OREGON AMBULATORY SURGERY CENTER ASSOCIATION

Our Patients Come First

Ensuring Patient Safety / Pain Management for Outpatient Procedures

OREGON AMBULATORY SURGERY CENTER ASSOCIATION

Our Patients Come First

- **Ambulatory Surgery Centers:** Less than 24 hours
- **Convalescent Care Centers:** Up to 72 hours in Colorado; Proposed 36-48 hours for Oregon
  - Excellent clinical outcomes;
  - Outstanding patient satisfaction;
  - Significant cost savings for employers, patients and insurers;
  - With 5,000 patients at model CO facility, about 24% of the surgical patients stay one or more nights.

Procedures

- Total joint replacements: hip, knee, shoulder, ankle
- Arthroscopy: shoulder, knee, ankle
- Sports medicine: ACL repairs, rotator cuff
- Spine & neck: fusions
- Hand & upper extremity
- Foot and ankle reconstruction
- Pain management
- Pediatrics
- Trauma and fractures
- Worker's Compensation care

Cost Comparisons

ORTHOPEDIC ASC - COLORADO	2013 Average Charge
Knee/Hip Replacement	$22,000-$23,000
Major Joint Replacement (MSDRG 470)	**2013 Average Hospital Charge**
McKee Medical Center	$46,207
Poudre Valley Hospital	$54,642
Medical Center of the Rockies	$66,041
No. Colorado Medical Center	$61,867
Good Samaritan Medical Center	$80,164
Kaiser Foundation Health Plan	$22,423 (average reimbursement)

Quality Measures

	2012	2013	2014
Surgery Patients	3,987	4,279	4,218
Recovery Center Patients (with at least one night stay)	933	979	1,043
Surgery Center complication rate	.53%	.38%	.57%
Surgery Center infection rate	.18%	.10%	.07%
Patients transferred to hospitals	3	3	4
Nurse/Patient ratio	1:3 (4 max)		

Quality Measures

	2012	2013	2014
Patient satisfaction surveys	294	717	998
Satisfaction with surgical experience	97%	97%	97%
Satisfaction with Recovery Center experience	95%	98%	97%
Nurse/Patient ratio	1:3 (4 max)		

Quality Measures

- Low Cost/High Quality Care
- Regulatory Indicators:
  - CDC, CMS, CDPHE, WHO
- Total Joints: mandatory reporting to CDPHE
- Committees: infection, safety, policy, medication safety, chart audits
- Risk Management: infection, safety, occurrence reports, complications
- Staff/Physician engagement
- Formal, quarterly QAPI/MAC meetings:
  - Assess, implement, evaluate, audit processes

OREGON AMBULATORY
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Background:

During the early 1990's, medical technology progressed and resulting clinical improvements enabled more numerous and complex surgical procedures to be performed safely on an outpatient basis. Most states approved these procedures in "outpatient" or "ambulatory" surgery centers but also imposed a 23 hour limitation on the duration of the stay. For the vast majority of patients, that is more than sufficient. In some limited circumstances, flexibility is needed to allow patients longer recovery time either for patient safety or for pain management. Many states have now moved to extend the period of time allowed to up to 72 hours. Colorado is one such state that has moved in this direction.

There are many examples of states moving to allow extended recovery care services to be provided at a Convalescent Center after treatment at an ASC for factors including patient safety, pain management, better health outcomes as well as patient and physician choice. In some states, various private insurers are presently reimbursing CC facilities for overnight stays, at a substantial cost savings when compared with similar care provided elsewhere.

Proposal:

Ask the Oregon Health Authority to establish by rule a licensed system that would allow for extended stays in an "extended stay recovery center" following outpatient treatment in instances where a patient needs additional care for patient safety, pain management or other factors.

Contact: ***Doug Riggs or Jessica Chambers NGrC***
For the Oregon Ambulatory Surgery Center Association
503-702-5120 or 971-219-7817

OREGON AMBULATORY SURGERY CENTER ASSOCIATION
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ISSUE BRIEF | Spring 2013

The Economic Impact of Ambulatory Surgery Centers in Oregon

In 2012, the total statewide economic impact of ASCs in Oregon was $611.6 million.

Executive Summary

Ambulatory surgery centers (ASCs) have become a very important component of the U.S. healthcare system, with approximately 5,300 freestanding centers nationwide. The quality of care provided by ASCs is at least equal to and in most cases better than hospital outpatient departments (HOPDs).[1] ASCs also have lower overhead than HOPDs, and are paid less by Medicare, thus they help reduce medical care expenditures.[2]

In addition to providing high-quality care at a lower cost, ASCs have a substantial positive economic impact on their communities and states. This is because in the course of providing high quality medical care, ASCs pay doctors, nurses, managers, and support staff. They also buy food and supplies. The majority of these expenditures stay local—either in the community or in the state. This in turn generates other economic activity in the state. In this study we measure the amount of economic activity that is generated by ASCs in Oregon.

We employ a standard economic method, referred to as "input-output" analysis, to calculate economic impact.[3] First, we collect data on ASC expenditures from a sample of ASCs. We extrapolate the sample to the state-level by multiplying the sample average expenditures per ASC by the number of ASCs in the state. We then apply a "multiplier" to the state total; multipliers are obtained from the US Bureau of Economic Analysis' RIMS II database.[4]

The results can be summarized as follows:[5]

- ***For every $1 spent in the ASC sector of Oregon's economy, by ASCs, $2.21 of economic value is created within the state.***
- ***Oregon's 85 ASCs had a direct economic impact in the state of nearly $570 million in 2012. Adding the economic impact of taxes paid, the total economic impact of ASCs in Oregon in 2012 was close to $612 million (Figure 1).***

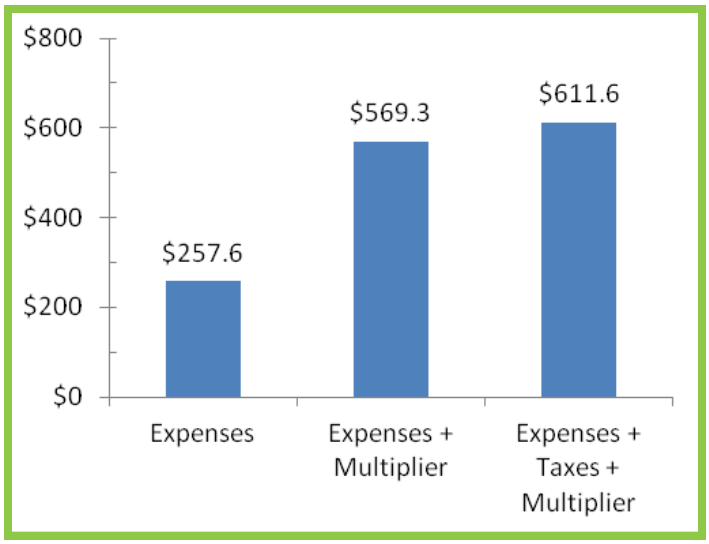

Figure 1 – ASC Economic Impact in Oregon

[1] See generally A. Chukmaitov, Devers, Harless, Menachemi, & Brooks, 2011; A. S. Chukmaitov, Menachemi, Brown, Saunders, & Brooks, 2008; Fleisher, Pasternak, Herbert, & Anderson, 2004; Hollingsworth et al., 2012; Marla & Stallard, 2009

[2] Koenig & Gu, 2013

[3] Described in the Analysis section (Page 2) in greater detail.

[4] US Bureau of Economic Analysis, 1997

[5] Described in the Analysis section (Page 2) in greater detail.

ANALYSIS

The US Bureau of Economic Analysis (BEA) Regional Input-Output Modeling System ("RIMS II") uses an input-output model to calculate "multipliers" by industry sector.[6] The input-output models rely on large US industry datasets to determine the relationship between inputs and outputs. In this analysis, the multiplier for the ASC sector of the economy exceeds 2, meaning that a dollar spent in the ASC sector will result in more than double the economic impact.

First, we collect data on ASC expenditures from a sample of ASCs. We extrapolate the sample to the state-level by multiplying the sample average expenditures per ASC by the number of ASCs in the state. We then apply the BEA multiplier to the state total.

DETAILED FINDINGS

Table 1 – Summary Data, 2012

Number of ASCs	85
FTE workers	1,758
Total expenditures	$257.6 million
Multiplier	2.21
Expenditure Impact	$569.3 million
Tax Impact	$39.5 million
Total Impact	**$611.6 million**

Table 1 summarizes some of the more detailed findings from the data collection and calculations. ***In Oregon, there are a total of 85 ASCs employing approximately 1,760 full-time equivalent (FTE) workers.*** The total expenditures for all ASCs in the state were $257.6 million in 2012.[7]

After applying the multiplier, the expenditure effect in the state totals $569.3 million. Adding in taxes paid by ASCs, which totaled $39.5 million in 2012, the total statewide economic impact of ASCs in Oregon is $611.6 million.

CONCLUSIONS

Using a simple and appropriate methodology for calculating economic impact, we find that ASCs in Oregon create about $612 million in economic activity. Given that state economies have not recovered since the 2008 recession, industries that create this level of economic activity and jobs should be recognized for their contribution.

[6] US Bureau of Economic Analysis, 1997
[7] These data were verified against VMG, the industry standard in data collection. See VMG Health, 2011

The quality of care provided by ASCs is at least equal to and in most cases better than hospital outpatient departments (HOPDs). Because only surgery is performed, and mainly on well patients, incidences of healthcare acquired infections are rare. And with less overhead than HOPDs and lower rates of Medicare reimbursement, ASCs help reduce medical-care expenditures by governments and consumers.

Between 5 and 10 percent of all patients contract at least one hospital-acquired infection—also known as a healthcare-associated infection or nosocomial infection—during their stay in an acute care hospital. According to estimates from the National Nosocomial Infections Surveillance (NNIS) system, in 2002, approximately 1.7 million cases of HAIs and 99,000 associated deaths occurred in U.S. hospitals, leading to extra costs of up to $6.5 billion each year …. one trend is clear: the infections are becoming more complicated to treat as their resistance to antibiotics grows.

From the National Conference of State Legislatures website, Issues & Research/Health/Hospital Acquired Infections FAQ

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The ECONOMIC IMPACT OF AMBULATORY SURGERY CENTERS in OREGON

OREGON AMBULATORY SURGERY CENTER ASSOCIATION

Our Patients Come First

Our Mission:

The Oregon Ambulatory Surgery Center Association is committed to ensuring that surgery centers continue to thrive as a distinct model for the delivery of safe, affordable, and advanced surgical services to Oregon's health care consumers.

Oregon Ambulatory Surgery Center Association
3333 S. Bannock St. Suite 400
Englewood CO 80110
303.761.1048 admin@oregonasc.com

Co-Provided by

Strategic Resources Group

Oxford Outcomes

Researched and written for OASCA by:
John E. Schneider, PhD, Senior Director, Oxford Outcomes, Inc.
161 Madison Ave., Suite 205, Morristown NJ 07960 862.242.2474 John.Schneider@OxfordOutcomes.com

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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.**

Technological 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.[1,2] 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.[3]

Between 1981 and 2005 the number of outpatient surgeries nationwide—performed either in hospital outpatient departments or in freestanding 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.[4]

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.[5] 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.[6] Similar to retail clinics that meet primary care needs, ASCs offer convenient, relatively low-cost access to health care services.[7]

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.[8]

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.[9] 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.[10]

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.[9,11] 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 reduced 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.[11–14] However, if hospitals are better equipped to treat high-risk patients, treating higher-risk patients in ASCs could have negative consequences for patient outcomes.

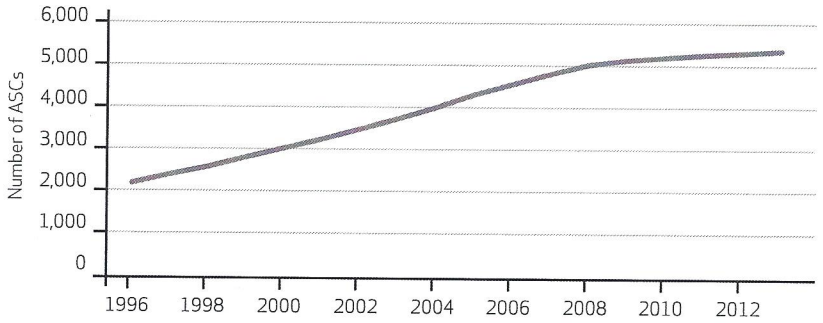
There is little evidence about the quality of care provided in ASCs or their ability to function as substitutes for hospitals in providing outpatient surgery. Comparisons of outcomes between these two types of outpatient facilities are complicated by the fact that ASCs tend to treat a healthier mix of 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.[15] In particular, we considered the likelihood that patients undergoing one of the five highest-volume outpatient procedures[16] 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.[17,18] These measures are also interesting from a policy perspective: As of October 2012, as part of the Ambulatory Surgical Center Quality Reporting Program,[19] 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.[12,20] 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.[21]

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.

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.[22] Our

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.[20] 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

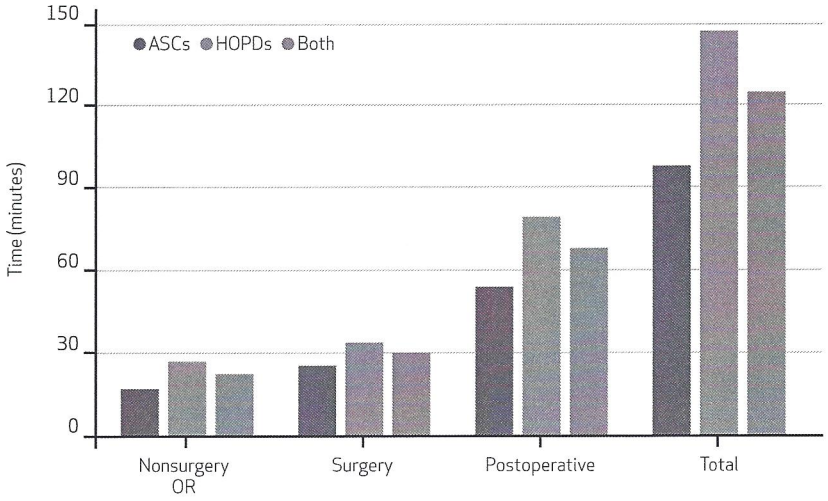
The findings presented here provide evidence that ASCs are a lower-cost alternative to hospitals for outpatient surgical procedures. The tremendous growth in the number of ASCs since the 1980s suggests that these facilities are quite flexible in meeting the growing demand for outpatient services. This 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.[23] 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.[24]

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).[25] Our estimates indicated that outpatient surgical volume in hospitals alone will increase by 8–16 percent annually between 2014 and 2021, compared to annual

EXHIBIT 3

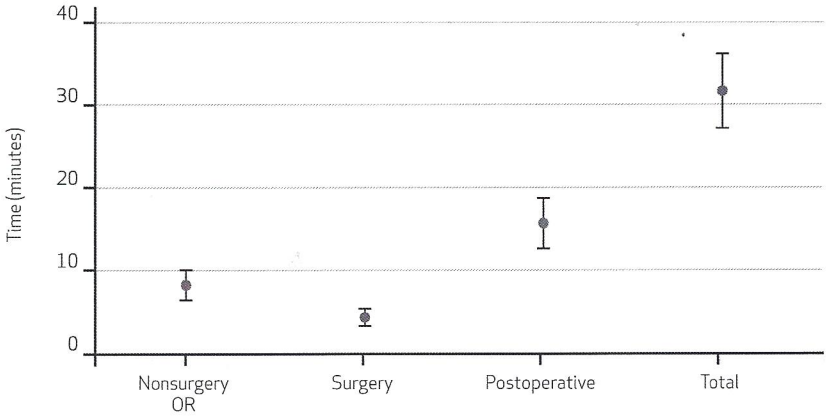
Average Outpatient Surgical Procedure Time, By Facility Type, 2006



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.

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.

25 million

Procedures

The roughly 5,300 ASCs in the United States provide more than 25 million procedures each year.

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.[9] 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.[26,27] The Ambulatory Surgery Center Association has estimated that roughly 5,300 ASCs provide more than twenty-five million procedures annually in the United States.[27]

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 adjusted 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.[28–31] In combination with research on the quality of care in ASCs,[15] 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. ■

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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Partners In Health

February 9, 2015

Representative Mitch Greenlick
Chair, Oregon House Health Committee
Oregon State Legislature
900 Court Street NE
Salem, OR 97301

Dear Mr. Chair,

Thank you for providing the opportunity to comment on HB 2570, creating a new class of healthcare facility called Convalescent Care Centers. This letter is to support the concept, as well as the testimony provided by the Oregon Ambulatory Surgery Center Association in creating the Convalescent Care Center model in Oregon.

I am the Administrator of the Surgery Center of Southern Oregon, located in Medford. We are a facility with 79 physicians that employs 76 staff at our facility and conduct approximately 11,500 procedures annually. As an ambulatory surgery center, we pride ourselves in providing high quality, low cost healthcare to patients throughout the great State of Oregon. Technology advancements have enabled our facility to provide higher acuity of care to our patients, while still maintaining exemplary clinical outcomes for our patients. Our patient satisfaction is consistently above 95% with an infection rate of less than .1 %.

HB2570 creates an opportunity to enhance the patient's experience, in circumstances where they have minimal support for recovery, persistent pain or nausea, or trouble controlling bodily functions. The health system saves money by avoiding an ambulatory ride and an in-patient admission to a hospital, where all they need is some additional monitoring in a clinical setting. Clinical outcomes from states with existing convalescent care centers demonstrate that this model does not pose a threat to patient safety, nor does it inflate the true cost of procedures.

Again, as a center in Medford we support the concept of HB 2570 and thank you for the opportunity to comment on this bill.

Thank you,

Michael Westmiller
Executive Director

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Dear Mr. Chair,

Thank you for providing the opportunity to comment on HB 2570, creating a new class of healthcare facility called Convalescent Care Centers. This letter is to support the concept as well as the testimony Provided by the Oregon Ambulatory Surgery Center Association, in creating the Convalescent Care Center model in Oregon.

I am the Clinical Director of Bend surgery Center, located in Bend Oregon. We are a facility employing a staff of 100 and utilized by 90 physicians, performing 11538 procedures in 2014. As an ambulatory surgery center, we pride ourselves in striving for the triple aim of improving the patient experience of care, improving the health of the population and reducing the cost of health care. Technological advancements have enabled our facility to provide higher acuity of care to our patients while still maintaining exemplary clinical outcomes to our patients. Our outstanding post-operative infection rate for 2014 of 0.017 is less than two infections in 10,000 patients, well beneath the national average.

HB 2570 creates an opportunity to enhance the patient's experience, in circumstances where they have minimal support for immediate postoperative homecare, persistent pain or nausea, or difficulty maintaining vital signs adequate for discharge to homecare. The health system saves money by avoiding an ambulance transport and an in-patient admission to a hospital, when all is needed is additional monitoring and assistance to achieve normalcy. Clinical outcomes from states with existing convalescent care centers demonstrate that this model does not pose a threat to patient safety, nor does it inflate the true cost of procedures.

Again, as an ambulatory surgery center in Oregon we support the concept of HB 2570 and thank you for the opportunity to comment on this bill.

Respectfully,

Scott Smallwood RN BSN CNOR

The OCR Surgery and Recovery Centers: A Report on Outcomes, Cost Savings

May 2014

Ambulatory Surgery Center & Recovery Center
Fort Collins, CO

ORTHOPAEDIC & SPINE
CENTER OF THE ROCKIES
www.orthohealth.com

Introduction

The Orthopaedic & Spine Center of the Rockies has years of experience in operating an Ambulatory Surgery Center and Recovery Center, and delivering:

- excellent clinical outcomes
- outstanding patient satisfaction
- significant cost savings for employers, patients, and insurers.

History of OCR's Surgery Center and Recovery Center

1988 – The OCR physicians vote to build our Surgery Center (single specialty)
1989 – Groundbreaking for new center
1990 – Surgery Center opens with one OR, and second room equipped
1991 -- Second OR opens
1995 – Four 23-hour beds established
1998 – Groundbreaking for Surgery Center expansion (3rd OR) and Recovery Center (10 beds)
1999 – Opening of the expansion
2013 – Remodeling of the Surgery Center and Recovery Center

Currently, more than 5,000 patients a year have surgery/pain procedures with us, with about 24% of the surgical patients staying one or more nights.

Scope of Services

We provide a full range of orthopaedic surgeries and pain procedures at the Surgery Center. They include: total hip replacement, total knee replacement, shoulder arthroscopy, ACL repairs, spinal fusion, hand and upper extremity procedures, foot and ankle reconstruction, etc.

See attachment #1 for list of our approved procedures.

National and Regional Recognition

The OCR Surgery Center and Recovery Center have been recognized at a national level for our low-cost, high-quality model of care which has been refined over a period of 24 years.

We have received national recognition from the National ASC Association, the Centers for Medicare and Medicaid (CMS), and the Office of Management and Budget (OMB).

The OCR physicians and our Surgery Center have been chosen as a "Center of Excellence" by Alpha Natural Resources for its coal mines in Gillette, WY, as well as by Reiman Corp. of Cheyenne, Hilltop Bank of Casper, and other Wyoming employers or professional associations. These selections are based on our high-quality surgical outcomes, low complication rates, and cost effective charges.

See attachments 2 and 3 for articles of recognition about OCR.

Factual summary

- We provide surgical care for more than 4,000 residents of Colorado, Wyoming, and Nebraska each year at our ASC.
- Pain management care is also provided.
- The last 5 years = 19,986 surgeries at OCR's Surgery Center.
- Additional patients have pain management injections.
- About 24% of patients stay one or more nights in our Recovery Center.
- Surgery Center and Recovery Center charges and historical reimbursement rates are far lower than those at hospitals in the region.
- OCR's Surgery Center and Recovery Center provide long-standing, demonstrated cost savings for employers, patients, and payors, along with high-level care and patient satisfaction.
- The OCR Surgery Center has a 24-year history of excellence in caring for patients from CO, WY, and NE.

Supporting data

Patient care quality

	2009	2010	2011	2012	2013
Surgery patients	3,728	3,774	3,987	4,279	4,218
Pain mgt patients	1,000	1,004	1,015	1,222	1,351
Recovery Center patients (with at least 1 overnight stay)	863	911	933	979	1,043
Surgery Center complication rate	0.75%	0.45%	0.53%	0.38%	0.57%
Surgery Center infection Rate	0.19%	0.08%	0.18%	0.10%	0.07%
Patients transferred to hospitals	4	4	3	3	4
Surgery Center patient satisfaction surveys	383	368	275	294	717
I was satisfied with my surgical experience (yes)	97%	96%	95%	97%	97%
I was satisfied with my stay In the Recovery Center (yes)	98%	97%	98%	95%	98%

Supporting data

Comparison of OCR & Colorado Hospital Charges: 2006 And 2012

Surgery	2012 Colorado "Other Urban" Hosp. Avg. Charge	2012 OCR Avg. Charge	OCR as % of Hosp. Charges
Hip Replacement	$62,388	$23,000	36.9%
Knee Replacement	$61,115	$22,000	36.0%

Hip Replacement: OCR and Hospital Avg. Charges

Hip Replacement	2006	2012
McKee Medical Center	$42,451	$55,650
Poudre Valley Hospital	$40,253	$57,790
Medical Ctr of the Rockies	NA	$59,461
North Colo Medical Ctr	$50,777	$66,220
University of Colo Hosp	$69,825	$76,814
Presbyterian-St. Luke's	$57,039	$91,160
OCR	$23,000	$23,000

Supporting data

Knee Replacement:
OCR and Hospital Avg. Charges

Knee Replacement	2006	2012
McKee Medical Ctr	$42,509	$49,973
Poudre Valley Hospital	$46,183	$61,273
Medical Ctr of the Rockies	NA	$67,995
North Colo Medical Ctr	$48,037	$63,894
University of Colo Hosp	$53,565	$71,145
Presbyterian-St Luke's	$54,383	$82,024
OCR	$22,000	$22,000

Notes

NA = not available

Sources: Orthopaedic & Spine Center of the Rockies data and August 2013 and July 2007 reports by Colorado Hospital Association, *Hospital Charges and Average Length of Stay*.

"Hospital charge" uses the average charge for "Other Urban" hospitals in Colorado for hip and knee replacement procedures.

"Other Urban" hospitals are located primarily along the Front Range outside Denver (i.e., Fort Collins, Loveland, Greeley, Boulder, Colorado Springs, Pueblo, etc.). "Charge" refers to the hospitals' posted prices for the surgery, and include the hospitals' facility fees and do not include the physicians' charges.

McKee Medical Center and Medical Center of the Rockies are located in Loveland, CO.
North Colorado Medical Center is in Greeley.
Poudre Valley Hospital is in Fort Collins.
University of Colorado Hospital and Presbyterian-St. Luke's are located in the Denver area.

Supporting data

Comparison of OCR & Wyoming Hospital Charges: 2011-12

Surgery	2011-12 OCR Avg. Charge
Hip Replacement	$23,000
Knee Replacement	$22,000

Major Joint Replacement or Reattachment of Lower Extremity without MCC – MSDRG 470	2011-12 Hosp. Avg. Charge
All WY Hosp. Avg	$49,751
Cheyenne Regional Med Ctr	$52,957
Ivinson Memorial Hospital	$44,736
Wyoming Medical Center	$62,258
Campbell County Memorial Hosp	NA

Major Joint Replacement or Reattachment of Lower Extremity with MCC – MSDRG 469	
WY Hosp. Avg	$65,177
Cheyenne Regional Med Ctr	$75,555
Ivinson Memorial Hospital	NA
Wyoming Medical Center	$66,013
Campbell County Memorial Hosp	NA

Notes

Sources are Orthopaedic & Spine Center of the Rockies data and Wyoming Hospital Association's www.wyopricepoint.com, accessed on January 8, 2014, using the basic query for MSDRG 470 and the comprehensive query for MSDRG 469.

WHA uses the MSDRG system. CHA uses the APR-DRG system. The DRG's are identified by different names and have different scopes.

Supporting data

Information from payors

Please see attachments 4 and 5 with information from two payors:

- Anthem Colorado letter to physicians, etc., on ASC-hospital cost comparisons, and ASC cost-effectiveness for surgical patients.
- United Healthcare update on the elimination of its former program of distinction for hospitals.

Orthopaedic & Spine Center of the Rockies
Licensed Ambulatory Surgery Center and Convalescent Center

2500 E. Prospect Road | Fort Collins, CO 80525 – Larimer County

Administrators/Contacts:
Mr. Michael Bergerson, MHA, CEO
Ms. Barb Hardes, RN, MSMHCA, BSN, CNOR, Director of Surgical Operations and Chief Operating Officer

Ownership type: PROFIT-CORPORATION

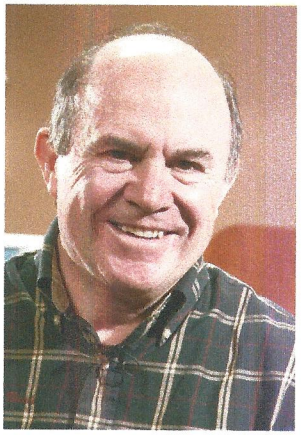
- OCR Ambulatory Surgery Center opened in 1990; 24 years of operation.
- Recovery Center opened in 1999; 15 years of operation.
- Three operating rooms, plus one room for minor procedures.
- 10 private rooms in Recovery Center.
- All patients admitted to Recovery Center are from Orthopaedic & Spine Center of the Rockies Surgery Center.
- Recovery Center has 24/7 nursing care for those patients who need one or more nights of supervised recovery after surgery.
- Nursing ratio is often 1 nurse for every 1-3 patients. Recovery Center staff are RN's, with one CNA.
- Additional postoperative care and instruction to help the pain control and healing process.
- Exercise instruction and immediate rehabilitation by OCR's PT and OT staff (provided on-site in the Recovery Center).
- Provides quiet comfort for the patient and family, catered meals, TV and music in each room, a family lounge for relaxation, and wireless internet for patients and families.
- Medical staff of 24 surgeons and physicians at Orthopaedic & Spine Center of the Rockies Surgery Center, with selected anesthesia/PM&R physicians for anesthesia and pain management services.

One patient's story:

"THE FACILITIES WERE FABULOUS, THE STAFF SO HELPFUL"

"I thought I was in a first-class hospital because I had all the Accommodations there—caring and experienced nurses, comfortable room, the food, all of it," said Ronny Bush, a long-time State Farm insurance agent in Fort Collins, CO.

Ronny is describing the Orthopaedic & Spine Center of the Rockies Surgery/Recovery Center, where he had an operation to replace both knees.



"It was extremely convenient. The facilities are fabulous. The staff was so helpful and so friendly and so accommodating. They took great care of me."

After his surgery, Ronny stayed several nights in our recovery center. Besides nursing care from our all-RN staff, Ronny also had physical therapy services. Patients typically are moved effortlessly from surgery to a private room in the recovery center.

Ronny enjoyed a routine and uneventful recovery from surgery during his four-day stay in the recovery center, except for one problem – he came down with a case of the hiccups. Now for most of us, the hiccups are annoying to be sure, but a passing inconvenience that disappears in a short time as mysteriously as it came. But for Ronny, hiccups can be serious. After a prior surgery, he had developed a case of the hiccups that painfully lasted for four full days.

This episode ended well because it ended soon. "The nurses were so helpful. They looked and they searched and they talked to the doctors, and they found a medicine that worked. I took it and that cured my hiccups! I had been really concerned."

About six months after his surgery, Ronny was back to doing what he loves. During the winter and spring, that means skiing. "…..I was skiing the Double Black Diamonds at Winter Park (a run for expert skiers). I skied all day and had a great time. What more do I need to say (about my recovery)?"

"My (leg) muscles were a bit weak, they're still getting stronger. They just needed some more exercise. But when I would go skiing before (the surgery), I would wake up stiff and sore the next day. When I got up today, there was no soreness, no pain. The surgery definitely did make a difference. It's a huge change. It gives you your life back."

Stiff and sore was how Ronny had spent a good deal of the past 12 years as the cartilage in both knees gradually wore down. "It got so I couldn't really walk up and down stairs. I had to go sideways. It was especially difficult going down because you have to put more weight on your leg."

"When I crossed the street, I tried to avoid the curb cut and look for a ramp."

"It was just a difficult situation. I thought I could exercise my way to health. I was kind of in a state of denial about it for many years."

Actually, what Ronny did made sense. He took care of himself. He exercised with skiing and mountain biking. He lifted weights to stay strong. But time took its inevitable toll on his cartilage and knees.

And he got to that point that people need to reach if they're having elective surgery like total knee replacement. "I finally decided where I had to have it," Ronny said. "It had become more and more painful."

When the pain, inconvenience, and lifestyle losses get bad enough for you, then you're motivated and ready to go through the surgery and work hard to recover your former physical abilities.

"You have to get to that point where you really can't take it anymore," Ronny remarked. He did during a trip to Washington, D. C. He and his wife were visiting the Washington Zoo with their grandson when the pain in his knees led him to search for a wheelchair. "I would've used it, but my wife and grandson couldn't push it up the steep inclines. So I enjoyed the zoo and just gutted it out."

"When I got back from the trip I scheduled the appointment," which he made with Kirk Kindsfater, MD, a joint replacement specialist at the Orthopaedic & Spine Center.

"I knew the Orthopaedic Center was a good place to do it. When I got to the appointment and saw Dr. Kindsfater, it took me about 30 seconds to know he was the right guy. And I knew I was doing the right thing; that was very important. We took the time to talk, and I knew quickly that he knew what my problem was."

Now, Ronny has gotten back to doing what he loves, such as skiing, and going through daily life's up-and-down staircase—and enjoying it with far less pain.

Medical and surgical staff

The Orthopaedic & Spine Center of the Rockies supports physicians in the orthopaedic specialties. OCR has been pleased to provide care to the people of northern Colorado, Wyoming and western Nebraska since 1969.

Our state-of-the- art practice combines compassionate care, advanced diagnostics, and an outpatient surgery and recovery center with a skilled team of medical professionals.

Orthopaedic & Spine Center of the Rockies offers specialized care for:

- Trauma and Fractures
- Hand and Upper Extremity
- Foot and Ankle
- Spine and Pediatric Spine
- Hip and Knee
- Shoulder
- Sports Medicine
- Joint Replacement and Arthritis
- Pediatric Orthopaedics
- Orthopaedic Worker's Compensation Care

See attachment #6 for details on the OCR physicians.