112 Surgery Center Administrators to Know p. 14

INSIDE

INDEX

BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

June 2012 • Vol. 2012 No. 5

From Independent Investors to Salaried Employees: How Hospital Employment Affects 5 Common Surgery Center Specialties

By Taryn Tawoda

Hospitals are hiring physicians in larger numbers and across broader specialties than ever before. According to the American Hospital Association, hospitals employed roughly 211,500 physicians in 2010, up 34 percent since 2000. In total, 25 percent of all active physicians are currently employed by hospitals.

continued on page 8

10 Ways to Cut Surgery Center Costs Before 2012 Ends

By Rachel Fields

Surgery centers can improve profitability in two basic ways: cut costs or increase volume. With payors cutting off referrals to out-of-network surgery centers and hospitals employing physicians, the task of increasing physician volume is becoming more challenging. Ten surgery center industry experts share their ideas to cut costs at your ASC before the end of the year.

continued on page 10

6 Steps to Prepare for the Future of Outpatient Spine Surgery

By Laura Miller

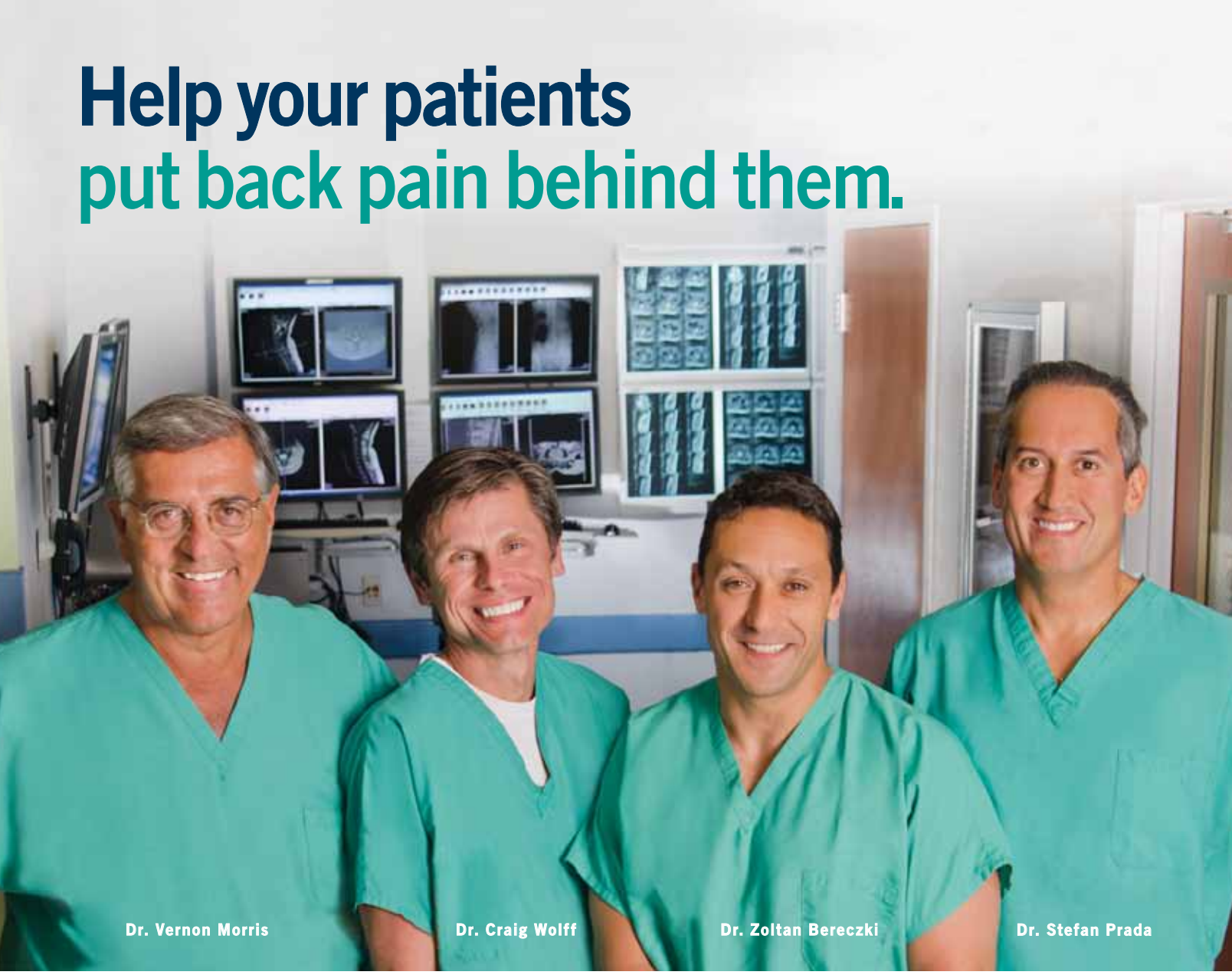
Robert S. Bray, Jr., MD, neurosurgeon and CEO of DISC Sports & Spine Center in Marina del Rey, Calif., believes that outpatient surgery centers and spine specialty hospitals are the future of elective spine surgery. He moved out of his role as head of the Cedars-Sinai Spine Center in Los Angeles to open his own practice, and has since developed two surgery centers where surgeons perform complex minimally invasive orthopedic and spine cases.

"I believe very firmly that spine over the next five to seven years — ten years max — will transition nearly completely to specialty hospitals or outpatient centers," says Dr. Bray. "The reason I believe we can do this is because procedures are much less invasive today than they were even 10 years ago."

In addition to the technology, several factors — including an emphasis on

continued on page 12

Help your patients put back pain behind them.



Find out why Laser Spine Institute's minimally invasive solutions are a safe and effective alternative to open neck and back surgery.

When your patients with neck and back pain no longer benefit from conservative treatment options, refer them to Laser Spine Institute. Our minimally invasive solutions offer a number of advantages over open neck and back surgery:

- Several types of endoscopic spine procedures are offered to treat a wide range of conditions.
- High standards of patient safety and sanitation resulting in an infection rate of 0.07% vs. national hospital average of 4.5%.
- All procedures are outpatient and nearly 75% of patients return to daily activities within two weeks post-operatively.
- Approximately 450 endoscopic surgeries performed each month with a 93% patient satisfaction rate.

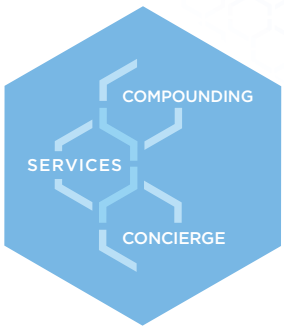
Download a free QR code app and scan this image to contact Laser Spine Institute now.

LASER SPINE INSTITUTE®
THE LEADER IN ENDOSCOPIC SPINE SURGERY

Call **1-866-382-8301** or visit **www.LSIPhysicianRelations.com** today, and learn how together, we can provide proven relief from chronic neck and back pain.

SURGICALMEDS

POWERED BY DOUGHERTY'S



SurgicalMeds provides compounded medications and point-of-care concierge services to ambulatory surgical centers, surgical hospitals and healthcare facilities.

For more information: 855-888-MEDS *(6337)*
or email info@surgicalmeds.com

SURGICALMEDS.COM

Advanced Endoscopic Treatment for Your GI ASC: Radiofrequency Ablation for Barrett's Esophagus

HALO^{90} and HALO^{60}
Ablation Catheters

Visit http://energysolutions.covidien.com/ASC-2012 to learn more.

COVIDIEN

positive results for life™

THIS IS A TEST.

Does your surgery center get a failing grade?

ARE YOU . . .

. . . Making less than 40 percent profit at your ASC?
. . . Stuck with unused block time?
. . . Failing to syndicate new physicians?
. . . Seeing patient satisfaction below 95%?
. . . Working overtime and feeling stressed?

ACE THE TEST INSTEAD!

. . . See profits grow by 30-to-40 percent.
. . . Have full caseloads—but leave every day at 5:00.
. . . Recruit new, productive physicians in specialties you need.
. . . Focus on surgery while others do the paperwork.
. . . Enjoy more of the good life with family and friends.

At Murphy HealthCare Group, we have more than 20 years' experience turning troubled ASCs into profitable ones—with more efficiency, quicker turnover, fewer complications, and more cases per day.

Better patient outcomes, more surgeon income.

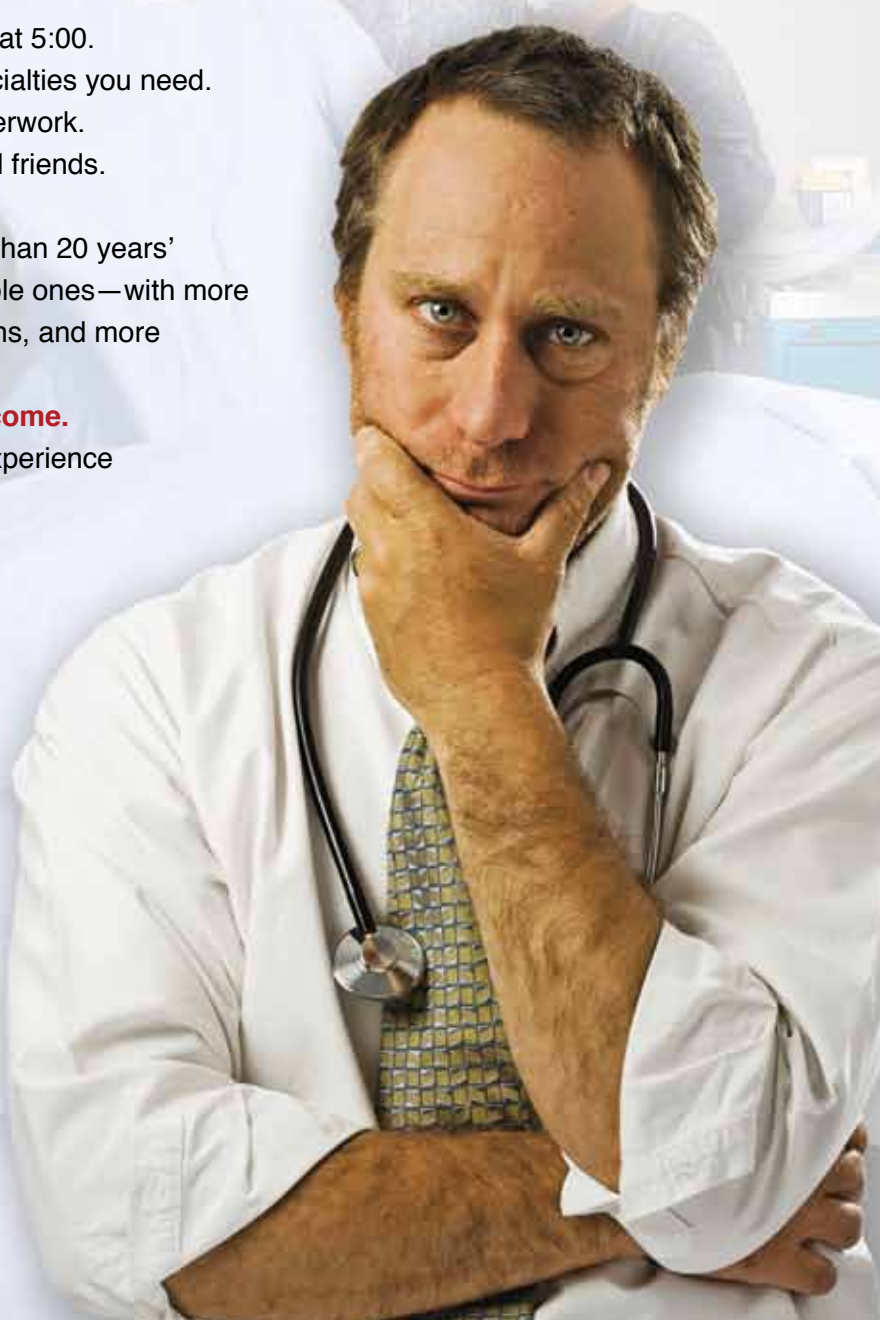
You can hear other surgeons describe their experience with us at www.ASCturnaround.com

If you want to improve your ASC's score, give me a call.

Robert Murphy, CEO
Murphy HealthCare Group
(212) 937-4911
RMurphy@SurgeryCenters.com

MURPHY HEALTHCARE GROUP

www.ASCturnaround.com



BECKER'S
ASCREVIEW
Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

June 2012 Vol. 2012 No. 5

FEATURES

Publisher's Letter

This issue of *Becker's ASC Review* concentrates on several issues dominating discussion in the ASC industry — namely hospital employment of physicians, the future of crucial specialties such as spine, and the continued need for cost-cutting. The June issue also features several articles on benchmarking and provides a range of surgery center statistics, from ASC administrator compensation to case volume.

In this issue, our list of "112 Surgery Center Administrators to Know" highlights surgery center leaders who work tirelessly to keep staff and physicians happy, negotiate profitable contracts, cut costs and provide quality care, all in the tumult of healthcare reform.

In addition, the Becker's Healthcare team will hold the 19th Annual Ambulatory Surgery Centers — Improving Profitability and Business and Legal Issues Conference from October 25-27, 2012, in Chicago. The conference will feature numerous speakers on ASC profitability and operations, as well as keynote speakers Tony LaRussa, Howard Dean and Ari Fletcher. Please join us during what promises to be an exciting time in healthcare, as the country prepares for the November presidential election. More information is available at www.BeckersASC.com.

Should you have any questions or if we can be of help in any manner, please do not hesitate to contact me at sbecker@beckershealthcare.com or call me at (800) 417-2035.

Very truly yours,

Scott Becker

From Independent Investors to Salaried Employees: How Hospital Employment Affects 5 Common Surgery Center Specialties
(continued from page 1)

Why are hospitals employing more specialists?

The reason for this surge in hospital employment can be traced to two root causes, according to Akram Boutros, MD, president of BusinessFirst Healthcare Solutions: the current healthcare economy and healthcare reform. "Hospitals feel pressured to protect or increase market share by expanding high-revenue specialty physicians and physicians whose practices are geared toward commercial and surgical patients," Dr. Boutros says.

According to Dr. Boutros, physicians turn to hospital employment as reimbursements decrease. "Physicians, especially those in specialties like orthopedics, cardiology and surgery, have been financially impacted by declining professional fees, the exclusion and reduction of ancillary services fees and declining volumes in procedures such as angioplasties," he says.

In 2009, for example, CMS reduced the relative value units assigned to specific cardiology-related procedures. "The cuts ranged from between 10 percent to 40 percent, depending on the procedure, with nuclear imaging witnessing a 41 percent decline in reimbursement," says Dr. Boutros. Most commercial insurers followed suit in 2010. In a two-year period, physician fees for cardiac catheterization decreased from an average of $800 to $250 per procedure, and laboratory testing fee have diminished by 21 percent.

Physicians feel that looming changes in healthcare create the need for hospital "protection." Further fee erosion, a heightened focus on the quality of care, and the possibility of being excluded from an accountable care program are all very relevant concerns for many physicians, Dr. Boutros says.

Which specialties are most impacted by hospital employment?

The hospital employment outlook differs markedly among specialties, physicians say. Procedure type and volume, reimbursements, the desire for independence and the ability to form large multi-specialty groups all play a role in determining which specialists are more and less likely to become hospital employees.

ENT

Some specialties, including ENT, are less prone to the hospital employment trend because of the tendency for these physicians to aggregate under large specialty-focused multi-state groups, says Dr. Boutros. "Allergy and ENT Associates [in Tarrytown, N.Y.], for example, have more than 125 physicians across [New York and New Jersey] and offer specialty services including head and neck surgery, asthma care and sleep centers," he says.

Larger groups are less vulnerable to the issues plaguing ENT physicians, such as the fact that ENT does not have the reimbursement power of specialties like spine or orthopedics, says Dr. Boutros. If a physician group can bring in a large volume of patients, the reimbursement issue can be successfully combated, and the group can continue to function independently.

Gastroenterology

Gastroenterology has experienced an upswing in hospital employment in recent years, according to Sri Komanduri, MD, a gastroenterologist with Northwestern Memorial Hospital in Chicago. "I think the pendulum is swinging toward where it's more beneficial to work with the hospital, which may take administrative costs like maintenance, cleaning, compliance with regulatory organizations, all out of the physician's direct hands," says Dr. Komanduri. "It's less of a headache than a cost relief. Those are the sorts of advantages that a hospital could use to bargain with physician groups, giving them an incentive to become employees."

Gastroenterologists may also tend to gravitate toward hospitals because more endoscopies are being performed there, says Dr. Komanduri. "The majority of what we do is procedurally based, and everyone is pushing for that to be done on the hospital format," he says.

Dr. Komanduri predicts that gastroenterologists who do not want to become employed by hospitals will start to combine their practices into large multi-specialty groups. "That's ultimately what would happen if a hospital buys out those groups anyway," he says.

Ophthalmology

Ophthalmologists are among the most independent specialists, according to Larry Patterson, MD, medical director of Eye Centers of Tennessee and the Cataract and Laser Center in Crossville, Tenn. "I think we're the last specialty to be affected by hospital employment," he says. "Seventy percent of cataract surgeries are done in ASCs, and you hear hospitals complaining that they don't make money off of cataract surgery anyway."

The most efficient ophthalmological practice arrangement consists of several physicians who work as a cohesive group, Dr. Patterson says. "Small, nimble practices work very well," he says, "There have been studies done that say once you have more than nine ophthalmologists in a group, income decreases and the practice becomes less efficient."

Hospitals and ophthalmologists, meanwhile, do not seem to have a strong practical need for one another, he says. "I don't ever have patients in the hospital, and I can go years without having to enter a hospital," Dr. Patterson says. "A lot of us have gotten off of hospital staffs because it became too difficult to provide services and be on call when, in reality, we don't need the hospital. We're in the clinics and surgery centers."

Orthopedics

In an increasingly vulnerable healthcare environment, the stability of a consistent salary and a guaranteed referral base can be alluring for orthopedic surgeons. "The one thing that I envy about my colleagues who have joined hospitals is that they walk right into a referral base," says Ashraf Darwish, MD, an orthopedic surgeon at Oak Orthopedics in Bradley, Ill. "If a hospital has 35 primary care doctors and you're the orthopedic surgeon on staff, you automatically get those referrals. And at a hospital, you know exactly how much money you're going to make, and the salary is always the same. In private practice, it's your job to market yourself and make people come to you."

The desire for independence and control over scheduling and case volume, however, can be a strong influence in an orthopedic surgeon's decision to stay in private practice. "Many of us have a fear that we may lose some of our autonomy by joining a hospital groups, and it's a well-founded concern," says Dr. Darwish. "I've definitely seen the trend towards hospital employment in my five years of residency — senior residents end up being employed by hospitals or multi-specialty groups. But then you'll hear about someone who joined a hospital and their salary was cut in half two or three years later, or they're asked to do something they weren't asked to do in the initial contract."

The prospect of tailoring the schedule and caseload of a private practice —as opposed to being assigned work by a hospital — continues to appeal to orthopedists. "I can limit my practice and it may decrease the amount of work I do, as opposed to working for a hospital that would dictate the amount of work for me," says Dr. Darwish. "The only person I have to answer to in private practice is me."

Pain management

Anesthesia and pain management are affected "tremendously" by the hospital employment trend, according to Robert S. Bray, Jr., MD, neurosurgeon and CEO of DISC Sports & Spine Center in Marina del Rey, Calif. "It's becoming a difficult topic because hospitals are cutting contracts with anesthesia groups and restricting the entire hospital to that group," he says. "Many outside anesthesiologists can't get on hospital staffs because they all have structures exclusive to a group."

Consequently, pain management physicians find that they have fewer options for obtaining credentials and staff positions. "Where do they go? How [do they] get credentialed?" says Dr. Bray. "They have to be credentialed in a Joint Commission approved facility, but they can't get on a staff anywhere because hospitals have begun excluding outside physicians from staff privileges if they are not part of their group." ■

10 Ways to Cut Surgery Center Costs Before 2012 Ends (continued from page 1)

1. Form a list of cost-effective implants. Dale Holmes, administrator of Warner Park Surgery Center in Chandler, Ariz., says his surgery center has a formulary committee headed by a member of the medical executive committee. The committee has approved a list of cost-effective implants, and if a physician wants to bring a case with high-priced implants to the center, it has to be approved by the committee chairperson. "Even if it's a contracted insurer, we can deny it and have it taken to the hospital if the implant is not approved," he says. "Many insurers don't want to cover implants, so it ends up costing them more as it's done in a hospital."

2. Hold a "relationship meeting" with your bank. Joan Shearer, administrator of Lawrence (Kan.) Surgery Center, says she schedules a "relationship meeting" with her bank annually to identify new cost savings programs, reduce bank fees and explore investment opportunities and refinancing opportunities. "Every year, I am able to find some saving," she says.

3. Review your packs. Jennifer Hunara, administrator of the Surgery Center of Allentown in Allentown, Pa., says her biggest cost-savings initiative this year was performing a review of the surgery center's packs. "After four years in business, we hadn't done research to see if we could not only get them cheaper from another vendor, but also look at the contents of each pack to see if any items could be added or deleted." She says the surgery center managed to save $56,000 through this initiative.

4. Engage in a fresh RFP process to reduce office supply and utility costs. "In our experience, indirect overhead costs are an area that is frequently overlooked by a center, but can have dramatic effects on the profitability of the center," says Jason Smith, vice president of marketing for Alliance Cost Containment, a financial efficiency company providing cost management solutions. These can include office supplies, janitorial supplies, insurance and utilities, to name a few. "Typically an ambulatory surgical center will spend up to 15 percent of their expenditure on these overhead costs, so reducing them can have a dramatic effect on the profitability of the center," he says.

When reviewing janitorial supply expenses for an ASC, for example, Alliance Cost Containment totaled the yearly expenses allocated to supplies such as toilet tissue, paper towels, cleaners and waste liners with the center's current vendor. They documented hundreds of recent common purchases in this category alone from the current vendor. With this purchase history at hand, they created an RFP that was sent out to the current vendor and two competing vendors. In this case, Alliance Cost Containment was able to negotiate a reduced price with the current vendor through the RFP process, and the center was able to save approximately 34 percent on janitorial supplies per year.

5. Educate physicians on medical supply costs and present alternative products. John Brock, administrator at NorthStar Surgical Center in Lubbock, Texas, says an ASC's two greatest expense line items are salaries and medical supplies. "We absolutely do not standardize medical supplies because our physician owners should be able use their preferred products," Mr. Brock says. "However, we educate the physicians as to cost and let them decide whether a less expensive product will be acceptable. We are also very careful as to waste and are constantly looking at new vendors, the possibility of price renegotiation when contracts expire and whether things such as reprocessing are applicable."

Along those lines, at Physicians Day Surgery Center in Naples, Fla., employees are trained to avoid unnecessary financial burdens for the cen-

ter by paying close attention to supply costs and reimbursement, particularly when working with physicians during surgery.

"Our staff is very much aware of the fact that you can make an otherwise profitable case in the OR unprofitable by opening too many surgical trays if you're not sure that you need them," says Karen Cannizzaro, CASC, administrator at Physicians Day Surgery Center in Naples, Fla. "They may suggest an alternative product to physicians, or wait to open something so that 12 trays of instruments and implants aren't opened unnecessarily for one procedure."

6. Use a pre-certification tool. Laurie Simon, administrator of Western Reserve Surgery Center in Kent, Ohio, has brought her center's revenue cycle under control by purchasing a pre-certification tool, Encircle, and processing patient payments through e-PAY. "Encircle helps us know what the patient responsibility is before they come in," she says. "e-PAY allows patients to pay online and set up payment plans under the parameters that we set up for automatic payment withdrawal from a credit card or checking account, with notification if they default on a payment," she says.

7. Pre-screen patients for co-payments. Stuart Katz, director of TMC Orthopaedic Outpatient Surgery in Tucson, Ariz., says pre-screening patients for co-payments and contacting them ahead of surgery to discuss financial responsibility has saved money for his ASC.

"[We contact them] ahead of surgery, both via telephone and mail, to discuss their expected out-of-pocket expenses and make arrangements to collect them before or on the day of surgery," he says. "This has saved us a ton of money, as we are not chasing them for their portion after being paid by the insurance company." He says if the actual payment is within $25 of what the surgery center estimated, they do not pursue the extra dollars due from the patient.

8. Implement online registration. Becky Ziegler-Otis, administrator of the Ambulatory Surgical Center of Stevens Point (Wis.), says her surgery center implemented online registration for patients this year. "This helped with the efficiency of registration and reduced the workload for the RNs," she says. "We were able to not replace a 0.8 FTE for nursing as a result of the efficiency with this product."

9. Request a reduction of or exemption from property taxes. "If you own the building that you're in or even if you rent and are responsible for property taxes, you may want to consider a tax abatement," says Randy Hagen, CEO of Precision Surgical Partners, an ASC management company. Tax abatement requests are increasing due to the state of the economy and the fact that the commercial real estate market is rebounding, he says, and many are being granted. "More municipalities understand this and are willing to grant these types of abatements to help businesses stay in business," Mr. Hagen adds.

To begin the process, a surgery center administrator should speak to the tax assessor at the local municipality and ask for the appropriate paperwork to file a tax abatement. "In a situation where you're looking to squeeze and save any way you can, an extra $2,000 to $3,000 per month can make a big difference to someone in terms of breaking even versus being profitable, especially to those smaller centers" Mr. Hagen says. "Municipalities would rather have a performing ASC paying taxes going forward than have an empty space where they've got nothing."

10. Find a good purchasing agent. According to Tona Savoie, administrator of Bayou Region Surgical Center in Thibodaux, La., her biggest cost-efficiency strategy is a good purchasing agent. "I cannot stress enough how important it is to have a single person designated for purchasing that is organized, aware and aggressive," she says. "Vendors will change pricing with no notice, and physicians will use items twice the price of other items without knowing. A good purchasing agent constantly keeps a watchful eye on daily activities with supplies and vendors."

She says keeping vendors competitive also helps surgery centers achieve the best possible price. "It's amazing how prices can change overnight with the use or non-use of a product," she says. Surgery centers looking to trim their budgets should assess all aspects of the center's operations — including office supplies, property taxes, staff efficiency and surgical supply costs — in order to pinpoint where and how to effectively cut costs. Here are four key financial points to consider. ■

6 Steps to Prepare for the Future of Outpatient Spine Surgery

(continued from page 1)

providing cost-effective and infection-free care — will drive further growth of spine procedures into the surgery center and specialty hospital setting. Here, Dr. Bray discusses six ways surgeons and surgery centers can prepare for this future.

1. Create a rational business plan. Planning is an important part of every business venture, and surgery centers are no different. If a group of physicians wants to develop a center, they must have a detailed plan — not just deep pockets — to make the venture successful.

"The future is in surgery centers and specialty hospitals, so it's important to rationally and reasonably develop a business plan, budget and commitment to the center," says Dr. Bray. "Centers were we perform high acuity cases aren't little surgery centers where you perform 10 minute procedures; they must be designed and developed well to meet the needs of your patients."

Equipping a high end, high scale surgery center with the appropriate infection control measures and surgical equipment is a costly endeavor. Dr. Bray estimates it may take around a $9 million investment for a new spine surgery center, but having a savvy business plan could mean partners recoup those costs quickly through solid contracts.

"Put your business concepts together so the surgery center can survive as a business," says Dr. Bray. "If you can make the center survive as a business, it will flourish and have a purpose. Our center is financially solid; we have never had a non-profitable month and we are growing at an alarming rate."

2. Hire a high-quality administrator. While physician owners may be able to cut costs in several areas of their surgery center, skimping on administrator salary isn't acceptable. "You can't do this without a really top quality administrator," says Dr. Bray. "I'm the CEO of the center, but my administrator can answer any questions you have about the center. If you are going to run high acuity cases and run them with good outcomes, you need that type of person on your side."

Karen Reiter, administrator of DISC, had 27 years of experience in the healthcare industry — including time running an implant company — before taking her current position. DISC recently expanded to open a new surgery center in Newport, and Ms. Reiter was able to lead those efforts and achieve accreditation without any deficiencies.

"The details it takes to run these places is immense," says Dr. Bray. "They are complex buildings with a high level of professionals working inside. You must have good surgeons and nurses to work with the patients, but that doesn't matter if you don't have a quality administrator to take care of everything else."

Your administrator should be proficient in business, but also understand the healthcare environment. Healthcare is a unique business with special circumstance that demands experienced professionals in order to succeed.

3. Develop in-network contracts with private payors. Surgery centers are increasingly seeking in-network contracts with private payors to ensure long lasting success of the ASC. There are a few steps surgery centers can take to make sure they attract the best contracts available:

- Document outcomes to prove surgery can be successful in an ASC
- Demonstrate strict infection control protocols
- Provide your complication rate and risk management protocols
- Show the companies you are meeting clinical and financial benchmarks
- Emphasize cost savings associated with performing cases in the surgery center

"We just had a four-hour tour with a major private payor to go through our protocols and records," says Dr. Bray. "The company's representative decided they wanted to work with us. It's this type of detail that has to be developed because that's where the future of surgery lies. We are raising the bar for surgery centers so there's no question these high acuity cases can be performed here."

4. Pull out all the stops to fight infections. One of the biggest complications associated with spine surgery — and the source of a huge burden to the economics of healthcare — is infections. "Infections are out of control in the United States," says Dr. Bray. "We are fighting a battle against the bugs and we aren't winning with antibiotics. The bugs are smarter and faster, and it's becoming dangerous to do elective surgery in a regular hospital operating room. If we want elective surgery to survive, we must take a different path."

Some surgeons have chosen to remove their elective spine cases from the regular inpatient ward and into a spine or orthopedics specialty hospital; others have found solace in ambulatory surgery centers, which often have a lower rate of infection than hospitals. However, it takes extra effort to build a center where surgeons can perform 4,000-plus cases and without any infection—which is currently DISC's record.

"We took a different path with DISC," says Dr. Bray. "It isn't an average surgery center. We have 100 percent deep filtered air and strict nursing protocols to avoid infections. There is massive attention paid to every detail."

For example, there is a terminal employees enter before coming into the building and if nurses had been working at another hospital they are required to discard their old scrubs in favor of new, clean scrubs before continuing into the center. Patients are also separated in the postoperative area to make sure they don't spread infections from one room to the next.

"You can't put sick people in ICUs next to patients who hare having hip revisions or microspine surgery in the next room," says Dr. Bray. "This is how we can win against the bugs; we can put patients where the bugs aren't."

5. Invest in technology to improve efficiency. We live in an age where technology is a key aspect in running any business because it can accelerate tasks and make care delivery more efficient. DISC surgery centers include a vision computer system that does inventory management, supply control management and stocking management.

"You have to be at a computerized level to look at everything across the board," says Dr. Bray. "You have to have information at your finger tips. It's become necessary in this day and age to integrate technology."

6. Seek out more high acuity cases. Spine surgery is a high acuity, low volume subspecialty for a surgery center, which can be a great business model when done appropriately. However, once you are able to perform spine cases, consider bringing on other specialists who perform high acuity cases, such as partial knee replacements, hip scopes and shoulder reconstructions.

"We are adding high acuity, love volume cases, which bring our centers higher revenue," says Dr. Bray. We are able to perform complex cases and deliver better outcomes than in other settings because the complication and infection rate is lower."

However, adding these cases to a multi-specialty surgery center that usually does low acuity cases requires significant investment of resources. You'll need to purchase additional equipment and revise your payor mix before adding high acuity cases. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

112 Surgery Center Administrators to Know

By Rachel Fields

Here are profiles of 112 surgery center administrators who work tirelessly to recruit physicians, ensure patient satisfaction, build staff morale, negotiate profitable contracts and promote high-quality, cost-effective healthcare.

Margaret Acker, RN, MSN, CASC (Southwest Surgical Center in Grand Rapids, Mich.). Ms. Acker is the administrator of Southwest Surgical Center, a multi-specialty freestanding ASC, and the chair of the Michigan Ambulatory Surgery Association Membership Committee. She was formerly CEO with Blake Woods Medical Park Surgical Center in Jackson, Mich., a multi-specialty, physician-owned center. She has worked in the ASC industry for over a decade as a consultant, administrator and presenter. Ms. Acker holds a master's degree in nursing from Eastern Michigan University and serves on the "approver committee" for the American Society of Ophthalmic Registered Nurses continuing education. She also serves on the board of directors for St. Luke's Clinic, providing healthcare for the poor and medically underserved.

Traci Albers (North Memorial Ambulatory Surgery Center at Maple Grove in Maple Grove, Minn. and High Pointe Surgery Center in Lake Elmo, Minn.). Ms. Albers has over 15 years of ASC and healthcare management experience, beginning her career as the administrator at a critical access hospital and rural health clinic. After several years at the critical access hospital, Ms. Albers joined Surgical Management Professionals in 2002, where she served as the executive director of High Pointe Surgery Center, a physician-hospital joint venture facility. She worked at the facility for five years and then transferred to a new role working for the ASC's partner hospital. During her tenure with the hospital, Ms. Albers was responsible for system marketing and hospital operations. In 2010, Ms. Albers transitioned back to the ambulatory surgery center market with SMP. She currently serves as executive director for High Pointe Surgery Center and North Memorial Ambulatory Surgery Center – Maple Grove. During her tenure with these facilities, she has added a new specialty, managed a major expansion project and achieved excellent patient and physician satisfaction scores. Reed Martin, SMP COO, says, "Traci is a very organized and experienced manager who excels in process management and communication. These strengths have driven superior results in terms of patient satisfaction and financial performance."

Kathleen Allman, CASC (Millennium Surgery Center in Bakersfield, Calif.). Ms. Allman is the administrator of Millennium Surgery Center. She came to Bakersfield after retiring from trauma and, within two years, was opening seven cost centers at Mercy Southwest Hospital, including pre-op, admitting, OR, PACU, sterile processing, GI and anesthesia services. She also completed her master's degree, MSA-HCM. "I am passionate about federal and state laws regarding ASCs," she says. "We have toured Congressman Kevin McCarthy at our facility and met with Senator Rubio regarding Board of Pharmacy Clinic Permits and Licensure in the state of California." Ms. Allman was on the board of the California Ambulatory Surgery Association for two years ending December 2011. "I was proud of the opportunity to work with them," she says. "This has to be one of the best state associations."

Kim Andry, CASC (Great Lakes Surgical Center in Southfield, Mich.). Ms. Andry, the administrator at Great Lakes Surgical Center, serves as business manager and administrator of her multispecialty physician-owned facility, which currently performs 6,000 to 7,000 cases year. According to Keith Metz, MD, the center's medical director, Ms. Andry has helped GLSC excel in quality and patient and surgeon satisfaction and helped the ASC become one of the most profitable ASCs in the Midwest. Ms. Andry has also been a member of the leadership team of the Michigan ASC Association for the past several years, and she recently achieved AAAHC surveyor certification. Dr. Metz says Ms. Andry is "responsive and professional with surgeons, assertive and understanding with staff, and exceptional in those rare instances of a difficult or angry patient." In addition to her outstanding work with ASC operations, Ms. Andry has made the ASC experience "as pleasant as possible" for the more than 3,000 children that receive care at the center each year by adding children's movies, in-house slushy desserts and take-home gifts, according to Dr. Metz.

Jennifer Arellano (Pueblo Surgery Center in Pueblo, Colo.) Ms. Arellano began her career with Pueblo Surgery Center in 1998 and has been its administrator for the past 13 years. During this time, she has successfully led the ASC through an evolution of ownership changes, as well as case mix diversification. In 2011, the center added ophthalmology as another service line, which will expand further in 2012. Also during her tenure, Pueblo Surgery Center began what is now an annual event of providing free surgery one day per year. This program was set up in conjunction with its community physicians, hospitals, and various local supporting businesses and agencies. The event began in 2008 and continues to draw regional attention, including patients and volunteers from in and around the state. Ms. Arellano's leadership extends well beyond Pueblo, Colorado, through her board seat with the ASC state association as well her work in mentoring new ASC leaders within the Surgical Care Affiliates community.

Robyn Archer (Salt Lake Surgical Center in Salt Lake City, Utah). Ms. Archer joined Salt Lake Surgical Center as a nurse over 30 years ago and moved through various positions until rising to the administrator role in 2006. In 2011, Salt Lake Surgical Center celebrated its 35th anniversary, totaling 150,000 patients served during its history. The center opened in 1976 and was one of the first few ASCs in Utah and the country. It is known to have locally pioneered orthopedic arthroscopic surgery, among many other accomplishments. Managed in partnership with Surgical Care Affiliates, the center has consistently demonstrated outstanding clinical outcomes and teammate satisfaction survey results under Ms. Archer's leadership. Most recently, Ms. Archer was acknowledged for her contributions to the ASC state association with another term as its president.

Brent Ashby, CASC (Audubon Surgery Center in Colorado Springs, Colo.). Mr. Ashby is the administrator of two surgery centers — Audubon Surgery Center and Audubon ASC at St. Francis, both located in Colorado Springs, Colo. The two Audubon centers contain 15 ORs and four procedure rooms between them and perform an estimated 19,000 cases annually. Mr. Ashby has led the surgery centers through several successful initiatives, including the implementation of an IT system, the creation of a staff profit-sharing program and a boycott of payors who are unwilling to offer reasonable payment rates. Before opening Audubon, he was the administrator of the Provo (Utah) Surgical Center for seven years and practiced law at a large firm in Phoenix. Mr. Ashby has also served as treasurer for the Colorado Ambulatory Surgery Center Association for the past year, where he helped spearhead a pilot program in Colorado with Medicaid to move certain cases away from hospitals and ASCs in return for higher payments from Medicaid. Mr. Ashby says following a hepatitis C scare at his center, "Not only did our organization survive, but we have continued to grow and enjoy significant success."

Cathy Atwater (Banner Health-Union Hills Surgery Center and Banner Thunderbird Surgery Center in Peoria, Ariz.). Ms. Atwater serves as the administrator of Banner Health-Union Hills Surgery Center and Banner Thunderbird Surgery Center, positions she has held since Jan. 2010 and Feb. 2005, respectively. Prior to joining Banner, she worked as a gynecology practice manager at North Valley Obstetrics and a manager of operations at Argent Healthcare/Paralign Revenue Management. According to Angela Surratt, pre-op/PACU clinical manager at Banner Thunderbird, Ms. Atwater is often seen rounding through the pre-op and PACU areas of her surgery center and dedicates significant effort to marketing the center, despite the highly saturated nature of the local area. "She is consistently encouraging her staff, especially myself and the OR clinical manager, to further our management education and is often having us sign up for any classes that Banner offers," says Ms. Surratt. "Through these classes and her direction … she has helped me grow as a leader."

Beverly Baker (Timberlake Surgery Center in Chesterfield, Mo.). Ms. Baker has served as the administrator of the Timberlake Surgery Center since 2008 and has been an administrator in the ASC field for over seven years. Prior to joining Timberlake Surgery Center, she worked as a healthcare consultant specializing in practice operations and an administrator for private physician practices. She was instrumental with the new facility's start-up phase, achieving a three-year accreditation with AAAHC and receiving Symbion's President's Club Award in 2008. She currently serves on the board of Missouri Ambulatory Surgery Center Association.

Rob Bashore (Same Day SurgiCenter in Orlando, Fla.). Mr. Bashore went to graduate school at the Medical College of Virginia, where he received a partial scholarship from Columbia HCA — the catalyst that started his career with the health system. He worked on the hospital side of HCA for a while after graduation and then moved to the surgery center industry in 2003, leaving briefly to join another hospital company and then coming back to HCA several years later. "HCA is a fantastic company to work for," he says. He has been with his current surgery center for about a year and a half, during which time the center has achieved three-year re-accreditation from AAAHC and increased its EBITDA. The surgery center has five ORs and three pain treatment rooms and performs approximately 550 cases a month with 44 physician partners. The center, which is owned 51 percent by HCA, recently added a breast treatment center and now performs breast procedures in its pain treatment rooms on Fridays.

Tracey Baughey (Laser Spine Institute in Wayne, Pa.). With more than 27 years of administration and management experience, Ms. Baughey brings a great deal of knowledge and insight to the clinical operations of the ASC. She has held a variety of positions focusing on facility management, compliance and regulatory issues, streamlining and developing new systems, and customer service excellence. She was instrumental in the opening Laser Spine Institute's Pennsylvania and Oklahoma facilities, assisting the teams in achieving state licensure and AAAHC accreditation. Rhonda Dunn, executive director of Laser Spine Institute, commented, "Tracey identifies and executes the highest standards of care and service for the patients of Laser Spine institute within the clinical operations, on-call services and postoperative care enterprise-wide."

Linda Beaver, RN, MSN, MHA (Gateway Endoscopy Center in St. Louis, Mo.). Ms. Beaver serves as administrator of Gateway Endoscopy Center, a busy endoscopy facility in western St. Louis County managed by United Surgical Partners International. She started her career as a critical care nurse who specialized in cardiovascular recovery before moving into the management sector as a nursing supervisor, nurse manager and clinical director of multiple unit specialties in an acute-care hospital. Under Ms Beaver's leadership, Gateway Endoscopy Center obtained accreditation by AAAHC, recertification by CMS and the recertification by the state of Missouri. The center also successfully completed multiple quality improvement projects, including procedural documentation, applying abdominal pressure during a colonoscopy and scope withdrawal times. The facility consistently receives outstanding patient, physician, and employee satisfaction scores and decreased supply costs 16 percent during the last year by renegotiating with vendors.

Christine Behm, BSN, CASC (Surgery Center of San BuenaVentura in Ventura, Calif.). Ms. Behm has served as the administrator of San BuenaVentura Surgery Center since 1991. She has been with the center since 1991, when she joined as nurse manager upon the center's inception; she was promoted to administrator a few years later. Over the past year, she has put an emphasis on case costing and reimbursement, which resulted in the termination of a Blue Cross contract at the beginning of 2011, as well as an Aetna contract which will terminate in spring 2012. Chris works closely with her business office, clinical manager and physicians to evaluate every case to ensure payment will cover the cost of the case. Net revenue per case more than doubled in 2011, and the center performed its first spine procedure in 2011.

Sandy Berreth, RN, MS, CASC (Brainerd Lakes Surgery Center in Baxter, Minn.). Ms. Berreth serves as the administrator of Brainerd Lakes Surgery Center, a multi-specialty ASC that performs approximately 5,000 cases a year. She has been in the ambulatory surgery management arena for 13 years and has worked at her current center since 2004. Ms. Berreth has been an AAAHC surveyor for two years and is currently juggling being an AAAHC surveyor with her accountability to her own organization. Speaking on her experience in the healthcare, Ms. Berreth says, "As an RN with 35 years of experience in multiple areas in the healthcare arena, I have developed a unique set of values that I believe is essential to succeed in the ambulatory surgery center business arena. I believe the primary goal of any ASC administrator is the commitment to delivering high-quality surgical services to ensure a superior patient experience and clinical outcomes, as well as developing a sound business plan and futuristic goals to achieve financial success for its partners." During Ms. Berreth's tenure, Brainerd Lakes has achieved the Edgesurvey's APEX Quality Award for overall patient satisfaction for the last two years. Ms. Berreth holds a master's degree in business organization and management.

Josh Billstein (The Polyclinic in Seattle). Mr. Billstein spent 10 years as a clinician and practice manager at a busy physician clinic before joining The Polyclinic in June 2010. He currently serves as administrator for the three-OR, multi-specialty ASC. As a board member of the Washington Ambulatory Surgery Center Association, he and his colleagues collaborated with the Department of Health to create a pilot program that improved ASC reimbursement for DSHS cases. This resulted in cost savings for the state, as the cases moved from the hospital to the ASC setting. Mr. Billstein says his personal philosophy as an ASC leader is "to recruit and retain exceptional individuals who, when integrated into our center's team, utilize their unique talents to make our center excel."

Stephen E. Blake, JD, MBA, CPA (Central Park Surgery Center in Arlington, Texas). Stephen Blake serves as the administrator of Central Park Surgery Center, a 100-percent physician-owned facility accredited by the AAAHC. According to Kathy Kennison, RN, the ASC's nurse manager, the center has achieved better than 99 percent patient satisfaction survey results since its inception in 2006 — due in no small part to Mr. Blake's efforts. "Steve Blake's commitment to ensuring the delivery of the highest quality, cost-effective healthcare possible is what makes him stand out," says Ms. Kennison. "[He] is a tireless leader whose knowledge, skills and work ethic are a shining example of what is right in American healthcare." Mr. Blake also serves as an active member of the Texas ASC Society Board of Directors and recently completed his term as the society's president.

Steven Blom, RN, MAHSM, CASC (Specialty Surgery Center in San Antonio, Texas). Mr. Blom has been the executive director of the Specialty Surgery Center in San Antonio for just over 11 years, a position he fills in addition to his work as regional director for national surgical care at National Surgical Care. He says his biggest accomplishment with SSC has been the center's consistent growth. When it opened its doors, the ASC had two ORs with nine physicians performing around 3,000 cases annually. Today, the ASC is up to 30 physicians performing over 9,000 cases annually. The center's leaders were able to design and build a new, five-OR facility in 2005. "The challenges are dealing with the increased complexity of the regulatory issues we have to comply with and struggles we face in reimbursement and cost controls," he says. "I really enjoy the people I work with and the people I meet and interact with throughout the industry." He says his personal administrative philosophy is to hire the right people and take care of them. "Never be afraid to get in there yourself and support the staff," he says. "And never forget our existence is based [on] excellent patient care and the quality of the relationships we have with our physicians."

Chris E. Bockelman, CPA (Foundation Surgery Center of Oklahoma in Oklahoma City, Okla.). Mr. Bockelman has served as administrator of Foundation Surgery Center since April 2010. During his time at the center, he has increased case volume by recruiting three new surgeons previously considered "unattainable," as well as two more busy surgeons who are currently preparing to join the center. He also increased patient census over the course of eight months and will continue to grow volume into 2011. A former area vice president with Option Care/Walgreens in home IV therapy, Mr. Bockelman says he believes ASC administrator success is "in the details."

Betty Bozzuto, RN, MBA, CASC (Naugatuck Valley Surgical Center in Waterbury, Conn.). Ms. Bozzuto is executive director of Naugatuck Valley Surgical Center and former president and a founding member of the Connecticut Association of Ambulatory Surgery Centers. She is a former board member of FASA. Ms. Bozzuto is also a surveyor for AAAHC and president of Connecticut's Ambulatory Surgery Center Patient Safety Organization. Ms. Bozzuto holds an MBA from the University of New Haven.

Rick Brochu (The Surgery Center of Genesee County in Flint, Mich.). Mr. Brochu joined The Surgery Center of Genesee County in 2007, after working for a marketing company that handled all of General Motors' events and sponsorships. His path to his current position is unusual considering his lack of clinical background, he says: "I was hired because I didn't have any hospital or clinical background — completely opposite of what is normal." In his five years with the center, The Surgery Center of Genesee County has celebrated its 10-year anniversary and moved away from a significant volume of pain management, as site-of-service differentials push pain business into physician offices. The surgery center has also added several new procedures, such as lithotripsy, which can be performed in the center in two hours compared to five hours in the local hospital. The surgery center performs over 5,000 cases a year in a variety of specialties, including ophthalmology, orthopedics, podiatry, pain management, ENT, general surgery and interventional radiology. Mr. Brochu says the center stands out because it also performs vascular surgery, a rarity in the Michigan ASC industry.

John D. Brock, MSHA (NorthStar Surgical Center in Lubbock, Texas). Mr. Brock has served as the administrator of NorthStar Surgical Center for 6.5 years. During his time at NorthStar, Mr. Brock has grown case volume, syndicated multiple new physician partners, added a new service line in gastric lap banding and opened a sixth OR, among other accomplishments. When asked about his personal philosophy as an administrator, Mr. Brock says, "First and foremost, my profession is about people and relationships. Healthcare is a service industry, and at NorthStar Surgical Center, it's all about the experience … I recognize that as the administrator, I play but one small part in the overall work that goes on each day." Prior to his current role, he served as CEO of three different hospitals, COO of one hospital and executive at a large, faith-based health system.

Chuck Brown (Bidwell Surgery Center in Middletown, Ohio). Mr. Brown worked for Health Inventures in ASC development for the first 10 years of his career before he had the opportunity to open Bidwell Surgery Center. The center has struggled financially because of the economy of the local area — Medicaid represents 33 percent of the ASC's payor mix. Due to these challenges, Mr. Brown says his main goals are to keep staff morale high, maintain costs and provide excellent patient care. "One thing I'm proud of is that our patient satisfaction scores are in the top echelon," he says. "There are no egos [on our team]. We all pitch in and do everything. I think that helps morale, when you're got everyone at all levels doing all they can to help it run smoothly." Bidwell Surgery Center contains five ORs and one procedure room and spans around 18,500 square feet. The center performed just under 3,000 cases last year, mostly in the areas of pain and GI.

Ron Bullen (Moreland Surgery Center in Waukesha, Wis.). Mr. Bullen is a 23-year Major retired from the U.S. Army; he owns his own consulting business and manages a medical services outsourcing company, a medical lab, and a diagnostic imaging center in addition to running his seven-OR multi-specialty ASC. Mr. Bullen is also a member of the board of directors of the Association of Wisconsin Surgery Centers. With his help, non-owner volumes have grown by 30 percent and overall facility volume has grown by 11 percent in the last year. The entity continues to achieve strong patient satisfaction scores, high quality outcomes and increased surgeon and employee satisfaction, which translates into financial success, according to Mr. Bullen. Describing his staff, Mr. Bullen says, "They have truly transcended from a hospital employee mentality to a sense of ownership in the organization. We work together to remove barriers that keep us from doing our jobs efficiently and effectively while always striving to increase our knowledge, skills and abilities. The success we have is truly because of a great management team and dedicated and high performing employees."

Jennifer Butterfield, RN, BSN, CNOR (West Bloomfield Surgery Center in West Bloomfield, Mich.). Ms. Butterfield is the Administrator of West Bloomfield Surgery Center, a multi-specialty, Joint Commission-accredited ASC that performs over 5,600 cases per year. She has worked in the ASC industry for over seven years, serving as OR manager and director of nursing prior to becoming an administrator. According to medical records coordinator Jen Hagerty, Ms. Butterfield has been instrumental in starting a spine program at the center and recruiting physicians for the program. While other ASCs in the area are struggling, WBSC is increasing patient volume. Ms. Hagerty credits the growth to excellent physician and staff dedication.

Karen Cannizzaro, CASC (Physicians Day Surgery Center in Naples, Fla.). Ms. Cannizzaro started her career in ambulatory surgery in 1992, working as a surgery scheduler. During her first six years in the ASC industry, she performed every non-nursing position, from ordering supplies to working with accounting. She says she "literally worked her way into administration" and received her CASC certification in 2006. Ms. Cannizzaro was recruited to the newly-opened Physicians Day Surgery Center in 1998, and other than a two-year break to pursue another interest, she has been there ever since. In the last year, case volume at Physicians Day Surgery Center rose 50 percent due to the recruitment of several new physicians. "A competing center in our town closed, and we were able to have some of their physicians begin working with us," Ms. Cannizzaro says. "We absorbed the extra volume with minimal staff increases." She says she

anticipates case volume to reach 4,500 to 5,000 cases for 2012. "We have been able to accommodate the extra volume and still maintain over 99 percent patient satisfaction and retain all our original staff," she says.

Connie Casey (Northpoint Surgery and Laser Center in West Palm Beach, Fla.). Ms. Casey is the administrator of Northpoint Surgery and Laser Center, the first physician-owned surgery center in the West Palm Beach area. When the center opened in 1996, the owners were told they would never make it. Local providers weren't used to the ASC model and believed competitors would force the facility out of business. Sixteen years later, Northpoint Surgery and Laser Center is one of the most profitable healthcare facilities in the area, staffing 80 employees and featuring five ORs, two endoscopy procedure rooms and a pain management center. "Our physicians work together solidly," Ms. Casey says. "All physicians are a team. They understand the concept of the business and what it takes to make it work." Ms. Casey credits her center's success to its dedicated employees, many of whom have been with the center for more than 10 years. "When we took on [National Surgical Care as] an equity partner in 2003, the stipulation was that the employees were treated the same," she says. The equity partner changed to AmSurg this year, and the center continues to thrive, inviting new physicians to join as they enter the area.

Chris Collins, RN, BSHCA (Metropolitan Surgery Center in Hackensack, N.J.). Mr. Collins has been with Metropolitan Surgery Center since January 2012, when the facility was acquired by UPSI. Prior to his current role, he worked in another New Jersey surgery center and did in-hospital ambulatory work for 20 years. His current center has two ORs and one procedure room and performs approximately 4,000 cases a year, in the arenas of orthopedics, orthopedic hand, pediatric ENT, urology and podiatry. Mr. Collins says the last few months have been an exciting and challenging time, as he has worked to transition the center to a new management company. The center is in the process of transitioning its inventory system and plans to move to an EHR in the near future. "It's been a fun ride," he says. "I came on immediately post-acquisition of the center, and it's been a real challenge managed the transitional aspects — finances, policies and procedures, staffing changes, doctor changes, etc."

Cynthia Condron (South Shore Surgery Center in Bay Shore, N.Y.). Ms. Condron serves as the administrator of South Shore Surgery Center, a facility that opened in collaboration with ASCOA in Dec. 2010. The newly constructed facility is an 11,000-square-foot center with three operating rooms and two procedure rooms. The center achieved successful New York State licensure on Dec. 17 and performed its first case on Dec. 20. Prior to joining South Shore, Ms. Condron served as facility administrator in the construction and development of an orthopedic ASC on the north shore of Long Island, a position she held for six years. She also attained successful New York State licensure and Medicare/AAAHC certification with her prior center. Ms. Condron holds an MBA from Palm Beach Atlantic University in West Palm Beach, Fla., and has over 15 years of experience in healthcare.

Rebecca Craig, RN, CNOR, CASC, CPC-H (Harmon Surgery Center in Fort Collins, Colo.). Ms. Craig is CEO of Harmony Surgery Center, a multi-specialty, Joint Commission-accredited ASC. Ms. Craig helped to open the joint-venture center 12 years ago. She began her career as a registered nurse, working at a rural hospital in the OR, PACU, gastroenterology and

pain management areas. She held several leadership roles in perioperative services before moving into outpatient and ambulatory surgery. In addition to her work with Harmony Surgery Center, Ms. Craig served as president for the Colorado Ambulatory Surgery Center Association from 2004 to 2007 and currently continues to participate as a board member. Ms. Craig had the pleasure of helping with the development of two new surgery centers in the Northern Colorado area in 2008. In May 2011, Ms. Craig was elected to serve on the ASC Association and ASC Foundation Board of Directors. Ms. Craig was recently appointed to the Joint Commission Ambulatory Care Professional and Technical Advisory Committee and continues to serve on the OR Manager Ambulatory Surgery Advisory Board.

Tracy Cregg CASC (Surgery Center of Silverdale in Silverdale, Wash.). Ms. Cregg was initially hired as the center's business manager before it opened in May 2007, and together with the medical director, completed the implementation of services at the center, including setting up the practice management system, hiring the staff, planning for the services and achieving accreditation and Medicare certification. The center received both AAAHC accreditation and CMS certification through an early option survey immediately upon opening its doors. Ms. Cregg was promoted to administrator in Feb. 2009 and has since added specialties and continued AAAHC accreditation, and received her CASC credential in 2011. Additionally, Ms. Cregg is very active in the Washington ASC Association and serves on the ASC Leadership Assembly for the Medical Group Management Association. The Surgery Center of Silverdale is currently adding another operating room to accommodate additional surgeons, and Ms. Cregg says her biggest challenge has been to continue to grow the business through the economic downturn.

Deborah Lee Crook, RN, CASC (Valley Ambulatory Surgery Center & Valley Medical Inn in St. Charles, Ill.). Mrs. Crook's ASC, Valley Ambulatory Surgery Center & Valley Medical Inn, is a seven-OR, multispecialty surgical facility with an attached post-surgical recovery care center . The center sees over 5,300 cases annually and is celebrating its 25th anniversary this year. Ms Crook has worked in professional nursing and administration for over 25 years, with 19 years of her career spent at the ASC. Since assuming her role as administrator in 2006, she has implemented improvements and changes in communication, staffing patterns, teaching, use of technology, change in processes and expense management to increase the efficiency of the center. Ms. Crook says she has recently worked to increase and replace volume from retiring partners and medical staff, implement new procedures and seek opportunities for local growth in a changing healthcare environment.

Dean Daringer, MBA (Surgery Center of Chester County, Pa.). Mr. Daringer has over 20 years of experience in healthcare administration, specializing in joint venture ASC start-ups, as well as problematic centers. Mr. Daringer has worked in the past for Quarum and CHI as well as management groups such as ACCA and Relative Health. Since coming to the center, he has been through re-accreditation surveys with AAAHC and has moved billing in-house. Mr. Daringer increased the bottom line over 10,000 percent the first year. He assumed his current position in 2009.

Louise DeChesser, RN, CNOR, MS (Middlesex Surgery Center for Advanced Orthopedics in Middletown, Ct.). As administrator of Middlesex Surgery Center for Advanced Orthopedics and clinical director for Healthcare Venture Professionals, Ms. DeChesser has over 40 years of perioperative healthcare leadership experience. Ms DeChesser has served as director of surgical services for large New England Hospitals, as president of her own surgery center consulting company, Surgical Solutions, and in various regional, operational and administrator positions in surgery centers throughout the Northeast. In addition to her corporate responsibilities with HVP and her administrator position with MCAOS, she also sits on the board of directors for the Connecticut Patient Safety Organization, as well as the state committee to develop the state of Connecticut healthcare plan.

Greg DeConciliis, PA-C, CASC (Boston Out-Patient Surgical Suites in Waltham, Mass.). Mr. DeConciliis serves as the administrator of Boston Out-Patient Surgical Suites, which opened in July 2004 as a multi-specialty center specializing in orthopedics and pain management. Prior to joining the center, Mr. DeConciliis worked as a physician assistant at the New England Baptist Hospital for five years. He is still a licensed PA and assists on more complex orthopedic cases at the center. In March 2010, the center sold a majority interest to AmSurg. The center has maintained profit margins above 50 percent. Speaking about his personal philosophy as an ASC administrator, Mr. DeConciliis says, "I believe in fostering a family environment, which they in turn pass along to the patients. I am extremely active with all of the staff and their needs and try to cultivate a culture of excellence in all we do." He says the center has achieved over 98 percent "excellent" ratings on patient satisfaction surveys, an accomplishment he credits to the outstanding quality of care that surgeons and staff provide to patients.

Linda Deeming, RN, BSN, MBA/HCM, CNOR, CASC (Longmont Surgery Center in Longmont, Colo). Ms. Deeming has served as the administrator of Longmont Surgery Center since Jan. 2009. The multi-specialty surgery center, which opened in Oct. 1996, has grown to include five ORs, two endoscopy suites and one procedure room. During this past year, Ms. Deeming was a speaker at the CASCA spring convention in Denver, achieved her CASC credentials, added five new procedures and seven new surgeons and increased the surgical and procedure numbers as well as the center's net profit. She credits her center's success to her board of directors, clinical and office staff, surgeons and anesthesiologists, who provide a dynamic, high-quality, friendly alternative for patients in need of surgical services. Additionally, this year she will serve as the committee chair for the 2012 CASCA Annual Spring Education Conference and is a member of the CASCA Government Relations Committee.

Roxanne Degnan, RN (Riverview Ambulatory Surgical Center in Kingston, Pa.). Ms Degnan has been administrator at Riverview since November 2009. She received her CASC credential in 2006, a Master of Science in Organizational Management in 2008 and has been a surveyor for AAAHC since 2000. She is on the Board of Ambulatory Surgery Certification and the Pennsylvania Ambulatory Surgery Association. Since becoming administrator, Ms. Degnan has made recruiting of physicians, inventory consignment, utilization of staff, employee satisfaction and building a more robust performance improvement program a priority. Over the past 2.5 years, she has recruited 12 new physicians and added a GYN specialty to Riverview.

Jody Delahunty, RN, CNOR (Heartland Surgery Center in Kearney, Neb.). Ms. Delahunty started at Heartland Surgery Center as clinical director when it opened in May 2001 and was asked to move into the administrator role one month later. The center's first few years were "slow and steady," she says, but when a large orthopedic group moved its cases to the center, case volume jumped from 2,000 cases annually to 5,600. Ms. Delahunty was instrumental in attracting the group to Heartland, as well as purchasing instruments, supplies and implants. Ms. Delahunty says the surgery center added a hand surgeon in 2011. Prior to her role at Heartland, Ms. Delahunty worked at Good Samaritan Hospital in Kearney for 21 years, serving as an RN in the surgery department. She has been an RN for 32 years and holds the CNOR credential. "I enjoy my challenging job and see it constantly evolving," she says.

Lynda Dowman Simon (St. John's Clinic: Head & Neck Surgery in Springfield, Mo.). Ms. Simon is the administrator at St. John's Clinic: Head & Neck Surgery. Ms. Simon has been at her center since 1994. Prior to coming to St. John's, she worked for 13 years at a local hospital in the open heart center and urology. According to Ms. Dowman Simon, St. John's is the only ASC in Missouri dedicated solely to ENT procedures, and the center's patient satisfaction rating currently sits at 98.17 percent. Ms. Dowman Simon listed a few issues plaguing surgery centers, including decreased reimburse-

ments, high deductibles, increased use of Medicare/Medicaid as a payor sources and an aging nursing population. "The [nursing] workforce is aging out and the nursing schools are not offering surgery rotations," she says. "Patients are also waiting longer to have necessary surgery, which means sicker patients with more co-morbidities, slower healing, poorer outcomes, litigation and increased infections."

Vicki Edelman, RN, BSN, CASC (Blue Bell Surgery Center, Blue Bell, Pa.). Ms. Edelman is the Administrator of Blue Bell Surgery Center and currently is employed by ASCOA. The center is a four-room, multi-specialty ASC that operates with 22 surgical partners and an additional 5 affiliated physicians. Blue Bell Surgery Center specializes in orthopedics, ENT, pain management, plastic surgery, general surgery, ophthalmology, and gastroenterology and services over 300 patients per month. Ms. Edelman has been with Blue Bell since May 2008, during the center's construction phase. Ms. Edelman credits her center's success to the energy, resourcefulness and dedication of her team. "My job would not be possible without their tireless efforts to maintain our high standards, and their support in providing quality patient care to the community we serve," she says. She has been a nurse for 33 years and began her career in medical surgical nursing.

Teva Eiler (UPMC Hamot Surgery Center in Hamot, Pa.). Ms. Eiler joined Hamot Surgery Center (now UPMC Hamot Surgery Center) in 2006 and worked as the surgery center's purchasing manager and human resources coordinator for three years. In 2009, she was named administrative director of the surgery center. Prior to joining Hamot Surgery Center, she worked at Vantage Healthcare Network as the director of materials management, a role in which she worked with Premier affiliates to maximize savings, establish regional contracts and solicit potential new affiliates. Ms. Eiler earned an MS in health services administration from Gannon University in 1993 and became a Registered Laundry and Linen Director in 2001.

Pamela J. Ertel, RN, BSN, RNFA, CNOR, FABC, CASC (The Reading Hospital SurgiCenter at Spring Ridge in Reading, Pa.). Ms. Ertel oversees daily operations at The Reading Hospital SurgiCenter at Spring Ridge, a multi-specialty ASC that includes eight operating rooms, 10 pre-operative bays, 19 post-operative bays and one special procedure room. She also serves as president of the Pennsylvania Ambulatory Surgery Association. Under Ms. Ertel's leadership in 2011, the center implemented a new business office software and is currently in the process of implementing an EMR system. In addition, the center participated in a safety culture survey conducted by an outside benchmarking business, with resulting scores placing the ASC in the 99th percentile for safety culture. As president of PASA, she provided testimony to the Pennsylvania House Insurance Committee and met with the Executive Deputy Secretary and Secretary of Health to discuss challenges to the ASC industry.

Allison Estes, RN, BSN (Lakeview Surgery Center in Warner Robins, Ga.). Ms. Estes is the administrator of Lakeview Surgery Center, a two-room, single-specialty interventional pain management facility that opened in Feb. 2011. The center performs an average of 300-350 cases a month and provides interventional pain management options to over 36 counties. Ms. Estes entered the pain management field in 2006 as a founding administrator for an interventional pain management facility with an in-house procedure suite that grew into Lakeview Surgery Center. Prior to that, she worked as a nurse administrator in a podiatric surgery center, which she helped lead through the AAAHC re-accreditation process. She also helped open another AAAHC-accredited gastroenterological ASC, supporting the center as a staff RN and quality improvement supervisor. Under her guidance, her current ASC has implemented a thorough check system for each step of the patient care continuum, and Lakeview

Surgery Center has seen continued growth since its inception, growing from one to two physicians in the past year. "Our practice has been able to maintain growth at a time when other businesses are struggling. I believe that our high standards of care and the quality of the services we provide are key components to this success," she says.

Carolyn Evec, RN, CNOR (The Surgery Center at Beaufort in South Carolina). Ms. Evec has served as the administrator at The Surgery Center of Beaufort for over 10 years, after opening a surgery center in Missouri where she served as nurse manager. She has 40 years of nursing and administrative experience and has held various management positions including director of surgery, director of medical and surgical services, vice president of patient services and director of rural health clinics. Ms. Evec has served as president, president-elect and is currently secretary for the South Carolina Ambulatory Surgery Center Association. Ms. Evec has helped improve efficiency at her center in many ways. "With the help of the staff, we developed an ordering system for supplies that now involves all of the staff and eliminated a part-time staff position," she says. "We now order supplies two days a week, and it takes only about an hour to complete the process."

Andrea Fann (Orthopaedic South Surgical Center in Morrow, Ga.). Ms. Fann serves as the administrator of Orthopaedic South Surgical Center, a United Surgical Partners International facility. She has served in the position — her first administrator role — since 2005, before which she worked as business office manager for Buckhead Ambulatory Surgery Center and as director of front office operations for Atlanta Outpatient Surgery Center (both HCA facilities). She prides herself on providing an honest, warm and caring atmosphere for everyone who enters her center: employees, physicians, visitors and patients. "When we take care of our employees and provide strong leadership, they are more productive, and their happiness is seen by our patients and physicians," she says. Ms. Fann doesn't take her role for granted. She firmly believes that a manager does not automatically become a leader and that installing the right team is essential for ASC success.

Jon Farrar (Laser Spine Institute in Tampa, Fla.). As administrator of Laser Spine Institute, Jon Farrar oversees the daily operations of the Laser Spine Institute Tampa clinic and collaborates with other department leaders to align strategic goals and optimize patient outcomes and satisfaction. He identifies all medical practice standards for clinical operations, on-call services and postoperative care enterprise-wide and works closely with Laser Spine Institute's medical staff. Mr. Farrar joined Laser Spine Institute in 2008 with 15 years of physician assistant and executive level healthcare experience. According to Irene Rademeyer, Vice President of Clinical Operations and Diagnostic Services, "Mr. Farrar is highly respected by all of our physicians, senior management and clinical staff members for the high standard of care he brings to Laser Spine Institute. He is our leader in clinical operations and clinical accreditation processes enterprise-wide."

Judy Fladeboe (Willmar Surgery Center in Willmar, Minn.). Ms. Fladeboe serves as the administrator of Willmar Surgery Center. During her career, Ms. Fladeboe has accumulated 25 years of experience working in emergency departments and GI/endoscopy units, including 15 years as manager. She also has five years of administrative experience in a multi-specialty clinic setting and seven years of management experience in a multi-specialty ASC. In her current position, she has led the ASC through a successful EMR implementation — Willmar Surgery Center has been using ProVation Medical software for five years. She has also helped

the center achieve AAAHC accreditation. On her personal philosophy as an administrator, Ms. Fladeboe says, "My greatest reward is seeing staff develop to their full potential."

Dana Folstrom, RN, CASC (Mirage Endoscopy Center in Rancho Mirage, Calif.). Mr. Folstrom, administrator of Mirage Endoscopy Center (managed by Health Inventures), calls his biggest success in 2011 the ability to continue profitability in the face of physician employment. He says the center has focused on increasing its visibility by developing a website — "something we hadn't felt we needed in the past." He says in order to increase inefficiency and prepare for reporting of quality indicators, the surgery center is assessing different EHR products available to GI centers. "We are of course continuing to upgrade current equipment to stay with state-of-the-art practices in GI," he says. He says the center has managed to produce consistent distributions by reworking payor contracts, promoting aggressive collections and operating efficiently. "It takes the cooperation of everyone involved, from contracted housekeeping to the physicians and their offices," he says. Prior to joining his current center, Mr. Folstrom worked in the GI department of Eisenhower Medical Center and as director of nursing for the Hebrew Homes of San Diego.

Kerri Gantt (Barkley Surgicenter in Fort Myers, Fla.). Ms. Gantt has been employed by Gastroenterology Associates of S.W. Florida and Barkley Surgicenter for over 19 years. As administrator of the two organizations, she oversees business and clinical operations. According to Catherine Musselwhite, clinical supervisor of Gastroenterology Associates of S.W. Florida, Ms. Gantt's contributions are critical to the success of the organizations. "Kerri tirelessly researchers ways to improve day-to-day functions and to make this a sensible and enjoyable work place," she says. "There are many employees who have been here for over 10 years due to her commitment to the staff. The physicians count on her and she never lets them down." Ms. Gantt oversees the facility's compliance and is well versed with the JACHO standards and CMS regulations. She has served as past president of Health Management Association and is an active member of the Professional Association of Health Care Office Managers and the Medical Group Management Association. Ms. Gantt is also a licensed healthcare risk manager in the state of Florida, a certified medical manager and a Fellow in the American College of Medical Practice Executives.

Nancy Goldbranson (The Virginia Spine Institute in Reston, Va.). Ms. Goldbranson, practice administrator of The Virginia Spine Institute, is the practice's most seasoned member after CEO and President Thomas C. Schuler, MD. She has committed herself to the institute for nearly 13 years, prior to which she studied business administrator at East Carolina University. According to her colleagues, Ms. Goldbranson ensures the six-physician practice runs seamlessly day in and day out, and her experience in all facets of the organization has proven to be a vital factor in its success. "I have known Nancy for 19 years," says Dr. Schuler. "She is bright, honest, ethical, compassionate and possesses great integrity. She is unparalleled in her understanding of customer service." Ms. Goldbranson's senior administrative assistant, Linda Brock, says Ms. Goldbranson's vision inspired her to want her current job in the first place. Under her direction, the practice won a "Best Places to Work" award from Washingtonian Magazine and the Washington Business Journal. According to Erin Orr, marketing director with Virginia Spine Institute, Ms. Goldbranson is "dedicated to ensuring employees are well-rounded and dedicated to constant self-improvement — basic skills training and beyond."

Judy Graham (Cypress Surgery Center in Wichita, Kan.). Ms. Graham is administrator of Cypress Surgery Center, a freestanding, multi-specialty ASC that opened in Dec. 2000. In 2006, the physicians that founded Cypress entered into a joint venture with Symbion Healthcare. Ms. Graham has been with Cypress for 9.5 years, since construction on the facility began. She has a strong clinical background in the OR and ambulatory surgery and previously served as an OR manager and a clinical director in ASCs before moving into the role of administrator. Ms. Graham has faced many challenges, including developing a partnership between a privately owned center and a corporate partner. When it comes to Cypress' success, Ms. Graham says, "Our employees have always been the source of our success, and it has been such an honor and privilege to lead them the past 11 years. Cypress is very fortunate to have a great group of physicians who work well together and treat the staff with dignity and respect." She says her greatest challenges during 2011 have been keeping the center successful during the changing economic and healthcare environments.

Judi Green, RN (San Francisco Endoscopy Center in San Francisco, Calif.). Ms. Green is the administrator of San Francisco Endoscopy Center, a joint venture ASC with Surgical Care Affiliates and California Pacific Medical Center (a Sutter Health affiliate). This single-specialty GI center in San Francisco provides services to over 7,500 patients annually. Ms. Green joined the San Francisco Endoscopy Center in September 2004 as a staff nurse. Since then, she has served in numerous capacities, such as the clinical lead nurse. She was recently appointed by the governing body to the role of Administrator. Ms. Green is a dedicated coach and mentor to the members of her staff and is an excellent example of "walking the walk and talking the talk." Her "new grad" orientation program recently gained attention for the creative ways it introduces teammates to the center. Her ability to juggle this task with the other demands of the ASC is a skill Ms. Green attributes to her management company. "SCA encourages and expects administrators to know all functions of the center, and provides the tools and support to achieve this," she says. "I believe you cannot be a top administrator if you are unable to relate to the work that is required of your teammates."

Julie Greene (Muskegon Surgery Center in Muskegon, Mich.). Ms. Greene is the CEO of Muskegon Surgery Center in Muskegon, Michigan and Regional Healthcare Man-

agement Solutions, LLC, a consulting organization. A longtime member of the Michigan Ambulatory Surgery Association Board, Ms. Greene has been involved in several projects including working with BCBS of Michigan to increase reimbursement to a level that allows spine surgeries to be performed in the ASC setting. Currently, Ms. Greene is encouraging the development of a Midwest, multi-state Purchasing Alliance that enables independent ASCs to enjoy the benefits of negotiated purchasing together.

Debra Hagendorn (South Shore Ambulatory Surgical Center in Lynbrook, N.Y.) Ms. Hagendorn, administrator of South Shore Ambulatory Surgical Center, started her career at South Shore as the OR nurse manager and was promoted to the administrator position. When Ms. Hagendorn stepped into the position, the surgery center was having problems: missing policy and procedures, inadequately defined governance structure and lack of credentialing. According to Stephen Dayan, MD, "All these issues were successfully overcome." Under Ms. Hagendorn's leadership, the AAAHC was passé don the first attempt and the center was given a three-year certificate. Dr. Dayan says that in addition to the routine responsibilities of forecasting budgets, recruiting surgeons and managing personnel, Ms. Hagendorn had to handle a surprise New York state inspection that found structural defects and deficiencies in the physical plant of the center. "Debbie singlehandedly kept the ASC open by working with New York State," he says.

Kimble Hatridge (Texarkana Surgery Center in Texarkana, Texas). Ms. Hatridge serves as administrator of Texarkana Surgery Center, one of Symbion Healthcare's 62 surgical facilities. Texarkana Surgery Center is a multi-specialty surgery facility that opened in 1995. Ms. Hatridge has 20 years experience in the healthcare industry, and her track record includes successful recruitment and retention of physician partners, strong financial growth, and the development of a strong team of healthcare professionals. Ms. Hatridge's experience includes facility startup, strategic planning, budgeting, performance improvement, risk management, development of business office practices. Ms. Hatridge is actively involved in the Texas Ambulatory Surgery Center Society and currently serves on their Legislative Committee.

Tom Holecek (Palos Surgicenter in Palos Heights, Ill.). After several years of managing GI labs and medical practices in the hospital setting, Mr. Holecek became the administrator at Palos Surgicenter, managed by Regent Surgical Health, in Sept. 2007. At the time Mr. Holecek joined the center, the ASC was just realizing the benefits of a hospital joint-venture agreement established in Jan. 2007. Despite the center's early success, the facility was still lacking in several areas: Among other issues, more space was needed for quicker turnaround of cases, the waiting room needed modernizing and monitors and patient carts were "well past their useful lives," says Mr. Holecek. In Sept. 2009, after months of meetings and discussions, Mr. Holecek was able to gain consensus between the hospital landlord and the board of managers to embark on a $2 million renovation project that would take 12 months and three phases to complete.

Carolyn Hollowood, RN, BSN, CNOR, RNFA, CASC (City Place Surgery Center in Creve Coeur, Mo.). Ms. Hollowood is the administrator of a four-OR, orthopedic-driven surgery center in West St. Louis County. She has been with the center for almost 12 years, starting when it operated out of a two-OR surgery center. Six years ago, she helped design the new center — a medical office building which is now open. In Sept. 2009, the center partnered with Meridian Surgical Partners. During her tenure at City Place, Ms. Hollowood has managed to standardize much of the equipment the surgeons use at the center, as well as introduce new procedures and processes into daily operations. With 20 years of nursing experience under her belt, Ms. Hollowood knows how to pitch in and help out around her center. In addition to her full time administrator position, she has spent some time consulting for a newly constructed center. She also finds time to do AAAHC surveys. Prior to joining City Place, she worked as an RN first assistant at an acute care center.

Dale Holmes (Warner Park Surgery Center in Chandler, Ariz.). Mr. Holmes was hired by USPI in 2009 to turn around the center. He successfully upgraded the facility, passed CMS and AAAHC surveys and brought the ASC ahead of budget. He enjoys recruiting new physicians, helping the current medical staff grow their practices, consolidating the schedule and starting new service lines. Currently his interest is maintained by planning a re-location of the center in six months across from a partner hospital. This is generating physician interest to the extent that cases exceeded budget by 140 cases last month. Prior to joining Warner Park Surgery Center, he served as administrator and CEO of Banner Health's Surgicenter in Phoenix — the first freestanding ASC in the country. At Surgicenter, he was responsible for overseeing 850 cases per month and managed to break the center's record number of cases per month in its 35-year history. He also led the Banner Health system in profits, employee engagement and surgeon and patient satisfaction — in addition to doubling the center's share value in three years and negotiating deals to benefit all the centers in the system.

Karen Howey, CASC (Matrix Surgery Center in Saginaw, Mich.). In the 11 years she spent as a financial manager for Citigroup in Michigan, Ms. Howey always dreamed of going back to the medical community, the path she had imagined for herself when she graduated from Michigan State University with a degree in health communications in 1994. In 2005, her opportunity arrived: A new, single-specialty ASC was planned for Saginaw, Mich., and Ms. Howey was invited to oversee construction and licensing with the help of the center's management group, Titan Health Corp. With a strong financial background but limited medical background, she pursued her CASC certification almost immediately and received her certification 18 months after becoming the center's administrator. During

her time at the center, MSC has received Joint Commission accreditation, added five more specialties and grown to over 32 full-time employees. Ms. Howey says the center's biggest challenge occurred when its founding physician, Richard Lingenfelter, MD, passed away unexpectedly in 2009. Ultimately the center was able to become closer as a team from the experience, as well as recover the substantial loss in case volume resulting from Dr. Lingenfelter's death.

Stuart Katz (Tucson Orthopaedic Surgery Center in Arizona). Mr. Katz will celebrate his 40th anniversary in healthcare on March 21 as executive director of the Tucson Orthopaedic Surgery Center. In his current role, Mr. Katz has helped reduce cost on a per case basis for an ACL from more than $3,000 to under $1,800 by asking surgeons to use more autografts and reduce the ASC's dependence on allografts. The ASC has worked with Tucson Medical Center for more than 44 months under a co-management agreement, a deal projected to save the hospital more than $23 million by the end of 2012 on orthopedic costs. Because of this work, the hospital is building a new four story addition which will house the Tucson Orthopaedic Institute, 24 new operating Rooms (10 of which are for inpatient and outpatient orthopedic surgery) and 40 orthopedic in-patient beds. The center has been under 40 days in A/R since 2007. In addition to his work with Tucson Orthopaedic, Mr. Katz was the founding president of the Arizona Ambulatory Surgery Center Association, for which he served as president for three years. "The new facility will make all of our lives a little easier and staff will have more options to work," he says. Prior to his current role, Mr. Katz worked as director of the Health Inventures managed Physicians Surgery Center in Daily City, Calif.

David Kelly, MBA, CASC (Samaritan North Surgery Center in Dayton, Ohio). Mr. Kelly was employed by Miami Valley Hospital, a member of Premier Health Partners, in Dayton, Ohio, prior to becoming administrator of Samaritan North Surgery Center in Dayton in late 2006. The ASC is a joint venture between Good Samaritan Hospital and local physicians and is managed by Health Inventures. "At the center, we continually strive for performance improvement by applying data-driven solutions to quality, customer satisfaction, operational and financial goals," he says. "While I am not a clinician by degree, I prefer to throw on scrubs, engage directly in the operations to get at the root cause of an issue, measure the center's performance against both external and internal benchmarks, and identify opportunities for improvement." For example, in the past year, despite continued migration from commercial to the government payers, the center's bottom line increased 16 percent over the prior year due in part to various performance improvement initiatives to reduce bad debt by improving cash collections. Additionally, changes in the pre-admission screening process led to the reduction in hospital transfers by 18 percent without turning more patients away.

Mary Ann Kelly (Madison Surgery Center in Madison, Ala.). Ms. Kelly began at Madison Surgery Center in Alabama as the clinical director prior to completion of construction. In his role, she was involved in staffing the facility, purchasing supplies and completing capital purchases as the staff prepared the physical facility for opening. Shortly after the center opened, the previous administrator resigned and Ms. Kelly became the onsite de facto administrator. She transitioned into the administrator position in 2006. The surgery center is a multi-specialty, physician-owned center with five ORs and five procedure rooms. "As a result of successful physician recruitment, we have grown from 4,000 patients a year to over 11,000 patients a year," she says. "We have had three successful AAAHC Medicare Deemed surveys in our weight years, receiving three-year accreditations each time." Two years ago, the center transitioned completely to electronic medical records, a move that Ms. Kelly says has been "extremely successful and could not have been accomplished without the support of the staff and physicians during the development and 'go live' phases."

Faith Kycia (Surgical Center of Fairfield County in Bridgeport, Conn.). Ms. Kycia has served as administrator of the Surgical Center of Fairfield County, an affiliate of Surgical Care Affiliates, since 2006. Since her promotion from business manager to head administrator, the surgical center has continued to maintain outstanding volume and attract new partners. The center now has blueprints and plans for a new state-of-the-art surgical center building. According to her colleagues, Ms. Kycia has managed to lower cost per case and maintain a dedicated, experienced staff, despite the economic challenges facing the region. On a national level, Ms. Kycia is the chairperson of the Teammate Support Network, a group that makes funds available for any teammate in the SCA group of surgical centers that has come upon hard times. She also helps to coordinate regional strategy for surgical center volume growth in the New England region for SCA. "Faith has a great sense of humor, a keen business sense and a great level of compassion," says Michael R. Redler, MD, of The OSM Center. "She is hands on and can often be seen wheeling patients out to their cars after the completion of their surgical center stay. This level of dedication has led to the soon-to-be-announced groundbreaking of a new state-of-the-art integrated surgical center … definitive proof that hard work as an outstanding administrator can lead to fabulous things."

Angela Laux (Bellin Orthopedic Surgery Center in Green Bay, Wis.). Ms. Laux started as the administrator of Bellin Orthopedic Surgery Center in June 2010. In 2011, the center surpassed all its budget goals for case volume and revenue. "I believe that this was accomplished due to listening carefully to the requests of the surgeons and making this a place that they and their patients enjoy coming to for surgery," she says. "Because of the increased volume, we were able to open our fourth OR last month." In 2011, the center also launched a website that includes many patient education information forms and videos. Prior to joining Bellin Orthopedic, Ms. Laux served as director of quality and outpatient joint program coordinator at The Orthopedics and Sports Institute in Appleton, Wis. In this role, she assured the institute followed all AAAHC/CMS requirements and served as staff educator for the facility. Ms. Laux graduated from Marian University with a master's degree in organizational leadership and quality in 2009.

Beverly LeMaster (Physicians' Surgical Center in Belleville, Ill.). Ms. LeMaster serves as clinical director and administrator of Physicians' Surgical Center in Belleville, Ill., a position she has held since 2010, when the two positions were combined. Ms. LeMaster is a registered nurse with an ER/OR background who previously worked in a multi-specialty center. With her current center, a Meridian Surgical Partners facility, she has been instrumental in the expansion of the facility's GI program, recruiting two new physician partners. She is currently facilitating the expansion of pain management services within the center. Ms. LeMaster describes herself as having a passion for inventory control, cost-saving opportunities and staff development through cross training.

Brad D. Lerner, MD, FACS (Summit Ambulatory Surgical Centers in Baltimore, Md.). Dr. Brad Lerner has practiced urology for over 20 years and has served as the clinical director of ASCs for 15 years. In this position for Summit Ambulatory Surgical Centers, he serves as the center's administrative leadership along with Stacy Zemencik, RN, director of nursing. According to Chesapeake Urology Associates, "Dr. Lerner is in a unique position to keep the centers on the leading edge of medical expertise and clinical care" through his dual role as practicing physician and administrator. One of the mid-Atlantic's leading urologists, Dr. Lerner was one of the first fertility specialists in Maryland and is regarded as one of the best known and most experienced urologic microsurgeons in the state. Prior to joining Summit Ambulatory Surgery Centers, Dr. Lerner served as clinical director of Urologic Surgery Associates ASCs in Baltimore for 11 years. Mr. Lerner is also chief of urology at Union Memorial Hospital in Baltimore and urologic consultant to the Baltimore Ravens football team.

Dr. Nicholas Lygizos (Golf Surgical Center in Des Plaines, Ill.). Nicholas Lygizos, MD, administrator of Golf Surgical Center, is board-certified in otolaryngology-head and neck

surgery and maintains a teaching position at the University of Illinois as clinical assistant professor, in addition to his clinical and administrative duties. He enjoys treating children and adults within the full scope of ENT problems, including diseases of the tonsils and adenoids, chronic ear infections, hearing loss and balance disorders, sinus infections requiring surgery, airway obstruction of the nose and throat and other ailments. According to Rachel Shulkin, RN, of Golf Surgical Center, Dr. Lygizos is well-recognized around Golf Surgical Center for his caring nature and commitment to employee recognition. "He plays a big role in keeping us working together as a team and considers himself both the leader and a member of our team," she says.

Neal Maerki, RN, CASC (Bend Surgery Center in Bend, Ore.). Mr. Maerki is the administrator of Bend Surgery Center, a four-OR, three-procedure room, multi-specialty surgery center. The ASC opened in 1997 and moved to its new location in Oct. 2005. BSC is 100 percent physician-owned, with 38 owners and 60 users who perform over 10,000 cases annually. Specialties include orthopedics, general surgery, spine, ENT, ophthalmology, GI, pain management, plastics, pediatric dentistry, podiatry and oral maxillofacial surgery. The success of BSC can be attributed to a dedication to communications and rigorous tracking of financial benchmarks at the center, Mr. Maerki says. "We hold weekly administrative meetings with our board chairman, medical director and the administrative team. We utilize multiple dashboards to track financial variations. We utilize a weekly financial review to track cash, receivables and deposits." In 2012, the center will bring on urology as a service line and hope to include gynecology by year's end. "This next year will bring the challenge of being a crucial part of Coordinated Care Organizations in our state," Mr. Maerki says.

Becky Mann (Houston Orthopedic Surgery Center in Warner Robbins, Ga.). Ms. Mann is the director of Houston Orthopedic Surgery Center. Ms. Mann came to Houston Orthopedic in May 2007 and was involved in the development of the center. Ms. Mann has been working in the medical industry for 38 years in surgery or in post-surgical care. The surgery center added an additional orthopedic surgeon in 2011 and had an AAAHC survey the Monday after Thanksgiving, receiving a three-year accreditation. She says the staff has also updated the center's 4010 and 5010 claims forms, and they are in the process of attending courses regarding ICD-10. "I continue to say that being director of Houston Orthopedic Surgery Center is the best job I have ever had," she says. "I look forward to being here for many years."

Lori Martin (SUMMIT Surgery Center at Saint Mary's Galena in Reno, Nev.). Ms. Martin, administrator and director of nursing at SUMMIT Surgery Center since 2009, is responsible for the day-to-day operations of one of the newest surgery centers in Reno. She was an integral part of opening the center and is now focused on recruiting physicians, hiring quality staff and achieving financial success. In 2011, Ms. Martin was diagnosed with stage three colon cancer and received chemotherapy for six months. "During this time, I continued to work full-time, and the center has flourished," Ms. Martin says. "Our patient satisfaction scores are the highest that they have ever been, and our monthly volumes are consistent and growing." Ms. Martin continues to serve as secretary for the Nevada Ambulatory Surgery Center Association, and the center recently underwent a state survey with zero deficiencies.

Amy McKiernan, RN (Louisville Surgery Center in Kentucky). Ms. McKiernan joined Louisville Surgery Center in Jan. 2005, three months after the center opened. She says

the center has grown tremendously since her first day; in the first year, the ASC performed 814 cases and in 2010, the number had jumped to 3,431 cases. The center currently performs plastics, orthopedics, ENT and pain management in two ORs and seven pre-op/recovery bays. She says the center has also benefitted from ASD Management's bonus program. Since the implementation of the program, the staff has looked to every area of the center for cost savings. She says the center received AAAHC re-accreditation in June with zero Medicare deficiencies — "a huge relief," according to Ms. McKiernan. She says the center lost two physicians to another surgery center, but staff were moved around without having to let anyone go. "By showing our ENT physicians case-costing on their tonsillectomies and adenoidectomies, we are now saving anywhere from $115 to $160 per case," she says.

Dave Milton (Surgicenter in Phoenix). Mr. Milton is the administrator at Surgicenter in Phoenix, the first ASC in the United States. He says that since being hired by Banner Heatlh, he has been asked many times about his leadership style. "It is very simple," he says. "The first thing I learned during my 20 years in the military is, 'Take care of the troops, and they will take care of the mission.'" He says the second lesson he learned is that, 'What we do today is our reputation tomorrow' — advice he has followed in and out of the military. Brenda Mastopietro, chief nursing officer for Banner Surgery Centers, says, "He is extremely well-liked by his physician partners, his healthcare system entity, Banner Health, and his staff. He brings to life teamwork by asking for help when needed and hence has been successful in bringing down cost and staff hours per case." Mr. Milton runs seven ORs and three endoscopy suites at his surgery center.

Dee Moncrief (Big Creek Surgery Center in Middleburg Heights, Ohio). Ms. Moncrief has been with her center since October 2005 and was involved with the development, initial staff hiring and start up of the center. She brings 15 years of experience in the ASC industry to her current role, having previously served as a nurse's aid and ICU nurse at a hospital. She also served as the administrator of another center for 3.5 years before coming to Big Creek Surgery Center. Ms. Moncrief earned her BSN from the University of Akron in Ohio.

David Moody, RN (Knightsbridge Surgery Center in Columbus, Ohio). Mr. Moody arrived at Knightsbridge Surgery Center three months after Regent Surgical Health took over the facility in 2004. KSC is a multi-specialty center that performs urology, general surgery, gynecology, plastics, pain, colorectal and neurosurgery procedures. Four years ago, the center entered into a partnership with the Ohio Health hospital system, which currently holds a 49 percent ownership stake in KSC. During Mr. Moody's tenure with Knightsbridge, he says the center has seen two pivotal changes: the introduction of Regent Surgical Health and the partnership with Ohio Health. He says both partnerships have resulted in tremendous benefits for the center. Regent helped turn the center around into a state of profitability and top patient care, while Ohio Health assisted in achieving a predictable cash flow and cost-savings opportunities.

Jennifer Morris (Stateline Surgery Center in Galena, Kan.). Ms. Morris serves as administrator of Stateline Surgery Center, which opened March 28, 2010. The center has two ORs and performs primarily orthopedic cases. According to Carrie Ellefsen, RN, assistant director of nursing at the center, she and Ms. Morris worked together at Four States Surgery Center in Joplin, Mo., for 10 years before arriving at Stateline together. "We had less than three months to get the surgery center ready," she says. "It was an empty shell when we came, so we had to help design it, order supplies and equipment, develop policies and procedures and do everything else there is to do to meet regulations in less than three months." In 2011, the center experienced significant growth; after the Joplin, Mo., tornado, volume doubled overnight, requiring the addition of a third operating room. She says while not all the specialties added during the tornado were retained, the center did retain a GI physician and is planning to recruit a second GI physician in the fall.

Thomas Mulhern, MBA, CASC (Limestone Surgery Center in Wilmington, Del.). Mr. Mulhern is the executive director of the Limestone Surgery Center, which opened in 1987 as the first ASC in Delaware. He has been with the surgery center since it opened 25 years ago. He is a former member Delaware's certificate of need board. Limestone is a multi-specialty center consisting of four operating rooms and one procedure room and performs over 9,000 cases annually. "I was fortunate to have been here since the beginning and have the opportunity to transition from one generation of surgeons to another," Mr. Mulhern says. "Over the past 10 years, we recognized that we had an aging partner population and have worked hard to recruit new surgeons to become partners. This effort was a team approach and has been a real success. It has infused fresh ideas and has decreased the average age of a partner to 50 years old." Mr. Mulhern says being an administrator provides him with daily challenges that keep the job interesting. "It's never boring managing the various pieces of the organizational puzzle," he says. "On any given day, I'm challenged with a variety of different issues that are all interrelated."

Susan Nance, RN, CASC (Gateway Surgery Center in Phoenix, Ariz.). Gateway Surgery Center is a primarily orthopedic-driven, free-standing surgery center owned partly by physicians and partly by AmSurg. According to Peg Jahn, BS, RN, nurse manager at the center, Ms. Nance leads the center by example and has implemented many positive changes to enhance patient care. "She leads by example and has implemented many positive changes to enhance the care we provide for our patients and their families," she says. "She fosters teamwork between all areas of the center and is always creative in coming up with new ideas to keep the staff motivated and enthusiastic."

Joseph G. Ollayos, MHA, CASC (Tri-Cities Surgery Center in Geneva, Ill.). Mr. Ollayos has been employed in the ambulatory surgery industry since 1999 and currently serves as the administrator at Tri-Cities Surgery Center. The surgery center, which opened in May 2007, is celebrating its 5th anniversary this year. Mr. Ollayos also serves as the 2012 President of the Ambulatory Surgery Center Association of Illinois. He has held the CASC credential since 2005.

Amber Patterson (Westside Surgery Center in Douglas, Ga.). "I'm young, but I'm working extremely hard to become an excellent administrator," says Ms. Patterson, practice administrator of Ear Nose & Throat Clinic and Westside Surgery Center in Douglas, Ga. She came to Westside Surgery Center in Dec. 2008, when she inherited the administrator position of the freestanding, physician-owned ASC. In her first three years with the center, she has researched the best deals on ASC equipment, worked with a consultant to ensure the facility was built according to state guidelines, hired and trained new staff, completed the state survey and Joint Commission accreditation and maintained compliance with federal regulations. In constant pursuit of professional development, Ms. Patterson is currently pursuing a degree in business administration. "The business side of the medical field is my passion," Ms. Patterson says. "I absolutely love learning more about the industry." Her main role at the surgery center currently is to oversee the quality improvement program, staffing and business operations.

Larry Parrish, MBA (Illinois Sports Medicine & Orthopedic Surgery Center in Morton Grove, Ill.). Mr. Parrish is the administrator of ISMOSC, a physician-owned, multi-specialty ASC specializing in orthopedic and spine surgery, podiatry and pain management. ISMOSC has four ORs and one procedure room and performs a wide variety of orthopedic ambulatory surgical procedures, including arthroscopies, ACL reconstructions, arthroplasties, carpal tunnel releases and rotator cuff repairs. Mr. Parrish credits some of his success with the center to his ability to schedule cases efficiently and keep physicians happy. He advises ASC administrators to help surgeons schedule outside their block times when necessary in order to keep physician satisfaction high. He also advises ASC leaders to keep patients informed about delays or scheduling snafus. "On rare occasions, usually due to child care issues, a patient who is still in the waiting room may opt to reschedule the case and go home," Mr. Parrish says. Prepped patients, on the other hand, are usually willing to stick it out. "It's a tough situation and there's not a whole lot the surgery center's staff can do about it except to keep the patient informed and give them and their family members as much comfort as possible," he says.

Mike Pankey (Ambulatory Surgery Center of Spartanburg in Spartanburg, S.C.). Mr. Pankey helped open his current center, the Ambulatory Surgery Center of Spartanburg, in 2002. In 2003, he and his team added two endoscopy suites, and over the next few years, they built volume from 5,000 cases in year one to over 10,000 cases in years six through eight. As the president of the South Carolina Ambulatory Surgery Center Association, he led a workers' compensation lawsuit against South Carolina. On his personal philosophy as an administrator, Mr. Pankey says he follows the mantra: "Do the right thing every time." If you follow that advice in every choice you make, "it will never come back to bite you," he says. As administrator of the Ambulatory Surgery Center of Spartanburg, Mr. Pankey oversees seven operating rooms and two endoscopy suites and takes responsibility for clinical and business operations. He previously worked as the administrator at Lee Island Coast Surgery Center in Fort Myers, Fla.

Linda Phillips, RN (Southgate Surgery Center in Southgate, Mich.). Ms. Phillips has served as administrator of Southgate Surgery Center in Michigan since 1999, when she was promoted to the position from OR supervisor. During her tenure as administrator, she expanded the ASC from a one-room, single-specialty center to a four-room, multispecialty ASC and increased the number of surgeons on staff from one to 20. She's proud to say that she recently added a GI doctor and an ocuplastic surgeon to the surgical staff. She is also very proud of the addition of the surgery center's humanitarian programs, Neighbors in Need and Colon Cancer Awareness, which offer GI and ophthalmic procedures to patients that are uninsured and experience financial hardship. "It's very rewarding to offer these programs as a way to give back to our community," Ms. Phillips says.

Toni Rambeau (SurgCenter of Glen Burnie, Ind.) Ms. Rambeau started at SurgCenter of Glen Burnie in Aug. 2008 as materials manager and was promoted to administrator in May 2009. During her time at the center, she has helped increase patient revenue, case volume and the amount of the providers credentialed at the center. The center achieved a three-year AAAAHC accreditation in 2010 and has since helped sister centers with questions and issues surrounding accreditation. According to Ms. Rambeau, the center consistently achieves low infection control rates, high revenue and great patient care surveys, three goals the ASC team doggedly pursues. "The center is running very smoothly and efficiently," she says. "The staff here has made my job an easy one. The center continues to achieve excellent patient satisfaction scores, below average infection rates and is a very profitable business." She says even when the center's schedule is packed, her "never say no policy" means all patients are accommodated.

Anne Remm (Miracle Hills Surgery Center in Omaha, Neb.). Ms. Remm, administrator of Miracle Hills Surgery Center, has over 28 years nursing experience with 20 years of surgical management experience in the acute-care hospital and ASC settings. Ms. Remm has worked for Meridian Surgical Partners for the past three years and is a member of the Nebraska Association of Independent Ambulatory Centers. Ms. Remm has been a speaker at Becker's Healthcare meeting sand has been named a "great administrator to know" for two years. While at Miracle Hills Surgery Center, she has strived for high quality surgical services to ensure a great patient experience with exceptional clinical outcomes, while following a profitable business plan.

Gary A. Richberg, RN, BSN, CASC (Pacific Rim Outpatient Surgery Center in Bellingham, Wash.). Mr. Richberg has been the administrator of Pacific Rim Outpatient Surgery Center since 2006, prior to which he served as administrator of the Institute of Orthopaedic Surgery in Las Vegas for four years. His responsibilities include oversight of the fiscal and clinical management of the 23,000-square-foot multi-specialty surgery center, which performs approximately 450 cases per month. The cases include a very successful outpatient joint replacement program, as well as an advanced neurosurgery and orthopedic spine program. Mr. Richberg also works as a legal nurse consultant and an RN coder and auditor. He received his CASC credential in 2003.

Anne Roberts, RN (Surgery Center of Reno, Nev.). Ms. Roberts is the administrator at the Surgery Center at Reno, a multi-specialty ASC that is owned by physician partners, a hospital partner — Saint Mary's Hospital, and a managing partner — Regent Surgical Health. Ms. Roberts came to the Surgery Center at Reno in Feb. 2006 when it opened and became administrator in Oct. 2006. She began her career as a nurse in the emergency department, spending 16 years as a staff nurse and 10 years as the manager of a busy ED. She says this experience lends itself well to the challenges faced daily in the outpatient surgery arena. "We have an outstanding staff and physician group that makes such a difference and provides excellent care to our patients," Ms. Roberts says. "It is such a pleasure to work in this facility with such great people." Vicki Webb, business manager at Surgery Center of Reno, says that Ms. Roberts "is the best boss I have ever worked for."

Kate Rock (Doylestown Surgery Center in Warrington, Pa.). Ms. Rock has over 15 years of healthcare leadership. She currently serves as executive director of Doylestown Surgery Center in Warrington, Pennsylvania, a community 30 minutes north of Philadelphia. The multi-specialty center, which opened in May 2001, sees an annual case volume of 4,500 cases and received its three-year AAAHC accreditation in Nov. 2010. Ms. Rock was hired in Feb. 2010, and within 10 months, the center presented a positive bottom line and reduced expenses by over $400,000 from the previous year. In 2011, the center saw a continued decrease in ex-

penses. Ms. Rock and her team realized these significant changes by reviewing and re-evaluating staffing; reviewing and re-negotiating every vendor contract; hiring a full-time materials manager; adding several new surgeons; and starting the reprocessing of single-use instruments. "The relationship between the physicians and the staff is extraordinary, because everyone is treated with respect and dignity," Ms Rock says. "Attention to quality and safety, coupled with compassion, are hallmarks of our culture. Our goal is to create and maintain a 'culture of excellence.'"

Lauri Rose (Stonegate Surgery Center in Austin, Texas). Ms. Rose has been involved in the development and management of ambulatory surgery centers since 1997. In that time, she has been successful in providing both physician owners and general partners a surgical center of excellence to perform safe, efficient and cost-effective outpatient surgical procedures. Ms. Rose is highly regarded by staff, physicians and patients to provide administrative leadership to the facility. In her career, she has successfully developed, managed, and improved the financial stability in over 15 ambulatory surgery centers throughout the country. Ms. Rose has also taught healthcare administration in the School of Nursing at the University of Phoenix for over six years. She has been in her current role of administrator at Stonegate Surgery Center for over a year.

Mary Ryan, RN, CASC (Tri State Surgery Center in Dubuque, Iowa). Ms. Ryan is the administrator of Tri State Surgery Center, a multi-specialty facility in eastern Iowa with three ORs and two procedure rooms. Tri State performs over 5,000 cases annually. The specialties at the facility include ENT, gastroenterology, general surgery, gynecology, ophthalmology, orthopedics, pain management, plastic surgery, podiatry and urology. The evolution of the center began with its building and opening in 1998 by Medical Associates Clinics and Health Plans and Mercy Hospital. The center is managed by Health Inventures. Ms. Ryan is known by her staff for advocating continuous improvement, whereby she relentlessly strives to improve the centers performance in every area: clinical, financial and operationally. In addition, she often volunteers to help her management company, Health Inventures, with projects outside of her center. Ms. Ryan is a past AORN chapter president, a founding member of the Iowa ASC Association and is currently serving her third term on the board as president elect.

Kris Sabo, RN (Pend Oreille Surgery Center in Ponderay, Idaho). Ms. Sabo has been involved with Pend Oreille Surgery Center since 2007, when the center was still an unrealized dream. After meeting Mike DiBendetto, MD, Ms. Sabo helped research the possibilities of building an ASC and recruited other like-minded providers. Her early involvement with Pend Oreille involved research and feasibility, physician recruiting, architect selection, contractor and consultant work, construction project coordination, supply purchasing and staff recruiting. She currently holds the position of executive director of the center, in which she oversees 17 employees and 11 providers or various specialties. She recently completed the AORN Ambulatory Surgery Administrator Certificate Program. "These are trying times in healthcare, and I want to encourage all stakeholders in our industry to 'dig in and hang on'!" she says. "We know the value of our services and I am confident that, in time, our government and insurance payors will realize it too. In the meantime, do not get caught up in the negatives, but focus on the great talent you have surrounded yourselves with and the quality services you provide."

Glenda Satterly, RN (Kentucky Surgery Center in Lexington, Ky.). Ms. Satterly — formerly Ms. Beasley, prior to her marriage in 2011 — is the administrative director of the Kentucky Surgery Center, a multi-

specialty surgery center opened in 1986. Ms. Satterly joined the center in 1990 and celebrated her 20-year anniversary with KSC in July 2010. She started at the center as an OR circulator and was promoted to OR/PACU/pre-operative supervisor and then clinical director before becoming the administrative director. In 2011, Kentucky Surgery Center performed over 10,000 cases. "Being an administrator in a busy surgery center is demanding and hectic," Ms. Satterly says. "However, we deliver the best patient care possible, and the entire staff strives to be the best they can be on a daily basis." She says she can speak for her staff when she says they love their jobs and are lucky to be part of a great surgery center.

Tona Savoie (Bayou Region Surgery Center in Thibodaux, La.). Ms. Savoie is the administrative director of Bayou Region Surgical Center, a multi-specialty surgery center that opened in July 2007. In her time as an ASC administrator, Ms. Savoie says, "I've discovered this position to be an acquired art form. There is constant evolution and new challenges daily, which keeps my energy and interests in high gear. I am proud to be a part of this wonderful contribution to our community." Bayou Region Surgical Center is a free-standing facility with four ORs and one procedure room. Surgeons at Bayou Region specialize in orthopedics, ENT, neurology, general surgery, urology, GI, ophthalmology and pain management. The ASC operates as a 50-50 partnership between physician-investors and a subsidiary of the local community hospital, Thibodaux Regional Medical Center. It is managed by ASD Management.

David Schlactus (Willamette Surgery Center in Salem, Ore.). As CEO of Willamette Surgery Center, Mr. Schlactus has been successful in renegotiating payor contracts to maintain profitability even through the economic downturn. He has also educated numerous legislators on the benefit of ASCs by providing tours of his facility and has spearheaded the efforts of the Oregon ASC Association in Salem. He says WSC had a particularly successful year in 2011, passing two Joint Commission surveys and performing two total knee replacements at the surgery center. "Our hope is to develop and expand this line of business for the future," he says. "The outcomes were so good that the patients decided to go home just a mere four hours after surgery, forgoing an overnight stay that was available to them." He says the center has started piloting the use of FDA-approved generic implants, which has the potential to save up to $80,000 in 2012.

Lisa Schriver, RN, CNOR (Turk's Head Surgery Center, West Chester, Pa.). Ms. Schriver is the administrator of Turk's Head Surgery Center in West Chester, Pa, a multi-specialty, freestanding surgery center that offers general surgery, GI, orthopedics, ophthalmology, ENT, urology, gynecology and podiatry. Turk's Head is a physician-hospital joint venture that opened in May 2005. Ms. Schriver started with Turk's Head in 2005 as the clinical director and moved up to become administrator. Prior to coming to the center, she had a varied career in nursing and served in various departments including OR, endoscopy and perioperative. From there, she moved to a hospital-based surgery center and became the nurse manager. She has also worked with an anesthesiologist at the hospital that joint ventures with Turk's Head. Ms. Schriver enjoys her role as an administrator because of the changing nature of her job. "Everyday is different, and I can use my sense of adventure to tackle each day. Some days this never-ending change is overwhelming, but at a basic level it really very much appeals to my personality and who I really am," she says.

Reed Simmons (Treasure Coast Center for Surgery in Stuart, Fla.). Mr. Simmons holds 16 years of experience in the ASC industry, managing the business office functions for several surgical facilities in the Florida area. He currently serves as the acting administrator at Treasure Coast Center for Surgery, a multi-specialty ASC located in Stuart, Fla. His background includes handling revenue cycle management, managing a staff of business office personnel, accounts receivable and credentialing, and performing human resources functions. Prior to Treasure Coast, Reed served as business office manager at Palms West Surgicenter in Royal Palm Beach, Fla., and as a reimbursement specialist at Physicians Practice Solutions in Jacksonville, Fla.

Laurie Simon (Western Reserve Surgery Center in Kent, Ohio). Ms. Simon, administrator of Western Reserve Surgery Center, started her career on the physician side of practice management and ancillary services management. In 1994, she took a position with a physician group that planned to open an ASC — the model for which she says has gone through many changes, from physician ownership to management company/physician ownership with two different national companies. In Feb. 2005, Ms. Simon completed the AORN ASC Administrator Certificate Program to prepare for a return to physician ownership. "These changes have provided me with countless opportunities for personal growth," she says. "Membership and committee activity in our Ohio Association has kept me current managing this multi-specialty center."

Carol S. Slagle, CASC (Specialty Surgery Center of CNY in Liverpool, N.Y.). Ms. Slagle has been the administrator of Specialty Surgery Center of CNY, which is managed by ASCOA, since its inception in 1999. She says the experience of setting up Specialty Surgery Center was incredible. "It was an honor and privilege to have the opportunity to be hired and oversee the build-out and initial set-up of all operations of our surgery center," she says. While the surgery center started out with five physicians and 11 employees with a specialization in ophthalmology, the ASC has since become a multi-specialty center and currently has 31 credentialed surgeons and 54 employees. "We underwent a major expansion and total renovation of the ASC in 2009 and successfully orchestrated this project while open for business," Ms. Slagle says. Ms. Slagle was in the first group to take the CASC credential test and was awarded the CASC credential shortly thereafter. The surgery center performed 8,965 cases in 2011.

Laura Smith (Tampa Bay Specialty Surgery Center in Pinellas Park, Fla.). Ms. Smith has been employed with Tampa Bay Specialty Surgery Center since 2004, when she joined the center as a pre-op registered nurse. In 2005, she was promoted to nurse manager, and in 2006, to clinical director — a position that prompted her to receive her State of Florida Risk Management License. In 2008, she was promoted to administrator and helped the center earn a three-year accreditation. Although she is fully involved in the financial and management aspects of running the ASC, she is still involved in daily operations of the center, including patient care. In 2011, the center achieved AAAHC re-accreditation, which was followed by an unannounced CMS visit that resulted in "Great success." She says the center also achieved certification in the ASGE Quality Endoscopy Unit Recognition Plan and recruited a urology physician to add to the center's multi-specialty mix.

Steve Smith, RN, CASC (Surgery Center of Wisconsin Rapids in Wisconsin Rapids, Wis.). Mr. Smith, director of the Surgery Center of Wisconsin Rapids, was hired as the circulating nurse when the ASC opened its doors in 2006. When he joined Surgery Center of Wisconsin Rapids (managed by ASD Management), he was tasked with organizing and

preparing the center for orthopedic and pain procedures, a responsibility that involved preparing chart forms, meeting with vendors and preparing equipment for use. In April 2007, the center's physicians approached Mr. Smith with the offer to be the administrative director of the ASC. In 2011, the center added an ophthalmology service line, along with three ophthalmology physicians. He says the center also received three-year AAAHC accreditation in July 2010 and underwent a CMS survey in December 2010.

Jim Stilley, MHA, CASC, FACHE (Northwest Michigan Surgery Center in Traverse City, Mich.). Mr. Stilley is the current CEO and administrator of Northwest Michigan Surgery Center, a position he has held for the last seven years. In 2011, the Northwest Michigan Surgery Center performed 18,000 cases, had 72 surgeons utilizing the facility and was partnered with the Munson Healthcare health system, 21 anesthesiologists and 21 CRNAs. NMSC continues to perform in the top 1-2 percent nationally in all statistics, including size, volume, and quality of care indicators, infection rates and patient satisfaction. In addition to his work with NMSC, Mr. Stilley has actively lobbied for Medicaid and worker's compensation reimbursement reform at the state level. He served for four years as a past president of the Michigan Ambulatory Surgical Association. Jim has more than 27 years' experience in hospital, group practice, health plan and surgery center management.

Maggie Summerfelt (Advanced SurgeryCenter in Omaha, Neb.). Ms. Summerfelt serves as administrator of AdvancedSurgeryCenter, a physician-owned facility with two ORs, two procedure rooms and specialties that include orthopedics, podiatry and pain management. Ms. Summerfelt was hired in Oct. 2005 to manage construction of the ASC, hire staff and obtain initial state licensure and Medicare certification. The center opened in 2006, and bought out its original management company, SurgCenter Development, in Oct. 2008. In 2011, the surgery center added a new partner and now features 12 physician owners. "We have also added a new and very busy hand surgeon who is a non-owner at this time," she says. "Volume is looking great for 2012." She says one of the challenges over the next year is receiving reimbursement for implants in a timely fashion. "Vendors want to be paid in 30 days, and it is taking over 90 days for insurance companies to pay us," she says. "Fortunately our vendors are willing to work with us, and we have negotiated excellent pricing for our larger ticket items."

Sue Sumpter (Creekside Surgery Center in Anchorage, Alaska). Ms. Sumpter has been with Creekside Surgery Center (also Providence Surgery Centers LLC) for a little over a year. She was recruited in March 2011 to turnaround the finances and case volume of the failing center and has since increased volume significantly and improved profitability. Ms. Sumpter has also implemented a total joint program at the center and is currently working on developing a spine program. The ASC, which has four ORs and 17 physician owners, specializes in orthopedics but also performs ENT, podiatry and pain management. Prior to joining Creekside, Ms. Sumpter worked at Loveland Surgery Center from 2003 to 2011, where she was initially recruited to establish all systems, policies and procedures for the startup surgery center.

Elaine Thomas, RN (St. Francis Mooresville Surgery Center in Mooresville, Ind.). Ms. Thomas began her position as administrator manager in the St. Francis Mooresville Surgery Center in June 2006, and was promoted to director in 2007. The primary scope of her practice has focused on the pre- and post-operative arenas, circulating in the surgical suite and quality management in another major hospital in the Indianapolis area. She is a member of AORN and the Indiana Federation of Ambulatory Surgery Centers. Additionally, she has taught online courses at a local college for Healthcare Administration for Associate level students. She has been a nurse since 1982, and, since that time, has acquired her associate degree in 1996, her BSN in 2003 and most recently completed her MBA in healthcare in July 2006.

Meg Tomlinson (Baylor Surgicare at Carrollton in Carrollton, Texas). Ms. Tomlinson has served as administrator of Metrocrest Surgery Center (currently doing business as Baylor Surgicare at Carrollton) since Sept. 2002. The center merged with USPI effective July 1, 2010, and has seen various changes to the business office staff since that time. "If it had not been for the USPI CSO doing our coding, billing and AP, I'm not sure we could have made it," she says. "We have so many more resources and assistance from USPI." She says her patients are still happy, patient satisfaction is still high and physician owners are satisfied. "They say they can do more cases here in less time than at the hospitals," she says.

Kimberly L. Tude Thuot (Yakima Ambulatory Surgical Center in Yakima, Wash.). Ms. Tude Thuot has been in healthcare administration since 1997 and joined the physician-owned Yakima Ambulatory Surgical Center in Aug. 2009. She holds a master's degree in organizational management. She is also currently board-certified in the ACMPE and is actively pursuing fellowship, as well as her CASC and CPC. Since she joined Yakima ASC, the center has been through a re-accreditation survey with AAAHC, moved billing back in-house and is in the process of adding neurosurgery and spine to the multi-specialty facility.

Susan Vitort, BSN, CNOR (Physicians Surgery Center of Tempe in Tempe, Ariz.). Ms. Vitort is the Administrator of Physicians Surgery Center of Tempe, a two-OR, one-procedure room, multi-specialty surgery center that opened in Sept. 1999. Physicians Surgery Center performed 4,550 cases in 2011, which was 26 percent more case volume than in 2010. The center particularly grew its pain management service line over the past year. "Some of our pain physicians moved out to start office-based practices, while other pain physicians moved in to use the center," Ms. Vitort says. "Our orthopedic mix also more than doubled in 2011, which was

the specialty we wanted to grow." Physicians Surgery Center of Tempe is 90 percent physician owned and 10 percent owned by USPI, an affiliation Ms. Vitort says allows for collaboration and benchmarking opportunities. Prior to her position with Physicians Surgery Center, Ms. Vitort served as director of perioperative services, endoscopy at the Cardiovascular Center at Banner Desert Samaritan Medical Center from 1990 to 2002.

Kara Vittetoe, CASC (Thomas Johnson Surgery Center in Frederick, Md.). Ms. Vittetoe is the administrator of a one-OR, two-procedure room, multi-specialty surgery in a growing rural area. Thomas Johnson Surgery Center in Frederick, Md., which is managed by ASCOA, features surgeons specializing in general surgery, gynecology, neuro-spine, podiatry and urology. Ms. Vittetoe has been with the center since it opened in 2008. Prior to joining Thomas Johnson, she spent the majority of her career in the private sector of healthcare management. Concerning the transition from management to ambulatory surgery, she says, "The learning curve was huge, but the basis of the care and business was the same. What made the transition so palatable was the support from our corporate partner (ASCOA) and the brilliant vice president I was working directly under." Life isn't always easy for the rural ASC: The small Frederick community is competitive, and the center is limited to recruiting in the one-hospital town. To meet this challenge, she says, "Our partners are active in their commitment to quality and safety and are great proponents for our patients and the community. It is what makes and keeps us harmonious."

Andrew Weiss (The Endo Center at Vorhees in Vorhees, N.J.). Mr. Weiss has been administrator of The Endo Center at Vorhees since 2003, prior to which he served as an on-site consultant at the center. The surgery center is a six-room GI center that performs over 20,000 procedures a year. "As administrator, I have responsibility for daily operations," Mr. Weiss says. "Last year, we relocated the ASC to a larger facility. I had a leadership role in the expansion from pro forma through licensure." Mr. Weiss also serves as treasurer of the New Jersey Association of Ambulatory Surgery Centers and is on the board of directors of the ASCA PAC.

Lexa L. Woodyard (Cabell Huntington Surgery Center at Huntington, W.V.) During her five years as administrator of Cabell Huntington Surgery Center, Ms. Woodyard has racked up an impressive list of accomplishments. Along with her staff, managed care team and surgeons, she has decreased supply expenses per case over previous calendar year, increased net revenue per case from previous calendar year by introducing cases with better payor mixes, streamlined processes to make posting cases and gathering anesthesia required testing easier for surgeon's offices, and negotiated better paying contracts with selected insurance carriers. "Volume is key to success. If you don't have a high volume of cases with a good payor mix you'll struggle to keep your head above water," she says. "Anything a surgery center can do to make their center more accessible and more reliable than the competition to surgeons and patients is necessary for survival." She says her center is blessed with staff and surgeons who are willing to make an effort to cut costs, increase revenue and improve patient satisfaction. "The staff are my skilled experts and I trust their input and knowledge," she says. "You don't have to be a nurse to run a surgery center, but you do have to have excellent, highly professional and proactive nurses on staff to help push the center forward."

Bryan Wright (Florida Hospital East – Surgery Center in Orlando, Fla.). Mr. Wright has worked for Florida Hospital East – Surgery Center for almost two years, having joined upon the center's inception as its administrator. Prior to his role with Florida Hospital East – Surgery Center, Mr. Wright worked for Richard L. Scott Investments, managing acquisitions, joint ventures and development of urgent care facilities. Mr. Wright says his center has broken several Florida Hospital records in the last year, achieving 100 percent on-time case starts in March 2012, 12.04 room turnover times (in minutes, excluding flip rooms) in February 2012 and 81 percent block time utilization. The center also achieved 76 percent upfront cash collections and saw a 33 percent increase in case volume over the first quarter of the prior year. The multi-specialty center currently has two operating rooms and two endoscopy procedure rooms and is expanding to include two more operating rooms.

Cindy Young, RN, CASC (Surgery Center of Farmington in Michigan). Ms. Young has been with the Surgery Center of Farmington for the past 13 years, during which time the center has shown consistent quarter-over-quarter profit increases, high patient, staff and physician satisfaction scores and quick turnover times. Ms. Young helped the ASC achieve a three-year accreditation from AAAHC in 2002, 2005 and 2008 and currently manages 28 employees, 16 credentialed physicians, two ORs and two procedure rooms. Prior to joining the Surgery Center of Farmington, Ms. Young served as a staff nurse at Arcadia Valley Hospital in Pilot Knob, Mo., where she was responsible for emergency transfers, supervising the night shift and maintaining central supply and central sterilization.

Monica M. Ziegler, MSN, CASC (Physicians Surgical Center in Lebanon, Pa. & Center for Specialized Surgery in Bethlehem, Pa.). Ms. Ziegler has been the administrator for Physicians Surgical Center since its inception seven years ago, growing case volume to a current 5,300 cases a year. Ms. Ziegler was given the responsibility of a second center, the Center for Specialized Surgery, one year ago. Both centers are multi-specialty facilities serving a combined total of eight procedure/OR rooms. Although very similar centers, the surrounding hospital networks for each facility are very different, each presenting unique economic and political challenges for an administrator and supporting management team. Ms. Ziegler believes strategic vision is a key to the success of any organization. "[It's about] knowing your environment, your strengths and weaknesses and how you can create benefits for your centers — seeking 'win win' opportunities for all should be a daily practice," she says. Ms. Ziegler also serves as president-elect of the Pennsylvania Ambulatory Surgery Association and the chairperson of the legislative committee.

Becky Ziegler-Otis (Ambulatory Surgical Center of Stevens Point in Stevens Point, Wis.). Ms. Ziegler-Otis has served in her current role as administrator of the Ambulatory Surgical Center of Stevens Point since Jan. 2008. In this position, Ms. Ziegler-Otis has worked diligently to keep days in A/R at benchmark levels. When she took over as administrator, the center was at almost 100 days in A/R. Through her continued efforts and her work with an outsourced vendor, the center has stayed at 39-40 days in A/R for the past year. She also takes pride in the center's minimal employee turnover — since opening in 2006. In July 2011, she facilitated the implementation of an online registration product called Simple Admit, which resulted in a reduction of pre-operative nursing staff labor costs and significantly reduced patient check-in time. In October 2011, Ms. Ziegler-Otis achieved the CASC credential. ■

Please contact Rachel Fields at rfields@beckershealthcare.com.

6 Benchmark Goals for ASCs to Meet or Exceed in 2012

By Rachel Fields

Surgery centers can improve profitability, efficiency and satisfaction by creating clear goals and tracking progress toward those goals, says Bryan Wright, administrator of Florida Hospital Surgery Center in Orlando. He says the process starts with a culture that engages staff and physicians in the plan to improve the center. "The key to success in all these areas is setting clear accountabilities and goals with every stakeholder," he says. The surgery center leader should create a vision of exceeding expectations and providing the best customer service possible in a competitive environment.

"Things have to make sense to everyone, or they will never work," he says. With all these goals, he emphasizes providing information about your target to employees in a clear, easy-to-understand manner. "In order to create buy-in at all levels, you need to involve staff and physicians in the planning, implementation, execution, sustainment and recognition phases."

For example, Mr. Wright says a staff member may see the schedule only has two surgery cases for the day and decide to stretch out the day to get their hours. If you share that you need to keep turnover times low to market to new physicians, the staff member will be more likely to work quickly in accordance with the center's plan.

Here he shares six goals for surgery centers to meet or exceed benchmarks in 2012.

1. Achieve 100 percent on-time case starts. On-time case starts can affect surgery center efficiency and profitability significantly, as a late start at the beginning of the day can push back other cases and increase labor costs. Mr. Wright says his hospital system defines first case starts as occurring between 7 AM and 8:30 AM for the first case for the room with a five minute grace period. In December 2011, the surgery center reported 64.5 percent on-time case starts — a number Mr. Wright calls "alarming," It was frustrating to say the least, he says. "We can't market our facility to new physicians if we don't start our cases on time, regardless of the cause." The surgery center has since increased on-time case starts to 100 percent in March 2012 and 98 percent in April 2012 so far. Here's how:

- **Post information on case starts for staff and physicians.** In order to increase visibility around first case starts, they posted a notice on every OR door that lists the first case of the day, the physician, the expected start time, whether that time was met and — if it wasn't — why not. Mr. Wright then collected the sheets at the end of every day and addressed the cause in real time if the case started late. He also posted a monitor in the surgery center break room that charts the center's progress with all their key metrics, as well as first case starts for the day, week, month and year. If a physician has been consistently late, his or her name will appear on a bar graph that demonstrates that lateness. Mr. Wright says the bar graph is color-coded to explain the reason for lateness: For example, if the physician caused the delay, the bar graph will be colored red to indicate "surgeon late." Mr. Wright says that posting physicians names and results has motivated those physicians that were chronic offenders to improve.

- **Make sure staff know what you expect.** Mr. Wright also set clear expectations with his staff: The circulator had to be by the bedside 15 minutes before case start no matter what. If the physician was absent 15 minutes prior to the case, the staff had to call the physicians or alert the facility leadership. Staff members had to be prepared for the first case of the day by the night before. Staff also had to identify any barriers that could delay an on-time start in advance with anesthesia, supplies, equipment and vendors and make sure those issues were addressed.

- **Remind surgeons of case start times prior to surgery.** He says surgery center physicians are reminded about their case start times the day before surgery with a call or text (based on their preference) from the surgery center. This increases physicians' accountability to the center and decreases the likelihood that they will forget to come in.

2. Decrease room turnover times to around 12 minutes per case. Room turnover times at Mr. Wright's surgery center were as high as 18.68 minutes in April 2011, a number that has since been reduced to 12.04 minutes (excluding flips) and 10.91 (including flips), putting them in the 99th percentile nationally. Mr. Wright outlines several steps the staff and physicians took to decrease turnover times:

- **Sit down with all stakeholders.** Mr. Wright formed a committee of OR stakeholders and asked them to list every variable that could affect turnover times. "We came up with a tracking sheet that had orders, anesthesia, equipment issues, clearing issues, and we put down every single thing on one piece of paper," he says. This meeting started the conversation about why turnover times were so high in the first place — a critical step to lowering them, he says.

- **Inform staff members, physicians and anesthesia of your goal.** One problem causing high turnover times was the fact that staff members had no idea what to aim for, Mr. Wright says. In the past, he received data on room turnover times a month and 10 days after the data was collected, which had little significance for staff members. He instead implemented a system where staff members track turnovers for each physician on a sheet of paper. Each sheet has a place to list the turnover time and identify which problem caused the delay. The sheets are then gathered at the end of the day, and one of the facility's leadership creates a weekly and monthly report that lets staff members know their progress. "Now the staff can answer on the spot whether they had a good turnover or not, and they watch the clock in-between cases," Mr. Wright says.

- **Involve physicians.** Physicians are crucial to this as well, Mr. Wright says. They can improve turnover times dramatically by doing things such as: staying in the immediate proximately of the operating rooms, scheduling cases in an order that takes all turnover variables into account, or seeing multiple patients in advance of the first case to ensure they are ready and doing blocks. Anesthesia is also a crucial component in getting patients to recovery and then quickly flipping over to pre-op. "Every person has to be on board with the goal," he says.

- **Talk to vendors about your plan.** Mr. Wright recommends speaking to vendors about the plan to decrease turnover times. His center performs urology cases that require lithotripsy equipment, so vendor techs must understand that equipment needs to be moved out of the room quickly following the case. He says the vendors were open to this conversation and worked with the techs to improve their efficiency.

3. Increase block time utilization to above 75 percent. Mr. Wright's center and physicians have increased block time utilization to an average of 81 percent in February, with a first quarter average of 76 percent — well above the health system's goal of 63 percent. He says this issue also came down to analyzing the root cause of low block time utilization. He says center leadership worked with physicians to install reminders that prompted them to release block time in advance of their 48 or 72 auto-

matic drop if they weren't going to use it. This reminder to drop block time manually improved the statistics because the physicians didn't realize that allowing the computer to drop block time automatically counted negatively towards utilization statistics.

He says he also reduced hours for physicians if he noticed they were consistently not filling their block time. "One physician had 7 AM to 3 PM, and we noticed he wasn't utilizing it fully over a three-month period," he says. "They also didn't understand that they might have one case booked for their whole block and should drop part of it." They also communicated the consequences of low utilization to both the facility and the physicians in terms of potential loss of block time.

4. Achieve more than 76 percent upfront cash collections. Mr. Wright and physician leadership came to the current surgery center with a philosophy that patients should meet their co-pays, co-insurance and deductibles prior to surgery to avoid bad debt and increasing health care costs. "This is a patient's financial responsibility based on their individual insurance plan," Mr. Wright says. "We started to really understand that there was a cultural problem with people who don't understand insurance and think their procedure should be covered 100 percent." In order to increase cash collections to above 75 percent, he implemented the following tactics:

- **Expect 100 percent upfront collection from staff members.** Staff members at Mr. Wright's surgery center know they are expected to collect 100 percent of a patient financial responsibility defined by their insurance provider prior to surgery for their outpatient elective procedures. Two days before surgery, a staff member calls the patient to explain how their insurance works and what they will owe. The staff member explains the surgery center has a policy of collecting in full rather than billing after the fact. Mr. Wright says if the staff member has a legitimate reason for not collecting 100 percent, they are allowed to reduce collections to 75 percent and then 50 percent with a interest free payment plan of one or two years. However, payment plans should only be used when the patient truly cannot pay the bill upfront.

- **Offer payment plans to patients who need them.** If a patient can't pay the bill upfront, don't let him walk through the door without setting up a payment plan, Mr. Wright says. The patient should be expected to provide credit card information and make substantial payments to the surgery center on a regular basis until the debt is cleared. The only exception to this is if a patient truly is a hardship case or it is deemed medically necessary. In those cases, Mr. Wright says, "The mission of Florida Hospital is to extend the healing ministry of Christ, and we absolutely display this compassion to those that are need through our financial assistance programs The expectation is that those that have the ability to pay make a good faith attempt, and that is why we offer payment plans to work with them."

- **Reward employees who report high collections.** Mr. Wright says it helps to motivate team members with rewards for those who collect in full. If surgery center staff members meet their monthly total or percentage goals, they can receive additional compensation incentives.

5. Get to the 90th percentile in patient satisfaction. Patient satisfaction is a clear driver of success: It increases case volume, bolsters your reputation in the community and keeps staff morale high. Mr. Wright details several ways his surgery center has prioritized patient satisfaction in the last year, reaching the 90th percentile in the health system in the first quarter:

- **Improve your physical plant.** Making improvements to your physical plant can affect patient satisfaction significantly, Mr. Wright says. His surgery center added more televisions to the surgery center waiting area, improved the ambience and inviting feel in the center and added amenities throughout. The surgery center also offers a guestbook with an introduction from Mr. Wright and visitor information to make their stay more comfortable, as well as gourmet coffee and a souvenir bag that gives patients a place to put their personal possessions. "The team's goal was to take the best practices from the customer service industries and apply them to our healthcare facility," Mr. Wright says.

- **Increase staff professionalism.** Mr. Wright says his center took a cue from the hospitality industry: No staff members walk through the waiting area with their lunch or wearing street clothes. All staff members are attired in logoed uniforms, and Mr. Wright and the front desk staff wear suits. The team has bought into being "On Stage" in front of patients and do not display use of cell phones or anything else that would be of a personal nature.

- **Take care of patients before and after surgery.** Patients want to feel "looked after" for the entire surgical experience, Mr. Wright says. Prior to surgery, staff members call the patient to remind them of their appointment time, go over financial details and answer any questions. After surgery, one of Mr. Wright's nurses calls every patient to see how their recovering. Each patient also gets an email from Mr. Wright, thanking them for using the surgery center and inquiring if there was anything they could have done better.

- **Distribute satisfaction scores to staff regularly.** Mr. Wright's center uses Press Ganey to calculate satisfaction scores, and those results are distributed to staff on a regular basis via email. "They see the patient comments along with the overall scores, as well as an executive summary on the monthly scores from me," he says. He adds the staff meets as a team after the scores come out to determine how the surgery center could improve. "The team takes the scores and patient comments very personally and analyze all the variables," Mr. Wright says. "They identify the opportunities for improvement and make an action plan to address each item."

6. Achieve these results without increasing costs. During the first quarter 2012, the surgery center was under budget on labor, supplies and total expense while accomplishing these results. "It is possible to make improvements without increasing costs," Mr. Wright says. "The most important driver goes back to having the right team of staff and physicians that are engaged in the vision." ■

Contact Rachel Fields at rfields@beckershealthcare.com.

5 Ways to Achieve Double-Digit Surgery Center Growth This Year

By Taryn Tawoda

Due to a range of economic factors and insurance challenges, the ambulatory surgery center industry has seen less than one percent volume growth each of the last two years. In this climate, ASCs must be increasingly strategic when identifying sources for center growth.

According to Chris Bishop, senior vice president of acquisitions and business development with Blue Chip Surgical Center Partners, the key to double-digit surgery center growth rests on two factors: assessing a surgery center's capacity for additional cases and targeting prospective physician partners to fill the open space.

1. Measure the surgery center's capacity. The first step in assessing a surgery center's potential for profitability is to determine whether or not the center has the capacity to host additional cases and ensuring your physician board is in agreement that we should pursue new surgeons.

The majority of centers are at less than 50 percent capacity, Mr. Bishop says. If a center has two rooms open on Monday and Thursday afternoons, for example, and if existing physician partners are on board with recruiting new physicians, a surgery center should begin identifying and recruiting physicians to fill the OR space.

2. Ensure that payor contracts allow the center to profit on targeted specialties. A center that is considering adding a new specialty should first examine its payor contracts to ensure that its current rates do not present a roadblock to profitability, says Mr. Bishop. Surgery centers' initial payor contracts may neglect specialties that the center does not currently focus on, and unless those rates are renegotiated to secure greater reimbursements, they can prevent the center from recruiting physicians for new specialties.

"We're very focused on the spine community, for example," says Mr. Bishop. "Since most centers don't perform spine, they might have an insurance contract that focused the majority of their negotiating efforts on endoscopy and ENT. In that case, you have to be mindful of going back to payors and redoing these contracts, because the current contract rate for spine may be so low, it doesn't make sense to recruit spine doctors."

3. Ask existing physician partners to target prospective physician investors. Existing physician partners can be a vital source of information when it comes to assessing other physicians in the surrounding community, says Mr. Bishop. They may know which physicians have a good reputation, which physicians are dissatisfied with their current hospital or center and which physicians perform procedures that could be easily added to the center.

Anesthesia providers and OR nurses can make particularly useful sources for targeting prospective physicians as well because they often work at multiple sites, hospitals and surgery centers, Mr. Bishop adds. As a result, they may interact with a wider variety of physicians on a daily basis and can provide valuable background information.

Once the prospects have been identified by physicians or nurses, the ASC board members should discuss and give approval prior to the outreach process. The nominating physicians or nurses can then contact the prospects and arrange for them to visit the surgery center.

4. Gather detailed background information to engage the physician in the initial meeting. It is best to be over-prepared with information when inviting the prospective physician to visit the surgery center, Mr. Bishop says. The physician partner who made the initial contact with the prospect should pass on key information to the meeting coordinator, including where the prospect went to school, where they were trained, and where their "pain" is — essentially, why they are frustrated with their current facility.

"Are the physician's cases getting bumped because of emergency cases?" says Mr. Bishop. "Are his start times really starting at 8:15 instead of the scheduled 7:30? A lot of hospitals can average an hour in turnover time, but our ASCs should average 10 minutes or less."

Based on the information gathered about the prospective physician and any difficulties he may be having with his current facility, Mr. Bishop says it is useful to prepare a list of five questions to engage the physician in conversation and discuss the advantages to switching to the surgery center. The center should be presented as a solution to the physician's present difficulties, he says.

The initial meeting also serves as an opportunity to discuss a physician's interest in making an investment in the center. An ASC should be prepared to discuss the estimated return that a physician can anticipate on his investment based on how the center has performed historically, Mr. Bishop says.

5. Set up a trial period. If the physician and the ASC appear compatible in the first meeting, the physician should plan to participate in a 60-day trial at minimum, says Mr. Bishop. The trial, during which the physician performs cases at the center and interacts with the staff, is a chance for both parties to assess whether he can succeed at the ASC.

"Do they show up on time? Do they treat the staff well? Are their clinical outcomes good?" says Mr. Bishop. "Look at case costs — are their cases profitable in the center? This period gives us an opportunity to see how profitable they are for the center."

The trial period also allows the prospective physician to gauge their compatibility with the center. "We want them to trial us," says Mr. Bishop. "We want to make sure they feel like Thursday morning starts at 7:30 a.m. are what they're looking for. If not, committed physician partners may be willing to shift their schedule to bring the new physician prospect in."

If, by the end of the trial period, a physician has performed a number of successful cases and has interacted well with the staff, he should be invited to a board meeting to ask physician partners any outstanding questions and to receive a glimpse into the governance of the surgery center, says Mr. Bishop. If the physician partners and the prospect mutually agree on compatibility, the physician will then be offered a subscription agreement to review, sign and complete investment.

Ultimately, according to Mr. Bishop, measuring a surgery center's open capacity and filling that space with additional physician partners will maximize the surgery center's potential for double-digit growth. ■

Contact Taryn Tawoda at ttawoda@beckershealthcare.com.

Hiring an Outstanding Administrator: 4 Steps to Finding the Right Personality for Your ASC

By Taryn Tawoda

Beth Johnson, vice president of clinical systems at Blue Chip Partners, provides four tips on targeting, interviewing and hiring the best administrator for a surgery center based on that center's specific culture and goals. "The real point to drive home is that we hand-pick the behaviors that we're looking for prior to the interview," she says.

1. Identify the surgery center's values, and make sure the administrator's strengths align with them. Before determining a new administrator's ideal traits, a surgery center must have a clear understanding of its mission and culture. "We build our relationships off of trust, and we want our administrator to exemplify that by creating a culture of trust amongst the employees, physicians and partners," says Ms. Johnson. With this ideal in mind, Ms. Johnson targets potential administrators with the qualities that are conducive to building trust: effective communication skills and a commitment to upholding the surgery center's reputation by following through on all tasks.

"An administrator has to be able to communicate ideas so that they're credible — both in a group and on a one-on-one basis," says Ms. Johnson. "We also believe very strongly in the idea that we do what we say we're going to do, in the promised time frame."

2. Ask situational questions. To identify these ideal traits early on in the application process, potential candidates are asked to take a 45-minute personality test online prior to their initial in person interview, Ms. Johnson says. The test, which consists entirely of situational questions that target the administrator's behavior, is then compared to the top traits that the surgery center has identified for the position — in this case, clear communication and a commitment to follow-through.

The personality test results come into play during the face-to-face interview. Ms. Johnson will begin the interview with a thorough review of the candidate's resume, taking note of how he or she explains career decisions, transitions and goals. "It's not so much what they did after they went to college, but why they made certain choices along the way," she says.

3. Give the candidate an opportunity to explain perceived weaknesses. An interview panel consisting of several Blue Chip Partners executives will examine the results of a candidate's personality profile before the interview begins, creating a list of specific questions based on the candidate's measured strengths and areas of concern.

"Say that someone's score is lower than what we would consider 'average' on their conflict management skills," Ms. Johnson says. "A question we might ask is, 'Can you describe a time when you had to step away from a conflict? What did you do or not do, and why? When in your previous jobs have you taken a stand and advanced your convictions at the risk of causing conflict?'"

In addition to comparing a candidate's behavioral responses to the surgery center's ideal traits, Ms. Johnson takes this opportunity to explore any perceived weaknesses or disadvantages, such as a lack of experience in a certain specialty. "For example, Blue Chip's specialty niche is outpatient spine surgery. If a candidate doesn't have spine experience noted on the resume, we'll discuss that with them at this time," says Ms. Johnson.

Blue Chip Partners also uses the behavior-based model retrospectively when comparing a candidate's long-term compatibility with the surgery center. "If we have an administrator or business office manager who wasn't a good fit for the facility, we go back and look at what their personality profile said," says Ms. Johnson. "It makes us better at what we do moving forward, when we're interviewing and looking for that ideal candidate." Similarly, Ms. Johnson can review successful candidates' personality assessments several months later to make note of patterns in recurring behavioral traits and strengths.

4. Look out for red flags on the resume and during the interview. In addition to the traditional pause points in an interview — gaps between positions on a resume or incomplete education programs, for example — Ms. Johnson says that a conveyed lack of enthusiasm for the position and its responsibilities is a significant red flag in an applicant.

"We're very passionate about we do. And if somebody is not passionate about outpatient surgery, developing trust, or delivering quality care in an efficient manner, that's a problem," she says. Nonverbal communication can also be very telling, she adds.

"We want to see the fire in their eyes," Ms. Johnson says. "If they can't display that during the interview, they certainly won't be able to sit in a board meeting and get excited with the doctors or get the staff fired up about a new initiative." ■

Contact Taryn Tawoda at ttawoda@beckershealthcare.com.

8 Critical Areas for Monthly Surgery Center Benchmarks

By Laura Miller

Here are eight areas surgery center administrators should benchmark monthly to optimize success.

1. Infections, complications and transfers. Clinical benchmarking is important for proving the quality of procedures performed at your center. Some surgery centers, such as Blue Ridge Surgery Center, have a quality coordinator who reports on infection rates, complications, wrong site surgery and unplanned transfers. The categories can be broken down even further to track antibiotic delivery and shaving instances.

"If we feel like we are seeing a negative trend on one of these issues, we bring the leadership team together to discuss what the problem might be and how to achieve the best resolution," says Kathy Leibl, administrator at Blue Ridge Surgery Center in Raleigh, N.C., which is affiliated with Surgical Care Affiliates. "We communicate with our team about the data, which is updated each quarter. If our data is improved, we give kudos to our team. We are always trying to improve."

Additional benchmarks Carolyn R. Hollowood, administrator at City Place Surgery Center in St. Louis which is affiliated with Meridian Surgical Partners, tracks at City Place Surgery Center include:

- When the antibiotic was administered
- Unexpected patient care within 24 hours after surgery
- Patients who remain in the recovery room longer than two hours
- Patient burns
- Patient falls
- Post-surgical wound infections
- Surgical site hair removal

"We use these benchmarks to provide safe and efficient patient care," says Ms. Hollowood. "We also conduct handwashing surveillance to make sure everyone is doing what they should in terms of infection control when as they transfer from patient to patient. In addition, we practice mask surveillance to make sure no one is wearing their mask outside of the sterile quarter."

2. Room utilization. Every month, Ms. Hollowood gathers the data from hours spent delivering care per patient and room utilization to derive the monthly percentage of room use. "I balance what we have available with what we actually used so we can improve for the next month," she says. "Usually it's a pretty easy fix, if you are watching it on a monthly basis. If you let the problem go for six months, it's not as easy to find a solution."

Efficiency is a key element to physician satisfaction, says Diane Lampron, administrator at The Surgery Center at Lutheran in Wheat Ridge,

Colo., and Peak One Surgery Center in Frisco, Colo., and quick turnover times are important. "We benchmark how long it takes for us to clean the room and set it up for the next case after the first patient leaves the OR," she says. "We also look at how physicians are using block time in the OR. If they are using the room for surgery 75 percent to 80 percent of the time, that's good. If the physician is only using the room 50 percent of the four hour block schedule, we need to adjust their schedule for a higher utilization rate."

Adjusting the schedule might mean finding a different time or day that works better within the physician's schedule.

3. Physician growth. It's important for surgery centers to grow from year to year, and one of the ways to measure growth is through physician performance. Ms. Leibl's surgery center looks at physician case volume on a monthly basis and compares their numbers to previous year. There are several factors that could impact case volume, including vacation time, seasonality and the economy.

"The economy has periodically affected patient volume over the past few years," says Ms. Leibl. "Deductibles are becoming higher. For instance, ENT physicians may see a lower case volume because co-payments have grown from $25 to $75."

4. Patient and staff revenues. Ms. Hollowood receives critical management reports every month detailing revenue factors. "On the revenue side, review at gross patient revenue — were there refunds? — and then I review net patient revenue and then net patient revenue per patient," she says.

The revenue reports also depict efficiency based on staffing. Ms. Hollowood looks at paid time off hours each month, total hours worked by all staff and how many full time employees worked per month. "With this report, I can look at the hours staff spends per patient and the payroll expense," she says. "I look at the payroll per case and then I look at the total payroll as a percentage of net revenue."

5. Accounts receivable. Each month, Ms. Hollowood is able to see data on the center's accounts receivable and A/R days outstanding. These reports also include the total operating income, operating income per patient and operating margin as a percentage of net revenue.

"I look at all of these numbers every moth to give me a snap shot of activity," she says. If there are still outstanding claims or denied claims the center needs to resubmit, Ms. Hollowood knows the issue and can make sure it's dealt with. She compares her center's revenue cycle management statistics with others in several categories, including:

- Number of claims denied
- Number of claims filed
- Collection goal met
- Dictation delays greater than 48 hours
- Medical records reviewed

"We use these accounts receivable benchmarks to figure out whether there are claims we haven't collected on or accounts we must resubmit for paper or electronic claims," says Ms. Lampron. "Identify the accounts to need to re-examine for reimbursement. If you are getting a lot of denials, figure out what you need to do to lower that number."

For example, if your claims are often denied for incomplete patient information, implement a strategy with your front office staff so they get all the information upfront for submitting to payors. Other problems may occur if the claims aren't sent out quickly enough.

"We look at how quickly we are billing insurance payors, and if we aren't quick enough, we try to find out what is impeding that process," says Ms. Lampron. "Physicians might not have the dictated operative report needed for the coder. If there is a lag time between the operation and dictation, we work with the front office staff and medical records personnel to help facilitate the physicians getting their dictions in more quickly."

6. Case scheduling. Surgery centers can glean helpful information by monitoring the number of cases scheduled per month. Record the number of cases scheduled inappropriately — such as scheduling the wrong procedure or scheduling the procedure on the wrong day — and work toward minimizing mistakes. The statistics Ms. Lampron looks at include:

- Whether the cases are scheduled accurately
- Efficiency of case scheduling
- Whether cases are scheduled 24 hours to 48 hours before an operation
- Whether the staff has enough time to prepare for the case
- Procedure start times
- Amount of time taken for each case
- Cancellations

"To stay efficient, we need to know whether the cases are running on time or going over," says Ms. Lampron. "If a is surgeon often over time we want to know whether they are taking a break or whether their cases are just running 45 minutes longer on a regular basis."

7. Cancellations. Cancellations on the day of surgery can have a big impact on your surgery center. By the morning of surgery, staff members are already scheduled and the OR is already reserved, so when cancellations occur those resources are lost. Ms. Lampron looks at information every month on the cancellation rate for patients after are admitted as well as the reasons behind those cancellations.

"The cancellation is usually based on the patient's health status, meaning there was an issue that wasn't known ahead of time, such as a blood pressure increase on the morning of surgery," says Ms. Lampron. "However, there are some things that could have been caught during a pre-surgical phone call — such as the medications patients didn't stop taking before surgery — and we need to catch those to decrease cancellations."

8. Staffing needs and payroll. Every month Ms. Lampron examines the daily, weekly and monthly statistics about how many full time employees are on payroll and how many hours staff members reported working per case. She also looks at how many cases per work FTE are being done.

"We are continually looking to meet our staffing goals," Ms. Lampron says. "Salaries are one of the highest costs for surgery centers and we want to make sure we are being efficient based on case volume." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

50 Benchmarks on Surgery Center Case Volume

By Rachel Fields

Here are 50 benchmarking statistics on surgery center case volume, according to data from VMG Health's *Multi-Specialty ASC Intellimarker 2010*.

Total Annual Cases Per Center

All surveyed ASCs

Average cases per year: 4,698

Based on center location

West: 4,471
Southwest: 3,552
Midwest: 3,681
Southeast: 4,330
Northeast: 4,384

Based on ASC net revenue

Less than $4.5 million: 2,800
$4.5 million - $6.99 million: 4,217
More than $6.99 million: 5,592

Based on number of operating rooms

1-2 ORs: 2,319
3-4 ORs: 3,540
More than 4 ORs: 5,598

Case Volume Mix as Percentage of Total Cases

The following statistics demonstrate how common ASC specialties comprise total case volume in all surveyed surgery centers.

ENT: 8 percent of total case volume
GI/Endoscopy: 24 percent
General Surgery: 8 percent
OB/GYN: 3 percent
Ophthalmology: 19 percent
Oral Surgery: 1 percent
Orthopedics: 17 percent
Pain Management: 14 percent
Plastics: 5 percent
Podiatry: 3 percent
Urology: 3 percent
Other: 1 percent

Surgical Cases Per Operating Room

All surveyed ASCs

Average cases per year: 705

Based on center location

West: 543
Southwest: 596
Midwest: 676
Southeast: 676
Northeast: 846

Based on ASC net revenue

Less than $4.5 million: 569
$4.5 million - $6.99 million: 597
More than $6.99 million: 761

Based on number of operating rooms

1-2 ORs: 613
3-4 ORs: 694
More than 4 ORs: 644

% of Cases Performed By Top 5 Physicians

All surveyed ASCs

Percentage of cases performed by top 5 physicians: 53 percent

Based on center location

West: 47 percent
Southwest: 51 percent
Midwest: 52 percent
Southeast: 54 percent
Northeast: 44 percent

Based on ASC net revenue

Less than $4.5 million: 63 percent
$4.5 million - $6.99 million: 53 percent
More than $6.99 million: 44 percent

Based on number of operating rooms

1-2 ORs: 72 percent
3-4 ORs: 53 percent
More than 4 ORs: 43 percent ■

Contact Rachel Fields at rfields@beckershealthcare.com.

Learn more about VMG Health at h www.vmghealth.com.

---

15 Statistics on ASC Administrator Compensation

Here are 15 statistics on ASC administrator annual salary, based on data from VMG Health's *Multi-Specialty ASC Intellimarker 2011*.

Mean salary: $109,184

Based on location

West: $114,109

Southwest: $100,779

Midwest: $104,372

Southeast: $110,311

Northeast: $109,268

Based on facility size

1-2 ORs: $95,750

3-4 ORs: $106,271

More than 4 ORs: $109,286

Based on net revenue

Less than $4.5 million: $100,942

$4.5 - $6.99 million - $105,040

More than $6.99 million: $113,100

Based on case volume

Less than 3,000 cases: $101,850

3,000 – 5,999 cases: $104,998

More than 5,999 cases: $109,448 ■

Learn more about VMG Health at www.vmghealth.com.

Contact Rachel Fields at rfields@beckershealthcare.com.

Start to Finish in 3 Months: 8 Reasons Why Prairie SurgiCare Could Make It Happen

By Laura Miller

Richard Kube, MD, an orthopedic spine surgeon, formed Prairie Spine & Pain Institute in Peoria, Ill., three years ago with the goal of becoming a comprehensive integrated care spine center. This month, he got one step closer to his goal by opening an ambulatory surgical treatment facility, fully accredited by the Accreditation Association for Ambulatory Health Care. Prairie SurgiCare was designed for exclusively spine and back pain patients, and with a strict timeline Dr. Kube and his team were able to open the center only three months after beginning the project.

"Demolition on our building started on Jan. 4 and we had the certificate of occupancy by Feb. 15," says Dr. Kube. "We began doing small cases by the beginning of March. The AAAHC survey was at the end of March and we received approval on April 3. That's a short timeline." Also of note, is that the AAAHC accreditation surveyor found zero defects and praised the facility as one of the best he had ever seen.

As the facility received accreditation without any deficiencies, Dr. Kube commenced performing minimally invasive lumbar fusion procedures on-site in early April 2012. His current schedule includes patients for cervical disc replacements, fusion procedures and pain management treatments. "I could convert about 80 percent of my practice outpatient using minimally invasive techniques," says Dr. Kube. "I don't do major reconstruction of the spine in outpatient facilities, but there are other types of procedures where patients can go home the same day."

There were several factors allowing Dr. Kube and his team to open the center on such a short timeline and experience success despite the recession. Here, Dr. Kube and Chief Operating Officer of Prairie SurgiCare Scott R. Anderson discuss the key elements of their success.

1. The goal was clear. Dr. Kube's goal was to have the surgical facility up and running by the beginning of April, and everyone understood their roles in making it happen. In the long term, Dr. Kube's goal was to create a comprehensive integrated care spine center, which means significantly expanding the services his group currently provides. He also wanted to increase the number of physicians working out of the center and expand to satellite offices throughout Illinois.

"Being able to bring on more spine and pain specialists will add a ton to the practice," says Dr. Kube. "We are also opening up satellite sites and depending on how well that works we'll be duplicating our services in each of the new satellite office locations. The patient volume is there and the satellites are spread out far enough that it makes sense to move forward."

In addition to spine surgeons, Dr. Kube would like to bring on interventional pain physicians, occupational therapists, physical therapists and social workers for patients who deal with chronic pain.

2. Decisions were made quickly and efficiently. At some facilities, it takes an entire committee to make decisions, especially when it comes to spending money. These committees take time and energy away from the practice, making the group less nimble. However, when surgery centers have fewer people who are all empowered to make decisions, the process goes much more smoothly.

"A committee of one doesn't hurt when you need a decision made," says Mr. Anderson. "The decision can be made in one minute flat. Dr. Kube provided our entire team with the latitude to make decisions about the project. That was a big part of the equation; he knew what he wanted and we were able to implement it fast."

For example, there is often a lot of discussion around which implants surgeons use and whether surgeons can purchase a more expensive device for certain cases. For Dr. Kube, this decision is easy.

"When it comes to whether we can use products that will cost us $15,000 to $20,000, most places have a committee to figure that out, but we figured it out on the same day," says Dr. Kube. "There was another issue about which air flow system to use to make sure air being pumped into the operating room was clean and sterile. We have a rule of thumb that we will always error on the side of patient care. Even if a better system costs extra money, we can usually recoup that in the 12 month cycle."

Everyone on the team was able to make the appropriate decisions quickly so the project could move forward on the compressed timeline. "There are little challenges but our goals are to solve the challenge in real time and move forward," says Dr. Kube. "Otherwise, the challenges will back up and become more daunting so we wouldn't be able to adjust them to our goals."

3. Leadership was experienced. Before joining Prairie Spine & Pain Institute, Mr. Anderson had experience opening multiple medical facilities, including pain management facilities, and was able to draw upon that expertise throughout the process. "We had an experienced COO and his perspective was very beneficial," says Dr. Kube. "It's crucial to have someone with experience and the ability to guide a variety of people and skill sets."

Mr. Anderson had experience with the accreditation process in the past and was able to equip Prairie SurgiCare with the appropriate policies and procedures to ensure the survey went on without a hitch.

4. They weren't afraid to hire consultants. There are several aspects of healthcare business that benefit from the knowledge of experts, which in some cases means hiring consultants. Dr. Kube hired a consultant to produce policies and procedures for the center that would give his center a professional edge.

"The policies and procedures are very important pieces of the process," he says. "We used existing polices and procedures to start the project and received example policies and procedures from consulting firms as well. I hired a consultant to make sure everything was professional." We used Bell Design Technologies (Dr. Edith Bell) as well, as they specialize in rapid deployment of a wide variety of business performance and process improvements.

The center also had a consultant on equipment and supplies. "Our consultant for materials acquisition made sure everything was available and in place when we were ready to go," says Mr. Anderson. "We brought everyone in and shared our plan. We let them know the value of time and set key milestones to make it happen. If they couldn't hit those milestones, we used someone else."

5. The community was supportive. Many of the vendors and contractors working on the Prairie SurgiCare project were local, and the city of Peoria really supported Dr. Kube's vision. "We were very fortunate to have a local government that worked closely with us," says Mr. Anderson. "The city of Peoria is very pro-business."

Local companies were able to provide all of the mechanical work, electrical installation, plumbing, oxygen systems and building design. The team's architect and general contractor worked with the "Physical Environment Checklist" that was provided by the AAAHC to make sure the facility included all the right components for accreditation and overall patient safety.

6. Incentives were provided for construction to stay on time. One of the biggest hurdles for any company trying to open a

new facility occurs when the construction company runs behind. Appropriate incentives can make sure the construction company and workers are on the same timeline as the ASC.

"The key was putting a Gantt Chart in front of them telling them what we wanted to do and asking whether they wanted to be a part of it," says Mr. Anderson. "We gave them a contract with significant deducts if the construction wasn't finished on time. There was a 15 percent profit if the project was done on time; that was cut to 10 percent if the project was finished one week late and 5 percent if they were two weeks late. If they were three weeks late, they were to be paid equal to their costs. You can't always do that, but sometimes it works." The good news for the contractors is they were paid according to their full rate, as they got everything done according to schedule. Incentives can be a powerful tool to get a project done on time.

A construction supervisor was hired that worked for Prairie SurgiCare to rapidly implement all of our requirements. Dr. Kube was willing to invest more upfront to have the project done quicker because the return from having the center open and doing cases would recoup the cost. "If the building takes an extra two or three weeks to complete, that's a loss of revenue," he says. "The extra we spent to make sure it was done on time was easily off-set by having the center open."

7. Employees were valued throughout the process. Having a strong support staff is crucial for success with any new surgical facility. "We hired a phenomenal Director of Nursing (Ms. Nicole Dentino, RN) who worked on credentialing and certifications, to make sure all the pieces of the puzzle were together," says Dr. Kube. "Every single person has to feel valued in the equation if you are going to do this."

Staff members quickly committed themselves to the project and were able to overcome any obstacles set in their path. The standing joke was that no one would ever work more than seven days a week, no matter what….

"To be successful you have to put in the effort and perseverance to do the job," says Dr. Kube. "Being on a team that really kept their eye on the ball for the entire 12-week process was crucial — the genie in the bottle. You need a lot of people who are interested in staying positive; we didn't have any negative energy."

It's also important to maintain that level of quality. Throughout the process of opening the center and achieving accreditation, staff members met daily so everyone was on the same page. "There were lots of checklists and coordination during those daily meetings," says Mr. Anderson. "We wanted to make sure we reviewed every issue at the beginning of the day and then reviewed it the next day to make sure it was fixed."

8. They were willing to invest in new staff members. Hiring new staff members can be a challenging process and you also want your staff members to stick around because employee turnover drains resources from the center. To find quality personnel, surgery centers must look beyond the resume and invest in their new employees.

"We have never placed anyone in our center based on their resume alone," says Dr. Kube. "We also consider their personality, work ethic and culture. We aggressively interview people and see if they flinch; when they flinch, we know they won't fit into our group."

Even though the most qualified people command higher salaries, paying for good staff members who will stick around is often less expensive than paying for mediocre staff members who may be gone within a few years.

"There is a tendency for a lot of folks to try to squeeze the overhead down by a few percent by paying employees less," says Dr. Kube. "At the end of the day, having a quality staff that is paid well eliminates turnover and promotes employee satisfaction. Positive energy is worth several percentage points in overhead." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

stryker®

Experience the full breadth of our **single source minimally invasive solutions.**

RADIOFREQUENCY • BIOACTIVE & PMMA CEMENTS[1] • VCF TREATMENTS • DISC THERAPIES

MultiGen™
Radiofrequency Generator

Cortoss® Bone
Augmentation Material

iVAS™ Vertebral
Augmentation System

With a comprehensive portfolio of minimally invasive products, Stryker is the only vendor to offer a best in class radiofrequency generator, a robust toolkit of customized treatment options for vertebral compression fractures and solutions for treating symptomatic discs.

Our unprecedented solutions let you customize your treatment approach to help contain costs and avoid wastes.

To learn more about your single source for minimally invasive solutions, visit **StrykerIVS.com**

[1] The bioactive response of Cortoss has not been assessed in any clinical investigation and the results from laboratory or animal testing may not be predictive of human clinical experience.

1000-001-196 Rev None

7 Reasons for Claim Denials in Surgery Centers — and How to Fix the Problem

By Rachel Fields

Denied claims slow reimbursements endanger profitability and are a window into the integrity of the processes and workflow of surgery centers. Here, Bill Gilbert and Brice Voithofer of AdvantEdge Healthcare Solutions discuss seven reasons for claim denials in surgery centers, as well as proven strategies to address and hopefully reduce the frequency of problems caused by denied claims.

1. Missing information on the claim. Mr. Gilbert and Mr. Voithofer say missing information on the claim is one of the biggest reasons for denied claims, according to published reports by the health insurance industry. For the most part, these denials are completely avoidable. Payors that receive claims with incomplete information will generally reject them automatically, they say, which is why surgery center staff must be trained to catch omissions. The sophisticated claims adjudication systems deployed by payors are much more advanced than they were five years ago, and in many cases, the software deployed by centers has not caught up.

"Studies show that if you had that information on the claim upfront, the vast majority of those claims would not be denied," Mr. Voithofer says. Missing information could include the group tax ID number and the group address and constitutes the most common cause of "administrative denials," they say. Administrative denials, for the most part, are self-inflicted issues which should be avoided.

2. Inaccurate information on the patient. Mr. Voithofer says claims are commonly denied due to inaccurate patient information, such as subscriber ID number, date of birth or date of injury. He recommends a staff member call the patient ahead of time and confirm all personal information. He says this can help avoid errors that occur when a patient unexpectedly switches their insurance plan. "I scheduled a surgery six months down the road once, and when it went over into the new year, I had a new insurance plan," he says. "They never thought of calling me to ask if I had new insurance." In this case, an ounce of prevention is worth a pound of cure. A simple call that takes up three minutes of staff time can help avoid costly denial management on the back end.

He says this phone call is also a good time to talk to patients about their financial responsibility. Many patients do not understand how their insurance works, and they may need to be reminded that they owe a co-pay or deductible. "The more you make the patient aware of their financial obligations on the front end, the easier it'll be to collect on the back end," he says.

3. Untrained front desk staff. Mr. Gilbert and Mr. Voithofer say they frequently see centers where front desk and phone staff don't understand the importance of collecting accurate patient information. "They may not have an appreciation for how important it really is," Mr. Gilbert says. "At some level, everyone knows it has some importance downstream, but they're never involved in the billing process or in the work of resolving a preventable denial."

He says the surgery center administrator should educate the front desk personnel about the life cycle of a claim, perhaps giving them a chance to shadow the back office. Once they understand how their actions affect the day-to-day work of the back office manager, they may be more conscientious about tracking down patient information. He says in some cases, the front desk manager may not even know he or she has to collect this information. If your surgery center staffs different desk staff on different days of the week, he recommends looking at denial rates by day to determine where the problem areas lie.

4. Inexperienced coding staff. Your surgery center should be using a certified coder to code your claims, Mr. Voithofer says. "Inexperienced coders often default to codes they use a lot without digging down to find the right code," he says. "This can not only be a denial risk costing the center time and money, but also a compliance risk, which could cost the center substantial fines and licensure exposure." If a physician provides poor documentation, the coder may decide to "fill in the blanks" without consulting the physician, which can lead to problems if they guess incorrectly. Mr. Voithofer recommends hiring an experienced certified coder and performing audits on a semi-regular basis to determine whether procedures are being coded correctly. Filling in the blanks or assuming what the surgeons "intend" should never be part of your coders daily process. The record needs to stand on its own, and the coders action's should not be additive to the medical record.

5. Poor physician documentation. Coders will find it difficult to code a procedure if the physician provides inaccurate or sloppy documentation, Mr. Gilbert says. While you shouldn't accuse your physicians of providing poor documentation, you should sit down with them and go over 10 recent case studies to point out any problems. "Education with doctors should focus on 10 real cases they've done and where they're deficient," he says. "You might say, 'We had to downcode this because you missed a level, or we couldn't code the procedure at all because this information was missing.'"

He says his company keeps a document that they share with each physician group on a regular basis. The document tracks incomplete claims by patient, by location and by surgeon and lists the documentation needed to file the claim. Over time, this document helps to keep track of which physicians need additional education. Physicians generally want to do the right thing when it comes to documentation and are receptive to information that helps them document more accurately, increases revenue and decreases costs.

6. Problem with the payor's system. If your surgery center is receiving a lot of denials from the same payor and you can't identify the cause, there may be a problem with the payor's system. "If we have enough data to support a trend, we speak with the payor to say, 'Hey, there's something wrong with your system,'" Mr. Voithofer says. "Their system is the same as any other, where the edits are electronic and humans touch fewer than 5 percent of claims. We need to isolate the error, because they're not going to spend the time and effort to correct an error they are not aware of." For example, he says the payor may have an incorrect ICD-9 CPT code crosswalk or may be using the wrong error rates to kick claims to medical review.

7. Missing documentation attached to the claim. Payors may require additional documentation, such as the operative note or implant invoice, attached to the claim. Mr. Gilbert and Mr. Voithofer say this can be a stalling tactic by payors to avoid paying the claim.

To avoid receiving continual requests for additional documentation, they recommend sitting down with the payor and laying out which documents are needed to get the claim paid. "Otherwise the payor will request medical records for one claim, and then an op note for another, and then something else for another," Mr. Voithofer says. "It's essential to sit down with them and say, 'What do you really need to process this claim in a timely manner?" ■

Contact Rachel Fields at rfields@beckershealthcare.com.

5 Concepts on Renting Surgery Center Space for Additional Revenue

By Laura Miller

Editor's Note: Surgery center leaders considering this tactic should consult with their state department of health and legal counsel before taking further action.

Linda Peterson, MBA, CEO of Executive Solutions, discusses the finer points about renting surgery center space to outside groups.

1. Benefits of renting the space

Renting space out to various groups can be a significant revenue generator if the agreement is drawn in the right way. "I've seen rent at $20,000 per month for a little pain group to use the surgery center," says Ms. Peterson. "The extra revenue could help with overhead, which the center must pay regardless of their financial situation."

In addition to the financial benefits, renting the space brings additional patient flow through the center. Even if the renters are bringing in different types of patients, the general public will become more aware of your facility and seek it out next time they need surgical care.

When it's appropriate to rent out the center Surgery centers operate within a defined time frame every day; however, later in the evening or on days when the center isn't open, the facility can be rented out to other physicians or groups for various activities.

"You can't rent out a room to someone else while you are still operating as your surgery center," says Ms. Peterson. "You might not have patients one or two days per week, or if you consolidate cases to a few days per week, you can rent the surgery center out to another entity on the days you have off."

That other entity could include:

- A physician group in the process of constructing their own surgery center and they want to begin bringing cases into the outpatient setting
- An office-based physician group — such as pain management physicians — who want to perform a few cases per week in the surgery center
- A group that wants to use the center as an infusion clinic
- A group that wants to use the lobby for classes or other community events

"It works best if you have a multispecialty ASC and the group that wants to rent performs the same types of procedures so they would use similar equipment and workflow," says Ms. Peterson. "If you do orthopedics and they do orthopedics, the agreement could work out very well because everything is already set up and it doesn't require investment in more expensive technology or a change in workflow."

While renting the center to a non-medical community group to use the space isn't very lucrative, it still may generate some extra revenue and spread awareness of your center.

2. Coordinating the transition between groups

The surgery center owners and renters must have separate licensure and accreditation, says Ms. Peterson. They must also have a separating billing process and medical records. If the renting group doesn't already have a staff prepared, you can draw up a separate contract to "rent" your staff to them.

"If you have really experienced staff and they aren't able to provide their own, you can lease your staff to them," says Ms. Peterson. "A lot of times they want to use their own staff. Otherwise, they have to contract for paying the staff members in addition to their lease agreement."

The renting group must also have separate medical records. In some cases, their electronic medical record system is different from the one at your center and they may need to connect on line somehow, or bring their own servers. Conversely a new company would need to be created in your system for your software, so that everything is separate. There is a cost to add this new company typically from the software provider. Other times, especially among small groups, the physicians will continue using paper charts.

3. Drawing up the contract

Work with professionals when drawing up the contract for your renters. Some will want to rent by the square foot, but that doesn't make sense from the owner's perspective because more than just the space is used; renters will be using the phone system, copy machines and hot water, among other things, already at the surgery center.

"You have to make sure you look at every possible thing within the contract," says Ms. Peterson. "It can be labor intensive to coordinate, but it's worthwhile from an income standpoint. I highly recommend the use of a comprehensive matrix of who is responsible for what and a very clear grievance process for issues that can and will arise when you 'cohabitate.'"

The contract should also address breakage or loss of instruments and equipment while the center is under the renter's care. Additional points to consider include:

- Whether the renting group will bring their own instruments or use instrumentation in the center
- Whether the renting group will provide their own implants
- Terms of the contract
- Length of time they will be renting'
- Language to ensure the providers continue to comply with HIPAA
- The ability to quickly terminate the agreement under certain circumstances

Both the owners and renters should have the ability to terminate the agreement, but build in a penalty charge if the renting group decides to depart from the contract early . Before signing the contract, make sure it won't violate any federal or state regulations.

4. Renter red flags

While you might be in the ideal situation to rent out your surgery center's space, not every group will make a good tenant. Research the renting group to make sure they have a good reputation within the community and will use your facility appropriately.

"Even though they are using your surgery center under a different name on the days they are there, if they don't have a good reputation people will associate them with you," says Ms. Peterson. "If you rent to the wrong group, your quality and brand in the community can be compromised. You must make sure you are vetting potential tenants very well."

In other cases, the renters might have a good reputation within the community but may not be respectful of your space. The renters shouldn't leave a mess for your staff to clean the next morning and you don't want them removing items from the center. "There are challenges because now you are sharing your space with someone else and there will be wear and tear on the facility," says Ms. Peterson.

It's often beneficial to stage a "trial period" where the renters use the space on a very limited basis before signing the full-blown contract.

5. When renting isn't a good idea

It may be unwise to rent space in the surgery center out in some situations, even if the ASC could use the extra revenue. Owners should not rent the surgery center out to their competitors or groups that already have a shady reputation.

"If you are doing okay and your physicians are happy, don't rock the boat by taking on renters," says Ms. Peterson. Also consider whether your surgeons may want to revise their surgical practices in the future. If the center is currently closed on Fridays and you rent it out, your surgeons couldn't revise their schedule to perform cases on Fridays in the future and may decide to leave the ASC as a result.

Make sure the final contract reflects your goals as the owner first and foremost. "If you want to grow and you just need to cover the space for a short time, make a short term agreement with the renters," says Ms. Peterson. "Additionally, anything that is a compromise to your license is not a good idea." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

6 Ways to Increase Physician Satisfaction at Your Surgery Center

By Rachel Fields

Physician satisfaction is crucial to building a good reputation in the community, recruiting new providers and providing efficient, high-quality care, says David Milton, administrator of Phoenix (Ariz.) Surgicenter, the first surgery center in the United States. Here he discusses six ways to keep your surgeons happy and productive.

1. Prioritize surgical equipment/instruments over marketing. Mr. Milton says the majority of your "marketing" budget should go towards providing physicians with the things they need rather than posting billboards in the community. "I used dollars from marketing to buy surgical instruments when faced with adding pediatric surgeons and being unprepared with instruments," he says. "If you think about it, a surgeon would rather have the instruments he needs than go out for a meal." He says if you meet your physicians' requests for new surgical instruments, word will get around that your surgery center treats its physicians well. This is more likely to attract new physicians to the center than an ad in the local newspaper, he says. Physicians may only work at one surgery center, but many see each other in the same hospital, and they do talk, he says.

Of course, buying surgical equipment, instruments and supplies can become very expensive very quickly, and many surgery centers operate on a tight budget. Mr. Milton says many physicians are cornered by vendors at conferences or in the office and convinced to try a new product or device. "I have worked very closely with the physicians at Surgicenter about not committing us to something without speaking with me first," he says. "They trust me and the OR manager to make good decisions."

2. Find workarounds when requested equipment is very expensive. Sometimes a physician will request a new piece of equipment the surgery can't afford, or a new physician will want to bring cases the center isn't equipped for, Mr. Milton says. When these scenarios arise, he recommends looking for a cheaper workaround. For example, when a potential new ophthalmologist met with Mr. Milton, he stated what he was looking for and outlined his usual case load. The surgeon's request required the purchase of two microscopes and two phaco units.

"Our facility only has one room equipped for cataract surgery, and this surgeon was to work when another eye surgeon was there," Mr. Milton says. Instead of purchasing equipment that would have cost hundreds of thousands of dollars, Mr. Milton is working with a cataract outsourcing company for a per-case fee. They bring the equipment and charge by the case, which Mr. Milton feels is a smarter solution than investing in the capital equipment upfront.

3. Ask staff to thank physicians whenever they see them. Mr. Milton says small gestures can go a long way in a surgery center. "As we go forward, I'm instilling with my staff that there are two words we can say to our doctors that carry more weight than any checkbook: thank you," he says. "We have staff tell every doctor, 'Thank you for being here today, and thank you for bringing this case.'"

He says while some surgery centers view patients as their customers, the real customer should be the physician. Make sure physicians know that you understand they could take their business elsewhere and that you appreciate them choosing your facility. "With 65 percent of the physicians that bring cases here as non-partners, 'thank you' can go a long way," he says.

4. Be honest with new recruits. Mr. Milton doesn't do a lot of advertising for new physicians — in fact, he hasn't made a cold call in years. Instead, he pays very close attention to what is happening in the marketplace and talks to vendors and medical staff on physician opportunities at Surgicenter, which performed the first case ever in an ASC in 1970. In the past 24 months, 30 physicians have joined his facility.

When meeting with new physicians, he is sometimes asked about equipment or start times the surgery center simply can't provide. "I am always brutally honest when talking with physicians, especially when we can't meet their need," he says. What we do today is our reputation tomorrow. Always be truthful." He says it all boils down to honesty: If you give an honest response, a physician may say no today but yes in the future.

5. Invest in an experienced scheduler. Mr. Milton's scheduler has been with the surgery center since it opened. He says she is essential to physician satisfaction at the center; after all, if a physician can't easily schedule a case, he'll take it somewhere else. "If the doctor asks for a time that isn't available, the first thing she'll do is offer alternatives," he says. "If that's not doable, she'll get with me or the OR director and look at the schedule to see if we can move anyone's case. Our partners have been very amenable to accommodating non-partner cases."

He says if a physician can't be accommodated on the schedule, honesty is the best policy. He recommends telling the physician as soon as possible that they won't be able to accommodate the 7:30 a.m. start, for example, and bringing up the schedule to demonstrate why.

6. Provide free lunch. While amenities aren't everything, Mr. Milton says his surgery center makes sure to provide lunch to physicians who bring cases over the lunch hour. "It's such a small investment, but it pays off," he says. He says the center also has coffee machines in the break room so that physicians can refuel throughout the day. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

4 Steps to a Thriving GI Surgery Center

By Taryn Tawoda

As the administrator of a surgery center that performs more than 10,000 GI cases and an additional 2,000 other specialty cases per year, Tim Luckett, RN, CRNFA, has developed a set of key strategies for maintaining a smoothly-run ASC. Time management, supply cost containment, contract negotiations and patient feedback are among the crucial strategies he cites for running a profitable and sustainable operation at Advanced Diagnostic and Surgical Center in Alhambra, Calif.

1. Distribute reports of all supply and staff costs to increase awareness. Physicians and surgery staff members are more likely to be conscious of scheduling and supply use if presented with hard data that confirms how these costs affect center profitability, Mr. Luckett says.

"You can't know what you're making unless you know how much you're putting out," he says. "From the time the staff hits the door until the time they leave, I include the time spent in pre-op, what was used — IV, cap, shoe covers, gown, linen, any premedication — the amount of labor, the cost of sterilizing supplies, and how much each room per hour costs per day in an eight-hour day," he says. "I factor all of those things in and come out with a fairly accurate report — it's usually within 10 percent either way."

When Mr. Luckett compiles the reports — a process that typically take several weeks and involves collaboration with the accounting department — he then meets with the medical director and the president of the surgery center board to review all of the statistics, which are later presented at the board meeting.

"The takeaway message shows what cases you make the most money on and the importance of volume," Mr. Luckett says. "It gives them a sense of, 'Yes I know what's going on here, I understand the impact of showing up at 10:30 when I'm requested at 9. I understand that labor costs are fixed, and that [late arrivals] back people up through the whole system.'"

2. Coordinate with other ASCs to contract with biomedical suppliers. Mr. Luckett is currently engaged in an effort to lower the center's biomedical supply and repair costs, which are among the highest costs the center incurs over time. These supply contracts affect many areas of the ASC, he says, including X-ray machines, lasers, anesthesia machines, OR tables, recovery room beds and monitoring equipment.

Biomedical suppliers may charge the center $120 per hour for work, for example, but that cost can be lowered to approximately $50 if a larger group of centers approaches the same supplier seeking contracts. Having had discussions with biomedical suppliers about the discount possibilities, Mr. Luckett aims to form a consortium of ten area ASCs before approaching a supplier for discounted rates.

3. Create a centralized supply room. After joining the center as administrator, Mr. Luckett began to consolidate all of the center's supply rooms into one central location: a 400-square-foot room that formerly held the center's medical records. The room now contains wire racks that hold all of the center's supplies, which simplifies the inventory process and allows Mr. Luckett to ensure that the center is not over- or under-stocked.

"It's very easy to get in and out of racks, and everything is out in the open," he says. "It's easy to keep track of everything that goes in and out of the room."

All operating supplies first enter the centralized stock room to be inventoried before they are brought to the ORs, Mr. Luckett adds. Center staff members come to the stock room every day prior to performing any procedures, and they keep a log of which supplies are taken to the OR. Mr. Luckett says the center is also beginning to implement a scanning system so that staff members can simply scan each item's bar code prior to removing it from the room.

4. Distribute patient surveys. Surgery centers can maximize patient satisfaction by asking for feedback following their procedures at the center. Mr. Luckett says that his center distributes an optional survey to every patient that is printed in both English and Chinese due to the high Asian population in the community.

The survey contains several questions that allow patients to express any concerns they had during their visit to the center: Was there anything you were not prepared for? Could we have done anything different to make your procedure or post-op experience more pleasant? If you could change anything about the treatment, what would it be?

"We get hundreds of surveys back every month, and our satisfaction rate runs 97.5 percent," Mr. Luckett says. ■

Contact Taryn Tawoda at ttawoda@beckershealthcare.com.

How Much Should You Pay ASC Staff? 35 New Statistics on ASC Staff Compensation

By Rachel Fields

Here are 35 new statistics on surgery center staff compensation, based on data from VMG Health's *Multi-Specialty ASC Intellimarker 2011*.

All ASCs

Nurse staff: $32.12

Tech staff: $20.92

Administrative staff: $23.09

Total hourly: $27.03

Administrator salary: $109,184

Based on location

West

Nurse staff: $36.61

Tech staff: $23.04

Administrative staff: $23.98

Total hourly: $29.25

Administrator salary: $114,109

Southwest

Nurse staff: $31.58

Tech staff: $20.64

Administrative staff: $21.36

Total hourly: $26.34

Administrator salary: $100,779

Midwest

Nurse staff: $29.79

Tech staff: $19.43

Administrative staff: $22.38

Total hourly: $25.83

Administrator salary: $104,372

Southeast

Nurse staff: $30.28

Tech staff: $18.95

Administrative staff: $22.78

Total hourly: $26.12

Administrator salary: $110,311

Northeast

Nurse staff: $32.58

Tech staff: $20.26

Administrative staff: $24.49

Total hourly: $27.48

Administrator salary: $109,268 ■

Learn more about VMG Health publications at the VMG Health website.

Contact Rachel Fields at rfields@beckershealthcare.com.

- ACUTE CARE HOSPITALS
- SPECIALTY HOSPITALS
- SURGERY CENTERS
- REHAB HOSPITALS
- LTAC HOSPITALS
- DIAGNOSTIC IMAGING CENTERS
- DIALYSIS CENTERS
- CANCER & RADIATION THERAPY CENTERS
- PROVIDER ORGANIZATIONS

PROVIDING INSIGHT
CREATING VALUE

EXPERTS IN FAIR MARKET VALUE. FOCUSED IN HEALTHCARE. TRUSTED BY CLIENTS.

Valuations For:

- **Physician/Hospital Transactions**
- **Acquisitions & Divestitures**
- **Professional Service Agreements**
- **Real Estate Transactions**
- **Purchase Price Allocations**

Evolving obstacles in healthcare have caused fair market valuations to become a critical step in meeting regulatory requirements. Leading companies, health systems, attorneys and investors rely on VMG Health as the most trusted valuation and transaction advisory source in healthcare.

Contact VMG today to learn how we can help you with all of your valuation needs.

www.vmghealth.com
Dallas 214.369.4888
Nashville 615.777.7300

VMG HEALTH
WE VALUE HEALTHCARE