact on Market Share.* This ASF has been in operation since 2016 and continues to provide high quality outpatient surgical services to its patients. NWES Seattle performs over 900 surgeries per year. EEC Seattle is the only free- standing ASF in the planning area capable that focuses on outpatient ophthalmic surgeries. Allowing EEC Seattle to operate as a CON-approved facility will not detrimentally impact the other providers of outpatient surgeries in the planning area.

2. *Facility is Necessary to Provide Access to Specific Surgical Types.* As noted above, EEC Seattle is the only outpatient ASF in the planning area providing these types of surgeries. EEC Seattle has the necessary equipment to serve these patients in an outpatient setting. With the continued push by Medicare and private payers to free standing ambulatory surgery centers, EEC Seattle's facility is necessary to provide lower cost and high quality ophthalmic surgeries.

3. *Existing Healthcare System Supports Continued Operation of the Facility.* Without the continued operation of EEC Seattle, patients requiring cataracts, glaucoma, and other eye related surgeries would have no other option but to have the surgeries performed at a hospital or outside of the planning area. The existence of EEC Seattle as a free-standing ASF open to all surgeons is necessary to continue to provide patients access to care and choice of providers.

Identify and justify all assumptions related to changes in use rate, market share, intensity of service, and others.

Referencing Table 16, In 2017, 76.9% of EEC Seattle patients originated outside of the Central King planning area with only 23.1% of their patients within the planning area.

In regard to market share within the Central King planning area, EEC Seattle performs 16.2% of the ophthalmic procedures. There are no other ophthalmic surgery centers in the planning area. 83.8% of the ophthalmic predicted patients will potentially seek care outside the planning area.

Evidence of the number of persons now using the service(s) who will continue to use the service(s). Utilization experience for existing services involved in the project should be reported for up to the last ten years, as available. Such utilization should be reported in recognized units of measure appropriate to the service.

In part, this question is not applicable to this project. The surgeries and procedures performed at EEC Seattle are done on a one or two-time basis, with the complications as the only exception, and patients do not need subsequent services.

EEC Seattle utilizes its co-management program with the patient's primary care physician, OD, nurse practitioner, or physician assistant for follow up and continuity of care.<sup>10</sup>

As evidence in Table 6, the number of ophthalmic surgeries has increased over the past 5 years suggesting an increase in patient utilization of EEC Seattle.

Evidence of the number of persons who will begin to use the services(s).

As outlined in the above “Overview of the Project Rationale”, it is evidenced that the use of ASF’s for surgeries that can be performed safely in an outpatient setting are becoming the location of choice. National trends show a safe, cost savings approach with physicians preferring to operate in an ASF. Additionally, ophthalmology makes up 28% of all procedures done in an ASFs

In an article printed in the American Academy of Ophthalmology<sup>11</sup>, the reasons why there is a rising cataract surgery rate were identified. “Cataract surgery is the most frequently performed surgical procedure in many developed countries, providing significant, long-term, and cost-effective improvements in the quality of life for patients of all ages. Advances in cataract surgery techniques and technologies over the last decades have led to improved patient safety and better surgical outcomes, resulting in significant changes in the frequency with which cataract surgery is performed.” Second eye surgery is now performed earlier and more frequent than it was before simply because “people don’t know what they want until you show it to them” (Steve Jobs). The patient’s expectations have been met and they want both eyes functioning correctly. In regard to supply and demand, George Gilder, author of *Wealth and Poverty* stated, “The key is not an increase in the same supply, but rather an increase in a new, inventive supply that exceeds people’s expectations and takes them to new heights in their lives”. The author of the article, Jay C. Erie, M.D. believes that this statement describes the evolution of ophthalmology and the specialty surgical procedures to include cataract surgery. With improved technologies, the ophthalmic surgery has become very safe and effective, which is providing better outcomes and ultimately improving patient lives. This in itself is increasing patient demand. The article also points out that at the time of publication, the World Health Organization has set a minimum number of cataract surgeries per year to eliminate cataract blindness. This number is 3,000 per million people. In developed countries, the cataract surgeries performed range from 7,000 – 11,000 per million people. Additionally, increased ophthalmic surgery rates can be explained by the aging population, ability for the procedures to be safely performed in an outpatient (ASF) facility, and adopting widening thresholds for the indication of the ophthalmic surgery.

As evidenced by the percent of patient origin is 76.9% outside of the planning area, it would suggest that patients are driving to be seen by the EEC surgeons.

Provide information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which “*compete*” with the applicant.

Identify all existing providers of services similar to those proposed and include sufficient utilization experience of those providers that demonstrates that such existing services are not available in sufficient supply to meet all or some portion of the forecaster utilization.

A list of existing providers in the Central King planning area is listed in Table 5.

If existing services are available to the defined population, demonstrate that such services are not accessible to that population. Time and distance factors, among others, are to be analyzed in this section.

As previously discussed, demand for outpatient ambulatory surgeries is increasing for a number of factors. With a shortage of outpatient facilities, patients in need will need to resort to traveling farther distances in order to receive appropriate services. This is particularly problematic for patients with limited mobility, or those who depend on transit systems or third-party transportation services. In addition, EEC Seattle is the only ASF in the Central King planning area performing specialized ophthalmic surgery.

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<sup>11</sup> "Rising Cataract Surgery Rates; Demand and Supply" is located in Exhibit 34.

If existing services are available and accessible to the defined population, justify why the proposed project does not constitute an unnecessary duplication of services.

EEC Seattle is the only existing ASF facility that specializes in ophthalmic surgery. EEC Seattle currently provides 16.2% of the market for specialized ophthalmic surgery. Without EEC Seattle, the projected utilization forecast will not be met.

In the context of the criteria contained in WAC 246-310-210 (1) (a) and (b), document the manner in which:

Access of low-income persons, racial and ethnic minorities, women, mentally handicapped persons, and other under-served groups to the services proposed is commensurate with needs for the health services.

Patients are admitted to EEC Seattle based on clinical need. Our services are provided regardless of race, color, sex, national origin, religion, sexual preference, or disabilities; as is illustrated in the Patient Rights and Responsibility policy and Non-Discrimination policy (Appendix).

As shown in Table 10, Medicare is 24% of our payer source and 56% of our patients. It is projected that the amount of revenue received from Medicare will increase as EEC continues to serve those patients in need, based on population forecasts and trending increase in need of ASFs.

In the case of the relocation of a facility or service, or the reduction or elimination of a service, the present needs of the defined population for that facility or service, including the needs of under-served groups, will continue to be met by the proposed relocation by alternative arrangements.

As this is a Certificate of Need application of an existing facility with no intent of relocating, this question does not apply.

**Applicants should include the following:**

Copy of admissions policy;

Please see Appendix

Copy of community service policy;

Please see Appendix

Copy of its charity care policy

Please see Appendix

Reference appropriate access problems and discuss how this project addresses such problems;

As EEC Seattle is the only ASF that performs primarily ophthalmic surgeries, it provided 16.2% of the total ophthalmic procedures performed in the Central King area in 2017. The continued operation of EEC Seattle will provide an easily accessible and less costly alternative for ophthalmic surgeries within Central King planning area. Opening EEC Seattle ASF to non-employed physicians will increase access to patients needing eye related surgeries within the area.

As appropriate, reference health facility related access problems of under-served groups noted in social services plan documents;

Not applicable

As applicable, substantiate the following special needs and circumstances that the proposed project is to serve.

The special needs and circumstances of entities such as medical and other health professions' schools, multi-disciplinary clinics, and specialty centers that provide a substantial portion of their services, resources, or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health services areas.

Not applicable

The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

Not applicable

The special needs and circumstances of osteopathic hospitals and non-allopathic services with which the proposed facility/service would be affiliated.

Not applicable

#### ***B. Financial Feasibility (WAC 246-310-220)***

Proposed capital expenditures should be broken out in detail and should account for at least the following:

The EEC Seattle project does not require any construction or change in physical property. As such there is no associated capital expenditures for the proposed project.

The method and sources for calculating construction costs and other estimated capital expenditures should be fully explained.

The question is not applicable because there is no construction required for the proposed project.

Documentation of project impact on (a) capital costs, and (b) operating costs and charges for health services.

#### **Capital Expenditures**

There will be no capital expenditures relative to this project. See Fixed Operating Expenses for a note on depreciation expense.

#### **Revenues**

2017 gross and net revenue are the actual revenues observed by EEC.

The 2017 gross revenues by payer illustrate which payer class would have been considered primary on the claim. The 2017 actual was found by pulling all claims for a sample period and recording the primary payer percentages. Projected payer mix is assumed to remain constant through the projection.

Inflation of gross revenue was set to a constant 2.3% year over year. From 2016 to 2017, EEC has experienced a minimum of 2.3% annual increase in gross revenue. EEC believes this is a good indicator of future growth.

### **Variable Operating Expenses**

2017 FTE figures are representative of the EEC current Seattle ASC-specific employee census (by job category).

Wage and salary figures for each class of FTE are representative of 2017 averages pulled from the payroll roster. It is assumed that an FTE works 2,080 hours per year.

Actual 2017 benefits, taxes, etc. were calculated as 24% of total wages and salaries. This figure is representative of EEC 2017 actuals.

All other “variable” operating expenses are assumed to continue at the actual rate relative to net revenue observed in 2017.

### **Fixed Operating Expenses**

All fixed operating expenses are based on 2017 actuals. Each subsequent year is expected to experience inflation at a constant 3%.

It is worth noting that depreciation expense is not treated any differently than the other fixed operating expenses. There will be no significant capital expenditures associated with certificate of need approval. Hence, a constant 3% inflation rate is appropriate.

All indirect (billing office, call center, compliance, etc.) people costs are outlined in the “Allocations LESS bad debt” section of the pro forma. These line items include all expenses associated with the specified cost center, not just people costs. Once again, they are expected to grow at a constant rate of 3% year over year.

Source(s) of financing (*loan, grant, gifts, etc.*). Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, and/or maintenance repair contracts should be provided. The proposed lease should be capitalized with interest expense and principal separated. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

EEC Seattle did not procure financing for this project because there will be no capital expenditures. The costs associated with the increased minutes will be treated as operating expenses, rather than capital expenditure.

Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board-designated reserves, and interfund loan or bank loan. Provide the rationale for choosing the financing method selected.

As the proposed project is a request for CON approval of an existing facility with no change in services or operating rooms, this questions not applicable.

Provide a pro forma balance sheet and the accounting statement, statement of changes in financial position of unrestricted funds and changes in components of working capital.

Please see Appendix for EEC Seattle forecast pro forma income statement. There are no capital expenditures associated with the process, therefore the pro forma balance sheet was omitted. The following items should help to clarify some of the figures/methodologies present within the pro forma.

### **Revenue**

Due to EEC Seattle's limited time of being open, an inflation of gross revenue was set to a constant 2.3% year over year. From 2016 to 2017, EEC has experienced a minimum of 2.3% annual increase in gross revenue. EEC believes this is a good indicator of future growth.

The payer mix breakdown is an illustration of the expected percentage of gross revenues being billed to each (primary) payer class. The proportions are representative of 2017 actual primary payer responsibility. It is worth noting that the distribution of charges by primary payer responsibility will NOT follow the distribution of patients by insurance class. The major difference will be due to various 100% elective/patient-pay (not covered by insurance) add-ons. These patients would be classified according to their primary insurance subscription, while 100% patient-pay charges (\$) would be classified as "Self-pay".

### **Cost of Revenue**

Cost of revenue consists of a few different classes of items/expenses.

- **Medication** – InjecTables, drops, and oral medications that are not billed for explicitly using a HCPCS code.
- **Medical Supplies** – this describes any medical supplies not being billed for explicitly.
- **Pass-Thru Technology** – implants and tissues being billed for explicitly using a HCPCS code.
- **Financing Discount** – If a patient chooses to finance their procedure(s) through a 3<sup>rd</sup> party financing company, EEC observes an expense due to the 3<sup>rd</sup> party not paying the surgery in full.

### **Operating Expenses**

Operating expenses have been classified as VARIABLE and FIXED. Excluding personnel expense, it is assumed that the variable variety will scale similar to revenue. Hence, the projection maintains a constant percentage. Personnel expense will scale according to the FTE breakdown. All fixed operating expenses assume a constant 3% inflation year over year.

### **FTE**

The FTE projections are based off 2017 actual figures pulled from our payroll software.

Provide a capital expenditure budget through the project completion and for three years following completion of the project.

The question is not applicable as there are no associated capital expenditures for the proposed project.

The expected sources of revenues for the applicant's total operations (e.g., Medicaid, Blue Cross, Labor and Industries, etc.) with anticipated percentage of revenue from each source.

Please refer to Table 10 – Sources of patient revenue with anticipated percentages

Expense and revenue statements for the last three full years.

Included are income statements for EEC for the most recent three-year period (2015, 2016, and 2017).  
Cash flow statement for the last three full years.

Included are the Cash Flow Statements for EEC for the most recent three-year period (2015, 2016, 2017).

Balance sheets detailing the assets, liabilities, and net worth of facility for the last three full *fiscal* years

Included are the Balance Sheets for EEC Central King for the most recent three-year period (2015, 2016, 2017).

Indicate the reduction or addition of FTEs with the salaries, wages, employee benefits for each FTE affected.

**Table 20– Historical and Projected Full-Time Equivalent (FTE) Employees,  
By Type 2017-2022**

<b>Seattle Ambulatory Surgery Center</b>						
Year	2017	2018	2019	2020	2021	2022
<b>Number of FTEs per Year (Productive)</b>						
Office/Clerical Employees	1.00	1.00	1.00	1.00	1.00	1.00
Registered Nurses	1.50	1.50	1.50	1.50	1.50	1.50
Operating Room Technicians	2.00	2.00	2.00	2.00	2.00	2.00
Manager	1.00	1.00	1.00	1.00	1.00	1.00
<b>Total FTE's</b>	<b>5.50</b>	<b>5.50</b>	<b>5.50</b>	<b>5.50</b>	<b>5.50</b>	<b>5.50</b>
<b>Total Wages and Salaries</b>						
Office/Clerical Employees	38,043	39,184	40,360	41,571	42,818	44,102
Registered Nurses	99,341	102,321	105,391	108,552	111,809	115,163
Operating Room Technicians	89,648	92,337	95,108	97,961	100,900	103,927
Manager	74,880	77,126	79,440	81,823	84,278	86,806
<b>Total Employee Salaries</b>	<b>301,673</b>	<b>310,969</b>	<b>320,298</b>	<b>329,907</b>	<b>339,805</b>	<b>349,999</b>
<b>Employee Benefits &amp; Taxes</b>	<b>72,402</b>	<b>74,633</b>	<b>76,872</b>	<b>79,178</b>	<b>81,553</b>	<b>84,000</b>
<b>Total Salaries and Benefits</b>	<b>\$ 374,075</b>	<b>\$ 385,602</b>	<b>\$ 397,170</b>	<b>\$ 409,085</b>	<b>\$ 421,358</b>	<b>\$ 433,998</b>
<b>Annual Change</b>		<b>\$ 11,527</b>	<b>\$ 11,568</b>	<b>\$ 11,915</b>	<b>\$ 12,273</b>	<b>\$ 12,641</b>

Source: EEC Seattle pro forma

**C. Structure and Process (Quality) of Care (WAC 246-310-230)**

Please document the following associated with structure and process of care.

The availability of sufficient numbers of qualified health manpower and management personnel. If the staff availability is a problem, describe the manner in which the problem will be addressed.

EEC Seattle offers a facility and work environment that is attractive to work for, along with competitive hours and pay. EEC Seattle has not had a problem recruiting, hiring and retaining qualified medical professionals.

Identify the facility’s Medical Director, Director of Nursing, and other key staff. For each provide their professional license number for Washington. If they are also licensed in other states, provide their license number for those states.

**Table 21 – EEC Seattle Professional Directors**

Medical Director	John Whitehead	MD60070926
Director of Surgical Services	Kelly Goff	MR60632038

Source: EEC Organizational Chart

For the Medical Director indicate if he/she will be an employee of the facility or contractual. If performing his/her duties through a contract, provide a copy. A draft is acceptable only if all parties identified in the draft agreement provide a signed “Letter of Intent to finalize” the agreement and all terms and costs are included.

Dr. Whitehead is an employed surgeon for EEC. There is not an additional contractual agreement and there is not a financial reward with the position.

The relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.

EEC Seattle currently provides ophthalmic surgery in the Central King planning area. Our existing support capacity and third-party contracts sufficiently support the services offered at EEC Seattle and meet all the demands of patient care within the facility.

The specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health service resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.

EEC Seattle works closely with the medical professionals they associate with. Valuing a commitment to collaborative care, EEC advocates cooperative care of postsurgical patients. EEC believes that once patients are stable following surgery, their care can be managed safely and successfully by their optometric physician. EEC Seattle strives to facilitate the communication with their patients and their patients primary care provider so that the best quality can be performed to promote safe and effective care that will leave patients feeling satisfied and happy.

EEC Seattle physicians have transfer agreements with Providence Regional Medical Center Everett and UW Medicine/Harborview Medical center for patients requiring hospitalization.

Fully describe any history of the applicant entity with respect to the actions noted in Certificate of Need rules and regulations WAC 246-310-230 (5) (a). If there is such history, provide clear, cogent, and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.

EEC has no history of convictions or sanctions as described in WAC 246-310-230(5)(a).

EEC Surgeons, Corporate Officers and Billing Personnel are not on the OIG exclusion list.

Services to be provided will be provided (a) in a manner that ensures safe and adequate care, and (b) in accord with applicable federal and state laws, rules, and regulations.

EEC Seattle is a currently licensed ASF with the State of Washington and as such must meet certain regulations set by the State of Washington to remain so. EEC Seattle is subject to inspections from investigators at the state level and has a duty to comply with any recommendations that are set forth.

EEC Seattle is also licensed and subject to investigations with Medicare and Medicaid.

All visits by any investigator has left EEC Seattle in a position to continue to provide quality safe care.

**D. Cost containment (WAC 246-310-240)**

Please document the following associated with cost containment.

Exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, merger, contract services, and different methods of service provision, including different spacial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:

- Decision making criteria (*cost limits, availability, quality of care, legal restriction, etc.*):
- Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweigh each other by application of the decision-making criteria;
- Capital costs;
- Staffing impact.

EEC Seattle is requesting certificate of need approval of its existing two-operating room ASF to convert to a CON-approved ASF. Our project will help address net need for outpatient operating rooms in Central King planning area by providing non-EEC surgeons and their patients access to our ASF. This will increase the number of case as well as expand the availability of lower cost outpatient operating rooms for physicians and patients.

EEC Seattle Considered the following options:

- No project – continue as a licensed, certificate of need exempt facility
- Certificate of Need facility and the requested project.
- Partnering with other organizations.

**Table 22- Alternative Analysis: Promoting Access to Healthcare Services**

Option:	Advantages/Disadvantages:
No project	<ul style="list-style-type: none"> <li>• There is no advantage or disadvantage to Continuing as is in terms of improving access. The current EEC Seattle surgical center has been in place for many years without access issues. (Neutral)</li> <li>• The principal disadvantage is this option does nothing to address the ambulatory surgery OR shortages forecast in the Planning Area. (Disadvantage)</li> </ul>
Requested Project	<ul style="list-style-type: none"> <li>• The requested project best meets current and future access issues identified in the Planning Area and provides a low-cost alternative to all area ophthalmologists. (Advantage)</li> <li>• From an improved access perspective, there are no disadvantages. (Advantage)</li> </ul>

Source: EEC Director Discussion

**Table 23- Alternative Analysis: Promoting Quality of Care**

<b>Option:</b>	<b>Advantages/Disadvantages:</b>
No project	<ul style="list-style-type: none"> <li>• There are no advantages from a quality of care perspective. However, there are no current quality of care issues. (Neutral)</li> <li>• The principal disadvantage with maintaining the current situation is driven by projected shortages of outpatient ambulatory surgery suites. Over time, as access is constrained, there will be adverse impacts on quality of care if Planning Area physicians and their patients either have to wait for surgical capacity or travel to other locations outside the Planning Area, assuming this is an option. (Disadvantage)</li> </ul>
Requested Project	<ul style="list-style-type: none"> <li>• The requested project best meets and promotes quality and continuity of care issues in the Planning Area. (Advantage)</li> <li>• From a quality of care perspective, there are only advantages. (Advantage)</li> </ul>

Source: EEC Director Discussion

**Table 24 - Alternative Analysis: Promoting Cost and Operating Efficiency**

<b>Option:</b>	<b>Advantages/Disadvantages:</b>
No project	<ul style="list-style-type: none"> <li>• Under this option, there would be no impacts on cost or efficiency – the surgery center would continue as presently. (Neutral)</li> <li>• However, EEC has already incurred all capital costs for two operating suites. It is much more efficient (lower cost) to better utilize fixed plant and equipment with greater volumes/throughput – average operating costs fall. This option constrains others' use of the ASC, and as a result, constrains case volumes at the ASC. As a direct result, the No Project option will reduce efficiency and cost-effectiveness. This is the principal disadvantage from an efficiency perspective. (Disadvantage)</li> </ul>
Requested Project	<ul style="list-style-type: none"> <li>• EEC has already incurred all capital costs for its two operating suites. It is much more efficient to better utilize fixed plant and equipment with greater volumes/throughput. This option allows EEC to best utilize its ASF resources, hence improves efficiency and increases cost-effectiveness. (Advantage)</li> <li>• There are no disadvantages. (Neutral)</li> </ul>

Source: EEC Director Discussion

**Table 25 - Alternative Analysis: Staffing Impact**

<b>Option:</b>	<b>Advantages/Disadvantages:</b>
No project	<ul style="list-style-type: none"> <li>• There are no disadvantages from a staffing point-of-view. (Neutral)</li> </ul>
Requested Project	<ul style="list-style-type: none"> <li>• This Requested Project allows EEC the opportunity to hire a modest number of additional staff, which will likely create economies of scale for EEC across its staff as volumes increase and staff are utilized more productively. Greater volumes will also increase the attractiveness of EEC to employment candidates – this can act to improve staff quality. (Advantage)</li> <li>• The principal disadvantage would be the necessity for EEC to hire, employ, and train additional ASC staff. This disadvantage is temporary because EEC has administrative, technical,</li> </ul>

	human resource support to accommodate surgical centers in the northwest with as many or more FTEs that will be required in Seattle. (Disadvantage)
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Source: EEC Director Discussion

**Table 26- Alternative Analysis: Legal Restrictions**

<b>Option:</b>	<b>Advantages/Disadvantages:</b>
No project	<ul style="list-style-type: none"> <li>• There are no legal restrictions to continuing operations as presently. (Advantage)</li> </ul>
Requested Project	<ul style="list-style-type: none"> <li>• The principal advantage would be allowing EEC the ability to “open” its ASC to non-EEC physicians. This will improve access, quality and continuity of care and promote highest, efficient use of EEC assets as compared to the No Project option. (Advantage)</li> <li>• Requires certificate of need approval. This requires time and expense. (Disadvantage)</li> </ul>

Source: EEC Director Discussion

**Table 27 - Alternative Analysis: Promoting Access to Healthcare Services**

Option:	Advantages/Disadvantages:
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	<ul style="list-style-type: none"> <li>• Advantage – If partnering with another provider and/or hospital to develop a new ASF, the ASF would be advantageous if it did more than ophthalmology. An ASF fee schedule is substantially lower than a hospital setting making it more affordable compared to a hospital. In addition, an ASF runs more efficiently than a hospital in-regards to OR time. More operating minutes would be available with another surgery center for a variety of procedures. Referencing the above statement, EEC does not intend to do any other type of procedure other than ophthalmology with this project.</li> <li>• Disadvantage – Creating a new center would be subject to CN approval and would have to show a need, in which it may or may not be able to. If it does not show a need, the new center would not have a history to show the need that was identified in the CN department interpretive statement issued on January 19, 2018. Partnering, building, licensing and credentialing a new surgery center would take several years before patients can realize an increase in access.</li> <li>• In-regards to ophthalmology, EEC already has a fully functional ASF that is equipped for ophthalmic surgery. Opening up another center with just ophthalmic services without increasing the minutes available at EEC would not improve access to ophthalmology services in the immediate future.</li> </ul>
Any other options considered (Example would be downsizing, EEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology)	<ul style="list-style-type: none"> <li>• Discussion – Access to ophthalmology services would not improve if EEC downsized and closed their ASF. If EEC opened up another ASF within the planning area, they would have to go through the CN process. By making the current ASF more efficient by extending hours and allowing non-EEC surgeons to operate would make the increase to access immediate. Opening up the ASF to other procedures besides ophthalmology requires more time, money and credentialing then EEC would like to pursue at this time.</li> <li>• Utilizing the fully operational ASF at EEC by allowing non-EEC to operate would be the most cost-effective approach for EEC to increase access to ophthalmology in the North King planning area.</li> </ul>

**Table 28 -Alternative Analysis: Promoting Quality of Care**

Option:	Advantages/Disadvantages:
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	<ul style="list-style-type: none"> <li>• Advantages – Partnering with others to create a new surgery center would bring all the advantages of having a surgery center as compared to a hospital. There is a higher infection rate in a hospital setting; CDC showed that in 2010, 8.95/1000 developed a surgical site infection within the hospital setting, whereas in an ASF, 4.84/1000 developed a surgical site infection. Within the ASF setting there are generally higher satisfaction rates, patients and families feel it is a more personable setting, and there is better pricing within an ASF that allows for more affordable care.</li> <li>• Disadvantage – At times, larger institutions (more levels of management and/or partners) can allow small key components that make up quality to fall through the cracks. This can be the cause of poor communication or the inability to fix problems in a fast-efficient manner.</li> </ul>

	<ul style="list-style-type: none"> <li>The ASF setting is the concept that EEC believes in and uses to provide excellent quality care for ophthalmology. EEC does not need to partner with an entity to continue to provide and promote quality of care.</li> </ul>
Any other options considered (Example would be downsizing, EEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology).	<ul style="list-style-type: none"> <li>Discussion – Downsizing EEC organization would not affect the quality of care that is provided at EEC Seattle. The ASF quality of care would continue even if another EEC ASF was built within the planning area. Adding additional non-ophthalmic procedures may decrease the quality of care until the level of proficiency is reached through education and repetition.</li> <li>By extending the minutes and allowing non-EEC surgeons to operate, the quality of care would not be diminished for ophthalmic surgeries. The same quality care, policies and procedures that are currently given and followed would continue. As the art of eye care develops with new procedures and care plans, EEC is able to monitor and adapt because it is their specialty and their focus.</li> </ul>

**Table 29 - Alternative Analysis: Promoting Cost and Operating Efficiency**

<b>Option:</b>	<b>Advantages/Disadvantages:</b>
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	<ul style="list-style-type: none"> <li>Advantages – by partnering with a larger system to open up a new center the resources for training, job description specialization, streamlining processes, purchasing and negotiating power increases.</li> <li>Disadvantage – If EEC partnered with a hospital, the fee scheduled would be based on HOPD rates, increasing the cost of ophthalmic services to their patients. Partnering with another entity, which increases the size of the organization, usually diminishes response time with regards to change which can lead to inefficiency and higher overhead costs.</li> <li>In-regards to ophthalmology, EEC already has a fully functional ASF that is equipped for ophthalmic surgery. Opening up another center with just ophthalmic services without increasing the minutes available at EEC would result in an unnecessary cost.</li> </ul>
Any other options considered (Example would be downsizing, EEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology).	<ul style="list-style-type: none"> <li>Discussion – EEC downsizing may or may not promote cost or operating efficiency. As the organization grows in a sustainable manner, it relies on all locations for leveraging costs and efficiency. It is not cost efficient to open up another EEC facility within the planning area when there is already a fully operational EEC ASF that has the ability to add more physicians and operating minutes. Although EEC does not intend to add other services besides ophthalmology, adding additional services would promote a cost savings for the planning area by offering outpatient services outside a hospital setting. EEC does not want to spend the time, cash and resources to open up to other specialties at this time.</li> <li>As an ASF, EEC promotes a cost savings approach for their ophthalmic patients. With the number of facilities EEC has, it allows for their processes to be ran in an efficient manner.</li> </ul>

**Table 30-Alternative Analysis: Staffing Impact**

Option:	Advantages/Disadvantages:
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	<ul style="list-style-type: none"> <li>• Advantages – Partnering with someone to open a new center would increase the number of healthcare positions available in the planning area, improving the economy within the area. Additionally, with a new surgery center that does multiple procedures, it would allow a “working” interview for EEC to hire and pick from the personnel pool within the facility.</li> <li>• Disadvantages – Working for a large organization can be a deterrent for some people because they feel that their voice doesn’t matter, or they don’t feel as valued for their work efforts. It is also discouraging when change is needed but it takes a while for it to happen.</li> </ul>
Any other options considered (Example would be downsizing, EEC opening another site within the planning area, extending hours of operation and/or add additional procedures besides ophthalmology).	<ul style="list-style-type: none"> <li>• Discussion – Downsizing EEC would mean that personnel would have to be let go. The positive side of the downsize/restructure would be that the best employees could be retained. EEC opening up another ASF within the planning area would also increase the number of personnel, having a positive impact on the economy. Opening up to additional procedures would have a positive impact on the staffing because of the increase in the personnel pool and the ability to specialize in their field of expertise.</li> <li>• EEC continues to look for those employees who stand out in their field. The overall impact of downsizing, adding an additional facility or expanding the services would not have a large impact on the staffing practices of EEC because the process of finding, hiring and retaining a competent staff is already in place.</li> </ul>

**Table 31 -Alternative Analysis: Legal Restrictions**

Option:	Advantages/Disadvantages:
Partnering with another provider (hospital or physicians) to create a new surgery center in the planning area	<ul style="list-style-type: none"> <li>• Advantages – Partnering with someone to build out a new surgery center would spread out the risk of the venture.</li> <li>• Disadvantages – Time, expense and partners are a disadvantage. There may not be an alignment in goals or outcomes. The larger the organization becomes, the more legal and government involvement. At times, this involvement may outweigh the desire to follow an idea and can stifle growth.</li> </ul>
Any other options considered (Example would be downsizing, EEC opening another site within the planning area, extending hours	<ul style="list-style-type: none"> <li>• Discussion – Out of the three examples given, downsizing would probably result in the least amount of time spent and expense. Opening up another ASF in the planning area and adding additional services will all require a significant amount of legal time and governmental regulations that need to be met before actually opening up for patient access.</li> <li>• Using the operational ASF facility and expanding the minutes and ability for non-physicians to practice, allows EEC to meet the needs of the public with the least amount of legal and government restrictions.</li> </ul>

of operation and/or add additional procedures besides ophthalmology).	
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The specific ways in which the project will promote staff or system efficiency or productivity.

In the above analysis, we found that the best option for EEC Seattle would be to move forward in trying to establish the facility as a CON approved facility. As the population grows along with the age of the population, the foreseeable future dictates that the need for ophthalmic surgery will not be diminished, but in fact continue to grow. Increasing the operating minutes of the Central King planning area in an already established ASF will contribute to a cost saving approach for those looking to improve their eye health. As an approved CON, EEC Seattle will be able to attract non EEC surgeons and give them an opportunity to do their patient surgeries within an ASF setting.

In the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.

This question is not applicable as there is no associated construction, renovation, or expansion for the requested CON approval of the existing EEC Seattle ASF.

In the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.

This question is not applicable as there is no associated construction, renovation, or expansion for the requested CON approval of the existing EEC Seattle ASF.

Exhibit 1  
EEC Seattle Letter of Intent



Leadership. Technology. Commitment.

May 21, 2018

Janis Sigman, Program Manager  
Certificate of Need Program  
Department of Health  
111 Israel Road S.E.  
Tumwater, WA 98501

RECEIVED

MAY 21 2018

CERTIFICATE OF NEED PROGRAM  
DEPARTMENT OF HEALTH

Re: Letter of Intent – Evergreen Eye Center Seattle

Dear Janis Sigman, Program Manager:

In Accordance with WAC 246-310-080, Evergreen Eye Center Inc. P.S. (“Evergreen Eye Center”) hereby submits a letter of intent proposing to establish and operate the Evergreen Eye Center Seattle surgery center as a free-standing ambulatory surgery center (ASC) in Central King County. Evergreen Eye Center Seattle surgery center historically operates as a certificate of need exempt ASC.

In conformance with WAC 246-310-080, the following information is provided:

1. A Description of the Extent of Services Proposed:
  - a. Evergreen Eye Center proposes to establish and operate the Evergreen Eye Center Seattle existing one-operating room surgical center as a free-standing ASC.
2. Estimated Cost of the Proposed Project:
  - a. The estimated capital expenditure is \$0. This operating room is fully built-out and operational.
3. Description of the Service Areas:
  - a. The primary service area will be Central King Health Services planning area.

Thank you for your interest in this matter. Please contact my office with any questions.

Sincerely,

John J. Whitehead, M.D.  
Owner

Exhibit 2  
EEC Organizational Chart

# Evergreen Eye Center

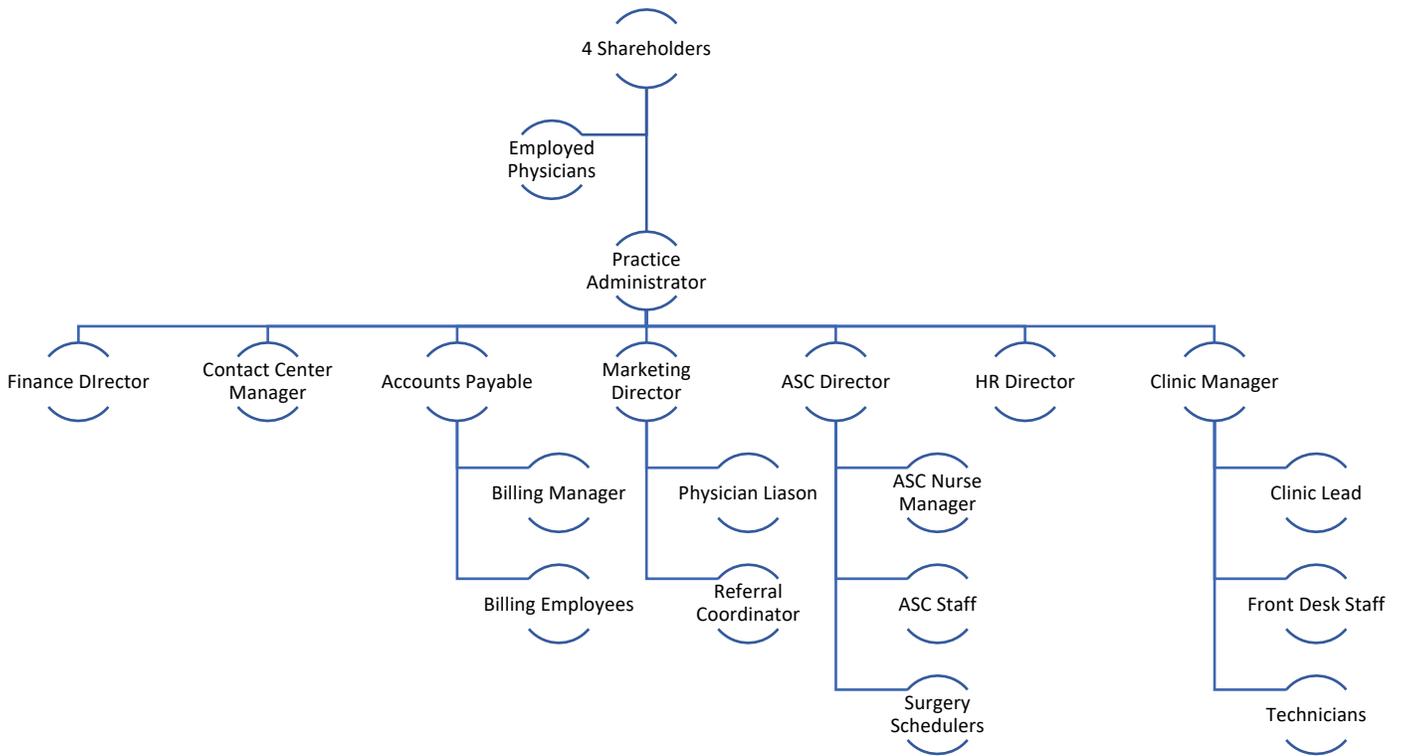


Exhibit 3  
Governance Policy

## **GOVERNING BODY BYLAWS**

The name of the facility shall be Evergreen Eye Surgery Center whose principal address is 34719 6<sup>th</sup> Avenue South, Federal Way, WA 98003.

This facility serves to provide care for patients in need of ambulatory surgical procedures.

### **PREAMBLE**

WHEREAS, Evergreen Eye Surgery Center is a for-profit company organized under the laws of the state of Washington; and

WHEREAS, its purpose is to serve as an ambulatory surgical center providing care and service to patients; and

WHEREAS, it is recognized that the medical staff is responsible for the quality of medical care in the facility and must accept and discharge the responsibility, subject to the ultimate authority of the facility's Governing Body, and the cooperative effort of the medical staff, the Clinical Director and the Governing Body are necessary to fulfill the facility's obligations to its patients; and

WHEREAS, the Governing Body, the medical staff, and any of their committees or agents, in order to promote professional peer review activity designated to establish a harmonious environment in which appropriate standards of medical care may be achieved, constitute themselves as professional review bodies as defined in the Health Care Quality Improvement Act of 1986, and claim all of the privileges and immunities of this act.

### **INITIAL OBJECTIVES**

- Making the decision to build Evergreen Eye Surgery Center.
- Approving plans and design.
- Developing staffing plan.
- Developing the organizational structure.
- Appointing a Medical Director.
- Appointing a Clinical Director.
- Developing Governing Body and Medical Staff bylaws.
- Developing a list of surgeries to be performed in this facility.

## **DEFINITIONS**

### Appropriateness

The extent to which a particular procedure, treatment, test or service is efficacious, is clearly indicated, is not excessive, is adequate in quantity, and is provided in the setting best suited to the patient's needs.

### Bylaws

These bylaws of the Governing Body and medical staff of Evergreen Eye Surgery Center.

### Clinical Privileges

The permission granted to the physician to render specific diagnostic, therapeutic, medical or surgical procedures.

### Clinical Director

A registered nurse (RN) appointed to oversee all aspects of patient care on a daily basis.

### Function

A group of related duties and responsibilities in a given area of care or service.

### Governing Body

The individual(s), group or agency that has ultimate authority and responsibility for the overall operation of the organization.

### Medical Staff

All physicians and limited license practitioners who are privileged to attend to patients in the facility.

### Medical Director

Physician who is chief officer of the medical staff appointed by the Governing Body.

### Minutes

A record of business introduced, transactions and reports made, conclusions reached, and recommendations made. Reports to officers and committees may be summarized briefly or mentioned as having been presented

### Monitoring

The systematic and routine collection, compilation and organization of data pertaining to important aspects of care in order that problems or opportunities to improve care can be identified.

### Nursing Process

A systematic, dynamic way of providing care to patients; it is an ongoing process that begins when a patient is admitted to the facility and continues until he or she is discharged. The nursing process includes four components: assessment, planning, intervention and evaluation.

### Nursing Service

Patient care services pertaining to the curative, restorative and preventative aspects of nursing that are performed and/or supervised by a registered nurse pursuant to the medical care plan of the physician and the nursing care plan.

### Peer Review

Peer review functions shall include the review of competence and professional conduct of professional health care providers leading to determinations concerning the granting of privileges or medical staff membership, the scope and condition of such privileges of membership, and the modification of such privileges or membership. Evaluation of patient care shall include the accuracy of diagnosis, propriety, quality, appropriateness or necessity of care. Peer review functions may be performed by a Peer Review Committee, a Medical Advisory Committee, an outside physician who has agreed to perform peer review or other structure approved by the Governing Body.

### Physician

An individual who has received a Doctor of Medicine or a Doctor of Osteopathy degree and who holds a fully unrestricted license to practice medicine in the state.

### Professional Review Action

An action or recommendation of a peer review committee, which is taken or made in the conduct of professional review activity or peer review.

### Quality

The degree of adherence to generally recognized contemporary standards of good practice and the achievement of anticipated outcomes for a particular service, procedure, diagnosis or clinical problem.

### Registered Nurse

An individual who is qualified by an approved post secondary program or baccalaureate or higher degree in nursing and licensed by the state to practice nursing.

## **ARTICLE I PHILOSOPHY AND OBJECTIVES**

### **1.1 PHILOSOPHY**

Evergreen Eye Surgery Center is a specialty care facility designed to provide individual, quality care for patients undergoing outpatient surgical procedures, which meet the criteria for medical necessity of surgical care.

Evergreen Eye Surgery Center is designated as a facility which is planned and administered to render a safe, comfortable, effective environment for patients and personnel, and to give assistance to the medical staff in meeting certain restorative health needs of patients without regard to race, color, religion, sex, age or national origin.

## 1.2 OBJECTIVES

- To create a safe physical environment in preparation for the scheduled procedure, during the procedure and immediately following the procedure.
- To provide an atmosphere of compassion and understanding with minimal stress and anxiety.
- To function at a high level of efficiency to accommodate the convenience of both the patient and the physician.
- To assist the physicians in execution of a method of surgical treatment individually designed for each patient.
- To promote knowledge and skills of Evergreen Eye Surgery Center staff as a means of meeting technical and scientific progress in the delivery of health care and to be aware of new research, new products and new ideas which may modify and improve present activities and procedures.
- To initiate and maintain rules and regulations of self-governance for the medical staff as set forth by the Governing Body.

## ARTICLE II GOVERNING BODY RESPONSIBILITY

The Governing Body assumes full legal responsibility for determining, implementing and monitoring policies governing Evergreen Eye Surgery Center's total operation. The Governing Body has oversight and accountability for the annual operating budget, Quality Assessment and Performance Improvement Program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan. When services are contracted with an outside resource, the Governing Body at Evergreen Eye Surgery Center will assure that these services are provided in a safe and effective manner (Reference: Federal Regulation # 416.41).

The Governing Body shall ensure that all personnel for whom state licenses, certification or registration are required are currently licensed, certified or registered as appropriate, in Washington. The Governing Body also ensures that practices of the facility and the improvement of patient care as indicated by the involvement and participation of the Quality Assessment and Performance Improvement (QAPI) committee include a physician peer review.

The Governing Body shall develop its mission, goals, objectives and long range plan, and will review it at least annually. Additions, deletions or revisions to the scope of services, policies and procedures, and organizational programs shall be reviewed concurrently. Procedures to be performed must be approved by the Governing Body and updated as needed. The Governing Body shall establish a system of financial management and accountability.

The Governing Body shall appoint officers and/or employ personnel to direct the clinical and business activities of the organization. The authority, responsibility and functions are documented in job descriptions specific to each position. The Governing Body encourages personnel to participate in continuing education relevant to their responsibilities.

### **ARTICLE III COMMITTEES**

The Governing Body, by resolution, adopted by a majority of the full Governing Body may designate a Medical Advisory Committee and any other appropriate committees.

The Governing Body shall be responsible for total overall operation of the facility and the approval of the medical staff appointments as recommended by the Medical Advisory Committee. The Governing Body shall have documented evidence on file that physicians admitted to practice in the facility are granted privileges consistent with their individual training, experience and other qualifications. The Governing Body shall have the power for granting, restricting and terminating privileges. The Governing Body shall conduct medical staff reappointments every two years. The reappointment process shall include any relevant findings of peer review activities.

The Governing Body shall assure the medical staff complies with its medical staff bylaws, rules and regulations.

The Governing Body shall review all policy and procedure manuals, ancillary and/or contracted services, and all other programs annually to assure they comply with applicable state and federal regulations.

The Governing Body shall review the QAPI subcommittee's quarterly reports and approve its implementation to assure quality patient care is being provided.

The Governing Body shall act on all medico-administrative matters of the organization.

The Governing Body is ultimately responsible for all activity of the facility, which is demonstrated by protecting patient's rights and responsibilities and their privacy and confidentiality.

### **ARTICLE IV GOVERNING BODY QUALIFICATIONS**

Members of the Governing Body shall be selected on the basis of interest in and agreement with the objectives and philosophies of the medical staff, willingness to accept responsibility for governance, ability to participate actively and effectively in governing activities and experience in organizational and community activities.

## **ARTICLE V FUNCTIONS**

The Governing Body shall perform their duties as members of any committee of the Governing Body upon which they may serve, in good faith, in a manner they reasonably believe to be in the best interest of the facility, and with such care as an ordinarily prudent person in a like position would use under similar circumstances.

## **ARTICLE VI TERM OF OFFICE, ELECTION AND VACANCIES**

John Jarstad, MD, Robert Tester, MD and Gary Chung, MD are the Shareholders of Evergreen Eye Surgery Center. For the purposes of governance, John Jarstad, MD, Robert Tester, MD and Gary Chung, MD, serve as the permanent Governing Body. They will remain in this position until such time as (1) they retire or become disabled or unable to function; or (2) in the event of death.

## **ARTICLE VII RESIGNATION AND REMOVAL OF DIRECTORS**

The Governing Body may resign at any time by documenting such resignation. Unless otherwise specified therein, such resignation shall take effect immediately.

## **ARTICLE VIII MEETINGS**

The Governing Body, or its designated representative, shall meet quarterly with the Medical Advisory Committee. A permanent record of minutes shall be kept. A copy will be approved and signed by the Governing Body. Should the occasion arise for interim decision making prior to the next scheduled meeting, the issue will be addressed and handled accordingly by a Shareholder of the Governing Body and communicated to concerned parties.

Exhibit 4  
Medical Policies

## **MEDICAL STAFF BYLAWS**

### **EVERGREEN EYE SURGERY CENTER**

#### **PREAMBLE**

These bylaws are adopted in order to provide for the organization of the medical staff of Evergreen Eye Surgery Center. These bylaws are prepared for compliance with appropriate licensing laws and accreditation standards to provide the professional and legal structure for medical staff operations and relations with applicants and members of the medical staff.

#### **DEFINITIONS**

##### Authorized Representative or Evergreen Eye Surgery Center Authorized Representative

An individual designated by the Medical Advisory Committee to provide information to, and request information from, the National Practitioner Data Bank and other agencies according to the terms of these bylaws.

##### Clinical Privileges or Privileges

Specified services that may be exercised by authorized individuals on approval of the Governing Body, based on the individual's professional license, documented current competence, education, training, health status, experience and judgment.

##### Facility

Evergreen Eye Surgery Center

##### Governing Body

The Governing Body of this facility, delegated authority and responsibility and appointed by the owners of the facility.

##### Investigation

A process specifically initiated by the Medical Advisory Committee to determine the validity, if any, of a concern or complaint raised against a member of the medical staff.

##### Medical Advisory Committee

The committee responsible for governing the medical staff as described in these bylaws.

Medical Disciplinary Cause or Reason (MDCR)

That aspect of an applicant's or member's competence or professional conduct which is likely to be detrimental to patient safety or the delivery of patient care.

Medical Staff

All physicians, (M.D. or D.O.) and CRNAs holding current, unrestricted licenses in Washington, who are privileged to attend to patients in the facility within their scope of licensure and approved clinical privileges.

Medical Staff Year

The period from January 1 through December 31.

Member

A physician who has been granted and maintains medical staff membership and clinical privileges in good standing pursuant to these bylaws.

Physician

"Physician" as defined in 1861(r), of the Social Security Act to include:

- o Doctor of Medicine or Osteopathy;
- o Doctor of Dental Surgery or of Dental Medicine
- o Doctor of Podiatric Medicine

All of the above must practice in accordance with state licensure.

Practitioner

A physician with a current, unrestricted license issued by Washington.

**MISCELLANEOUS**

The use of masculine pronouns he, his and him throughout these bylaws is applicable to either male or female.

**ARTICLE I  
NAME**

These are the bylaws of the medical staff of Evergreen Eye Surgery Center.

## **ARTICLE II PURPOSES AND RESPONSIBILITIES**

### **2.1 PURPOSES OF THE MEDICAL STAFF**

Purposes of the medical staff are to:

- provide an organized body through which the benefit of staff membership may be obtained by each staff member and the obligations of staff membership may be fulfilled;
- serve as the primary means for accountability to the Governing Body for the quality and appropriateness of professional performance and ethical conduct of its members;
- develop a structure that adequately defines responsibility, and when appropriate the authority and accountability of each medical staff member; and
- provide a means through which the medical staff may contribute to policy-making and planning within the facility.

### **2.2 RESPONSIBILITIES OF THE MEDICAL STAFF**

The responsibilities of the medical staff, which may be performed by the Medical Advisory Committee, are to account for the quality and appropriateness of patient care rendered in the facility by the following means:

- processing credentials in a manner that aligns qualifications, performance and competence with clinical privileges;
- making recommendations to the Governing Body with respect to medical staff appointments, reappointments and clinical privileges;
- participating in the Quality Assessment and Performance Improvement Program by conducting objectively all required peer evaluation activities through medical staff review;
- providing continuing education that is relevant to patient care provided in the facility as determined, to the degree reasonably possible, from the findings of quality improvement activities;
- initiating and pursuing corrective action when indicated;

- enforcing these medical staff bylaws uniformly and consistently; and
- striving to continuously improve the quality of patient care.

### **ARTICLE III MEDICAL STAFF MEMBERSHIP**

#### **3.1 NATURE OF MEMBERSHIP**

Membership on the medical staff is a privilege extended only to professionally competent physicians who continuously meet the qualifications, standards and requirements set forth in these bylaws, and all policies adopted pursuant thereto. Appointment to and subsequent membership on the medical staff shall confer on the member only such clinical privileges and rights as have been granted by the Governing Body in accordance with these bylaws.

#### **3.2 QUALIFICATIONS FOR MEMBERSHIP**

##### General Qualifications

Only physicians and CRNAs who:

- document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, (5) current active hospital privileges, and (6) adequate physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
- are determined to (1) adhere to the ethics of their respective professions, (2) be able to work cooperatively with others so as not to adversely affect patient care, (3) keep confidential, as required by law, all information or records received in the physician-patient relationship, and (4) be willing to participate in and properly discharge those responsibilities determined by the medical staff;
- maintain in force professional liability insurance in not less than the minimum policy limits of \$1,000,000 per claim and \$3,000,000 aggregate per year or other such amounts as may be deemed appropriate by the Governing Body and provide the facility with a current certificate of insurance;

- are board eligible or board certified by the applicable and recognized board of the applicant's surgical specialty or submit documentation of a current, validated curriculum of post-graduate training and five (5) years of practice in good standing in applicant's specialty at an accredited health care facility, with the exception of CRNAs; and
- when applicable, provide proof of certification and training for new or innovative procedures applied for, for example, laser, accompanied by evidence that applicant's malpractice coverage includes the new or innovative procedures, shall be deemed to possess qualifications for membership on the medical staff.

#### Particular Qualifications

- Medical Doctor or Osteopaths. An applicant for medical doctor or osteopath membership on the medical staff must hold a MD or DO degree, and must also hold a valid and unrestricted certificate to practice medicine issued by the Medical Board of Washington or the Board of Osteopathic Examiners of the State of Washington.

### **3.3 NONDISCRIMINATION**

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of race, age, sex, sexual orientation, ethnicity, religion or disability.

### **3.4 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP**

In addition to the other responsibilities and obligations listed in these bylaws, each applicant, by applying for or being granted membership or clinical privileges, thereby obligates himself to:

- adhere to generally recognized standards of professional ethics of his profession;
- provide continuous care and supervision of his patients;
- perform all of the applicable obligations of a member of the medical staff and voluntarily subject himself to the processes, decisions and judgments made concerning his practice at the facility;
- participate in peer review activities, including proctoring when asked to do so by the Medical Director and/or Clinical Director;

- prepare and complete in timely fashion medical records for all the patients to whom the member provides care in the facility;
- obtain appropriate informed consent from all patients and/or other appropriate persons;
- work cooperatively with others so as not to adversely affect patient care;
- reasonably cooperate with the facility in its efforts to comply with accreditation, reimbursement and legal or other regulatory matters;
- maintain confidentiality of all medical staff peer review matters, pursuant to these bylaws;
- understand and accept that any act, communication, report, recommendation or disclosure concerning his practice, performed or made at the request of an authorized representative of Evergreen Eye Surgery Center or any other health care facility for the purpose of achieving or maintaining quality patient care in this facility or any other health care facility, shall be pursued to the fullest extent permitted by law;
- give immediate notice to the Medical Advisory Committee in the event that his professional license, DEA number or professional liability insurance is revoked or suspended or in the event that his privileges or membership at any other health facility are curtailed, limited, suspended or revoked upon the grounds of actual or asserted medical cause or reason and irrespective of the fact that, in the opinion of the physician, such action is not justified;
- consent to the facility's inspection of all records and documents that may be material to an evaluation of his professional qualifications for the clinical privileges requested;
- avoid disruptive or other inappropriate behavior while at the facility;
- refuse to engage in improper inducements for patient referral; and
- acknowledge that there shall be, to the fullest extent permitted by law, immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed or made in connection with this or any other health care institution's activities related, but not limited to:
  - application for appointment or clinical privileges;
  - periodic reappraisals for reappointment or clinical privileges;

- corrective action, including summary suspension;
- hearings and reviews;
- medical care evaluations;
- utilization reviews, and
- other Evergreen Eye Surgery Center's activities related to quality patient care and inter-professional conduct.

### **3.5 CONDITIONS AND DURATION OF APPOINTMENT**

The Governing Body upon the advice and recommendations of the Medical Advisory Committee shall make all appointments and reappointments to the medical staff. Initial appointments and reappointments shall be for a period of two (2) years, commencing on the effective date of the appointment. The above notwithstanding, appointments and reappointments shall expire on the last day of the month of the expiration of the two (2) year term. Appointment to the medical staff confers on the appointee only such clinical privileges as have been specifically granted to the member.

## **ARTICLE IV CATEGORIES OF MEDICAL STAFF MEMBERSHIP**

### **4.1 CATEGORIES**

The categories of medical staff shall be active, courtesy, temporary and emergency. At each time of reappointment, the member's staff category shall be determined.

### **4.2 ACTIVE STAFF**

#### Qualifications

The active medical staff shall consist of members who:

- meet the general qualifications for membership set forth in Section 3.2; and
- regularly care for an excess of ten (10) patients per calendar year in the facility.

### Prerogatives

Except as otherwise provided, the prerogatives of an active medical staff member shall be entitled to:

- admit patients and exercise such clinical privileges as granted pursuant to Article VI;
- attend and vote on matters presented at general and special meetings of the medical staff and of the committees of which he is a member; and
- hold staff office and serve as a voting member of committees to which he is duly appointed or elected by the medical staff or duly authorized representative thereof.

## **4.3 COURTESY MEDICAL STAFF**

### Qualifications

The courtesy medical staff shall consist of members who:

- meet the general qualifications for membership set forth in Section 3.2; and
- regularly care for not more than nine (9) patients per calendar year in the facility.

### Prerogatives

Except as otherwise provided, the courtesy medical staff member shall be entitled to:

- admit patients and exercise such clinical privileges as granted pursuant to Article VI; and
- attend meetings of the medical staff in a non-voting capacity, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Courtesy staff members shall not be eligible to hold office in the medical staff.

### Courtesy Reappointment

The Governing Body shall have the authority not to renew a member's courtesy staff privileges if such member has not admitted or cared for any patient in the facility during the prior two years.

#### 4.4 TEMPORARY PRIVILEGES

##### Qualifications For Temporary Privileges

Prior to temporary privileges being granted, a physician must demonstrate that he has appropriate professional qualifications, a valid license in Washington, a current DEA and applicable Washington drug registration and professional liability insurance coverage, and a query may be submitted to the National Practitioner Data Bank. By applying for temporary privileges all physicians agree to be bound by the medical staff bylaws, rules and regulations, and applicable facility policies.

##### Authority To Grant Temporary Privileges/Conditions

The Medical Director, or his designee, may grant temporary privileges under the circumstances described below. In all cases, temporary privileges shall be granted for a specific period of time, not to exceed sixty (60) days. After that period of time, the physician may request a renewal of temporary privileges for another specific period of time, not to exceed sixty (60) days. Temporary privileges shall terminate automatically at the end of the specific time period for which they were granted, without the hearing and appeal rights set forth in these bylaws. Special requirements of supervision and consultation may be imposed upon the granting of temporary privileges.

- *Care of a Specific Patient:* Temporary privileges may be granted to a physician who is not an applicant for membership but is required for the care of a specific patient. Such privileges are restricted to the treatment of no more than five (5) patients by any one physician, after which he shall be required to apply for staff membership before being permitted to attend to additional patients.
- *Locum Tenens:* Temporary privileges may be granted to a qualified physician service locum tenens for a member of the medical staff. Such privileges shall be limited based on the locum tenens physician's individual training, experience and qualifications.

- *Pending Appointment to the Medical Staff:* In addition to the requirements noted under “Qualifications for Temporary Privileges” above, the applicant’s professional degree must be verified (e.g., M.D., D.O.) as well as his current license, current DEA registration, any specialty training claimed, at least two (2) references relating positively to his professional and ethical status, which shall include at least two (2) letters from peers and documentation of the current requisite amount of professional liability insurance coverage. Under no circumstances shall temporary privileges be extended under this paragraph for more than a total of one hundred twenty (120) days. The Medical Director or his designee may impose special consultation requirements and reporting.

#### Denial, Termination or Restriction of Temporary Privileges

Temporary privileges, unless acted upon pursuant to other provisions of these bylaws, shall terminate automatically at the end of the specific period for which they are granted, without the hearing and appeal rights under these bylaws. The Medical Director or his designee may terminate or restrict temporary privileges for any reason, at any time. A physician is entitled to the hearing and appeal rights set forth in these bylaws for a denial, non-renewal, restriction or termination of temporary privileges based on the physician’s professional conduct or competence. In the event a physician’s temporary privileges are terminated or restricted, the Medical Director shall assign the physician’s patients then in the facility to another physician. The wishes of the patient shall be considered, when feasible, in choosing a substitute physician.

#### **4.5 EMERGENCY PRIVILEGES**

In the event of an emergency, any physician, to the extent permitted by his license and regardless of staff status, or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm.

For the purpose of this section, “emergency” is defined as the condition, which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm or danger.

## **ARTICLE V APPOINTMENT AND REAPPOINTMENT**

### **5.1 GENERAL**

Except as otherwise specified herein, no person shall exercise clinical privileges in the organization unless that person applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these bylaws.

### **5.2 APPOINTMENT AUTHORITY**

Appointments, denials and revocations of appointments to the medical staff shall be made as set forth in these bylaws.

### **5.3 DURATION OF APPOINTMENT AND REAPPOINTMENT**

Except as otherwise provided in these bylaws, initial appointments to the medical staff shall be for a period of two (2) years. Reappointments shall be for a period of two (2) years.

### **5.4 APPLICATION FOR APPOINTMENT AND REAPPOINTMENT**

#### Application Form

An application form shall be developed, which shall require detailed information including, but not be limited to, information concerning:

- the applicant's qualifications, including but not limited to, education, professional training and experience, current licensure, current DEA registration and continuing medical education information related to the services to be performed by the applicant;
- peer references familiar with the applicant's professional competence and ethical character;
- request for specified clinical privileges;
- past or pending professional disciplinary action, licensure limitations or related matters;
- physical and mental health status;
- final judgments or settlements made against the applicant in professional liability cases and any filed cases pending; and

- professional liability coverage.

Each application for initial appointment to the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these bylaws, the medical staff rules and regulations and summaries or other applicable policies relating to clinical practice in the facility, if any.

#### Effect Of Application

By applying for appointment to the medical staff each applicant:

- signifies willingness to appear for interviews regarding the applications;
- authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
- consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- consents for disclosure to other organizations, hospitals, medical associations, licensing boards and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the organization or medical staff may have, and releases the medical staff and Governing Body from liability for so doing to the fullest extent permitted by law; and
- pledges to provide for continuous quality care for patients in the facility.

### Verification Of Information

The applicant shall deliver a completed application to the appropriate individual per application instructions. The Medical Advisory Committee or its designee shall expeditiously seek to collect and verify the references, licensure status and other evidence submitted in support of the application. The facility's authorized representative will query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Medical Advisory Committee for inclusion in the applicant's or member's credentialing file. The applicant shall be notified of any problems in obtaining the required information. When collection and verification is accomplished, all such information shall be transmitted to the Medical Advisory Committee.

### Medical Advisory Committee Action

At the next regularly scheduled meeting after receipt of the completed application file, or as soon thereafter as practicable, the Medical Advisory Committee shall consider the application. The Medical Advisory Committee may request additional information, and/or elect to interview the applicant. The Medical Advisory Committee shall render a decision in writing as to medical staff appointment and, if appointment is recommended, any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for the decision shall be stated.

### Effect Of Medical Advisory Committee Action

- *Favorable Recommendation:* When the recommendation of the Medical Advisory Committee is favorable to the applicant, it shall be promptly forwarded to the Governing Body together with supporting documentation.
- *Adverse Recommendation:* When a final recommendation of the Medical Advisory Committee is adverse to the applicant, the applicant shall be promptly informed by written notice advising the applicant of his hearing and appeal rights set forth in these bylaws.
- *Notice:* Notice of adverse recommendation shall be forwarded to the Governing Body for its information, but shall not be acted upon until after the affected individual has exercised or waived his right to a hearing under these bylaws.

### Action on the Application

In taking action under this section, the Governing Body shall give great weight to the recommendation of the Medical Advisory Committee and shall not act arbitrarily or capriciously.

- If the Governing Body adopts the recommendation of the Medical Advisory Committee, it shall become the final action of the facility.
- If the Governing Body does not adopt the recommendation of the Medical Advisory Committee, the Governing Body may refer the matter back to the Medical Advisory Committee with instructions for further review and recommendation. The Medical Advisory Committee shall review the matter and promptly forward its recommendation to the Governing Body. If the Governing Body adopts the recommendation of the Medical Advisory Committee, it shall become the final action of the facility.
- If the action of the Governing Body is adverse to the applicant, the Governing Body shall notify the Medical Advisory Committee, and the chairman shall promptly send a written notice to the applicant advising the applicant of his hearing and appeal rights under these bylaws.
- An adverse decision of the Governing Body shall not become final until the applicant has exercised or waived his hearing and appeal rights under these bylaws. The fact that such adverse decision is not yet final shall not be deemed to confer membership or privileges when none existed before.

After all the affected individual's hearing and appeal rights under these bylaws have been exhausted or waived, the Governing Body shall take final action. All decisions to appoint shall include a delineation of clinical privileges, staff category and any applicable conditions and the applicant shall be so notified.

Subject to any applicable provisions of Article VIII, notice of the Governing Body shall be given in writing through the chairmen of the Medical Advisory Committee to the applicant within five (5) days of the arbitrator's final decision.

#### Notice Of Final Decision

- Notice of the final decision shall be given to the applicant.
- A decision and notice to appoint or reappoint shall include, if applicable, (1) the clinical privileges granted and (2) any special conditions attached to the appointment.

### **5.5 REAPPOINTMENT**

Medical staff privileges must be periodically reappraised, not less than every two (2) years. The scope of procedures performed in the organization must be periodically reviewed and amended as appropriate. The reappointment time is every two (2) years.

### Reapplication

At least three (3) months prior to the expiration date of the current staff appointment, a reapplication form, developed by the Medical Advisory Committee, shall be mailed or delivered to the member. At least thirty (30) days prior to the expiration date, each medical staff member shall submit to the Medical Advisory Committee the completed application form for renewal of appointment to the staff, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant. Upon receipt of the application, the information shall be processed.

### Failure To File Reappointment Application

If the member fails without good cause to file a completed application within seven (7) days past the date it was due, the member shall be deemed to have resigned membership in the facility and the hearing and appeal rights set forth in these bylaws shall not apply.

## **ARTICLE VI CLINICAL PRIVILEGES**

### **6.1 EXERCISE OF PRIVILEGES**

Except as otherwise provided in these bylaws, a member providing clinical services at this facility shall be entitled to exercise only those clinical privileges specifically granted. These privileges and services must be organization specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon. Medical staff privileges may be granted, continued, modified or terminated by the Governing Body only upon recommendation of the Medical Advisory Committee, only for reasons directly related to quality of care and other provisions of these medical staff bylaws, and only following the procedures outlined in these bylaws.

### **6.2 DELINEATION OF PRIVILEGES IN GENERAL**

#### Requests

Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

### Basis For Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from outside sources.

## **6.3 PROCTORING**

### General Provisions

Except as otherwise determined by the Medical Advisory Committee, all new members and all members granted new clinical privileges may be subject to a period of proctoring. All efforts will be made to conduct on-site proctoring. If on-site proctoring cannot be reasonably carried out within the confines of the facility, evidence of proctoring from a local organization or hospital may be accepted. Performance on an appropriate number of cases as established by the Medical Advisory Committee may be observed by the appropriate members, as determined by the Medical Advisory Committee during the period of proctoring specified by the Medical Advisory Committee, to determine suitability to continue to perform services within the facility. The member shall remain subject to such proctoring until the Medical Advisory Committee furnishes a report describing the types and number of cases observed, an evaluation of the applicant's performance, and a statement that the applicant appears to meet all of the qualifications for unsupervised practice in the facility.

### Failure To Obtain Certification

If a new member or member exercising new clinical privileges fails to obtain such certification within the time allowed by the Medical Advisory Committee, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article VIII, if such failure is due to a medical disciplinary cause or reason.

## ARTICLE VII CORRECTIVE ACTION

### 7.1 CORRECTIVE ACTION

#### Criteria For Initiation

Any person may provide information to the Medical Advisory Committee about the conduct, performance, or competence of medical staff members. When reliable information indicates a member may have exhibited acts, demeanor or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the organization; (2) unethical; (3) contrary to the medical staff bylaws and rules and regulations; or (4) below applicable professional standards, a request for an investigation or action against such members may be made.

#### Initiation

A request for an investigation must be in writing, submitted to the Medical Advisory Committee, and supported by reference to specific activities or conduct alleged. If the Medical Advisory Committee initiates the request, it shall file appropriate documentation of the reasons.

#### Investigation

If the Medical Advisory Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Advisory Committee may conduct the investigation to be undertaken. The Medical Advisory Committee may conduct the investigation itself, or may assign the task to an appropriate medical staff member or committee. If the investigation is delegated to a member or committee, such person(s) shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Advisory Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VIII, nor shall the procedural rules with respect to hearings apply. Despite the status of any investigation, the Medical Advisory Committee shall retain authority and discretion at all times to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process or other action.

### Medical Advisory Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Advisory Committee shall take action, which may include, without limitation:

- determining no corrective action be taken and, if the Medical Advisory Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- deferring action for a reasonable time;
- issuing letters of admonition, censure, reprimand or warning. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
- recommending the imposition of terms of probation or special limitation upon continued organization membership including, without limitation, requirements for mandatory consultation or monitoring; and
- recommending termination of membership.

### Subsequent Action

- If the Medical Advisory Committee recommends corrective action, that recommendation shall be subject to final action by the Governing Body.
- So long as the recommendation is supported by substantial evidence, the recommendation of the Medical Advisory Committee shall be adopted by the Governing Body as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VIII, if applicable.

## **7.2 SUMMARY RESTRICTION OR SUSPENSION**

### Criteria for Initiation

Whenever a member's conduct appears to require immediate action be taken to reduce a substantial and imminent likelihood of significant impairment of the life, health or safety of any person, the Medical Advisory Committee, may summarily suspend the membership of such member. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the member and the Governing Body. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

### Medical Advisory Committee Action

As soon as practical after such summary restriction or suspension has been imposed, a meeting of the Medical Advisory Committee as a whole shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Advisory Committee may impose. In no event, however, shall any meeting of the Medical Advisory Committee, with or without the member, constitute a "hearing" within the meaning of Article VIII, nor shall any procedural rules apply. The Medical Advisory Committee may recommend modification, continuance or termination of the summary suspension. Such recommendation will be subject to final action of the Governing Body.

### Subsequent Action

- The Medical Advisory Committee recommendation shall be subject to final action by the Governing Body.
- So long as the recommendation is supported by substantial evidence, the recommendation of the Medical Advisory Committee shall be adopted by the Governing Body as final action unless the member requires a hearing, in which case the final decision shall be determined as set forth in Article VIII, if applicable.

### Procedural Rights

Unless the Governing Body promptly terminates the summary suspension, the member shall be entitled to the procedural rights afforded by Article VIII.

## **7.3 AUTOMATIC SUSPENSION OR LIMITATION**

In the following instances, membership may be suspended or limited as described, and a hearing, if requested, shall be an informal hearing before the Medical Advisory Committee limited to the questions of whether the grounds for automatic suspension as set forth below have occurred.

### Licensure

- *Revocation and Suspension:* Whenever a member's license or other legal credential authorizing practice in Washington, is revoked or suspended, medical staff membership shall be automatically revoked as of the date such action becomes effective.

- *Restriction:* Whenever a member's license or other legal credential authorizing practice in Washington, is limited or restricted by the applicable licensing or certifying authority, any clinical privileges exercised at Evergreen Eye Surgery Center which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- *Probation:* Whenever a member is placed on probation by the applicable licensing or certifying authority, his membership status shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

#### Controlled Substances

- Whenever a member's DEA certificate is revoked, limited or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- *Probation:* Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

#### Medical Records

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Advisory Committee, and in any event no later than thirty (30) days from the date treatment was provided. A limited suspension, in the form of withdrawal of the right to treat future patients at the facility until medical records are completed, shall be imposed by the Medical Advisory Committee, after notice of delinquency or failure to complete medical records within such period. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Advisory Committee. The suspension shall continue until lifted by the Medical Advisory Committee.

#### Professional Liability Insurance

Failure to maintain professional liability insurance shall be grounds for automatic suspension of a member's clinical privileges, and if within seven (7) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

## **ARTICLE VIII HEARINGS**

These procedures apply to all applicant/member physicians applying to practice or practicing within the facility.

### **8.1 TIMELY COMPLETION OF PROCESS**

The hearing process shall be completed within a reasonable time.

### **8.2 GROUNDS FOR HEARING**

Except as otherwise specified in these bylaws, any of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing, if such action occurred in part for a medical disciplinary cause or reason (MDCR), even if there were other reasons for the action.

- o Denial of medical staff membership;
- o Denial of medical staff reappointment;
- o Suspension of medical staff membership;
- o Revocation of medical staff membership;
- o Denial of requested clinical privileges;
- o Involuntary reduction of current clinical privileges;
- o Suspension of clinical privileges;
- o Termination of all clinical privileges; or
- o Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to privilege status or otherwise for purposes of investigation only).

Exhaustion of Remedies: If any of the above adverse actions are taken or recommended, the member must exhaust the remedies afforded by these procedures before resorting to legal action.

### **8.3 NOTICE OF REASONS/ACTION**

Whenever any of the actions listed above are taken or proposed for a non-MDCR, the member shall receive a written statement of the reasons therefore. However, the Article VIII sections below apply only where action was taken or proposed for an MDCR.

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2 for MDCR, the Medical Advisory Committee shall give the member prompt written notice of, (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the medical board of Washington; (2) the reasons for the proposed action, including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 7.4, and that such hearing must be requested within thirty (30) days; and (4) a summary of the rights granted in the hearing pursuant to the medical staff bylaws. If the recommendation or final proposed action adversely affects the clinical privileges of a physician for a period longer than thirty (30) days, said written notice shall state that the action, if adopted, will be reported to the National Practitioner Data Bank, and shall state the text of the proposed report.

#### **8.4 REQUEST FOR HEARING**

The member shall have thirty (30) days following receipt of notice of action taken or proposed for MDCR to request a hearing. The request shall be in writing, addressed to the Medical Advisory Committee with a copy to the Governing Body. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

#### **8.5 TIME AND PLACE FOR HEARING**

Upon receipt of a request for hearing, the Medical Advisory Committee shall schedule a hearing and within fifteen (15) days, give notice to the member of the time, place and date of the hearing. Unless extended by the arbitrator, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request for a hearing; provided, however, that when the request is received from a member whose membership has been terminated, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.

#### **8.6 NOTICE OF HEARING**

Together with the notice stating the place, time and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice unless waived by a member under summary suspension, the Medical Advisory Committee shall provide a list of the charts in question, where applicable, and a list of witnesses (if any) expected to testify at the hearing on behalf of the Medical Advisory Committee. The content of this list is subject to update pursuant to Section 8.10.

## **8.7 ARBITRATOR**

When a hearing is requested, the Medical Advisory Committee and the member may select an arbitrator mutually agreeable to both sides or, if they cannot agree, each side selects one arbitrator and the two arbitrators selected will appoint a third.

## **8.8 FAILURE TO APPEAR OR PROCEED**

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or action involved.

## **8.9 POSTPONEMENTS AND EXTENSIONS**

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the hearing officer on a showing of good cause or upon agreement of the parties.

## **8.10 PRE-HEARING PROCEDURES**

If either party to the hearing requests, in writing, a list of witnesses, within fifteen (15) days of such a request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall also have the right to receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges, which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Advisory Committee and any exculpatory evidence in the possession of the facility. The member and the Medical Advisory Committee shall have the right to receive all evidence, which will be made available to the arbitrator.

- The Medical Advisory Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in his possession or control as soon as practicable after receiving the request.
- The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

- The arbitrator shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In doing so, the arbitrator shall consider:
  - whether the information sought may be introduced to support or defend the charges;
  - the exculpatory or inculpatory nature of the information sought, if any;
  - the burden imposed on the party in possession of the information sought, if access is granted; and
  - any previous requests for access to information submitted or resisted by the parties.
  
- It shall be the duty of the member and the Medical Advisory Committee to exercise reasonable diligence in notifying the arbitrator of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made succinctly at all times at the hearing.

#### **8.11 REPRESENTATION**

The member shall be entitled to representation by legal counsel in any phase of the hearing, should he so choose, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a physician licensed to practice in the state of Washington, who is not also an attorney at law, and the Medical Advisory Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses and respond to appropriate questions. An attorney at law shall not represent the Medical Advisory Committee if the member is not so represented.

#### **8.12 RECORD OF THE HEARING**

A shorthand reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the arbitrator. The cost of attendance of the shorthand reporter shall be borne by the organization, but the cost of the transcript, if any, shall be borne by the party requesting it. The arbitrator may, but shall not be required to, order that oral evidence shall be taken only on an oath administered by any person lawfully authorized to administer such oaths.

### **8.13 RIGHTS OF THE PARTIES**

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Advisory Committee and examined as if under cross-examination.

### **8.14 MISCELLANEOUS RULES**

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses and presentation of evidence shall not apply to a hearing conducted under these procedures. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The arbitrator may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the arbitrator may request or permit both sides to file written arguments.

### **8.15 BURDENS OF PRESENTING EVIDENCE AND PROOF**

At the hearing, unless otherwise determined for good cause, the Medical Advisory Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

An applicant shall bear the burden of persuading the arbitrator, by a preponderance of the evidence, of his current qualifications for membership and reasonable doubts concerning his current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff but not produced during the application process unless the applicant establishes the information could not have been produced previously in the exercise of reasonable diligence.

Except as provided above for applicants, throughout the hearing, the Medical Advisory Committee shall bear the burden of persuading the arbitrator, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

## **8.16 ADJOURNMENT AND CONCLUSION**

The arbitrator may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Advisory Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

## **8.17 BASIS FOR DECISION**

The decision of the arbitrator shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

## **8.18 DECISION OF THE ARBITRATOR**

Within thirty (30) days after final adjournment of the hearing, the arbitrator shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the parties. If the member's membership is currently terminated however, the time for the decision and report shall be fifteen (15) days. The report shall contain a concise statement of the reasons in support of the decision, including finding of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. The decision of the arbitrator shall be the final action.

## **8.19 NATIONAL PRACTITIONER DATA BANK REPORTING**

### Adverse Actions

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the arbitrator. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

### Dispute Process

If no hearing was requested, a member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Medical Advisory Committee and a Governing Body member.

If a hearing was held, the dispute process shall be deemed to have been completed.

## ARTICLE IX OFFICERS

### 9.1 OFFICERS OF THE MEDICAL STAFF

#### Identification

The officers of the medical staff shall be the Medical Director and the Assistant Medical Director.

#### Qualifications

Officers must be members of the active medical staff at the time of their nominations and election or appointment, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

#### Appointment

Officers shall be appointed by the principals of the facility.

#### Term of Elected Office

Each officer shall serve a two (2) year term, commencing on the first day of the medical staff year following his appointment. Each officer shall serve in each office until the end of that officer's term, or until a successor is appointed, unless that officer shall resign sooner or be removed from office.

#### Recall of Officers

Except as otherwise provided, recall of a medical staff officer may be initiated by the Medical Advisory Committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

### Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies shall be filled by appointment by the Governing Body.

## **9.2 DUTIES OF OFFICERS**

### Medical Director

The Medical Director shall serve as the chief officer of the medical staff. The duties of the Medical Director shall include, but not be limited to:

- enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- calling, presiding at and being responsible for the agenda of all meetings of the medical staff;
- serving as chairman of the Medical Advisory Committee;
- serving as an ex officio member of all other staff committees without vote, unless his membership in a particular committee is required by these bylaws;
- interacting with the Governing Body in all matters of mutual concern within the facility;
- appointing, in consultation with the Medical Advisory Committee, committee members for all standing and special medical staff, liaison or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairperson of these committees; and
- performing such other functions as may be assigned to the Medical Director by these bylaws, the medical staff or by the Medical Advisory Committee.

### Assistant Medical Director

The Assistant Medical Director shall assume all duties and authority of the Medical Director in the absence of the Medical Director. The Assistant Medical Director shall be a member of the Medical Advisory Committee and shall perform such other duties as the Medical Director may assign or as may be delegated by these bylaws, or by the Medical Advisory Committee.

## **ARTICLE X COMMITTEES**

### **10.1 GENERAL CONSIDERATIONS**

#### Committee Structure

The Medical Advisory Committee shall be responsible for the general supervision of the medical staff and for the duties and responsibilities described in these bylaws.

Other committees shall be identified and structured as the Medical Advisory Committee, the Governing Body, or these bylaws designate.

The committee shall maintain a permanent record of their proceedings, including pertinent discussion and any conclusions, recommendations and actions.

The Medical Director and a Governing Body designee may serve on all medical staff committees to which they are not expressly appointed.

Whenever these bylaws require that a function be performed by:

- a medical staff committee, but no committee has been specified, the Medical Advisory Committee shall perform the function or designate a committee to perform it;
- the Medical Advisory Committee, but a committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

All committee participants shall sign and date a confidentiality statement acknowledging that each agrees to maintain the confidentiality of all committee matters.

### **10.2 MEDICAL ADVISORY COMMITTEE**

#### Composition

The Medical Advisory Committee shall be a standing committee of the medical staff and shall consist of the officers of the medical staff and additional members as appointed by the Governing Body. Ex-officio members, without vote, may include the Administrator, Clinical Director and others as appointed by the Medical Director. Each voting member shall have one vote. The Governing Body shall resolve a tie vote. The Governing Body shall have the authority to establish the number of consecutive terms a member may serve as a voting member.

## Duties

The duties of the Medical Advisory Committee shall be to:

- perform the functions outlined in these bylaws;
- coordinate and implement the professional and organizational activities and policies of the medical staff;
- receive and act upon reports and recommendations from medical staff committees;
- recommend actions to the Governing Body on matters of a medico-administrative nature;
- review, investigate and recommend to the Governing Body on all matters relating to credentialing, appointments and reappointments, clinical privileges, staff category and clinical and corrective action;
- when designated allied health professionals provide or are recommended to provide services in the facility, make recommendations to the Governing Body on their qualifications and the degree of supervision required;
- coordinate activities of, and policies adopted by the staff and committees;
- fulfill the medical staff's accountability to the Governing Body for the medical care delivered in the facility;
- initiate, investigate and pursue corrective action when warranted, in accordance with these bylaws;
- designate such committees and make appointments to those committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff;
- take all reasonable steps to assure professional ethical conduct, competence and clinical performance;
- designate the organization's authorized representative for National Practitioner Data Bank purposes;
- review medical staff bylaws and rules and regulations annually and make recommendations for modifications to these documents as necessary;

- formulate appropriate administrative policies and procedures regarding employment of personnel, fiscal concerns and the purchasing of equipment;
- report to the medical staff and Governing Body the findings and results of all medical staff quality management activities;
- promote medical staff and facility staff continuing education activities, relevant to the care and services provided in the facility, and in particular, to the findings of peer review and other quality management activities;
- monitor compliance with licensure and certification; and
- perform such other duties as the Governing Body may reasonably request.

Other specific responsibilities of the Medical Advisory Committee shall include:

- implementation of a Quality Management program to include the functions of performance improvement, utilization review, risk management, peer review, infection control, tissue review, pharmacy and therapeutics, medical record documentation and other functions and activities as necessary to ensure quality patient care at Evergreen Eye Surgery Center.

### Meetings

The Medical Advisory Committee shall meet as often as necessary, but at least quarterly and shall maintain a record of its proceedings and actions. The quarterly meeting may be in conjunction with the Governing Body meeting.

## **ARTICLE XI CONFIDENTIALITY/IMMUNITY FROM LIABILITY**

### **11.1 CONFIDENTIALITY**

Records and proceedings of all medical staff committees having the responsibility for the quality of care rendered in this facility, including, but not limited to, meetings of the medical staff committee of the whole, meetings of committees, and meetings of special or ad hoc committees created by the Medical Advisory Committee and including information regarding any member or applicant to this medical staff, shall be confidential, subject to release only in accordance with policies of the medical staff and privileged to the fullest extent permitted by law.

All individuals participating in or attending committee meetings or entitled to access information, agree to keep all proceedings, minutes and documents related to any peer review or quality management matter confidential and subject to release only in accordance with policies of the medical staff.

Inasmuch as effective peer review, credentialing and quality management activities must be based on free and candid discussions, any breach of confidentiality of the discussion, deliberations or records of any medical staff meeting is outside appropriate standards of conduct and will be deemed disruptive to the operation of the facility and as having an adverse impact on the quality of patient care.

## **11.2 IMMUNITY**

### Privileges

Any act, communication, report, recommendation or disclosure with respect to any applicant or member of the medical staff, committee member or clinical privileges performed or made for the purpose of assessing patient care or achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law.

### Application

Such privileges shall extend to the facility and its affiliates, and to all individuals participating in the process of assessing patient care or achieving and maintaining quality patient care including, but not limited to, members of the medical staff, Governing Body, Medical Director, Administrator, Clinical Director and all third parties who supply information to any of the individuals authorized to receive, release or act upon such information. For the purpose of this Article, the term "third parties" means both individuals and organizations from which information has been requested and/or received by an authorized representative of the facility, its Governing Body, medical staff or any committee or component thereof.

### Immunity

Immunity from civil liability for any act, communication, report, recommendation or disclosure shall be absolute and to the fullest extent permitted by law. Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with the facility or any other health care organization's activities related to, but not limited to:

- applications for appointment of clinical privileges;

- periodic appraisals for appointment of clinical privileges;
- any and all investigations and all corrective action, including summary suspension;
- hearings and reviews;
- quality management activities and medical care evaluations;
- peer review materials;
- utilization review materials; and,
- other facility or committee related activities related to quality patient care and intraprofessional conduct.

The acts, communications, reports, recommendations and disclosures referred to in Article XI may relate to a physician's professional qualifications, clinical competency, character, mental or emotional stability, criminal activity, disruptive behavior, physical condition, ethics or any other matters that might directly or indirectly have an effect on patient care.

### **11.3 APPLICATION**

The confidentiality, immunities, privileges, releases and other items in this Article XI shall be express conditions to any physician's application for or exercise of privileges at the facility and shall survive a physician's corrective action.

### **11.4 RELEASES**

All applicants or members shall execute releases of liability and of confidentiality upon request of the facility in accordance with this Article.

**ARTICLE XII  
ADOPTION AND AMENDMENTS OF  
BYLAWS, RULES AND REGULATIONS**

**12.1 RULES AND REGULATIONS**

The medical staff (through the Medical Advisory Committee) shall initiate and adopt such rules and regulations, as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current medical staff practice. Recommended changes to the rules and regulations shall be submitted to the Medical Advisory Committee for review and evaluation prior to presentation for consideration by the medical staff as a whole under such review or approval mechanism as the medical staff shall establish. Following adoption, such rules and regulations shall become effective. Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment or repeal of the medical staff rules and regulations.

**12.2 BYLAWS**

Upon the request of the Medical Advisory Committee or upon timely written petition signed by at least ten percent of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment or repeal of these bylaws. Such action shall be taken at a regular or special meeting provided, (1) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the medical staff, and such changes were offered at such prior meeting and (2) notice of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered. Both notices shall include the exact wording of the existing bylaw language, if any, and the proposed change(s).

Action On Bylaw Change

If a quorum is present for the purpose of enacting a bylaw change, the change shall require an affirmation vote of fifty-one percent of the members voting in person or by written ballot.

## **SCOPE OF CARE AT EVERGREEN EYE SURGERY CENTER**

Evergreen Eye Surgery Center is a licensed, Medicare Certified Ambulatory Surgery Center. Its hours of operation are Monday through Friday, 6 am to 5 pm, except holidays. The facility performs elective surgical procedures to ambulatory patients in ASA level one, two or three. Physicians, with privileges at the facility, perform the procedures and appropriately trained personnel assist them. These procedures are:

### **ANESTHESIA (CRNA)**

- Emergency treatment
- Emergency/therapeutic laryngoscopy
- Intravenous Anesthesia
- Local Anesthesia
- Monitored Anesthesia Care
- Pre and postop consultation and evaluation
- Regional Anesthesia
- Resuscitation
- Topical Anesthesia

### **OPHTHALMOLOGY**

#### Conjunctiva

- Repair of major laceration
- Conjunctivoplasty – without graft
- Conjunctivoplasty – with sliding graft
- Conjunctivoplasty – with mucous membrane graft
- Flap to repair/restore anterior chamber
- Gundersen flap
- Excision of conjunctival tumor
- Excision of conjunctival cyst
- Pterygiectomy

#### Cornea

- Repair of laceration
- Removal of (superficial) foreign body
- Keratomileusis
- Keratoplasty – lamellar
- Excision of pterygium with/without graft
- Repair of wound leak
- Resuturing for astigmatism
- Astigmatic keratotomy

## **OPHTHALMOLOGY (cont)**

### Sclera

- Repair of laceration
- Sclerotomy
- Sclerotomy – partial of full thickness

### Anterior Chamber

- Tap/irrigation
- Reformation
- Removal of foreign body
- Paracentesis
- Pupilloplasty

### Lid

- Repair major laceration
- Repair marginal laceration
- Canthoplasty
- Tarsorrhaphy
- Blepharoplasty
- Excision of lesion with reconstruction
- Excision of lesion with skin graft
- Punctal repair
- Entropion repair
- Ectropion repair
- Ptosis repair
- Dermatochalasis repair
- Severing tarsorrhaphy

### Lens

- Discission
- Capsulotomy
- Extraction – extracapsular
- Extraction – intracapsular
- Extraction with intraocular lens implant
- Removal/reposition intraocular lens
- Exchange intraocular lens (replacement)

### Iris

- Iridotomy
- Iridectomy
- Excision of lesion
- Repair of prolapse
- Repair of dialysis
- Laser photocoagulation
- Iridoplasty
- Argon laser trabeculectomy
- Trabeculoplasty

## **OPHTHALMOLOGY (cont)**

### Ciliary Body

- Cyclodiathermy
- Cyclocryopexy
- Excision of prolapse
- Cyclodialysis
- Repair of dialysis

### Miscellaneous

- Anesthesia: local
- Anesthesia: regional
- Anesthesia: topical
- History and physical
- Supervision of non-physician personnel
- Goniotomy
- Goniopuncture
- Vitreous tap
- Vitrectomy, anterior
- Vitrectomy, posterior
- Laser photocoagulation for branch retinal vein occlusion
- Anterior membranectomy
- Synechiolysis
- Yag laser capsulotomy
- Lasik

## **MEDICAL STAFF RULES AND REGULATIONS**

### **EVERGREEN EYE SURGERY CENTER**

#### **ADMISSION**

Every patient must be admitted by and remain under the care of a member of the medical staff.

Patients will be admitted to Evergreen Eye Surgery Center for treatment without regard to race, color, religion, sex, age, national origin, handicap or sexual preference.

Patients must be accompanied to and from Evergreen Eye Surgery Center by a "responsible individual".

It is the responsibility of the physician to obtain "written informed consent", by the patient, parent or legal guardian, for any surgery performed at Evergreen Eye Surgery Center. The patient will sign a facility consent validating that they did receive informed consent from their surgeon.

No lab work is required at Evergreen Eye Surgery Center. All female patients in child bearing years (ages 10-54) will have a screening pregnancy test (HCG) or sign a refusal for testing. All diabetic patients will have their blood glucose tested preoperatively.

A comprehensive history and physical examination, current within 30 days, which contains a provisional diagnosis and current medications, shall be on the patient chart prior to the surgical procedure.

Patients who are admitted to the facility will remain under the care of a medical staff member throughout their stay in the facility.

#### **ANESTHESIA**

Anesthetic procedures performed at Evergreen Eye Surgery Center may include regional, topical, local, oral controlled substances and/or monitored anesthesia care (MAC). The amount of local anesthesia and intraoperative medication shall not exceed toxic levels.

The administration of anesthesia for cases shall be the responsibility of a qualified anesthesiologist or a CRNA.

Anesthesia will not be started until the surgeon is present at Evergreen Eye Surgery Center.

Administration of local, topical and/or infiltrative anesthesia for local cases shall be the sole responsibility of the medical staff physician.

No explosive agents will be available at the facility. The prevention of certain explosive anesthetic agents from being used in the operating room suite is the responsibility of the anesthesia providers.

Strict adherence to the recommended safety precautions outlined in the 2000 edition of the NFPA Life and Safety Code 101 are in effect at the facility.

## **DRUGS**

Drugs used shall meet the standards of the U.S. Pharmacopoeia, National Formulary and New and Non-Official Remedies.

Only those drugs approved for use in the Evergreen Eye Surgery Center formulary may be administered in the facility.

No drugs will be dispensed from Evergreen Eye Surgery Center.

## **DISCHARGE**

Patients shall be discharged after a discharge order is signed by the physician who performed the procedure, as outlined in the policies and procedures incorporated by the medical staff and approved by the Governing Body.

After the patient has been sedated, discharge from the facility is based upon the patient's ability to leave the facility safely when accompanied by a responsible adult and when the physician's postoperative orders have been completed. If no sedative is administered, the patient may be discharged without a chaperone following the written discharge orders of the physician.

An anesthesiologist / anesthetist or another physician qualified in resuscitative techniques is present or immediately available until all patients operated on that day have been discharged.

## **MEDICAL RECORDS**

The physician shall be responsible for the preparation of a complete medical record for each patient.

The medical record must contain an operative summary with a complete description of the operative procedure, any complications and the physician's signature. Prognosis and infection classification, when appropriate, should be included.

The physician shall oversee the record is complete and signed.

All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a registered nurse and signed by the physician, at his/her next visit to the facility, or within forty eight (48) hours.

Orders dictated over the telephone shall be signed by the person to whom dictated, with the name of the physician, per his/her own name. The physician shall sign such orders, with signature, at his/her next visit to the facility, or within forty eight (48) hours.

Medical records remaining incomplete for thirty (30) days following the patient's discharge shall be considered delinquent. Physicians with delinquent charts will be notified verbally and this will be recorded. If charts are not completed within thirty (30) days, surgical privileges may be suspended until records are completed.

All surgical procedures performed shall be fully described by the operating surgeon and placed in the patient's chart.

All tissue (except as noted on the tissue exempt list) removed during the operative procedure shall be sent to the facility's contracted lab, which shall make such examinations as may be considered necessary to arrive at a pathological diagnosis.

The surgeon will sign, date and time the pathology report, which shall become a part of the permanent medical record.

All records shall remain the property of Evergreen Eye Surgery Center and shall not be taken from the facility without the express written permission of the Governing Body.

In the case of re-admission of a patient, previous records will be made available for the use of the physician. This shall apply whether the patient is to be attended by the same or another physician.

Members of the medical staff, who are in good standing, shall have access to medical records of all patients under his/her care.

Upon written permission of the Governing Body, patient records may be used for approved study and research, while preserving the confidentiality of personal information regarding the individual patients.

Subject to the discretion of the Governing Body of Evergreen Eye Surgery Center, former members of the medical staff shall be permitted access to information from the medical records of their patients covering all procedures in which they attended their patients in this facility.

Abbreviations used in the medical record must appear on the Evergreen Eye Surgery Center Approved Abbreviations list.

Errors during documentation in the medical record shall be corrected in the proper manner. The method shall include: a) a single line through the part to be corrected; b) corrections made; c) initials of person correcting; and d) date and time correction is made, with an explanation for the correction if appropriate.

### **POST ANESTHESIA CARE UNIT (PACU)**

The PACU will be under the direction of the Medical Director or his/her designate. The Clinical Director will oversee daily operations of the entire facility, reporting to the Medical Director.

Evergreen Eye Surgery Center will not provide accommodations for overnight observation. The admitting practitioner will transfer patients requiring prolonged or overnight observation, due to unanticipated complications, to a hospital.

### **SCHEDULING**

All treatment provided at Evergreen Eye Surgery Center shall be on an elective and pre-scheduled basis.

Physicians admitting patients shall be responsible for giving any known information, as necessary, to secure the protection of other patients and staff from those who are a source of danger from any cause whatsoever.

Patient Criteria for Scheduling:

Patients who are candidates for outpatient procedures must meet the following criteria:

- The patient must be in good health (A.S.A. Class I) or with mild systemic disease, which is under good control and does not require special case management (A.S.A. Class II). A.S.A. Class III patients must have recent medical evaluation sufficient to assure that the mild systemic disease is in good control, and such documentation must accompany the patient at the time of admission; e.g., medical clearance from the patient's private physician.
- The patient and/or person signing the consent for procedures must knowingly agree with the concept of outpatient procedures/anesthesia, and must exhibit the ability to use judgment and follow instruction.
- The patient's physical and emotional environment must be conducive to successful outcome.

Criteria for scheduling procedures: Procedures are recommended by the medical staff and approved by the Governing Body. Only those procedures approved in the Evergreen Eye Surgery Center's scope of care will be performed in the facility.

### **STAFF PRIVILEGES**

Only physicians who have submitted proper credentials and have been duly appointed to the medical staff by the Governing Body may treat patients.

All case privileges must be granted in writing for each procedure and signed by the Medical Director and Governing Body of Evergreen Eye Surgery Center.

**NOTE:** A case privilege is a request to perform a procedure, which is not outlined in the privilege request included on the application of the physician.

Temporary privileges may be granted in accord with the parameters outlined in the medical staff bylaws, subject to the approval of the Medical Director and Governing Body.

### **STAFF REQUIREMENTS**

The admitting physician will be available at the facility within sufficient time to evaluate the patient adequately before procedures.

Physicians shall be in the operating room and ready to commence the surgery at the time scheduled, and the operating room will not be held longer than fifteen (15) minutes after the time scheduled. The case may be rescheduled when reasonably possible.

All members of the medical staff must abide by the policies of Evergreen Eye Surgery Center.

## **COMMITTEE RELATIONSHIPS**

### **EVERGREEN EYE SURGERY CENTER**

The Governing Body, by resolution, adopted by a majority of the full Governing Body may designate a Medical Advisory Committee and any other appropriate committees.

The Governing Body, by resolution, adopted in accordance with its article, may designate one or more members as alternate members of any such committee, who may act in the place and instead of, any absent member or members at any meeting of such committee.

#### **MEDICAL ADVISORY COMMITTEE**

The Medical Advisory Committee shall consist of the Medical Director, who shall be its chairman. Additional members may include Assistant Medical Director, other members of the medical staff, the Administrator and the Clinical Director.

The committee may include ad hoc members such as the various professional consultants with whom the facility shall have agreements for health related services. The ad hoc members may include a pharmacist, risk manager, infection control specialist, medical records, etc. The committee shall meet at least quarterly in combined meetings with the Governing Body in conjunction with the QAPI committee to review all matters relating to the operation of the facility, including, but not limited to, infection control, tissue review, pharmacy and therapeutics, scope of care, safety and medical records. The committee shall serve as the medical administrative liaison between the medical staff and the Governing Body concerning all rules and regulations for the governance of the facility, or amendments thereto, which the committee considers to be in the best interests of the facility and to assure the proper care of its patients.

#### **AD HOC COMMITTEES**

The Medical Advisory Committee may appoint ad hoc committees with the concurrence of the Governing Body for such special tasks as circumstances warrant. An ad hoc committee shall limit its activities to the accomplishments of the task for which it is appointed and shall have no power to act except as specifically authorized by action by the Governing Body. Upon completion of the task for which it is appointed, such ad hoc committees shall stand discharged.

## **STATEMENT OF MISSION, GOALS AND OBJECTIVES**

### **EVERGREEN EYE SURGERY CENTER**

#### **MISSION**

Provide quality elective ambulatory surgical care to promote the health and optimal function required to lead active lives.

#### **VISION**

Evergreen Eye Surgery Center will provide excellent ambulatory surgical care in our community. We will be the ambulatory surgery healthcare provider of choice. We will have a team of professional personnel who are passionate about patient care and committed to continuously improving our services to our patients. A spirit of collaboration and trust is evident among the medical staff, nursing staff, administrative staff and ancillary personnel.

#### **GOALS AND OBJECTIVES**

- To create a safe, convenient and user-friendly environment for patients, physicians and staff
- To provide an atmosphere of compassion and understanding with minimal stress and anxiety.
- To function at a high level of efficiency to accommodate the convenience of both the patient and the physician.
- To facilitate a plan of diagnostic and surgical treatment for each patient.
- To promote knowledge and skills of the facility's staff as a means of meeting technical and scientific progress in the delivery of health care and to be aware of new research, new products and new ideas which may modify and improve present activities and procedures.
- To assure that all information regarding patients is kept private and confidential.
- To ensure that the medical staff, clinical and non-clinical personnel display professional performance and conduct.
- To ensure all patients receive the highest quality care on a completely non-discriminatory basis as to sex, race, color, creed or national origin.

## NARRATIVE PROGRAM

### EVERGREEN EYE SURGERY CENTER

1. Evergreen Eye Surgery Center is an ambulatory surgical facility established to provide surgical services in a safe, efficient, cost-effective and user-friendly environment. Procedures performed are limited to those identified in the Scope of Care, as approved by the Governing Body. Surgical services are limited to those, which can be safely and effectively provided on an outpatient basis and are typically elective and non-emergent in nature.
2. The staffing will consist of:

Administrator	Admissions Clerk
Clinical Director	Instrument Technician
LPN	Medical Assistant
Preop/PACU RN	Operating Room RN
Surgical Technologist	
3. The office will be open for telephone calls and deliveries between 6 am and 5 pm, Monday through Friday.
4. The anticipated surgical volume will initially require approximately 9 hours of operation in one (1) operating room and two (2) procedure room, five (5) days per week.
5. The center will consist of the following rooms and areas, encompassing approximately 3000 square feet:  

6. The facility will employ sufficient numbers of professional and support staff to ensure efficient, quality patient care, which might include RNs, LPNs, assistants and technicians. A registered nurse will direct clinical operations.
7. The facility will develop and ensure fiscal soundness through proper budgeting and performance analysis.
8. The facility may utilize professional consultants, as needed, to ensure legal and regulatory compliance.
9. The patient flow process will be as follows:

- The patient and responsible party will enter the waiting room, be greeted by a receptionist, and checked in for the surgical encounter. Every effort will be made to complete all necessary paperwork prior to admission. Any remaining documentation will be completed at this time.
- The patient will be escorted to the assigned preoperative area. Here, they may remove some of their “street clothes” and don appropriate surgical attire. All patients entering the restricted area will don head covers. Patient belongings will be secured in a locker.
- The patient is made comfortable in the preoperative area.
- The preoperative nurse will interview the patient, perform a preoperative assessment, confirm the patient’s history and understanding of the planned procedure, confirm surgical site identification and implement preoperative physician orders.
- The anesthesia provider will assess the patient preoperatively to evaluate the risk of anesthesia and of the procedure to be performed. This will include a heart and lung assessment. The proposed plan for anesthesia will be discussed with the patient at this time. This will be documented in the patient’s medical record.
- The surgeon will confirm the surgical site identification and examine the patient preoperatively for any changes in the patient’s condition since completion of the most recently documented medical history and physical assessment. This will be documented in the patient’s medical record.
- After the operating room nurse has reconfirmed surgical site identification with the patient, the patient will be transported into the operating room or procedure room. The operating room nurse will position the patient and anesthesia personnel will attach monitoring devices to the patient.
- Anesthesia appropriate to the length and nature of the surgical procedure is administered. This may involve an anesthesiologist/anesthetist, the surgeon and/or an RN nurse monitor.
- The patient is prepped with an antiseptic solution as ordered by the surgeon and sterile drapes are applied to establish a sterile field per surgeon preference.
- When the procedure has been completed, a dressing may be applied, the drapes are discarded, monitoring devices are removed and the patient is transferred to PACU.

- Soiled instruments are covered and transferred, to soiled utility for decontamination per facility protocol.
- Decontaminated instruments are then transferred to clean utility for sterile processing and storage.
- All soiled waste is removed from the operating room daily and between cases as needed, and securely stored in the biohazard/dirty linen room.
- Biohazardous waste is collected by qualified vendors for proper disposal.
- Soiled linen is collected by qualified vendors for laundering.
- The PACU nursing staff monitors the patient, provides appropriate pain management as needed, and discharge instructions are given to the patient and family as appropriate.
- Prior to discharge, a physician assesses the patient and a discharge order is documented in the medical record.
- The patient is offered nourishment, assisted with changing clothes as needed, and released from the facility to the care of a responsible adult.

## EXEMPT TISSUE LIST

### EVERGREEN EYE SURGERY CENTER

All tissues removed from the patient during operative and diagnostic procedures will be reviewed by a pathologist with the following exceptions:

- Skin
- Cataracts
- Intraocular lenses
- Foreign bodies
- Cysts
- Chalazion
- Pterygium

Exhibit 5  
Seattle ASF License

## Facility Information

NEW SEARCH

RESULTS

**Facility Name:** Northwest Glaucoma and Cataract

**Address:** 1229 Madison St Ste 1250, Seattle, WA, 98104-3568

**Owner's Name:** Northwest Glaucoma and Cataract Consultants LLC

**License #:** ASF.FS.60685668

**Facility Status:** ACTIVE

**Facility Type:** Ambulatory Surgical Facility License

**License Expires On:** 07/01/2021

If you find any errors in this description, please complete the [Feedback](#) form and send it to us.

Exhibit 6  
Central King County Secondary Health Services Planning  
Area

# Report Map



ZIP Code

Exhibit 7

Federal Way Historic Services; Identified by Top 30 CPT Codes

**Top procedures performed amounts per year Seattle ASC (\*note 2016 ASC started operating in Nov**

CPT	2016*	CPT	2017
1	66984	1	66984
2	LASIK	2	65855
3	65855	3	66761
4	66821	4	66821
5	66183	5	66982
6	66170	6	LASIK
7	66761	7	66170
8	66982	8	66183
9	66172	9	65820
10	66825	10	66986
11	66986	11	0474T
12	0191T	12	66250
13	65426	13	67010
14	65820	14	0191T
15	66250	15	66825
16	67010	16	66172
		17	65426

- 65426 Excision of Pterygium with Graft
- 65820 Goniotomy
- 65855 LASER Trabeculoplasty-SLT
- 66170 Trabeculectomy
- 66172 Trabeculectomy with Previous Scarring
- 66174 Canaloplasty Ab Interno
- 66183 Shunt to Extraocular reservoir
- 66250 Repair of wound in Anterior Segment
- 66761 LASER Iridotomy/Iridectomy-LPI
- 66821 YAG Capsulotomy
- 66825 Reposition of Intraocular lens prosthesis

66982 Cataract Surgery Complex  
66984 Cataract Surgery  
66986 IOL Exchange  
67010 Anterior Vitrectomy

0191T I Stent  
0474T Cypass

Exhibit 8  
Patient Admission and Expected Outcomes Policy

Section 1 Policies and Procedures	Evergreen Eye Surgery Center	
Policy Name: <b>ADMISSION / TREATMENT</b>	Page 1 of 1	
Approved: Jan 2018	Revised: Jan 2018	

**POLICY:**

It is the policy of this facility to admit and treat all persons without regard to race, color, national origin, handicap, sex, sexual orientation, religious or fraternal organization, or age. The same requirements are applied to all, and patients are assigned without regard to race, color, national origin, handicap, sex, sexual orientation, religious or fraternal organization, or age. All services are available without distinction to patients and visitors regardless of race, color, national origin, handicap, sex, sexual orientation, religious or fraternal organization, or age. All persons and organizations having occasion to refer persons for services or to recommend the center are advised to do so without regard to the person's race, color, national origin, handicap, sex, sexual orientation, religious or fraternal organization, or age.

Section 1 Policies and Procedures	Evergreen Eye Surgery Center	
Policy Name: <b>SCOPE OF SERVICES</b>	Page 1 of 2	
Approved: Jan 2018	Revised: Jan 2018	

**POLICY:**

Evergreen Eye Surgery Center provides ambulatory surgical care.

**Patients Served**

The patient population served by this facility includes adult patients seeking surgical intervention to diagnose, maintain or restore optimal wellness.

The following defines Evergreen Eye Surgery Center’s patient population:

- Young Adult (19-45 years)
- Middle Adult (45-60 years)
- Older Adult (>60 years)

**Scope and Complexity of Patient Care Needs**

The facility provides a safe and comfortable environment for patients and personnel to assist providers in meeting the health care needs of our patients. The staff provides quality, cost effective, competent care respectful of each patient’s rights and dignity. Only ophthalmology procedures are performed at this facility. In the immediate post-procedure phase of the surgical encounter, patients are under the direct supervision of the surgeon or a qualified anesthesia provider, who maintains responsibility for the patient until they have been appropriately discharged from the facility.

Invasive procedures and/or procedures requiring sedation will be performed in an operating room and/or procedure room to meet established facility patient monitoring and personnel requirements.

**Staffing**

Members of the staff will be assigned daily patient care responsibilities by the Clinical Director. Sufficient nursing personnel will be available to assist with preoperative, intra-operative and postoperative care of patients undergoing surgical procedures per the following standards:

- An ACLS certified RN will be present in the facility whenever patients are present.
- During the intraoperative phase, an RN and physician will be present in the operating room.

Section 1 Policies and Procedures	Evergreen Eye Surgery Center
Policy Name: <b>SCOPE OF SERVICES</b>	Page 2 of 2

- An RN will be present in the PACU area while patients are present.
- The schedule will be evaluated and personnel assigned to nursing care in preoperative area, the operating rooms, PACU areas or other areas, as needed. Other personnel will be assigned according to the type of procedure, expertise, abilities, etc., keeping in mind the number of personnel available, as well as ancillary tasks to be performed, to allow for smooth functioning of the ambulatory surgery facility.
- A physician will be present, not merely immediately available, until all patients operated on that day have been physically discharged.
- In the event of their prolonged absences, the Clinical Director and Medical Director will determine the division of duties among the remaining personnel. During short-term absence such as illness or vacation, a designated RN will assume daily duties.

### **Staff Qualifications**

The nursing staff maintains current licensure and BLS certification. ACLS certification is required for RN's. Organizational membership in the Association of Peri-Operative Registered Nurses (AORN), and the American Society of Post Anesthesia Nurses (ASPAN) is encouraged. A continuous program of inservice education and periodic skills for all personnel is maintained to ensure quality care is provided.

### **Standards of Practice**

The Association of Peri-Operative Registered Nurses (AORN), the American Society of Post Anesthesia Nurses (ASPAN) and the Association for the Advancement of Medical Instrumentation (AAMI) standards are referenced as used in the formulation and review of policies and standards of practice, as well as input from the expertise of the staff.

Section 1 Policies and Procedures	Evergreen Eye Surgery Center	
Policy Name: <b>EXPECTED PATIENT OUTCOMES</b>	Page 1 of 2	
Approved: Jan 2018	Revised: Jan 2018	

**POLICY:**

The patient, who upon a physician’s order submits to an outpatient surgery procedure, can expect to be discharged from the facility with the following assurances:

- That the patient understands each form, which requires a signature, and why their signature, or that of a responsible party, is necessary.
- That the patient understands who and how financial responsibility for the procedure will be handled and who generates the bills, if other than the facility.
- That the patient’s safety is assured, when appropriate, by having a responsible person available to provide transportation home.
- That the procedures were coordinated in such a way as to provide for accuracy of scheduling as well as efficiency of time.
- That the procedure was performed safely and accurately by qualified personnel and only according to the physician’s specific instructions and plan of care.
- That qualified personnel were available at all times to answer questions.
- That the patient’s privacy has been provided for and respected.
- That the patient suffered no undue anxiety because the procedure was insufficiently explained.
- That the patient’s pain was treated as effectively as possible.
- That precaution to ensure the patient’s safety has been practiced at all times.
- That, should a sudden change in the patient’s condition occur requiring emergency interventions, trained personnel and necessary equipment were readily available.
- That the patient’s valuables and belongings have been kept in safekeeping until discharge.
- That the patient understands what the postop prescriptions are for, when to take them and precautions to observe when taking certain drugs which affect sensory-motor function, when applicable.

Section 1 Policies and Procedures	Evergreen Eye Surgery Center
Policy Name: <b>EXPECTED PATIENT OUTCOMES</b>	Page 2 of 2

- That the patient and responsible party understand exactly how to take responsibility for home care.
- That the patient and responsible party know exactly what untoward signs and/or symptoms to look for after discharge, which would alert them to possible problems.
- That the patient knows who to call for help, if untoward signs and/or symptoms become apparent.
- That the patient was treated as a unique individual with the respect and dignity, which are recognized as a fundamental right of every patient entering this facility.

Exhibit 9  
Patient Rights and Responsibilities

Section 1 Policies and Procedures	Evergreen Eye Surgery Center	
Policy Name: <b>PATIENT RIGHTS AND RESPONSIBILITIES</b>	Page 1 of 5	
Approved: Jan 2018	Revised: Jan 2018	

Evergreen Eye Surgery Center has established this Patient's Bill of Rights as a policy with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his/her physician, and the facility organization. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organized structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

No catalog of rights can guarantee the patient the kind of treatment he has a right to expect. This facility has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients. All these activities must be conducted with an overriding concern for the patient, and above all, the recognition of his/her dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

**AS A PATIENT, YOU HAVE THE RIGHT TO:**

- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy and security for self and property.
- Have a surrogate (parent, legal guardian, person with medical power of attorney) exercise the Patient Rights when you are unable to do so, without coercion, discrimination or retaliation.
- Confidentiality of records and disclosures and the right to access information contained in your clinical record. Except when required by law, you have the right to approve or refuse the release of records.
- Information concerning your diagnosis, treatment and prognosis, to the degree known.
- Participate in decisions involving your healthcare and be fully informed of and to consent or refuse to participate in any unusual, experimental or research project without compromising your access to services.
- Make decisions about medical care, including the right to accept or refuse medical or surgical treatment after being adequately informed of the benefits, risks and alternatives, without coercion, discrimination or retaliation.

Section 1 Policies and Procedures	Evergreen Eye Surgery Center
Policy Name: <b>PATIENT RIGHTS AND RESPONSIBILITIES</b>	Page 2 of 5

- Self-determination including the rights to accept or to refuse treatment and the right to formulate an advance directive.
- Competent, caring healthcare providers who act as your advocates and treats your pain as effectively as possible.
- Know the identity and professional status of individuals providing service and be provided with adequate education regarding self-care at home, written in language you can understand.
- Be free from unnecessary use of physical or chemical restraint and or seclusion as a means of coercion, convenience or retaliation. Be able to access protective services as needed.
- Know the reason(s) for your transfer either inside or outside the facility.
- Impartial access to treatment and spiritual care regardless of race, age, sex, ethnicity, religion, sexual orientation, or disability.
- Receive an itemized bill for all services within a reasonable period of time and be informed of the source of reimbursement and any limitations or constraints placed upon your care.
- File a grievance with the facility by contacting the Clinical Director, via telephone or in writing, when you feel your rights have been violated.

Jill Fielding, RN  
34719 6<sup>th</sup> Avenue South  
Federal Way, WA 98003  
(206) 212-2118 Phone

- Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
- Know about any business relationships among the facility, healthcare providers, and others that might influence your care or treatment.
- File a complaint of suspected violations of health department regulations and/or patient rights. Complaints may be filed at:

HSQA Complaint Intake  
Post Office Box 47857  
Olympia, WA 98504-7857  
(360) 236-4700  
(800) 633-6828  
HSQAComplaintIntake@doh.wa.gov

Section 1 Policies and Procedures	Evergreen Eye Surgery Center
Policy Name: <b>PATIENT RIGHTS AND RESPONSIBILITIES</b>	Page 3 of 5

Office of the Medicare Beneficiary Ombudsman  
<http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>

**AS A PATIENT, YOU ARE RESPONSIBLE FOR:**

- Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate physician(s).
- Following the treatment plan recommended by the primary physician involved in your case.
- Providing an adult to transport you home after surgery and an adult to be responsible for you at home for the first 24 hours after surgery.
- Indicating whether you clearly understand a contemplated course of action, and what is expected of you, and ask questions when you need further information.
- Your actions if you refuse treatment, leave the facility against the advice of the physician, and/or do not follow the physician’s instructions relating to your care.
- Ensuring that the financial obligations of your healthcare are fulfilled as expediently as possible.
- Providing information about, and/or copies of any living will, power of attorney or other directive that you desire us to know about.

**COMO PACIENTE, USTED TIENE DERECHO A:**

- En todo momento y bajo cualquier circunstancia se le debe tratar con respeto y consideración a su dignidad personal.
- Privacidad personal e informacional al igual que seguridad propia y de propiedad.
- Tener un sustituto (padre, madre, guardián, persona con poder medico de un abogado) que ejerza los derechos del paciente dado que sea incapaz de hacerlo, sin coerción, discriminación, o venganza.
- Confidencialidad de información, registros e revelaciones y el derecho a conseguir acceso a información contenida en su registro clínico. Aparte de cuando la información sea requerida por la ley, usted tiene el derecho de aprobar o negar el hacer público sus registros.
- Información respecto al diagnóstico, tratamiento y pronóstico, del tema tratado.
- Participar y estar informado en decisiones que estén relacionadas con su salud y la aprobación o la negación de participar en algo inusual, experimental o algún proyecto de investigación sin comprometer su acceso a servicios.

Section 1 Policies and Procedures	Evergreen Eye Surgery Center
Policy Name: <b>PATIENT RIGHTS AND RESPONSIBILITIES</b>	Page 4 of 5

- Tomar decisiones sobre su cuidado medico, incluyendo el derecho a aceptar o negar tratamiento médico o quirúrgico después de haber sido informado adecuadamente de los beneficios, riesgos y alternativas sin coacción, discriminación, o venganza.
- Personal competente que actúe como su defensor y que trate su dolor tan efectivamente como sea posible.
- Saber la identidad y capacidad profesional de las personas que le proveen un servicio y ser proveído con los conocimientos adecuados de sus cuidados en casa, escritos en un lenguaje que usted pueda entender.
- Ser libre de uso innecesario de restricción física o química y del aislamiento como un medio de coerción, conveniencia o venganza. Ser capaz de acceder a los servicios de protección, según sea necesario.
- Conocer la razón de su traslado dentro o afuera de la sala quirúrgica.
- Acceso imparcial de tratamiento y la atención espiritual, sin importar raza, edad, sexo, etnicidad, orientación sexual, nacionalidad, religión, o discapacidad.
- Recibir la cuenta desglosada por todos los servicios en un periodo de tiempo razonable y ser informado de la fuente de reembolso y cualquier limitación o restricción colocado sobre su cuidado.
- Cuando crees que tus derechos han sido violados reporta un agravio con la facilidad con el director de la clínica a:

Jill Fielding, RN  
34719 6<sup>th</sup> Avenue South  
Federal Way, WA 98003  
(206) 212-2118 Phone

- Reportar cualquier comentario sobre la calidad de los servicios recibidos en su estadía en la clínica y recibir un seguimiento justo a sus comentarios.
- Conocer de cualquier relación de negocios que tenga el lugar, proveedores de cuidado y otros que puedan influenciar su cuidado o tratamiento.
- Presentar una queja de sospecho de violaciones de regulaciones o derechos de pacientes del departamento de salud. Quejas pueden ser presentadas a:

HSQA Complaint Intake  
Post Office Box 47857  
Olympia, WA 98504-7857  
(360) 236-4700  
(800) 633-6828  
HSQAComplaintIntake@doh.wa.gov

Section 1 Policies and Procedures	Evergreen Eye Surgery Center
Policy Name: <b>PATIENT RIGHTS AND RESPONSIBILITIES</b>	Page 5 of 5

Oficina de Beneficiario de Medicare Defensor del Pueblo  
<http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>

**COMO UN PACIENTE, USTED ES RESPONSABLE DE:**

- Proveer lo mejor que pueda de información completa acerca de su salud e actual historial médico pasado y reportar cualquier cambio inesperado a los practicantes presentes.
- Seguir el tratamiento recomendado por el médico involucrado directamente en su caso.
- Asignar a una persona adulta que lo transporte a casa después de una cirugía, así como también un adulto responsable por su cuidado en casa por las primeras 24 horas después de la cirugía.
- Indicar claramente si ha entendido, el curso de acción y que es esperado de su parte. Así como hacer preguntas cuando necesite; información adicional.
- Sus acciones si se niega al tratamiento, abandona, el lugar en contra de lo expuesto por el practicante, y/o no seguir las indicaciones del practicante que estén relacionadas con su cuidado.
- Asegurarse de que sus obligaciones financieras por su cuidado medico estén cubiertas.
- Proveer información acerca de o copias de cualquier testamento en vida, poder legal u otra indicación que usted tenga dispuesta.

Exhibit 10  
Non-Discrimination Policy

Section 1 Policies and Procedures	Evergreen Eye Surgery Center	
Policy Name: <b>EMPLOYEE NON-DISCRIMINATION</b>	Page 1 of 1	
Approved: Jan 2018	Revised: Jan 2018	

**POLICY:**

With regard to employment, the facility does not discriminate on the basis of disability; in addition, there is no discrimination on the basis of age, sex, sexual orientation, race, color, religion and national origin where such discrimination would have a discriminatory effect on beneficiaries.

This information is presented to all employees and volunteers as part of new employee orientation. This information is reviewed annually with each employee as part of the health and safety training.

All applicants for positions at the facility are presented with the policy of non-discrimination upon application.

Employees are assured immunity from discrimination, if they decline an assignment as a matter of conscience or religious values.

Policies and procedures have been established for patients and employees to file a grievance when an issue of perceived discrimination arises.

Exhibit 11

Charity Care and Community Service Plan Policy

## Financial Hardship Policy

Patients are expected to pay for services rendered. Billing will assist patients who indicate they are unable to meet their financial obligations resulting from care provided by our practice. Patients may be determined as eligible for partial to full discounts utilizing the current poverty guidelines issued by the state and federal government.

1. Exclusions from this policy are:
  - a. Medical care defined as not medically necessary (cosmetic surgery, etc)
  - b. Services rendered to persons who are eligible, but have not applied for, medical insurance or assistance programs sponsored by Federal, State, or local government.
  
2. Financial Hardship/Charity Care may be extended to those who qualify for all four (4) of these reasons:
  - a. The patient is not eligible for Medicaid or pending Medicaid approval;
  - b. The patient is determined to be unable to pay for services provided;
  - c. The patient is unable to accept an installment payment arrangement; and
  - d. The patient agrees to make payment at the time the discount is granted.

If a patient is identified by the billing office to be considered for financial hardship/charity care they will be mailed a "Financial Hardship" application to complete which must be returned within 30 days to be eligible. The patient must also provide one of the accepted OIG documents listed below to verify income.

- a. W-2 withholding statements
  - b. Income tax return
  - c. Forms from Medicaid or other state funded medical programs
  - d. Forms from employers or welfare agencies.
- 
2. Patient has other circumstances that indicate financial hardship:
    - a. Catastrophic situations (death or disability in family)
    - b. Other documentation that shows patient would not be able to pay the medical bill.

Financial hardship or charity care discounts will be calculated using a percentage based on the patient’s annual income and the current State/Federal Poverty Level.

<b>Percent of State/Federal Poverty Level-Annual Income 2017</b>		
<b>Family Size</b>	<b>100% = 75%</b>	<b>200% = 50%</b>
1	\$12,060	\$24,120
2	\$16,240	\$32,480
3	\$20,420	\$40,840
4	\$24,600	\$49,200
5	\$28,780	\$57,560
6	\$32,960	\$65,920
7	\$37,140	\$74,289
8	\$41,320	\$82,640
Each Add'l	\$4,180	\$8,360

Returned Hardship applications will be given the billing manager to review and determine if the patient qualifies for any type of financial assistance. The patient will be sent a notification letter within 30 days of receipt outlining whether or not their application has been approved. The documents will be scanned into the “secured billing tab” in Nextech and the discount amount granted will be entered in the patient’s account notes tab. The manager will adjust the balance using the adjustment category code “Hardship”.

The patient’s account status will never be permanently designated as charity care or financial hardship. The financial assistance is considered/approved for the current balance due at the time the request is made.

## Patient Financial Hardship Application

PATIENT INFORMATION			
Name		Date(s) of Service	
Phone		<input type="checkbox"/> Employed <i>Employer name and address:</i>	<input type="checkbox"/> Unemployed <i>If unemployed, how long?</i>
Name of Responsible Party			
Relationship to Patient			
Address, City, State, ZIP			

HOUSEHOLD INFORMATION			
Spouse Name		Number of family members living in household	
<input type="checkbox"/> Employed <i>Employer name and address:</i>	<input type="checkbox"/> Unemployed <i>If unemployed, how long?</i>	Other family member employer name and address	Other family member employer name and address
Employer Address, City, State, ZIP			

MONTHLY FAMILY INCOME AND SOURCE			
<input checked="" type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Responsible Party <input type="checkbox"/> Children Working			
Monthly Salary (Gross)	\$	Social Security Benefits	\$
Public Assistance Benefits	\$	Worker's Compensation	\$
Unemployment Benefits	\$	Child Support:	\$
Other (Alimony, etc.) <i>Specify</i>	\$		
Deny		<b>Total Family Income:</b>	\$

### AGREEMENT

By my signature below, I certify that this information is true and complete. I grant this office permission to verify the information, and I acknowledge that completion of this form does not guarantee discount, payment plan, or forgiveness of debt.

SIGNATURE(S)			
Signature		Signature	
Print Name		Print Name	
Date		Date	

*Your request will NOT be processed if this application is not signed and/or the requested information is not provided.  
Application must be returned by mail or in-person within 30 days of receipt to be considered.*

Disapproved by: \_\_\_\_\_ Date: \_\_\_\_\_

-This section staff use only-

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

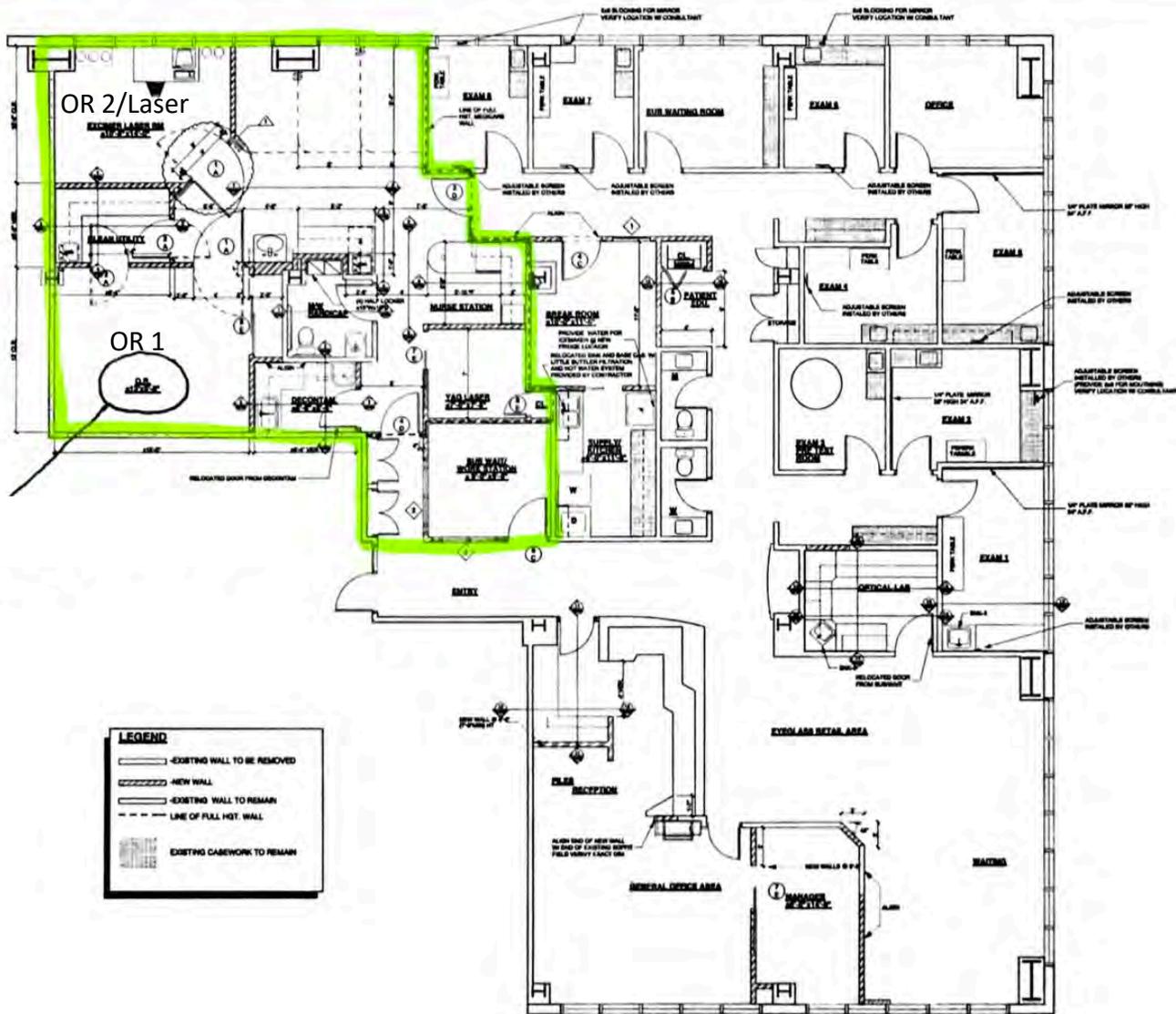
Exhibit 12  
Single Line Drawing



760 Aloha Street  
Seattle, Washington  
98109  
206/284-4440 FAX 206/283-3867

1229 MADISON ST  
SUITE 1250  
SEATTLE, WA 98101

LOCATION



**LEGEND**

- EXISTING WALL TO BE REMOVED
- NEW WALL
- EXISTING WALL TO REMAIN
- LINE OF FULL HGT. WALL
- EXISTING CASEWORK TO REMAIN

**FLOOR PLAN**  
Scale: 1/4" = 1'-0"

**REVISIONS**

NO.	DATE	DESCRIPTION

NO. DATE DESCRIPTION  
DRAWN BY: DP  
CHECKED BY: DP  
SCALE: 1/4" = 1'-0"  
DATE: SEPTEMBER 24, 2004  
JOB NO.  
SHEET TITLE

FLOOR PLAN

ID.01

Exhibit 13  
Lease Agreement

**Sam Barnes**  
sbarnes@omwlaw.com

**VIA Email**

May 25, 2018

Vision Condo, LLC  
Dr. Stephen Phillips & Sara Robertson  
1702 Lake Washington Boulevard  
Seattle, WA 98122

Re: Consent to Deemed Assignment/Change in Control

To Whom It May Concern:

As you know, we represent Northwest Glaucoma and Cataract Consultants, LLC (the "Company"). The Company and Vision Condo, LLC are parties to a lease agreement (the "Lease") dated June 22, 2016. Under the terms of the Lease, the Company is writing to inform you that the Company anticipates undergoing a deemed transfer pursuant to a transaction that will change the ownership of the Company (the "Proposed Transaction").

Following closing the Proposed Transaction, the combined organization (which will be comprised of the Company and Evergreen Eye Center, Inc., P.S. will be beneficially owned by four physicians who will each own 25% of the issued and outstanding interest in the combined organization. Namely, Dr. Whitehead (sole member of the Company), and Drs. Gary Chung, Robert Tester and Brice Nicholson. The combined organization represents a significantly stronger organization financially than the current Company. The Company's identity remains unchanged, however the Company will be beneficially owned by the four named physicians. As part of the transaction, there is a two-year probationary period, which could result in everything being returned to the status quo with the Company once again being beneficially owned solely by Dr. Whitehead. Alternatively, at the end of the two-year probationary period described above, it is contemplated that the Company and Evergreen Eye Center, Inc., P.S. may elect to merge in which case Evergreen Eye Center, Inc., P.S. will become the tenant under the Lease.

As part of the Proposed Transaction, employees of the combined organization will provide clinical services at the leased premises.

Vision Condo, LLC  
Dr. Stephen Phillips & Sara Robertson  
May 25, 2018  
Page 2

By signing below, you hereby acknowledge and consent to the consummation of the Proposed Transaction, and each of its steps, for all purposes under the Lease (including with respect to any right of termination that you may have). Please indicate such consent by signing this letter in the space below and returning a copy to me by email at sbarnes@omwlaw.com and an original to me by U.S. mail.

Except as otherwise noted herein, each of the terms and conditions of the Lease and the guaranty of the Lease by Dr. John Whitehead shall remain unchanged.

Please note the Proposed Transaction and the identity of the parties to the Proposed Transaction are confidential. By signing below, you agree not to disclose any information related to the Proposed Transaction except to your advisors for the purpose of evaluating your rights and obligations under the Lease or as may otherwise be required by applicable law.

Your immediate attention to this matter is greatly appreciated. If you have any questions, please do not hesitate to contact me directly at (206) 447-7000 or at the email address indicated above.

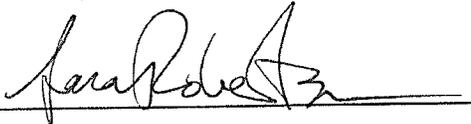
Very Truly Yours,

  
Sam W. Barnes

**CONSENT TO DEEMED PROPOSED TRANSACTION GRANTED:**

The undersigned hereby consents to the consummation of the Proposed Transaction, and each of its steps, for all purposes under the Lease, including with respect to any right of termination that you may otherwise have or with respect to any consent right for a deemed assignment of the Lease that you may have.

**VISION CONDO, LLC**

By:   
Name: SARA ROBERTSON  
Title: Co-owner  
Date: 5/31/18



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 Seattle, WA 98101  
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 Fax: (206) 292-6033

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CBA Form ST-NNN  
 Single Tenant NNN Lease  
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 Page 21 of 24

**LEASE AGREEMENT**  
 (Single Tenant For Entire Parcel - NNN)

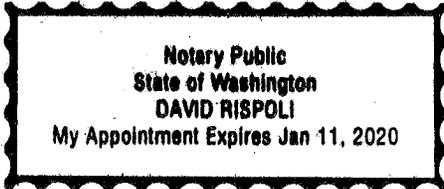
STATE OF WASHINGTON

COUNTY OF King

ss.

I certify that I know or have satisfactory evidence that STEPHEN G. PHILLIPS is the person who appeared before me and said person acknowledged that STEPHEN G. PHILLIPS signed this instrument, on oath stated that STEPHEN G. PHILLIPS was authorized to execute the instrument and acknowledged it as the owner of VISION CONDO LLC to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 23 day of June, 2016.



[Signature]  
 (Signature of Notary)

(Legibly Print or Stamp Name of Notary)  
 Notary public in and for the state of Washington,  
 residing at Seattle  
 My appointment expires 1/11/20

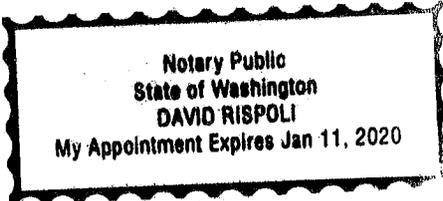
STATE OF WASHINGTON

COUNTY OF King

ss.

I certify that I know or have satisfactory evidence that SARA ROBERTSON is the person who appeared before me and said person acknowledged that SARA ROBERTSON signed this instrument, on oath stated that SARA ROBERTSON was authorized to execute the instrument and acknowledged it as the owner of VISION CONDO LLC to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 23 day of June, 2016.



[Signature]  
 (Signature of Notary)

(Legibly Print or Stamp Name of Notary)  
 Notary public in and for the state of Washington,  
 residing at Seattle  
 My appointment expires 1/11/20



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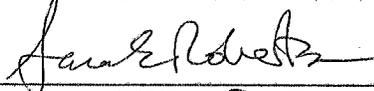


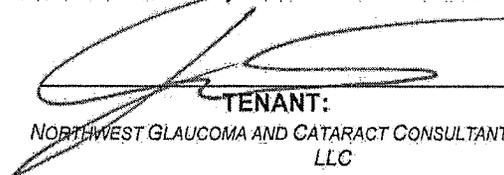
CBA Form ST-NNN  
 Single Tenant NNN Lease  
 Rev. 3/2011  
 Page 20 of 24

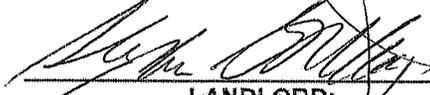
**LEASE AGREEMENT**  
 (Single Tenant For Entire Parcel - NNN)

LANDLORD AND TENANT ARE EACH ADVISED TO SEEK INDEPENDENT LEGAL ADVICE ON THESE AND OTHER MATTERS ARISING UNDER THIS LEASE.

IN WITNESS WHEREOF this Lease has been executed the date and year first above written.

  
 \_\_\_\_\_  
**LANDLORD:**  
 VISION CONDO LLC

  
 \_\_\_\_\_  
**TENANT:**  
 NORTHWEST GLAUCOMA AND CATARACT CONSULTANTS  
 LLC

  
 \_\_\_\_\_  
**LANDLORD:**  
 VISION CONDO LLC

\_\_\_\_\_  
**TENANT:**

SARA ROBERTSON & STEPHEN PHILLIPS  
 BY: \_\_\_\_\_

JOHN J. CHERTKOW  
 BY: \_\_\_\_\_

CO-OWNERS  
 \_\_\_\_\_  
 ITS:

MANAGING MEMBER  
 \_\_\_\_\_  
 ITS:



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 Rev. 5/07  
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**ADDENDUM/AMENDMENT TO  
 CBA LEASES**

CBA Text Disclaimer: Text deleted by licensee indicated by strike.

The following is part of the Commercial Lease Agreement dated June 22, 2016.

Between Vision Condo LLC ("Landlord")

And Northwest Glaucoma and Cataract Consultants, LLC and/or assigns ("Tenant")

regarding the lease of the Property known as: Commercial Condominium Unit #1250, containing 5,076 Rentable Square Feet (RSF) at Elmer J. Nordstrom Medical Tower, 1229 Madison Street, Seattle, WA 98104

IT IS AGREED BETWEEN THE LANDLORD AND TENANT AS FOLLOWS:

**Option to Purchase:** If Tenant is not otherwise in default, Tenant shall have the right (but not the obligation) to purchase the Premises during the Option Period (as defined below) (the "Option"). Upon a date of the Landlord's choosing during the period beginning with the eighteenth (18<sup>th</sup>) month after the Commencement Date of this Lease and continuing up to but not including the seventy-third (73<sup>rd</sup>) month after the Commencement Date of this Lease (the "Option Period"), the Landlord shall provide written notice to Tenant of its readiness to sell the Premises ("*INITIAL NOTICE*"), after which Tenant shall have fifteen (15) days to notify Landlord in writing if it desires to exercise the Option to purchase the Premises.

*THE PURCHASE PRICE FOR THE PREMISES SHALL BE SET AT "FAIR MARKET VALUE," WHICH SHALL BE AS AGREED BY LANDLORD AND TENANT WITHIN FIFTEEN (15) DAYS AFTER TENANT NOTIFIES LANDLORD THAT TENANT DESIRES TO EXERCISE THE OPTION TO PURCHASE THE PREMISES. IF LANDLORD AND TENANT CANNOT REACH SUCH AGREEMENT WITHIN THE TIME HEREIN PROVIDED, THEN EACH PARTY SHALL SELECT A QUALIFIED, MAI REAL ESTATE APPRAISER WITHIN TEN (10) DAYS THEREAFTER. IF ONE OF THE PARTIES DOES NOT SELECT A QUALIFIED APPRAISER WITHIN THE REQUIRED TIME PERIOD, THE DECISION OF THE APPRAISER SELECTED BY THE OTHER PARTY SHALL BE BINDING UPON BOTH PARTIES. IF TWO APPRAISERS ARE SELECTED BY THE PARTIES, THOSE APPRAISERS SHALL EACH CONDUCT AN APPRAISAL OF THE PREMISES (WITH EACH PARTY PAYING THE EXPENSE OF ITS OWN APPRAISAL) WHICH SHALL BE COMPLETED NO LATER THAN SIXTY (60) DAYS AFTER THE INITIAL NOTICE. THE LANDLORD SHALL PROVIDE THE APPRAISERS WITH ACCESS TO THE PREMISES AND ACCESS (AND COPIES, AS REQUESTED) TO ALL LEASES AND OTHER AGREEMENTS, BOOKS AND RECORDS RELATED TO THE PREMISES WHICH THE APPRAISERS MAY REASONABLY REQUEST DURING THE CONDUCT OF THEIR APPRAISALS. THE FAIR MARKET VALUE WILL BE THE AVERAGE OF THE TWO APPRAISAL VALUATIONS; PROVIDED, HOWEVER, THAT IF THE DIFFERENCE DETERMINED BY SUBTRACTING THE LOWER APPRAISAL FROM THE HIGHER APPRAISAL IS GREATER THAN TEN PERCENT (10%) OF THE LOWER APPRAISAL, THE FAIR MARKET VALUE SHALL BE DETERMINED AS FOLLOWS:*

*(ii) THE APPRAISERS SELECTED BY EACH PARTY SHALL AGREE ON A THIRD, QUALIFIED, MAI REAL ESTATE APPRAISER. IN ABSENCE OF AGREEMENT ON THE THIRD APPRAISER WITHIN SIXTY (60) DAYS OF THE DATE OF THE INITIAL NOTICE, EITHER PARTY MAY MAKE APPLICATION TO THE SUPERIOR COURT FOR KING COUNTY FOR*

AGENT (COMPANY): \_\_\_\_\_ By: \_\_\_\_\_

ALL OTHER TERMS AND CONDITIONS of said Agreement remain unchanged.

INITIALS:  
 Tenant/Lessee: JJA Date 6/22/16 Landlord/Lessor: [Signature] Date 6/23/16  
 Tenant/Lessee: \_\_\_\_\_ Date \_\_\_\_\_ Landlord/Lessor: [Signature] Date 6/23/16



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 SEATTLE, WA 98101  
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 Rev. 05/07  
 Page 2 of 3

**ADDENDUM/AMENDMENT TO  
 CBA LEASES**

**CBA TEXT DISCLAIMER: TEXT DELETED BY LICENSEE INDICATED BY STRIKE.**

~~APPOINTMENT OF A QUALIFIED MAI REAL ESTATE APPRAISER BY THE PRESIDING JUDGE OF SUCH COURT. THE THIRD APPRAISER SELECTED, BY EITHER METHOD PROVIDED HEREIN, SHALL DETERMINE THE FAIR MARKET VALUE OF THE PROPERTY, AS OF THE DATE OF THE INITIAL NOTICE, WITHIN NINETY (90) DAYS OF THE DATE OF THE INITIAL NOTICE, WHICH DETERMINATION SHALL BE BINDING UPON BOTH LANDLORD AND TENANT; PROVIDED, THE FAIR MARKET VALUE SET BY THE THIRD APPRAISER MAY BE NO HIGHER OR LOWER THAN THE HIGHEST AND LOWEST PRICES SET BY THE FIRST TWO APPRAISERS. EACH PARTY SHALL BEAR THE COST OF ITS OWN APPRAISER AND SHALL SHARE EQUALLY IN THE COST OF THE THIRD APPRAISER, PLUS THE AMOUNT OF ANY COURT COSTS AND ATTORNEYS' FEES IF APPLICATION TO THE KING COUNTY SUPERIOR COURT IS REQUIRED, AS SET FORTH HEREIN.~~

~~If the Tenant timely exercises its Option, the Landlord shall (at Tenant's expense) select an M.A.I. certified appraiser of Landlord's choosing to perform an appraisal to determine the then current fair market value of the Premises, the results of which shall be binding and conclusive and shall be the purchase price for the Premises. The parties shall execute a purchase and sale agreement for an as-is sale with a fifteen (15) day due diligence period and a closing date fifteen (15) days thereafter, and containing such terms/conditions and allocation of closing costs as is customary for a transaction of this nature. At closing, the Tenant shall reimburse the Landlord for the unamortized amount of the six (6) months of abated rent. However, if Tenant (a) fails to timely exercise the Option; or (b) timely exercise the Option, but is unable to reach an agreement with the Landlord regarding the form and substance of the purchase and sale agreement, or fails to close for any reason other than a default by the Landlord, the Option shall forever terminate.~~

**Parking:** Tenant shall have the same right as the Landlord to park in up to twelve (12) parking stalls in the Nordstrom garage at market rate.

**KEY MAN INSURANCE:** LANDLORD MAY IN ITS DISCRETION (AS AN OPERATING COST TO BE REIMBURSED BY THE TENANT) OBTAIN AND KEEP IN FORCE DURING THE TERM OF THE LEASE A "KEY MAN" LIFE INSURANCE POLICY ON JOHN WHITEHEAD IN AN AMOUNT NOT TO EXCEED \$500,000 AND WITH SUCH COMPANY AS DETERMINED BY LANDLORD IN ITS SOLE DISCRETION. IN THE EVENT FUNDS ARE PAID OUT FROM SAID POLICY DURING THE TERM OF THE LEASE, AN AMOUNT EQUAL TO TWELVE (12) MONTHS OF RENT AND OPERATING COSTS SHALL BE RETAINED BY LANDLORD, AND THE BALANCE SHALL BE PAID TO THE PERSONAL REPRESENTATIVE OF THE ESTATE OF JOHN WHITEHEAD.

AGENT (COMPANY): \_\_\_\_\_ By: \_\_\_\_\_

ALL OTHER TERMS AND CONDITIONS of said Agreement remain unchanged.

INITIALS:  
 Tenant/Lessee: JSes Date 6/20/19 Landlord/Lessor SSR Date 6/23/16  
 Tenant/Lessee: \_\_\_\_\_ Date \_\_\_\_\_ Landlord/Lessor [Signature] Date 8/23/18



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 Page 3 of 3

**ADDENDUM/AMENDMENT TO  
 CBA LEASES**

CBA TEXT DISCLAIMER: TEXT DELETED BY LICENSEE INDICATED BY STRIKE.

**HVAC REPLACEMENT:** LANDLORD SHALL (AT LANDLORD'S EXPENSE) UPGRADE THE SPECIAL LIEBERT COOLING UNIT FOR THE SURGERY SUITE WITHIN 30 DAYS AFTER THE COMMENCEMENT DATE OF THE LEASE. IN THE EVENT THE REPLACEMENT OF THE HEAT PUMPS FOR THE HVAC UNITS SERVING THE PREMISES EXCEED \$7,000 IN A CALENDAR YEAR, THE LANDLORD WILL PAY FOR HALF OF ANY AMOUNT IN EXCESS OF \$7,000.00. FOR EXAMPLE PURPOSES, IF THE HEAT PUMP COSTS \$10,000, THE TENANT SHALL BE RESPONSIBLE FOR \$8,500, AND THE LANDLORD SHALL BE RESPONSIBLE FOR \$1,500 (I.E., 1/2 OF THE AMOUNT THAT EXCEEDED \$7,000).

AGENT (COMPANY): \_\_\_\_\_ By: \_\_\_\_\_

ALL OTHER TERMS AND CONDITIONS of said Agreement remain unchanged.

INITIALS:

Tenant/Lessee: STC Date 6/22/16 Landlord/Lessor: [Signature] Date 6/23/16  
 Tenant/Lessee: \_\_\_\_\_ Date \_\_\_\_\_ Landlord/Lessor: [Signature] Date 6/23/16



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CBA Form RR  
 Rent Rider  
 Rev. 1/2011  
 Page 1 of 2

**RENT RIDER**

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 New text inserted by licensee indicated by small capital letters.

This Rent Rider ("Rider") is a part of the lease agreement dated June 22, 2016 (the "Lease") between Vision Condo LLC ("Landlord") and Northwest Glaucoma and Cataract Consultants LLC and/or assigns ("Tenant") concerning the space commonly known as Commercial Condominium Unit #1250, containing 5,076 Rentable Square Feet (RSF) (the "Premises"), located at the property commonly known as Elmer J. Nordstrom Tower, 1229 Madison Street, Seattle, WA 98104 (the "Property").

**1. BASE MONTHLY RENT SCHEDULE.** Tenant shall pay Landlord base monthly rent during the Lease Term according to the following schedule:

Lease Year (Stated in Years or Months)	Base Monthly Rent Amount
<u>Months 1-6</u>	<u>\$ Abated</u>
<u>Months 7-12</u>	<u>\$ 14,382.00</u>
<u>Months 13-24</u>	<u>\$ 14,813.46</u>
<u>Months 25-36</u>	<u>\$ 15,257.86</u>
<u>Months 37-48</u>	<u>\$ 15,715.60</u>
<u>MONTHS 49-60</u>	<u>\$ 16,187.07</u>
<u>MONTHS 61-72</u>	<u>\$ 16,672.68</u>
<u>MONTHS 73-84</u>	<u>\$ 17,172.86</u>
<u>MONTHS 85-96</u>	<u>\$ 17,688.05</u>
<u>MONTHS 97-108</u>	<u>\$ 18,218.69</u>
<u>MONTHS 109-120</u>	<u>\$ 18,765.25</u>
<u>MONTHS 121-126</u>	<u>\$ 19,328.21</u>

**2. CONSUMER PRICE INDEX ADJUSTMENT ON BASE MONTHLY RENT.** ~~The base monthly rent shall be increased on the first day of the second year of the Lease and on the first day of each year of the Lease thereafter (each, an "Adjustment Date") during the term of this Lease (but not during any extension term(s) unless specifically set forth elsewhere in the Lease or another Rider attached thereto). The increase shall be determined in accordance with the increase in the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (all items for the geographical statistical area in which the Premises is located on the basis of 1982-1984 equals 100) (the "Index"). The base monthly rent payable immediately prior to the applicable adjustment date shall be increased by the percentage that the Index published for the date nearest preceding the applicable Adjustment Date has increased over the Index published for the date nearest preceding the first day of the Lease Year from which the adjustment is being measured. Upon the calculation of each increase, Landlord shall notify Tenant of the new base monthly rent payable hereunder. Within twenty (20) days of the date of Landlord's notice, Tenant shall pay to Landlord the amount of any deficiency in Rent paid by Tenant for the period following the subject Adjustment Date, and shall thereafter pay the increased Rent until receiving the next notice of increase from Landlord. If the components of the Index are materially changed after the Commencement Date, or if the Index is discontinued~~

INITIALS: LANDLORD SSR DATE 6/23/16 TENANT SSR DATE 6/23/16  
 LANDLORD SSR DATE 6/23/16 TENANT SSR DATE 6/23/16



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 Seattle, WA 98101  
 Phone: (206) 292-1600  
 Fax: (206) 292-6033

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**RENT RIDER**

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~~during the Lease term, Landlord shall notify Tenant of a substitute published index which, in Landlord's reasonable discretion, approximates the Index, and shall use the substitute index to make subsequent adjustments in base monthly rent. In no event shall base monthly rent be decreased pursuant to this Rider.~~

INITIALS: LANDLORD SM DATE 6/23/16 TENANT JJW DATE 6/22/16  
 LANDLORD DB DATE 6/23/16 TENANT \_\_\_\_\_ DATE \_\_\_\_\_



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CBA Form LOR  
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**GUARANTY OF TENANT'S LEASE OBLIGATIONS RIDER**

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 New text inserted by licensee indicated by small, capital letters.

This Guaranty of Tenant's Lease Obligations Rider (the "Guaranty") is made by John J. Whitehead and his Spouse, whose address is 1409 West Horizon Drive, Mukilteo, WA 98275 ("Guarantor"), for the benefit of Vision Condo LLC ("Landlord"), whose address is 1702 Lake Washington Blvd, Seattle, WA 98122.

1. **Underlying Lease.** Landlord and Northwest Glaucoma and Cataract Consultants, LLC and/or assigns ("Tenant"), have entered into that certain Lease Agreement dated June 22, 2016 (the "Lease") concerning the leased space DESCRIBED AS COMMERCIAL CONDOMINIUM UNIT #1250, CONTAINING 5,076 RENTABLE SQUARE FEET (RSF) commonly known as ELMER J. NORDSTROM MEDICAL TOWER, 1229 MADISON STREET, SEATTLE, WA 98104 (the "Premises").
2. **Guaranty.** Guarantor induced Landlord to enter into the Lease in consideration for Guarantor's guaranty, and Guarantor further acknowledges that it receives direct financial and economic benefits because Tenant will lease the Premises. Therefore, Guarantor absolutely, unconditionally and irrevocably guarantees to Landlord and its successors and assigns, without deduction by reason of set-off, defense or counterclaim, a) the full, punctual, and complete payment of all rent and other sums to be paid to Landlord under the Lease, including all attorney's fees, costs and expenses of collection incurred by Landlord in enforcing its rights and remedies under the Lease and this Guaranty; and b) the full, punctual, and complete discharge and performance of each and every other term, covenant, obligation and warranty of Tenant contained in the Lease. If Tenant defaults or breaches the Lease, Guarantor shall perform Tenant's obligations on Tenant's behalf. This Guaranty shall remain in full force and effect until all the terms, covenants, conditions, and agreements contained in the Lease are fully performed and observed. This Guaranty shall be enforceable against Guarantor without the necessity of any suit or proceeding on the part of Landlord against Tenant or any other party.
3. **No Discharge of Guarantor.** This Guaranty shall not be discharged and the liability of Guarantor shall in no way be affected by (a) the release or discharge of Tenant in any receivership, bankruptcy or other proceeding; (b) the impairment, limitation or modification of any liability to Landlord of Tenant or the estate of Tenant in bankruptcy, or of any remedy for the enforcement of Tenant's liability under the Lease or resulting from the operation of any present or future provision of federal or state bankruptcy or insolvency laws or other statute or from the decision in any court; (c) the rejection or disaffirmance of the Lease in any bankruptcy, insolvency, or similar proceeding; (d) the assignment, transfer, or encumbrance of all or any portion of the Tenant's interest in the Lease, the subletting of all or any portion of the Premises, or the granting to any third party of any rights of occupancy of all or any portion of the Premises; (e) waiver of discharge by Landlord of default or future performance by Tenant of any term of the Lease or Guaranty; (f) the exercise, forbearance, or election by Landlord of any of its rights or remedies reserved under the Lease, this Guaranty, or by law; (g) the release by Landlord of any security given to Landlord; or (h) any extension, renewal, amendment, expansion, or termination of the Lease.
4. **Notice.** Landlord shall have no obligation to notify Guarantor of any of the events described in Paragraph 3 of this Guaranty, and Guarantor waives any such notice and acknowledges specifically that such waiver includes notice of acceptance of this Guaranty, notice of any event of default under the Lease or this Guaranty, opportunity to cure any event of default under the Lease or this Guaranty, and proof of notice or demand to Tenant relating to any event of default. Guarantor hereby further waives any and all defenses, rights of subrogation, reimbursement, indemnification, contribution, and any other rights and defenses that are or may become available to it. Until all of the obligations of Tenant set forth in the Lease are fully performed and observed (including without limitation the

INITIALS: LANDLORD [Signature] DATE 6/23/16 TENANT JJW DATE 6/22/16  
 LANDLORD [Signature] DATE 6/23/16 TENANT CAR DATE 6/22/16



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 Page 2 of 2

**GUARANTY OF TENANT'S LEASE OBLIGATIONS RIDER**

payment of all rent and other sums required to be paid by Tenant to Landlord), Guarantor shall have no right of subrogation against Tenant by reason of any payments or acts of performance by Guarantor hereunder, and subordinates any liability or indebtedness of Tenant now or hereafter held by Guarantor to the obligations of Tenant to Landlord under the Lease.

- 5. **Attorneys' Fees.** If either party is required to employ an attorney to enforce or declare its rights hereunder, including in any appeal, bankruptcy or insolvency proceeding involving Tenant or any Guarantor, the prevailing party in any such action shall be entitled to recover its attorneys' fees and costs.
- 6. **Successors and Assigns.** The benefits of this Guaranty shall inure to the successors and assigns of Landlord and shall be binding upon Guarantor's successors, assigns, heirs, and legal and personal representatives.

 <hr/> GUARANTOR <span style="float: right;">DATE</span>	<hr/> GUARANTOR <span style="float: right;">DATE</span>
 <hr/> SPOUSE (if personal guaranty) <span style="float: right;">DATE</span>	<hr/> SPOUSE (if personal guaranty) <span style="float: right;">DATE</span>

INITIALS: LANDLORD SLR DATE 6/23/16 TENANT JJA DATE 6/22/16  
 LANDLORD SLR DATE 6/23/16 TENANT CAZ DATE 6/22/16

Exhibit 14  
Construction Review

# Letter of Transmittal

July 26, 2018



Construction Review Services  
111 Israel Rd. SE  
Tumwater, WA 98501

PO Box 47852  
Olympia, Washington 98504-7852

www.doh.wa.gov/crs  
tel. 360-236-2944  
fax. 360-236-2321

Document Delivery Method (internal use only):

Electronic       Hard Copy

Northwest Glaucoma and Cataract  
Attn: John Whitehead, M.D.  
1229 Madison St Ste 1250  
Seattle, WA 98104

### Project Info:

CRS# 60680908      Project location: 1229 Madison St Ste 1250  
Northwest Glaucoma and Cataract      Seattle, WA 98104  
Chapter 246-330 WAC Ambulatory Surgery Facilities  
ASF Change of Ownership      Local Permit #:

### Key People:

Assigned DOH Reviewer:	Steve Pennington steve.pennington@doh.wa.gov	Facility Contact:	Northwest Glaucoma and Cataract Barbra Balkema 1229 Madison St Ste 1250 Seattle, WA 98104 (206) 622-2020 x. bbalkema@nwgcsurgery.com
Facility Administrator:	Northwest Glaucoma and Cataract Consultants John Whitehead 1229 Madison St Ste 1250 Seattle, WA 98104 (206) 622-2020 x. jwhitehead@nwgcsurgery.com	Local AHJ:	City of Seattle Jon Siu 206-684-8850 http://www.seattle.gov/dpd/ x.
Architect / Engineer:	The Wager Group Inc Michael Wager 950 Pacific Ave Ste 207 Tacoma, WA 98402 (253) 460-0276 x. thewagergroup@msn.com	Consultant:	N/A
Consultant:	N/A	Consultant:	N/A
Contact:	N/A	Contact:	N/A

### Copies To:

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Local AHJ: City of Seattle                | <input type="checkbox"/> DOH Child Birth Center Licensing           |
| <input checked="" type="checkbox"/> Architect / Engineer: The Wager Group Inc | <input type="checkbox"/> DOH Office of Investigations & Inspections |
| <input type="checkbox"/> Consultant: N/A                                      | <input type="checkbox"/> L&I Electrical Section                     |
| <input type="checkbox"/> Consultant: N/A                                      | <input type="checkbox"/> L&I Factory Assembled Structures           |
| <input type="checkbox"/> Contact: N/A   | <input type="checkbox"/>  |
| <input type="checkbox"/> Contact: N/A   | <input checked="" type="checkbox"/> CRS File                        |

## Facility Data Certificate:

<b>Facility Name:</b> Northwest Glaucoma and Cataract	<b>Licensee UBI#:</b> 603596596
<b>Site Address:</b> 1229 Madison St Ste 1250 Seattle, WA 98104	<b>Critical Access Facility:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Estimated Date of Occupancy:</b> Unknown	

<b>ALL FACILITY TYPES</b>	Occupancy Group: <b>B</b>	Construction Type: <b>1-A</b>	Applicable Code: <b>2012 NFPA 101</b>		
	Number of Beds:	Current: N/A	Added: _____	Removed: _____	Total: _____
	Automatic Fire Sprinkler System:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Type 13		
	Automatic Fire Alarm System:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	Compartmentation req'd:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Smoke Control System Provided:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Delayed Egress Control:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Location:		
Certificate of Need Required:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	CON Approval Granted:	<input type="checkbox"/> Yes <input type="checkbox"/> No	CON Number : _____	

<b>RESIDENTIAL CARE FACILITIES ONLY</b>	Number of units:	Private occupancy:	Two person occupancy:
	Based on size of rooms used for sleeping	Residents	
	Based on size of common rooms	Residents	
	Maximum allowable licensable beds: _____		
	Qualifies for Assisted Living Funding Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of qualifying units: _____

<b>NOTES</b>	<p>Change of ownership of an eye surgery facility with one Class "A" operating room and a lazak procedure room. Medicare is billed for this facility and no general anesthesia is administered. Project submitted to configure walls to meet Medicare distinct entity rule.</p>
--------------	---

**The data above is based on the information presented to CRS. Any change in the facility or facility program that causes the above information to be incorrect is subject to review by CRS. Approval for construction is not approval for licensure. A copy of the facility data certificate will be sent to the licensing agency.**

**Project Status:**

**– Approved –**

The stamped approved copy of the documents shall be kept available on site for survey and inspection staff. The local building official is responsible for building construction permitting and occupancy.

Please note the following:

- Final licensing approval may be subject to a site inspection by a licensing surveyor to verify compliance with licensing regulations.

If you have any questions please feel free to contact Construction Review Services. You can monitor project status and fill out our online survey at [www.doh.wa.gov/crs](http://www.doh.wa.gov/crs).

**Preliminary Comments**

Comment ID #													
	<p>Preliminary Conference – July 21<sup>st</sup>, 2016</p> <p>Attendees:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Steve Pennington (<a href="mailto:steve.pennington@doh.wa.gov">steve.pennington@doh.wa.gov</a>)</td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 35%;">Department of Health</td> </tr> <tr> <td>Rachelle Deskins</td> <td style="text-align: center;">-</td> <td>Department of Health</td> </tr> <tr> <td>Dr. John Whitehead</td> <td style="text-align: center;">-</td> <td>NW Glaucoma and Cataract</td> </tr> <tr> <td>Glynis Thakur</td> <td style="text-align: center;">-</td> <td>Consultant</td> </tr> </table> <p>The preceding are preliminary notes provided as information and for use preparing the construction documents. These preliminary notes may be revised during subsequent submissions/conferences. Additional preliminary comments may be made during subsequent submissions.</p> <p>Items Received: TA application and fee</p>	Steve Pennington ( <a href="mailto:steve.pennington@doh.wa.gov">steve.pennington@doh.wa.gov</a> )	-	Department of Health	Rachelle Deskins	-	Department of Health	Dr. John Whitehead	-	NW Glaucoma and Cataract	Glynis Thakur	-	Consultant
Steve Pennington ( <a href="mailto:steve.pennington@doh.wa.gov">steve.pennington@doh.wa.gov</a> )	-	Department of Health											
Rachelle Deskins	-	Department of Health											
Dr. John Whitehead	-	NW Glaucoma and Cataract											
Glynis Thakur	-	Consultant											
	<b>General:</b>												
T1	<ul style="list-style-type: none"> <li>➤ This facility will be billing Medicare as an ASC.</li> <li>➤ Performs Cataract, Glaucoma and Lasik procedures</li> <li>➤ No general anesthesia is used.</li> <li>➤ Paper medical records exist today, but they will be going to an electronic system.(EMR)</li> <li>➤ Laundry will be contacted out.</li> <li>➤ Only adults will be treated at this facility.</li> <li>➤ There is one Class “A” operating room and one procedure room.</li> <li>➤ The exit signs and pull stations meet the required standards per the Life Safety Code.</li> <li>➤ The clinic exam rooms and offices were not reviewed as they are not part of the ASF and no hazards were noted that could affect the ASF/ASC in these areas.</li> </ul>												
T2	<p>There are no piped medical gases and this facility would be considered a Category 3 facility due to the low risk of injury to patients if the facilities infra-structure systems failed. As such portable gases consisting on no less than one portable suction unit and one oxygen bottle will need to be available.</p> <p><b>Note:</b> Any quantity of oxygen bottles exceeding 504 cubic feet in total volume stored will require special storage arrangements per the International Fire Code.</p>												
T3	<p>As a change of ownership, construction review is not required per WAC 246-330-020 (5) for an existing State Licensed ASF.</p> <p>This technical assistance was to aid in evaluating the current physical space for any deficiencies that may have existed previously, that needs to be addressed in a timely manner.</p>												

	<b>Life Safety:</b>
T4	<p>The one hour fire barrier that is required to surround all the distinct entity parts of the ASC per CFR 416.2 requires that following areas to be updated;</p> <ul style="list-style-type: none"> <li>(a) The west wall along the current Medical records is not fire tapped or fire stopped to provide a one hour fire assembly rating. <b>(Project that needs submitting to CRS)</b></li> <li>(b) The wall above the entry door to the suite and on the south side of the decontamination room is missing one layer of 5/8” type X sheet rock and then the corresponding fire tapping and fire stopping to provide a one hour fire assembly. <b>(Project that needs submitting to CRS)</b></li> <li>(c) The entry door and side lights (glass) are not 20 minute rated and would need to be replaced with a 20 minute rated fire door/assembly. <b>(Project that needs submitting to CRS)</b></li> </ul>
T5	<p>Provide signage for the fire extinguisher locations so that they are not hidden from view to those who would be looking for them in a fire event. <b>(Maintenance item)</b></p>
	<b>Medicare:</b>
T6	<p>The clinic and ASC in its current configuration are not separated from each other to meet the distinct entity requirements of Medicare and CRF 416.2.          The clinic and the ASC cannot therefore be operated during the same time and Appendix “L” from CMS website describes how this condition works. <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_1_ambulatory.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_1_ambulatory.pdf</a>  <b>(Operational item)</b></p>
	<b>Main Waiting room:</b>
T7	<p>There are three tall display cabinets approximately 7 feet tall that are recommended to be tied back to the wall to prevent them from tipping over during a seismic event.  <b>(Maintenance item)</b></p>
	<b>Recovery:</b>
T8	<p>The ceiling tiles in the recovery room are not a cleanable type due to the multiple deep fissures in them. But if there is incorporated into the Policy and Procedures a system to replace individual tiles as they are stained, dirty or damaged.          This will meet the intent of the clean-ability requirements of WAC 246-330-176 (5) (h), by replacing damaged/dirty individual tiles as the situation occurs, without changing them all out.</p> <p>If the facility wishes to replace these tiles, a pre-approved list can be found on the CRS website at <a href="http://www.doh.wa.gov/Portals/1/Documents/2300/505-079Appceilingtiles.pdf">http://www.doh.wa.gov/Portals/1/Documents/2300/505-079Appceilingtiles.pdf</a>.</p> <p>It is recommended that the rough textured tiles and one with a hole in it be replaced.  <b>(Maintenance item)</b></p>

T9	Recommend the gaps under the window sills next to the counter at the head of the recovery bays be caulked to support cleaning. WAC 246-330-176 (5) (h) <b>(Maintenance item)</b>
T10	Only two of the bays in the level two recovery space meet the dimensional and functional clearances for access to the patient. The last cubicle next to the Lasik procedure room is best used for other purposes like storage.
T11	Clean items cannot be stored under the recovery room sink. See CDC, AORN or adopted standard by ASC facility for limitations or allowable storage items. <b>(Operational item)</b>
T12	One of the recovery chairs was fabric covered, which is not considered clean-able. <b>(Operational item)</b>
T13	Recommend that the three tack boards located at the nurse station in the recovery room be removed as these are not considered cleanable. WAC 246-330-176 (5)(h) <b>(Maintenance item)</b>
	<b>Procedure room:</b>
T14	<p>The following items were noted in the Procedure room;</p> <ul style="list-style-type: none"> <li>➤ Clean items stored in the open need to be containerized or covered to protect them from dust.</li> <li>➤ Original cardboard shipping container around compressed gas bottles in corner need to be removed.</li> <li>➤ A couple of ceiling tiles were broken or had holes that need to be replaced.</li> <li>➤ The wood backing that the tank support chains tie back to, is not considered cleanable on the raw wood ends. Recommend that this be painted.</li> <li>➤ One cover plate was missing on the wall and needs to be covered to support cleaning.</li> <li>➤ Wall finish was damaged in one area and needed re-painting.</li> <li>➤ This room was positively pressurized to the corridor and meets standard.</li> <li>➤ Note: The cleanable ceiling tiles in this room, do not need to be caulked around the edges as this is a procedure room and not an operating room.</li> </ul> <p><b>(All the T14 items above are Maintenance)</b></p>
	<b>Operating room:</b>
T15	The size of the operating room meets a Class “A” room size suitable for minor surgical procedures and fits the type of procedures that are planned to be performed at this facility.
T16	The operating room has cleanable ceiling tiles instead of a sheet rock ceiling that does not meet the free of crack and crevices requirement. All the gaps around each ceiling tile will need to be caulked in place to fill this gap where dust can gather and that cannot be cleaned. <b>(Maintenance item)</b>

T17	The fluorescent lights in the ceiling are of a type that have large non-cleanable gaps around them and will need to be changed out to a clean room type of light fixture. <b>(Project that needs submitting to CRS)</b>
T18	The existing non-hospital grade electrical receptacles are okay for the year the facility was built and would not be required to be changed out.
T19	The storage on the wire rack carts in the operating room are recommended to be removed from the operating room for the following reasons; <ul style="list-style-type: none"> <li>➤ They take so much space in this compact OR, that they may interfere with the nurse circulating space.</li> <li>➤ The terminal cleaning of these wire racks while possible to do with enough time, becomes very problematic as they have so many nocks and crevices.</li> <li>➤ Recommend that the containerized bulk storage be moved out to another storage space and only items needed most readily be keep in the storage cabinets of the operating room.</li> <li>➤ If additional cabinetry is added below exiting upper cabinets, this work would need to be reviewed by CRS</li> </ul> <b>(Operational if done with portable equipment)</b>
T20	Damage wall finishes in the operating room need to be refinished and gaps above upper cabinets next to ceiling will need to be caulked; or flashing installed and caulked; or other means to reduce places were dust can gather and to meet the scrub ability finish requirements. <b>(Maintenance)</b>
T21	Recommend that the large window in the operating room door receive window film to provide patient privacy. <b>(Maintenance)</b>
T22	The orange power cord to one of the pieces of equipment looks like it was replaced with a non-hospital grade cord. Recommend that when the patient care medical equipment are retested and tags updated that the non-hospital grade cord is also replaced. <b>(Maintenance)</b>
T23	Disposal of body fluids should be addressed in the Policy and Procedure as there is no clinical flush sink available at this facility. With the minimal amount of fluid generated with eye procedures, disposal could be via the red infectious waste bag/bin processes for disposal. <b>(Operational item)</b>
T24	The operating room tested positive to the corridor and meets the CDC Guidelines referenced standards for pressure relationships.
	<b>Sterile Processing room:</b>
T25	<ul style="list-style-type: none"> <li>➤ Recommend that a splash shield be placed next to the sink to prevent splashing on the clean instruments or counter are where wrapping takes place.</li> </ul>

	<ul style="list-style-type: none"> <li>➤ Recommend the spray wand in the sink be removed or a vacuum breaker installed to prevent back flow protection for the domestic water system.</li> <li>➤ Room tested positive to the corridor and meets the CDC standard referenced requirement.</li> <li>➤ If in future more counter space is needed, one of the double sinks can be eliminated, leaving just one sink for handwashing.</li> <li>➤ No clean storage is allowed under the sink and other items kept there will depend upon the infection control standard that is adopted in P&amp;P by the facility.</li> </ul> <p><b>(Operational)</b></p>
	<p><b>Decontamination room:</b></p>
T26	<ul style="list-style-type: none"> <li>➤ Recommend that room cleaning by using micro pads instead of a wet mop be considered to free up the mop sink space in the decontamination room to allow that space to then be designated for soiled holding of infectious waste, dirty linen or full needle boxes. <b>(Operational item)</b></li> <li>➤ This will also create more separation from the processing counter where instruments are being cleaned. <b>(Operational item)</b></li> <li>➤ Recommend that a back draft damper be installed on the plenum return grill in the ceiling to prevent dust from above getting into the decontamination room when the door is opened. <b>(Maintenance item)</b></li> <li>➤ Recommend that the spray wand be removed from the sink or a vacuum breaker installed to prevent back flow contamination of the domestic water system. <b>(Maintenance item)</b></li> <li>➤ The decontamination room tested negative to the corridor which meets standards referenced in the Guidelines of the CDC.</li> <li>➤ No clean storage is allowed under the sink and other items kept there will depend upon the infection control standard that is adopted in P&amp;P by the facility. <b>(Operational item)</b></li> </ul>
	<p><b>Changing room/restroom:</b></p>
T27	<ul style="list-style-type: none"> <li>➤ Recommend that the tall metal locker in the patient restroom be secured to the wall to prevent it from tipping over during a seismic event. <b>(Maintenance item)</b></li> <li>➤ Recommend that the surgical scrubs be locked up in the patient restroom if they remain stored there, to prevent tampering and cross contamination by a patient. <b>(Maintenance item)</b></li> </ul>
	<p><b>Yag Laser room:</b></p>
T28	<ul style="list-style-type: none"> <li>➤ No special pressure relationship is required for this room as nothing invasive occurs there.</li> <li>➤ No clean storage is allowed under the sink and other items kept there will depend upon the infection control standard that is adopted in P&amp;P by the facility. <b>(Operational item)</b></li> </ul>

**Plan Review Comments:**

Comment ID #	Approved	Not Approved	
1	<input checked="" type="checkbox"/>		Approved as submitted. SDP
2			Note: The gap around the ceiling light fixtures in the main operating room will need to be addressed as this is a cleaning issue. (Note T17)

*Compliance with the comments above provided by the Department of Health, Construction Review Services, are necessary for this facility to meet the requirements of the applicable licensing regulations found in the Washington State Administrative Code and associated references. These comments do not relieve the facility from the responsibility to meet the requirements of any other applicable federal, state or local regulations. In the event of conflicts between other jurisdictions and these written comments, the most stringent shall apply.*

Exhibit 15  
Central King County Planning Area Methodology  
Calculation Worksheet



## Central King ASC Need Methodology, 2017

Sevice Area Population, 2022

303,950

Claritas, 2018

a.i.	94,250	minutes per year, inpatient/mixed use OR							
a.ii	68,850	minutes per year, outpatient OR							
a.iii	99	dedicated mixed use ORs x 94,250	=	9,330,750	=	70,410	mixed use surgeries		
a.iv	21	dedicated OP ORs x 68,850 minutes	=	1,445,850	=	28,395	outpatient surgeries		
b.i.		2022 Projected inpatient/mixed use surgeries	=	71,342	=	6,723,983,500	minutes, mixed use surgeries		
		2022 Projected outpatient surgeries	=	22,700	=	1,562,895,000	minutes, outpatient surgeries		
b.ii.		Forecast number of outpatient surgeries minus capacity of dedicated outpatient ORs							
		22,700 -	28,395	=		=	-5,695		
b.iii.		Average time of mixed use surgeries		=	132.52	minutes			
		Average time of outpatient surgeries		=	50.92	minutes			
b.iv.		Mixed use surgeries, 2022 * average minutes/case							
				=	9,454,242	minutes			
		Remaining outpatient surgeries (b.ii) * average minutes/case							
				=	-289,966	minutes			
		Total		=	9,164,276	minutes			
c.i.		If b.iv. < a.iii., divide by (a.iii. - b.iv.) 94,250 to determine surplus of mixed use ORs							
		<b>Not applicable; proceed to c.iii.</b>							
	b.iv.	9,164,276							
	a.iii.	9,330,750							
		166,474 ÷	94,250	=	1.77				
c.ii.		If b.iv. > a.iii., divide (mixed use part of b.iv. - a.iii.) by 94,350 to determine shortage of mixed use ORs							
	b.iv.	9,454,242							
	a.iii.	9,330,750							
		123,491.84 ÷	94,250	=	1.31				
		Divide outpatient part of b.iv. By 68,850 to determine the shortage of dedicated outpatient ORs							
		-289,966 ÷	68,850	=	-4.21				

Exhibit 16  
Pro Forma

## Seattle Ambulatory Surgery Center

Year	2017	2018	2019	2020	2021	2022	2023
<b>REVENUE AND EXPENSE STATEMENT</b>							
ASC Volumes Totals OR Cases ("Procedures")	972	998	1,025	1,053	1,081	1,110	1,140
OR Minutes	18,468	18,962	19,475	20,007	20,539	21,090	21,660
Number of Operating Rooms Utilized*	0.27	0.28	0.28	0.29	0.30	0.31	0.31
<b>Net Revenue</b>							
Medicare	677,564	695,858	714,647	733,942	753,758	774,110	795,011
Medicaid	169,391	173,965	178,662	183,486	188,440	193,527	198,753
Commercial/Health Care Contractor	326,683	335,503	344,562	353,865	363,419	373,232	383,309
Self-pay	36,298	37,278	38,285	39,318	40,380	41,470	42,590
<b>Total</b>	<b>\$ 1,209,936</b>	<b>\$ 1,242,604</b>	<b>\$ 1,276,155</b>	<b>\$ 1,310,611</b>	<b>\$ 1,345,997</b>	<b>\$ 1,382,339</b>	<b>\$ 1,419,662</b>
<b>Operating Expenses (VARIABLE)</b>							
ASC Supplies	160,114	164,437	168,877	173,437	178,119	182,929	187,868
People	301,673	309,818	318,183	326,774	335,597	344,658	353,964
Marketing	85	87	90	92	95	97	100
Audit and Legal	3,019	3,101	3,184	3,270	3,359	3,449	3,542
Insurance	41,990	43,124	44,288	45,484	46,712	47,973	49,268
Office Supplies	4,640	4,765	4,894	5,026	5,162	5,301	5,444
Postage/Delivery	1,382	1,419	1,458	1,497	1,537	1,579	1,622
State/Local Taxes	14,440	14,830	15,230	15,642	16,064	16,498	16,943
<b>Total Operating Expenses (VARIABLE)</b>	<b>\$ 527,343</b>	<b>\$ 541,581</b>	<b>\$ 556,204</b>	<b>\$ 571,221</b>	<b>\$ 586,644</b>	<b>\$ 602,484</b>	<b>\$ 618,751</b>
<b>Contribution Margin</b>	<b>\$ 682,593</b>	<b>\$ 701,023</b>	<b>\$ 719,951</b>	<b>\$ 739,389</b>	<b>\$ 759,353</b>	<b>\$ 779,855</b>	<b>\$ 800,911</b>
<b>Non-Operating Expenses</b>							
Medical Equipment (Maint, PPT, etc.)	15,764	16,237	16,724	17,226	17,743	18,275	18,823
IT Hardware/Software (copier,	4,428	4,561	4,698	4,839	4,984	5,133	5,287
Certificate of Need Application		40,247	-	-	-	-	-
Charity Care		12,675	13,017	13,368	13,729	14,100	14,481
Lease Expense							
Lease fee	274,171	282,396	290,868	299,594	308,582	317,839	327,375
Utilities, Maintenance, RE Taxes (OpEx)	1,476	1,520	1,566	1,613	1,661	1,711	1,762
Interest Expense, Bank Service Charge, Etc.	9,496	9,781	10,074	10,377	10,688	11,008	11,339
Allocations LESS bad debt							
Billing Service	23,808	24,522	25,258	26,016	26,796	27,600	28,428
IT	18,349	18,899	19,466	20,050	20,652	21,272	21,910
Accounting	11,094	11,427	11,770	12,123	12,486	12,861	13,247
Other Expenses	124,646	128,385	132,237	136,204	140,290	144,499	148,834
<b>Total Non-Operating Expenses (FIXED)</b>	<b>\$ 483,232</b>	<b>\$ 422,265</b>	<b>\$ 393,441</b>	<b>\$ 405,205</b>	<b>\$ 417,321</b>	<b>\$ 429,799</b>	<b>\$ 442,651</b>
<b>Net Income (Loss) (Pre-Tax)</b>	<b>\$ 199,361</b>	<b>\$ 278,758</b>	<b>\$ 326,510</b>	<b>\$ 334,184</b>	<b>\$ 342,032</b>	<b>\$ 350,056</b>	<b>\$ 358,260</b>

## Seattle Ambulatory Surgery Center

Year	2017	2018	2019	2020	2021	2022	2023
<b>Revenues and Expenses per Case Billed</b>							
Revenues							
Billed Revenues	1,245	1,245	1,245	1,245	1,245	1,245	1,245
Net Revenue	1,245	1,245	1,245	1,245	1,245	1,245	1,245
Total Operating Expenses	543	543	543	542	543	543	543
Total Indirect Expenses	497	423	384	385	386	387	388
Total Expenses	1,040	966	926	927	929	930	931
Net Income (Loss)	\$ 205	\$ 279	\$ 319	\$ 317	\$ 316	\$ 315	\$ 314
<b>Revenues and Expenses per OR Minute</b>							
Net Revenue	66	66	66	66	66	66	66
Total Operating Expenses	29	29	29	29	29	29	29
Total Indirect Expenses	26	22	20	20	20	20	20
Total Expenses	55	51	49	49	49	49	49
Net Income (Loss)	\$ 11	\$ 15	\$ 17	\$ 17	\$ 17	\$ 17	\$ 17

### Footnotes:

\*Operating Room is defined as 68,850 minutes of surgery minutes per Washington State Certificate of Need Department.

## VOLUME AND REVENUE STATEMENT

### ASC Volumes

Operations on the Eye	972	998	1,025	1,053	1,081	1,110	1,140
Total ASC Volumes	972	998	1,025	1,053	1,081	1,110	1,140

### Cases by Payer

Medicare	544	559	574	590	605	622	638
Medicaid	136	140	144	147	151	155	160
Commercial/Health Care Contractor	262	269	277	284	292	300	308
Self-pay	29	30	31	32	32	33	34

### Cases by Payer-% of Total

Medicare	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%
Medicaid	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%
Commercial/Health Care Contractor	27.0%	27.0%	27.0%	27.0%	27.0%	27.0%	27.0%
Self-pay	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

### Number of FTEs per Year (Productive)

Office/Clerical Employees	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Registered Nurses	1.50	1.50	1.50	1.50	1.50	1.50	1.50
Operating Room Technicians	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Manager	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Total FTE's	5.50	5.50	5.50	5.50	5.50	5.50	5.50

### Total Wages and Salaries

Office/Clerical Employees	38,043	39,184	40,360	41,571	42,818	44,102	45,426
Registered Nurses	99,341	102,321	105,391	108,552	111,809	115,163	118,618
Operating Room Technicians	89,648	92,337	95,108	97,961	100,900	103,927	107,044
Manager	74,880	77,126	79,440	81,823	84,278	86,806	89,411
Total Employee Salaries	301,673	310,969	320,298	329,907	339,805	349,999	360,499
Employee Benefits & Taxes	72,402	74,633	76,872	79,178	81,553	84,000	86,520
Total Salaries and Benefits	\$ 374,075	\$ 385,602	\$ 397,170	\$ 409,085	\$ 421,358	\$ 433,998	\$ 447,018
Annual Change		\$ 11,527	\$ 11,568	\$ 11,915	\$ 12,273	\$ 12,641	\$ 13,020

Exhibit 17

2016, 2017 Financial Statements

# Northwest Glaucoma and Cataract Consultants PLLC

## Profit and Loss

November - December, 2016

	<u>Total</u>
<b>Income</b>	
Medical Services	100,464.17
<b>Total Income</b>	<u>\$ 100,464.17</u>
<b>Gross Profit</b>	<u>\$ 100,464.17</u>
<b>Expenses</b>	
Amortization Expense	3,889.00
ASC Supplies	11,025.87
B&O taxes	723.10
Bank Charges	544.89
Copier lease	418.74
Depreciation Expense	51,453.00
Dues & Subscriptions	300.00
Employee benefits	1,528.19
Garbage service	23.41
Insurance	376.56
Insurance, Health	3,010.08
Interest Expense	5,040.66
IT Consultant	1,260.40
Legal & Professional Fees	5,354.53
Miscellaneous	532.64
Office Expenses	1,035.15
Parking	1,442.76
Payroll service fee	689.26
Payroll taxes	5,588.17
Postage	252.22
Rent or Lease	8,626.04
Repair & Maintenance	5,952.10
Salaries & wages	59,002.92
Services	-3,289.98
Subcontractors	3,278.60
Supplies	578.00
Telephone/cable/internet	862.02
Training & education	1,384.27
Travel	234.00
Uniforms	20.19
<b>Total Expenses</b>	<u>\$ 171,136.79</u>
<b>Net Operating Income</b>	<u>\$ (70,672.62)</u>
<b>Net Income</b>	<u>\$ (70,672.62)</u>

Friday, Jun 29, 2018 07:11:46 AM GMT-7 - Cash Basis

**Northwest Glaucoma and Cataract Consultants PLLC**  
**Profit and Loss**  
January - December 2017

		<u>Total</u>
<b>Income</b>		
Medical Services		1,212,856.20
Refunds-Allowances		-2,920.00
<b>Total Income</b>	<b>\$</b>	<b>1,209,936.20</b>
<b>Gross Profit</b>	<b>\$</b>	<b>1,209,936.20</b>
<b>Expenses</b>		
Accounting		11,094.20
ASC Rpr/Maintenance		15,764.18
ASC Supplies		160,114.70
B&O taxes		14,440.03
Bank Charges		9,496.21
Billing Service		23,808.51
Clinic		170.00
Clinic/Supplies		275.75
Commissions & fees		3,331.62
Copier lease		4,428.37
Disposal Fees		250.00
Dues & Subscriptions		2,275.00
Employee benefits		1,283.82
Garbage service		111.64
Insurance - Disability		7,999.04
Insurance - Liability		6,271.00
Insurance, Dental		3,408.62
Insurance, Health		24,312.52
Interest Expense		36,599.60
IT Consultant		18,349.74
Kitchen		68.00
Legal & Professional Fees		3,019.44
License Renewal		645.00
Meals and Entertainment		84.90
medical staff		100.00
Office Expenses		2,556.75
Office Supplies		1,042.99
Parking		9,006.05
Payroll service fee		4,597.16
Payroll taxes		35,520.84
Postage		1,382.41
Rent or Lease		274,171.72
Repair & Maintenance		1,476.55
Salaries & wages		301,673.10
Service contract		12,081.16

Services		13.20
Staff Certification		1,014.00
Stationery & Printing		354.10
Subcontractors		4,948.98
Supplies		1,080.49
Taxes & Licenses		1,967.77
Telephone/cable/internet		7,205.17
Training & education		1,190.52
Transportation		80.00
Travel		1,510.00
Unapplied Cash Bill Payment Expense		0.00
<b>Total Expenses</b>	<b>\$</b>	<b>1,010,574.85</b>
<b>Net Operating Income</b>	<b>\$</b>	<b>199,361.35</b>
<b>Net Income</b>	<b>\$</b>	<b>199,361.35</b>

Friday, Jun 29, 2018 06:52:54 AM GMT-7 - Cash Basis

**Northwest Glaucoma and Cataract Consultants PLLC****Balance Sheet**

2017

**Assets**

## Current assets:

Cash	60,107
Accounts Receivable	-
Prepaid expenses	(3,889)
Inventory	-
<b>Total current assets</b>	<b>56,218</b>
Property & Equipment	1,522,135
Goodwill	100,000
<b>Total Assets</b>	<b>1,678,353</b>

**Liabilities**

Long-term debt	1,183,671
Other long-term liabilities	-
<b>Total Liabilities</b>	<b>1,183,671</b>

**Shareholder's Equity**

Equity Capital	731,888
Retained Earnings	(237,206)
<b>Shareholder's Equity</b>	<b>494,682</b>
<b>Total Liabilities &amp; Shareholder's Equity</b>	<b>1,678,353</b>

*Check*

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## Northwest Glaucoma and Cataract Consultants PLLC

### Cash Flow Statement

2017

#### Operating Cash Flow

Net Earnings	1,209,936
Plus: Depreciation & Amortization	55,342
Less: Changes in Working Capital	-
<b>Cash from Operations</b>	<b>1,265,278</b>

#### Investing Cash Flow

Investments in Property & Equipment	1,573,588
<b>Cash from Investing</b>	<b>1,573,588</b>

#### Financing Cash Flow

Issuance (repayment) of debt	(36,559)
Issuance (repayment) of equity	103,306
<b>Cash from Financing</b>	<b>66,747</b>

Net Increase (decrease) in Cash	(241,563)
Opening Cash Balance	791,995
<b>Closing Cash Balance</b>	<b>550,432</b>

Exhibit 18

National Health Statistics Reports; Number 11, January 28, 2009 –  
Revised September 4, 2009

An error discovered in the processing of the 2006 National Survey of Ambulatory Surgery procedure data resulted in a revised data set. All analyses involving procedure data were rerun and some reported findings have changed. The required revisions have been made. In addition, some standard errors for both visits and procedures were printed incorrectly in the original report and these have been corrected in this revised report. For more information, see the explanation at the end of the report.

# National Health Statistics Reports

Number 11 ■ January 28, 2009—Revised September 4, 2009

## Ambulatory Surgery in the United States, 2006

by Karen A. Cullen, Ph.D., M.P.H.; Margaret J. Hall, Ph.D.; and Aleksandr Golosinskiy,  
Division of Health Care Statistics

### Abstract

**Objectives**—This report presents national estimates of surgical and nonsurgical procedures performed on an ambulatory basis in hospitals and freestanding ambulatory surgery centers in the United States during 2006. Data are presented by types of facilities, age and sex of the patients, and geographic regions. Major categories of procedures and diagnoses are shown by age and sex. Selected estimates are compared between 1996 and 2006.

**Methods**—The estimates are based on data collected through the 2006 National Survey of Ambulatory Surgery by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS). The survey was conducted from 1994–1996 and again in 2006. Diagnoses and procedures presented are coded using the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

**Results**—In 2006, an estimated 53.3 million surgical and nonsurgical procedures were performed during 34.7 million ambulatory surgery visits. Of the 34.7 million visits, 19.9 million occurred in hospitals and 14.9 million occurred in freestanding ambulatory surgery centers. The rate of visits to freestanding ambulatory surgery centers increased about 300 percent from 1996 to 2006, whereas the rate of visits to hospital-based surgery centers remained largely unchanged during that time period. Females had significantly more ambulatory surgery visits (20.0 million) than males (14.7 million), and a significantly higher rate of visits (132.0 per 1,000 population) compared with males (100.4 per 1,000 population).

Average times for surgical visits were higher for ambulatory surgery visits to hospital-based ambulatory surgery centers than for visits to freestanding ambulatory surgery centers for the amount of time spent in the operating room (61.7 minutes compared with 43.2 minutes), the amount of time spent in surgery (34.2 minutes compared with 25.1 minutes), the amount of time spent in the postoperative recovery room (79.0 minutes compared with 53.1 minutes), and overall time (146.6 minutes compared with 97.7 minutes).

Although the majority of visits had only one or two procedures performed (59.8 percent and 27.7 percent, respectively), 1.0 percent had five or more procedures performed. Frequently performed procedures on ambulatory surgery patients included endoscopy of large intestine (5.7 million), endoscopy of small intestine (3.5 million), extraction of lens (3.1 million), injection of agent into spinal canal (2.0 million), and insertion of prosthetic lens (2.6 million). The leading diagnoses at ambulatory surgery visits included cataract (3.0 million); benign neoplasms (2.0 million), malignant neoplasms (1.2 million), diseases of the esophagus (1.1 million), and diverticula of the intestine (1.1 million).

**Keywords:** Outpatients • Diagnoses • Procedures • ICD–9–CM • National Survey of Ambulatory Surgery

### Introduction

This report presents data from the 2006 National Survey of Ambulatory Surgery (NSAS). The survey, previously conducted annually from 1994 through 1996, was conducted by NCHS to gather and disseminate data about ambulatory surgery in the United States. For NSAS, ambulatory surgery refers to surgical and nonsurgical procedures performed on an ambulatory (outpatient) basis in a hospital or freestanding center's general operating rooms, dedicated ambulatory surgery rooms, and other specialized rooms, such as endoscopy units and cardiac catheterization laboratories. NSAS is the principal source for national data on the characteristics of visits to hospital-based and freestanding ambulatory surgery centers.

Ambulatory surgery has been increasing in the United States since the early 1980s. Two major reasons for the increase are advances in medical technology and changes in payment arrangements. The medical advances include improvements in anesthesia, which enable patients to regain consciousness more quickly with fewer after effects and better analgesics for relief of pain. In addition, minimally invasive and noninvasive procedures have been developed and are being used with increasing frequency. Examples include laser surgery, laparoscopy, and endoscopy. These medical advances have made surgery less complex and risky (1) and have allowed many



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention  
National Center for Health Statistics



procedures to move from inpatient to ambulatory settings (2–6).

At the same time, concern about rising health care costs led to changes in the Medicare program that encouraged the development of ambulatory surgery. In the early 1980s, the Medicare program was expanded to cover care in ambulatory surgery centers, and a prospective payment system based on diagnosis-related groups was adopted for hospital inpatient care that created strong financial incentives for hospitals to shift less complex surgery to outpatient settings. Many state Medicaid plans and private insurers followed the lead of the Medicare program and adopted similar policies (7).

Additional changes in the health care system, such as the growth of managed care along with consolidation of hospitals, have furthered the growth of ambulatory surgery (3,8). As these changes occurred, many types of surgeries done in hospitals were increasingly performed during ambulatory visits. Both in conjunction with and as a result of these changes, the number of freestanding ambulatory surgery centers (ASCs) grew from 239 in 1983 (9) to over 3,300 nearly two decades later (3,10). The number of procedures being performed in ASCs also increased dramatically—from 380,000 procedures in 1983 to 31.5 million in 1996 (5).

The National Hospital Discharge Survey (NHDS), which has been conducted by NCHS every year since 1965, includes information on surgical and nonsurgical procedures performed in inpatient settings (11–13). Although NHDS remains a good source of data for procedures that can be done only on an inpatient basis, such as open-heart surgery or cesarean delivery, NHDS estimates have become incomplete for procedures that can be performed on an ambulatory basis. NSAS was undertaken to obtain information about ambulatory procedures. For many types of procedures, data from both NHDS and NSAS are now required to obtain national estimates. Reports that present both ambulatory and inpatient procedure data for 1994, 1995, and 1996 have been published (14–16).

NSAS and NHDS are two of the NCHS provider-based surveys that constitute the National Health Care Surveys (NHCS). The NHCS were designed to provide nationally representative data on the use of health care resources of major sectors of the health care delivery system. Information on ambulatory procedures is also collected in two other NHCS surveys. The National Ambulatory Medical Care Survey obtains information on procedures ordered or performed during visits to physicians' offices (17), and the National Hospital Ambulatory Medical Care Survey (NHAMCS) collects data on procedures ordered or performed during visits to hospital outpatient and emergency departments (18).

## Methods

### Data source

NSAS covers procedures performed in ambulatory surgery centers, both hospital-based and freestanding. The hospital universe includes noninstitutional hospitals exclusive of federal, military, and Department of Veterans Affairs hospitals located in the 50 states and the District of Columbia. Only short-stay hospitals (hospitals with an average length of stay for all patients of fewer than 30 days), or those whose specialty was general (medical or surgical), or children's general were included in the survey. These hospitals must also have had six beds or more staffed for patient use. This universe definition is the same as that used for the NHDS and the NHAMCS. For the 2006 NSAS, the hospital sample frame was constructed from the products of Verispan, L.L.C., specifically its "Healthcare Market Index, Updated June 15, 2005" and its "Hospital Market Profiling Solution, Second Quarter, 2005" (19). These products were formerly known as the SMG Hospital Market Database. In 2006, the sample consisted of 224 hospitals. Of the 224 hospitals, 35 were found to be out-of-scope (ineligible) because they went out of business or otherwise failed to meet the criteria for the NSAS universe. Of the 189 in-scope (eligible)

hospitals, 142 hospitals responded to the survey for a response rate of 75.1%.

The universe of freestanding facilities included ones that were regulated by the states or certified by the Centers for Medicare & Medicaid Services (CMS) for Medicare participation. The sampling frame consisted of facilities listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database (20) and Medicare-certified facilities included in the CMS Provider-of-Services (POS) file (21). Facilities specializing in dentistry, podiatry, abortion, family planning, or birthing were excluded. However, procedures commonly found in these settings were not excluded from in-scope locations. In 1994–1996, pain block locations were also excluded; however, they were included in the 2006 NSAS. In 2006, the sample consisted of 472 freestanding ASCs. Of the 472 freestanding ambulatory surgery centers, 74 were found to be out-of-scope (ineligible) because they failed to meet the criteria for the NSAS universe. Of the 398 in-scope (eligible) freestanding ambulatory surgery centers, 295 responded to the survey for a response rate of 74.1%. The overall response rate was 74.4%.

### Sample design

The NSAS sampled facilities were selected using a multistage probability design with facilities having varying selection probabilities. Independent samples of hospitals and freestanding ambulatory surgery centers were drawn. Unlike the 1994–1996 NSAS, which used a three-stage stratified cluster design, with the first stage consisting of geographic primary sampling units or PSUs, the 2006 NSAS used a two-stage list-based sample design. Facilities were stratified by facility type (hospital compared with freestanding), ambulatory surgery status of hospitals (i.e., whether or not the hospital performed such surgery), facility specialty, and geographic region.

The first stage of the design consisted of selection of facilities using systematic random sampling with probabilities proportional to the annual

number of ambulatory surgeries performed. For the stratum of hospitals which, according to the sampling frame data, did not have ambulatory surgery, a national sample of 25 hospitals was selected to permit estimates of surgery in hospitals that either added ambulatory surgery since the frame was selected or differed from the frame.

At the second stage, within sampled facilities, a sample of ambulatory surgery visits was selected using a systematic random sampling procedure. Selection of visits within each facility was performed separately for each location where ambulatory surgery was performed. These locations included main operating rooms; dedicated ambulatory surgery units; cardiac catheterization laboratories; and rooms for laser procedures, endoscopy, and laparoscopy. Locations within hospitals dedicated exclusively to abortion, dentistry, podiatry, or small procedures were not included. The exclusion of these specialty locations, as well as the exclusion of facilities dedicated exclusively to those specialties, was recommended based on the feasibility study for the NSAS that was conducted in 1989–1991. Based on the recommendation of outside experts who were consulted prior to the design of the 2006 NSAS, the 2006 NSAS includes pain block facilities, whereas the 1994–1996 NSAS did not (22). Because NSAS data are collected from a sample of visits, persons with multiple visits during the year may be sampled more than once. NSAS estimates are of the number of visits to or procedures performed in ambulatory surgery facilities, not the number of persons served by these facilities.

## Data collection

Sample selection and abstraction of information from medical records were performed at the facilities. Facility staff did the sampling in about 40 percent of facilities that participated in the 2006 survey, and facility staff abstracted the data in about 30 percent of the participating facilities. In the remaining facilities, the work was performed by personnel of the U.S. Census Bureau

acting on behalf of NCHS. Data processing and medical coding were performed by the Constella Group Inc., Durham, North Carolina. Editing and estimation were completed at NCHS.

The abstract form (“[Technical Notes](#)”) contains items relating to the personal characteristics of the patients such as age, sex, race, and ethnicity; and administrative items such as date of procedure, disposition, and expected sources of payment. The medical information includes up to seven diagnoses and six procedures, which were coded according to the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) (23).

A quality control program was conducted on the coding and entering of data from abstracts to electronic form. Approximately 10 percent of the abstractions were independently recoded by an NSAS coder at the Constella Group, Inc., with discrepancies resolved by a chief coder. The overall error rate for the 2006 NSAS was 0.3 percent for diagnosis coding and keying, 0.2 percent for procedure coding and keying, and 0.3 percent for demographic coding and keying.

## Estimation

Because of the complex multistage design of the NSAS, the survey data must be inflated or weighted in order to produce national estimates. The estimation procedure produces essentially unbiased national estimates, and has three basic components: inflation by reciprocals of the probabilities of sample selection, adjustment for nonresponse, and population weighting ratio adjustments. These three components of the final weight are described in more detail in another report (22).

## Standard errors

The standard error (SE) is primarily a measure of sampling variability that occurs by chance because only a sample, rather than the entire universe, is surveyed. Estimates of the sampling variability for this report were calculated

using Taylor approximations in SUDAAN, which takes into account the complex sample design of the NSAS. A description of the software and the approach it uses has been published (24). The SEs of statistics presented in this report are included in each of the tables.

## Testing of significance and rounding

In this report, statistical inference is based on the two-sided *t*-test with a critical value of 2.58 (0.01 level of significance). Terms such as “higher” and “less” indicate that differences are statistically significant. Terms such as “similar” or “no difference” mean that no statistically significant difference exists between the estimates being compared. A lack of comment on the difference between any two estimates does not mean that the difference was tested and found not to be significant.

The feasibility of using one weight to calculate estimates and variances was assessed to determine whether the SEs produced from the single-weight variable were for the most part greater than the SEs produced by the variance weights for the same estimates. For certain estimates, the single weights produced variances that underestimated the true variances. This underestimation can lead to Type I errors in which the null hypothesis is incorrectly rejected when using the commonly used significance level of  $\alpha=0.05$ . As a result, the decision was made that an  $\alpha$  of 0.01 should be used to reduce the likelihood of committing a Type I error.

Estimates of counts in the tables have been rounded to the nearest thousand. Therefore, figures within tables do not always add to the totals. Rates and percentages were calculated from unrounded figures and may not precisely agree with rates or percentages calculated from rounded data.

## Nonsampling error

As in any survey, results are subject to both sampling and nonsampling errors. Nonsampling errors include

reporting and processing errors as well as biases due to nonresponse and incomplete response. The magnitude of the nonsampling errors cannot be computed. However, these errors were kept to a minimum by procedures built into the operation of the survey. To eliminate ambiguities and to encourage uniform reporting, attention was given to the phrasing of items, terms, and definitions. Quality control procedures and consistency and edit checks reduced errors in data coding and processing. The unweighted response rate for the 2006 NSAS was 74.4%. [Table 1](#) presents weighted characteristics of NSAS respondents and nonrespondents, along with weighted response rates. Responding compared with nonresponding distributions were similar, with the exception of higher cooperation among facilities in a nonmetropolitan statistical area. The effect of this differential response is minimized in the visit estimates in most cases, as NSAS uses a nonresponse adjustment factor that takes annual visit volume, specialty, facility type, and geographic region into account. Item nonresponse rates in NSAS are generally low (5% or fewer). However, levels of nonresponse may vary considerably in the survey.

NSAS does not completely measure ambulatory procedures that are performed in locations such as physicians' offices, for example, injections of therapeutic substances, skin biopsies, and certain plastic surgery procedures. The National Ambulatory Medical Care Survey has data about procedures in physicians' offices (17) and the National Hospital Ambulatory Medical Care Survey provides information about procedures in other hospital outpatient and emergency departments (18). As medical technology continues to advance and changes in payment policy promote it, increasing numbers and types of procedures may move from NSAS facilities to elsewhere.

Because certain freestanding facilities and certain specialized locations within hospitals and freestanding facilities are excluded from the NSAS design, ambulatory

procedures performed in some specialties are not completely measured by the survey. Excluded specialties include dentistry, podiatry, abortion, family planning, and birthing; and locations that perform small procedures, such as removal of skin lesions, were also excluded. However, procedures in these specialties performed in general operating rooms or other in-scope locations are included in the survey.

The determination of whether an ambulatory surgery facility is a hospital or a freestanding center is based on the universe from which the facility was selected. In most cases, it was apparent whether a facility was a hospital or a freestanding ambulatory surgery center, but some facilities were not easily classified. For example, a "freestanding" facility may be owned by a hospital but located some distance away. If such a facility is separately listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database or in the CMS POS file and is selected into the NSAS sample from this universe, it is considered a freestanding facility. Additional definitions of terms used in the NSAS have been published (22).

## Use of tables

The statistics presented in this report are based on a sample, and therefore may differ from the figures that would be obtained if a complete census had been taken. Visits are reported by first-listed diagnosis, which is the one specified as the principal diagnosis on the face sheet or discharge summary of the medical record, or if a principal diagnosis was not specified, the first one listed on the face sheet or discharge summary of the medical record. It was usually the main cause of the visit. The number of first-listed diagnoses is the same as the number of visits.

The estimates shown in this report include surgical procedures, such as tonsillectomy; diagnostic procedures, such as ultrasound; and other therapeutic procedures, such as injection or infusion of cancer chemotherapeutic substance. Up to six procedures are coded for each

visit. All-listed procedures include all occurrences of the procedure coded regardless of the order on the medical record.

The diagnoses and procedures appear in separate tables of this report, presented by chapter of the ICD-9-CM. Within these chapters, subcategories of diagnoses or procedures are shown. These specific categories were selected primarily because of their large numbers or because they are of special interest.

According to the 2006 NSAS, an estimated 287,000 ambulatory surgery visits with procedures were admitted to the hospital as inpatients. Of these, 269,000 (93.8 percent) were visits to hospitals and 18,000 (6.2 percent) were visits to freestanding centers. In most instances, the ambulatory procedures for these patients become part of their inpatient records. People admitted as inpatients were included in this report, and procedures for these patients were included in the summaries of outpatient procedures, as described in the first version of this report for 1994 (5). These patients were excluded in the 1995 and 1996 *Advance Data Reports* (4,5) and will be excluded to avoid double counting from the Series 13 report in which data from the 2006 NHDS and 2006 NSAS will be presented together, following the same process as reports published using the 1994–1996 data (14–16).

The chances are about 40 in 100 that an estimate from the sample would differ from a complete census by more than the SE. The chances are 9 in 100 that the difference would be more than twice the SE, and about 4 in 100 that the difference would be more than 2.5 times as large as the SE.

The relative standard error (RSE) of an estimate is obtained by dividing the SE by the estimate itself. The RSE is expressed as a percentage of an estimate and can be multiplied by the estimate to obtain the SE. Because of low reliability, estimates with a RSE of more than 30 percent or those based on a sample of fewer than 30 records are replaced by asterisks (\*). The estimates that are based on 30 to 59 patient records are preceded by an asterisk (\*) to indicate that they also have low reliability.

The population estimates used in computing rates are for the U.S. civilian population, including institutionalized persons, as of July 1, 2006. Rates are computed using adjustments made after the 2000 census (postcensal estimates) of the civilian population of the United States. The data are from unpublished tabulations provided by the U.S. Census Bureau. Facilities are classified by location into one of the four geographic regions of the United States that correspond to those used by the U.S. Census Bureau.

## Results

### Patient and facility characteristics

- In 2006, an estimated 53.3 million surgical and nonsurgical procedures were performed during 34.7 million ambulatory surgery visits (Table 2).
- The 34.7 million ambulatory surgery visits accounted for about 61.6 percent of the combined total of ambulatory surgery visits and inpatient discharges with surgical and nonsurgical procedures (56.4 million) (Figure 1).
- An estimated 19.9 million (57.2 percent) of the ambulatory surgery visits occurred in hospitals and 14.9 million (42.8 percent) occurred in freestanding centers (Table 2, Figure 2).
- From 1996 to 2006, the change in the rate of visits to freestanding centers was larger than that for visits to hospital-based ambulatory surgery centers. The rate of visits to freestanding ambulatory surgery centers increased about 300 percent from 1996 to 2006, while the rate in hospital-based centers was flat (Figure 3).
- Females had significantly more ambulatory surgery visits (20.0 million) than males (14.7 million), and a significantly higher rate of visits (132.0 per 1,000 population) compared with males (100.4 per 1,000 population) (Table 2).
- Although the vast majority of ambulatory surgery visits had routine

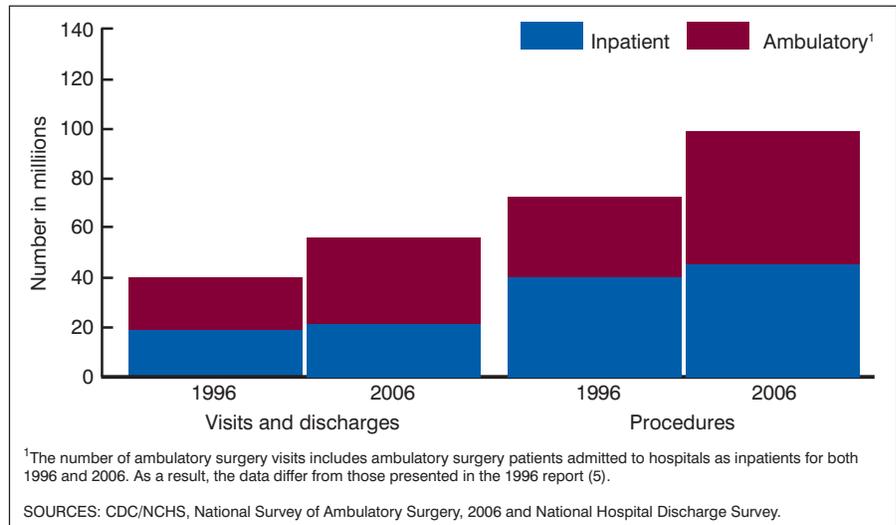


Figure 1. Ambulatory surgery visits and discharges of hospital inpatients with procedures: United States, 1996 and 2006 (revised)

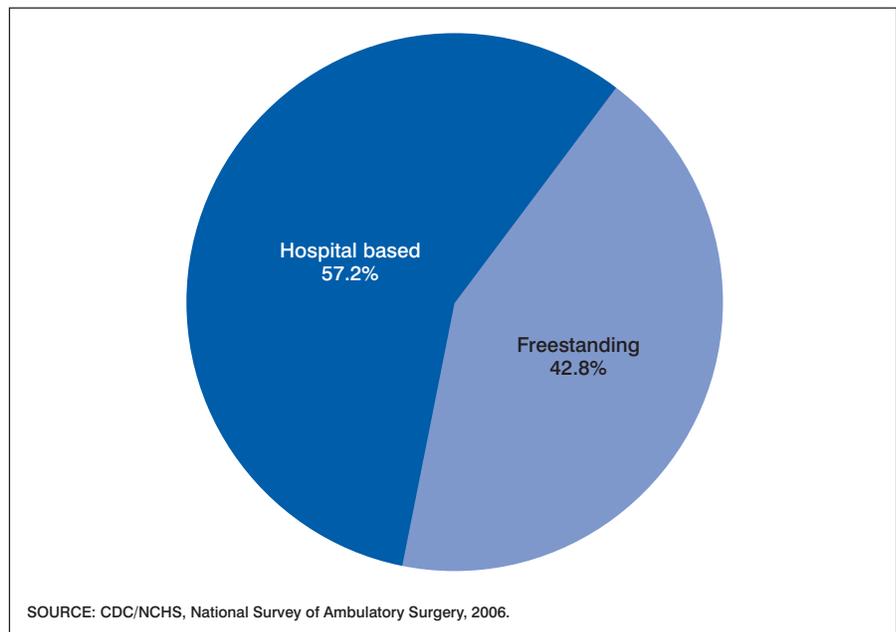
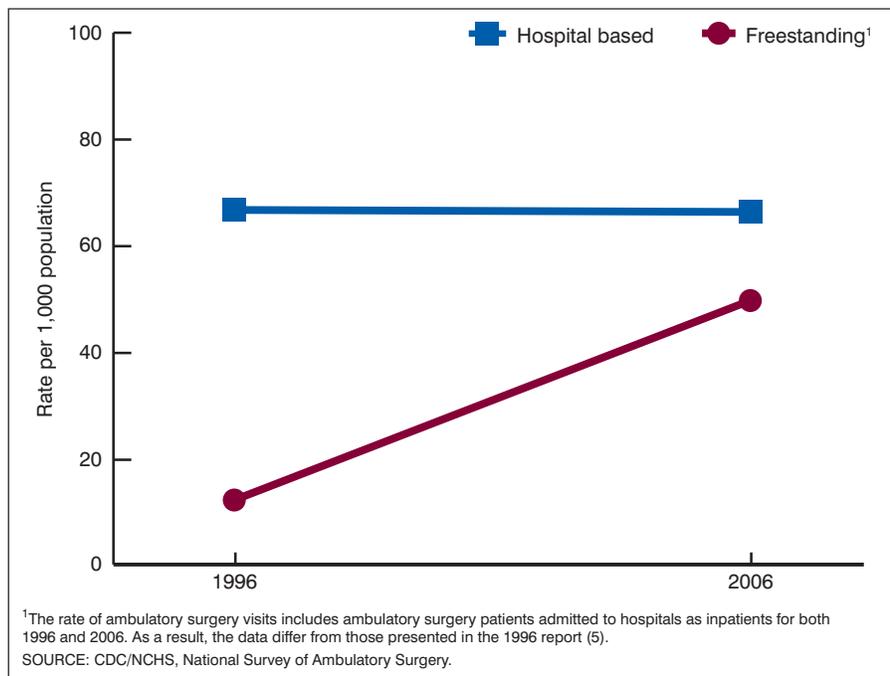


Figure 2. Percent distribution of ambulatory surgery visits by type of facility: United States, 2006

- discharges (93.1 percent), 0.8 percent were admitted as inpatients (Table 3).
- Although general anesthesia alone was provided in 30.7 percent of ambulatory surgery visits, 20.8 percent received anesthesia only intravenously, and 20.8 percent received multiple types of anesthesia (data not shown).

### Surgical times for ambulatory surgery visits

- Total time is defined as the length of time from when the patient enters the operating room to the time he or she leaves postoperative care. Operating room time is the length of time the patient is in the operating room. The surgical time is the portion of the



**Figure 3. Rates of ambulatory surgery visits by facility type: United States, 1996 and 2006**

time spent in the operating room during which the surgical procedure occurs. Typically, the surgical time is the time from when the incision is made until the wound is closed. After the surgical procedure, the patient recovers in the postoperative room before he or she is discharged; the time spent here is considered the post operative room time. Average times for surgical visits were higher for ambulatory surgery visits to hospital-based ambulatory surgery centers than for visits to freestanding ambulatory surgery centers for the amount of time spent in the operating room (61.7 minutes compared with 43.2 minutes), the amount of time spent in surgery (34.2 minutes compared with 25.1 minutes), the amount of time spent in the postoperative recovery room (79.0 minutes compared with 53.1 minutes), and overall time (146.6 minutes compared with 97.7 minutes) (Table 4).

- The average time spent in surgery also varied with the diagnosis. The average surgical time for inguinal hernia diagnoses was more than twice

that for diagnoses of benign neoplasm of the colon (49.4 minutes compared with 21.8 minutes) (Table 5).

### Ambulatory procedures

- Females had significantly more ambulatory surgery procedures (30.6 million) than males (22.7 million) and a significantly higher rate of procedures (2,020.2 per 10,000 population) than males (1,548.1 per 10,000 population) (Tables 6,7). This was driven by differences for females between 15 and 64 years of age (Figure 4).
- Although the majority of visits had only one or two procedures performed (59.8 percent and 27.7 percent, respectively), 1.0 percent had five or more procedures performed (Figure 5).
- Frequently performed procedures on ambulatory patients included endoscopy of large intestine (5.7 million), endoscopy of the small intestine (3.5 million), extraction of lens (3.1 million), injection of agent into spinal canal (2.0 million), and insertion of prosthetic lens (2.6 million) (Table 6).

- Females had higher rates per 10,000 population than males for certain ambulatory procedures, such as extraction (125.5 compared with 78.8) and insertion (105.2 compared with 67.4) of lens and endoscopy of the small (134.7 compared with 97.1) and large (217.8 compared with 166.4) intestine (Table 7).
- Ambulatory procedures often performed on children under 15 years included myringotomy with insertion of tube (667,000), tonsillectomy with or without adenoidectomy (530,000), and adenoidectomy without tonsillectomy (132,000) (Table 6).
- Common ambulatory procedures for persons 15–44 years of age were endoscopy of large intestine (779,000); endoscopy of small intestine (770,000); injection of agent into spinal canal (533,000); injection or infusion of therapeutic or prophylactic substance (429,000); and operations on muscle, tendon, fascia, and bursa (403,000) (Table 6).
- Ambulatory surgery procedures commonly performed on persons 45–64 years of age were endoscopy of large intestine (2.9 million), endoscopy of small intestine (1.4 million), injection of agent into spinal canal (835,000), and operations on muscle, tendon, fascia and bursa (755,000) (Table 6).
- For persons 65–74 years of age, endoscopy of large intestine (1.2 million), extraction of lens (1.1 million), insertion of lens (923,000), endoscopy of small intestine (648,000), and endoscopic polypectomy of the large intestine (424,000) were the most frequent ambulatory procedures (Table 6).
- Common ambulatory procedures for those 75 years of age or over were extraction of lens (1.3 million), insertion of lens (1.1 million), endoscopy of large intestine (778,000), endoscopy of small intestine (550,000), and injection of agent into spinal canal (336,000) (Table 6).

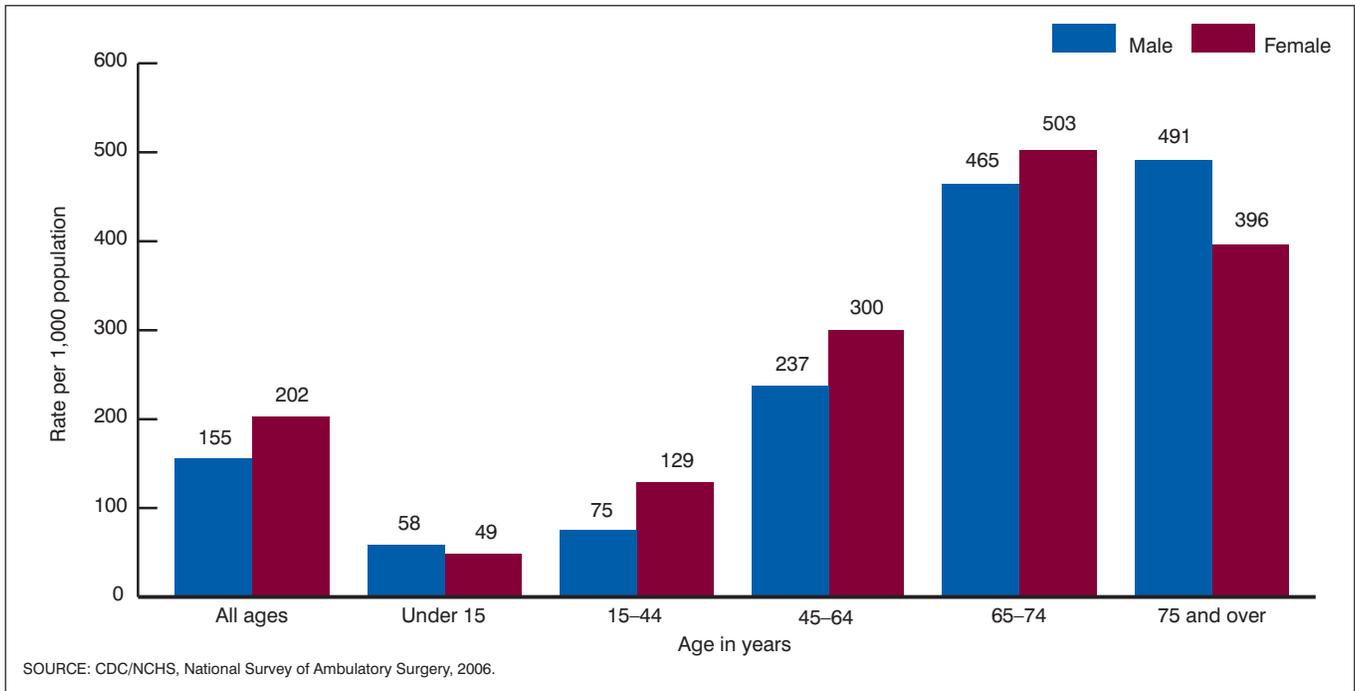


Figure 4. Rate of ambulatory surgery procedures by age and sex: United States, 2006 (revised)

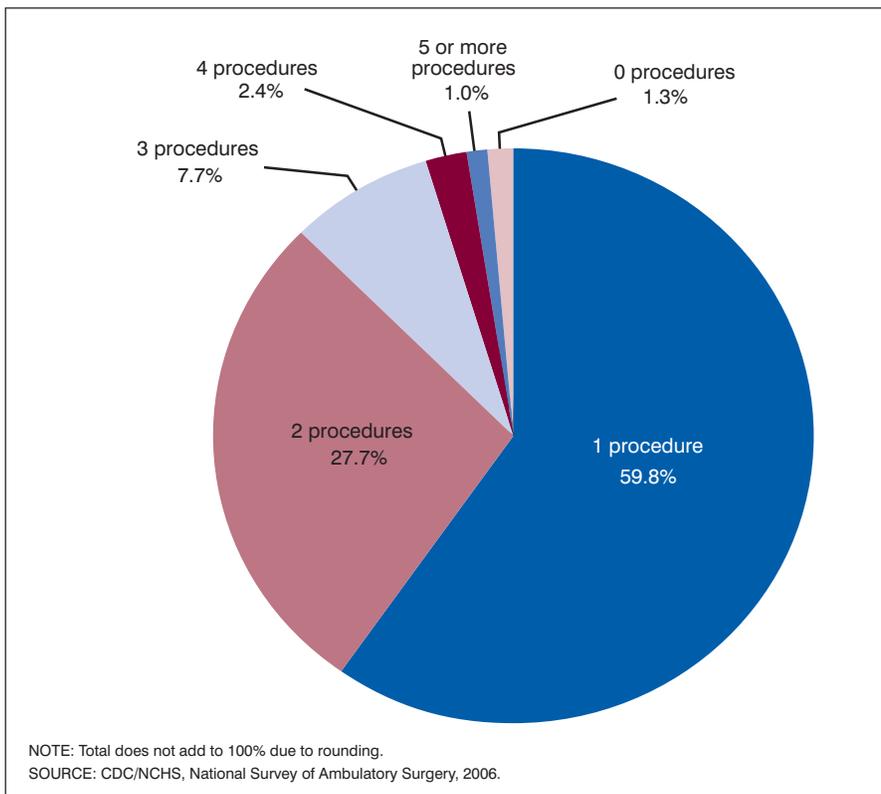


Figure 5. Percent distribution of the number of ambulatory surgery procedures performed per visit: United States, 2006 (revised)

### Diagnoses for ambulatory surgery visits

- The leading diagnoses at ambulatory surgery visits included cataract (3.0 million); benign neoplasms (2.0 million), malignant neoplasms (1.2 million), diseases of the esophagus (1.1 million), and diverticula of the intestine (1.1 million) (Table 8).
- Rates of ambulatory surgery visits per 10,000 population varied by gender. For example, the rate of ambulatory surgery visits was higher for females than for males for first-listed diagnoses of cataract (123.5 compared with 77.5) (Table 9).

### Discussion

**May 2009 revisions of NSAS 2006 data file originally released on October 22, 2008**

#### Identification of a double coding issue with NSAS 2006 data set

The 2006 NSAS public-use data files were released in October 2008. A

researcher contacted NCHS in mid February questioning the fact that the number of myringotomies in the 2006 NSAS was double the number of children under 15 years of age receiving this procedure. In the 1996 NSAS data, there was close to a one-to-one correspondence between these two estimates. The reason for the difference was that in 1996, myringotomy was coded once per record, even if the procedure was performed bilaterally; in 2006, myringotomy was coded twice if performed bilaterally. This inconsistency was unintentional.

Given this inconsistency, the entire 2006 NSAS data set was examined to see if there were other records with multiple identical procedure codes. It was determined that a total of 4,923 records (including myringotomies) of the original 52,233 records in 2006 NSAS had multiple coding (approximately 9%). Double coding was present in only 35 records of 125,000 in the 1996 NSAS.

### Coding guidelines followed for the 2006 NSAS data

The 1994–1996 NSAS procedure coding guidelines were based upon *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) inpatient coding guidelines that were in effect at that time. With the use of these guidelines, multiple coding rarely occurred, even if bilateral or other multiple procedure codes were listed in the record more than one time. Instead of using these ICD–9–CM inpatient coding guidelines, the 2006 NSAS used National Hospital Ambulatory Medical Care Survey (NHAMCS) procedure coding guidelines. Although NHAMCS guidelines were also based on ICD–9–CM codes, they differed in allowing double coding if the following circumstances occurred: if more than one site was specified, if a procedure was bilateral, and if an abstractor recorded a procedure multiple times. In NHAMCS, an editing process removed all double codes that were determined to be inappropriate. However, this step in the editing process was not incorporated

**Table A. A comparison of estimates of procedures from Table 2, by selected characteristics: United States, 2006**

Characteristic	Original NSAS (Number in thousands)	Revised NSAS (Number in thousands)	Revised/original (Percent)	Decrease	Percent decrease
Total procedures . . . . .	57,062	53,329	93.5	3,733	7
Facility type					
Hospital based . . . . .	32,320	30,761	95.2	1,559	5
Freestanding . . . . .	24,742	22,568	91.2	2,174	9
Male					
Hospital based . . . . .	14,051	13,286	94.6	765	5
Freestanding . . . . .	10,277	9,395	91.4	882	9
Female					
Hospital-based . . . . .	18,270	17,475	95.6	795	4
Freestanding . . . . .	14,465	13,173	91.1	1,292	9
Region					
Northeast . . . . .	8,551	8,018	93.8	533	6
Midwest . . . . .	13,583	12,575	92.6	1,008	7
South . . . . .	25,509	24,023	94.2	1,486	6
West . . . . .	9,420	8,713	92.5	707	8
Male					
Northeast . . . . .	3,710	3,486	94.0	224	6
Midwest . . . . .	5,803	5,321	91.7	482	8
South . . . . .	10,755	10,143	94.3	612	6
West . . . . .	4,060	3,730	91.9	330	8
Female					
Northeast . . . . .	4,841	4,532	93.6	309	6
Midwest . . . . .	7,780	7,254	93.2	526	7
South . . . . .	14,754	13,879	94.1	875	6
West . . . . .	5,359	4,983	93.0	376	7
Metropolitan status					
Metropolitan statistical area . . . . .	48,874	45,691	93.5	3,183	7
Nonmetropolitan statistical area . . . . .	8,189	7,638	93.3	551	7
Male					
Metropolitan statistical area . . . . .	20,821	19,399	93.2	1,422	7
Nonmetropolitan statistical area . . . . .	3,507	3,282	93.6	225	6
Female					
Metropolitan statistical area . . . . .	28,053	26,292	93.7	1,761	6
Nonmetropolitan statistical area . . . . .	4,682	4,356	93.0	326	7

NOTES: Table A is a comparison of the January 28, 2009, *National Health Statistics Report*, Number 11, procedure estimates (taken from Table 2) to the revised estimates in this September 4, 2009, revision. NSAS is the National Survey of Ambulatory Surgery.

into the 2006 NSAS data production, thereby creating the double coding issue.

### Revising the NSAS Data Set and How It Affected the Data

To maintain comparability with the 1994–1996 NSAS data, since multiple codes were not included in the 1996 NSAS, all multiple procedure codes were removed from the 2006 NSAS data. As a result, the estimate for the total number of 2006 NSAS procedures fell from 57,062,000 to 53,329,000, a

6.5% decrease. Categories were differentially affected. [Tables A and B](#) show the 2006 NSAS original and the 2006 NSAS revised estimates for some of the major procedure categories included in this and the January 28, 2009, NSAS *National Health Statistics Report*. The tables also include ratios of the revised estimates to the original estimates to show relative changes. As expected, the revised estimates decreased most for bilateral and other multiple site procedures.

**Table B. A comparison of estimates of procedures from Table 6, by selected characteristics: United States, 2006**

Characteristic	Original NSAS (Number in thousands)	Revised NSAS (Number in thousands)	Revised/original (Percent)	Decrease	Percent decrease
Total procedures	57,062	53,329	93.5	3,733	7
<b>Age</b>					
Under 15 years	4,034	3,266	81.0	768	19
15–44 years	13,691	12,780	93.3	911	7
45–64 years	21,369	20,167	94.4	1,202	6
65–74 years	9,622	9,182	95.4	440	5
75 years and over	8,345	7,934	95.1	411	5
<b>Sex</b>					
Male	24,328	22,681	93.2	1,647	7
Female	32,734	30,648	93.6	2,086	6
<b>Procedure category</b>					
Nervous system	4,106	3,198	77.9	908	22
Eye	7,296	7,085	97.1	211	3
Ear	1,723	1,114	64.7	609	35
Nose, mouth, and pharynx	3,179	2,864	90.1	315	10
Respiratory system	448	445	99.3	3	1
Cardiovascular system	1,395	1,376	98.6	19	1
Digestive system	14,677	14,414	98.2	263	2
Urinary system	1,799	1,776	98.7	23	1
Male genital organs	655	631	96.3	24	4
Female genital organs	2,503	2,497	99.8	6	0.2
Musculoskeletal system	8,439	7,944	94.1	495	6
Integumentary system	4,108	3,581	87.2	527	13
Misc diagnostic/therapeutic and new technologies	6,387	6,060	94.9	327	5
Other (includes endocrine system, hemic and lymphatic system, and obstetrical procedures)	346	344	99.4	2	1

NOTES: Table B is a comparison of the January 28, 2009, *National Health Statistics Reports*, Number 11, procedure estimates (taken from Table 6) to the revised estimates in this September 4, 2009, revision. NSAS is the National Survey of Ambulatory Surgery.

**The procedure estimates for the following chapters were most affected by the deletion of multiple codes:**

- Operations on the nervous system decreased 22% largely due to multiple coding of injection of agent into spinal canal.
- Operations on the ear decreased 35% largely due to double coding of myringotomy with insertion of tube.
- Operations on the nose, mouth, and pharynx decreased 10%.
- Operations on the integumentary system decreased 13% largely due to multiple coding of excision or destruction of lesion or tissue of skin and subcutaneous tissue.

Since myringotomies are a common procedure for children, estimates for both myringotomies and for overall

procedures for children decreased a great deal after double coding was eliminated. The children’s estimate decreased by 19% and the myringotomy estimate decreased by 44%.

**Steps taken to improve coding in the future**

A coding manual for the 2009 Ambulatory Surgical Center (ASC) data (now being gathered through NHAMCS) that clarifies the multiple coding issue is being prepared for coding of NHAMCS data. The differences between CPT and ICD–9–CM coding principles are discussed in the new manual along with what to do if the record contains only CPT codes. For the 2009 coding of ASC data, a crosswalk has been developed to generate ICD–9–CM codes from CPT codes. Instructions detailing how to

handle duplicate codes are also included.

When the 2009 NHAMCS data are processed, NCHS will examine all double coding and remove any codes that are found to be inappropriate.

Your suggestions are welcomed on how to handle multiple codes in future ASC data. Please send any suggestions to Nancy Sonnenfeld at [nsonnenfeld@cdc.gov](mailto:nsonnenfeld@cdc.gov).

**Steps data users should take upon receiving the revised data**

All data analyses based on the original NSAS data set should not be used. Instead, the analyses should be rerun using the revised data set. Similarly, any estimates or standard errors taken from the original NSAS *National Health Statistics Reports* (January 28, 2009) should not be used. Instead, these numbers should be obtained from this revised (September 4, 2009) report. Changes in this report are not limited to procedure estimates and standard errors affected by the method of handling multiple codes. Printing errors were also discovered, which affected some of the standard errors for visits and for procedures. These errors have been corrected in this revised report.

**What has changed in the revised NSAS data set**

As was indicated previously in the discussion of the data set revision, the estimates of some procedures (PROC1-PROC6), particularly those that were coded multiple times, have changed. They are lower because duplicates have been deleted. The values for other variables that were derived from the procedure data had to be derived again from the newer data set. The variables affected were NUMPROC (number of procedures per visit), SGFLAG1-SGFLAG6 (flags indicating if the procedures were surgical or nonsurgical), and PD1CLASS-PD6CLASS (the Agency for Health Care Research and Quality’s Procedure Class Tool variables). Because of the changes in certain estimates, standard errors for these estimates may also have changed.

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**Table 1. Characteristics of the 2006 National Survey of Ambulatory Surgery facility respondents and nonrespondents: United States**

Facility characteristic	Number of sampled in-scope facilities	Total percent distribution (weighted)	Responding facility percent distribution (weighted)	Nonresponding facility percent distribution (weighted)	Weighted response rate	Standard error
All facilities . . . . .	587	100.0	100.0	100.0	83.7	2.6
Facility type						
Hospital based . . . . .	189	49.9	51.2	43.1	85.9	3.8
Freestanding . . . . .	398	50.1	48.8	56.9	81.5	3.3
Geographic region						
Northeast . . . . .	90	11.7	12.5	8.2	88.7	4.5
Midwest . . . . .	126	24.1	23.7	25.9	82.5	6.8
South . . . . .	222	40.4	41.8	33.2	86.6	3.6
West . . . . .	149	23.7	22.0	32.8	77.5	5.2
Metropolitan status <sup>1</sup>						
Metropolitan statistical area . . . . .	521	73.1	70.1	88.6	80.3	2.9
Nonmetropolitan statistical area . . . . .	66	26.9	29.9	11.4	93.1	3.7
Growth area <sup>2</sup>						
Below 7.8% growth . . . . .	209	43.3	46.1	29.3	89.0	3.5
Above 7.8% growth . . . . .	378	56.7	53.9	70.7	80.0	3.4
Poverty status of area <sup>2</sup>						
Below 13.1% in poverty . . . . .	337	51.9	52.1	51.3	83.9	3.1
Above 13.1% in poverty . . . . .	250	48.1	47.9	48.7	83.5	4.2
Primary care shortage area <sup>2</sup>						
Nonshortage area . . . . .	99	22.5	24.3	13.7	90.1	5.0
Shortage area . . . . .	488	77.5	75.7	86.3	81.8	3.1

<sup>1</sup>Distribution between respondents and nonrespondents is significantly different ( $p < 0.05$ ).

<sup>2</sup>Based on the Area Resource File value for the county in which the facility is located. Growth is based on the population difference between 2006 and 1996. Poverty is based on the percentage of population below the poverty level. Shortage area includes full or partial shortage area for primary care physicians.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

**Table 2. Number, percent distribution, and rate of ambulatory surgery visits and all-listed procedures, by facility characteristics and sex: United States, 2006**

Characteristic	Both sexes		Male		Female	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
	Number in thousands					
Total visits . . . . .	34,738	1,829	14,707	781	20,032	1,072
Facility type						
Hospital based . . . . .	19,869	880	8,491	395	11,379	518
Freestanding . . . . .	14,869	1,603	6,216	674	8,653	939
Region						
Northeast . . . . .	5,298	645	2,248	273	3,051	385
Midwest . . . . .	8,047	610	3,378	272	4,669	355
South . . . . .	15,931	1,540	6,749	656	9,182	897
West . . . . .	5,462	427	2,331	179	3,130	266
Metropolitan status						
Metropolitan statistical area . . . . .	29,715	1,943	12,566	825	17,149	1,138
Nonmetropolitan statistical area . . . . .	5,024	937	2,140	407	2,883	537
	Percent distribution					
Total visits . . . . .	100.0	...	100.0	...	100.0	...
Facility type						
Hospital based . . . . .	57.2	2.9	57.7	2.9	56.8	2.9
Freestanding . . . . .	42.8	2.9	42.3	2.9	43.2	2.9
Region						
Northeast . . . . .	15.3	1.7	15.3	1.7	15.2	1.8
Midwest . . . . .	23.2	1.8	23.0	1.8	23.3	1.8
South . . . . .	45.9	2.7	45.9	2.8	45.8	2.8
West . . . . .	15.7	1.3	15.9	1.3	15.6	1.4
Metropolitan status						
Metropolitan statistical area . . . . .	85.5	2.7	85.4	2.8	85.6	2.7
Nonmetropolitan statistical area . . . . .	14.5	2.7	14.6	2.8	14.4	2.7
	Rate per 1,000 population <sup>1</sup>					
Total visits . . . . .	116.5	6.1	100.4	5.3	132.0	7.1
Facility type						
Hospital based . . . . .	66.6	3.0	58.0	2.7	75.0	3.4
Freestanding . . . . .	49.9	5.4	42.4	4.6	57.0	6.2
Region						
Northeast . . . . .	96.9	11.8	84.6	10.3	108.5	13.7
Midwest . . . . .	121.7	9.2	103.8	8.3	139.0	10.6
South . . . . .	147.0	14.2	127.3	12.4	165.7	16.2
West . . . . .	79.2	6.2	67.8	5.2	90.5	7.7
Metropolitan status						
Metropolitan statistical area . . . . .	119.3	7.8	102.7	6.7	135.5	9.0
Nonmetropolitan statistical area . . . . .	99.6	18.6	85.3	16.2	113.8	21.2

See footnotes at end of table.

**Table 2. Number, percent distribution, and rate of ambulatory surgery visits and all-listed procedures, by facility characteristics and sex: United States, 2006—Con.**

Characteristic	Both sexes		Male		Female	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
			Number in thousands			
Total procedures . . . . .	53,329	2,654	22,681	1,138	30,648	1,575
Facility type						
Hospital based . . . . .	30,761	1,276	13,286	593	17,475	751
Freestanding . . . . .	22,568	2,328	9,395	971	13,173	1,385
Region						
Northeast . . . . .	8,018	898	3,486	392	4,532	530
Midwest . . . . .	12,575	904	5,321	412	7,254	532
South . . . . .	24,023	2,224	10,143	939	13,879	1,316
West . . . . .	8,713	690	3,730	299	4,983	430
Metropolitan status						
Metropolitan statistical area . . . . .	45,691	2,853	19,399	1,213	26,292	1,686
Nonmetropolitan statistical area . . . . .	7,638	1,387	3,282	613	4,356	791
			Percent distribution			
Total procedures . . . . .	100.0	...	100.0	...	100.0	...
Facility type						
Hospital based . . . . .	57.7	2.7	58.6	2.7	57.0	2.8
Freestanding . . . . .	42.3	2.7	41.4	2.7	43.0	2.8
Region						
Northeast . . . . .	15.0	1.6	15.4	1.6	14.8	1.6
Midwest . . . . .	23.6	1.7	23.5	1.8	23.7	1.8
South . . . . .	45.0	2.6	44.7	2.6	45.3	2.7
West . . . . .	16.3	1.3	16.4	1.4	16.3	1.4
Metropolitan status						
Metropolitan statistical area . . . . .	85.7	2.6	85.5	2.7	85.8	2.6
Nonmetropolitan statistical area . . . . .	14.3	2.6	14.5	2.7	14.2	2.6
			Rate per 1,000 population <sup>1</sup>			
Total procedures . . . . .	178.8	8.9	154.8	7.8	202.0	10.4
Facility type						
Hospital based . . . . .	101.3	4.3	89.4	4.0	112.7	4.9
Freestanding . . . . .	77.5	7.8	65.4	6.6	89.3	9.1
Region						
Northeast . . . . .	146.6	16.4	131.3	14.7	161.1	18.8
Midwest . . . . .	190.2	13.7	163.5	12.7	215.9	15.8
South . . . . .	221.6	20.5	191.3	17.7	250.5	23.8
West . . . . .	126.3	10.0	108.4	8.7	144.0	12.4
Metropolitan status						
Metropolitan statistical area . . . . .	183.5	11.5	158.5	9.9	207.7	13.3
Nonmetropolitan statistical area . . . . .	151.5	27.5	130.8	24.4	172.0	31.2

... Category not applicable.

<sup>1</sup>Rates were calculated using U.S. Census Bureau 2000-based postcensal estimates of the civilian population as of July 1, 2006.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

**Table 3. Number of ambulatory surgery visits by disposition and principal expected source of payment: United States, 2006**

Characteristic	Estimate	Standard error	Percent distribution	Standard error
Number in thousands				
All visits . . . . .	34,738	1,829	100	...
Disposition of patient				
Routine <sup>1</sup> . . . . .	32,356	1,792	93.1	0.9
Observation status . . . . .	401	66	1.2	0.2
Inpatient admission . . . . .	287	43	0.8	0.1
Surgery cancelled . . . . .	79	19	0.2	0.1
Not stated . . . . .	944	174	2.7	0.5
Other . . . . .	*	*	*	*
Principal expected source of payment				
Private insurance . . . . .	18,070	1,045	53.0	1.2
Medicare . . . . .	10,996	660	32.2	0.9
Medicaid . . . . .	2,204	189	6.5	0.5
Workers compensation . . . . .	627	101	1.8	0.3
Other government insurance . . . . .	309	63	0.9	0.2
Self pay . . . . .	1,131	185	3.3	0.5
Other . . . . .	783	170	2.3	0.5

... Category not applicable.

\* Figure does not meet standards of reliability or precision.

<sup>1</sup>Patients with routine disposition were those who were discharged to their normal place of residence, i.e., home, nursing home, or prison.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

**Table 4. Distribution of times for surgical visits by ambulatory surgery facility type: United States, 2006**

Calculated time in minutes	Mean	Standard error	25th percentile	Median	75th percentile
Total					
Total <sup>1</sup> . . . . .	124.5	3.6	65	100	153
Operating room <sup>2</sup> . . . . .	53.7	1.4	25	40	65
Surgical <sup>3</sup> . . . . .	30.3	0.8	11	20	36
Postoperative room <sup>4</sup> . . . . .	66.9	2.0	32	51	81
Hospital based					
Total <sup>1</sup> . . . . .	146.6	5.3	84	120	177
Operating room <sup>2</sup> . . . . .	61.7	1.6	33	50	75
Surgical <sup>3</sup> . . . . .	34.2	0.9	13	24	43
Postoperative room <sup>4</sup> . . . . .	79.0	3.2	25	39	60
Freestanding					
Total <sup>1</sup> . . . . .	97.7	3.8	53	76	120
Operating room <sup>2</sup> . . . . .	43.2	2.0	20	30	50
Surgical <sup>3</sup> . . . . .	25.1	1.4	9	15	27
Postoperative room <sup>4</sup> . . . . .	53.1	2.3	29	43	66

<sup>1</sup>Total time was calculated by subtracting the time when the patient entered the operating room from the time the patient left postoperative care.

<sup>2</sup>Operating room time was calculated by subtracting the time when the patient entered the operating room from the time the patient left the operating room.

<sup>3</sup>Surgical time was calculated by subtracting the time the surgery began from the time the surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.

<sup>4</sup>Postoperative room time was calculated by subtracting the time when the patient entered postoperative care from the time the patient left postoperative care.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

**Table 5. Average surgical duration by selected diagnoses and ambulatory surgery facility type: United States, 2006**

Selected diagnoses and ICD–9–CM codes	Average total time (in minutes) <sup>1</sup>	Standard error	Average surgical time (in minutes) <sup>2</sup>	Standard error
Total				
Cataract . . . . .366	70.2	2.7	18.1	0.7
Benign neoplasm of the colon . . . . .211.3	90.3	4.1	21.8	0.7
Diverticula of the intestine . . . . .562	79.5	4.2	16.9	0.7
Intervertebral disc disorders . . . . .722	82.9	7.2	21.1	3.0
Hemorrhoids . . . . .455	86.7	4.0	18.2	0.9
Gastritis and duodenitis . . . . .535	91.0	6.5	14.2	1.3
Chronic diseases of tonsils and adenoids . . . . .474	155.2	7.9	22.5	1.0
Otitis media and Eustachian tube disorders . . . . .381–382	65.7	5.1	12.3	1.0
Carpal tunnel syndrome . . . . .354.0	96.0	3.6	18.2	0.9
Inguinal hernia . . . . .550	169.0	6.4	49.4	1.6
Hospital based				
Cataract . . . . .366	88.4	3.7	22.7	1.5
Benign neoplasm of the colon . . . . .211.3	111.5	7.5	24.6	1.4
Diverticula of the intestine . . . . .562	102.7	5.0	19.0	1.7
Intervertebral disc disorders . . . . .722	107.4	14.8	29.9	5.4
Hemorrhoids . . . . .455	112.0	6.6	20.7	1.3
Gastritis and duodenitis . . . . .535	111.4	7.8	17.9	1.7
Chronic diseases of tonsils and adenoids . . . . .474	161.6	11.0	23.4	1.5
Otitis media and Eustachian tube disorders . . . . .381–382	75.0	4.9	13.5	1.4
Carpal tunnel syndrome . . . . .354.0	111.2	5.6	19.1	1.1
Inguinal hernia . . . . .550	177.2	7.2	52.0	1.8
Freestanding				
Cataract . . . . .366	57.3	2.4	14.9	0.5
Benign neoplasm of the colon . . . . .211.3	77.9	3.0	20.0	0.7
Diverticula of the intestine . . . . .562	68.3	4.0	15.9	0.7
Intervertebral disc disorders . . . . .722	61.4	5.3	12.8	2.2
Hemorrhoids . . . . .455	75.1	4.0	16.9	1.3
Gastritis and duodenitis . . . . .535	68.9	6.6	10.0	1.0
Chronic diseases of tonsils and adenoids . . . . .474	148.9	10.2	20.6	0.9
Otitis media and Eustachian tube disorders . . . . .381–382	56.8	5.8	10.2	0.6
Carpal tunnel syndrome . . . . .354.0	83.8	3.2	17.1	1.3
Inguinal hernia . . . . .550	145.8	7.7	40.1	2.3

<sup>1</sup>Total time was calculated by subtracting the time when the patient entered the operating room from the time the patient left postoperative care.

<sup>2</sup>Surgical time was calculated by subtracting the time the surgery began from the time the surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 6. Number of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006

Procedure category and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
				Number in thousands				
All procedures . . . . .	53,329	22,681	30,648	3,266	12,780	20,167	9,182	7,934
Operations on the nervous system. . . . .01-05	3,198	1,272	1,926	*	888	1,385	427	484
Injection of agent into spinal canal . . . . .03.91-03.92	1,991	844	1,147	*	533	835	286	336
Release of carpal tunnel . . . . .04.43	577	179	398	*	143	279	73	81
Operations on the eye . . . . .08-16	7,085	2,803	4,283	103	266	1,651	2,289	2,775
Operations on eyelids . . . . .08	386	137	249	*29	39	156	75	87
Extraction of lens. . . . .13.1-13.6	3,058	1,154	1,904	*	38	610	1,070	1,335
Insertion of prosthetic lens (pseudophakos) . . . . .13.7	2,582	987	1,595	*	33	524	923	1,098
Operations on the ear . . . . .18-20	1,114	568	545	858	118	59	*38	41
Myringotomy with insertion of tube. . . . .20.01	715	382	333	667	*32	*	*	*
Operations on the nose, mouth, and pharynx . . . . .21-29	2,864	1,441	1,423	1,050	937	617	162	97
Incision, excision, and destruction of nose . . . . .21.1,21.3-21.4,21.6	293	142	151	*	144	77	*34	*18
Turbinectomy . . . . .21.6	196	100	96	*	110	54	*	*
Repair and plastic operations on the nose . . . . .21.8	308	160	147	*	153	100	*27	*
Operations on nasal sinuses . . . . .22	606	328	278	*	222	276	*	*
Tonsillectomy with or without adenoidectomy. . . . .28.2-28.3	737	314	423	530	186	*	*	-
Adenoidectomy without tonsillectomy . . . . .28.6	140	83	57	132	*	*	-	-
Operations on the respiratory system . . . . .30-34	445	225	220	*34	70	176	88	*77
Bronchoscopy with or without biopsy . . . . .33.21-33.24,33.27	173	71	102	*	*	*67	*43	*
Operations on the cardiovascular system . . . . .35-39,00.50-00.51,00.53-00.55,00.61-00.66	1,376	712	664	*	165	605	284	312
Cardiac catheterization. . . . .37.21-37.23	492	280	212	*	*41	238	123	88
Operations on the digestive system . . . . .42-54	14,414	6,500	7,914	*	2,824	6,448	2,925	1,956
Dilation of esophagus. . . . .42.92	341	140	201	*	*37	152	83	66
Endoscopy of small intestine with or without biopsy . . . . .45.11-45.14,45.16	3,467	1,423	2,044	*	770	1,390	648	550
Endoscopy of large intestine with or without biopsy . . . . .45.21-45.25	5,741	2,438	3,304	*	779	2,921	1,233	778
Endoscopic polypectomy of large intestine . . . . .45.42	1,399	788	611	*	69	701	424	207
Laparoscopic cholecystectomy . . . . .51.23	503	87	416	*	229	193	*	*
Hernia repair. . . . .53.0-53.1,53.2-53.9	920	724	196	73	298	331	133	84
Repair of inguinal hernia. . . . .53.0-53.1	526	482	*45	39	139	186	88	74
Operations on the urinary system . . . . .55-59	1,776	932	844	*	375	624	369	356
Cystoscopy with or without biopsy. . . . .57.31-57.33	751	406	345	*	147	271	157	169
Operations on the male genital organs . . . . .60-64	631	631	...	166	146	143	109	67
Operations on the female genital organs . . . . .65-71	2,497	...	2,497	*	1,633	689	109	*60
Hysteroscopy . . . . .68.12	313	...	313	-	159	121	*	*
Dilation and curettage of uterus . . . . .69.0	611	...	611	-	334	227	*29	*
Operations on the musculoskeletal system . . . . .76-84,00.70-00.73,00.80-00.84	7,944	3,856	4,088	295	2,602	3,696	871	479
Partial excision of bone . . . . .76.2-76.3,77.6-77.8	449	231	218	*	121	228	57	*31
Reduction of fracture . . . . .76.7,79.0-79.3	495	310	185	102	213	115	*35	*29
Injection of therapeutic substance into joint or ligament . . . . .76.96,81.92	218	87	131	*	45	112	32	*26
Removal of implanted devices from bone . . . . .76.97,78.6	212	108	104	27	85	58	*	*
Excision and repair of bunion and other toe deformities . . . . .77.5	461	68	394	*	115	226	83	*30
Arthroscopy of knee. . . . .80.26	956	502	455	*	358	448	103	*32
Excision of semilunar cartilage of knee. . . . .80.6	690	384	307	*	204	352	90	*42
Replacement or other repair of knee . . . . .81.42-81.47,81.54-81.55,00.80-00.84	463	260	203	*	216	190	*35	*
Operations on muscle, tendon, fascia, and bursa . . . . .82-83	1,465	642	823	55	403	755	165	88

See footnotes at end of table.

**Table 6. Number of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006—Con.**

Procedure category and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
Number in thousands								
Operations on the integumentary system . . . . .85-86	3,581	1,045	2,535	166	1,223	1,415	435	341
Biopsy of breast . . . . .85.11-85.12	261	*	250	*	79	130	*28	*
Local excision of lesion of breast (lumpectomy) . . . . .85.21	329	*	317	*	110	133	*52	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue . . . . .86.2-86.4	1,092	542	550	100	332	395	139	127
Miscellaneous diagnostic and therapeutic procedures and new technologies <sup>1</sup> . . . . .87-99.00	6,060	2,617	3,442	242	1,456	2,517	999	846
Arteriography and angiocardiology using contrast material . . . . .88.4-88.5	1,054	561	492	-	*74	471	297	213
Diagnostic ultrasound . . . . .88.7,00.21-00.25,00.28,00.29	322	159	162	*	53	147	70	50
Injection or infusion of therapeutic or prophylactic substance . . . . .99.1-99.2	1,462	529	933	35	429	599	202	196
Operations on the endocrine system, operations on the hemic and lymphatic system, and obstetrical procedures . . . . .06-07,40-41,72-75	344	78	266	*	77	140	*78	*41

\* Figure does not meet standards of reliability or precision.

. . . Category not applicable.

- Quantity zero.

<sup>1</sup>Chapter 00 codes included in this category: 00.01-00.03, 00.09, 00.10-00.18, 00.21-00.25, 00.28-00.29, 00.31-00.35, 00.39, 00.40-00.43, 00.45-00.48, 00.52, 00.74-00.76, and 00.91-00.93.

NOTES: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). The standard error (SE) of an estimate can be obtained by multiplying the estimate by the corresponding relative standard error (RSE). The RSE can be obtained by dividing the SE of the rate by the rate in Table 7.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 7. Rate and standard error for the rate of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006

Procedure category and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
				Rate per 10,000 population <sup>1</sup>				
All procedures . . . . .	1,788.3	1,548.1	2,020.2	537.5	1,019.2	2,695.9	4,854.0	4,325.3
Operations on the nervous system. . . . .01-05	107.2	86.9	126.9	*	70.8	185.2	225.7	263.8
Injection of agent into spinal canal . . . . .03.91-03.92	66.8	57.6	75.6	*	42.5	111.6	151.3	183.4
Release of carpal tunnel . . . . .04.43	19.3	12.2	26.2	*	11.4	37.3	38.7	44.2
Operations on the eye . . . . .08-16	237.6	191.3	282.3	17.0	21.2	220.8	1,210.0	1,513.0
Operations on eyelids . . . . .08	12.9	9.4	16.4	*4.7	3.1	20.9	39.6	47.5
Extraction of lens. . . . .13.1-13.6	102.5	78.8	125.5	*	3.0	81.6	565.7	727.6
Insertion of prosthetic lens (pseudophakos) . . . . .13.7	86.6	67.4	105.2	*	2.6	70.1	488.2	598.7
Operations on the ear . . . . .18-20	37.3	38.8	35.9	141.2	9.4	7.9	*20.2	22.3
Myringotomy with insertion of tube. . . . .20.01	24.0	26.1	21.9	109.7	*2.6	*	*	*
Operations on the nose, mouth, and pharynx . . . . .21-29	96.0	98.3	93.8	172.9	74.7	82.5	85.8	53.1
Incision, excision, and destruction of nose . . . . .21.1,21.3-21.4,21.6	9.8	9.7	9.9	*	11.5	10.3	*18.1	*9.6
Turbinectomy . . . . .21.6	6.6	6.8	6.4	*	8.8	7.2	*	*
Repair and plastic operations on the nose . . . . .21.8	10.3	11.0	9.7	*	12.2	13.3	*14.4	*
Operations on nasal sinuses . . . . .22	20.3	22.4	18.3	*	17.7	36.9	*	*
Tonsillectomy with or without adenoidectomy. . . . .28.2-28.3	24.7	21.4	27.9	87.2	14.9	*	*	-
Adenoidectomy without tonsillectomy . . . . .28.6	4.7	5.6	3.8	21.8	*	*	-	-
Operations on the respiratory system . . . . .30-34	14.9	15.4	14.5	*5.6	5.6	23.6	46.3	*42.1
Bronchoscopy with or without biopsy . . . . .33.21-33.24,33.27	5.8	4.8	6.8	*	*	*9.0	*22.7	*
Operations on the cardiovascular system . . . . .35-39,00.50-00.51,00.53-00.55,00.61-00.66	46.1	48.6	43.8	*	13.2	80.9	150.0	169.9
Cardiac catheterization. . . . .37.21-37.23	16.5	19.1	14.0	*	*3.2	31.9	65.0	48.0
Operations on the digestive system . . . . .42-54	483.3	443.7	521.7	*	225.2	861.9	1,546.3	1,066.2
Dilation of esophagus. . . . .42.92	11.4	9.6	13.2	*	*3.0	20.4	43.7	35.8
Endoscopy of small intestine with or without biopsy . . . . .45.11-45.14,45.16	116.3	97.1	134.7	*	61.4	185.9	342.6	299.6
Endoscopy of large intestine with or without biopsy . . . . .45.21-45.25	192.5	166.4	217.8	*	62.1	390.4	651.6	424.3
Endoscopic polypectomy of large intestine . . . . .45.42	46.9	53.8	40.3	*	5.5	93.7	223.9	112.6
Laparoscopic cholecystectomy . . . . .51.23	16.9	5.9	27.4	*	18.2	25.9	*	*
Hernia repair. . . . .53.0-53.1,53.2-53.9	30.9	49.4	12.9	11.9	23.8	44.3	70.6	46.0
Repair of inguinal hernia. . . . .53.0-53.1	17.7	32.9	*2.9	6.5	11.1	24.9	46.6	40.2
Operations on the urinary system . . . . .55-59	59.6	63.6	55.7	*	29.9	83.5	195.3	194.1
Cystoscopy with or without biopsy. . . . .57.31-57.33	25.2	27.7	22.7	*	11.7	36.2	83.1	92.2
Operations on the male genital organs . . . . .60-64	21.2	43.1	...	27.4	11.6	19.2	57.4	36.7
Operations on the female genital organs . . . . .65-71	83.7	...	164.6	*	130.2	92.1	57.4	*32.7
Hysteroscopy . . . . .68.12	10.5	...	20.7	-	12.7	16.2	*	*
Dilation and curettage of uterus . . . . .69.0	20.5	...	40.2	-	26.7	30.3	*15.4	*
Operations on the musculoskeletal system . . . . .76-84,00.70-00.73,00.80-00.84	266.4	263.2	269.5	48.6	207.5	494.1	460.5	261.3
Partial excision of bone . . . . .76.2-76.3,77.6-77.8	15.1	15.8	14.4	*	9.6	30.5	29.9	*17.0
Reduction of fracture . . . . .76.7,79.0-79.3	16.6	21.2	12.2	16.8	17.0	15.4	*18.5	*16.0
Injection of therapeutic substance into joint or ligament . . . . .76.96,81.92	7.3	5.9	8.6	*	3.6	14.9	16.9	*14.2
Removal of implanted devices from bone . . . . .76.97,78.6	7.1	7.3	6.9	4.4	6.8	7.7	*	*
Excision and repair of bunion and other toe deformities . . . . .77.5	15.5	4.6	26.0	*	9.1	30.3	44.1	*16.5
Arthroscopy of knee. . . . .80.26	32.1	34.2	30.0	*	28.5	59.9	54.3	*17.7
Excision of semilunar cartilage of knee. . . . .80.6	23.1	26.2	20.2	*	16.3	47.1	47.8	*22.8
Replacement or other repair of knee . . . . .81.42-81.47,81.54-81.55,00.80-00.84	15.5	17.7	13.4	*	17.2	25.4	*18.6	*
Operations on muscle, tendon, fascia, and bursa . . . . .82-83	49.1	43.8	54.2	9.0	32.1	100.9	87.3	47.8

See footnotes at end of table.

**Table 7. Rate and standard error for the rate of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006—Con.**

Procedure category and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
				Rate per 10,000 population <sup>1</sup>				
Operations on the integumentary system . . . . .85-86	120.1	71.3	167.1	27.3	97.5	189.2	229.9	186.1
Biopsy of breast . . . . .85.11-85.12	8.8	*	16.5	*	6.3	17.4	*14.7	*
Local excision of lesion of breast (lumpectomy) . . . . .85.21	11.0	*	20.9	*	8.8	17.8	*27.4	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue . . . . .86.2-86.4	36.6	37.0	36.3	16.4	26.5	52.8	73.4	69.2
Miscellaneous diagnostic and therapeutic procedures and new technologies <sup>2</sup> . . . . .87-99.00	203.2	178.6	226.9	39.8	116.1	336.4	528.1	461.4
Arteriography and angiocardiology using contrast material . . . . .88.4-88.5	35.3	38.3	32.5	-	*5.9	62.9	156.8	116.0
Diagnostic ultrasound . . . . .88.7,00.21-00.25,00.28,00.29	10.8	10.9	10.7	*	4.2	19.7	36.8	27.5
Injection or infusion of therapeutic or prophylactic substance . . . . .99.1-99.2	49.0	36.1	61.5	5.7	34.2	80.1	107.0	107.0
Operations on the endocrine system, operations on the hemic and lymphatic system, and obstetrical procedures . . . . .06-07,40-41,72-75	11.5	5.3	17.5	*	6.1	18.7	*41.2	*22.5
				Standard error				
All procedures . . . . .	89.00	77.65	103.83	72.44	57.38	148.54	286.03	231.38
Operations on the nervous system . . . . .01-05	11.32	10.57	12.94	*	9.57	19.50	27.43	37.71
Injection of agent into spinal canal . . . . .03.91-03.92	8.97	8.72	10.01	*	7.31	15.38	23.29	29.95
Release of carpal tunnel . . . . .04.43	2.07	1.55	2.99	*	1.95	5.05	6.50	9.35
Operations on the eye . . . . .08-16	21.50	16.25	27.63	3.06	3.11	21.09	142.35	134.99
Operations on eyelids . . . . .08	1.36	1.33	1.95	*1.30	0.58	3.23	6.31	8.37
Extraction of lens . . . . .13.1-13.6	10.02	7.09	13.29	*	0.54	9.41	67.74	67.42
Insertion of prosthetic lens (pseudophakos) . . . . .13.7	9.02	6.28	12.08	*	0.49	8.58	63.85	57.88
Operations on the ear . . . . .18-20	6.87	6.09	8.04	30.27	1.87	1.43	*5.08	6.62
Myringotomy with insertion of tube . . . . .20.01	5.20	5.28	5.41	25.32	*0.73	*	*	*
Operations on the nose, mouth, and pharynx . . . . .21-29	10.76	10.54	12.78	25.76	8.67	12.86	16.80	10.80
Incision, excision, and destruction of nose . . . . .21.1,21.3-21.4,21.6	1.28	1.34	1.83	*	2.14	1.63	*4.72	*2.33
Turbinectomy . . . . .21.6	0.95	1.14	1.23	*	1.45	1.35	*	*
Repair and plastic operations on the nose . . . . .21.8	1.17	1.58	1.24	*	1.66	2.12	*3.82	*
Operations on nasal sinuses . . . . .22	3.27	3.64	4.08	*	3.36	9.02	*	*
Tonsillectomy with or without adenoidectomy . . . . .28.2-28.3	4.15	3.52	5.17	16.93	2.15	*	*	-
Adenoidectomy without tonsillectomy . . . . .28.6	0.99	1.41	0.86	4.79	*	*	-	-
Operations on the respiratory system . . . . .30-34	1.98	2.17	2.48	*1.45	1.31	4.51	9.96	*8.10
Bronchoscopy with or without biopsy . . . . .33.21-33.24,33.27	0.97	0.78	1.63	*	*	*2.32	*6.07	*
Operations on the cardiovascular system . . . . .35-39,00.50-00.51,00.53-00.55,00.61-00.66	5.69	6.51	5.44	*	2.05	11.89	23.17	24.91
Cardiac catheterization . . . . .37.21-37.23	2.51	3.07	2.24	*	*0.84	5.78	12.17	11.18
Operations on the digestive system . . . . .42-54	41.17	39.15	44.18	*	20.69	77.38	158.44	94.26
Dilation of esophagus . . . . .42.92	1.63	1.55	2.14	*	*0.80	3.45	9.02	7.33
Endoscopy of small intestine with or without biopsy . . . . .45.11-45.14,45.16	10.46	9.45	12.04	*	7.33	18.77	32.51	29.46
Endoscopy of large intestine with or without biopsy . . . . .45.21-45.25	21.68	19.32	24.41	*	10.15	43.49	87.41	46.99
Endoscopic polypectomy of large intestine . . . . .45.42	5.76	6.72	5.30	*	1.25	11.00	36.55	14.02
Laparoscopic cholecystectomy . . . . .51.23	1.51	0.84	2.79	*	2.25	2.98	*	*
Hernia repair . . . . .53.0-53.1,53.2-53.9	2.42	4.22	1.29	2.58	2.20	4.99	10.61	7.07
Repair of inguinal hernia . . . . .53.0-53.1	1.48	2.87	*0.56	1.17	1.39	2.93	8.53	6.97
Operations on the urinary system . . . . .55-59	4.82	5.39	5.38	*	3.99	9.10	24.40	20.98
Cystoscopy with or without biopsy . . . . .57.31-57.33	2.95	3.40	3.05	*	2.29	4.82	12.46	12.97
Operations on the male genital organs . . . . .60-64	1.87	3.81	...	5.07	1.35	3.06	8.85	6.77
Operations on the female genital organs . . . . .65-71	7.20	...	14.15	*	11.67	9.85	11.27	*8.52
Hysteroscopy . . . . .68.12	1.60	...	3.14	-	2.37	2.54	*	*
Dilation and curettage of uterus . . . . .69.0	2.17	...	4.27	-	3.07	4.00	*3.48	*

See footnotes at end of table.

**Table 7. Rate and standard error for the rate of ambulatory surgery procedures, by procedure category, sex, and age: United States, 2006—Con.**

Procedure category and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
				Standard error				
Operations on the musculoskeletal system . . . . .76-84,00.70-00.73,00.80-00.84	19.47	21.20	20.32	5.85	19.10	38.44	48.77	24.82
Partial excision of bone . . . . .76.2-76.3,77.6-77.8	1.45	1.92	1.59	*	1.33	3.98	5.48	*3.78
Reduction of fracture . . . . .76.7,79.0-79.3	1.68	2.44	1.37	2.21	2.28	2.67	*4.88	*3.33
Injection of therapeutic substance into joint or ligament . . . . .76.96,81.92	0.87	1.00	1.16	*	0.78	2.26	3.20	*3.27
Removal of implanted devices from bone . . . . .76.97,78.6	0.94	1.29	1.01	1.20	1.27	1.17	*	*
Excision and repair of bunion and other toe deformities . . . . .77.5	1.79	0.84	3.30	*	1.69	4.23	8.82	*4.01
Arthroscopy of knee . . . . .80.26	3.72	4.43	3.69	*	3.98	7.18	9.35	*4.45
Excision of semilunar cartilage of knee . . . . .80.6	1.99	2.86	1.80	*	1.88	4.51	6.94	*4.92
Replacement or other repair of knee . . . . .81.42-81.47,81.54-81.55,00.80-00.84	1.97	2.81	1.64	*	2.86	3.28	*3.95	*
Operations on muscle, tendon, fascia, and bursa . . . . .82-83	5.22	3.37	8.29	1.75	4.43	12.84	13.25	7.76
Operations on the integumentary system . . . . .85-86	8.53	6.42	13.24	3.92	9.50	14.66	20.62	19.98
Biopsy of breast . . . . .85.11-85.12	1.26	*	2.43	*	1.23	2.93	*3.56	*
Local excision of lesion of breast (lumpectomy) . . . . .85.21	1.17	*	2.29	*	1.45	2.22	*6.37	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue . . . . .86.2-86.4	3.20	3.92	3.33	2.57	3.24	5.25	13.11	10.15
Miscellaneous diagnostic and therapeutic procedures and new technologies <sup>2</sup> . . . . .87-99.00	16.60	15.67	19.36	5.56	14.75	30.74	48.83	47.14
Arteriography and angiocardiology using contrast material . . . . .88.4-88.5	5.40	6.50	4.91	-	*1.61	10.60	27.50	25.38
Diagnostic ultrasound . . . . .88.7,00.21-00.25,00.28,00.29	1.76	1.79	2.12	*	0.95	3.86	8.70	6.49
Injection or infusion of therapeutic or prophylactic substance . . . . .99.1-99.2	7.20	4.86	10.46	1.09	7.30	13.78	16.48	13.21
Operations on the endocrine system, operations on the hemic and lymphatic system, and obstetrical procedures . . . . .06-07,40-41,72-75	1.16	0.77	1.98	*	1.07	2.53	*7.97	*5.08

\* Figure does not meet standards of reliability or precision.

- Quantity zero.

. . . Category not applicable.

<sup>1</sup>Rates were calculated using U.S. Census Bureau 2000-based postcensal estimates of the civilian population as of July 1, 2006.

<sup>2</sup>Chapter 00 codes included in this category: 00.01-00.03, 00.09, 00.10-00.18, 00.21-00.25, 00.28-00.29, 00.31-00.35, 00.39, 00.40-00.43, 00.45-00.48, 00.52, 00.74-00.76, 00.91-00.93.

NOTES: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). The relative standard error (RSE) can be obtained by dividing the standard error (SE) of the rate by the rate. The SE of a number in Table 6 can be obtained by multiplying the RSE by the estimate.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

Table 8. Number of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006

Category of first-listed diagnosis and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
				Number in thousands				
All conditions . . . . .	34,738	14,707	20,032	2,471	8,351	12,948	5,887	5,081
Infectious and parasitic diseases . . . . .001-139	145	64	81	*	*	*42	*	*
Neoplasms . . . . .140-239	3,285	1,626	1,659	69	381	1,474	772	589
Malignant neoplasms . . . . .140-208,230-234	1,173	534	639	*	117	446	285	314
Malignant neoplasm of skin . . . . .172-173,176.0,198.2	303	164	139	*	34	87	59	123
Malignant neoplasm of breast . . . . .174-175,198.81	235	*	234	-	*35	121	*52	*
Benign neoplasms . . . . .210-229	2,000	1,039	961	53	241	985	468	253
Benign neoplasm of colon . . . . .211.3	1,389	785	604	-	90	730	380	189
Lipoma . . . . .214	126	61	64	*	*23	76	*	*
Endocrine, nutritional and metabolic diseases, and immunity disorders . . . . .240-279	266	74	192	*	91	103	*34	*
Diseases of the nervous system and sense organs . . . . .320-389	5,308	2,114	3,194	729	412	1,243	1,317	1,607
Carpal tunnel syndrome . . . . .354.0	552	171	381	-	138	263	66	86
Cataract . . . . .366	3,009	1,135	1,874	*	34	592	1,066	1,313
Disorders of the eyelid . . . . .373-374	174	71	103	*	*12	58	45	48
Otitis media and Eustachian tube disorders . . . . .381-382	623	324	299	577	*	*	*	*
Diseases of the circulatory system . . . . .390-459	1,736	832	904	*	256	860	353	264
Heart disease . . . . .391-392.0,393-398,402,404,410-416,420-429	540	318	222	*	*41	241	131	128
Hemorrhoids . . . . .455	715	287	427	*	151	411	108	*45
Diseases of the respiratory system . . . . .460-519	1,294	591	703	572	396	207	81	*38
Deviated nasal septum . . . . .470	134	77	57	*	75	42	*	*
Chronic sinusitis . . . . .473	141	82	59	*	52	56	*	*
Chronic disease of tonsils and adenoids . . . . .474	680	273	407	496	172	*	-	-
Diseases of the digestive system . . . . .520-579	6,808	3,081	3,727	326	1,597	2,688	1,242	955
Diseases of teeth and supporting structures . . . . .520-525	221	114	107	171	*	*	*	*
Diseases of esophagus . . . . .530	1,132	531	601	*	255	447	224	177
Gastritis and duodenitis . . . . .535	703	228	475	*	170	257	146	118
Hernia . . . . .550-553	1,141	764	377	64	335	418	174	149
Inguinal hernia . . . . .550	515	470	*45	33	131	189	91	71
Noninfectious enteritis and colitis . . . . .555-558	228	102	126	*	81	87	*34	*
Diverticula of intestine . . . . .562	1,135	513	622	*	*59	522	306	248
Cholelithiasis . . . . .574	376	*64	312	*	178	130	*	*
Diseases of the genitourinary system . . . . .580-629	2,932	847	2,085	115	1,143	1,050	358	267
Calculus of kidney and ureter . . . . .592	381	178	204	*	144	165	*40	*31
Benign mammary dysplasias . . . . .610	94	-	94	-	*35	*45	*	*
Lump or mass in breast . . . . .611.72	198	*	191	*	83	85	*	*
Disorders of menstruation and other abnormal vaginal bleeding . . . . .626,627.0-627.1	481	...	481	-	250	201	*	*
Complications of pregnancy, childbirth, and the puerperium . . . . .630-677	322	...	322	-	315	*	-	-
Abortion and ectopic and molar pregnancy . . . . .630-639	260	...	260	-	253	*	-	-
Diseases of the skin and subcutaneous tissue . . . . .680-709	631	292	339	56	224	233	*	49
Sebaceous cyst . . . . .706.2	134	69	65	*	*44	53	*	*
Diseases of the musculoskeletal system and connective tissue . . . . .710-739	4,523	1,875	2,648	67	1,336	2,035	599	486
Arthropathies and related disorders . . . . .710-719	809	378	431	*	276	378	89	52
Internal derangement of knee . . . . .717	321	177	144	*	116	150	*33	*
Intervertebral disc disorders . . . . .722	861	404	456	-	312	389	93	67
Lumbago . . . . .724.2	156	64	91	-	35	57	31	33
Rheumatism, excluding back . . . . .725-729	968	382	586	*26	287	484	114	57
Acquired deformities of toe . . . . .735	287	58	229	*	74	121	61	*28

See footnotes at end of table.

**Table 8. Number of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006—Con.**

Category of first-listed diagnosis and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
Congenital anomalies . . . . .740-759	479	184	*	132	126	*	*	*
Symptoms, signs, and ill-defined conditions. . . . .780-799	1,390	548	842	*	403	520	185	147
Abdominal pain . . . . .789.0	167	51	116	*	53	71	*	*
Injury and poisoning . . . . .800-999	2,230	1,255	976	169	777	848	270	166
Fractures . . . . .800-829	513	321	192	102	237	107	*32	*35
Current tear of medial cartilage or meniscus of knee . . . . .836.0	424	253	171	*	120	231	53	*20
Supplementary classifications . . . . .V01-V85	3,134	1,245	1,890	74	778	1,406	503	373
Visit for sterilization . . . . .V25.2	292	50	242	*	263	*	-	-
Diseases of the blood and blood-forming organs, mental disorders, and certain conditions originating in the perinatal period . . . . .280-289,290-319,760-779	255	80	174	*	*47	88	*47	*62
Anemias . . . . .280-285	189	*58	131	*	*	*61	*40	*62

\* Figure does not meet standards of reliability or precision.

- Quantity zero.

. . . Category not applicable.

NOTES: Diagnostic categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). The standard error (SE) of an estimate can be obtained by multiplying the estimate by the corresponding relative standard error (RSE). The RSE can be obtained by dividing the SE of the rate by the rate in Table 9.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

**Table 9. Rate and standard error for the rate of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006**

Category of first-listed diagnosis and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
				Rate per 10,000 population <sup>1</sup>				
All conditions . . . . .	1,164.9	1,003.8	1,320.4	406.7	666.0	1,731.0	3,111.9	2,769.8
Infectious and parasitic diseases . . . . .001-139	4.9	4.4	5.4	*	*	*5.6	*	*
Neoplasms . . . . .140-239	110.2	111.0	109.4	11.4	30.4	197.0	408.2	320.9
Malignant neoplasms . . . . .140-208,230-234	39.3	36.4	42.1	*	9.3	59.6	150.9	171.1
Malignant neoplasm of skin . . . . .172-173,176.0,198.2	10.2	11.2	9.2	*	2.7	11.6	31.2	67.0
Malignant neoplasm of breast . . . . .174-175,198.81	7.9	*	15.4	-	*2.8	16.1	*27.4	*
Benign neoplasms . . . . .210-229	67.1	70.9	63.3	8.7	19.2	131.7	247.3	137.7
Benign neoplasm of colon . . . . .211.3	46.6	53.6	39.8	-	7.1	97.6	200.9	103.1
Lipoma . . . . .214	4.2	4.2	4.2	*	*1.8	10.2	*	*
Endocrine, nutritional and metabolic diseases, and immunity disorders . . . . .240-279	8.9	5.1	12.7	*	7.3	13.8	*18.2	*
Diseases of the nervous system and sense organs . . . . .320-389	178.0	144.3	210.5	120.1	32.8	166.1	696.1	876.3
Carpal tunnel syndrome . . . . .354.0	18.5	11.7	25.1	-	11.0	35.1	35.1	46.6
Cataract . . . . .366	100.9	77.5	123.5	*	2.7	79.2	563.7	715.6
Disorders of the eyelid . . . . .373-374	5.8	4.8	6.8	*	*0.9	7.7	24.0	26.0
Otitis media and Eustachian tube disorders . . . . .381-382	20.9	22.1	19.7	95.0	*	*	*	*
Diseases of the circulatory system . . . . .390-459	58.2	56.8	59.6	58.2	20.4	115.0	186.8	144.1
Heart disease . . . . .391-392.0,393-398,402,404,410-416,420-429	18.1	21.7	14.7	*	*3.2	32.2	69.2	69.7
Hemorrhoids . . . . .455	24.0	19.6	28.2	*	12.0	54.9	57.1	*24.3
Diseases of the respiratory system . . . . .460-519	43.4	40.3	46.3	94.2	31.5	27.7	42.6	*20.9
Deviated nasal septum . . . . .470	4.5	5.3	3.8	*	6.0	5.6	*	*
Chronic sinusitis . . . . .473	4.7	5.6	3.9	*	4.1	7.5	*	*
Chronic disease of tonsils and adenoids . . . . .474	22.8	18.6	26.8	81.7	13.7	*	-	-
Diseases of the digestive system . . . . .520-579	228.3	210.3	245.7	53.6	127.4	359.3	656.7	520.6
Diseases of teeth and supporting structures . . . . .520-525	7.4	7.8	7.1	28.1	*	*	*	*
Diseases of esophagus . . . . .530	37.9	36.2	39.6	*	20.3	59.8	118.2	96.5
Gastritis and duodenitis . . . . .535	23.6	15.5	31.3	*	13.6	34.3	77.0	64.4
Hernia . . . . .550-553	38.3	52.1	24.9	10.6	26.7	55.8	92.2	81.4
Inguinal hernia . . . . .550	17.3	32.1	*3.0	5.4	10.5	25.3	48.0	38.9
Noninfectious enteritis and colitis . . . . .555-558	7.6	6.9	8.3	*	6.4	11.7	*18.2	*
Diverticula of intestine . . . . .562	38.1	35.0	41.0	*	*4.7	69.8	161.7	135.0
Cholelithiasis . . . . .574	12.6	*4.4	20.6	*	14.2	17.4	*	*
Diseases of the genitourinary system . . . . .580-629	98.3	57.8	137.4	18.9	91.1	140.4	189.1	145.5
Calculus of kidney and ureter . . . . .592	12.8	12.1	13.4	*	11.5	22.0	*21.2	*16.8
Benign mammary dysplasias . . . . .610	3.2	-	6.2	-	*2.8	*6.0	*	*
Lump or mass in breast . . . . .611.72	6.6	*	12.6	*	6.6	11.4	*	*
Disorders of menstruation and other abnormal vaginal bleeding . . . . .626,627.0-627.1	16.1	...	31.7	-	20.0	26.9	*	*
Complications of pregnancy, childbirth, and the puerperium . . . . .630-677	10.8	...	21.2	-	25.1	*	-	-
Abortion and ectopic and molar pregnancy . . . . .630-639	8.7	...	17.1	-	20.2	*	-	-
Diseases of the skin and subcutaneous tissue . . . . .680-709	21.2	19.9	22.3	9.3	17.9	31.2	*	27.0
Sebaceous cyst . . . . .706.2	4.5	4.7	4.3	*	*3.5	7.1	*	*
Diseases of the musculoskeletal system and connective tissue . . . . .710-739	151.7	128.0	174.6	11.0	106.5	272.1	316.9	264.7
Arthropathies and related disorders . . . . .710-719	27.1	25.8	28.4	*	22.0	50.6	46.9	28.3
Internal derangement of knee . . . . .717	10.8	12.1	9.5	*	9.2	20.0	*17.2	*
Intervertebral disc disorders . . . . .722	28.9	27.6	30.1	-	24.9	52.0	49.1	36.4
Lumbago . . . . .724.2	5.2	4.4	6.0	-	2.8	7.6	16.6	17.8
Rheumatism, excluding back . . . . .725-729	32.5	26.1	38.6	*4.2	22.9	64.7	60.5	31.1
Acquired deformities of toe . . . . .735	9.6	3.9	15.1	*	5.9	16.2	32.2	*15.5

See footnotes at end of table.

Table 9. Rate and standard error for the rate of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006—Con.

Category of first-listed diagnosis and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
Rate per 10,000 population <sup>1</sup>								
Congenital anomalies . . . . .740-759	16.1	12.6	*	21.7	10.0	*	*	*
Symptoms, signs, and ill-defined conditions. . . . .780-799	46.6	37.4	55.5	*	32.2	69.5	97.7	80.3
Abdominal pain . . . . .789.0	5.6	3.5	7.7	*	4.2	9.4	*	*
Injury and poisoning . . . . .800-999	74.8	85.6	64.3	27.9	62.0	113.4	142.6	90.4
Fractures . . . . .800-829	17.2	21.9	12.7	16.8	18.9	14.3	*17.0	*19.1
Current tear of medial cartilage or meniscus of knee . . . . .836.0	14.2	17.3	11.3	*	9.5	30.9	28.0	*10.7
Supplementary classifications . . . . .V01-V85	105.1	84.9	124.6	12.2	62.1	187.9	265.9	203.4
Visit for sterilization . . . . .V25.2	9.8	3.4	16.0	*	20.9	*	-	-
Diseases of the blood and blood-forming organs, mental disorders, and certain conditions originating in the perinatal period. . . . .280-289,290-319,760-779	8.5	5.5	11.5	*	*3.8	11.8	*25.1	*33.8
Anemias . . . . .280-285	6.3	*4.0	8.6	*	*	*8.2	*21.1	*33.8
Standard error								
All conditions . . . . .	61.32	53.33	70.69	54.26	35.76	100.68	195.86	156.70
Infectious and parasitic diseases . . . . .001-139	0.90	0.85	1.24	*	*	*1.37	*	*
Neoplasms. . . . .140-239	7.96	8.89	7.90	1.94	2.75	16.81	39.52	25.97
Malignant neoplasms . . . . .140-208,230-234	2.76	3.20	3.01	*	1.22	5.11	15.04	18.58
Malignant neoplasm of skin . . . . .172-173,176.0,198.2	1.26	1.60	1.21	*	0.61	1.92	5.43	13.56
Malignant neoplasm of breast. . . . .174-175,198.81	0.77	*	1.52	-	*0.76	2.17	*5.07	*
Benign neoplasms. . . . .210-229	6.27	7.19	6.04	1.55	2.18	13.86	31.43	14.94
Benign neoplasm of colon. . . . .211.3	5.42	6.13	5.18	-	1.68	12.00	28.25	12.22
Lipoma . . . . .214	0.61	0.84	0.84	*	*0.46	1.93	*	*
Endocrine, nutritional and metabolic diseases, and immunity disorders . . . . .240-279	1.10	0.84	1.76	*	1.38	2.07	*4.00	*
Diseases of the nervous system and sense organs . . . . .320-389	13.69	10.58	17.50	22.75	3.62	13.98	75.05	75.91
Carpal tunnel syndrome . . . . .354.0	2.02	1.51	2.92	-	1.95	4.87	6.23	9.54
Cataract . . . . .366	9.90	6.98	13.19	*	0.50	9.24	67.68	66.28
Disorders of the eyelid . . . . .373-374	0.65	0.76	0.88	*	*0.25	1.34	4.50	4.36
Otitis media and Eustachian tube disorders . . . . .381-382	4.19	3.94	4.65	20.45	*	*	*	*
Diseases of the circulatory system . . . . .390-459	5.11	6.22	5.23	*	2.71	11.07	22.02	19.84
Heart disease . . . . .391-392.0,393-398,402,404,410-416,420-429	2.68	3.57	2.37	*	*0.86	5.61	12.87	13.80
Hemorrhoids . . . . .455	3.16	3.20	3.61	*	2.39	7.12	9.11	*5.26
Diseases of the respiratory system . . . . .460-519	5.73	5.15	6.92	20.07	3.55	4.41	7.87	*5.32
Deviated nasal septum . . . . .470	0.66	0.92	0.84	*	1.17	1.37	*	*
Chronic sinusitis . . . . .473	0.71	1.00	0.84	*	0.85	1.66	*	*
Chronic disease of tonsils and adenoids . . . . .474	4.48	3.48	5.71	18.27	2.03	*	-	-
Diseases of the digestive system . . . . .520-579	18.04	16.10	20.74	8.11	11.77	31.61	64.45	47.47
Diseases of teeth and supporting structures . . . . .520-525	1.21	1.38	1.35	4.99	*	*	*	*
Diseases of esophagus. . . . .530	4.31	4.28	4.86	*	2.81	7.88	17.63	12.02
Gastritis and duodenitis. . . . .535	3.12	2.19	4.38	*	2.43	4.92	13.40	11.48
Hernia . . . . .550-553	3.38	4.71	2.88	2.33	2.90	5.97	11.16	11.74
Inguinal hernia. . . . .550	1.58	3.09	*0.56	1.13	1.33	3.49	8.56	6.92
Noninfectious enteritis and colitis. . . . .555-558	1.42	1.38	2.11	*	1.68	2.28	*4.54	*
Diverticula of intestine. . . . .562	5.25	6.01	5.21	*	*1.03	12.67	22.33	19.19
Cholelithiasis . . . . .574	1.20	*0.71	2.22	*	1.98	2.42	*	*
Diseases of the genitourinary system . . . . .580-629	5.71	4.23	8.89	3.46	5.70	10.17	20.18	18.20
Calculus of kidney and ureter . . . . .592	1.32	1.54	1.60	*	1.95	2.73	*4.20	*4.63
Benign mammary dysplasias . . . . .610	0.61	-	1.21	-	*0.69	*1.48	*	*
Lump or mass in breast. . . . .611.72	1.07	*	2.04	*	1.22	2.57	*	*
Disorders of menstruation and other abnormal vaginal bleeding. . . . .626,627.0-627.1	1.90	...	3.73	-	2.59	3.25	*	*

See footnotes at end of table.

**Table 9. Rate and standard error for the rate of ambulatory surgery visits by first-listed diagnosis, sex, and age: United States, 2006—Con.**

Category of first-listed diagnosis and ICD-9-CM code	Total	Sex		Age				
		Male	Female	Under 15 years	15-44 years	45-64 years	65-74 years	75 years and over
				Standard error				
Complications of pregnancy, childbirth, and the puerperium . . . . . 630-677	1.35	...	2.65	-	3.17	*	-	-
Abortion and ectopic and molar pregnancy . . . . . 630-639	1.27	...	2.50	-	2.99	*	-	-
Diseases of the skin and subcutaneous tissue . . . . . 680-709	3.02	3.02	4.06	2.04	2.41	7.03	*	5.30
Sebaceous cyst . . . . . 706.2	0.69	1.11	0.77	*	*0.77	1.44	*	*
Diseases of the musculoskeletal system and connective tissue . . . . . 710-739	11.91	11.38	13.53	1.64	10.18	21.94	28.02	32.52
Arthropathies and related disorders . . . . . 710-719	2.96	3.44	3.01	*	3.58	5.37	6.84	4.84
Internal derangement of knee . . . . . 717	1.79	2.69	1.36	*	2.22	3.04	*4.09	*
Intervertebral disc disorders . . . . . 722	4.49	4.23	5.10	-	5.40	7.26	9.32	6.28
Lumbago . . . . . 724.2	0.93	0.95	1.18	-	0.80	1.51	4.55	4.40
Rheumatism, excluding back . . . . . 725-729	2.26	2.23	3.08	*0.97	2.12	5.56	7.55	5.40
Acquired deformities of toe . . . . . 735	1.35	0.81	2.21	*	1.21	2.78	8.32	*3.65
Congenital anomalies . . . . . 740-759	4.79	2.66	*	3.51	2.75	*	*	*
Symptoms, signs, and ill-defined conditions . . . . . 780-799	7.79	6.81	9.04	*	4.91	12.20	15.95	11.22
Abdominal pain . . . . . 789.0	0.95	0.71	1.49	*	0.89	2.16	*	*
Injury and poisoning . . . . . 800-999	5.15	6.22	5.27	3.51	5.05	8.65	20.49	11.84
Fractures . . . . . 800-829	1.49	2.23	1.31	2.23	2.20	2.51	*4.74	*4.17
Current tear of medial cartilage or meniscus of knee . . . . . 836.0	1.58	2.46	1.28	*	1.54	3.80	5.29	*2.77
Supplementary classifications . . . . . V01-V85	8.88	8.70	10.44	2.06	5.93	19.34	31.05	24.27
Visit for sterilization . . . . . V25.2	1.15	0.52	2.20	*	2.43	*	-	-
Diseases of the blood and blood-forming organs, mental disorders, and certain conditions originating in the perinatal period . . . . . 280-289,290-319,760-779	1.19	1.12	1.71	*	*0.74	2.78	*6.55	*7.27
Anemias . . . . . 280-285	1.01	*0.93	1.42	*	*	*2.09	*5.94	*7.27

\* Figure does not meet standards of reliability or precision.

- Quantity zero.

... Category not applicable.

<sup>1</sup>Rates were calculated using U.S. Census Bureau 2000-based postcensal estimates of the civilian population as of July 1, 2006.

NOTES: Diagnostic categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). The relative standard error (RSE) can be obtained by dividing the standard error (SE) of the rate by the rate. The SE of a number in Table 8 can be obtained by multiplying the RSE by the estimate.

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery.

## Technical Notes

Final Approval OMB No. 0950-0054 Approval Expires 11/30/2006

**NSAS-5** U.S. DEPARTMENT OF COMMERCE  
BUREAU OF ECONOMIC ANALYSIS  
NATIONAL SURVEY OF AMBULATORY SURGERY MEDICAL ABSTRACT

**Notice** - All information which would permit identification of an individual or an establishment will be held confidential - will be used only by persons engaged in and/or for the purpose of the survey, and will not be disclosed or released to other persons or used for any other purpose. Public reporting burden of this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and reviewing the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CCCIA/GDR, Records Clearance Officer, 1600 Clifton Road, NE, MS-B-74, Atlanta, GA 30303, ATTN: PRA (505)162344.

**A. PATIENT INFORMATION**

1. Facility number: \_\_\_\_\_ 2. ICD-9 number and its code: \_\_\_\_\_ 3. Date of surgery: Month \_\_\_\_\_ Day \_\_\_\_\_ Year **2 0 0** 4. Resident ZIP Code: \_\_\_\_\_ - \_\_\_\_\_

**B. PATIENT CHARACTERISTICS**

5. Date of birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ 6. Age (Complete only if date of birth not given): \_\_\_\_\_ years  Months  Days 7. Sex (Mark (X) one):  
 Male  
 Female  
 Not stated

8. Ethnicity (Mark (X) one):  
 Hispanic or Latino  
 Not Hispanic or Latino  
 Not stated

9. Race (Mark (X) one):  
 White  
 Black or African American  
 American Indian or Alaska Native  
 Asian  
 Native Hawaiian or Other Pacific Islander  
 Other \_\_\_\_\_  
 Not stated

10. Status/Disposition of Patient (Mark (X) the appropriate box):  
 Routine discharge to customary residence  
 Discharge to observation status  
 Discharge to postoperative recovery unit facility  
 Admitted to hospital as inpatient  
 Surgery cancelled or postponed  
 Other - Specify \_\_\_\_\_  
 Status/Disposition not stated

**C. PAYMENT INFORMATION**

11. Expected source of payment:

	Federal		Other sources	
	Medicare	Medicaid	Private insurance	Other sources
<b>GOVERNMENT SOURCES</b>				
Medicare (Mark (X) one only when Fee-for-service, HMO, PPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid (Mark (X) one only when Fee-for-service, HMO, PPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRICARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other government (If so, please specify _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PRIVATE INSURANCE</b>				
Private or commercial (Mark (X) one only when Fee-for-service, HMO, PPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER SOURCES</b>				
Self pay (No coverage/insurance, Had no health insurance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Charity care/Write off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No charge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No source of payment indicated	<input type="checkbox"/>			

12. Total charges: \$ \_\_\_\_\_ .00  Not available

**D. SURGICAL VISIT INFORMATION**

13. Time:  Not complete

a. Time in operating room: \_\_\_\_\_ AM \_\_\_\_\_ PM

b. Time surgery began: \_\_\_\_\_ AM \_\_\_\_\_ PM

c. Time surgery ended: \_\_\_\_\_ AM \_\_\_\_\_ PM

d. Time out of operating room: \_\_\_\_\_ AM \_\_\_\_\_ PM

e. Time in to postoperative care: \_\_\_\_\_ AM \_\_\_\_\_ PM

f. Time out of postoperative care: \_\_\_\_\_ AM \_\_\_\_\_ PM

14. Type of treatment: (Mark (X) at the surgery)

a. Traditional

b. Woundless

c. MAC (Minimally Invasive Approach)

d. Robotic

(1) Spine

(2) Spine

(3) Pelvic/abdominal

(4) Pelvic/abdominal

(5) Block

e. General

f. Other - Specify \_\_\_\_\_

g. None specified

15. Anesthesia administered by— (Mark (X) all that apply)

Anesthesiologist  Surgeon/Other physician

CRNA (Certified Registered Nurse Anesthetist)  Two (state PA or MD)

Please continue on the reverse side

E. MEDICAL INFORMATION																																				
<b>16. FINAL DIAGNOSIS (including E-codes diagnosis) – Narrative description</b>  Principal <u>1.</u> Other Additional <u>2.</u> <u>3.</u> <u>4.</u> <u>5.</u> <u>6.</u> <u>7.</u>		Optional – ICD-9-CM Codes																																		
<b>17. Surgical and medical procedures – Narrative description</b>  Principal <u>1.</u> Other Additional <u>2.</u> <u>3.</u> <u>4.</u> <u>5.</u> <u>6.</u>		Optional – OPT-4 Codes	Optional – ICD-9-CM Codes																																	
<input type="checkbox"/> None																																				
<b>18. Symptoms present during or after surgery. (Mark X) (circle all)</b>																																				
<table style="width:100%; border: none;"> <tr> <td style="width: 33%; border: none;"><input type="checkbox"/> Accidental laceration/puncture or perforation</td> <td style="width: 33%; border: none;"><input type="checkbox"/> High blood pressure/hypertension</td> <td style="width: 33%; border: none;"><input type="checkbox"/> None indicated</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Airway obstruction</td> <td style="border: none;"><input type="checkbox"/> Hypoxia</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Anemia</td> <td style="border: none;"><input type="checkbox"/> Incontinence</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Bleeding/hemorrhage</td> <td style="border: none;"><input type="checkbox"/> Low blood potassium/hypokalemia</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Blood transfusion needed</td> <td style="border: none;"><input type="checkbox"/> Malignant hyperthermia</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Cardiac arrest</td> <td style="border: none;"><input type="checkbox"/> Nausea</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Difficulty waking up</td> <td style="border: none;"><input type="checkbox"/> Postoperative site burn</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Dysrhythmia/arrhythmia</td> <td style="border: none;"><input type="checkbox"/> Shock</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Erythema</td> <td style="border: none;"><input type="checkbox"/> Vomiting</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Flaming/sutural/surgical site pain</td> <td style="border: none;"><input type="checkbox"/> Other – Please specify: _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Fetus</td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> </table>				<input type="checkbox"/> Accidental laceration/puncture or perforation	<input type="checkbox"/> High blood pressure/hypertension	<input type="checkbox"/> None indicated	<input type="checkbox"/> Airway obstruction	<input type="checkbox"/> Hypoxia		<input type="checkbox"/> Anemia	<input type="checkbox"/> Incontinence		<input type="checkbox"/> Bleeding/hemorrhage	<input type="checkbox"/> Low blood potassium/hypokalemia		<input type="checkbox"/> Blood transfusion needed	<input type="checkbox"/> Malignant hyperthermia		<input type="checkbox"/> Cardiac arrest	<input type="checkbox"/> Nausea		<input type="checkbox"/> Difficulty waking up	<input type="checkbox"/> Postoperative site burn		<input type="checkbox"/> Dysrhythmia/arrhythmia	<input type="checkbox"/> Shock		<input type="checkbox"/> Erythema	<input type="checkbox"/> Vomiting		<input type="checkbox"/> Flaming/sutural/surgical site pain	<input type="checkbox"/> Other – Please specify: _____		<input type="checkbox"/> Fetus		
<input type="checkbox"/> Accidental laceration/puncture or perforation	<input type="checkbox"/> High blood pressure/hypertension	<input type="checkbox"/> None indicated																																		
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<input type="checkbox"/> Cardiac arrest	<input type="checkbox"/> Nausea																																			
<input type="checkbox"/> Difficulty waking up	<input type="checkbox"/> Postoperative site burn																																			
<input type="checkbox"/> Dysrhythmia/arrhythmia	<input type="checkbox"/> Shock																																			
<input type="checkbox"/> Erythema	<input type="checkbox"/> Vomiting																																			
<input type="checkbox"/> Flaming/sutural/surgical site pain	<input type="checkbox"/> Other – Please specify: _____																																			
<input type="checkbox"/> Fetus																																				
F. FOLLOW-UP INFORMATION																																				
<b>19a. Did someone attempt to follow-up with the patient within 24 hours after the surgery?</b>		Yes <input type="checkbox"/>	No <input type="checkbox"/>																																	
<b>b. Did they reach the patient? (see 19a)</b>		Yes <input type="checkbox"/>	No <input type="checkbox"/>																																	
<b>(1) What was learned from this follow-up? (check all that apply)</b>																																				
<table style="width:100%; border: none;"> <tr> <td style="width: 33%; border: none;"><input type="checkbox"/> Patient had a question</td> <td style="width: 33%; border: none;"><input type="checkbox"/> Called the doctor</td> <td style="width: 33%; border: none;"><input type="checkbox"/> Went to an emergency department</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Patient had no problems</td> <td style="border: none;"><input type="checkbox"/> Went to the doctor</td> <td style="border: none;"><input type="checkbox"/> Was admitted to the hospital</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Patient had problem(s) and –</td> <td style="border: none;"><input type="checkbox"/> Called the ambulatory/surgery center</td> <td style="border: none;"><input type="checkbox"/> Other – Please specify: _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Came back to the ambulatory/surgery center</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Called the emergency department</td> <td style="border: none;"></td> </tr> </table>				<input type="checkbox"/> Patient had a question	<input type="checkbox"/> Called the doctor	<input type="checkbox"/> Went to an emergency department	<input type="checkbox"/> Patient had no problems	<input type="checkbox"/> Went to the doctor	<input type="checkbox"/> Was admitted to the hospital	<input type="checkbox"/> Patient had problem(s) and –	<input type="checkbox"/> Called the ambulatory/surgery center	<input type="checkbox"/> Other – Please specify: _____		<input type="checkbox"/> Came back to the ambulatory/surgery center			<input type="checkbox"/> Called the emergency department																			
<input type="checkbox"/> Patient had a question	<input type="checkbox"/> Called the doctor	<input type="checkbox"/> Went to an emergency department																																		
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	<input type="checkbox"/> Came back to the ambulatory/surgery center																																			
	<input type="checkbox"/> Called the emergency department																																			
<input type="checkbox"/> Nothing <input type="checkbox"/> Unknown																																				
<b>(2) What problem(s) did the patient mention (e.g., see drainage, symptoms, pain, nausea)?</b> _____ _____ _____																																				
<b>20. Completed by</b>		<b>21. Date</b>	<b>OFFICE USE ONLY</b> FF code																																	

### Acknowledgments

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CS206178  
T35151 (09/2009)

Exhibit 19

National Health Statistics Reports; Number 102, February 28, 2017

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# National Health Statistics Reports

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Number 102 ■ February 28, 2017

## Ambulatory Surgery Data From Hospitals and Ambulatory Surgery Centers: United States, 2010

by Margaret J. Hall, Ph.D., Alexander Schwartzman, Jin Zhang, and Xiang Liu, Division of Health Care Statistics

### Abstract

**Objectives**—This report presents national estimates of surgical and nonsurgical ambulatory procedures performed in hospitals and ambulatory surgery centers (ASCs) in the United States during 2010. Patient characteristics, including age, sex, expected payment source, duration of surgery, and discharge disposition are presented, as well as the number and types of procedures performed in these settings.

**Methods**—Estimates in this report are based on ambulatory surgery data collected in the 2010 National Hospital Ambulatory Medical Care Survey (NHAMCS). NHAMCS has collected outpatient department and emergency department data since 1992 and began gathering ambulatory surgery data from both hospitals and ASCs in 2010. Sample data were weighted to produce annual national estimates.

**Results**—In 2010, 48.3 million surgical and nonsurgical procedures were performed during 28.6 million ambulatory surgery visits to hospitals and ASCs combined. For both males and females, 39% of procedures were performed on those aged 45–64. For females, about 24% of procedures were performed on those aged 15–44 compared with 18% for males, whereas the percentage of procedures performed on those under 15 was lower for females than for males (4% compared with 9%). About 19% of procedures were performed on those aged 65–74, while about 14% were performed on those aged 75 and over. Private insurance was listed as the principal expected source of payment for 51% of ambulatory surgery visits, Medicare for 31% of visits, and Medicaid for 8% of visits. The most frequently performed procedures included endoscopy of large intestine (4.0 million), endoscopy of small intestine (2.2 million), extraction of lens (2.9 million), insertion of prosthetic lens (2.6 million), and injection of agent into spinal canal (2.9 million). Only 2% of visits with a discharge status were admitted to the hospital as an inpatient.

**Keywords:** outpatient surgery • procedures • ICD–9–CM • National Hospital Ambulatory Medical Care Survey (NHAMCS)

### Introduction

This report presents nationally representative estimates of ambulatory surgery performed in hospitals and ambulatory surgery centers (ASCs) gathered by the 2010 National Hospital Ambulatory Medical Care Survey (NHAMCS). Ambulatory surgery, also called outpatient surgery, refers to surgical and nonsurgical procedures that are nonemergency, scheduled in advance, and generally do not result in an overnight hospital stay.

Ambulatory surgery has increased in the United States since the early 1980s (1,2). Two factors that contributed to this increase were medical and technological advancements, including improvements in anesthesia and in analgesics for the relief of pain, and the development and expansion of minimally invasive and noninvasive procedures (such as laser surgery, laparoscopy, and endoscopy) (3–6). Before these advances, almost all surgery was performed in inpatient settings. Any outpatient surgery was likely to have been minor, performed in physicians' offices, and paid for by Medicare and insurers as part of the physician's office visit reimbursement.



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The above advances and concerns about rising health care costs led to changes in the Medicare program in the early 1980s that encouraged growth in ambulatory surgery. Medicare expanded coverage to include surgery performed in ASCs (both hospital-based and freestanding). In addition, a prospective payment system for hospitals based on diagnosis-related groups was adopted, and that created strong financial incentives for hospitals to shift some surgery out of the hospital (1–5). Ambulatory surgery proved to be popular among both physicians and patients (3,4,7,8), and the number of Medicare-certified ASCs increased steadily, from 239 in 1983 to 5,316 in 2010 (9,10).

This report covers ambulatory surgery performed in hospitals and ASCs that are independent of hospitals. Ambulatory surgery procedures performed in physicians' offices and independent screening or diagnostic centers were not included in this report.

## Methods

### Data source and sampling design

Data for this analysis are from the ambulatory surgery component of the 2010 NHAMCS, a nationally representative survey of hospitals and ASCs conducted by the National Center for Health Statistics (NCHS). This survey has provided data on ambulatory medical care services provided in hospital emergency and outpatient departments since 1992. From 2010 through 2012, NHAMCS gathered data on ambulatory surgery procedures in both hospitals and ASCs. In 2013, data collection in ASCs was suspended so a new sampling frame could be developed. Previously, during 1994–1996 and in 2006, the National Survey of Ambulatory Surgery (NSAS) gathered data from hospital-based ASCs (HBASCs) and from facilities independent of hospitals [then called freestanding ASCs (FSASCs)] (2). The terms HBASC and FSASC are no longer in use because Medicare, and other insurers following Medicare's lead, changed the name and nature of the reimbursement categories for these services. Ambulatory surgery

performed in hospitals is now called hospital outpatient department surgery. Facilities independent of hospitals that specialize in ambulatory surgery are now known as ASCs.

Independent samples of hospitals and ASCs were drawn for the NHAMCS ambulatory surgery component. The NHAMCS hospital sample (11) was selected using a multistage probability design, first sampling geographic units and then hospitals. Locations within the hospital where the services of interest were provided, in this case ambulatory surgery, were sampled next. Lastly, patient visits within these locations were sampled.

The hospitals that qualify for inclusion in this survey (the universe) include noninstitutional hospitals (excluding federal, military, and Department of Veterans Affairs hospitals) located in the 50 states and the District of Columbia. Only short-stay hospitals (hospitals with an average length of stay for all patients of fewer than 30 days), those with a general specialty (medical or surgical), and children's general were included in the survey. These hospitals must also have six or more beds staffed for patient use. The 2010 NHAMCS hospital sample frame was constructed from the products of SDI Health's "Healthcare Market Index," which was updated July 15, 2006, and its "Hospital Market Profiling Solution, Second Quarter, 2006" (12). These products were formerly known as the SMG Hospital Market Database.

In 2010, the sample consisted of 488 hospitals, of which 74 were out-of-scope (ineligible) because they went out of business or otherwise failed to meet the criteria for the NHAMCS universe. Of the 414 in-scope (eligible) hospitals, 275 had eligible ambulatory surgery locations. Of these, 227 participated, yielding an unweighted hospital ambulatory surgery response rate of 82.6% and a weighted response rate of 90.9%. All of the 321 ambulatory surgery locations within the 227 participating hospitals were selected for sampling, and 281 of these fully or adequately responded [at least one-half of the number of expected patient record forms (PRFs) were completed]. The resulting hospital ambulatory surgery

location sample response rate was 87.5% unweighted, and 86.9% weighted. The overall hospital response rate was 72.2% unweighted and 79.0% weighted. In all, 18,469 PRFs for ambulatory surgery visits were submitted by hospitals.

The ASCs that qualified for inclusion in the 2010 NHAMCS (the universe) only included facilities in the 2006 NSAS sample. This sample was drawn in 2005 from a universe consisting of facilities listed in the 2005 Verispan (later called SDI Health and then IMS Health) Freestanding Outpatient Surgery Center Database (13) or the Centers for Medicare & Medicaid Services' (CMS) Medicare Provider of Services file (14). Using both of these sources resulted in a list of facilities that were regulated or licensed by the states and those certified by CMS for Medicare participation. More details about the 2006 NSAS sample have been published elsewhere (2). Selection of the 2010 ASC sample began with the NSAS 2006 stratified list sample of 472 FSASCs, which had strata defined by four geographic regions and 17 facility specialty groups. Seventy-four facilities were out-of-scope, leaving 398 facilities from which to select the 2010 NHAMCS ASC sample. To the extent possible, the ASC sample was selected from the NHAMCS geographic sampling units. The 17 specialty group strata used in the 2006 NSAS sample were collapsed into 5 strata (ophthalmic, gastrointestinal, multispecialty, general, and other).

All of the in-scope 2006 NSAS sample facilities located within the NHAMCS geographic sampling units were selected, yielding 216 facilities. To achieve the desired 246 facilities, a stratified list sample of 30 facilities was drawn from the remaining in-scope 2006 NSAS sample facilities that were located outside of the NHAMCS geographic sampling units. Strata were defined by the four regions and the five collapsed surgery specialty groups.

There were 149 in-scope (eligible) ASCs and, of this number, 109 responded to the survey for an unweighted response rate of 73.2% and a weighted response rate of 70.2%. In all, 8,492 PRFs were submitted for ASCs.

The overall response rate for hospitals combined with ASCs was 72.2% unweighted and 79.0% weighted.

The combined number of PRFs from both of these settings was 26,961.

Facilities were selected using a multistage probability design, with facilities having varying selection probabilities. Patient visits to ASCs and to locations in the hospital where ambulatory surgery was provided were selected using systematic random sampling procedures.

Within each sampled hospital, a sample of ambulatory surgery visits was selected from all of the ambulatory surgery locations identified by hospital staff. These locations included main or general operating rooms; dedicated ambulatory surgery units; cardiac catheterization laboratories; and rooms for endoscopy, laparoscopy, laser procedures, and pain block. Locations within hospitals dedicated exclusively to abortion, dentistry, podiatry, family planning, birthing, or small procedures were excluded, but these procedures were included if performed at in-scope locations. In ASCs with in-scope specialties, all visits were sampled. Facilities specializing in abortion, dentistry, podiatry, family planning, birthing, or small procedures were excluded, but these procedures were included if performed at in-scope ASCs.

To minimize response burden for hospitals and ASCs, the samples were divided into 16 nationally representative panels, and those panels were randomly ordered for rotation over reporting periods of 4 weeks each. Within the reporting periods, patient visits were systematically selected. The visit lists could be sign-in sheets or appointment lists. The total targeted number of ambulatory surgery visit forms to be completed in each hospital and in each ASC was 100. In facilities or hospitals with volumes higher than these desired figures, visits were sampled by a systematic procedure that selects every  $n$ th visit after a random start. Visit sampling rates were determined from the expected number of patients to be seen during the reporting period and the desired number of completed PRFs.

## Data collection

Medical record abstraction was performed by facility staff or U.S. Census

Bureau personnel acting on behalf of NCHS. A PRF for each sampled visit was completed. A visit is defined as a direct personal exchange between a physician or a staff member operating under a physician's direction, for the purpose of seeking ambulatory surgery. Visits solely for administrative purposes and visits in which no medical care was provided are out-of-scope.

The PRF contains items relating to the personal characteristics of the patients, such as age, sex, race and ethnicity, and administrative items, such as the date of the procedure, expected source(s) of payment, and discharge disposition. Medical information collected includes provider of anesthesia and type of anesthesia, length of time in both the operating room and in surgery, symptoms present during or after the procedure, and up to five diagnoses and seven procedures, which were coded according to the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) (15). Information on up to 12 new or continuing prescription and over-the-counter drugs ordered, supplied, or administered during the visit or at discharge was also collected, and these drugs were coded using Multum Lexicon (16), a proprietary drug classification system used by NCHS.

## Limitations of NHAMCS Ambulatory Surgery Data

Limited resources did not permit updating the ASC frame for the 2010 NHAMCS, so the NSAS 2006 sample, based on ASCs in existence in 2005, was used. Based on annual data on the number of Medicare-certified ASCs from CMS, the increase in the number of these facilities was taken into account in the calculation of NHAMCS ASC survey weights. The visit total related to the increase in the number of ASCs was also accounted for in the weights, but any possible change in the number of visits per ASC was not accounted for because no data were available on the number of visits to ASCs over time. Final weighting is described in more detail elsewhere (11).

Based on the assumption that the characteristics of ambulatory surgery visits probably do not vary with facility age, the sample should enable the measurement of 2010 characteristics (if not numbers) of ambulatory visits. To the extent that the ASCs that existed in 2005 were different from those in existence in 2010, these differences would not have been fully captured by the 2010 NHAMCS (17).

Due to limited resources, the sample sizes for hospitals and for ASCs for the NHAMCS ambulatory surgery component were only about one-half of what they were for the 2006 NSAS, so the most recent estimates have larger standard errors. This makes it more difficult for differences to achieve statistical significance.

Until 2008, hospital ambulatory surgery was included under Medicare's HBASC payment category. Beginning in 2008, Medicare discontinued its use of this category and instead began paying for hospital ambulatory surgery as part of hospital outpatient department services. Hospitals also dropped the HBASC designation and, in some hospitals, this change led to a greater dispersion of ambulatory surgery procedures throughout the hospitals, including to various parts of the outpatient departments and locations within medical clinics.

Some hospitals had difficulty identifying all of the locations in the hospital where in-scope procedures were performed, especially in the first year of NHAMCS ambulatory surgery data collection (2009). This same year, after the problems became apparent, U.S. Census Bureau and NCHS staff provided additional information to field staff about how to identify locations in the hospital that were in-scope and out-of-scope for the ambulatory surgery component of NHAMCS. More formal training material on this point was provided in a 2010 training CD that was sent to all field staff. These efforts are believed to have corrected this problem. However, due to these issues, it is likely that some in-scope procedures were undercounted in 2009 and 2010.

A number of changes occurred in the health care system during 2008–2010 that could have affected the amount

of ambulatory surgery care that was provided in settings covered by this report and the amount provided in out-of-scope settings (e.g., physicians' offices). More information about the difficulties of gathering and comparing data on ambulatory surgery from these two time periods and surveys is available (18).

## Results

### Ambulatory surgery procedure and visit overview

- In 2010, 28.6 million ambulatory surgery visits to hospitals and ASCs occurred (Table 1). During these visits, an estimated 48.3 million surgical and nonsurgical procedures were performed (Table 2).
- An estimated 25.7 million (53%) ambulatory surgery procedures were performed in hospitals and 22.5 million (47%) were performed in ASCs (Table A).
- Private insurance was the expected payment source for 51% of the visits for ambulatory surgery, Medicare payment was expected for 31%, and Medicaid for 8%. Only 4% were self-pay (Figure 1).
- Ninety-five percent of the visits with a specified discharge disposition had a routine discharge, generally to the patient's home. Patients were admitted to the hospital as inpatients during only 2% of these visits (Table B).

### Ambulatory surgery procedures, by sex and age

- For both males and females, 39% of procedures were performed on those aged 45–64 (Figure 2).
- For females, about 24% of procedures were performed on those aged 15–44 compared with 18% for males, whereas the percentage of procedures performed on those under 15 was lower for females than for males (4% compared with 9%).
- About 19% of procedures were performed on those aged 65–74, with about 14% performed on those aged 75 and over.

**Table A. Ambulatory surgery procedures and visits to hospitals and ambulatory surgery centers: United States, 2010**

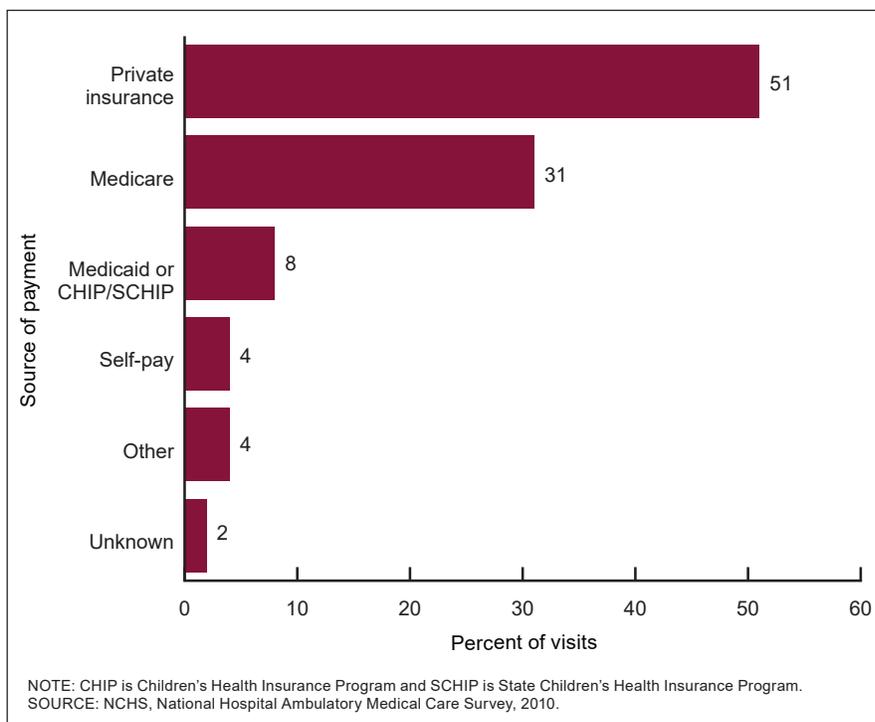
Ambulatory surgery utilization	Estimate	Standard error
Procedures (millions) . . . . .	48.3	4.3
in hospitals . . . . .	25.7	2.6
in ASCs . . . . .	22.5	3.3
Visits (millions) . . . . .	28.6	2.4
in hospitals . . . . .	15.7	1.6
in ASCs . . . . .	12.9	1.8

NOTE: ASC is ambulatory surgery center.  
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

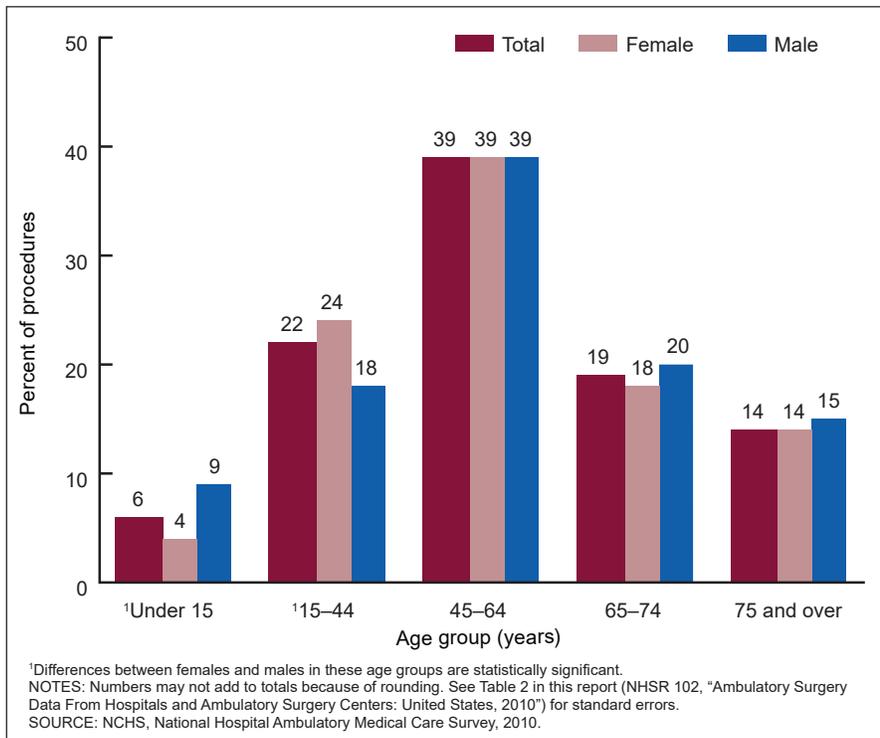
**Table B. Percent distribution of ambulatory surgery visits in hospitals and ambulatory surgery centers, by discharge disposition: United States, 2010**

Discharge disposition	Percent of visits
Routine discharge <sup>1</sup> . . . . .	95
Observation status <sup>2</sup> . . . . .	2
Admission to hospital as inpatient . . . . .	2
Other <sup>3</sup> . . . . .	1
Total <sup>4</sup> . . . . .	100

<sup>1</sup>Discharge to customary residence, generally home.  
<sup>2</sup>Discharge for further observation without being admitted to a hospital.  
<sup>3</sup>Includes discharge to postsurgical or recovery care facility, referral to emergency department, surgery terminated, and other options.  
<sup>4</sup>Excludes 1.2 million of the 28.6 million total visits with an unknown discharge disposition.  
SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.



**Figure 1. Percent distribution of ambulatory surgery visits in hospitals and ambulatory surgery centers, by principal expected source of payment: United States, 2010**



**Figure 2. Percent distribution of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by age and sex: United States, 2010**

## Types of procedures

Seventy percent of the 48.3 million ambulatory surgery procedures were included in the following clinical categories: operations on the digestive system (10 million or 21%), operations on the eye (7.9 million or 16%), operations on the musculoskeletal system (7.1 million or 15%), operations on the integumentary system (4.3 million or 9%), and operations on the nervous system (4.2 million or 9%) (Table 3). These procedure categories made up 72% of procedures performed on females and 67% of those performed on males. Within the above-mentioned categories, data on procedures performed more than 1 million times are presented below.

Under operations on the digestive system, endoscopy of large intestine—which included colonoscopies—was performed 4.0 million times, and endoscopy of small intestine was performed 2.2 million times. Endoscopic polypectomy of large intestine was performed an estimated 1.1 million times.

Eye operations included extraction of lens, performed 2.9 million times; insertion of lens, performed 2.6 million

times for cataracts; and operations on eyelids, performed 1.0 million times.

Musculoskeletal procedures included operations on muscle, tendon, fascia, and bursa (1.3 million).

Operations on the integumentary system included excision or destruction of lesion or tissue of skin and subcutaneous tissue (1.2 million).

Operations on the nervous system included injection of agent into spinal canal (2.9 million), including injections for pain relief.

## Duration of surgery

The average time in the operating room for ambulatory surgery was almost 1 hour (57 minutes). On average, about one-half of this time (33 minutes) was spent in surgery. Postoperative care averaged 70 minutes. Time spent in the operating room, surgery, and receiving postoperative care were all significantly longer for ambulatory surgery performed in hospitals compared with ASCs (Table C).

The average surgical times for selected ambulatory surgery procedures are shown in Table D. Endoscopies

averaged 14 minutes, while endoscopic polypectomy of the large intestine averaged 21 minutes. For cataract surgery, extraction or insertion of lens (often done together) averaged 10 minutes, and operations on the eyelids averaged 23 minutes. Arthroscopy of the knee averaged 32 minutes.

## Discussion

Keeping in mind the limitations that should be taken into account when comparing 2006 NSAS data and 2010 NHAMCS ambulatory surgery data, the 53.3 million ambulatory surgery procedures estimated using 2006 NSAS data were compared with the 48.3 million ambulatory surgery procedures estimated using 2010 NHAMCS data. The difference between these two figures was not statistically significant. A significant decrease of 18% (from 34.7 to 28.6 million) was seen in the number of ambulatory surgery visits during this same time period. It had been expected based upon the limited data that were available and on projections from past trends, that there would have been an increase in the numbers of both ambulatory surgery visits and procedures (9,10,19).

One reason for these findings could be an undercount in NHAMCS in 2010. Another reason that ambulatory surgery visit estimates could have decreased and ambulatory surgery procedures remained steady, could be the deep economic recession that began in 2007. By 2010, when NHAMCS began gathering ambulatory surgery data in both hospitals and ASCs, the economy had not fully recovered. The rate of unemployment and the number of people who did not have health insurance were higher in 2010 compared with 2006, and both of these factors could have affected patients' use of ambulatory surgery (20,21). Even for those who continued to have health insurance, increased out-of-pocket costs (higher deductibles and coinsurance payments) may have contributed to a decrease in the number of visits for ambulatory surgery (22).

An examination of various data sources, including Medicare, the American Hospital Association, and NHAMCS, was undertaken to evaluate if other national

**Table C. Distribution of times for surgical visits, by ambulatory surgery facility type: United States, 2010**

Calculated time of ambulatory surgical visit	Hospital		Ambulatory surgery center		All facilities	
	Average time (minutes)	Standard error	Average time (minutes)	Standard error	Average time (minutes)	Standard error
Operating room <sup>1</sup> . . . . .	63	1.9	50	3.7	57	2.2
Surgical <sup>2</sup> . . . . .	37	1.5	29	3.2	33	1.7
Postoperative care <sup>3</sup> . . . . .	89	2.9	51	3.8	70	2.6

<sup>1</sup>Calculated by subtracting the time when the patient entered the operating room from the time the patient left the operating room.  
<sup>2</sup>Calculated by subtracting the time the surgery began from the time the surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.  
<sup>3</sup>Calculated by subtracting the time when the patient entered postoperative care from the time the patient left postoperative care.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

data sources reached similar conclusions about trends in ambulatory surgery during 2006–2010 (19). This analysis revealed that the only nationally representative data during this time period were from the 2006 NSAS and the 2010 NHAMCS ambulatory surgery component. Medicare data on the number of certified ASCs over time existed, but only limited Medicare ambulatory surgery utilization and expenditure data were available, and almost all of it was from ASCs only and did not include data on ambulatory surgery in hospitals. Even so, Medicare utilization and expenditure data could not have been used to generalize to the entire population because Medicare only covers those aged 65 and over and people with disabilities. Close to 70% of ambulatory surgery procedures were paid for by sources other than Medicare.

## Ambulatory Surgery Data

The 2010 NHAMCS ambulatory surgery data used for this report have been released in a public-use file

available from: [ftp://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Datasets/NHAMCS](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NHAMCS). The data base documentation for this file is available from: [ftp://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Dataset\\_Documentation/NHAMCS](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHAMCS).

Among the options being explored for future data collection are the use of both claims data and electronic health record data.

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**Table D. Average surgical duration for selected procedures: United States, 2010**

Selected procedure <sup>1</sup>	ICD–9–CM codes	Average surgical time (minutes) <sup>2</sup>	Standard error
Endoscopy (including colonoscopy) . . . . .	45.11–45.14, 45.16, 45.21–45.25	14	0.87
Endoscopic polypectomy of large intestine . . . . .	45.42	21	0.97
Extraction or insertion of lens (cataracts) . . . . .	13.1–13.7	10	1.20
Operations on eyelids . . . . .	08	23	3.56
Arthroscopy of knee. . . . .	80.26	32	2.69

<sup>1</sup>Times were counted only for patients who had each of these selected procedures and no others during their ambulatory surgery visit.  
<sup>2</sup>Calculated by subtracting the time surgery began from the time surgery ended. Surgical time typically extends from when the first incision is made until the wound is closed.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

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**Table 1. Number and percent distribution of ambulatory surgery visits, by age and sex: United States, 2010**

Age group (years)	Both sexes		Female		Male	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
Number (thousands)						
Total . . . . .	28,588	2424	16,481	1,365	12,108	1,084
Under 15 . . . . .	1,812	302	712	122	1,100	184
15–44 . . . . .	6,426	619	4,201	411	2,225	223
45–64 . . . . .	10,911	1,010	6,256	555	4,659	474
65–74 . . . . .	5,301	446	2,951	242	2,350	213
75 and over . . . . .	4,139	360	2,365	205	1,774	167
Percent distribution						
Total . . . . .	100	...	100	...	100	...
Under 15 . . . . .	6	0.86	4	0.62	9	1.21
15–44 . . . . .	23	0.94	26	1.06	18	0.91
45–64 . . . . .	38	0.89	38	0.84	39	1.16
65–74 . . . . .	19	0.67	18	0.69	19	0.84
75 and over . . . . .	14	0.69	14	0.72	15	0.83

... Category not applicable.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

**Table 2. Number and percent distribution of ambulatory surgery procedures, by age and sex: United States, 2010**

Age group (years)	Both sexes		Female		Male	
	Estimate	Standard error	Estimate	Standard error	Estimate	Standard error
Number (thousands)						
Total . . . . .	48,263	4,253	27,595	2,373	20,669	1,932
Under 15 . . . . .	2,916	500	1,118	199	1,798	310
15–44 . . . . .	10,478	1,014	6,708	631	3,770	418
45–64 . . . . .	18,783	1,876	10,789	1,060	7,994	857
65–74 . . . . .	9,153	802	5,053	423	4,100	403
75 and over . . . . .	6,933	619	3,926	356	3,007	285
Percent distribution						
Total . . . . .	100	...	100	...	100	...
Under 15 . . . . .	6	0.82	4	0.57	9	1.20
15–44 . . . . .	22	0.89	24	0.92	18	1.10
45–64 . . . . .	39	1.02	39	1.05	39	1.23
65–74 . . . . .	19	0.79	18	0.78	20	1.00
75 and over . . . . .	14	0.80	14	0.84	15	0.89

... Category not applicable.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

**Table 3. Number of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010**

Procedure category and ICD-9-CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15-44	45-64	65-74	75 and over
Number (thousands)								
All procedures	48,263	27,595	20,669	2,916	10,478	18,783	9,153	6,933
Operations on the nervous system (01-05,1761)	4,226	2,385	1,841	*	1,002	1,981	631	590
Injection of agent into spinal canal (03.91-03.92)	2,918	1,588	1,330	*	712	1,313	437	453
Release of carpal tunnel (04.43)	444	266	178	-	66	240	80	*58
Operations on the eye (08-16)	7,880	4,622	3,258	93	321	2,122	2,697	2,646
Operations on eyelids (08)	1,021	651	371	*	*	482	276	*
Extraction of lens (13.1-13.6)	2,861	1,705	1,156	*	*	584	1,081	1,173
Insertion of prosthetic lens (pseudophakos) (13.7)	2,553	1,526	1,027	*	*	511	951	1,043
Operations on the ear (18-20)	1,054	442	612	847	72	58	*	*
Myringotomy with insertion of tube (20.01)	754	323	431	699	*	*	*	*
Operations on the nose, mouth, and pharynx (21-29)	2,407	1,117	1,290	903	689	575	166	*75
Incision, excision and destruction of nose and lesion of nose (21.1,21.3-21.4,21.6)	302	152	*	*	126	*	*	*
Turbinectomy (21.6)	190	78	112	*	106	*40	*	*
Repair and plastic operations on the nose (21.8)	393	179	214	*	175	135	*	*
Operations on nasal sinuses (22)	433	192	241	*	164	*	*	*
Tonsillectomy with or without adenoidectomy (28.2-28.3)	399	205	193	289	102	*	*	*
Adenoidectomy without tonsillectomy (28.6)	72	*32	*40	69	*	*	-	-
Operations on the respiratory system (30-34)	282	141	141	*	*40	86	81	*37
Bronchoscopy with or without biopsy (33.21-33.24,33.27,33.71-33.73,33.78-33.79)	106	*55	51	*	*	*30	*	*
Operations on the cardiovascular system (35-39,00.40-00.49,00.50-00.55,00.57,00.61-00.66,17.51-17.52,17.71)	1,072	519	553	*	88	369	356	245
Cardiac catheterization (37.21-37.23)	339	136	203	*	*	126	113	*
Operations on the digestive system (42-54,17.1-17.3,17.63)	10,045	5,418	4,627	*	1,826	4,759	2,044	1,198
Dilation of esophagus (42.92)	172	106	66	*	*	72	36	*38
Endoscopy of small intestine with or without biopsy (45.11-45.14,45.16)	2,172	1,312	861	*	468	936	387	325
Endoscopy of large intestine with or without biopsy (45.21-45.25)	3,987	2,202	1,785	*	474	2,132	916	431
Endoscopic polypectomy of large intestine (45.42)	1,060	485	575	*	*	520	354	158
Laparoscopic cholecystectomy (51.23)	436	325	111	*	196	162	*	*
Hernia repair (53.0-53.9,17.1-17.2)	777	196	581	*	178	355	83	88
Repair of inguinal hernia (53.0-53.1,17.1-17.2)	449	*52	*	*	82	198	54	66
Operations on the urinary system (55-59)	1,349	590	759	*67	311	456	294	220
Cystoscopy with or without biopsy (57.31-57.33)	479	219	260	*	128	155	104	82
Operations on the male genital organs (60-64)	525	-	525	*	98	131	89	*54
Operations on the female genital organs (65-71)	1,766	1,766	-	*	1,093	527	91	*
Hysteroscopy (68.12)	198	198	-	*	83	83	*	*
Dilation and curettage of uterus (69.0)	328	328	-	-	172	116	*	*

See footnotes at end of table.

**Table 3. Number of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010—Con.**

Procedure category and ICD-9-CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15-44	45-64	65-74	75 and over
Number (thousands)								
Operations on the musculoskeletal system..... (76-84,00.70-00.77,00.80-00.87)	7,076	3,802	3,275	173	2,114	3,456	885	448
Partial excision of bone..... (76.2-76.3,77.6-77.8)	241	132	109	*	49	141	*29	*
Reduction of fracture..... (76.7,79.0-79.3)	380	153	227	*52	160	111	*	*
Injection of therapeutic substance into joint or ligament..... (76.96,81.92)	267	183	84	*	*	127	*48	*
Removal of implanted devices from bone..... (76.97,78.6)	195	111	83	*	64	87	*	*
Excision and repair of bunion and other toe deformities..... (77.5)	379	327	*52	*	120	165	*55	*
Arthroscopy of knee..... (80.26)	692	332	359	*	254	333	80	*
Excision of semilunar cartilage of knee..... (80.6)	759	374	385	*	196	435	105	*
Replacement or other repair of knee..... (81.42-81.47,81.54-81.55,00.80-00.84)	571	285	286	*	201	*	*	*
Operations on muscle, tendon, fascia and bursa..... (82-83)	1,274	636	637	*	319	635	196	88
Operations on the integumentary system..... (85-86)	4,340	3,405	935	131	1,497	1,767	566	380
Biopsy of breast..... (85.11-85.12)	*	*	*	-	*	86	*	*
Local excision of lesion of breast (lumpectomy)..... (85.21)	268	*	*	*	64	151	*40	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue..... (86.2-86.4)	1,219	734	485	*	323	449	182	171
Miscellaneous diagnostic and therapeutic procedures and new technologies..... (87-99,00.01-00.03,00.09-00.19,00.21-00.25,00.28-00.29,00.31-00.35,00.39, 00.56, 00.58-00.59, 00.67-00.69,17.62,17.69,17.70,38.24,38.25,00.91-00.94,17.4)	5,892	3,102	2,790	228	1,225	2,358	1,158	923
Operations on the endocrine system, on the hemic and lymphatic system, and obstetrical procedures..... (06-07,40-41,72-75)	348	285	63	*	104	135	*62	32

\* Figure does not meet standards of reliability or precision. An asterisk with a number indicates that the estimate is based on a relatively small number of cases, and while reliable, should be used with caution.  
 - Quantity zero.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

**Table 4. Standard errors of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010**

Procedure category and ICD-9-CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15-44	45-64	65-74	75 and over
				Standard error				
All procedures	4,040	2,250	1,844	492	972	1,806	765	591
Operations on the nervous system (01-05,17.61)	703	398	316	*	240	377	90	92
Injection of agent into spinal canal (03.91-03.92)	557	305	265	*	208	297	74	82
Release of carpal tunnel (04.43)	102	61	45	-	14	61	24	*16
Operations on the eye (08-16)	1,005	569	454	21	80	318	322	392
Operations on eyelids (08)	203	130	100	*	*	106	69	*
Extraction of lens (13.1-13.6)	370	217	159	*	*	77	133	179
Insertion of prosthetic lens (pseudophakos) (13.7)	356	213	147	*	*	76	124	163
Operations on the ear (18-20)	188	107	94	184	12	16	*	*
Myringotomy with insertion of tube (20.01)	161	91	83	152	*	*	*	*
Operations on the nose, mouth, and pharynx (21-29)	312	155	173	194	88	101	35	*17
Incision, excision and destruction of nose and lesion of nose (21.1,21.3-21.4,21.6)	68	*	25	*	22	*	*	*
Turbinectomy (21.6)	31	18	20	*	19	*11	*	*
Repair and plastic operations on the nose (21.8)	78	*	32	*	35	29	*	*
Operations on nasal sinuses (22)	92	48	59	*	35	*	*	*
Tonsillectomy with or without adenoidectomy (28.2-28.3)	65	36	38	53	16	*	*	*
Adenoidectomy without tonsillectomy (28.6)	15	*8	*10	14	*	*	-	*
Operations on the respiratory system (30-34)	38	22	24	*	*11	17	17	*9
Bronchoscopy with or without biopsy (33.21-33.24,33.27,33.71-33.73,33.78-33.79)	18	*12	11	*	*	*8	*	*
Operations on the cardiovascular system (35-39,00.40-00.49,00.50-00.55,00.57,00.61-00.66,17.51-17.52,17.71)	197	98	109	*	18	62	105	53
Cardiac catheterization (37.21-37.23)	88	37	54	*	*	27	*	*
Operations on the digestive system (42-54,17.1-17.3,17.63)	1,148	608	555	*	196	599	278	144
Dilation of esophagus (42.92)	32	23	14	*	*	15	*9	*11
Endoscopy of small intestine with or without biopsy (45.11-45.14,45.16)	290	171	128	*	69	144	60	47
Endoscopy of large intestine with or without biopsy (45.21-45.25)	560	292	280	*	82	319	132	83
Endoscopic polypectomy of large intestine (45.42)	195	93	108	*	*	106	77	35
Laparoscopic cholecystectomy (51.23)	64	48	20	*	27	31	*	*
Hernia repair (53.0-53.9,17.1-17.2)	113	31	89	*	30	63	14	18
Repair of inguinal hernia (53.0-53.1,17.1-17.2)	72	*	61	*	19	37	11	16
Operations on the urinary system (55-59)	184	79	114	*20	61	67	49	33
Cystoscopy with or without biopsy (57.31-57.33)	75	38	44	*	31	25	21	15
Operations on the male genital organs (60-64)	106	-	106	*	16	*	*	*15
Operations on the female genital organs (65-71)	223	223	-	*	145	81	19	*
Hysteroscopy (68.12)	33	33	-	*	17	17	*	*
Dilation and curettage of uterus (69.0)	42	42	-	-	23	21	*	*

See footnotes at end of table.

**Table 4. Standard errors of ambulatory surgery procedures in hospitals and ambulatory surgery centers, by procedure category, sex, and age: United States, 2010—Con.**

Procedure category and ICD-9-CM code	Total	Sex		Age group (years)				
		Female	Male	Under 15	15-44	45-64	65-74	75 and over
				Standard error				
Operations on the musculoskeletal system . . . . . (76-84,00.70-00.77,00.80-00.87)	1,156	667	501	36	305	685	144	77
Partial excision of bone . . . . . (76.2-76.3,77.6-77.8)	35	27	18	*	9	26	*7	*
Reduction of fracture . . . . . (76.7,79.0-79.3)	50	19	36	*10	24	16	*	*
Injection of therapeutic substance into joint or ligament . . . . . (76.96,81.92)	58	43	20	*	*	32	*14	*
Removal of implanted devices from bone . . . . . (76.97,78.6)	37	27	15	*	16	22	*	*
Excision and repair of bunion and other toe deformities . . . . . (77.5)	72	69	*13	*	28	41	*15	*
Arthroscopy of knee . . . . . (80.26)	168	80	91	*	47	100	22	*
Excision of semilunar cartilage of knee . . . . . (80.6)	177	79	103	*	39	124	26	*
Replacement or other repair of knee . . . . . (81.42-81.47,81.54-81.55,00.80-00.84)	141	80	66	*	36	*	*	*
Operations on muscle, tendon, fascia and bursa . . . . . (82-83)	201	113	96	*	62	102	44	19
Operations on the integumentary system . . . . . (85-86)	496	423	111	32	217	254	65	51
Biopsy of breast . . . . . (85.11-85.12)	*	*	*	-	*	21	*	*
Local excision of lesion of breast (lumpectomy) . . . . . (85.21)	39	39	*	*	15	26	*10	*
Excision or destruction of lesion or tissue of skin and subcutaneous tissue . . . . . (86.2-86.4)	129	103	56	*	58	66	37	48
Miscellaneous diagnostic and therapeutic procedures and new technologies . . . . . (87-99,00.01-00.03,00.09-00.19,00.21-00.25, 00.28-00.29,00.31-00.35,00.39,00.56, 00.58-00.59, 00.67-00.69,17.62,17.69,17.70,38.24,38.25,00.91-00.94,17.4)	750	376	385	50	186	327	183	123
Operations on the endocrine system, on the hemic and lymphatic system, and obstetrical procedures . . . . . (06-07,40-41,72-75)	50	45	14	*	21	25	*13	*9

\* Figure does not meet standards of reliability or precision. An asterisk with a number indicates that the estimate is based on a relatively small number of cases, and while reliable, should be used with caution.  
 - Quantity zero.

NOTE: Procedure categories and code numbers are based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM).

SOURCE: NCHS, National Hospital Ambulatory Medical Care Survey, 2010.

## Technical Notes

Data processing and medical coding were performed by SRA International, Inc., Durham, N.C. Editing and estimation were completed by the National Center for Health Statistics.

### Estimation

Because of the complex multistage design of the National Hospital Ambulatory Medical Care Survey (NHAMCS), the survey data must be inflated or weighted to produce national estimates. The estimation procedure produces essentially unbiased national estimates and has three basic components: (a) inflation by reciprocals of the probabilities of sample selection, (b) adjustment for nonresponse, and (c) population weighting ratio adjustments. These three components of the final weight are described in more detail elsewhere (11).

Because NHAMCS ambulatory surgery data are collected from a sample of visits, persons with multiple visits during the year may be sampled more than once. Therefore, estimates are of the number of visits to, or procedures performed in, hospital ambulatory surgery locations and ASCs, and not the number of persons served by these facilities.

### Standard errors

The standard error is primarily a measure of sampling variability that occurs by chance because only a sample, rather than the entire universe, is surveyed. Estimates of the sampling variability for this report were calculated using Taylor approximations in SUDAAN, which take into account the complex sample design of NHAMCS. A description of the software and the approach it uses has been published elsewhere (23). The standard errors of estimates presented in the tables of this report are included, either as part of the table or, in the case of [Table 3](#), in a separate table ([Table 4](#)).

Data analyses were performed using the statistical packages SAS, version 9.3 (SAS Institute, Cary, N.C.) and SAS-callable SUDAAN, version 10.0

(RTI International, Research Triangle Park, N.C.).

### Testing of significance and rounding

Differences in the estimates were evaluated using a two-tailed *t* test ( $p < 0.05$ ). Terms such as “higher than” and “less than” indicate that differences are statistically significant. Terms such as “similar” or “no difference” indicate that no statistically significant difference exists between the estimates being compared. A lack of comment on the difference between any two estimates does not mean that the difference was tested and found not to be significant.

Estimates of counts in the tables have been rounded to the nearest thousand. Therefore, estimates within tables do not always add to the totals. Rates and percentages were calculated from unrounded figures and may not precisely agree with rates and percentages calculated from rounded data.

### Nonsampling errors

As in any survey, results are subject to both sampling and nonsampling errors. Nonsampling errors include reporting and processing errors as well as biases due to nonresponse and incomplete response. The magnitude of the nonsampling errors cannot be computed. However, efforts were made to keep these errors to a minimum by building procedures into the operation of the survey. To eliminate ambiguities and encourage uniform reporting, attention was given to the phrasing of items, terms, and definitions.

Quality control procedures and consistency and edit checks reduced errors in data coding and processing. A 5% quality control sample of survey records was independently keyed and coded. Item nonresponse rates were generally low, but levels of nonresponse did vary among different variables. The data shown in this report are based upon items with low nonresponse.

### Use of tables

The estimates presented in this report are based on a sample, and therefore may differ from the number that would

be obtained if a complete census had been taken. The estimates shown in this report include surgical procedures, such as tonsillectomy; diagnostic procedures, such as ultrasound; and other therapeutic procedures, such as injection or infusion of cancer chemotherapeutic substance.

In 2010, up to seven procedures were coded for each visit. All listed procedures include all occurrences of the procedure coded regardless of the order on the medical record.

The procedure data in this report are presented by chapter of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). In the Results section, selected chapters with large numbers of procedures are discussed along with specific categories of procedures performed 1 million or more times. The latter categories are included to give some examples of what was included under the chapters.

[Table 3](#) presents data using ICD-9-CM codes for chapters of procedures as well as selected procedures within these chapters. The procedures selected for inclusion in [Table 3](#) were those with relatively large frequencies, or because there was a clinical, epidemiological, or health services interest in them.

Data from the 2010 NHAMCS showed that an estimated 479,000 ambulatory surgery visits ended with an admission to the hospital as an inpatient. The visits made by these patients were included in this report [as they were in the 2006 National Survey of Ambulatory Surgery (NSAS) Report] (2), and the ambulatory surgery procedures they received were included in the estimates for all listed procedures.

Estimates were not presented in this report if they were based on fewer than 30 cases in the sample data or if the relative standard error (RSE) was greater than 30%. In these cases, only an asterisk (\*) appears in the tables. The RSE of an estimate is obtained by dividing the standard error by the estimate itself. The result is then expressed as a percentage of the estimate. Estimates based on 30 to 59 cases include an asterisk because, while their RSE is less than 30%, these estimates are based on a relatively small number of cases and should be used with caution.

**U.S. DEPARTMENT OF  
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National Center for Health Statistics  
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**National Center for Health Statistics**

Charles J. Rothwell, M.S., M.B.A., *Director*  
Jennifer H. Madans, Ph.D., *Associate Director  
for Science*

**Division of Health Care Statistics**

Denys T. Lau, Ph.D., *Acting Director*  
Alexander Strashny, Ph.D., *Associate Director  
for Science*

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Exhibit 20

Ambulatory Surgery Center Association “A Positive Trend in Health  
Care”

# Ambulatory Surgery Centers

## A Positive Trend in Health Care



*Ambulatory surgery centers (ASCs) are health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting. Since their inception more than four decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule.*

## A TRANSFORMATIVE MODEL FOR SURGICAL SERVICES

As our nation struggles with how to improve a troubled and costly health care system, the experience of ASCs is a great example of a successful transformation in health care delivery.

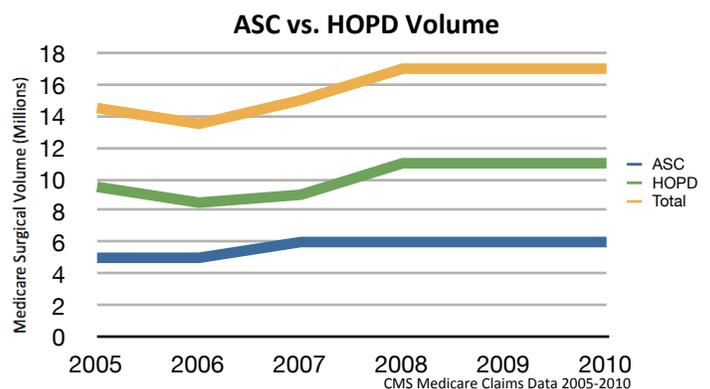
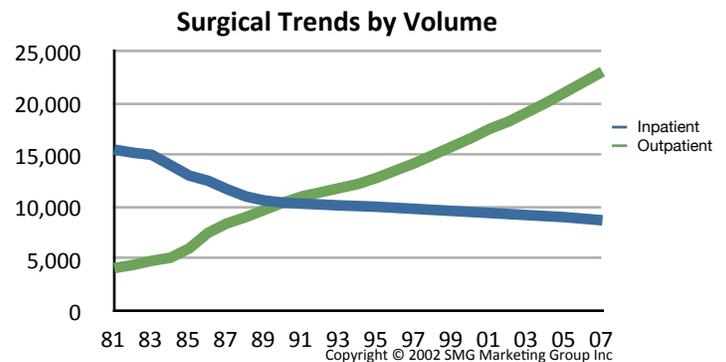
Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the US.

Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, slow operating room turnover times, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way—and developed it in ASCs.

Today, physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain increased control over their surgical practices.<sup>1</sup> In the ASC setting, physicians are able to schedule procedures more conveniently, assemble teams of specially trained and highly skilled staff, ensure that the equipment and supplies being used are best suited to their techniques, and design facilities tailored to their specialties and to the specific needs of their patients. Simply stated, physicians are striving for, and have found in ASCs, professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in an ASC (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Given the history of their involvement in making ASCs a reality, it is not surprising that physicians continue to have at least some ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace the value of the ASC model. According to the most recent data available, hospitals have ownership interest in 21% of all ASCs and 3% are owned entirely by hospitals.<sup>2</sup>

ASCs also add considerable value to the US economy, with a 2009 total nationwide economic impact of \$90 billion, including more than \$5.8 billion in tax payments. Additionally, ASCs employ the equivalent of approximately 117,700 full-time workers.<sup>3</sup>



## ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

Not only are ASCs focused on ensuring that patients have the best surgical experience possible, they also provide cost-effective care that save the government, third party payors and patients money. On average, the Medicare program and its beneficiaries share in more than \$2.6 billion in savings each year because the program pays significantly less for procedures performed in ASCs when compared to the rates paid to hospitals for the same procedures. Accordingly, patient co-pays are also significantly lower when care is received in an ASC.

If just half of the eligible surgical procedures moved from hospital outpatient departments to ASCs, Medicare would save an additional \$2.4 billion a year or \$24 billion over the next 10 years. Likewise, Medicaid and other insurers benefit from lower prices for services performed in the ASC setting.

Currently, Medicare pays ASCs 58% of the amount paid to hospital outpatient departments for performing the same services. For example, Medicare pays hospitals \$1,670 for performing an outpatient cataract surgery while paying ASCs only \$964 for performing the same surgery.

This huge payment disparity is a fairly recent phenomenon. In 2003, Medicare paid hospitals only 16% more, on average, than it paid ASCs. Today, Medicare pays hospitals 72% more than ASCs for outpatient surgery. There is no health or fiscal policy basis for providing ASCs with drastically lower payments than hospital outpatient departments.

In addition, patients typically pay less coinsurance for procedures performed in the ASC than for comparable procedures in the hospital setting. For example, a Medicare beneficiary could pay as much as \$496 in coinsurance for a cataract extraction procedure performed in a hospital outpatient department, whereas that same beneficiary's copayment in the ASC would be only \$195.

Without the emergence of ASCs as an option for care, health care expenditures would have been tens of billions of dollars higher over the past four decades. Private insurance companies tend to save similarly, which means employers also incur lower health care costs when employees utilize ASC services. For this reason, both employers and insurers have recently been exploring ways to incentivize the movement of patients and procedures to the ASC setting.

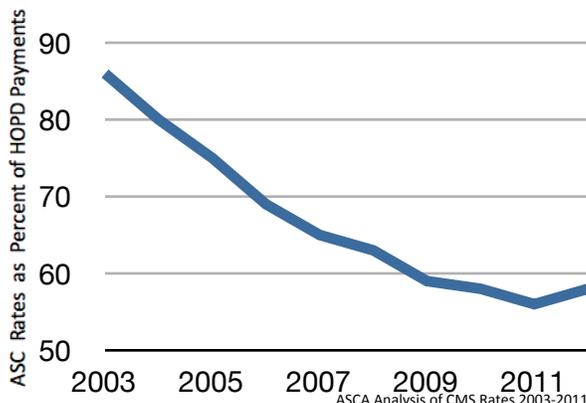
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased by hospitals and converted into hospital outpatient departments. Even if an ASC is not physically located next to a hospital, once it is part of a hospital, it can terminate its ASC license and become a unit of the hospital, entitling the hospital to bill for Medicare services provided in the former ASC at the 72% higher hospital outpatient rates.

**Cost Comparison:  
ASC v. Hospital Outpatient Department**

	Patient Cost		Medicare Cost	
	ASC Co-pay	HOPD Co-pay	Total Procedure Cost ASC	Total Procedure Cost HOPD
Cataract	\$193	\$490	\$964	\$1,670
Upper GI Endoscopy	\$68	\$139	\$341	\$591
Colonoscopy	\$76	\$186	\$378	\$655

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

**The Gap Between ASC and HOPD  
Payments Has Widened Significantly**

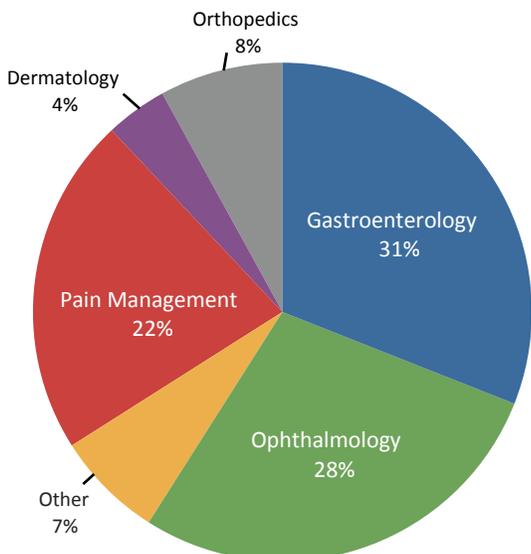


## THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price of the planned

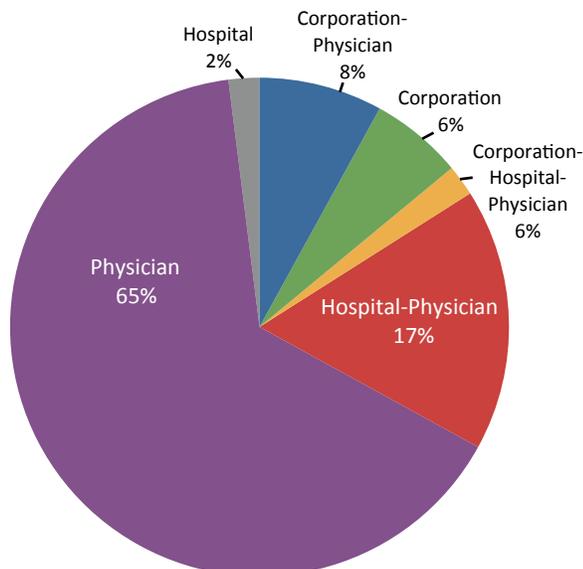
surgical procedure and the specific portion for which the patient would be responsible. This will empower health care consumers as they evaluate and compare costs for the same service amongst various health care providers.

### Medicare Case Volume by Specialty



ASCA Analysis of CMS Claims Data 2010

### ASC Ownership



ASCA's 2011 ASC Employee Salary & Benefits Survey

## ASCs = Efficient Quality Care + Convenience + Patient Satisfaction

The ASC health care delivery model enhances patient care by allowing physicians to:

- Focus exclusively on a small number of processes in a single setting, rather than having to rely on a hospital setting that has large-scale demands for space, resources and the attention of management
- Intensify quality control processes since ASCs are focused on a smaller space and a small number of operating rooms, and
- Allow patients to bring concerns directly to the physician operator who has direct knowledge about each patient’s case rather than deal with hospital administrators who almost never have detailed knowledge about individual patients or their experiences

Physician ownership also helps reduce frustrating wait-times for patients and allows for maximum specialization and patient–doctor interaction. Unlike large-scale institutions, ASCs

- Provide responsive, non-bureaucratic environments tailored to each individual patient’s needs
- Exercise better control over scheduling, so virtually no procedures are delayed or rescheduled due to the kinds of institutional demands that often occur in hospitals (unforeseen emergency room demands)
- Allow physicians to personally guide innovative strategies for governance, leadership and most importantly, quality initiatives

As a result, patients say they have a 92% satisfaction rate with both the care and service they receive from ASCs .<sup>4</sup> Safe and high quality service, ease of scheduling, greater personal attention and lower costs are among the main reasons cited for the growing popularity of ASCs.

## ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

ASCs are highly regulated by federal and state entities. The safety and quality of care offered in ASCs is evaluated by independent observers through three processes: state licensure, Medicare certification and voluntary accreditation.

Forty three states and the District of Columbia, currently require ASCs to be licensed in order to operate. The remaining seven states have some form of regulatory requirements for ASCs such as Medicare certification or accreditation by an independent accrediting organization. Each state determines the specific requirements ASCs must meet for licensure and most require rigorous initial and ongoing inspection and reporting.

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All ASCs serving Medicare beneficiaries must be certified by the Medicare program. In order to be certified, an ASC must comply with standards developed by the federal government for the specific purpose of ensuring the safety of the patient and the quality of the facility, physicians, staff, services and management of the ASC. The ASC must demonstrate compliance with these Medicare standards initially and on an ongoing basis.

In addition to state and federal inspections, many ASCs choose to go through voluntary accreditation by an independent accrediting organization. Accrediting organizations for ASCs include The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) and

## ASCs: A COMMITMENT TO QUALITY

Quality care has been a hallmark of the ASC health care delivery model since its earliest days. One example of the ASC community’s commitment to quality care is the ASC Quality Collaboration, an independent initiative that was established voluntarily by the ASC community to promote quality and safety in ASCs.

The ASC Quality Collaboration is committed to developing meaningful quality measures for the ASC setting. Six of those measures have already been endorsed by the National Quality Forum (NQF). The NQF is a non-profit organization dedicated to improving the quality of health care in America, and the entity the Medicare program consults when seeking appropriate measurements of quality care. More than 20% of all ASCs are already voluntarily reporting the results of the ASC quality measures that NQF has endorsed.

Since 2006, the ASC industry has urged the CMS to establish a uniform quality reporting system to allow all ASCs to publicly demonstrate their performance on quality measures. Starting on October 1, 2012, a new quality reporting system for ASCs will begin and will encompass five of the measures that ASCs are currently reporting voluntarily.

the American Osteopathic Association (AOA). ASCs must meet specific standards during on-site inspections by these organizations in order to be accredited. All accrediting organizations also require an ASC to engage in external benchmarking, which allows the facility to compare its performance to the performance of other ASCs.

In addition to requiring certification in order to participate in the Medicare program, federal regulations also limit the scope of surgical procedures reimbursed in ASCs. Even though ASCs and hospital outpatient departments are clinically identical, the Center for Medicare & Medicaid Services (CMS) applies different standards to the two settings.

### Reporting Measures

Measure	Data Collection Begins
Patient Burn	Oct 1, 2012
Patient Fall	Oct 1, 2012
Wrong Site, Side, Patient, Procedure	Oct 1, 2012
Hospital Admission	Oct 1, 2012
Prophylactic IV Antibiotic Timing	Oct 1, 2012
Safe Surgery Check List Use	Jan 1, 2012
Volume of Certain Procedures	Jan 1, 2012
Influenza Vaccination Coverage for Health Care Workers	Jan 1, 2013

76 Federal Regulation 74492 - 74517

## Specific Federal Requirements Governing ASCs

In order to participate in the Medicare program, ASCs are required to meet certain conditions set by the federal government to ensure that the facility is operated in a manner that assures the safety of patients and the quality of services.

ASCs are required to maintain complete, comprehensive and accurate medical records. The content of these records must include a medical history and physical examination relevant to the reason for the surgery and the type of anesthesia planned. In addition, a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and the procedure to be performed. Prior to discharge each patient must be evaluated by a physician for proper anesthesia recovery.

CMS requires ASCs to take steps to ensure that patients do not acquire infections during their care at these facilities. ASCs must establish a program for identifying and preventing infections, maintaining a sanitary environment and reporting outcomes to appropriate authorities. The program must be one of active surveillance and include specific procedures for prevention, early detection, control and investigation of infectious and communicable diseases in accordance with the recommendations of the Centers for Disease Control and Prevention. Thanks to these ongoing efforts, ASCs have very low infection rates.<sup>5</sup>

A registered nurse trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever a patient is in the ASC. To further protect patient safety, ASCs are also required to have an effective means of transferring patients to a hospital for additional care in the event of an emergency. Written guidelines outlining arrangements for ambulance services and transfer of medical information are mandatory. An ASC must have a written transfer agreement with a local hospital, or all physicians performing surgery in the ASC must have admitting privileges at the designated hospital. Although these safeguards are in place, hospital admissions as a result of complications following ambulatory surgery are rare.<sup>5</sup>

Continuous quality improvement is an important means of ensuring that patients are receiving the best care possible. An ASC, with the active participation of its medical staff, is required to conduct an ongoing, comprehensive assessment of the quality of care provided.

The excellent outcomes associated with ambulatory surgery reflect the commitment that the ASC industry has made to quality and safety. One of the many reasons that ASCs continue to be so successful with patients, physicians and insurers is their keen focus on ensuring the quality of the services provided.

## Medicare Health and Safety Requirements

Required Standards	ASCs	HOPDs
Compliance with State licensure law	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Governing body and management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Surgical services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Quality assessment and performance improvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Environment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Medical staff	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Nursing services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Medical records	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Pharmaceutical services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Laboratory and radiologic services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Patient rights	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Infection control	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Patient admission, assessment and discharge	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

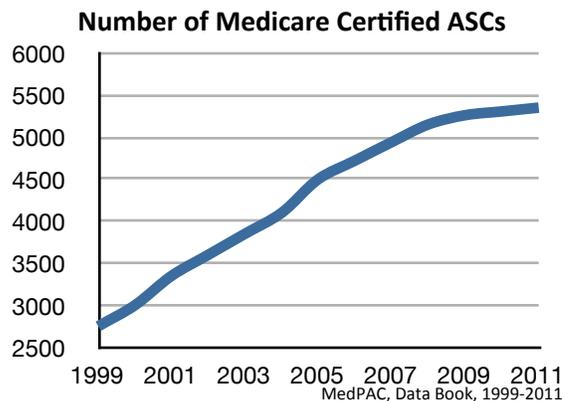
Source: 42 CFR 416 & 482

## CONTINUED DEMAND FOR ASC FACILITIES

Technological advancement has allowed a growing range of procedures to be performed safely on an outpatient basis (unfortunately, however, Medicare has been slow to recognize these advances and assure that its beneficiaries have access to them). Faster acting and more effective anesthetics and less invasive techniques, such as arthroscopy, have driven this outpatient migration. Procedures that only a few years ago required major incisions, long-acting anesthetics and extended convalescence can now be performed through closed techniques utilizing short-acting anesthetics, and with minimal recovery time. As medical innovation continues to advance, more and more procedures will be able to be performed safely in the outpatient setting.

Over the years, the number of ASCs has grown in response to demand from the key participants in surgical care—patients, physicians and insurers. While this demand has been made possible by technology, it has been driven by patient satisfaction, efficient physician practice, high levels of quality and the cost savings that have benefited all.

However, in a troubling trend, the growth of ASCs has slowed in recent years. If the supply of ASCs does not keep pace with the demand for outpatient surgery that patients require, that care will be provided in the less convenient and more costly hospital outpatient department.<sup>12</sup>



## ASCs CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

As a leader in the evolution of surgical care that has led to the establishment of affordable and safe outpatient surgery, the ASC industry has shown itself to be ahead of the curve in identifying promising avenues for improving the delivery of health care.

With a solid track record of performance in patient satisfaction, safety, quality and cost management, the ASC industry is already embracing the changes that will allow it to continue to play a leading role in raising the standards of performance in the delivery of outpatient surgical services.

As always, the ASC industry welcomes any opportunity to clarify the services it offers, the regulations and standards governing its operations, and the ways in which it ensures safe, high-quality care for patients.

## POLICY CONSIDERATIONS

Given the continued fiscal challenges posed by administering health care programs, policy makers and regulators should continue to focus on fostering innovative methods of health care delivery that offer safe, high-quality care so progressive changes in the nation’s health care system can be implemented.

Support should be reserved for those policies that foster competition and promote the utilization of sites of service providing more affordable care, while always maintaining high quality and stringent safety standards. In light of the many benefits ASCs have brought to the nation’s health care system, policymakers should develop and implement payment and coverage policies that increase access to, and utilization of, ASCs.

## END NOTES

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- 3 Oxford Outcomes ASC Impact Analysis, 2010.
- 4 Press-Ganey Associates, “Outpatient Pulse Report,” 2008.
- 5 ASCA Outcomes Monitoring Project, 3rd Quarter 2011.

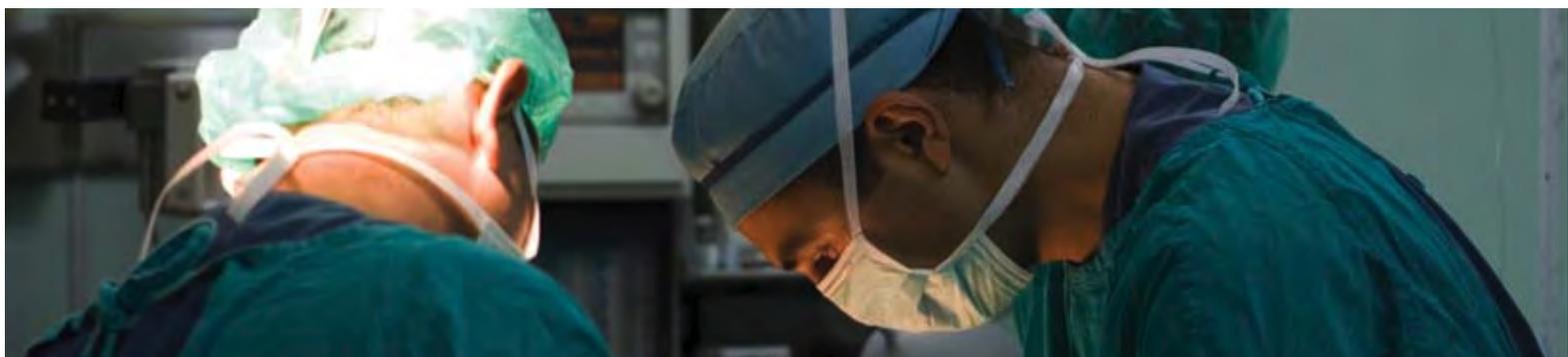


Exhibit 21

American Academy of Ophthalmology “Rising Cataract Surgery Rates: Demand and Supply”

## Rising Cataract Surgery Rates: Demand and Supply

Jay C. Erie, MD - Rochester, Minnesota

Cataract surgery is the most frequently performed surgical procedure in many developed countries, providing significant, long-term, and cost-effective improvements in the quality of life for patients of all ages.<sup>1,2</sup> Advances in cataract surgery techniques and technologies over the last decades have led to improved patient safety and better surgical outcomes, resulting in significant changes in the frequency with which cataract surgery is performed.

Longitudinal, population-based data on cataract surgery rates in the United States are limited. In this issue, Klein et al<sup>3</sup> provide timely, informative, population-based data on the changing incidence of cataract surgery in Beaver Dam, Wisconsin, during the 20-year period when cataract surgery shifted from planned extracapsular cataract extraction to small-incision phacoemulsification. Klein et al report that the age- and sex-adjusted incidence of cataract surgery increased 6.5-fold between 1988-90 and 2008-10 (1.8% vs. 11.7%) in Beaver Dam residents aged 43 to 86 years. The greatest increases were seen in the most recent 5-year interval (between 2003-05 and 2008-10) in persons older than 65 years of age and in persons with a visual acuity better than 20/40 or without a clinically significant cataract as determined at an examination 5 years before cataract surgery.

The strengths of this study include its population basis, 2 decades of cataract surgery incidence, a standardized assessment of cataract status and visual acuity, avoidance of inclusion and recall bias, and adjustment for multiple potential risk factors. Its limitations include a small cohort size (4926 residents), a lack of geographic and racial diversity (99% white), and the interpretation of preoperative cataract status and visual acuity based on measurements performed up to 5 years before cataract surgery.

The World Health Organization has set a cataract surgery rate of 3000 per million people per year as the minimum necessary to eliminate cataract blindness.<sup>4</sup> This rate is greatly exceeded in many developed countries (7000–11 000 per million persons),<sup>5–7</sup> and surgery rates are steadily increasing. Increasing cataract surgery rates have been explained, in part, by an aging demographic structure, reduced thresholds of visual impairment as an indication for surgery, increased frequency of second eye surgery, and increasing expectations by patients for better vision.

What can we learn from the Beaver Dam Eye Study? First, the rising cataract surgery rates observed in Beaver Dam also were seen during the same time period in other areas of the United States and in many developed countries, albeit of a significantly lesser magnitude. Across the Mississippi river and 220 miles to the west of Beaver Dam, population-based data from Olmsted County, Minnesota

(population 144 248 in 2010), showed a lower, but steady 2.5-fold increase in the rate of incident cataract surgery over the same time period (4400 surgeries/million residents in 1990 and 10 000 in 2010).<sup>7</sup> Furthermore, Olmsted County modeling showed that cataract surgery increased at a greater rate than could be attributed to changing demographics alone. Nationally, using U.S. Medicare beneficiary data, the rate of cataract surgery in persons older than 65 years of age increased 2.4-fold between 1987<sup>8</sup> and 2004.<sup>9</sup> In Australia, cataract surgery rates increased 1.4-fold between 2000 and 2005.<sup>5</sup> Rising surgery rates in the U.S. senior population are not unique to ophthalmology. In orthopedic surgery, improved surgical techniques and implant technologies have led to a 1.6- to 2.7-fold increase in total knee and hip arthroplasties over a comparable time period.<sup>10</sup>

Although cataract surgery rates were on the rise in Beaver Dam, rates in Sweden had stabilized between 2002 and 2009 at 8000 to 9000 procedures per million persons.<sup>6</sup> How were our Nordic colleagues able to accomplish this while at the same time slowly decreasing the surgery backlog, increasing the rate of second eye surgery, and operating on eyes with better preoperative Snellen visual acuity? The reason is multifactorial, but includes a limit on the number of annual cataract surgeries placed by many of Sweden's 22 counties/regions and increased competition for eye care resources from other fields within ophthalmology, primarily in the management of age-related macular degeneration. In 2008, the county of Stockholm removed the limit on the annual number of cataract surgeries allowed. Of note, cataract surgery rates subsequently increased in that area (Lundström M, personal communication, 2013).

Second, a reduced threshold of visual impairment is increasingly being used as an indication for surgery by surgeons, patients, and payers. Better preoperative vision before surgery has been documented in Beaver Dam, Olmsted County,<sup>7</sup> Australia,<sup>5</sup> Denmark,<sup>11</sup> England,<sup>12</sup> and Sweden.<sup>6</sup> In Sweden, for example, the fraction of residents with a Snellen visual acuity of 20/40 or better in the eye planned for surgery has increased from 56% in 1992 to 78% in 2009.<sup>6</sup> Not surprisingly, lower visual thresholds for surgery are associated with increased surgery rates. In Australia, when the visual impairment threshold changed from less than 20/200 to less than 20/30, cataract surgery rates increased approximately 5-fold.<sup>5</sup> However, one needs to remember that Snellen acuity alone is a functionally incomplete measure of visual function, and other quantifiable factors such as contrast sensitivity and glare contribute to patient visual dissatisfaction.

It is important for readers to note that the comments by Klein et al<sup>3</sup> regarding preoperative visual acuity threshold and

cataract status are based on measurements performed up to 5 years before cataract surgery. Although the authors think that it “seems unlikely” over a 5-year period “that a rapid change occurred in development of lens opacity and/or decreased vision related to cataract prior to surgery,” previous data from the Age-Related Eye Disease Study Research Group<sup>13</sup> report the 5-year cumulative incidence of progression from a grade of no or mild lens opacity at baseline to a moderate cataract of any kind to be approximately 24% among participants aged 55 to 80 years. Rather than mistakenly infer that cataract surgery is being performed in eyes without a cataract, it is more likely that Beaver Dam ophthalmologists and their patients—similar to their colleagues and patients in Olmsted County and in other countries—have reduced their visual impairment threshold for cataract surgery.

Why are we observing an increasing demand for cataract surgery at lower visual impairment thresholds in nearly all age groups? Columnist Rich Karlgaard<sup>14</sup> recently cited George Gilder, author of *Wealth and Poverty*, who argued that in economics, increased demand is due to increased supply. “The key is not an increase in the *same* supply, but rather an increase in a new, inventive supply that exceeds people’s expectations and takes them to new heights in their lives.”<sup>14</sup> This statement, in my opinion, aptly describes cataract surgery over the last decades. Through improved technologies and techniques, today’s ophthalmologists can safely and quickly remove a cloudy crystalline lens and fairly predictably decrease or eliminate postoperative spherical and astigmatic error. Our ability to provide a new, innovative cataract surgery “supply” has provided better outcomes, improved quality of life, and exceeded patient expectations, consequently, and quite naturally this has driven increased patient “demand” for our service.

To paraphrase Steve Jobs, “People don’t know what they want until you show it to them.”<sup>15</sup> For many patients, after first-eye cataract surgery, the previously minimally symptomatic 20/30 fellow eye now no longer seems adequate when compared with the new pseudophakic eye. The benefits of first-eye surgery seem to have changed our patients’ perceptions of disability and visual functioning in the fellow eye. This is evidenced by the significant increase in second-eye surgery in most surveys, now accounting for approximately 40% of all cataract operations. This is for good reason. Bilateral cataract surgery is cost-effective, improves patient satisfaction, and has better outcomes than surgery in one eye only.<sup>2,16,17</sup> Disturbed motion perception, disturbed stereoacuity, and disturbances from anisometropia are reported disabilities that persist after unilateral cataract surgery or with a cataract in the fellow eye after first-eye surgery.<sup>18</sup> Perhaps because of the documented benefits of bilateral cataract surgery, in the last 7 years we have seen a doubling of the rate of second-eye surgery in Olmsted County residents within the first 3 months after first-eye surgery (60% vs. 28%), with 86% of residents now undergoing second-eye surgery within 2 years of first-eye surgery.

Is more always better in cataract surgery? William Falk<sup>19</sup> writes that “if humans can, we will — whether or not we should.” Human history amply demonstrates our tendency to race ahead of our ability to think through all of the

consequences of our actions. This has been the case recently with the capabilities of drone technology and Internet metadata-analysis. The many documented benefits of cataract surgery have led to an ever-increasing demand for cataract surgery and, as a consequence, steadily higher surgery rates and an increasing need for more resources. Is this appropriate?

I believe it is. To do otherwise is to encourage mediocrity. Continued improvements in cataract surgery “supply” have naturally and appropriately stimulated patient “demand” for better vision. Predicting if or when cataract surgery rates will level off or decline is difficult. Placing limits on the annual number of cataract surgeries performed or shifting more cost to the patient will be contentious. Regardless, it is our responsibility as surgeons to continue to innovate, to improve safety and outcomes, and to reduce costs so that we enhance the value of cataract surgery for every patient we serve.

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Exhibit 22

Ophthalmology Times “The Future of Cataract Surgery”

## The future of cataract surgery

### Changes lie ahead as pressure on surgeons increases

July 10, 2017

By [Frank Goes, MD](#)



As the most common procedure performed by the ophthalmic surgeon, in 2014, 4.3 million cataract operations took place in the European Union Member States. It is estimated that more than 23 million procedures will be performed worldwide in 2016.<sup>1,2</sup>

Meanwhile, during the past 35 years, life expectancy has increased by 12 years in Western countries and by more than 25 years in most developing countries.<sup>3,4</sup>

Since we know that the occurrence of cataract increases with age; that the prevalence of cataract is greater in developing countries; and that more than 70% of people aged older than 85 years are affected<sup>5</sup>, the medical community faces the threat of insufficient numbers of ophthalmic surgeons.

In the United States, some 9,000 ophthalmic surgeons were performing 3.6 million cataract surgeries in 2015.<sup>2</sup> This means that in 5 years' time, 125,000 surgeons will be required to treat 50 million cataracts per year. In 10 years from now, the number of surgeons needed worldwide could soar to 250,000.

Faced with such numbers, robots and technicians will have to take over. Cataract surgery only recently became more automated, the femtosecond laser having taken over part of the job since 2013. Femtosecond laser-assisted cataract surgery will continue to grow in popularity and the recently introduced nanolaser photo-fragmentation takes over another significant part of the surgery. The insertion of a preloaded IOL by a technician or a robot might be a future development.

Beside robotics, technology will evolve to enable successful cataract procedures in both eyes during a single session, thus saving time. Immediately sequential bilateral cataract surgery will become the norm.

Techniques will also evolve so that treatment of both eyes on patients sitting in the upright position, as happens today in the dentist's chair, will be possible.

Further advancements could be that dilation of the pupil, an inconvenience that incapacitates patients for half a day, might no longer be necessary, and IOL power calculations might be made in the operating room on the day of surgery using ray-tracing techniques. Using three-dimensional technology, a preloaded IOL would be printed in the surgery room and personalised (unifocal-, bifocal- or accommodative) for each patient.

Also in the future, human intelligence is likely to find a way around the need to use an eye speculum for cataract surgery. Unmodified for more than 100 years since it was developed by Arruga and Barraquer, it is (probably) sometimes responsible for the only annoying sensation experienced by a patient during the procedure.

Finally, alternative potential strategies involving genetics are being explored for the prevention of cataracts that could lead to the end of cataract surgery.<sup>6,7</sup>

In summary, implementation of these steps could provide an answer to the overwhelming increase of cataracts requiring treatment worldwide. It will be interesting to review things again in 10 years' time!

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E: [\[email protected\]](#)

Dr Goes is medical director, Goes Eye Centre Left Bank in Antwerp, Belgium.

Dr Goes serves as a member of the *Ophthalmology Times Europe* Editorial Advisory Board. He did not indicate any proprietary interest relevant to the subject matter.

Exhibit 23

Michigan Medicine University of Michigan “Increased Use of Ambulatory Surgery Centers for Cataract Surgery”



NOVEMBER 22, 2017

Media Contact: [Shantell Kirkendoll \(mailto: smkirk@umich.edu\)](mailto:smkirk@umich.edu) 734-764-2220

## Increased use of ambulatory surgery centers for cataract surgery

### Study shows major shift in ocular surgery from hospitals to surgery centers

National data shows a major shift in eye surgeries from hospitals to less expensive ambulatory surgery centers where care may be delivered faster and closer to home for some patients.



(Stock image) From cataract surgery to glaucoma procedures, more patients are having eye surgery at local surgery centers.

Over the past decade the proportion of cataract surgeries performed at surgery centers increased steadily, reaching 73 percent in 2014, compared to 43.6 percent in 2001.

[University of Michigan Kellogg Eye Center \(http://www.umkelloggeye.org\)](http://www.umkelloggeye.org) researchers revealed the increased use of surgery centers for cataract surgery, but say more research is needed to determine if there's a difference in safety between hospitals and surgery centers.

For the large study, published Nov. 22 in [JAMA Ophthalmology \(https://jamanetwork.com/journals/jamaophthalmology/article-abstract/2664081?utm\\_source=TWITTER&utm\\_medium=social\\_in&utm\\_term=1149707952&utm\\_content=content\\_engagement%7carticle\\_engagement&utm\\_campaign=article\\_alert&linkId=44592660\)](https://jamanetwork.com/journals/jamaophthalmology/article-abstract/2664081?utm_source=TWITTER&utm_medium=social_in&utm_term=1149707952&utm_content=content_engagement%7carticle_engagement&utm_campaign=article_alert&linkId=44592660), researchers used claims data for 369,320 enrollees age 40 and older in a nationwide managed care network who had cataract surgery during the 13-year period.

“The increase in utilization occurred in many U.S. communities such that in some places nearly every cataract surgery took place in an ambulatory care center,” says senior author [Joshua Stein](http://www.umkelloggeye.org/profile/1466/joshua-daniel-stein-md) (<http://www.umkelloggeye.org/profile/1466/joshua-daniel-stein-md>), M.D., a glaucoma specialist at Kellogg Eye Center and eye policy researcher at the U-M Institute of Healthcare Policy and Innovation.

Cataract surgery is extremely effective in restoring focusing power that can deteriorate with age. It carries little risk. But well-equipped hospitals are more prepared than a surgery center if medical complications happen.

Still the reasons for the increasing popularity of ambulatory surgery centers compared to hospital-based care include convenience, lower out-of-pocket costs for patients and decreased cost-per-case for insurers.

One analysis estimated that cataract surgeries performed at ambulatory surgery centers rather than hospitals saved Medicare \$829 million in 2011.

Consumers save from the shift to surgery centers where average cataract co-pay in 2014 was \$190 compared to \$350 at a hospital outpatient department, authors write.

Patients were more likely to undergo cataract surgery at an ambulatory surgery center if they were younger age, had higher income, and lived in states without certificate-of-need laws. CON laws regulate the number of ambulatory care centers permitted to operate.

More affluent people were more likely to live in communities with more ambulatory care centers. This may have the indirect impact of limiting access to cataract surgery for less affluent patients.

“The increased use of ambulatory care centers raises questions about access and the effect on surgical outcomes, patient safety and patient satisfaction,” says [Brian Stagg, M.D.](http://www.umkelloggeye.org/profile/4333/brian-craig-stagg-md) (<http://www.umkelloggeye.org/profile/4333/brian-craig-stagg-md>), the study’s lead author and a clinical scholar at the U-M Institute for Healthcare Policy and Innovation.

The shift is happening beyond cataract surgery and includes cornea, glaucoma, retina and strabismus surgery.

The rate of increase in ambulatory surgery center use for cataract surgery of 2.34% a year was similar to the rate of increase for strabismus surgery and retina surgery.

The rate of increase for glaucoma surgery was faster than cataract surgery. The rate of increase for cornea surgery was slower than cataract surgery.

## Physicians / Providers

## News

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[Michigan Medicine offers groundbreaking surgery to restore eye sensation](/news/archive/201801/michigan-medicine-offers-groundbreaking-surgery-restore-eye)

[\(/news/archive/201801/michigan-medicine-offers-groundbreaking-surgery-restore-eye\)](/news/archive/201801/michigan-medicine-offers-groundbreaking-surgery-restore-eye)

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[U of M Med School Associate Dean Tackles Difficult Discussions Doctors have with Patients on](/news/archive/201801/u-m-med-school-associate-dean-tackles-difficult-discussions)

[New Podcast \(/news/archive/201801/u-m-med-school-associate-dean-tackles-difficult-discussions\)](/news/archive/201801/u-m-med-school-associate-dean-tackles-difficult-discussions)

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[University of Michigan Opens Second Clinical Simulation Center](/news/archive/201801/university-michigan-opens-second-clinical-simulation-center)

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Major shift in performing cataract surgery at ambulatory surgery centers rather than hospitals.

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Exhibit 24  
Washington State 2015 Charity Care Report

*2015 Washington State*

# **Charity Care in Washington Hospitals**

February 2017



For more information or  
additional copies of this report contact:

Community Health Systems  
PO Box 47853  
Olympia, WA 98504-7853  
360-236-4210

John Wiesman, DrPH, MPH  
Secretary of Health

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## Executive Summary

By law, hospitals in Washington cannot deny patients access to care based on an inability to pay. To this end, hospitals are required to develop a charity care policy and submit financial data on the charity care they provide to the Department of Health (department). This report summarizes the charity care data received from Washington hospitals for the fiscal year (FY) ending in 2015.

Overall, Washington hospitals reported \$532 million in charity care charges in FY 2015 or approximately \$186 million in actual expenses based on a cost-to-charge formula. These total charity care charges reflect a decrease of 44 percent from that reported in FY 2014, which was 34 percent less than FY 2013. Charity care declined two consecutive years for the first time since the department began collecting these data in 1989. The decrease is likely a result of the federal Affordable Care Act (ACA) implementation. The percentage of uninsured dropped dramatically compared to previous years as more Washingtonians are now covered by health insurance, by either expanded Medicaid or private insurance plans.

The hospital with the highest dollar amount of charity care in FY 2015 was Harborview Medical Center, which alone accounted for 12 percent of the statewide total charity care charges. Wide variation was seen in charity care charges among hospitals, ranging from \$0 to \$62 million. The median amount of charity care per hospital was \$1.6 million; however, the average was much higher at \$6.0 million because several hospitals provided significant amounts of charity care.

Since the charity care data in this report are based on billed charges, not the actual payment expected by the hospital, calculating the approximate cost of providing charity care can be estimated by applying a cost-to-charge ratio. Multiplying the charity care dollars by the cost-to-charge ratio results in an approximate cost of what hospitals actually spent providing charity care to patients. The statewide cost-to-charge ratio is 0.35. Based on the \$532 million reported in charity care charges in FY 2015, the overall cost of providing charity care statewide was approximately \$186 million.

More information on FY 2015 charity care, including detailed reports by hospital, is available on our webpage at

<http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalPatientInformationandCharityCare>

## **About this Report**

The department has issued an annual report since 1990 as directed by Chapter 70.170 of the Revised Code of Washington (RCW). Your feedback is important to us. Submit your comments by email at [charitycare@doh.wa.gov](mailto:charitycare@doh.wa.gov) to help us continue to improve the charity care report.

## **Background on Charity Care in Washington**

### **What is Charity Care and how is it Reported?**

Charity care is defined in Chapter 70.170 RCW as the “necessary inpatient and outpatient hospital health care rendered to indigent persons.” A person is considered indigent under Washington Administrative Code (WAC) 246-453-040 if family income is at or below 200 percent of the federal poverty level. Chapter 70.170 RCW prohibits any Washington hospital from denying patients access to care based on inability to pay or adopting admission policies that significantly reduce charity care.

Services eligible for charity care are defined as appropriate hospital-based medical services in WAC 246-453-010. Hospitals are required by the law and rules to submit charity care policies for review to the department at least 30 days prior to adoption. Hospitals are also required to submit an annual budget and year-end financial reports to the department within 180 days of the close of the hospital’s fiscal year. Hospitals report this information using a uniform system of accounting. The department uses the financial reports submitted by hospitals to report charity care data and trends for the state each year.

### **What are Hospitals Required to Report and When?**

Hospitals are required to report total patient services revenue, also called billed charges, and the amount of patient services revenue written-off as charity care to the department within 180 days of the close of the hospital’s fiscal year. Fiscal years vary among hospitals in Washington, ending on March 31, June 30, September 30, or December 31. Hospitals are also required to report bad debt. Bad debt is different from charity care and is defined as uncollectible amounts, excluding contractual adjustments, arising from failure to pay by patients whose care has not been classified as charity care. All of these data are reported as part of the hospital’s year-end financial report.

Hospitals report financial data to the department on an income statement. Below is an abbreviated example of an income statement to illustrate the relationships between the various revenue sources and expenses.

Hospital: Sample Community Hospital	Comment	Sample Hospital Revenue
<b>= TOTAL PATIENT SERVICES REVENUE</b>	Inpatient and outpatient revenue equivalent to Total Billed Charges	615,000,000
- Provision for Bad Debts	Unpaid charges billed to patients who are not eligible for charity care, deducted from total revenue	15,000,000
- Contractual Adjustments	Reductions from billed charges negotiated by insurance companies, deducted from total revenue	350,000,000
- Charity Care	Unpaid charges billed to patients eligible for charity care, deducted from total revenue	25,000,000
<b>= NET PATIENT SERVICE REVENUE</b>	Actual patient revenue received	225,000,000
+ OTHER OPERATING REVENUE	Actual revenue received for office rental, cafeteria income etc.	10,000,000
<b>= TOTAL OPERATING REVENUE</b>	Actual patient revenue and other operating revenue	235,000,000
- TOTAL OPERATING EXPENSES	Total expenses for operating the hospital	220,000,000
<b>= NET OPERATING REVENUE</b>	Cash remaining after operation of patient services	15,000,000
+/-NON-OPERATING REVENUE-NET OF EXPENSES	Nonpatient revenue (investments, partnership fees)	5,000,000
<b>= NET REVENUE BEFORE ITEMS LISTED BELOW</b>	Operating plus non operating remainder	20,000,000
+/-EXTRAORDINARY ITEM	One time cash revenue or cash expenses	0
<b>= NET REVENUE OR (EXPENSE)</b>	Net cash remaining after all the transactions	20,000,000

## How do Hospitals Report Charity Care and How is it Calculated?

The amount of charity care reported by hospitals is based on patient services revenue, or what is also called billed charges. These charges are based on the hospital's charge master rate sheet, which sets the price for every treatment and supply category a hospital uses. Every patient's total bill is comprised of the sum of the charge master rates of the various services or supplies during the stay before any adjustments based on insurance status. All patients, regardless of insurance status, receive the same billed charges for the same services.

The billed charges reflect a "markup" that varies between hospitals and is significantly higher than the amount the hospital actually expects to be paid. Medicaid and Medicare pay a set rate

for services regardless of billed charges, and private insurance companies negotiate with hospitals for large discounts off the master rate sheet.

Charity care is the amount of billed charges an indigent patient incurs for appropriate hospital-based medical services. Since these charges include the markup, the dollar amount of charity care reported by hospitals overestimates the true cost of providing charity care to indigent patients.

## **2015 Washington State Charity Care Data**

### **Statewide Charity Care Charges for Hospital Fiscal Year 2015**

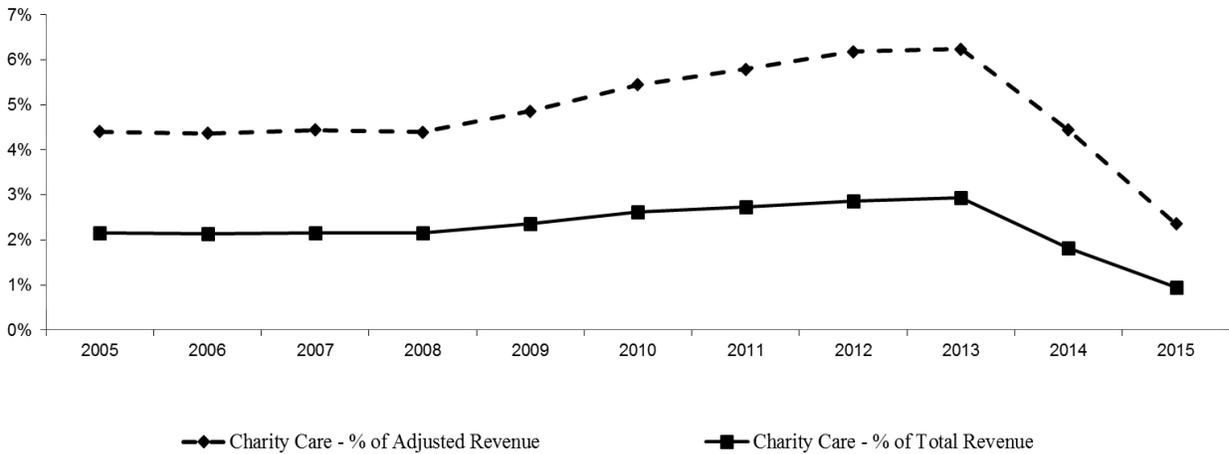
This report describes data collected from licensed Washington hospitals for their fiscal years (FY) ending in 2015. FY 2015 includes data for the twelve (12) months prior to the end of each hospital's fiscal calendar, including data for months in 2014 if the fiscal year end is prior to December 31, 2015.

All charity care data for FY 2015 were due to the department by June 30, 2016. Although the department provides reminders and follow-up by phone and in writing to hospitals that are late in reporting data, some hospitals still have not provided data for their 2015 fiscal year. For 2015, 86 of 99 hospitals had reported charity care information in year-end financial reports in time to be used in this report. Of the 13 hospitals that did not provide year-end reports, we have provided annual financial estimates for four hospitals based on their quarterly financial reports. For the other nine hospitals, no charity care data are available because no FY 2015 financial reports were submitted to the department.

Overall, Washington hospitals reported \$532 million of charity care charges written off in FY 2015. These charges amounted to 0.9 percent of total patient services revenue and 2.4 percent of adjusted patient services revenue. Adjusted patient services revenue is the amount of revenue for non-Medicare and non-Medicaid payers, which includes private insurance and self-pay. Looking at the adjusted patient services revenue allows a more meaningful comparison of charity care among hospitals.

From the years 2005 through 2015, statewide charity care charges increased by only 15.6 percent over the 10-year period while statewide hospital total patient services revenue, or billed charges, increased by 165 percent (Table 1). However, from 2013 to 2015, charity care decreased 62.6 percent while total patient services increased 17 percent. As a percent of total hospital patient services revenue, charity care charges dropped from 2.9 percent to 0.9 percent from 2013 to 2015 (Table 1 and Figure 1).

**Figure 1.** Statewide Hospital Charity Care in Washington as a Percent of Total Hospital Patient Service Revenue and as a Percent of Adjusted Patient Service Hospital Revenue, Fiscal Year 2005 - 2015.



*Figure 1 Notes:* Adjusted patient service revenue is the total patient service hospital revenue minus Medicare and Medicaid patient service charges. Patient Service Revenue is the same as Billed Charges.

**Table 1.** Statewide Hospital Charity Care in Washington, Fiscal Year 2005-2015

Year	in Millions			Charity Care		Operating Margin %
	Total Patient Services Revenue	Adjusted Patient Services Revenue	Total Charity Care (Billed Charges)	a % of Total Revenue	a % of Adjusted Revenue	
2005	\$21,357	\$10,457	\$461	2.2%	4.4%	4.8%
2006	\$23,911	\$11,667	\$510	2.1%	4.4%	4.3%
2007	\$27,502	\$13,315	\$592	2.2%	4.4%	5.5%
2008	\$30,847	\$15,187	\$668	2.2%	4.4%	5.3%
2009	\$34,884	\$16,962	\$824	2.4%	4.9%	6.1%
2010	\$38,172	\$18,378	\$1,001	2.6%	5.4%	5.6%
2011	\$41,182	\$19,398	\$1,123	2.7%	5.8%	3.4%
2012	\$44,728	\$20,775	\$1,285	2.9%	6.2%	5.5%
2013	\$48,482	\$22,795	\$1,422	2.9%	6.2%	4.9%
2014	\$51,993	\$21,288	\$944	1.8%	4.4%	4.6%
2015	\$56,739	\$22,595	\$532	0.9%	2.4%	5.3%

*Table 1 Notes:* Adjusted patient service revenue is the total hospital revenue minus Medicare and Medicaid charges. Operating margin is the total hospital patient service operating revenue (net of deductions) minus total patient service operating expenses expressed as a percent. Note: Patient Service Revenue is the same as Billed Charges.

## What Changed in 2015?

Some parts of the federal Patient Protection and Affordable Care Act (ACA) affecting health insurance coverage became effective in 2014. The ACA was signed into law on March 23, 2010, putting into place provisions for expanding healthcare coverage, controlling healthcare costs and improving the healthcare delivery system in the United States. The law requires certain employers to offer healthcare insurance; requires citizens and legal residents to have health insurance; creates health benefit exchanges; expands Medicaid coverage; creates an essential benefits package and consumer protections; and establishes tax credits, premium credits and cost-sharing subsidies, along with many other requirements aimed at cost-containment, preventive wellness, and quality improvement.

On January 1, 2014, the healthcare coverage requirement became effective. According to the U.S. Internal Revenue Code Chapter 48 Section 5000A, “An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.” This means all affected individuals must have health insurance or pay a federal tax penalty.

As part of the implementation, new private health insurance coverage options were offered through the marketplace, known as health benefit exchanges. The exchanges provide a one-stop shop for consumers to locate, compare, and enroll in ACA-qualified health plans and access financial assistance to make coverage affordable.<sup>1</sup> Some states chose to use the federal government exchange while other states created state-specific exchanges. Washington created the Washington Health Benefit Exchange, launched the Washington Healthplanfinder portal, and began open enrollment on October 1, 2013.

The ACA also expanded and simplified eligibility for Medicaid so that all adults with income up to 138 percent of the federal poverty level (FPL) have coverage under the program effective January 1, 2014. Washington was one of the states that expanded Medicaid coverage, significantly increasing the number of people covered.<sup>2</sup> As of March 9, 2015, more than half a million adults in Washington had gained health coverage through the Medicaid expansion.<sup>3</sup>

<sup>1</sup> Advance-payment premium tax credit subsidies, available on a sliding scale to those with income between 100 percent and 400 percent of FPL, were put in place to reduce the monthly premium people pay for non-group coverage.

<sup>2</sup> Washington State Health Services Research Project, Research Brief No. 076, April 2016, <http://ofm.wa.gov/researchbriefs/2016/brief076.pdf>

<sup>3</sup> Ibid

## **How did the Affordable Care Act affect Charity Care in Washington State?**

Because of the Medicaid expansion, patients who were not eligible for Medicaid in the past and therefore, were more likely to qualify for charity care are now covered. According to various sources, the uninsured rate in Washington decreased significantly in 2014 and 2015 as compared to previous years. A report published by the Washington State Insurance Commissioner estimates that 7.3 percent of the state's population was uninsured in 2015 as compared to 8.3 percent in 2014 and 14.5 percent at the end of 2013.<sup>4</sup> The growth of the insured population in Washington led to a 63 percent decline in the amount of hospital charges written off to charity care from 2013 to 2015.

In 2015 hospitals saw continuing decreases in the proportion of self-pay patients (those who pay strictly out of pocket) and increases in the proportion of Medicaid patients. Hospitals report revenue to the department by the payer types of Medicare, Medicaid and Other. Normally, the patient service revenue associated with each payer type increases each year about the same as the overall rate of increase. From 2014 to 2015, the Other payer revenue, which includes self-pay, increased by about 11.2 percent while Medicaid revenue increased by about 4.7 percent. In the prior 2013 to 2014 period, Other payer had actually decreased by about 2 percent. This compares to the overall increase of total patient service revenue of 9.1 percent. The result of these changes is that the proportion of total revenue from the Other payer category increased by 1.9 percent, the Medicaid proportion increased by 1 percent and the Medicare proportion decreased by 4 percent, despite total revenue in all three categories increasing. This shift toward Medicaid and Other may be the result of previously uninsured patients enrolling in Medicaid and commercial insurance at a higher rate than Medicare enrollment, which was not directly affected by the ACA.

### **Distribution of Charity Care among Washington Hospitals**

Charity care varied widely among hospitals, ranging from \$0 to \$167 million. The median amount of charity care per hospital was \$1.6 million; however, the average was much higher at \$6 million because several hospitals provided significant charity care. Amounts varied among hospitals in rural and urban areas and in different geographic areas of the state. These variations in charity care do not seem to be explained by population size. Some of the variation may be a function of the proportion of hospital revenue coming from Medicare and Medicaid.

Differences in charity care among hospitals may reflect demographic differences in service areas, hospital service availability, and differences in charity care practices within the hospital. A high level of reported charity care, for example, may reflect greater need for charity care in the

<sup>4</sup> The State of Washington's Uninsured 2014-2015, Office of the Insurance Commissioner, February 3, 2016. <https://www.insurance.wa.gov/about-oic/reports/commissioner-reports/documents/2014-2015-state-of-uninsured.pdf>

community. Likewise, a low level of charity care may reflect a relative absence of need for charity care in a hospital’s service area.

### **Adjusting Billed Charges to Determine Actual Cost of Providing Charity Care**

Because billed charges reflect “mark-ups” that vary between hospitals and are significantly higher than the expected payment, determining the actual cost of providing charity care to eligible patients is challenging. One way to estimate the cost of providing charity care is to use a cost-to-charge ratio<sup>5</sup>. The formula is total operating expenses (the actual cost of running the hospital and providing services) divided by total patient services revenue (billed charges). This report uses the basic formula; however, there are other focused formulas that may look at only inpatient revenue and expenses or include or exclude certain hospital revenue/expense categories.

As an example of how the cost-to-charge ratio works, if a hospital had billed charges of \$1,000,000 and a cost to charge ratio of .345, the actual cost for that hospital to treat patients is \$345,000. If that same hospital reported charity care billed charges of \$100,000, the cost of treating those patients is \$34,500. The higher the ratio, the closer the operating costs are to the actual cost of treating patients. This is only an estimate based on overall hospital performance.

Washington hospitals’ cost-to-charge ratios range from .18 to 1.8. The statewide average was .35 with a majority of hospitals between .32 and .56. Below are some examples of cost to charge ratios for Washington hospitals, including a high, average, and low cost-to-charge ratio. Cost to charge ratios for all hospitals are listed in Appendix 2.

Hospital	Charity Care Charges	Cost to Charge Ratio	Estimated Cost of Charity Care
UW Medicine/Harborview	62.8 million	.414	26 million
Overlake Medical Center	8.9 million	.368	3.3 million
Cascade Medical Center	204,000	.887	181,000

<sup>5</sup> <http://medical-dictionary.thefreedictionary.com/hospital+cost-to-charge+ratio>

## Contribution of all Purchasers of Care to Hospital Charity Care

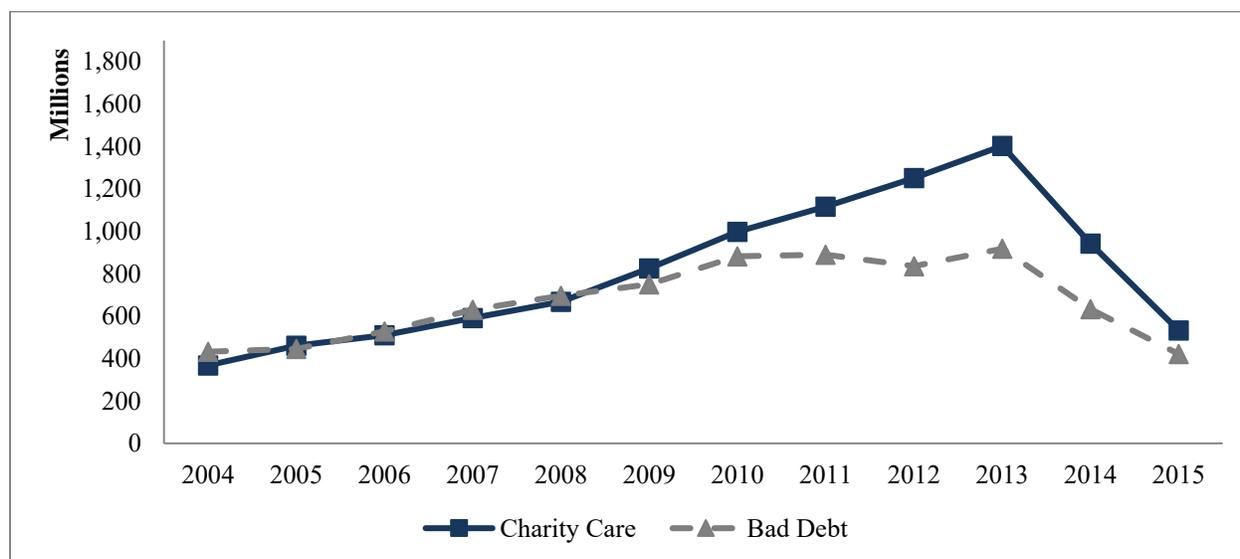
Charity care as a percent of adjusted (non-Medicare, non-Medicaid) revenue increased from 4.4 percent to 6.2 percent from FY 2005 through FY 2013, then declined to 4.4 percent in FY 2014 and 2.4 percent in FY 2015. Because charity care is unreimbursed, all payers—including insurance companies and patients who self-pay—contribute to the cost of charity care to the hospital. Throughout this time, fluctuations in statewide operating margin, which is a measure of hospital profitability, do not appear to have adversely affected the amount of charity care provided in Washington (Table 1).

## Uncompensated Care in Washington

Uncompensated care includes both charity care and bad debt. Looking at uncompensated care gives us a bigger picture of the impact of the ACA and a way to compare Washington State to other states.

In 2015, the amount of charity care and bad debt continued to drop due to the increase in people with healthcare insurance. Both charity care and bad debt had been increasing over the past 10 years. In recent years, charity care was rising faster than bad debt (Figure 2). Both had more than doubled between FY 2004 and FY 2013.

**Figure 2.** Hospital Charity Care and Bad Debt Patient Service Charges in Washington, Fiscal Year 2005 - 2015

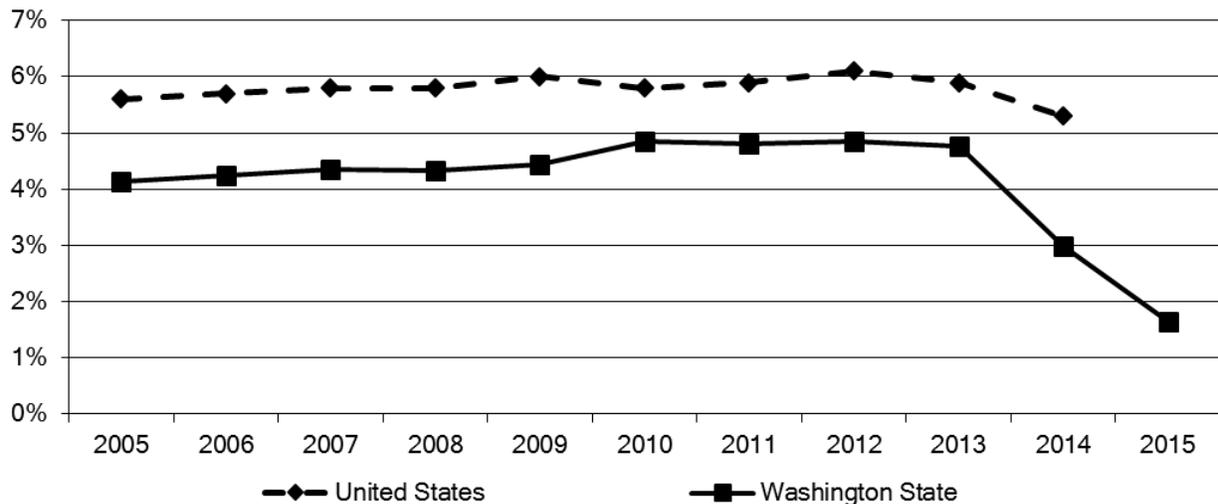


## How does Washington Compare to the U.S. in Uncompensated Care?

There are no national charity care data available to draw comparisons between Washington and the rest of the United States (U.S.). However, national data are available for uncompensated care, which includes both charity care and bad debt. The national uncompensated care number is built using a formula that includes a cost-to-charge ratio that translates the billed charges written off to uncompensated care into a “cost” or expense. The result is a proxy with which uncompensated care expenses are then compared to total operating costs, not total patient services revenue. The Washington State uncompensated care number is built using the same formula.

Uncompensated care as a percent of hospital expenses is lower in Washington than it is in the U.S. as a whole (Figure 3). In both Washington and the U.S., uncompensated care remained relatively steady over most of the past 10 years, declining from 2013 onward. In the U.S. uncompensated care accounted for 5.3 percent of hospital expenses in FY 2014, the most recent year of data available. In Washington, uncompensated care accounted for 1.6 percent of hospital expenses in FY 2015. (Figure 3).

**Figure 3.** Hospital Uncompensated Care in Washington and the U.S. as a Percent of Hospital Expenses, Fiscal Years 2005 - 2015



*Figure 3 Notes: Uncompensated care includes bad debt and charity care. Uncompensated care as a percent of hospital expenses is calculated by multiplying uncompensated care by the ratio of total expenses to gross patient and other operating revenues. Uncompensated care data for 2015 are not yet available for the U.S. The U.S. data were derived from an American Hospital Association report<sup>6</sup>.*

<sup>6</sup> <http://www.aha.org/content/16/uncompensatedcarefactsheet.pdf>

## **Summary**

Implementation of the ACA continues to change the landscape of charity care in Washington State. More patients have health coverage, either through Medicaid expansion or through purchase of private coverage. As a result, Washington saw the first decline in the amount of charity care reported by hospitals since the department began gathering these data.

The ACA has not been fully implemented and certain requirements may become effective over the next few years depending upon the Trump Administration and the new Congress' actions related to ACA. One major phase set for 2018 is the introduction of a penalty if an employer provides a high-cost health insurance plan. Also in 2018, all health insurance plans must cover approved preventive care and checkups without co-payment. If the ACA becomes fully effective, and the number of insured stabilizes, we will likely see a continued decline in charity care in Washington over the next few years before it levels off again.

## Appendix 1 Charity Care by Hospital by Region by Adjusted Patient Service Revenue

**Total Patient Service Revenue, Adjusted Patient Service Revenue, and Amount of Charity Care as a Percent for Washington Hospital Fiscal Years Ending During Calendar Year 2015**

Revenue Categories - Patient Service Revenue - (Billed Charges)							
Region/Hospital	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as a % of Total Patient Service Revenue	Charity Care as a % of Adjusted Patient Service Revenue
<b>KING COUNTY (N=22)</b>							
Cascade Behavioral Health	35,922,820	21,067,125	7,591,875	7,263,820	20,353	0.06%	0.28%
CHI/Highline Community Hospital	759,417,495	317,599,619	208,350,326	233,467,550	(2,245,998)	-0.30%	-0.96%
CHI/Regional Hospital	40,966,581	31,047,635	3,010,278	6,908,668	874,412	2.13%	12.66%
CHI/Saint Elizabeth Hospital	151,841,881	41,913,626	29,664,589	80,263,666	922,646	0.61%	1.15%
CHI/Saint Francis Community Hospital	969,970,981	363,113,057	217,056,838	389,801,086	8,989,727	0.93%	2.31%
EvergreenHealth/Kirkland	1,512,772,435	588,414,315	147,077,316	777,280,804	4,940,939	0.33%	0.64%
Kindred Hospital Seattle	126,139,047	61,117,016	6,029,865	58,992,166	0	0.00%	0.00%
MultiCare/Auburn Regional Medical Center*	717,781,091	305,153,866	192,604,257	220,022,968	8,175,121	1.14%	3.72%
Navos	19,147,898	6,474,729	9,155,282	3,517,887	604,020	3.15%	17.17%
Overlake Hospital Medical Center	1,269,191,611	553,309,296	83,673,084	632,209,231	8,890,648	0.70%	1.41%
Providence/Swedish - Cherry Hill	1,667,865,050	834,654,108	217,996,881	615,214,061	14,309,385	0.86%	2.33%
Providence/Swedish - First Hill	3,543,189,488	1,248,537,286	614,499,785	1,680,152,417	24,465,167	0.69%	1.46%
Providence/Swedish - Issaquah	513,667,550	173,381,194	46,580,644	293,705,712	3,834,146	0.75%	1.31%
Seattle Cancer Care Alliance	765,473,963	243,092,765	84,312,810	438,068,388	6,057,574	0.79%	1.38%
Seattle Children's Hospital	2,018,295,479	22,598,469	944,053,131	1,051,643,879	26,061,772	1.29%	2.48%
Snoqualmie Valley Hospital	40,717,733	20,804,889	5,520,928	14,391,916	1,461,873	3.59%	10.16%
UHS/BHC Fairfax Hospital	135,717,138	19,270,127	37,100,831	79,346,180	797,076	0.59%	1.00%
UW Medicine/Harborview Medical Center	2,099,326,843	630,722,132	691,789,660	776,815,051	62,804,689	2.99%	8.08%
UW Medicine/Northwest Hospital	975,532,206	443,105,476	130,044,322	402,382,408	7,341,000	0.75%	1.82%
UW Medicine/University of Washington	2,194,854,816	708,116,252	391,886,447	1,094,852,117	18,046,234	0.82%	1.65%
UW Medicine/Valley Medical Center	1,550,749,311	523,225,604	363,442,241	664,081,466	8,671,895	0.56%	1.31%
Virginia Mason Medical Center	2,107,499,167	899,466,889	128,566,297	1,079,465,981	12,496,081	0.59%	1.16%
<b>KING COUNTY TOTALS</b>	<b>23,216,040,584</b>	<b>8,056,185,475</b>	<b>4,560,007,687</b>	<b>10,599,847,422</b>	<b>217,518,760</b>	<b>0.94%</b>	<b>2.05%</b>
<b>PUGET SOUND REGION (Less King Co. N=21)</b>							
Cascade Valley Hospital	Hospital Late in Reporting to Department of Health			-			
CHI/Harrison Memorial Hospital	1,604,179,392	823,607,710	292,858,164	487,713,518	7,669,635	0.48%	1.57%
CHI/Saint Anthony Hospital	568,546,279	276,803,599	92,997,461	198,745,219	2,216,296	0.39%	1.12%
CHI/Saint Clare Hospital	720,758,427	298,898,160	213,360,018	208,500,249	9,094,400	1.26%	4.36%
CHI/Saint Joseph Medical Center - Tacoma	2,450,746,243	1,148,620,658	314,566,682	987,558,903	17,160,029	0.70%	1.74%
EvergreenHealth/Monroe	Hospital Late in Reporting to Department of Health			-			
Forks Community Hospital	39,955,049	12,193,582	8,863,350	18,898,117	180,274	0.45%	0.95%
Island Hospital	225,545,000	92,592,850	13,584,233	119,367,917	311,603	0.14%	0.26%
Jefferson Healthcare	164,864,437	92,843,428	30,349,902	41,671,107	1,007,943	0.61%	2.42%
MultiCare/Good Samaritan Hospital	1,702,668,468	73,929,446	365,601,432	1,263,137,590	22,002,554	1.29%	1.74%
MultiCare/Mary Bridge Children's Health	673,133,231	557,479	408,232,765	264,342,987	3,963,682	0.59%	1.50%
MultiCare/Tacoma General - Allenmore*	2,790,337,060	1,120,035,497	732,706,178	937,595,385	37,624,390	1.35%	4.01%
Olympic Medical Center	308,879,814	181,106,463	52,358,014	75,415,337	1,303,014	0.42%	1.73%
PeaceHealth/Peace Island Medical Center	18,766,468	10,097,353	2,190,385	6,478,730	140,745	0.75%	2.17%
PeaceHealth/Saint Joseph Hospital	1,172,398,898	590,364,640	214,127,953	367,906,305	6,671,949	0.57%	1.81%
PeaceHealth/United General Hospital	84,221,506	42,478,245	19,438,060	22,305,201	1,098,171	1.30%	4.92%
Providence/Regional Medical Center Everett	1,899,664,541	844,127,582	386,227,209	669,309,750	25,270,273	1.33%	3.78%
Providence/Swedish - Edmonds	720,793,408	329,573,018	119,854,714	271,365,676	7,853,691	1.09%	2.89%
Skagit Valley Hospital	913,794,508	447,784,120	203,698,429	262,311,959	4,794,499	0.52%	1.83%
UHS/BHC Fairfax Hospital - North	27,817,904	5,227,600	8,803,200	13,787,104	147,786	0.53%	1.07%
Whidbey General Hospital	234,410,493	107,068,837	36,345,598	90,996,058	851,462	0.36%	0.94%
<b>PUGET SOUND REGION TOTALS</b>	<b>16,321,481,126</b>	<b>6,497,910,267</b>	<b>3,516,163,747</b>	<b>6,307,407,112</b>	<b>149,362,396</b>	<b>0.92%</b>	<b>2.37%</b>

**Total Patient Service Revenue, Adjusted Patient Service Revenue, and Amount of Charity Care as a Percent  
for Washington Hospital Fiscal Years Ending During Calendar Year 2015**

Revenue Categories - Patient Service Revenue - (Billed Charges)							
Region/Hospital	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as a % of Total Patient Service Revenue	Charity Care as a % of Adjusted Patient Service Revenue
<b>SOUTHWEST WASHINGTON REGION (N=14)</b>							
Capella/Capital Medical Center	456,192,832	175,046,912	11,639,931	269,505,989	1,187,656	0.26%	0.44%
Grays Harbor Community Hospital	377,004,651	161,864,873	104,918,138	110,221,640	1,383,763	0.37%	1.26%
Klickitat Valley Hospital	35,638,075	16,014,077	9,873,120	9,750,878	298,921	0.84%	3.07%
Legacy/Salmon Creek Hospital	745,888,157	315,480,303	171,646,822	258,761,032	12,966,543	1.74%	5.01%
Mason General Hospital	181,123,561	80,908,810	54,524,928	45,689,823	2,209,564	1.22%	4.84%
Morton General Hospital	33,617,299	19,037,575	6,349,569	8,230,155	95,921	0.29%	1.17%
Ocean Beach Hospital	32,797,644	24,283,605	491,598	8,022,441	96,387	0.29%	1.20%
PeaceHealth/Saint John Medical Center	675,707,379	327,522,739	177,196,117	170,988,523	4,958,034	0.73%	2.90%
PeaceHealth/Southwest Medical Center	1,608,840,057	655,542,318	401,330,863	551,966,876	15,527,029	0.97%	2.81%
Providence/Centralia Hospital	569,816,902	282,503,015	135,516,735	151,797,152	10,258,251	1.80%	6.76%
Providence/Saint Peter Hospital	1,604,220,493	851,833,701	279,240,243	473,146,549	16,773,244	1.05%	3.55%
Skyline Hospital	27,956,366	12,431,417	5,616,423	9,908,526	111,829	0.40%	1.13%
Summit Pacific Medical Center	57,982,978	19,623,200	17,657,619	20,702,159	485,792	0.84%	2.35%
Willapa Harbor Hospital	24,684,025	13,192,032	472,326	11,019,667	376,337	1.52%	3.42%
<b>SOUTHWEST WASH REGION TOTALS</b>	<b>6,431,470,419</b>	<b>2,955,284,577</b>	<b>1,376,474,432</b>	<b>2,099,711,410</b>	<b>66,729,271</b>	<b>1.04%</b>	<b>3.18%</b>
<b>CENTRAL WASHINGTON REGION (N=21)</b>							
Ascension/Lourdes Counseling Center	34,252,756	6,103,052	20,168,631	7,981,073	173,932	0.51%	2.18%
Ascension/Lourdes Medical Center	233,108,574	88,010,801	50,550,607	94,547,166	3,847,632	1.65%	4.07%
Cascade Medical Center	16,879,692	9,272,022	2,190,212	5,417,458	204,078	1.21%	3.77%
CHS/Toppenish Community Hospital	100,630,801	18,525,363	57,470,351	24,635,087	561,969	0.56%	2.28%
CHS/Yakima Regional Medical Center	575,960,865	261,675,642	138,683,455	175,601,768	1,374,246	0.24%	0.78%
Columbia Basin Hospital	19,477,007	7,915,241	6,125,736	5,436,030	57,605	0.30%	1.06%
Confluence/Central Washington Hospital*	659,632,746	359,905,146	121,505,993	178,221,607	5,302,615	0.80%	2.98%
Confluence/Wenatchee Valley Hospital	Hospital Late in Reporting to Department of Health			-			
Coulee Community Hospital	34,226,660	12,261,245	10,292,945	11,672,470	162,685	0.48%	1.39%
Kittitas Valley Hospital	119,500,425	41,358,400	19,102,603	59,039,422	638,704	0.53%	1.08%
Lake Chelan Community Hospital	42,956,753	16,548,757	9,670,359	16,737,637	376,248	0.88%	2.25%
Mid Valley Hospital	66,943,002	28,559,460	20,408,544	17,974,998	742,731	1.11%	4.13%
North Valley Hospital	37,526,542	16,836,065	11,279,723	9,410,754	298,083	0.79%	3.17%
PMH Medical Center	91,280,329	28,251,241	29,432,965	33,596,123	1,391,827	1.52%	4.14%
Providence/Kadlec Medical Center	1,433,385,271	573,018,800	323,485,049	536,881,422	14,547,155	1.01%	2.71%
Quincy Valley Hospital	Hospital Late in Reporting to Department of Health			-			
Samaritan Hospital	186,248,139	56,129,769	11,370,476	118,747,894	3,081,965	1.65%	2.60%
Sunnyside Community Hospital	Hospital Late in Reporting to Department of Health			-			
Three Rivers Hospital	19,694,182	6,573,174	1,598,572	11,522,436	363,876	1.85%	3.16%
Trios Health	489,223,045	191,453,319	118,914,861	178,854,865	3,018,675	0.62%	1.69%
Yakima Valley Memorial Hospital	939,156,729	403,809,128	250,508,938	284,838,663	7,466,519	0.80%	2.62%
<b>CENTRAL WASH REGION TOTALS</b>	<b>5,100,083,518</b>	<b>2,126,206,625</b>	<b>1,202,760,020</b>	<b>1,771,116,873</b>	<b>43,610,545</b>	<b>0.86%</b>	<b>2.46%</b>

**Total Patient Service Revenue, Adjusted Patient Service Revenue, and Amount of Charity Care as a Percent  
for Washington Hospital Fiscal Years Ending During Calendar Year 2015**

Revenue Categories - Patient Service Revenue - (Billed Charges)							
Region/Hospital	Total Patient Service Revenue	(Less) Medicare Revenue	(Less) Medicaid Revenue	Adjusted Patient Service Revenue	Charity Care	Charity Care as a % of Total Patient Service Revenue	Charity Care as a % of Adjusted Patient Service Revenue
<b>EASTERN WASHINGTON REGION (N=21)</b>							
Adventist West/Walla Walla General Hospital*	146,145,896	57,432,415	32,272,011	56,441,470	2,306,608	1.58%	4.09%
CHS/Deaconess Hospital	1,167,493,910	579,593,059	260,050,939	327,849,912	2,361,694	0.20%	0.72%
CHS/Valley Hospital	509,116,270	228,012,615	112,887,090	168,216,565	2,069,346	0.41%	1.23%
Dayton General Hospital	14,661,464	6,091,612	2,587,373	5,982,479	44,389	0.30%	0.74%
East Adams Rural Hospital	10,600,417	3,980,772	1,587,868	5,031,777	26,008	0.25%	0.52%
Ferry County Memorial Hospital	Hospital Late in Reporting to Department of Health			-			
Garfield County Memorial Hospital	Hospital Late in Reporting to Department of Health			-			
Lincoln Hospital	19,263,993	10,190,286	4,041,689	5,032,018	200,103	1.04%	3.98%
Newport Community Hospital	41,779,985	17,279,144	13,141,722	11,359,119	431,044	1.03%	3.79%
Odessa Memorial Hospital	5,510,518	1,134,898	1,655,237	2,720,383	26,613	0.48%	0.98%
Othello Community Hospital	Hospital Late in Reporting to Department of Health			-			
Providence/Holy Family Hospital	626,691,910	273,588,615	170,435,568	182,667,727	9,471,514	1.51%	5.19%
Providence/Mount Carmel Hospital	99,762,218	48,013,172	24,124,597	27,624,449	1,581,675	1.59%	5.73%
Providence/Sacred Heart Medical Center	2,255,877,755	933,228,736	573,059,032	749,589,987	24,730,105	1.10%	3.30%
Providence/Saint Joseph's Hospital	41,031,348	20,767,469	11,902,543	8,361,336	584,343	1.42%	6.99%
Providence/Saint Mary Medical Center	408,539,589	210,240,526	64,911,132	133,387,931	6,226,551	1.52%	4.67%
Pullman Regional Hospital	98,855,020	34,650,235	11,965,075	52,239,710	385,497	0.39%	0.74%
Saint Luke's Rehabilitation Institute	70,399,379	39,812,985	10,809,221	19,777,173	270,257	0.38%	1.37%
Shriners Hospital for Children - Spokane	35,017,530	-	15,309,125	19,708,405	3,448,819	9.85%	17.50%
Tri-State Memorial Hospital	119,527,461	65,999,793	12,123,996	41,403,672	1,040,211	0.87%	2.51%
Whitman Medical Center	Hospital Late in Reporting to Department of Health			-			
<b>EASTERN WASH REGION TOTALS</b>	<b>5,670,274,663</b>	<b>2,530,016,332</b>	<b>1,322,864,218</b>	<b>1,817,394,113</b>	<b>55,204,777</b>	<b>0.97%</b>	<b>3.04%</b>
<b>STATEWIDE TOTALS (N=99)</b>	<b>56,739,350,310</b>	<b>22,165,603,276</b>	<b>11,978,270,104</b>	<b>22,595,476,930</b>	<b>532,425,749</b>	<b>0.94%</b>	<b>2.36%</b>

\*Hospital late in reporting final data to Department of Health. Amounts displayed are estimates calculated from quarterly reports.

*Appendix 1 notes: Group Health Central Hospital is not included in this report because healthcare charges are prepaid through member subscriptions; therefore, uncompensated healthcare is generally not incurred. State-owned psychiatric hospitals, federal Veterans Affairs hospitals, and federal military hospitals are also excluded.*

## Appendix 2 Charity Care Adjusted for Cost to Charge Ratio

### Total Patient Service Revenue, Total Operating Expense, Cost to Charge Ratio and Mark-Up for Washington Hospital Fiscal Years Ending During Calendar Year 2015

Region/Hospital	Total Patient Service Revenue	Operating Expense	Cost to Charge Ratio	Mark-Up	Charity Care as reported by the hospital	Charity Care after modified by Cost to
Adventist West/Walla Walla General Hospital*	146,145,896	63,020,339	0.431	2.319	2,306,608	994,645
BHC Fairfax Hospital	135,717,138	46,616,119	0.343	2.911	797,076	273,780
Capital Medical Center	456,192,832	91,526,612	0.201	4.984	1,187,656	238,281
Cascade Behavioral Health	35,922,820	20,005,860	0.557	1.796	20,353	11,335
Cascade Medical Center	16,879,692	14,970,256	0.887	1.128	204,078	180,993
Cascade Valley Hospital	Hospital Late in Reporting to Department of Health					-
CHI/Harrison Memorial Hospital	1,604,179,392	413,381,705	0.258	3.881	7,669,635	1,976,392
CHI/Highline Community Hospital	759,417,495	174,824,492	0.230	4.344	(2,245,998)	(517,048)
CHI/Regional Hospital	40,966,581	16,572,868	0.405	2.472	874,412	353,740
CHI/Saint Anthony Hospital	568,546,279	111,355,624	0.196	5.106	2,216,296	434,084
CHI/Saint Clare Hospital	720,758,427	129,447,603	0.180	5.568	9,094,400	1,633,347
CHI/Saint Elizabeth Hospital	151,841,881	44,726,656	0.295	3.395	922,646	271,775
CHI/Saint Francis Community Hospital	969,970,981	187,887,840	0.194	5.163	8,989,727	1,741,351
CHI/Saint Joseph Medical Center - Tacoma	2,450,746,243	585,313,128	0.239	4.187	17,160,029	4,098,340
CHS/Deaconess Hospital	1,167,493,910	264,997,698	0.227	4.406	2,361,694	536,057
CHS/Valley Hospital	509,116,270	89,542,610	0.176	5.686	2,069,346	363,953
CHS/Yakima Regional Medical Center	575,960,865	103,154,850	0.179	5.583	1,374,246	246,128
Columbia Basin Hospital	19,477,007	16,774,718	0.861	1.161	57,605	49,613
Confluence/Central Washington Hospital*	659,632,746	279,025,218	0.423	2.364	5,302,615	2,243,011
Confluence/Wenatchee Valley Hospital	Hospital Late in Reporting to Department of Health					-
Coulee Community Hospital	34,226,660	26,230,108	0.766	1.305	162,685	124,676
Dayton General Hospital	14,661,464	26,230,108	1.789	0.559	44,389	79,414
East Adams Rural Hospital	10,600,417	8,170,377	0.771	1.297	26,008	20,046
EvergreenHealth - Kirkland*	1,512,772,435	606,563,820	0.401	2.494	4,940,939	1,981,127
EvergreenHealth - Monroe	Hospital Late in Reporting to Department of Health					-
Fairfax North	27,817,904	7,250,969	0.261	3.836	147,786	38,522
Ferry County Memorial Hospital	Hospital Late in Reporting to Department of Health					-
Forks Community Hospital	39,955,049	27,360,687	0.685	1.460	180,274	123,449
Garfield County Memorial Hospital	Hospital Late in Reporting to Department of Health					-
Grays Harbor Community Hospital	377,004,651	100,678,098	0.267	3.745	1,383,763	369,530
Island Hospital	225,545,000	94,742,698	0.420	2.381	311,603	130,892
Jefferson Healthcare	164,864,437	78,772,668	0.478	2.093	1,007,943	481,598
Kindred Hospital Seattle	126,139,047	40,281,777	0.319	3.131	-	-
Kittitas Valley Hospital	119,500,425	66,068,983	0.553	1.809	638,704	353,124
Klickitat Valley Hospital	35,638,075	20,876,510	0.586	1.707	298,921	175,106
Lake Chelan Community Hospital	42,956,753	25,351,186	0.590	1.694	376,248	222,045
Legacy/Salmon Creek Hospital	745,888,157	254,068,252	0.341	2.936	12,966,543	4,416,730
Lincoln Hospital	19,263,993	22,189,037	1.152	0.868	200,103	230,487
Lourdes Counseling Center	34,252,756	17,172,452	0.501	1.995	173,932	87,200
Lourdes Medical Center	233,108,574	91,156,698	0.391	2.557	3,847,632	1,504,610
Mason General Hospital	181,123,561	86,857,600	0.480	2.085	2,209,564	1,059,594
Mid Valley Hospital	66,943,002	31,129,577	0.465	2.150	742,731	345,382
Morton General Hospital	33,617,299	24,016,207	0.714	1.400	95,921	68,526
MultiCare Auburn Regional Medical Center*	717,781,091	157,087,554	0.219	4.569	8,175,121	1,789,138
MultiCare/Good Samaritan Hospital	1,702,668,468	411,602,210	0.242	4.137	22,002,554	5,318,886
MultiCare/Mary Bridge Children's Health	673,133,231	190,231,363	0.283	3.538	3,963,682	1,120,160
MultiCare/Tacoma General - Allenmore*	2,790,337,060	709,249,883	0.254	3.934	37,624,390	9,563,395
Navos	19,147,898	9,282,664	0.485	2.063	604,020	292,821
Newport Community Hospital	41,779,985	26,543,616	0.635	1.574	431,044	273,850
North Valley Hospital	37,526,542	20,837,678	0.555	1.801	298,083	165,519
Ocean Beach Hospital	32,797,644	19,886,478	0.606	1.649	96,387	58,443

**Total Patient Service Revenue, Total Operating Expense, Cost to Charge Ratio and Mark-Up  
for Washington Hospital Fiscal Years Ending During Calendar Year 2015**

Region/Hospital	Total Patient Service Revenue	Operating Expense	Cost to Charge Ratio	Mark-Up	Charity Care as reported by the hospital	Charity Care after modified by Cost to Charge Ratio
Odesssa Memorial Hospital	5,510,518	7,506,444	1.362	0.734	26,613	36,252
Olympic Medical Center	308,879,814	152,918,844	0.495	2.020	1,303,014	645,090
Othello Community Hospital	Hospital Late in Reporting to Department of Health					-
Overlake Hospital Medical Center	1,269,191,611	467,283,698	0.368	2.716	8,890,648	3,273,308
PeaceHealth/Peace Island Medical Center	18,766,468	15,148,949	0.807	1.239	140,745	113,614
PeaceHealth/Saint John Medical Center	675,707,379	255,195,198	0.378	2.648	4,958,034	1,872,507
PeaceHealth/Saint Joseph Hospital	1,172,398,898	460,505,004	0.393	2.546	6,671,949	2,620,666
PeaceHealth/Southwest Medical Center	1,608,840,057	552,671,335	0.344	2.911	15,527,029	5,333,870
PeaceHealth/United General Hospital	84,221,506	39,615,155	0.470	2.126	1,098,171	516,545
PMH Medical Center	91,280,329	41,704,337	0.457	2.189	1,391,827	635,901
Providence/Centralia Hospital	569,816,902	151,417,795	0.266	3.763	10,258,251	2,725,931
Providence/Holy Family Hospital	626,691,910	203,546,700	0.325	3.079	9,471,514	3,076,305
Providence/Kadlec Medical Center	1,433,385,271	508,092,710	0.354	2.821	14,547,155	5,156,536
Providence/Mount Carmel Hospital	99,762,218	44,119,825	0.442	2.261	1,581,675	699,496
Providence/Regional Medical Center Everett	1,899,664,541	682,537,900	0.359	2.783	25,270,273	9,079,455
Providence/Sacred Heart Medical Center	2,255,877,755	855,828,295	0.379	2.636	24,730,105	9,382,035
Providence/Saint Joseph's Hospital	41,031,348	21,426,304	0.522	1.915	584,343	305,140
Providence/Saint Mary Medical Center	408,539,589	163,370,304	0.400	2.501	6,226,551	2,489,926
Providence/Saint Peter Hospital	1,604,220,493	442,675,619	0.276	3.624	16,773,244	4,628,482
Providence/Swedish - Cherry Hill	1,667,865,050	471,090,725	0.282	3.540	14,309,385	4,041,705
Providence/Swedish - Edmonds	720,793,408	258,206,831	0.358	2.792	7,853,691	2,813,395
Providence/Swedish - First Hill	3,543,189,488	1,187,245,516	0.335	2.984	24,465,167	8,197,744
Providence/Swedish - Issaquah	513,667,550	202,562,418	0.394	2.536	3,834,146	1,511,978
Pullman Regional Hospital	98,855,020	56,629,376	0.573	1.746	385,497	220,833
Quincy Valley Hospital	Hospital Late in Reporting to Department of Health					-
Saint Luke's Rehabilitation Institute	70,399,379	40,422,671	0.574	1.742	270,257	155,179
Samaritan Hospital	186,248,139	69,618,298	0.374	2.675	3,081,965	1,152,018
Seattle Cancer Care Alliance	765,473,963	441,516,235	0.577	1.734	6,057,574	3,493,936
Seattle Children's Hospital	2,018,295,479	1,072,908,699	0.532	1.881	26,061,772	13,854,216
Shriner Hospital for Children - Spokane	35,017,530	21,718,515	0.620	1.612	3,448,819	2,139,021
Skagit Valley Hospital	913,794,508	297,176,343	0.325	3.075	4,794,499	1,559,225
Skyline Hospital	27,956,366	17,454,165	0.624	1.602	111,829	69,819
Snoqualmie Valley Hospital	40,717,733	37,742,545	0.927	1.079	1,461,873	1,355,056
Summit Pacific Medical Center	57,982,978	23,389,907	0.403	2.479	485,792	195,965
Sunnyside Community Hospital	Hospital Late in Reporting to Department of Health					-
Three Rivers Hospital	19,694,182	12,713,844	0.646	1.549	363,876	234,905
Toppenish Community Hospital	100,630,801	20,888,493	0.208	4.818	561,969	116,651
Trios Health	489,223,045	191,371,526	0.391	2.556	3,018,675	1,180,828
Tri-State Memorial Hospital	119,527,461	65,067,077	0.544	1.837	1,040,211	566,259
UW Medicine/Harborview Medical Center	2,099,326,843	868,911,119	0.414	2.416	62,804,689	25,994,853
UW Medicine/Northwest Hospital	975,532,206	343,919,000	0.353	2.837	7,341,000	2,588,033
UW Medicine/University of Washington	2,194,854,816	1,029,969,829	0.469	2.131	18,046,234	8,468,477
UW Medicine/Valley Medical Center	1,550,749,311	502,083,025	0.324	3.089	8,671,895	2,807,682
Virginia Mason Medical Center	2,107,499,167	1,046,814,313	0.497	2.013	12,496,081	6,206,919
Whidbey General Hospital	234,410,493	99,606,131	0.425	2.353	851,462	361,805
Whitman Medical Center	Hospital Late in Reporting to Department of Health					-
Willapa Harbor Hospital	24,684,025	18,637,584	0.755	1.324	376,337	284,152
Yakima Valley Memorial Hospital	939,156,729	391,708,193	0.417	2.398	7,466,519	3,114,173
<b>Statewide Totals</b>	<b>56,739,350,310</b>	<b>19,707,970,248</b>	<b>0.347</b>	<b>2.879</b>	<b>532,425,749</b>	<b>184,933,926</b>

*Appendix 2 notes: Cost-to-Charge formula is total operating expense / total patient services revenue while Mark up is total patient services revenue/total operating expense.*

Exhibit 25  
WAC 246-310-270

## WAC 246-310-270

### Ambulatory surgery.

(1) To receive approval, an ambulatory surgical facility must meet the following standards in addition to applicable review criteria in WAC [246-310-210](#), [246-310-220](#), [246-310-230](#), and [246-310-240](#).

(2) The area to be used to plan for operating rooms and ambulatory surgical facilities is the secondary health services planning area.

(3) Secondary health services planning areas are: San Juan, Whatcom, East Skagit, Whidbey-Fidalgo, Western North Olympic, East Clallam, East Jefferson, North Snohomish, Central Snohomish, East Snohomish, Southwest Snohomish, Kitsap, North King, East King, Central King, Southwest King, Southeast King, Central Pierce, West Pierce, East Pierce, Mason, West Grays Harbor, Southeast Grays Harbor, Thurston, North Pacific, South Pacific, West Lewis, East Lewis, Cowlitz-Wahkiakum-Skamania, Clark, West Klickitat, East Klickitat, Okanogan, Chelan-Douglas, Grant, Kittitas, Yakima, Benton-Franklin, Ferry, North Stevens, North Pend Oreille, South Stevens, South Pend Oreille, Southwest Lincoln, Central Lincoln, Spokane, Southwest Adams, Central Adams, Central Whitman, East Whitman, Walla Walla, Columbia, Garfield, and Asotin.

(4) Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.

(5) When a need exists in planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.

(6) An ambulatory surgical facility shall have a minimum of two operating rooms.

(7) Ambulatory surgical facilities shall document and provide assurances of implementation of policies to provide access to individuals unable to pay consistent with charity care levels provided by hospitals affected by the proposed ambulatory surgical facility. The amount of an ambulatory surgical facility's annual revenue utilized to finance charity care shall be at least equal to or greater than the average percentage of total patient revenue, other than medicare or medicaid, that affected hospitals in the planning area utilized to provide charity care in the last available reporting year.

(8) The need for operating rooms will be determined using the method identified in subsection (9) of this section.

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or

minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

[Statutory Authority: RCW **70.38.135** and **70.38.919**. WSR 92-02-018 (Order 224), § 246-310-270, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW **43.70.040**. WSR 91-02-049 (Order 121), recodified as § 246-310-270, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW **70.38.919**. WSR 90-16-058 (Order 073), § 248-19-700, filed 7/27/90, effective 8/27/90.]

Exhibit 26

Health Affairs “Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up.”

By Elizabeth L. Munnich and Stephen T. Parente

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# Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up

**Elizabeth L. Munnich** (beth.munnich@louisville.edu) is an assistant professor of economics at the University of Louisville, in Kentucky.

**Stephen T. Parente** is a professor of finance and associate dean at the Carlson School of Management, University of Minnesota, in Minneapolis.

**ABSTRACT** During the past thirty years outpatient surgery has become an increasingly important part of medical care in the United States. The number of outpatient procedures has risen dramatically since 1981, and the majority of surgeries performed in the United States now take place in outpatient settings. Using data on procedure length, we show that ambulatory surgery centers (ASCs) provide a lower-cost alternative to hospitals as venues for outpatient surgeries. On average, procedures performed in ASCs take 31.8 fewer minutes than those performed in hospitals—a 25 percent difference relative to the mean procedure time. Given the rapid growth in the number of surgeries performed in ASCs in recent years, our findings suggest that ASCs provide an efficient way to meet future growth in demand for outpatient surgeries and can help fulfill the Affordable Care Act's goals of reducing costs while improving the quality of health care delivery.

**T**echnological developments in medicine have dramatically changed the provision of surgical care in the United States during the past thirty years. Advances in anesthesia and the development of laparoscopic surgery in the 1980s and 1990s made it possible for patients to be discharged the same day as their surgery, whereas previously they would have had to spend several days in the hospital recovering.<sup>1,2</sup> The introduction of the Medicare inpatient prospective payment system in 1983 created additional incentives for hospitals to shift patient care from inpatient to outpatient departments.<sup>3</sup>

Between 1981 and 2005 the number of outpatient surgeries nationwide—performed either in hospital outpatient departments or in free-standing ambulatory surgery centers (ASCs)—grew almost tenfold, from 3.7 million to over 32.0 million. Outpatient procedures represented over 60 percent of all surgeries in the United States in 2011, up from 19 percent in 1981.<sup>4</sup>

The expansion of health insurance coverage

under the Affordable Care Act (ACA) presents opportunities to explore new ways to accommodate the increased demand for outpatient services. In addition, the ACA's goals of reducing the cost and improving the quality of health care delivery makes it increasingly important to find alternatives to existing methods of care delivery that cost less and are in more flexible settings.

ASCs are such an alternative to hospital outpatient departments. The number of ASCs has grown quickly to meet the rising demand for outpatient surgery services since the 1980s.<sup>5</sup> Whereas outpatient departments provide a range of complex services, including inpatient and emergency services, ASCs provide outpatient surgery exclusively. Since most ASCs focus on a limited number of services, they may provide higher-quality care at a lower cost than hospitals that offer a broad range of services.<sup>6</sup> Similar to retail clinics that meet primary care needs, ASCs offer convenient, relatively low-cost access to health care services.<sup>7</sup>

This article addresses the possibilities for ASCs

to generate substantial cost savings in outpatient surgery by presenting new evidence on the cost advantages of these centers relative to hospital outpatient departments. This is particularly important in light of the anticipated growth in demand for outpatient surgeries, in part as a result of the ACA.

## Background On Ambulatory Surgery Centers

The number of outpatient surgeries has grown considerably in the United States since the early 1980s. Outpatient surgery volume across both hospital-based and freestanding facilities grew by 64 percent between 1996 and 2006, according to the National Survey of Ambulatory Surgery.<sup>8</sup>

Physicians receive the same payment for an outpatient procedure, regardless of whether it occurred in an ASC or a hospital. However, payments to facilities differ between settings. In general, reimbursements for outpatient procedures in hospitals are higher than those for procedures in ASCs, to account for the fact that compared to ASCs, hospitals must meet additional regulatory requirements and treat patients whose medical conditions are more complex.<sup>9</sup> However, there is little evidence about the extent of cost advantages of ASCs, since these facilities have not historically reported cost or volume data. In spite of the limited availability of information about ASC costs, the Centers for Medicare and Medicaid Services has adjusted the relative facility payments over time to reflect speculative cost differentials across the two types of outpatient surgery facilities.<sup>10</sup>

Changes in reimbursement levels for outpatient procedures have likely contributed to fluctuations in the number of ASCs in recent years. In 2000 Medicare's traditional cost-based reimbursement system for outpatient care in hospitals was replaced with the outpatient prospective payment system, which reimburses hospitals on a predetermined basis for what the service provided is expected to cost.

Noting the dramatic growth in outpatient surgeries performed in ASCs relative to hospitals around the same time, the Centers for Medicare and Medicaid Services subsequently made efforts to reduce ASCs' payments. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 froze ASCs' payment updates, and between 2008 and 2012 Medicare phased in a new system for ASCs' payments based on the outpatient prospective payment system.<sup>9,11</sup> The rates were set so that for any outpatient procedure, payments to ASCs would be no more than 59 percent of payments made to hospitals, phased in fully by 2012. This policy change re-

duced incentives to treat patients in ASCs, which may have contributed to slower growth in this sector in recent years (Exhibit 1).

In spite of reduced incentives for treating patients outside of hospitals, growth in outpatient volume was greater in ASCs than in hospitals during the period 2007–11. For example, volume among Medicare beneficiaries grew by 23.7 percent in ASCs, compared to 4.3 percent in hospital outpatient departments (Exhibit 2). This suggests that physicians and patients still increasingly prefer outpatient surgery in ASCs to that in hospitals, because of either perceived advantages in cost and quality or resource constraints that inhibit hospitals' ability to meet the growing demand for outpatient surgeries.

ASCs have been praised for their potential to provide less expensive, faster services for low-risk procedures and more convenient locations for patients and physicians, compared to outpatient departments.<sup>11–14</sup> However, if hospitals are better equipped to treat high-risk patients, treating higher-risk patients in ASCs could have negative consequences for patient outcomes.

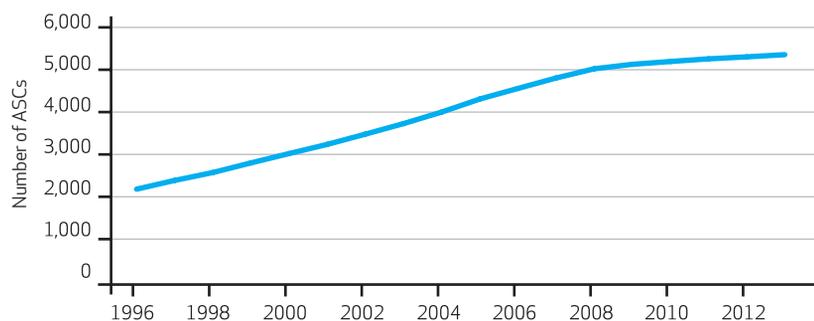
There is little evidence about the quality of care provided in ASCs or their ability to function as substitutes for hospitals in providing outpatient surgery. Comparisons of outcomes between these two types of outpatient facilities are complicated by the fact that ASCs tend to treat a healthier mix of patients than hospitals do. Thus, any differences in observed outcomes between the two settings could reflect differences in underlying patient health instead of differences in quality of care.

Elsewhere, we used variations in ASC use generated by changes in Medicare reimbursements to outpatient facilities to show that patients treated in ASCs fare better than those treated in hospitals.<sup>15</sup> In particular, we considered the likelihood that patients undergoing one of the five highest-volume outpatient procedures<sup>16</sup> visited an emergency department or were admitted to the hospital after surgery. These outcomes have been used in the medical literature as proxies for quality in outpatient surgical care.<sup>17,18</sup> These measures are also interesting from a policy perspective: As of October 2012, as part of the Ambulatory Surgical Center Quality Reporting Program,<sup>19</sup> ASCs are required to report transfers of patients directly from the ASC to a hospital and hospital admissions of ASC patients upon discharge from the facility.

Our findings indicate that the highest-risk Medicare patients were less likely than other high-risk Medicare patients to visit an emergency department or be admitted to a hospital following an outpatient surgery when they were treated in an ASC, even among similar patients

EXHIBIT 1

Number Of Medicare-Certified Ambulatory Surgery Centers (ASCs), 1996-2013



SOURCE Kay Tucker, director of communications, Ambulatory Surgery Center Association, October 29, 2013.

undergoing the same procedure who were treated by the same physician in an ASC and a hospital. These results indicate that ASCs provide high-quality care, even for the most vulnerable patients.

In this article we examine the question of whether or not ASCs are less costly than hospital outpatient departments. The answer to this question is not straightforward, since little is known about surgery cost and volume in ASCs. The often-cited cost differential between ASCs and outpatient departments is frequently attributed to differences in reimbursement rates for the two types of facilities, which reflect hospitals' greater complexity of patients and procedures. But for an average patient undergoing a high-volume procedure, are ASCs more efficient than hospital outpatient departments?

Study Data And Methods

Our analysis incorporated one important aspect of cost in the outpatient surgery setting: the time it takes to perform procedures in ASCs and hospital outpatient departments. For data on that time, we used the National Survey of Ambulatory

Surgery. This survey of outpatient surgery in hospitals and freestanding surgery centers in the United States was conducted by the Centers for Disease Control and Prevention from 1994 to 1996 and in 2006.

The 2006 data include patients' diagnoses, demographic characteristics, and surgical procedures, as well as information about length of surgery and recovery for 52,000 visits at 437 facilities. There are four length-of-surgery measures: time in the operating room; time in surgery (a subset of time in the operating room); time in postoperative care; and total procedure time (time in the operating room, time in postoperative care, and transport time between the operating room and the recovery room).

Previous research has documented differences in surgery time between ASCs and hospital outpatient departments.<sup>12,20</sup> However, observed differences in procedure time may reflect underlying differences in patients' characteristics, instead of differences in efficiency between the two types of facilities. To address this concern, we estimated the relationship between outpatient setting and procedure time, controlling for a patient's primary procedure, number of procedures, and characteristics such as underlying health and demographics.<sup>21</sup>

Study Results

It is the nature of outpatient procedures that the patient spends most of his or her time in a surgical facility preparing for and recovering from surgery, not actually undergoing the surgery (Exhibit 3). This suggests that organization, staffing, and specialization may play a large role in the cost differences between ASCs and hospital outpatient departments.

Our estimates of the time savings for ASC treatment suggest that ASCs are substantially faster than hospitals at performing outpatient procedures, after procedure type and observed patient characteristics are controlled for (Exhibit 4). On average, patients who were treated in ASCs spent 31.8 fewer minutes undergoing procedures than patients who were treated in hospitals—a difference of 25 percent relative to the mean procedure time of 125 minutes (Exhibit 3). Thus, for an ASC and a hospital outpatient department that have the same number of staff and of operating and recovery rooms, the ASC can perform more procedures per day than the hospital can.

We estimated the cost savings for an outpatient procedure performed in an ASC using the results presented above and estimates of the cost of operating room time. Estimated charges for this time are \$29–\$80 per minute, not including fees for the surgeon and anesthesia provider.<sup>22</sup> Our

EXHIBIT 2

Number Of Outpatient Surgery Visits, By Facility Type, 2007 And 2011

Type	2007	2011	Change (%)
Ambulatory surgery center	373,284	461,718	23.7
Freestanding	260,466	344,292	32.2
Hospital-based	112,818	117,426	4.1
Hospital outpatient department	1,173,309	1,224,218	4.3
All types	1,546,593	1,685,936	9.0

SOURCE Authors' analysis of a 5 percent sample of Medicare claims data. NOTE The numbers of outpatient department visits include only those that involved at least one surgical procedure.

calculation suggests that even excluding physician payments and time savings outside of the operating room, ASCs could generate savings of \$363–\$1,000 per outpatient case.

These results support the claim that ASCs provide outpatient surgery at lower costs than hospitals. However, they provide little information about what is driving these cost differences.

Terrence Trentman and coauthors discuss several factors that affect patient flow and could result in differences in preoperative and recovery times for outpatient procedures between in ASCs and hospitals.<sup>20</sup> For example, compared to the situation in hospitals, in ASCs surgeons are more likely to be assigned to a single operating room for all cases, which reduces delays; the operating room is often closer to the preoperative and recovery rooms, because facilities are smaller; teams of staff have clearer and more consistent roles, with less personnel turnover; and staffing is not done by shifts—that is, staff members go home only after all cases are finished, which creates incentives to work quickly. In addition, hospitals may be more likely to have emergency add-on and bring-back cases for more complex cases that compete with outpatient procedures for operating room time.

These differences suggest that hospitals would have to adopt a substantially different and highly specialized organizational model to achieve the same efficiencies as ASCs.

## Discussion

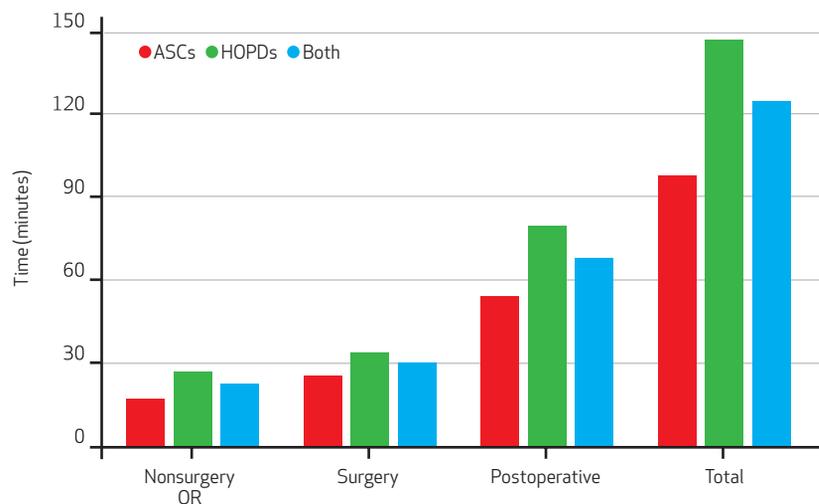
The findings presented here provide evidence that ASCs are a lower-cost alternative to hospitals for outpatient surgical procedures. The tremendous growth in the number of ASCs since the 1980s suggests that these facilities are quite flexible in meeting the growing demand for outpatient services. This is not surprising, given that ASCs have a smaller footprint than hospitals, which makes them less costly to build—particularly in urban environments, where available land may be scarce or difficult to acquire.

The Congressional Budget Office projects that as a result of the ACA, an additional twenty-five million people will have health insurance by 2016.<sup>23</sup> The question of whether the current supply of health care providers will be able to accommodate the anticipated surge in demand for services resulting from the ACA has received a considerable amount of attention.<sup>24</sup>

To get a sense of the magnitude of the anticipated growth in the outpatient surgery market following the ACA, we used a microsimulation model to project hospital outpatient surgical volume through 2021 (for details about the model, see the online Appendix).<sup>25</sup> Our estimates indi-

### EXHIBIT 3

Average Outpatient Surgical Procedure Time, By Facility Type, 2006

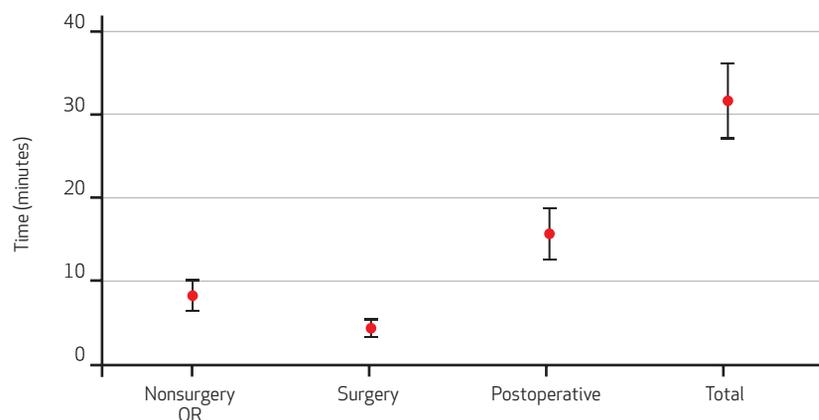


**SOURCE** Authors' analysis of data from the 2006 National Survey of Ambulatory Surgery. **NOTES** Estimates were weighted using sample weights. ASC is ambulatory surgery center. HOPD is hospital outpatient department. "Both" is both types of facilities. OR is operating room. "Total" is total procedure time, from entering the operating room to leaving postoperative care, as described in the text.

cated that outpatient surgical volume in hospitals alone will increase by 8–16 percent annually between 2014 and 2021, compared to annual

### EXHIBIT 4

Estimated Time Savings for Ambulatory Surgery Centers (ASCs) Relative to Hospital Outpatient Departments



**SOURCE** Authors' analysis of data from the 2006 National Survey of Ambulatory Surgery. **NOTES** Estimates and standard error bars represent results from separate ordinary least squares regressions of nonsurgical time in the operating room, surgery time, postoperative recovery time, and total time on an indicator for treatment in an ASC. (Total time is total procedure time, from entering the operating room to leaving postoperative care, as described in the text.) All regressions controlled for primary procedure, total number of procedures, patient's risk score, age, sex, disability status, type of insurance, and an indicator for whether the facility was located in a Metropolitan Statistical Area. The full specifications for these regressions are available in the online Appendix (see Note 25 in text). Data were balanced across surgery and postoperative time components; the final sample included 34,467 observations. Estimates were weighted using sample weights. Standard errors were clustered at the facility level. All estimates are significant ( $p < 0.01$ ). OR is operating room.

growth rates of 1–3 percent in the previous ten years.

We did not have adequate data on surgical volume in ASCs to produce an equally precise estimate for the projected demand in this sector attributable to the ACA. However, our results indicate substantial growth even in hospital outpatient surgical volume, which has been growing at a much slower rate than ASC surgical volume. The trends in the growth in the number of ASCs before the passage of the ACA and our model for projected growth in the number of hospital outpatient department procedures suggest that it will be increasingly important to identify ways to accommodate growing demand for outpatient surgery. This is particularly important since hospitals will also likely face increased demand for other types of outpatient visits besides surgery after the ACA is implemented.

The rapid growth in the number of procedures performed at ASCs in recent years is a good indication of the ability of the market to expand quickly when there are sufficient incentives for it to do so. The range of surgeries performed in ASCs has increased considerably since the 1980s. In 1981 Medicare covered 200 procedures that were provided in ASCs. Today about 3,600 different surgical procedures are covered under Medicare's ASC payment system.<sup>9</sup> Consequently, the volume of procedures performed in ASCs has increased dramatically, and the share of all outpatient surgeries performed in freestanding ASCs increased from 4 percent in 1981 to 38 percent in 2005.<sup>26,27</sup> The Ambulatory Surgery Center Association has estimated that roughly 5,300 ASCs provide more than twenty-five million procedures annually in the United States.<sup>27</sup>

Physicians who have an ownership stake in an ASC obtain greater profits from performing procedures in these facilities rather than in hospitals. Since physicians receive the same payment for their services regardless of whether procedures are performed in an ASC or a hospital, one implication of ASCs' lowering the cost of outpatient surgery without the price being ad-

justed accordingly—therefore leading to higher profit per procedure—is that it could create greater incentives for providers to recommend unnecessary procedures in physician-owned ASCs, a concept known as demand inducement. Another consequence of demand inducement is that physicians may respond to the increased number of patients with health insurance—as a result of the ACA—by performing surgeries that are not clinically indicated. Future research should examine the implications of reductions in the cost of outpatient surgery for demand inducement.

## Conclusion

The ASC market faces challenges to meeting increased demand for outpatient surgery. As noted above, recent reimbursement changes have lowered payments to ASCs, which reduces the incentives to start or expand these facilities.

This gap in reimbursement is likely to continue to widen because Medicare's reimbursement rates for hospital procedures are updated annually according to projected changes in hospital prices, whereas ASC reimbursements are updated annually according to projected changes in the prices of all goods purchased by urban consumers, and medical spending is increasing at a much faster rate than other spending in the US economy. Furthermore, the disparity between medical and other consumer spending is expected to increase over time.

Critics of ASCs argue that these facilities “cherry pick” profitable patients and procedures, diverting important revenue streams from hospitals.<sup>28–31</sup> In combination with research on the quality of care in ASCs,<sup>15</sup> the findings in this article indicate that ASCs are a high-quality, lower-cost substitute for hospitals as venues for outpatient surgery. Increased use of ASCs may generate substantial cost savings, helping achieve the ACA's goals of reducing the cost and improving the quality of health care delivery. ■

# 25 million

## Procedures

The roughly 5,300 ASCs in the United States provide more than 25 million procedures each year.

These findings were previously presented at the National Bureau of Economic Research Hospital Organization and Productivity Conference, Harwich, Massachusetts, October 4–5, 2013.

## NOTES

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