30 ASCs Performing More Than 10,000 Cases a Year p. 28

INSIDE

INDEX

BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

May/June 2012 • Vol. 2012 No. 4

5 Ways Physician Employment Affects Surgery Center Valuation

By Rachel Fields

Hospitals are increasingly employing physicians to gain market share and integrate providers into hospital operations, creating a problem for surgery centers that depend on surgical case volume from independent practitioners. Jason Ruchaber, CFA, ASA, partner at HealthCare Appraisers, discusses six ways physician employment by hospitals affects pricing for ASCs.

1. Physician employment creates downward pressure on pricing multiples for surgery centers. While predicting the impact of physician employment on ASC values is not an exact science,

continued on page 8

100 Great Places to Work in Healthcare

Becker's Hospital Review and *Becker's ASC Review* have announced its annual list of "100 Great Places to Work in Healthcare." The 2012 list was developed through nominations and extensive research, and the following organizations were chosen for their demonstrated excellence in providing robust benefits, wellness initiatives, professional development opportunities and atmospheres of employee unity and satisfaction.

Advocate Health Care (Oak Brook, Ill.)

Type of Facility: Hospital/health system

continued on page 9

6 Situations Where Out-of-Network Reimbursement Still Works

By Rachel Fields

Out-of-network reimbursement used to be a profitable strategy for surgery centers, but times have changed. Pressure from payors, high-deductible insurance plans and the elimination of out-of-network benefits has made it increasingly difficult to survive on out-of-network. Eric Woollen, vice president of managed care for Practice Partners in Healthcare, discusses six situations where the strategy still works.

1. Signing a contract with an insurer would make cases unprofitable. Because of the risk of out-of-network reimbursement these days, many surgery centers dependent on out-of-network choose not to contract with payors because the contracts offer prohibitively low reimbursement on cases. "Payors, networks and commercial insurance companies can often dictate the market and produce contract rates that are fiscally unreasonable," Mr.

continued on page 26

ASP®

25 YEAR Anniversary

HELPING YOU RAISE THE STANDARD OF CARE

For the last 25 years, ASP has been providing the education, training and solutions you need to prevent healthcare-associated infections (HAIs) and create safe healthcare environments.

The latest innovations in STERRAD® Technology help you meet your facility's need to run efficiently and safely achieve terminal sterilization for your patients.

The STERRAD® Sterility Guide (SSG) is an easy-to-use interactive tool which lists devices that fall within cleared claims for sterility.

Scan the QR code to download the SSG mobile app.

For more information, please contact your ASP representative, call 1-888-783-7723 or visit www.aspjj.com.

Follow us on Twitter.com/ASPJJ

Like us on Facebook.com/ASPJJ

ADVANCED STERILIZATION PRODUCTS

Division of Ethicon, Inc.

a Johnson & Johnson company

AD-120080-01-US_A

Having patients shouldn't involve testing yours.

ScanChart

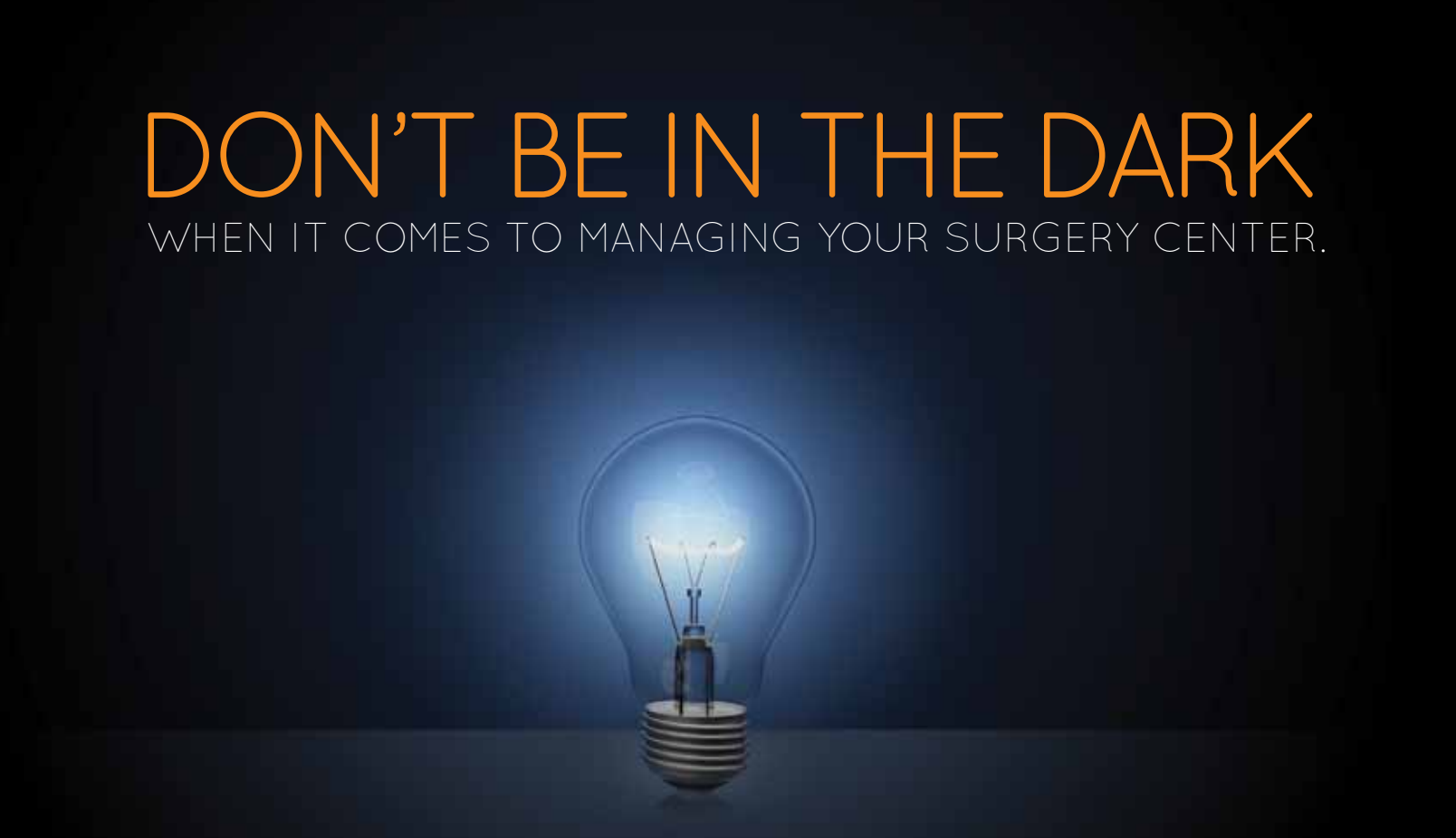
Simplify your practice. If your facility is like most ASCs, you spend hours every day preparing patient charts. ScanChart automates this process by printing your current facility forms with all patient information, based on the physician and procedure, and a barcode allows you to scan the patient chart back into the system post-operatively. The ScanChart solution integrates with your practice management system.

For a live demo call **(800)459-5616**
or email us at sales@surgicalnotes.com

SurgicalNotes

DON'T BE IN THE DARK

WHEN IT COMES TO MANAGING YOUR SURGERY CENTER.



Manage My ASC is a real-time interactive management tool that provides an unprecedented view into the financial and operational performance of your center with tracking, benchmarking, analysis and recommendations. *MMASC* consolidates data from all of your functional systems — billing, collections, accounting, finance, payroll and inventory — to create the only picture of how your center is performing.

***MMASC* enables you solve problems, recognize opportunities and get results.**

Coming Soon

MANAGEMYASC.COM

AccredAbility

ACCREDITATION COMPLIANCE SOLUTIONS

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.

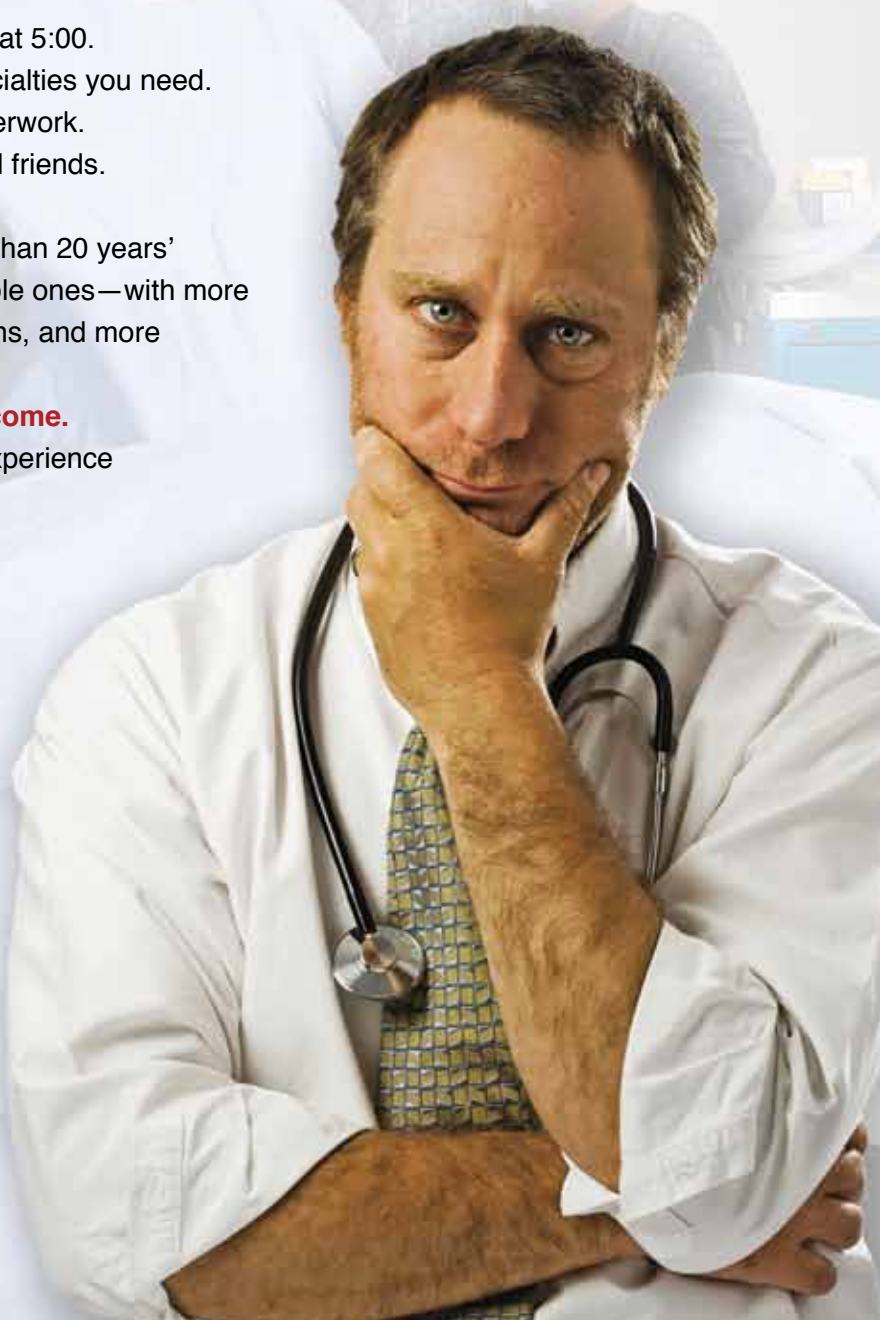
You can hear other surgeons describe their experience with us at www.ASCturnaround.com

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

May/June 2012 Vol. 2012 No. 4

FEATURES

Publisher's Letter

This issue of Becker's ASC Review focuses on some of the most pressing issues facing our industry, including:

- **The future of out-of-network reimbursement.** In several articles, we explore the future of out-of-network, as the once-profitable strategy becomes less feasible for surgery centers across the country. While payors are increasingly pressuring centers to move in-network, some markets can still support an out-of-network strategy, depending on local health plans, patient deductibles and the presence of "capped payments" for out-of-network reimbursement.

- **Physician employment.** The trend of hospitals employing physicians continues, though some experts predict a reversal in the coming years as both parties become disillusioned with compensation arrangements and bureaucratic hurdles. We explore how physician employment is affecting surgery center valuation and profitability as hospitals look to increase market share.

- **Increased focus on benchmarking.** Surgery centers can significantly improve profitability by setting financial and operational goals and measuring progress. Benchmarking is increasingly crucial as surgery centers prepare to be evaluated based on quality indicators starting in 2012.

We have also included in this issue the brochure for our 10th Annual Orthopedic, Spine and Pain Management Driven ASC Conference, held June 14th to 16th in Chicago. We have an incredible agenda focusing on the most important issues for surgery centers. Keynote speakers include legendary Coach Lou Holtz and Washington personalities Sam Donaldson and Tucker Carlson.

We hope things are going well. If we can be of assistance in any manner, please contact Scott Becker at sbecker@beckershealthcare.com.

Very truly yours,

Scott Becker

5 Ways Physician Employment Affects Surgery Center Valuation
(continued from page 1)

Mr. Ruchaber says the trend does create downward pressure on multiples. With hospital employment, freestanding surgery centers are more likely to struggle for business and case volume as their referral sources become hospital employees, he says. "The two key factors that go into a valuation multiple are anticipated growth and risk," he says. "Physician employment negatively affects both factors."

This means that when a company like HealthCare Appraisers assesses the value of a surgery center, they look at physician participation and overall case volume trends. If a hospital in the community is employing physicians and acquiring practices, the surgery center may be at risk to lose its participating surgeons or referring providers (e.g. primary care).

2. Hospitals are increasingly looking to fully acquire their joint venture ASCs. Mr. Ruchaber says while valuation multiples may be lower due to the employment of physicians, this may be partially offset by the increased demand by hospitals to buy the facility outright. "Hospitals are actively looking to acquire surgery centers outright, particularly those where they currently have an interest," he says. He says in the past, hospitals looked to partner with surgery centers to align with physicians and mitigate some of the financial loss associated with surgical case volume moving to the free-standing setting.

Though hospital/physician ASC joint venture models were and continue to be successful, as more physicians opt for hospital employment, Mr. Ruchaber says hospitals are increasingly incentivized to buy their joint venture centers outright and convert them to hospital outpatient departments. By purchasing the centers in full, the hospitals can increase their OR capacity to support employed physicians and often increase reimbursement by converting the surgery center to a HOPD.

3. Physicians cannot receive higher ASC pricing because of the potential for HOPD conversion. When determining fair market value for a surgery center, Mr. Ruchaber says the potential for conversion to a HOPD cannot be factored into the pricing. "When a hospital buys a surgery center outright, their intent may be to convert it into a HOPD to receive that immediate uptick in reimbursement," he says.

In this situations, physician owners generally want to see the uptick factored into the price they are paid for the surgery center. They believe if the hospital is going to make more money off the surgery center than they are currently making, they should receive compensation for that increase. Unfortunately, Mr. Ruchaber says, this is an economic benefit available only to a specific buyer (i.e., the hospital), and consideration of this uptick would be inconsistent with the requirements of fair market value.

4. Physician employment is becoming more flexible. In the past, employed physicians were generally required to divest their ownership interest in surgery centers as part of their hospital employment contract. But Mr. Ruchaber says as hospital employment becomes more common, hospital compensation and employment arrangements are also becoming more flexible. For example, if a physician is interested in employment but has ownership in a surgery center, the hospital may allow the investment to continue. "It's not the norm, but it's certainly an option on the table," he says. If a surgeon is not required to divest of his or her interest as a condition of employment, the downward pressure on multiples in that community may be lessened.

He says physicians are also increasingly compensated for their participation in co-management and other arrangements, meaning employed physicians could remain economically incentivized to participate in the in the clinical and operational success of hospital's outpatient surgery department.

5. Significant participation by non-owners can pose substantial risk. Physician employment may disproportionately affect centers with high non-owner case volumes, Mr. Ruchaber says. If the surgery center's case volume is heavily dependent on non-owners, the ASC's pricing may be depressed because of the risk that the physicians will cease to participate without notice. "Owners tend to have more stable surgical volumes because they're invested and have a financial stake in the business," says Mr. Ruchaber. "Non-owner physicians are easier targets for employment, and if there's no tie to that center, the case volume could disappear overnight."

****

Mr. Ruchaber says while physician employment is currently very active, the trend may unravel in the coming years as hospitals realize they can't afford hospital employment or physicians desire a return to independence. "I think there are already a number of deals where hospitals have received bad advice from consultants involving exceptionally robust compensation models," he says. "In some cases the hospital may have rushed to the table in a competitive acquisition, and they get the deal done and suddenly they're losing $2 million a year to physician employment." These deals are not likely to be renewed after the initial employment period.

He says in other cases, hospitals are discovering that their employed physicians do not enjoy the bureaucratic structure of the hospital or its control over their clinical decisions. "It's not just about having clinical expertise — some physicians are great clinicians, but they're not great employees," he says. He believes that as two- and three-year physician contracts come up for renewal, the industry may see a rethinking of hospital employment strategies.

Contact Rachel Fields at rachel@beckershealthcare.com.

Learn more about HealthCare Appraisers at www.healthcareappraisers.com.

100 Great Places to Work in Healthcare (continued from page 1)

What makes it a Great Place to Work: Advocate Health Care is one of Chicagoland's largest employers, with more than 32,000 associates, including 6,000 affiliated physicians and 9,000 nurses. Advocate's Healthe You program provides incentives for completing health activities such as participation in a walking club, taking online assessments or working with a health coach. Employees can also earn credits, if involved in the medical plan and dependent on the type of plan, which convert to a dollar amount, anywhere from $200 to $600, which can be used to pay for health services throughout the year.

Akron General Medical Center (Ohio)

Type of Facility: Hospital/health system

What makes it a Great Place to Work: Akron General serves more than 1.2 million people in five Ohio counties and has been named one of the 99 best places to work in Northeast Ohio by the Employers Resource Council, a recognition that honors employers that excel in compensation, benefits, training and education and other services. Employees can use on-site dry cleaning pick-up, as well as film developing and discounts on local family entertainment and area businesses. Akron employees come together every year for the annual employee picnic.

Arkansas Children's Hospital (Little Rock)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Arkansas Children's Hospital is a 316-bed non-profit hospital that treats patients from birth to age 21. As the only pediatric medical center in the state and one of the biggest in the country, ACH employs more than 4,400 people. ACH offers several professional development options, including training modules for leadership development and online educational programs. In addition, the hospital provides many personal development opportunities, including workshops on interpersonal styles, interaction skills, teamwork, computer training and personal finance.

AtlantiCare (Egg Harbor Township, N.J.)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Employees at AtlantiCare join a system of 5,000 staff members contributing to the health of Southeastern New Jersey. The system offers a wide array of complimentary development opportunities for staff, including hundreds of e-learning courses and several "tracks" designed to turn staff members into organization leaders. For example, the "Pathways to Leadership" track is designed for front-line staff with high potential for moving into a leadership role.

Atlantic Health System (Morristown, N.J.)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Atlantic Health System is a four-hospital system with more than 11,000 employees. As the primary academic and clinical affiliate in New Jersey of The Mount Sinai School of Medicine and The Mount Sinai Hospital, located in New York, the health system invests in employees' professional development. RNs and certain other health professionals have the opportunity to participate in the Professional Advancement Clinical Tracks program, which helps them advance within their current position.

The Access Effect.

You shouldn't operate without it.

Your **patients** will be better informed about every aspect of their procedure.

Your **physicians** will have exactly what they need to be their very best.

Your **payers** will have accurate, timely accounting of every procedure and expense.

Your **facilities** will coordinate physicians, implants and procedures with surgical precision.

And you'll have the most efficient processes available for every implantable procedure you do.

It's The Access Effect.

See how it can change the day you operate.
Contact us today for more information.

Toll free: **877.985.4850** | Online: **www.accessmediquip.com**

Access
MEDIQUIP

Aurora Sheboygan Memorial Medical Center (Milwaukee)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Aurora Sheboygan Memorial staffs 150 physicians and provides services more than in 25 specialties to serve Sheboygan County. Full- or part-time employees who have worked for Aurora for at least one year, and who qualify for a mortgage loan, are eligible for the Employee Homeownership Program, which provides a five-year, 0 percent interest forgivable loan of up to $3,000 for the purchase of any new or existing home, including single-family, duplex, multiple-use property or condominium.

Bailey Medical Center (Owasso, Okla.)

Type of Facility: Hospital/health system

What makes it a Great Place to Work: Bailey Medical Center is a 73-bed acute-care, 178-employee hospital that is owned by Ardent Health Services and physicians. In its most recent employee satisfaction survey, 94 percent of employees said they were "satisfied" or "very satisfied" with their employment, and 95 percent said they would recommend employment at the hospital. Bailey has installed a variety of activities to build employee engagement, including employee lunches, an employee activities committee and an "Above and Beyond" program that recognizes fellow employees.

Baptist Health South Florida (Coral Gables)

Type of Facility: Hospital/health system

What makes it a Great Place to Work: Baptist Health South Florida was created in 1990, bringing the region's top non-profit hospitals under one name for the first time. Baptist practices a "promote-from-within policy," meaning existing employees will always be considered for open positions if they possess the qualifications and experience appropriate for the job. Each year, Baptist Health's Scholars Program provides more than 200 nursing scholarships to qualified employees.

Barnabas Health (West Orange, N.J.)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Barnabas Health is the largest non-profit integrated healthcare delivery system in New Jersey. Employee tenure is a good indication of the strength of Barnabas' workplace: 55 percent of Barnabas employees have worked with the system for 10 years or more, 31 percent have 10-20 years of tenure and 24 percent have more than 20 years of service. The health system relies heavily on employee referrals as a hiring resource, hiring 25 percent of new employees directly from employee referrals and paying over $350,000 historically to employees for their referrals.

Barnes-Jewish Hospital (St. Louis)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Barnes-Jewish Hospital, a member of the BJC HealthCare system, is one of the largest employers in St. Louis. Employees can participate in merit pay programs and employee recognition for staff members who exhibit exemplary performance. For example, the Health Hall of Fame recognizes achievements in lifestyle that improve overall health and well-being, and the Excellence in Leadership Award honors one member of management for demonstration of exceptional leadership.

BayCare Clinic (Green Bay, Wis.)

Type of facility: Specialty clinic

What makes it a Great Place to Work: BayCare Clinic is the largest specialty healthcare clinic in Northeast Wisconsin and Michigan's Upper Peninsula. According to its leadership, BayCare is well on its way to meeting its stated goal of being "the most fit company in Brown County." Upon the inception of the clinic's Healthy Lifestyles Premium Discount Program, 21 percent of participants tested at an "excellent" level of body composition and fitness; one year later, the number jumped to 58 percent, with obesity dropping dramatically.

BayCare Health System (Tampa Bay, Fla.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Composed of 10 non-profit hospitals and 70 outpatient facilities, BayCare Health System is a leading community-based health system in the Tampa Bay area. The organization's benefits include wellness programs with incentives for improving employee health, discounts for non-smokers, college tuition programs, online education opportunities and financial assistance for employee hardship. Employees can foster relationships with each other through holiday celebrations, team-building activities, fundraisers, wellness events and family picnics.

Baylor Health Care System (Dallas/Fort Worth, Texas)
Type of Facility: Hospital/health system

What makes it a Best Place to Work: Twenty-six hospitals, 23 ambulatory surgery centers and 50 outpatient facilities are owned, operated, joint ventured or affiliated with Baylor Health Care System in Dallas. Among its more creative benefits, Baylor offers adoption assistance, an employee trust fund and discounted cell phone contracts. The system also owns a gym in downtown Dallas, where employees can go to exercise and work with trainers for free.

Beaumont Hospitals (Royal Oak, Mich.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Beaumont encourages and supports the career and educational advancement of its employees with a variety of programs. Its internal job bidding program helps employees transfer to different departments and apply for promotions within the organization, and educational assistance provides up to $1,200 a year for full-time employees. Beaumont stands behind its belief that "a healthy work place starts with healthy people." myOptimal Health Onsite provides health education, recreational programs and health resources to system employees, and a variety of fitness facilities are available at discounted rates.

Beebe Medical Center (Lewes, Del.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Founded in 1916 by two physician brothers, Beebe Medical Center is a 210-bed, non-profit seaside community hospital. Staff members are also given ongoing educational opportunities, including up to $3,500 a year in tuition reimbursement for full-time team members. An extra nine percent for evening shift, 14 percent for night shift and nine percent for weekend shift is paid for all hourly employees, with an additional 18 percent for weekend evening and 23 percent for weekend night.

Berkshire Medical Center (Pittsfield, Mass.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Part of the Berkshire Health System, Berkshire Medical Center, a 302-bed community hospital in Pittsfield, Mass., is a teaching facility affiliated with the University of Massachusetts Medical School. Staff are deeply involved in hospital projects, including the development and construction of a 30,000-square-foot, eight-OR ambulatory surgery center. In addition to generous earned time and holiday benefits, employees receive both paid educational time and tuition reimbursement benefits and enjoy an annual employee recognition and awards dinner.

Brigham and Women's Hospital (Boston)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: The 777-bed Brigham and Women's Hospital is a teaching affiliate of Harvard Medical School and part of Partners HealthCare, a 10-hospital network in Massachusetts. Employees are entitled to subsidized memberships at fully equipped fitness centers at a variety of locations in the city and suburbs, and the hospital provides two types of backup child care services for emergencies. The hospital's transportation program applies to all Brigham employees and offers a 50 percent subsidy on all Massachusetts Bay Transportation Authority passes.

Carolinas Medical Center (Charlotte, N.C.)

Type of Facility: Hospital/health system

What makes it a Great Place to Work: Carolinas HealthCare System prides itself on diversity and inclusion, a goal demonstrated by its reception of the 2010 Belk Innovation in Diversity Award from the Charlotte Chamber. The hospital's eXtras Program also provides listings of discounts and incentives available through various area merchants. Carolinas Medical Center provides up to $2,000 in relocation assistance for nursing and allied health professionals.

Cedars-Sinai Medical Center (Los Angeles)

Type of Facility: Hospital/health system

What makes it a Great Place to Work: Cedars-Sinai Medical Center offers employees a competitive compensation and benefits program that allows employees to choose between a defined contribution plan and defined benefit plan retirement programs. Childcare resource services, including referrals to public or private schools and access to parenting specialists, are available for hospital employees. CSMC also participates in the environmentally friendly Rideshare Incentives program that incentivizes employees to ride to work with coworkers.

Centegra Health System (Crystal Lake, Ill.)

Type of Facility: Hospital/health system

What makes it a Great Place to Work: Centegra Health System was formed in 1995, when Memorial Medical Center in Woodstock, Ill., and North Illinois Medical Center in McHenry, Ill., combined their facilities and staff. Discounts at Centegra abound: 25 percent off in the cafeteria, 10 percent off in the gift shop, discounts to the Health Bridge fitness center and discounts to hospital services for staff members and their families. The system's wellness program has introduced a $20 incentive for health risk assessments.

Central Park ENT & Surgery Center (Arlington, Texas)

Type of facility: Physician practice and ambulatory surgery center

What makes it a Great Place to Work: Central Park ENT & Surgery Center aims to provide its employees with a series of robust benefits, including medical and vision insurance policies for which the center pays 100 percent. The center encourages employee unity through various annual events, including cook-outs where the CEO barbecues, a holiday party where physicians and staff play laser tag, sporting events, a Halloween costume competition and plenty of birthday and potlucks.

Children's Healthcare of Atlanta (Atlanta, Ga.)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Children's Healthcare of Atlanta is a three-hospital system that specializes in children and teens. Children's offers several conveniences for employees, including Sittercity — an online database of 3,000 baby, pet and house sitters as well as nannies in metro

Atlanta — and tuition discounts for certain childcare centers. The health system also provides concierge services to aid employees in making personal travel reservations, gift and flower orders and dining and entertainment plans.

Children's Medical Center Dallas (Dallas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: One of the largest pediatric healthcare providers in the nation, Children's Medical Center is a private, non-profit healthcare facility that serves as the primary pediatric teaching facility for The University of Texas Southwestern Medical Center at Dallas. In addition to a robust health insurance plan, Children's employees receive a 50 percent discount on outpatient services and a 25 percent discount on inpatient services their children receive at the hospital. The hospital's wellness program includes tobacco cessation coaching, a healthy pregnancy program, a $10 monthly fitness incentive and Weight Watchers meetings at work.

Children's Memorial Hospital (Chicago)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Along with competitive salaries, health insurance and tuition reimbursement, Children's offers new employees 29 days of paid time off accrued per year as well as concierge services to improve employees' work/life balance. Children's Memorial excelled in its areas of back-up family care, its on-site MBA program and its overall benefits program. Employees also receive 50 percent off hospital charges after insurance has been applied and are eligible for adoption assistance reimbursement of $5,000 per child.

Christiana Care Health System (Wilmington, Del.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: With more than 10,400 employees, Christiana Care is the largest private employer in Delaware and the 10th largest in the Philadelphia region. Employees can also take advantage of wellness program reimbursement, which gives up to $100 per calendar year for paid athletic or wellness activities. The health system provides an on-site childcare center at Christiana Hospital, on-site financial seminars and assistance for retirement planning, fitness trails, therapeutic massage and an on-site fitness center to assist in healthy living goals.

Cleveland Clinic (Ohio)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: With 2,700 physicians and scientists and over 4.2 million patient visits a year, Cleveland Clinic is one of the country's most prominent hospitals. Aside from exceptional medical, vision and dental coverage that pays for nearly 100 percent of all costs, the Cleveland Clinic offers free membership to Weight Watchers, Curves and other local workout facilities, employee discounts to sporting events, theaters and restaurants, free courses at the Cleveland Clinic Academy and an employer-contributed pension plan.

Cullman Outpatient Surgery Center (Alabama)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Cullman Outpatient Surgery Center annually provides outstanding care to over 5,000 patients while ensuring superior patient, staff member and physician partner satisfaction. A servant leadership culture positively impacts the surgery center's 33 teammates, and competitive benefits are provided through association with the center's parent company, Surgical Care Affiliates. Cullen Outpatient Surgery's themed celebrations and competitions, such as line dancing, consistently engage teammates.

Deaconess Health System (Evansville, Ind.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Deaconess Health System is a system of five hospitals in southwestern Indiana. Deaconess' nursing services division aims to be a regional leader among community hospitals in the area. The system provides incentives to employees for working straight evening or night shifts in designated areas, as well as incentives for working straight weekends in certain areas. Staff can enjoy a plethora of information at three on-site libraries: the health science library, the holistic resources library and the lighter side library — the latter of which provides books and videos on non-healthcare topics.

Doctors Hospital of Sarasota (Florida)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Doctors Hospital of Sarasota, part of HCA's West Florida division, is a 155-bed acute and general care facility. The hospital provides the HCA Hope Fund, a non-profit organization run by employees for employees who are in need of financial assistance due to a disaster or personal crisis. Employees are also recognized for their valuable ideas through the HCA Innovators Award.

Ephrata Community Hospital (Pennsylvania)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Ephrata Community Hospital has been serving the community of north Lancaster County, Pa., for over 65 years. Reduced-cost health, wellness and educational programs are available to all employees through the ECH Wellness Center and Center for Women's Health, including CPR training, diabetes programs, smoking cessation assistance, nutrition consults, yoga, pilates, self-defense and massage therapy. Employees also have free use of exercise equipment at any ECH rehab center location across Lancaster County.

The Eye Surgery Center of Michigan (Troy, Mich.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: The Eye Surgery Center of Michigan was developed by local physicians in partnership with St. John Providence Health System. The center features 10 physicians specializing in eye surgery and ophthalmology. When employees notice a staff member going above and beyond in their work, they can write the person a "star" to be placed in the "star employee reward box." Every month, administration holds a drawing, and the chosen employee receives a gift card.

Fremont Surgical Center (Fremont, Neb.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Fremont Surgical Center sees an average of 3,800 cases annually with specialties including gastroenterology, pulmonology, orthopedics, pain management, ophthalmology and dental. The culture of teamwork at FSC is apparent in the results of the center's 2010 patient satisfaction survey: The patient satisfaction rating is 95 percent. The center's employees are also able to enjoy more traditional benefits, including health, dental and life insurance and 401(k).

Harborside Surgery Center (Punta Gorda, Fla.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Harborside Surgery Center is a triangular joint venture between Interventional Management Services and the local HMA hospital Charlotte Regional Medical Center. The ASC experiences very little turnover and some personnel have worked there more than 15 years. Staff members are rewarded for their efforts, with a comprehensive benefits package that includes health insurance, 401k, group life insurance and long-term disability insurance.

Henrico Doctors' Hospital (Richmond, Va.)

Type of Facility: Hospital/health system

What makes it a Great Place to Work: This 767-bed acute care hospital, part of the HCA Virginia Health System, has three campuses offering state-of-the-art medical technology in a community hospital setting. In addition to health, dental, life insurance and other basic benefits, Henrico Doctors' gives employees complimentary fitness club memberships, massage therapy, yoga classes, phone service and discounts on purchases in the hospital pharmacy and cafeteria. The hospital's Parham campus includes Children's Choice, an on-site childcare center for hospital employees that promotes a literacy-based curriculum.

Geisinger Health System (Danville, Pa.)

Type of facility: Hospital/health system

What makes it a Great Place to Work: A physician-led system founded in 1915, Geisinger Health System provides service spanning 43 counties of 20,000 square miles to 2.6 million people. The Geisinger MyHealth Rewards Program is designed to encourage employees to better their health. The program includes a confidential health risk assessment, free medications for hypertension, high cholesterol and diabetes, a wellness program to help employees lose weight, stop smoking and eat better and an enrollment incentive of $200.

Golden Triangle SurgiCenter (Murrieta, Calif.)

Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Golden Triangle is a freestanding surgery center managed by Surgical Care Affiliates. Although the center staffs fewer than 35 people, the sense of community and loyalty is evident in the lack of employee turnover: Many staff members have spent more than seven years in their positions. This year, the center began recognizing all teammates with a week-long appreciation celebration, calling out the pre-op/PACU nurses, surgical techs and administrative assistants separately throughout the year.

Hackensack University Medical Center (New Jersey)

Type of facility: Hospital/health system

What makes it a Great Place to Work: HackensackUMC is a private, non-profit academic medical center that serves the Northern New Jersey and New York City metropolitan areas and employs nearly 8,000 people. According to the hospital, being a best place to work is apparent in its turnover rate: The hospital's voluntary turnover rate as of Dec. 31, 2011, was 5.56 percent. The hospital's Colleague-to-Colleague Fund was established to help employees in need; the money for financially needy employees is donated by other staff members, and all employees are eligible to receive assistance from the fund.

Hancock Regional Hospital (Greenfield, Ind.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Employees at Hancock Regional Hospital are incented to bring more talent to the hospital every year. Associates can receive up to $1,000 for each successful referral, as well as a $25 thank-you gift card on the referred associate's first day. The hospital-owned wellness center is available for employees for $10 a month, and once an employee visits the center 100 times, they are reimbursed half the membership fee.

High Plains Surgery Center (Lubbock, Texas)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: High Plains Surgery Center features a center designed collaboratively by physicians and staff members. Employee satisfaction is so highly regarded at High Plains that employee turnover at High Plains Surgery Center has been less than 2 percent annually. Employees enjoy benefits including health, dental and vision benefits, life insurance, retirement benefits and a daily lunch provided by the center.

Houston Northwest Medical Center (Houston, Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: A 340-bed hospital and member of Tenet Healthcare, Houston Northwest Medical Center was named one of Achiever's 50 Most Engaged Workplaces in the United States in 2011, the only hospital in Texas to earn the designation. HNMC has the highest level of participation in the Tenet wellness program of Tenet's 50 facilities. The program includes personal health coaching, chronic condition management and prevention and regular "lunch and learn" seminars on stress, work/life balance and personal life.

Indiana (Penn.) Regional Medical Center
Type of facility: Hospital/health system

What makes it a Great Place to Work: Indiana Regional Medical Center opened to the public in 1914 as a 40-bed facility with 13 private rooms. IRMC has been named one of the top five places to work in Pennsylvania by the Best Places to Work in PA program for five years in a row. IRMC encourages employees to seek promotions inside the organization; job openings are posted internally so qualified employees have the opportunity to apply, and continuing education is provided on-site.

Iowa Health System (Des Moines)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Iowa Health System employs the state's largest non-profit workforce, with nearly 20,000 workers. Employees and physicians have the opportunity to develop skills through the system's Management Leadership Academy and Physician Leadership Academy. Upon completion of the latter, graduated physicians will be close to earning their master's degree. The system remains focused on creating a healthy workforce: The employee health plan includes annual health risk appraisals, and employees can take advantage of an internal mail order pharmacy.

IU Health Goshen (Ind.) Hospital
Type of facility: Hospital/health system

What makes it a Great Place to Work: IU Health Goshen Hospital is a non-profit community hospital with more than 900 employees. In addition to traditional benefits, IU Health Goshen Hospital offers free annual memberships to the Goshen College Gingerich Recreation-Fitness Center, a child care voucher program to help colleagues pay for child care and an employee assistance program that offers free counseling services.

Jacksonville Medical Center (Jacksonville, Ala.)

Type of Facility: Hospital/health system

What makes it a Great Place to Work: Jacksonville Medical Center is an 89-bed, full-service hospital. Employees receive a comprehensive and competitive compensation and benefits package, healthcare insurance, paid vacation and a friendly, supportive work environment. Additionally, Jacksonville Medical Center is dedicated to enhancing the professional and personal knowledge and skills of its employees so professional development is strongly encouraged through ongoing education and training.

JerseyCity Medical Center (Jersey City, N.J.).

Type of facility: Hospital/health system

What makes it a Great Place to Work: JerseyCity Medical Center prides itself in its recent improvements in employee satisfaction — moving from "worst to first" in just four years, according to Human Resources Vice President Mary Cataudella. Every employee and candidate signs a Values Commitment Contract, agreeing to abide by the organization's mission and values. To further these values, CEO Joseph Scott communicates with all staff weekly via his "letter from the CEO," emailed to all employees and board members on Friday afternoons.

Lakewood Health System (Staples, Minn.)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Lakewood Health System has achieved significant increases in employee engagement scores — from 36 percent to 72 percent — in just four years. The health system has implemented initiatives such as quarterly employee forums, organizational excellence training sessions, employee feedback surveys for each department and an extensive employee recognition structure.

Lehigh Valley Health Network (Allentown, Pa.)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Lehigh Valley Health Network is a non-profit community health system. As the largest employer in the Lehigh Valley, it has more than 9,500 employees and 1,100 physicians, 400 of whom are employed. Forty percent of all new hires come from employee referrals — a sign that LVHN employees enjoy where they work. The health system offers employees and their dependents $700 to use for wellness programs, such as exercise and fitness programs or massage therapy, at their discretion.

LifeBridge Health (Baltimore)

Type of facility: Hospital/health system

What makes it a Great Place to Work: Two-hospital system LifeBridge Health recognizes employees through various programs, including LB points that reward employees for performance and can be redeemed for merchandise, travel and gift cards; employee appreciation days that highlight specific roles; and cash rewards for referring a hired candidate. Employees can also receive up to $5,000 annual reimbursement for higher education courses.

Lovelace Women's Hospital (Albuquerque, N.M.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Lovelace Women's Hospital is New Mexico's first and only hospital dedicated to women's health. The 736 employees enjoy a dynamic, quality-focused work environment. Employees also enjoy flexible benefit options, flexible spending accounts and tuition reimbursement. Some positions are eligible for sign-on bonuses, employees receive reimbursement for referring other employees, and returning alumni receive special incentives.

Lowell General Hospital (Massachusetts)
Type of facility: Hospital/health system

What makes it a Great Place to Work: This 217-bed community hospital offers a particularly healthy work environment. It was recently recognized by the American Heart Association as a 2010 gold level company, meaning the hospital met AHA criteria for employee fitness and is a tobacco-free campus that offers an American Lung Association smoking cessation program. Along with its focus on employee health, Lowell General has a structured and balanced governance system with a focus on nursing representation.

Massachusetts General Hospital (Boston)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Massachusetts General Hospital, part of Partners HealthCare, is a non-profit, 907-bed hospital that celebrated its bicentennial in 2011. The hospital offers several professional development opportunities through its Training and Workforce Development office, including English classes for non-native English speakers; human resources courses on conflict communication and other skills; the MGH Leadership Academy for the hospital's managers; medical terminology classes; and Spanish language classes.

Mayo Clinic (Rochester, Minn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Mayo Clinic is a non-profit health system that has more than 49,000 administrative and allied health staff. In 2012, Mayo was named among the "100 Best Companies to Work For" by *Fortune* magazine for the ninth consecutive year. Mayo offers several lifestyle benefits to its employees, including discounts for movie passes, special attractions, events and travel; cooking demonstrations; and an annual Heritage Day celebrating Mayo Clinic.

McBride Orthopedic Hospital (Oklahoma City)
Type of facility: Hospital/health system

What makes it a Great Place to Work: McBride Orthopedic Hospital was founded on the philosophy of Earl D. McBride, MD, who said, "Whatever you do, do something for mankind." High-performing employees are eligible to win financial rewards from $250 to $500, accompanied by a letter from the CEO, and an annual Employee Appreciation Week celebrates staff members' hard work with trivia contests, hourly giveaways and catered meals.

Medical Center of Lewisville (Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Medical Center of Lewisville pursues a philosophy of "shared governance," meaning employees have the opportunity to share their opinions in professional practice councils and committees. On-site programs include an employee wellness room, exercise equipment, weight loss programs, monthly on-site massage, an employee lactation room and free flu shots. Employees can also participate in a tuition reimbursement program, as well as an on-site "Grow Your Own" program that assists employees wishing to enter to nursing field.

The Medical Center of Plano (Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: The Medical Center of Plano is a 427-bed acute-care facility with more than 1,300 employees and more than 1,000 physicians, serving more than 70 specialties and subspecialties. Employee benefits include financial assistance for any formal job-related education, including up to $5,250 per year for full-time employees and up to $2,625 per year for those working part-time and unlimited access to online continuing education courses through Nursing Spectrum and Texas Tech University Health Science Center.

Melbourne Surgery Center (Florida)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Melbourne Surgery Center, which features four operating rooms and a procedure room, serves the Central Florida Brevard County communities. The center emphasizes a family-oriented environment with its physicians and staff members, which Wanda Coulter, RN, director of nursing, says is a refreshing approach to operating a surgery center. Melbourne Surgery Center has a formal process that allows physicians and staff members to come forward freely to share and implement ideas for improvement.

Memorial Healthcare System (Hollywood, Fla.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Memorial Healthcare System is currently the fifth-largest public healthcare system in the nation, employing more than 10,000 workers. The hospital's 2010 employee satisfaction survey ranked it in the 96th percentile nationwide, while the physician satisfaction survey placed the hospital in the 97th percentile. Once employees accept a job at Memorial Healthcare System, they are eligible for an attractive sign-on bonus: up to $6,000 for qualified full-time and part-time positions.

The Memorial Hospital at Craig (Colorado)
Type of facility: Hospital/health system

What makes it a Great Place to Work: The Memorial Hospital at Craig is a 25-bed, critical access hospital that employs 200 staff members and nine physicians. The hospital recently began a working relationship with the Studer Group in order to bring "focused attention to hardwiring behavioral change to make healthcare better," according to Chief of Organizational Excellence Jennifer Riley. The hospital holds an annual employee barbecue, quarterly cook-offs, pancake breakfasts served by administration during Hospital Week and an annual party at a local establishment.

Methodist Health System (Dallas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Methodist Health System in Dallas was selected through an employee survey in 2011 as a "Best Place to Work" in the *Dallas Business Journal* for the eighth consecutive year. Employee unity is apparent in the health system's "30 Minute Club," which was established in 2005 to support the welfare of Methodist patient and employees by collecting employee donations. In fiscal year 2011, the fund provided more than $100,000 to Methodist employees in short-term financial crisis.

Missoula Bone and Joint and Surgery Center (Montana)
Type of facility: Physician medical practice and ambulatory surgery center

What makes it a Great Place to Work: Missoula Bone and Joint Surgery Center believes its employees are the "cornerstone of our services," according to CEO Sami Spencer, CMPE, CMM. The workplace pays 100 percent of health insurance costs for its employees and provides up to $250 per month toward family health insurance benefits. Most positions at the center offer a flexible schedule, with more than 60 percent of Missoula Bone and Joint and Surgery Center employees working less than 40 hours per week.

Are you ready for a smarter way to exchange patient data with your referring surgeons?

Announcing ECHO for Surgery Centers

Encircle Healthcare

ECHO is a revolutionary technology that eliminates the manual and costly methods of exchanging patient data when booking cases.

No more blurry faxes and time consuming phone calls between surgeon practices and your facility. ECHO is compatible with any practice management system, and allows your referring surgeons to easily push all required patient data at the time of booking, making your booking and registration process more efficient while adding convenience for the surgeon's office.

Your surgery center saves time and improves accuracy, and your surgeon's offices will find it easier to refer cases to your facility. Efficiency and case volume grow!

To learn more about how Encircle and ECHO will bring greater efficiency to your center, email info@encirclehealth.com or call 800-847-6690

Nanticoke Health Services (Seaford, Del.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: With 1,000 employees serving across three entities, Nanticoke Health Services strives for every employee to embody the values in its booklet Standards of Performance. In 2012, Nanticoke Health Services implemented several programs to boost employee satisfaction and retention, including the Employee of the Month Program and a "Hidden Treasures" program that recognizes "behind the scenes" employees.

Nebraska Orthopaedic Hospital (Omaha)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Opened in April 2004, Nebraska Orthopaedic Hospital is the region's first hospital dedicated to the care and treatment of orthopedic patients. With 400 employees, Nebraska Orthopaedic Hospital has maintained a low employee turnover rate — less than 2 percent — year-over-year. On a quarterly basis, CEO Tom Macy conducts face-to-face "all staff" meetings, giving staff members a chance to ask questions and interact directly with their CEO.

Neosho Memorial Regional Medical Center (Chanute, Kan.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: One of the largest employers in southeast Kansas, Neosho Memorial Regional Medical Center is a clinical training site for six allied health schools, including a physician's family medicine program. Neosha Memorial employees receive numerous benefits, including access to free vaccinations, meal discounts, continuing education, a fitness center membership and scholarships for children entering college.

North Coast Surgery Center (Oceanside, Calif.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: The 'teammates' at North Coast Surgery Center are part of the Surgical Care Affiliates family, a privately-held company of 100-plus surgery centers throughout the United States. Most teammates are full-time with benefits, but other options are available — from one to four days per week. Staff members enjoy a predictable home life with a Monday to Friday schedule with weekends and holidays off, and the center provides free breakfast and lunch to each staff member every day.

North Shore-LIJ Health System (Great Neck, N.Y.).
Type of facility: Hospital/health system

What makes it a Great Place to Work: The North Shore-Long Island Jewish Health System is the nation's second-largest non-profit, secular health system, with more than 43,000 employees across 15 hospitals. The health system has several programs in place designed to identify, develop and fast track its top performers and recently launched a wellness program that offers Zumba, yoga, guided imagery, meditation, nutrition and walking classes to employees.

NorthShore University HealthSystem (Evanston, Ill.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: NorthShore University HealthSystem is an integrated health system with approximately 9,000 employees and 2,400 affiliated physicians. NorthShore strives to help its employees achieve a comfortable work/life balance, providing weekly Weight Watchers meetings at many locations and offering "alternative work arrangement" options, such as a compressed work week or a weekend work program for RNs. The health system also partners with PerkSpot to bring employees a one-stop shop for hundreds of online discounts.

Northwest Michigan Surgery Center (Traverse City)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Developed by local physicians and a partnership with Munson Medical Center in 2004, Northwest Michigan Surgery Center staffs 120 employees and cares for more than 17,900 patients. Staff members receive up to 208 paid time off hours and local discounts, including 25 percent off AT&T and discounts to dry cleaning and massages. Employees can be reimbursed for pursuing an active lifestyle through gym membership, yoga classes and other paid athletic activities.

OhioHealth (Columbus)
Type of facility: Hospital/health system

What makes it a Great Place to Work: OhioHealth is a non-profit health system that includes 18 hospitals and 21,000 associates, physicians and volunteers. One unique benefit OhioHealth offers its employees is the OhioHealth Research and Innovation Institute, which was created in 2006 and helps make clinicians' and employees' ideas become a reality. In the past few years, 75 physicians, nurses and employees have introduced more than 130 new product ideas to the program. These ideas resulted in 11 new companies and seven products in clinical use.

OrthoCarolina (Charlotte, N.C.)
Type of facility: Physician practice and surgical facility

What makes it a Great Place to Work: OrthoCarolina has been honored for its workplace several times in recent years, by the *Charlotte Business Journal* "Best Places to Work" program in 2010 and 2011 and Charlotte's Healthiest Employers in 2011. Employees receive discounts on gym memberships, fitness programs, cell phones and Costco memberships, as well as paid time off to volunteer, use of gym equipment at the practice and discounted clinical attire.

OrthoIndy (Indianapolis)
Type of facility: Physician practice

What makes it a Great Place to Work: OrthoIndy is an orthopedic practice with 14 locations around Indiana and is focused on providing quality bone, joint, spine and muscle care. OrthoIndy provides employees with employer-sponsored health insurance, dental insurance and vision discount programs. To promote growth among employees, OrthoIndy offers a clinical ladder program, paid license renewal and other paid continuing education opportunities for full-time employees.

Poudre Valley Health System (Fort Collins, Colo.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Poudre Valley Health System is a non-profit health system consisting of two hospitals, a behavioral health center and multiple outpatient facilities. PVHS offers the FlexibleFit Plan, which allows employees to design their own benefit package from different options. PVHS also offers convenience services on site, including an gym and massage therapy.

Renown Health (Reno, Nev.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Renown Health is a non-profit integrated health system with nearly 5,000 employees and three acute-care hospitals, among other facilities. The health system provides several conveniences to employees on site through its Tahoe Tower. In addition to patient suites and trauma, emergency and surgical spaces, the building houses The Shops at Renown. These shops include Starbucks, a pharmacy for employees, dry cleaning, a mail center and a uniform store.

Dr. Gregory Hickman's goal is to avoid narcotic-based pain control and its potential consequences whenever possible. He succeeds by practicing Regional Anesthesia, "which also gets patients quickly and more comfortably out of the surgery center, opens up beds and makes nurses available to take care of more patients."

"We've been successful. We were recently honored by Outpatient Surgery Magazine for our Regional Anesthesia techniques and post op pain management and within the past year have reported that our recovery room narcotics usage has been less than 12%."

Join Dr. Hickman and other patient advocates nationwide at www.RAadvantages.com.

REGIONAL ANESTHESIA
& ACUTE PAIN MANAGEMENT

RAadvantages.com

12-3086_ASC_3/12_KE

Rex Hospital (Raleigh, N.C.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Rex Hospital is a 665-bed acute-care hospital under Rex Healthcare. The hospital offers employees discounts on enrollment and monthly membership fees at its four wellness centers and free enrollment in its on-site Rex Child Development Center. Rex Hospital incentivizes employee wellness by providing discounts on health insurance premiums for employees who participate in the Rex Taking Care of You wellness program.

Riverside Methodist Hospital (Columbus, Ohio)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Located in Columbus, Ohio, Riverside Methodist Hospital has served the central region of the state since 1892. Employee benefits include up to $3,000 toward adopting a child; a child care center; an employee assistance counseling program; tuition reimbursement ranging from $1,500 to $3,500 per year; and full tuition reimbursement for full-time schooling in master's programs at Columbus State Community College and Capital University.

Rothman Institute (Philadelphia)
Type of facility: Orthopedic practice

What makes it a Great Place to Work: In 2010, Rothman Institute was ranked as one of the top places to work in Pennsylvania by *Central PA Business Journal*. The company offers competitive compensation for employees to join its rapidly growing team. This year, 184 team members at Rothman Institute participated in the Arthritis Foundation's Jingle Ball Run/Walk 5K and raised more than $25,000, making the organization the top fundraiser nationwide for the event.

Rush University Medical Center (Chicago)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Named a top hospital by *U.S. News & World Report*, Rush University Medical Center remains one of Chicago's highest-ranked hospitals. Rush prides itself on a "culture of inclusion," meaning the hospital makes significant effort to promote diversity. Founded in 1991, the Rush ADA Task Force aims to implement policies for individuals with disabilities and has initiated at least 24 programs for improved access and services, as well as 19 disability training, outreach and education programs.

Saint Thomas Health Services (Nashville, Tenn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Saint Thomas Health Services is a leading faith-based healthcare system in Tennessee and is part of Ascension Health, one of the largest non-profit healthcare systems in the country. The system's partnership with First Tennessee Bank offers an innovative "work perks" program that includes workplace banking, personal services, financial planning advice and free workshops. The system also grants employees free credit consultation and debt counseling.

Scripps Health (San Diego, Calif.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Scripps Health is an integrated health system that includes four acute-care hospitals and more than 20 primary and specialty care outpatient centers. Scripps has several educational opportunities for employees, including the Scripps Center for Learning and Innovation, which has courses to drive talent development, performance solutions and leadership development; educational scholarships and loans; and tuition reimbursement.

Siouxland Surgery Center (Dakota Dunes, S.D.)
Type of facility: Surgical specialty hospital

What makes it a Great Place to Work: In addition to a generous benefit package that includes health, dental, life, voluntary life and generous PTO accruement, Siouxland Surgery Center employees receive annual profit-sharing from the hospital's physician owners, free lunch every day and numerous employee outings throughout the year. During employee appreciation week, staff members receive special meals from favorite area restaurants, as well as gift cards and door prizes.

South Nassau Communities Hospital (Oceanside, N.Y.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: South Nassau Communities Hospital is one of the region's largest hospitals, with 435 beds, more than 900 physicians and 3,000 employees. In 2010, over 1,600 employees participated in the hospital's employee satisfaction survey, and the results showed that 83 percent of respondents were either generally or extremely satisfied with working at the hospital. Employees are rewarded with one bonus day for each six months worked without an absence.

Southern Ohio Medical Center (Portsmouth, Ohio)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: In addition to comprehensive medical, dental and vision coverage, retirement programs and financial benefits employees have access to an employee emergency relief fun, education assistance and adoption reimbursement. Southern Ohio Medical Center employees also enjoy free online tutoring, AAA Travel Club discount, discounted theme park and cinema tickets, Sam's Club memberships and cellular phone discounts with AT&T and Sprint.

St. Cloud Hospital (St. Cloud, Minn.)
Type of facility: Hospital/health system

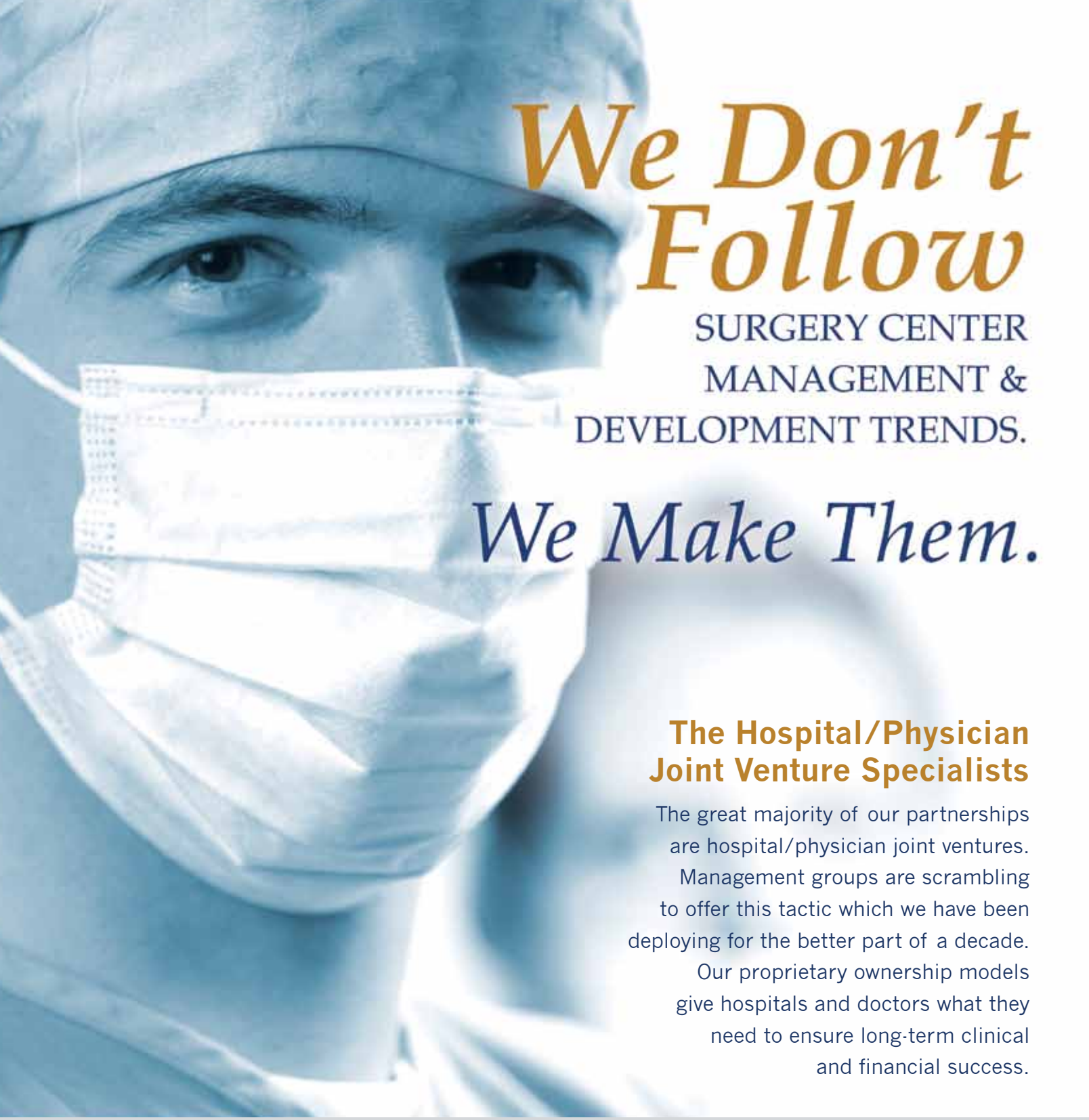
What makes it a Great Place to Work: St. Cloud Hospital is a 489-bed, Catholic, regional hospital. As the largest employer in the St. Cloud area, the hospital employs nearly 4,300 people. Under the Mission Matters program, employees can recognize a coworker for demonstrating the hospital's mission statement and core values, which include collaboration, hospitality, respect, integrity, service and trusteeship. Each month one of the employees recognized by colleagues is chosen at random and can select a gift from the Mission Matters online store.

St. John Providence Health System (Detroit)
Type of facility: Hospital/health system

What makes it a Great Place to Work: The largest provider of inpatient care in Southeast Michigan and one of the largest employers in metro Detroit, St. John Providence Health System established an Associate Hardship Program to provide confidential financial help to associates experiencing an immediate, significant financial burden. To date, more than 400 associates have been helped by more than $300,000 donated by other physicians and associates.

St. Joseph Hospital (Kokomo, Ind.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: For nearly 100 years, St. Joseph Hospital, a St. Vincent Health hospital, has been the hometown hospital for Kokomo citizens. Employees can take advantage of tuition reimbursement at all levels of education as well as generous vacation time and the PerkSpot Associate Discount program which offers discounts at nationwide merchants like Best Buy, Southwest Airlines, Panasonic, Dell, Target, Disney, Ann Taylor and Sprint.



We Don't Follow

SURGERY CENTER MANAGEMENT & DEVELOPMENT TRENDS.

We Make Them.

The Hospital/Physician Joint Venture Specialists

The great majority of our partnerships are hospital/physician joint ventures. Management groups are scrambling to offer this tactic which we have been deploying for the better part of a decade. Our proprietary ownership models give hospitals and doctors what they need to ensure long-term clinical and financial success.

REGENT SURGICAL HEALTH

4 Westbrook Corporate Center, Suite 440
Westchester, Illinois 60154

www.regentsurgicalhealth.com

VISIT OUR BOOTH AT THE BECKER'S HOSPITAL REVIEW ANNUAL MEETING

or Contact Jeff Simmons, Regent CDO directly at **708-492-0531** or **partnerships@regentsurgicalhealth.com**

St. Joseph's Healthcare System (Paterson, N.J.).
Type of facility: Hospital/health system

What makes it a Great Place to Work: St. Joseph's Healthcare System is comprised of several acute-care hospitals, a children's hospital and a nursing home in the Paterson, N.J., area. The health system's employee retention rate is 94.5 percent, and the nursing vacancy rate is also less than 1 percent. In 2012, employees at St. Joseph's Healthcare System will pay an average of only 22 percent of their healthcare and prescription drug costs, and employees can see physicians and other providers within the health system at virtually no cost.

St. Jude Children's Research Hospital (Memphis, Tenn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: St. Jude Children's Research Hospital has six affiliate hospitals and more than 3,600 employees. St. Jude has a Shared Decision Making program for employees in patient care services. Under this program, patient care services employees attend staff meetings and serve on support, steering or unit councils to provide input in the organization's policies and procedures.

St. Luke's Hospital (St. Louis)
Type of facility: Hospital/health system

What makes it a Great Place to Work: St. Luke's Hospital has been honored as a "best place to work" in St. Louis for the last two years by the *St. Louis Business Journal* and was recognized as one of America's 50 Best Hospitals by HealthGrades from 2007 to 2012. The St. Luke's wellness program encourages employee fitness through regular wellness events and an on-site fitness center and track.

Stanford Hospital & Clinics (Palo Alto, Calif.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Stanford Hospital & Clinics and the adjacent pediatric teaching hospital Lucile Packard Children's Hospital employ more than 8,500 people. SHC and LPCH offer a wellness incentive program that rewards employees for working to improve or maintain their health. The most recent incentive awarded employees $100 for completing the Stanford Health and Lifestyle Assessment.

Surgical Center of South Jersey (Mount Laurel, N.J.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: As an affiliate of one of the largest ambulatory surgery center companies in the country, the Surgical Center of South Jersey prides itself on providing outstanding patient care by leveraging the satisfaction and morale of its employees. Each year, the team at the center is recognized during its week long "Teammate Appreciation" initiative. During this time, administration caters to the needs of their team by serving them treats, food and gifts for each day of the week.

Texas Back Institute (Plano)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Texas Back Institute is one of the largest free-standing spine specialty clinics in the United States, offering a range of services to treat back and neck pain. The Institute's team is made up of more than 150 physicians and staff. TBI prides itself on its ability to offer flexible hours, allowing employees to take time off work for school activities or sporting events. The facility also attempts to promote from within whenever possible and provide its employees with a strong support system.

Texas Health Presbyterian Hospital Rockwall (Rockwall, Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Employees at Texas Health Presbyterian Hospital Rockwall are rewarded for their hard work in numerous ways. Patient compliments are routinely distributed throughout the hospital, and high performers are given "rock star" awards, which include hospital-wide recognition as well as a bonus. Texas Health Rockwall also offers employees affordable payroll-deduction options for a variety of services, including already-discounted café meals, gift shop purchases, book fairs, Rockwall auxiliary activities and medical expenses incurred at the facility.

The Everett Clinic (Everett, Wash.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: The Everett Clinic is a physician group practice with 16 locations, nearly 400 physicians and more than 2,000 staff members. The practice encourages employees to participate in wellness programs by providing an opportunity to win prizes for meeting wellness goals. Each quarter, The Everett Clinic begins a new wellness promotion program and sets wellness goals. Employees are entered into a drawing for prizes for each goal they meet.

The Women's Hospital (Newburgh, Ind.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: The Women's Hospital, owned by Deaconess Health System, provides a complete range of healthcare services to women and infants in a soothing, "spa-like" atmosphere. Women's Hospital offers employees a total compensation program including medical and dental insurance, long-term and short-term disability and options for healthcare expense accounts. Additionally, employees can receive financial reimbursement and 401(k) options, and uniforms are furnished.

Tri-City Medical Center (Oceanside, Calif.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: With 2,300 employees, Tri-City Medical Center operates two advanced clinical institutes and staffs more than 500 physicians practicing in 60 specialties. The hospital works hard to increase patient satisfaction scores on an annual basis: Last year's survey showed employee engagement was up 23 percent, satisfaction was up 9 percent and partnership was up 18 percent from the previous year's survey.

University of Chicago Medicine (Illinois)
Type of facility: Hospital/health system

What makes it a Great Place to Work: University of Chicago Medicine, formerly called the University of Chicago Medical Center, has more than 9,500 employees. Hospital employees benefit from a range of educational opportunities. The University of Chicago Medical Center Academy is an on-site corporate quality university that offers classes in computer skills and business writing, among others. In addition, nurses receive 100 percent tuition reimbursement for a BSN or MSN degree at a nursing school of their choice.

University of Washington Medical Center (Seattle)
Type of facility: Hospital/health system

What makes it a Great Place to Work: UW Medical Center is the flagship of UW Medicine, which owns or operates three hospitals and is affiliated with the University of Washington School of Medicine. For a workout, employees can visit the on-campus health club, golf driving range, waterfront activities center and other facilities; to increase control over their own health, staff can take advantage of counseling and support, classes and educational materials, smoking cessation services and weight management assistance.

Upland Outpatient Surgical Center (Upland, Calif.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Upland Outpatient Surgical Center, managed by Surgical Care Affiliates, also hosts a quarterly teammate town hall to allow staff members to voice their concerns and suggest opportunities for improvement. The center also conducts an annual employee satisfaction survey to hold leaders accountable for meeting employee and physician satisfaction benchmarks.

Vanderbilt University Medical Center (Nashville, Tenn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Vanderbilt University Medical Center hires around 10,000 employees each year, and they receive perks including discounts on apartments, cars, cellphones, computers and gym memberships. This year, the medical center was Vanderbilt University Medical Center awarded a five-year, $20 million federal grant to coordinate a national consortium that aims to advance biomedical research nationwide.

The Virginia Spine Institute (Reston)
Type of facility: Spine center

What makes it a Great Place to Work: The Virginia Spine Institute is a 26,000-square-foot center for spinal healthcare in the Washington, D.C. metro area. To increase its reach in the local community, VSI has developed a formal volunteer program for employees, which encourages the entire staff to donate items and participate in events with the local YMCA, the public school system, little league teams and many other local charities. Employee benefits include an onsite fitness facility, Pilates classes, personal training and a discounted on-site nutritionist and massage therapists.

Yale-New Haven Hospital (New Haven, Conn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Yale-New Haven Hospital is the 944-bed flagship of three-hospital Yale-New Haven Health System. The Yale-New Haven Hospital Daycare Center is available to employees with children aged three months to five years, and employees who work 24 hours or more per week are eligible for adoption assistance of up to $6,000 per child. Employees can also save money on taxes by electing a pre-tax paycheck deduction of up to $115 a month to apply toward commuting expenses. ■

6 Situations Where Out-of-Network Reimbursement Still Works
(continued from page 1)

Woollen says. He says a single unprofitable case should not be cause to move out-of-network, but aggregate unprofitability can be.

He recommends surgery centers look at their case volume as a whole to determine whether the offered contracts would damage profitability. For example, the surgery center might lose money on Case A but make significant profit on Cases B, C and D, meaning the surgery center can stay in-network as long as volume for profitable cases doesn't decrease. "As long as you're going to generate positive revenues overall, you might want to go ahead and move forward with the agreement," Mr. Woollen says. If, on the other hand, your aggregate reimbursement is too low to keep your center profitable, you might want to consider out-of-network.

2. Local health plans offer strong out-of-network benefits. The profitability of out-of-network reimbursement is often dictated by the health plans sold to employers in your market, Mr. Woollen says. He says essentially, a health plan will shop a range of plans to an employer group and will offer preferable premiumpricing if the employer chooses to minimize, reduce or even eliminate out-of-network benefits.

"The employer might say, 'Well, your network is very inclusive of the majority of providers we see in our area, so let's go ahead and save the money on premiums and potentially pass those savings on to our employees,'" Mr. Woollen says. While the decision to exclude out-of-network benefits limits employee choice, some employers prioritize cost savings over the ability to seek care from any provider in an area. Mr. Woollen says before a surgery center goes out-of-network, the leaders should understand the percentage breakdown of a payor's membership with out-of-network benefits. He also says some insurers will provide data on the split between self-insured and fully-insured members by county.

3. Payors have created a "closed network" in your market. Mr. Woollen says there are markets where payors have essentially created "closed networks" that don't allow additional contracting. "We've seen areas where payors say they won't add a single-specialty surgery center like a pain management center," he says. "You don't even have an opportunity to accept their rates and become a participating provider."

He says the payors may feel they already have a complete network without your facility and do not require any more saturation in the market. In this case, you have no choice but to go out-of-network because the payor won't allow you to contract with them.

4. Your volume will not suffer significantly if you go out-of-network. When surgery centers sign contracts with insurance companies, they essentially accept lower reimbursement rates in exchange for increased volume and steerage, Mr. Woollen says. The hope is that the payor network will drive patients to your facility, making up in volume what you may lack in individual case profitability.

If you're considering going out-of-network, you should have an idea of how the decision will affect your volume, Mr. Woollen says. The incremental volume gained via an agreement should at a minimum offset the discount given versus the current per case out-of network reimbursements. Additionally, some patients cannot visit out-of-network facilities at all based on their health plans, and payors have been known to threaten physicians' professional contracts if they refer patients to out-of-network facilities.

5. Your patients' deductibles are not aggressively high. Mr. Woollen says aggressive benefit design is one way payors prevent providers from going out-of-network. If a payor has a significant number of plans with out-of-network benefits, they may increase the financial responsibility to the patient to incentivize staying in-network.

"I've seen plans with out of network deductibles of $10,000, so basically they're showing the patients there's a significant cost savings in going to an in-network provider," Mr. Woollen says. If your patients have very high deductibles, they may be less likely to come to the surgery center in the first place, and if they do, you may struggle to collect full payment after the procedure. Communication is critical for the process of out-of-network to function properly.

6. Payors in your area have not capped out-of-network payments. Mr. Woollen says certain payors are capping out-of-network payments by creating "maximum allowables," or the maximum amount of money the insurance company will pay for an out-of-network case. This strategy makes out-of-network infeasible by essentially creating a one-sided contract that your surgery center has not agreed to. No matter what you bill for an out-of-network case, you will only receive a certain amount from the payor. ■

Contact Rachel Fields at rachel@beckershealthcare.com.

Learn more about Practice Partners in Healthcare at www.practicepartners.org.

A BETTER WAY!

MURPHY HEALTHCARE GROUP

www.ASCturnaround.com

THE OLD WAY . . .

. . . You're stressed and working late.

. . . Your center has unused block time.

. . . The docs are bickering; the staff can feel it.

. . . Profits are less than 40 percent and falling.

THE MURPHY HEALTHCARE WAY . . .

. . . You're syndicating new surgeons.

. . . Your center is humming with cases all day.

. . . Patients say they feel like guests.

. . . Profits are growing 30-to-40 percent.

. . . You have dinner at home at 5:30!

At **Murphy HealthCare Group**, we have more than 20 years' experience turning troubled ASCs into happy, efficient, profitable ones. If your center needs to find a better way, call me!

Robert Murphy, CEO
212-937-4911

Photo: *The big guy shaking hands with me is orthopedist Dr. John Vitolo, who has been a surgeon-owner with us for over a decade. Does he look happy, or what?*

30 ASCs Performing More Than 10,000 Procedures a Year

By Abby Callard

Here is a list of 30 ambulatory surgery centers across the country with an annual case volume of more than 10,000 procedures.

Advanced Endoscopy Center (Bronx, N.Y.). The Advanced Endoscopy Center opened in April 2007 as a joint venture between a group of physicians, Physicians Endoscopy and a local hospital in the Bronx. This single-specialty GI center performed more than 10,000 procedures last year. In total, 22 physicians use the facility — 10 of which own interest in the center. The Advanced Endoscopy Center is AAAHC-accredited and recognized as an ASGE Center of Excellence. "We have a great team of physicians and staff, and they work really hard to make sure patients are processed efficiently and quickly," says administrator Steve Housberg. "Our average wait time is an hour and a half from start to finish, and we have state-of-the-art equipment."

Allied Physicians Surgery Center (South Bend, Ind.). This center opened in Feb. 2000 and has performed more than 10,000 procedures a year since 2003 — and more than 20,000 a year since 2007. More than 80 physicians perform procedures in the center's seven operating rooms and two minor procedure rooms. The center is AAAHC-accredited and specializes in orthopedics, podiatry, ophthalmology, pain, ENT, general surgery, gynecology and urology. Executive and clinical director Chuck M. Strasser, RN, CASC, says much of the ASC's success comes from a commitment by surgeons and staff to maintaining high patient satisfaction and excellent clinical outcomes and low infection rates.

Ambulatory Surgery Center of Spartanburg (Spartanburg, S.C.). The ASC of Spartanburg is a joint venture between Spartanburg Regional Medical Center and a group of 34 physicians and was opened in April 2002. The center's 52 surgeons do procedures in seven operating rooms and two endoscopy procedures rooms. The center has performed more than 10,000 procedures for the past six years, including 10,096 in 2011. The center's specialties are gastroenterology, ophthalmology, general surgery, orthopedics, ENT, podiatry, pain and gynecology.

Administrator Mike Pankey, RN, MBA, says block scheduling and leaving certain rooms open for last-minute cases have helped the center maintain its high volume. "We've been doing more than 10,000 procedures for awhile, so it's a normal routine for us at this point," he says. "As you're growing, block scheduling helps a lot and reviewing the block scheduling for utilization helps a lot." Mr. Pankey says that if a surgeon is not filling up their block, they will be moved out. He says this drives the surgeons to bring in more cases and compete to keep their preferred time slots.

Bend (Ore.) Surgery Center. Bend Surgery Center opened in 1997 and moved to a new location in Oct. 2005. The center has been doing more than 10,000 cases a year for the past four years, including 10,388 last year. BSC is 100 percent physician-owned, with 38 owners and 60 users who specialize in orthopedics, general surgery, spine, ENT, ophthalmology, GI, pain management, plastics, pediatric dentistry, podiatry and oral maxillofacial surgery. BSC is Joint Commission accredited and a charter member of the Oregon Patient Safety Commission.

"We've continued to increase volumes over time and have been able to make changes to accommodate the increased volume," says administrator Neal Maerki. "We have a substantial per diem pool."

Berks Center for Digestive Health (Wyomissing, Pa.). This single-specialty GI center opened in Dec. 2001 and has done more than 10,000 cases a year since 2005. The center is a joint venture between 11 physician owners and Physicians Endoscopy. There are 13 gastroenterologists performing procedures in three procedure rooms.

Executive director John Gleason stresses creativity and adaptability as the key components to operating a successful ASC. Since the opening of the facility, hours have been extended to allow cases to end at a later time, schedules have been readjusted and turnover of procedures has been kept up in order to facilitate more procedures. "We are constantly considering ways to add additional procedures to the schedule so as to increase volume," says Mr. Gleason. "And our staff and doctors have been adaptable enough to change to meet the center needs for the schedule." He also says the facility is considering a move to a bigger facility to keep up with increasing case volume.

Birmingham (Ala.) Outpatient CareCenter. This center has been open since 1984 and performed more than 10,000 procedures in 2000, 2004 and every year since 2007. The center's 94 physicians performed 13,671 procedures in 2011. The center is managed by Surgical Care Affiliates and specializes in ophthalmology, pain management, orthopedics, ENT, gynecology, podiatry, urology, plastics and dermatology.

"Our dedicated team is a good mix of the best and brightest teammates with decades of experience in outpatient surgery as well as newcomers with fresh ideas and new perspectives on best demonstrated practices," says administrator Dennis Rowlen. "They, along with talented physicians committed to doing their part in maintaining the process, allow us to provide wonderful care to our patients in a highly efficient environment."

Centennial Surgery Center (Voorhees, N.J.). The physician-owned Centennial Surgery Center was established in Sept. 1999 by a group of 16 physicians. The center now has more than 60 physicians, four operating rooms, two endoscopy rooms and two short procedure rooms and has done more than 10,000 procedures a year since 2004. The center specializes in orthopedics, general surgery, urology, gastroenterology, colon/rectal, plastics, pain management and podiatry.

"We are an organization that is continually looking to find better and more efficient ways to provide the highest quality of care," says Steve Barainyak, MBA, CASC, executive director. "Sometimes we find that what we are currently doing is the best approach to providing the best service we can, but every once in a while we find something that helps us to tweak the system and make it even better. I think this more than anything else helps us to continue to operate smoothly with the volume of cases we perform."

Center for Ambulatory Surgery (West Seneca, N.Y.). Equipped with four surgery suites and five endoscopy suites, this 18,000-square-foot center does more than 15,000 procedures every year. The center is a 50-50 equity partnership between 16 physician-owners and The C/N Group, which provides management services, including all administrative functions of the facility. The AAAHC-accredited center specializes in orthopedics, gastroenterology, general surgery, ophthalmology, gynecology, podiatry, urology and reconstructive surgery.

Charlotte (N.C.) Surgery Center. This SCA-managed center opened in 1984 and has been performing more than 10,000 procedures since 2007. The center opened with just three operating rooms but has since expanded to include seven operating rooms and one procedures room that enable the center to incorporate pain management and orthopedics. The center currently has 95 physicians who specialize in foot and ankle surgery, gynecology, hand surgery, ophthalmology, orthopedic, ENT, pain management, plastic surgery, podiatry and gastric banding.

"We have a highly dedicated team that live our core values every day," says administrator Rick Brisson, RN. "Through a lot of hard work, initiative, motivation, creativity and teamwork among our physicians, teammates, anesthesia staff and support staff, we are able to optimize our schedule and capitalize on every opportunity to gain volume. No case gets left behind!"

Cincinnati Eye Institute Surgery Center (Cincinnati, Ohio). This AAAHC-accredited center opened in 1985 and features six ORs and three procedure rooms in a 17,000-square-foot surgery center. The center has performed more than 10,000 procedures since 2007. The center's 25 physicians specialize in cataract, retina, plastics, glaucoma, cornea, YAG laser and argon laser procedures. Cataract surgery makes up about 70 percent of the center's cases each year. Todd D. Albertz, director of surgical services, says training and educating staff has helped to maintain success at the Cincinnati Eye Institute. In regards to maintaining volume, he says using technology to strategize open block time has been essential.

Cypress Surgery Center (Wichita, Kan.). The AAAHC-accredited Cypress Surgery Center was founded by medical director David Grainger, MD; Michael Brown, MD; and Bruce Tjaden, DO, and opened in Nov. 2000. Since 2008, the center has done more than 10,000 procedures a year, including 11,350 last year alone. The center has more than 70 physicians on active staff who perform procedures in six ORs, three procedure rooms and two GI suites. The center specializes in orthopedics, gynecology, ENT, ophthalmology, gastroenterology, urology, oral and maxillofacial, general surgery, plastics and pain management.

Administrator Sandra Hartloff, who took over for veteran administrator Judy Graham late last year, attributes the center's success to the great staff. "It all has to do with the staff, and we have working managers that are directly involved," she says.

Dearborn (Mich.) Surgery Center. The Dearborn Surgery Center was established in June of 2005 and has been performing more than 10,000 procedures a year since 2006 — averaging 12,500 per year. The center's 94 practicing physicians specialize in endoscopy, orthopedic, general surgery, ENT, ophthalmology, gynecology, plastic, urology, vascular, podiatry and pain management.

"The efficiency that the DSC has is based upon the unified goal that the physician is a key customer," says Ricardo D. Borrego, MD, MSBA, medical director. "Turnover differentiates us from hospital-based services, and patient satisfaction keeps us motivated. To clarify this, our patients' satisfaction and safety are our core values but the difference is most facilities stop short of recognizing that the physicians' satisfaction is key to continued success. Our differentiation is always starting on time, maintaining consistent low turn over times and expediting the patients without any feeling of being rushed."

Eastside Endoscopy Center (Bellevue, Wash.). This AAAHC-accredited center has been performing more than 10,000 procedures a year for the past four years including 10,516 procedures in 2011. This single-specialty GI/endoscopy center has 10 practicing physicians that specialize in colonoscopy, upper endoscopy and flexible sigmoidoscopy. A new center in Issaquah is scheduled to open later this year. Michelle Steele, BSN, CGRN, nurse administrator, attributes the center's success to streamlined processes, skilled staff that are cross-trained, team work and the use of propofol and CO2 for insufflation.

Eastside Endoscopy Center (St. Clair Shores, Mich.). The Eastside Endoscopy Center opened in April 1996 and has been doing more than 10,000 procedures since 2008. The AAAHC-accredited center is a joint venture between eight physician owners and St. John Hospital and Medical Center in Detroit. Between two locations, the center collectively has six procedure rooms and 12 physicians performing procedures. Administrator Beth Miller, RN, CASC, says paying special attention to patient and referral physician satisfaction, being patient-oriented and offering cost-effective services have all facilitated the growth of the facility.

Fayetteville (N.C.) Surgery Center. This multi-specialty center opened in 1982 and has been doing more than 10,000 procedures a year for more than a decade, including 12,719 last year. The center has expanded to include 11 operating rooms, three procedure rooms and an overnight recovery care center. The center's 105 physicians specialize in orthopedics, ophthalmology, ENT, gastroenterology, podiatry, gynecology, pain management, neurology, urology and plastic surgery. Administrator Teresa Craven attributes the center's success to the great staff and committed surgeons. The center is managed by SCA.

Fort Sutter Surgery Center (Sacramento, Calif.). This multi-specialty center has been doing more than 10,000 procedures for the past four years, including 10,823 last year. The center's 49 physicians and 30 anesthesiologists specialize in gastroenterology, gynecology, spine, ophthalmology, oral surgery, orthopedics, plastic, pain management, podiatry and urology. The center is managed by SCA.

"We have dedicated staff that know their jobs really well," administrator Dale Bowman says. "We like to say that we are a "well-oiled machine" that keeps everything moving. We are a values-driven organization, and the number one "value" is clinical quality. We want each patient to know that they are important and cared for. Teamwork is another "value" that plays a huge role in our success. Everyone must work together to focus on efficiency and productivity."

Gateway Surgery Center (Concord, N.C.). This multi-specialty center opened Jan. 1, 2006 and has been doing more than 10,000 cases a year for the past four years, including just under 11,000 last year. The center's 72 physicians specialize in ENT, orthopedics, gastroenterology, general surgery, pain management, urology, gynecology, ophthalmology, pediatric dental, plastic surgery and podiatry. Executive director Craig Bryan attributes the center's success to its motivated staff, efficient facility design and effective schedule management.

Greensboro (N.C.) Surgery Center. The Surgical Center of Greensboro opened in Dec. 1983 and has been doing more than 10,000 procedures since 2003, including 13,035 last year. The center's recovery care center opened in 1988 and provides overnight care to patients who need additional care following their procedures. The center's 94 physicians specialize in general surgery, gynecology, neurosurgery, ophthalmology, oral and maxillofacial surgery, ENT, otology and neurotology, pain management, cosmetic and reconstructive surgery, podiatry, urology and vascular surgery. The center is managed by SCA.

"By working together on staffing, supplies, equipment needs and patient flow we have created a model that pushes for continuous improvement and service excellence for the patients and physicians that we serve," says administrator Jennifer Graham, RNFA, CNOR. "Our teams are focused on clinical quality and take personal accountability for each patient that walks through our doors."

Kemp Surgery Center (Everett, Wash.). The Kemp Surgery Center was opened in Nov. 1997 by the Everett Clinic and has done more than 10,000 procedures a year since 2001, including more than 16,000 in 2011. The center's primary focus is on gastroenterology, though the facility also handles cases in ENT, orthopedics and urology. The center is owned by the 300-physician multi-specialty Everett clinic and is accredited by Medicare. Medical director Nick Marassi, MD, says the ASC focuses on providing great service to surgeons and physicians as well as patients. The center also offers state-of-the-art equipment for surgeons in the facility to utilize in order to maintain high quality care.

Kentucky Surgery Center (Lexington, Ky.) This AAAHC-accredited center opened in Dec. 1986 and has been doing more than 10,000 cases a year since 2007. This physician-owned facility is 28,000 square feet and has seven ORs and three procedure rooms. Started by a small group of surgeons and anesthesiologists, the center now has more than 100 surgeons on staff and specializes in orthopedics, ENT, gastroenterology, general surgery, plastics, podiatry, dentistry, pain management, urology, vascular, colorectal and pulmonary surgery.

Administrative director Glenda Beasley, RN, says maintaining high case volume has been possible because the staff and physicians provide quality patient care with excellent patient outcomes. "Raising the bar with expectations of only providing care that can be parallel to none is the goal of the center on a daily basis," she says. "Every team member must buy into the notion of bringing their top performance and positive attitude everyday to maintain success on every level."

Lakeland Surgical and Diagnostic Center (Lakeland, Fla.). The AAAHC-accredited Lakeland Surgical and Diagnostic Center opened in April 1996 as a joint venture by the Watson Clinic and the Lakeland Regional Medical Center. The center is owned by the two largest physician groups in the area and the largest regional medical center and runs six ORs in three locations. The center has been performing more than 10,000 procedures since 2001 and hit more than 20,000 in 2010. The center's specialties include endoscopy, pain management, eye, cosmetic surgery, reconstructive surgery, general surgery, eye, gynecology, orthopedics, urology, radiation oncology, podiatry and ENT.

Memorial Mission Surgery Center (Chattanooga, Tenn.). The Memorial Mission Surgery Center opened in 2003 and performed 11,000 total cases in 2011. The center, which opened in 2003, is owned primarily by GI and orthopedic physicians, as well as two general surgeons and one ENT. The center is owned 70 percent by physicians and 30 percent by the local health system.

Menomonee Falls (Wis.) Ambulatory Surgery Center. This AAAHC-accredited center opened in 1994 and is a joint venture between a community hospital and two large medical groups. This multi-specialty center has done more than 12,000 cases since 2002. The center's 45 active physicians do cases in gastroenterology, general surgery, orthopedics, pain, ENT, gynecology, podiatry, ophthalmology, urology and plastic surgery in five ORs, four minor procedures rooms and a laser room. Executive director Dianne Wallace, RN, BSM, BMA, says the center's plan for continued growth includes recruiting more physicians.

Michigan Endoscopy Center (Farmington Hills, Mich.). This AAAHC-accredited, single-specialty GI center opened in March 2003 as a joint venture between 16 physicians and Physicians Endoscopy and has been performing more than 16,000 procedures each year since 2006.The center's 19 physicians do procedures in three operating rooms and three procedure rooms.

Administrator Brien Fausone says MEC is a very busy surgery center, averaging 62 procedures a day and more than 80 on high-demand days. "We were a low cost/high volume provider with an outdated and cramped waiting room," he says. "In 2010, we made the decision to acquire an additional 3,000 square feet of adjacent space to build out a new waiting room and business office. The patient response — and more importantly, the physician referral response — has been overwhelmingly positive."

Midtown Endoscopy Center (Atlanta, Ga.). Midtown Endoscopy Center opened in 2001 under an affiliation with Atlanta Gastroenterology Associates and performs about 10,620 cases a year. The physician-owned center has 18 physicians, four ORs and is accredited by the AAAHC. Steven Morris, MD, managing partner, and Jana Baker, practice administrator with AGA, attribute the center's success to "skilled, experienced physicians and staff" and "attention to individual patient needs."

New York GI Center (Bronx, N.Y.). This single-specialty GI center opened in March 2007 and does 10,800 procedures a year. Since opening, the center has been accredited by the AAAHC, implemented electronic medical records and expanded to 18 gastroenterologists on staff. The current facility includes fives ORs, but an expansion planned for this year will add two additional ORs and enhanced facilities for staff and patients.

Northpoint Surgery and Laser Center (West Palm Beach, Fla.). This center opened in Sept. 1996 as a limited partnership with 13 physician owners an entered into a joint venture with National Surgical Care in 2003. The center has been doing more than 20,000 cases a year since 2006. The center houses five ORs, two endoscopy suites and a pain management center with its own waiting room, preoperative and postoperative room as well as a procedure room. This AAAHC- and AHCA-accredited facility now has 32 physician owners and 25 other physicians on staff who specialize in ENT, gastroenterology, gynecology, ophthalmology, retina, oral/maxillofacial, orthopedics, pain management and podiatry.

Northwest Michigan Surgery Center (Traverse City, Mich.). This AAAHC-accredited center open in April 2004 and currently does 18,000 cases a year. The center specializes in gastroenterology, ophthalmology, orthopedics, urology, plastic surgery, ENT and gynecology. The center recently renovated its patient waiting area adding 30 percent more space. The center also implemented Source Medical's Vision Electronic Health Record in the past year which has simplified documentation, decreased staffing requirements and provided access to quality assurance measures. Versus Technology is another tool to keep up with a large volume that the center will implement this March. The system allows staff to see how many patients are in the lobby, where and when they interacted with staff and where each patient is in terms of the visit progression. Jim Stilley, CEO, attributes the flexibility and commitment of our 80 physicians, 42 anesthesia providers and the 126 members of NMSC's staff to the success of the ASC's high case volume.

Physicians Endoscopy Center (Houston). This single-specialty center opened in December 2002 and performs more than 13,000 cases every year. The center is a joint venture between HCA Ambulatory Surgery Division and several physicians who originally founded the center. Celebrating its 10th anniversary, the center currently has 18 physician owners and eight procedure rooms.

St. Cloud (Minn.) Surgery Center. This center has been in business for more than four decades and has performed more than 10,000 procedures a year since 1999. The center's 81 physicians specialize in oral surgery, ENT, general surgery, neurosurgery, gynecology, orthopedics, podiatry, urology and gastroenterology. The center is managed by SCA.

"We actually do our best in high volume times," says administrator Jeannette Stack. "[We have] dedicated, efficient and flexible teammates, positive attitudes, communication through monthly general staff and department meetings, use of preference cards in OR and PACU, high morale with little turnover of staff and a dedicated group of anesthesiologist that work as a team with our teammates." ■

Contact Rachel Fields at rachel@beckershealthcare.com.

13 Essential ASC Benchmarks & How to Stay Ahead of the Curve

By Laura Miller

Measurable benchmarks are crucial to running a successful surgery center. The most successful surgery centers track clinical, financial and efficiency-focused data. Administrators can track data from one month to the next to identify and project growth. They can also compare the center's data with local and national statistics to see how they compare. When surgery centers are involved with management companies, they can benchmark against other centers managed by the same company. They can also use numbers gathered by the Ambulatory Surgery Center Association and companies such as VMG Health to benchmark their center on a national stage.

"We are looking at our data continuously and comparing those benchmarks of our facility with the rest of Pinnacle III facilities and the ASC Association," says Diane Lampron, administrator at The Surgery Center at Lutheran in Wheat Ridge, Colo., and Peak One Surgery Center in Frisco, Colo., which are affiliated with Pinnacle III. "It gives us a lot of knowledge as to what other people are doing and where we fit in."

Here, three surgery center administrators discuss what benchmarks they rely on daily, monthly and annually to run a profitable ASC.

Daily benchmarks

1. Staffing needs. Kathy Leibl, administrator at Blue Ridge Surgery Center in Raleigh, N.C., which is affiliated with Surgical Care Affiliates, directs her managers to utilize a daily hours log to help the center develop labor targets.

"The hours log helps us judge where we are going to be on our labor so we can develop our staffing needs and patient flow throughout the day," says Ms. Leibl.

Carolyn R. Hollowood, administrator at City Place Surgery Center in St. Louis, which is affiliated with Meridian Surgical Partners, says her surgery center also benchmarks staffing hours per patient. "I make sure the staffing involved coincides with the number of patients we have," she says. On a weekly basis, she examines how many hours each staff member is spending per patient from the time patients arrive at the office through their departure.

2. Spending reports. Ms. Leibl receives spending reports daily from SCA, which she compares to the estimated annual budget for the year. "This is a good tracking tool to allow us to see what our spending is on a daily basis," she says. "We can see if we are over or under budget."

If the center is over budget, Ms. Leibl meets with the purchasing coordinator to see whether there were any issues requiring special supplies for certain cases.

"These reports help us manage the inventory and our costs," says Ms. Leibl. "The purchasing coordinator knows the supplies he needs and he reviews special needs with the OR manager

before submitting them to me. I approve everything he orders or requisitions first. Once it's ordered and I've approved it, the order comes back to me before we pay for it."

3. Case volume. Monitoring case volume daily is essential, both to maximize volume for the month and to understand the long-term trends. Ms. Leibl and her team compare each physician's volume to their plan for the month and use the information to have conversations with the physicians and the office staff.

"We try to plan for every physician vacation when we set the budget and it's not always perfect, so by studying the data daily and having an open dialogue with the doctors about their volumes we can identify opportunities to capture more cases," says Ms. Leibl.

4. Patient satisfaction. Surgery centers should have a way to measure patient satisfaction, which often means collecting patient satisfaction surveys. At Ms. Leibl's surgery center, patients can drop their surveys in a lock box before leaving the center and she tracks their responses.

"I can monitor the feedback from patients, which alerts me if there is an issue," says Ms. Leibl. "At least once per week we have core leadership team meetings of the management team and we discuss any issues that arise. We are a very close-knit group, and meeting regularly helps us communicate. That's important to having a successful facility."

Monthly benchmarks

5. Infections, complications and transfers. Clinical benchmarking is important for proving the quality of procedures performed at a 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 Ms. Leibl. "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 Ms. Hollowood 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 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."

6. 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 Ms. Lampron, 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.

7. 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 these numbers to the previous year's volume. 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."

8. 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."

9. 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 month 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 you 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 claims are often denied for incomplete patient information, ASCs should implement a strategy with 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 dictat-

LUCEA LED & ALPHACLASSIC PRO
THE PERFECT COMBINATION FOR YOUR AMBULATORY SURGERY CENTER

MAQUET
GETINGE GROUP

High Performance and Great Value Across the Continuum of Care

MAQUET has united its evolutionary light and table innovations for Ambulatory Surgery Centers, providing quality surgical lighting and versatile table positioning to help optimize patient outcomes.

LUCEA Surgical Lights

- Bright illumination
- Minimum heat output
- Cool color temperature
- Maximum shadow control

ALPHACLASSIC PRO Surgical Table

- Extensive positioning options and accessories
- Full imaging for C-arm or cassette films
- Easy mobility from 4 large casters
- Excellent surgeon access

Performance you can trust at a value you can expect.

www.maquetusa.com

AT BECKER'S JUNE ASC CONFERENCE, VISIT MAQUET BOOTH #31

ed 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."

10. 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 surgeon is 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."

11. Cancellations. Cancellations on the day of surgery can have a big impact on a 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 they 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."

12. 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."

Yearly

13. Physician satisfaction. Along with compiling all the clinical and financial data from the previous 12 months, it's important to gauge physician satisfaction every year to resolve any issues physicians have and accommodate their continued use of the center. Key questions to ask physicians include:

- Would they recommend the facility to a colleague
- How well they like working at the facility
- How well they feel the management company handles issues
- Whether there are any issues with their staff

"We found that if you ask a few direct questions you get a better response rate," says Ms. Leibl. "We also give them an opportunity to respond if they have a comment about the center. We're fortunate that our physicians are extremely happy; we have recorded 99 percent to 100 percent physician satisfaction over the past three years." ■

Contact Laura Miller at laura@beckershealthcare.com.

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

BECKER'S
ORTHOPEDIC, SPINE & PAIN MANAGEMENT REVIEW
Business and Legal Issues for Orthopedics, Spine and Pain Management

10th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

Improving Profitability and Business and Legal Issues

June 14-16, 2012

Westin Hotel • North Michigan Avenue • Chicago, Illinois


Lou Holtz


Sam Donaldson


Tucker Carlson

- Keynote Coach Lou Holtz, Legendary Football Coach, Analyst, ESPN
- Keynote Tucker Carlson, Contributor, FOX News, Editor-In-Chief, The Daily Caller and Senior Fellow, The Cato Institute - An Outlook on Politics and The Election
- The Best Ideas and Biggest Threats to Orthopedics and Spine - Tom Mallon, CEO, Regent Surgical Health, Brian Cole, MD, MBA, Professor, Dept. of Orthopedics, Dept. of Anatomy and Cell Biology, Section Head, Cartilage Restoration Center, Rush Division of Sports Medicine, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, and Jeff Leland, CEO, Blue Chip Surgical Center Partners, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News
- Healthcare Reform, Politics, and The Next 4 Years - Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians, Thomas J. Bombardier, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, John Caruso, MD, Neurosurgeon, Parkway Surgery Center, and Robert Zasa, MSHHA, FACMPE, Founder, ASD Management, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News
- Evolving Clinical Developments in Interventional Pain Management - Mark Coleman, MD, Senior Partner, National Spine and Pain Centers, LLC
- Moving Spine Procedures to ASCs - Key Business and Clinical Issues - Panel Discussion with Paul Schwaegler, MD, Seattle Spine Institute, PLLC, Richard Kube, MD, CEO, Founder/Owner, Prairie Spine & Pain Institute, Devin Datta, MD, Melbourne Surgery Center, moderated by Jeff Leland, President & CEO, Blue Chip Surgical Center Partners
- Key Concepts to Fixing Physician Hospital Joint Ventures Gone South - Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America
- 10 Best Practices to Improve Billing and Collections - Lisa Rock, President, National Medical Billing Services
- Orthopedics Hospital Joint Ventures, Bundled Payments, 16,000 Cases and Are There Lessons That Can Be Applied to Other Facilities and Systems - James T. Caillouette, MD, Surgeon In Chief, Hoag Orthopedic Institute
- The Key Legislative Priorities of the ASC Industry - William Prentice, JD, Executive Director, ASC Association
- Hand Surgery – Key Business Issues for ASCs and Physician Owned Hospitals - R. Blake Curd, MD, Board Chairman, Surgical Management Professionals
- Developing a Spine-Driven ASC: The Essentials for Success - Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners
- The State of The ASC Industry - Andrew Hayek, President & CEO, Surgical Care Affiliates, and Chairman of The Advocacy Committee
- 7 Keys to Make Orthopedic and Pain-Driven ASCs More Profitable - Larry Taylor, President & CEO, Practice Partners in Healthcare, Inc.
- 102 Sessions, 134 Speakers

For more information, call (800) 417-2035

If you would like to sponsor or exhibit at this event, please call (800) 417-2035

To Register, Call (800) 417-2035 • Fax (866) 678-5755

Email registration@beckersasc.com

Register Online at http://www.regonline.com/10thorthopedicspineASC

Improving the Profitability of Your Orthopedic, Spine and Pain Management-Driven ASC – Thrive Now and in the Future

This exclusive orthopedic, spine and pain management-focused ASC conference brings together surgeons, physician leaders, administrators and ASC business and clinical leaders to discuss how to improve your ASC and its bottom line and how to manage challenging clinical, business and financial issues.

- 102 Sessions
- 134 Speakers
- 25 CEOs as Speakers
- 30 Physician Leaders as Speakers
- Lou Holtz, Legendary Football Coach, Analyst, ESPN
- Tucker Carlson, Contributor FOX News and Editor-In-Chief, The Daily Caller
- Keynote Panels led by Sam Donaldson, ABC News Veteran
- Great Participants From All Over the Country
- Business, Clinical and Legal Issues

The Becker's ASC Review/ASC Communications difference:

1) Benefit from the efforts of Becker's ASC Review and ASC Communications to attract attendees and speakers that are among the smartest people in the ASC industry today.
2) Take discussion and thinking to the highest levels, focusing on the physician-owners, medical directors, ASC administrators and business minded directors of nursing.
3) Access expert views from all sides of the ASC world.

PROGRAM SCHEDULE

Pre Conference – Thursday, June 14, 2012

11:30am – 1:00pm	Registration
12:00pm – 4:30pm	Exhibitor Set-Up
1:00pm – 5:40pm	Pre-Conference Workshop • Concurrent Sessions A, B, C, D, E, F
5:40pm - 7:00pm	Reception, Cash Raffles and Exhibits

Main Conference – Friday, June 15, 2012

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:20pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:20pm – 6:30pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday, June 16, 2012

7:00am – 8:00am	Continental Breakfast and Registration
8:10am – 12:30pm	Conference

Thursday, June 14, 2012

Track A Improving Profits, Valuation and Transaction Issues

1:00 – 1:40 pm
Key Concepts to Fixing Physician Hospital Joint Ventures Gone South
Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America

1:45 – 2:15 pm
10 Statistics Your ASC Should Review Each Day, Week and Month, and What To Do About Them
Brian Brown, Regional Vice President, Operations, Meridian Surgical Partners

2:20 – 2:50 pm
Utilizing Spine Cases to Improve the Profitability of Underutilized Poorly Performing ASCs
Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners,

2:55 – 3:25 pm
7 Keys to Make Orthopedic and Pain-Driven ASCs More Profitable
Larry Taylor, President & CEO, Practice Partners in Healthcare, Inc.

3:30 – 4:00 pm
An Integrated Approach to Introducing Direct to Consumer Marketing to Your Practice
How it Can Deliver Superior Financial Results - Jimmy St. Louis, CEO, Advanced Healthcare Partners

4:05 – 4:35 pm
What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements, Valuations and Other Issues
Jen Johnson, CFA, Managing Director, VMG Health

4:40 – 5:40 pm - KEYNOTE
Leadership and Management in 2012
Lou Holtz, Legendary Football Coach and Analyst, ESPN

Track B – Spine

1:00 – 1:40 pm
Business Planning for Spine-Driven Centers
Jeff Leland, CEO, Blue Chip Surgical Center Partners, and Devin Datta, MD, Melbourne Surgery Center

1:45 – 2:15 pm
Minimally Invasive Multi-Level Fusions in ASCs
Richard Kaul, MD, Owner, New Jersey Spine and Rehabilitation

2:20 – 2:50 pm
Moving Spine Procedures to ASCs – Key Business and Clinical Issues
Paul Schwaegler, MD, Seattle Spine Institute, PLLC, Richard Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute, Devin Datta, MD, Melbourne Surgery Center, moderated by Jeff Leland, President & CEO, Blue Chip Surgical Center Partners

2:55 – 3:25 pm
The Best Ideas for Marketing Spine and Patient Development
Daniel Goldberg, Director of Business Development, New Jersey Spine and Rehabilitation

3:30 – 4:00 pm
Bundled Contracting Initiatives for Orthopedics and Spine
Marshall Steele, MD, Orthopedic Surgery, Marshall Steele & Associates

4:05 – 4:35 pm
Minimally Invasive Spine Surgery for Degenerative Spine Conditions
Miquel Lis-Planells, MD, Michigan Head & Spine Institute

Track C – Pain Management and Spine

1:00 – 1:40 pm
Evolving Clinical Developments in Interventional Pain Management, The Mild Procedure
Mark Coleman, MD, Senior Partner, National Spine and Pain Centers, LLC

To Register, Call 800-417-2035 • Fax 866-678-5755 • Email registration@beckersasc.com
Register Online at http://www.regonline.com/10thorthopedicspineASC

1:45 – 2:15 pm
The Best Ideas Now; Key Ways to Improve Physician Owned Hospital Profits
Larry Teuber, MD, President Medical Facilities Corp. Michael J. Lipomi, President & CEO, Surgical Management Professionals, Goran Dragolovic, SVP, Operations, Surgical Care Affiliates, moderated by Amber McGraw Walsh, Partner McGuireWoods LLP

2:20 – 2:50 pm
Managing Pain Practice Protocols, Branding and Other Tips to Improve Profitability
Vishal Lal, CEO, Advanced Pain Management

2:55 – 3:25 pm
Interventional Pain Management - New Concepts to Reduce ER Visits, Hospitalizations and Re-Admissions
Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago

3:30 – 4:00 pm
Keys to Successfully Establishing and Growing a Premier Pain Center
Stephen Rosenbaum, CEO, and Robin Fowler, MD, Chairman, Medical Director, Interventional Spine & Pain Management

4:05 – 4:35 pm
Intradiscal Biologics Injections for Mild to Degenerative Disc Disease
Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, President & CEO, Alpha Diagnostics, Intraoperative Neurophysiologic Monitoring Board of Directors, American Board of Neurophysiologic Monitoring Board of Directors

Track D – Orthopedics

1:00 – 1:40 pm
5 Key Steps to Improve Profits in Orthopedic-Driven ASCs
Gregory P. DeConciliis, PA-C, CASC, Administrator, Boston Out-Patient Surgical Suites, LLC

1:45 – 2:15 pm
Complex Hand Cases in ASCs, Business and Reimbursement Issues
Steven S. Shin, MD, Kerlan-Jobe Orthopaedic Clinic, and John Seitz, Chairman & CEO, Ambulatory Surgical Group, LLC

2:20 – 2:50 pm
Emerging Orthopedic Procedures in ASCs - Business and Clinical Issues
Michael R. Redler, MD, The OSM Center

2:55 – 4:00 pm
Orthopedic Practices – Why Merging Two Practices Can Help, What Are The Choices for Orthopedic Surgeons, Stay the Course or Sell
Leslie R. "Les" Jebson, Executive Director, University of Florida Ortho and Sports Medicine

3:30 – 4:00 pm
Hand Surgery – Key Business Issues for ASCs and Physician Owned Hospitals
R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

4:05 – 4:35 pm
Succeeding in the Face of Challenges, Dealing with Vendors, Focusing on Clinical Operations and Other Strategies from the Front Line
Charley Gordon, MD, Texas Spine and Joint Hospital

Track E – Business and Profitability Issues; Revenue Cycle; Managed Care Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Selling Your ASC; What Price Can You Expect; What Are The Deal Terms?
Blayne Rush, MHP, MBA, President, Ambulatory Alliances, Patrick J. Simers, EVP, Principle Valuation, LLC, Thomas J. Chirillo, SVP Corporate Development, Surgery Partners, Matt Searles, Managing Director, Merritt Healthcare, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

1:45 – 2:15 pm
Keys to Transforming Surgery Centers Into a Profitable Business
Tom Yerden, CEO, TRY Healthcare Solutions, Jimbo Cross, VP Acquisitions & Development, Ambulatory Surgical Centers of America, Jeff Peo, VP Acquisitions & Development, Ambulatory Surgical Centers of America, moderated by Barton C. Walker, Associate, McGuireWoods LLP

2:20 – 2:50 pm
How to Smartly Use Technology to Become More Efficient in Operations
Scott McDade, Vice President, Surgery Centers, McKesson Medical

2:55 – 3:25 pm
A Step by Step Plan for Selling Your ASC – How to Maximize the Price, Terms and Results and How to Handle the Process
Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America, Introduced by Amber McGraw Walsh, Partner, McGuireWoods LLP

3:30 – 4:00 pm
The Key Legislative Priorities of the ASC Industry
William Prentice, JD, Executive Director, ASC Association

4:05 – 4:35 pm
Physician Owned Hospitals - Adding Ancillaries, Reducing Costs and Legal Compliance
Terry L. Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital, Michael Weaver, Vice President, Symbion, Inc., Amber McGraw Walsh, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track F – Quality, Infection Control, Accreditation, Management

1:00 – 1:40 pm
Developing the Right Clinical Environment for Complex Spine and Orthopedic Cases
Linda Lansing, SVP Clinical Services, Surgical Care Affiliates

1:45 – 2:15 pm
The New CMS Quality Reporting System and What a Center Needs to Do
David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

2:20 – 2:50 pm
Most Common Accreditation Problems in Orthopedic, Spine and Pain-Driven ASCs
Nancy Jo Vinson, RN, RBA, CASC, Principal, NJM Consulting, Nurse Surveyor, AAAHC, Accreditation Association for Ambulatory Health Care

2:55 – 3:25 pm
Infection Control in ASCs – 10 Best Key Practices
Jean Day, RN, CNOR, Director of Clinical Operations, Pinnacle III

3:30 – 4:00 pm
10 Great Ideas for QI Studies
Mary Sturm, SVP of Clinical Operations, Surgical Management Professionals

4:05 – 4:35 pm
ICD-10
Kevin McDonald, SVP of Sales, Revenue Cycle Solutions Division, SoureMedical Solutions

Friday, June 15, 2012

7:00 – 8:00 am –REGISTRATION and CONTINENTAL BREAKFAST

GENERAL SESSION
8:00 am
Introductions - Scott Becker, JD, CPA, Partner – McGuireWoods LLP

8:10 – 8:55 am - Keynote
An Outlook on Politics, Healthcare and the Election
Tucker Carlson, Contributor, FOX News, Editor-In-Chief, The Daily Caller and Senior Fellow, The Cato Institute

9:00 – 9:40 am – Keynote Panel
Healthcare Reform, Politics, and The Next 4 Years
Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians, Thomas J. Bombardier, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, John Caruso, MD, Neurosurgeon, Parkway Surgery Center, and Robert Zasa, MSHHA, FACMPE, Founder, ASD Management, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

9:45 – 10:35 am
The Best Ideas and Biggest Threats to Orthopedics and Spine
Tom Mallon, CEO, Regent Surgical Health, Brian Cole, MD, MBA, Professor, Dept. of Orthopedics, Dept. of Anatomy and Cell Biology, Section Head, Cartilage Restoration Center, Rush Division of Sports Medicine, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, and Jeff Leland, CEO, Blue Chip Surgical Center Partners, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

10:35 – 11:05 am – Networking Break & Exhibits

11:05 – 11:35 am
The State of The ASC Industry
Andrew Hayek, President & CEO, Surgical Care Affiliates, and Chairman of The Advocacy Committee

Track A

11:40 – 12:20 pm
Orthopedics Hospital Joint Ventures, Bundled Payments, 16,000 Cases and Are There Lessons That Can Be Applied to Other Facilities and Systems
James T. Caillouette, MD, Surgeon In Chief, Hoag Orthopedic Institute

12:25 – 1:05 pm
Developing a Spine-Driven ASC: The Essentials for Success
Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

Track B

11:40 – 12:20 pm
Key Concepts to Improve the Profitability and Outcomes of Spine Programs
Kenneth Pettine, MD, Loveland Surgery Center, Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Larry Teuber, MD, President, Medical Facilities Corp., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:25 – 1:05 pm
Spine Surgery: The Next 5 Years
David Abraham, MD, Reading Neck and Spine Center, Bob Reznik, MBA, President, Prizm Development, Inc., David Rothbart, MD, FACS, FACPE, Medical Director, Spine Team Texas, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track C

11:40 – 12:20 pm
The Best Ideas for Improving the Profits of Pain Management-Driven ASC Centers
Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago, Girish Juneja, MD, West Michigan Pain, Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

12:25 – 1:05 pm
The Important of Measuring Clinical Outcomes for Pain Management
Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

Track D

11:40 – 12:20 pm
The Best Ideas for Orthopedics Now
Michael Redler, MD, The OSM Center, Geoffrey S. Connor, MD, Orthopedic Sports Surgery, Alabama Orthopaedic Spine and Sports Medicine Associates, and Greg Horner, MD, Managing Partner, Smithfield , moderated by Charles S. Lauer, Author, Consultant, Speaker and Former Publisher of Modern Healthcare Magazine

12:25 – 1:05 pm
Strategies for Transitioning from Out of Network to a Contracted ASC Model
Greg Horner, MD, Managing Partner, Smithfield Surgical Partners, LLC

Track E

11:40 – 1:05 pm
An 80 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits
Robert Westergard, CPA, CFO, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, Ambulatory Surgical Centers of America

Track F

11:40 – 12:20 pm
Physician Engagement and ICD-10: The Role of the Physician in a Succession Transition
Christy A. May, MS, RHIA, and Kathy Lindstrom, RHIT, ProVation Medical

12:25 - 1:05 pm
Comparing the Reimbursement of Spine Procedures; ASCs vs. Hospitals
Richard N. W. Wohns, MD, JD, MBA, South Sound Neurosurgery, PLLC

1:05 – 1:50 PM – Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E, F

Track A – Improving Profits, Valuation and Transaction Issues

1:50 – 2:30 pm
Physician Hospital Alignment and Business Relationships
Allan Fine, SVP & Chief Strategy and Operations Officer, The New York Eye and Ear Infirmary, Charles "Chuck" Peck, CEO, Health Inventures, and Carole Guinane, Novant Health Ambulatory Care, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

2:35 – 3:05 pm
Assessing the Profitability of Orthopedics and Spine Cases
Andrea Woodell, Managed Care Manager and Matt Lau, Director of Financial Analysis, Regent Surgical Health

3:10 – 3:45 pm
How to Maintain Practice Independence While Effectively Partnering with Hospitals
Charles "Chuck" Peck, CEO, and Christian Ellison, Vice President, Health Inventures, LLC

3:45 – 4:15 pm - Networking Break & Exhibits

4:15 – 4:45 pm
The Best Ideas for Handling Out of Network Patients
Edward Hetrick, President & CEO, Facility Development & Management, Jeff Leland, CEO, Blue Chip Surgical Center Partners, and Danny Bundren, CPA, JD, Symbion Healthcare, Kevin McDonald, EVP ASC Billing Service, SourceMedical, moderated by Melissa Szabad, Partner, McGuireWoods LLP

4:50 – 5:20 pm
What Should Great Medical Directors, Administrators, and DONs be Paid?
Greg Zoch, Partner and Managing Director, Kaye/Bassman International Corp., Christopher Collins, RN, BSHCS, Administrator, Metropolitan Surgery Center, moderated by Rachel Fields, Editor In Chief, Becker's ASC Review

Track B – Spine

1:50 – 2:00 pm
Complex Revision Spine Surgery and ALIF's, TLIFs, DLIFs in ASCs
Lessons Learned, Mistakes to Avoid, Tips to Consider - Devin Datta, MD, Melbourne Surgery Center

2:35 – 3:05 pm
Complex Cervical Spine – Key Developments
Krzystof "Kris" Siemienow, MD, Adult and Pediatric Spine Surgery, Lutheran General Hospital, UIC

3:10 – 3:45 pm
Everything You Need to Know to Successfully Perform Spine Surgery in an ASC
Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm
Intraoperative Monitoring for Spine Cases in the ASC Setting "Understanding the Technology and What a Surgery Center Should and Should Not Pay For
Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, President/CEO, Alpha Diagnostics, Intraoperative Neurophysiologic Monitoring Board of Directors, Spalding Surgery Center, Board of Directors, American Board of Neurophysiologic Monitoring

4:50 – 5:20 pm
Minimally Invasive Outpatient Lumbar Fusions – A Study on Clinical Outcomes in the ASC
Alan Villavicencio, MD, Boulder Neurological & Spine Associates, LLC

Track C – Orthopedics, Spine and Pain Management

1:50 – 2:30 pm
The Use of Implanted Epidural Catheters for Painful Orthopedic Procedures
Tim Lubenow, MD, Rush SurgiCenter

2:35 – 3:05 pm
Developing Spine Centers of Excellence
Bob Reznik, MBA, President, Prizm Development, Inc.

3:10 – 3:45 pm
Getting Started with Spine Surgery in ASCs – 6 Key Concepts
John Peloza, MD, Center for Spine Care

3:10 – 3:40 pm – Networking Break & Exhibits

4:15 – 4:45 pm
Creating a Minimally Invasive Center for Spine and Orthopedics
Sev Hrywnak, DPM, MD, CEO, AASC, Inc.

4:50 – 5:20 pm
Pain Management – Is In-Office Pain Management or Investing in an ASC the Smarter Business Decision
David M. Thoene, Managing Partner, Medical Surgical Partners, LLC

Track D – Management and Development

1:50 – 2:30 pm
Physicians, Hospitals, and Management Companies – What It Takes to Make a Winning Partnership and ASC
Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

2:35 – 3:05 pm
New Developments in Orthopedic and Spine Devices and Implants
Chris Zorn, Vice President of Sales, Spine Surgical Innovation, Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center and Bryan Massoud, MD, Spine Centers of America, moderated by Helen H. Suh, Associate, McGuireWoods LLP

3:10 – 3:45 pm
23 Hour Plus Recovery Care in ASCs
Geoffrey S. Connor, MD, Orthopedic Sports Surgery, Alabama Orthopaedic Spine and Sports Medicine Associates

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm
Third Party Device Acquisition in an Outpatient Pain Management ASC
Nameer R. Haider, MD, Spinal & Skeletal Pain Medicine

4:50 – 5:20 pm
Global Fees and Transparency in Healthcare
Nick Vailas, CEO & Founder, Bedford Ambulatory Surgical Center

Track E – Business and Profitability Issues, Managed Care and Contracting for ASCs

1:50 – 2:30 pm
Orthopedic and Spine Contracting - A Review of Cost Analysis for Orthopedic and Spine and How to Present and Negotiate with Payors
I. Naya Kehayes, MPH, Managing Principal and CEO, and Matt Kilton, MBA, MHA, Princpal and Chief Operating Officer, Eveia Health Consulting & Management

2:35 – 3:10 pm
Orthopedic and Spine-Driven Hospitals – Best Practices
David Rothbart, MD, FACS, FACPE, Medical Director, Spine Team Texas

3:10 – 3:45 pm
Evolving Business, Clinical and Competitive Issues in Spine and Pain
John Prunskis, MD, FIPP, Co-Medical Director, Illinois Pain Institute, Nicholas Qandah, Director of Complex Spine, Associate Residency Program Director, Assistant Professor of Neurosurgery, Virginia Tech University Carilion Clinic, moderated by Holly Carnell, Associate, McGuireWoods LLP

3:45 – 4:15 pm – Networking Break & Exhibitis

4:15 – 4:45 pm
How to Improve Profits – Billing Process Improvement 101
Bill Gilbert, Vice President, Marketing, and Brice Voithofer, Vice President Anesthesia and ASC Services, AdvantEdge Healthcare Solutions

4:50 – 5:20 pm
Health Insurance Plans Are Taking Notice in Fraud and Abuse of Surgical Implants - What Are They Figuring Out and How to Prevent It?
Steven Arnold, MD, Chief Medical Officer, Access MediQuip

Track F – Quality, Infection Control, Accreditation Management

1:50 – 2:30 pm
10 Best Practices to Improve Billing and Collections
Lisa Rock, President, National Medical Billing Services

2:35 – 3:05 pm
Reading the Tea Leaves – Assessing ASC Valuation Trends Utilizing the Latest Industry Data
Elliott Jeter, CFA, CPA/ABV, Partner, and Colin McDermott, CFA, CPA/ABV, Senior Manager, VMG Health

3:10 – 3:45 pm
Key Legal and Legislative Issues
Kristian A. Werling, Partner, McGuireWoods LLP, Bobby Hillert, Executive Director, Texas Ambulatory Surgery Center Society, Stephanie A. Kennan, SVP Government Relations, McGuireWoods Consulting, LLC, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

3:45 – 4:15 pm - Networking Break & Exhibits

4:15 – 4:45 pm
Selecting the Best Staff, Preparing and Training the Staff for Complex Spine Cases in the ASC
Nancy Boyd, Administrator of Crane Creek Surgery Center, and Gina Dolsen, Vice President of Operations, Blue Chip Surgical Center Partners

4:50 – 5:20 pm
Maximizing ASC and Anesthesia Group Relationships
Charles Militana, MD, North American Partners in Anesthesia

5:20 – 6:30 PM - Cocktail Reception, Cash Raffles and Exhibits

Saturday, June 16, 2012

7:00 – 8:10 am – Continental Breakfast

Track A

8:10 – 8:50 am
Orthopedic, Spine and Pain Management Practices and ASCs – 6 Defining Issues
Michael Redler, MD, The OSM Center, Richard N.W. Wohns, MD, JD, MBA, South Sound Neurosurgery, PLLC, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

8:55 – 9:30 am
Cervical Myelopathy
Fernando Techy, MD, Adult & Pediatric Spine Surgery, Lutheran General Hospital, UIC Chicago

9:35 – 10:10 am
Building a More Robust Case for Spinal Surgery
Stephen Rothenberg, JD, Consultant, Numerof & Associates, Inc.

10:15 – 10:50 am
Healthcare False Claims and Anti-Trust Litigation
Jeffrey C. Clark, Partner, and David J. Pivnick, Associate, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

10:55 – 11:30 am
The Business of Spine Reimbursement and Coding Changes
Barbara Cataletto, MBA, CPE, CEO, Business Dynamics, Ltd.

Track B

8:10 – 8:50 am
Information Technology for Surgery Centers – Achieving Positive Outcome and Avoiding Complications
Michael Rauh, MD, UB, Orthopaedics and Sports Medicine, Marion Jenkins, PhD, Founder & CEO, QSE Technologies, Inc., moderated by Holly Carnell, Associate, McGuireWoods, LLP

8:55 – 9:30 am
10 Key Concepts from Top Performing Pain Management Programs
Amy Mowles, President & CEO, Mowles Practice Management

9:35 – 10:10 am
New Advances in Sacroiliac Joint Problems
Richard A. Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute

10:15 – 10:50 am
Managed Care Contracting - Tips to Succeed with ASC Contracting
Andrea Woodell, Managed Care Manager, Regent Surgical Health

10:55 – 11:30 am
Sell Your ASC or Stay the Course - 7 Key Considerations
Helen Suh, Associate, McGuireWoods LLP, and Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track C

8:10 – 8:50 am
Optimizing Your Revenue Cycle
Catherine Meredith, RN, BS, CASC, Vice President of Finance, Ambulatory Surgical Centers of America

8:55 – 9:30 am
Key Practices to Improve Infection Rates and Clinical Quality
Sandra Jones, MBA, MS, CASC, FHFMA, CEO, EVP, ASD Management

9:35 – 10:10 am
Challenges of Spine in a Multi-Specialty ASC and the Administrator's Role in Turning Around a Poorly Performing ASC – A Case Study
Nancy Boyd, Administrator, Crane Creek Surgery Center, and Gina Dolsen, Vice President, Blue Chip Surgical Center Partners

10:15 – 10:50 am
15 CPT and Coding Issues for Orthopedics and Spine
Stephanie Ellis, RN, CPC, Ellis Medical Consulting, Inc.

10:55 – 11:30 am
How ASCs Can Meet Meaningful Use, ICD 9 and Other IT Challenges
Suzanne Webb, ASC Billing Specialists, LLC

Track D

8:55 – 9:30 am
HR Practices That Dramatically Improve Quality and Profits
Thomas H. Jacobs, President & CEO, MedHQ

9:35 – 10:10 am
Key Tips for Quality Assurance and Infection Prevention
Dotty J. Bollinger, RN, JD, CASC, LHRM, Chief Operating Officer, and Nicole Gritton, MSN/MBA, Director of Nursing, Laser Spine Institute

10:15 – 10:50 am
Key Implantable Device Benefit Management (DBM) Issues Facing ASCs
Chris Crisman, National Vice President & General Manager, Implantable Provider Group, Inc. and Lynne Stoldt, Administrator at Melbourne Same Day Surgery Center

GENERAL SESSION
11: 35 – 12:30 pm
Conducting a Compliance Review of Your ASC or Physician Owned Hospital
Holly Carnell, Associate, and Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:30 pm – Meeting Adjourns

Register by May 1, 2012 and SAVE!

10th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

Improving Profitability and Business and Legal Issues

Great topics and speakers focused on key business, clinical and legal issues facing ASCs –

- **102 Sessions**
- **134 Speakers**

To register, contact
ASC Communications
Call (800) 417-2035 • Fax (866) 678-5755
Email registration@beckersasc.com
Register Online at http://www.regonline.com/10thorthopedicspineASC

Improving the Profitability of Orthopedic, Spine and Pain Management-Driven ASC – Thrive Now and in the Future

- Keynote Coach Lou Holtz, Legendary NCAA Football Coach, Analyst, ESPN
- Keynote Tucker Carlson, Contributor, FOX News, Editor-In-Chief, The Daily Caller and Senior Fellow, The Cato Institute - An Outlook on Politics and The Election,
- Great topics and speakers focused on key business, financial, clinical and legal issues facing Orthopedic, Spine and Pain Management-Driven ASCs
- 101 Sessions, 134 Speakers
- 30 Physician Leaders as Speakers, 29 CEOs as Speakers
- Focused on Orthopedic Surgeons, Orthopedic Spine Surgeons, Neurosurgeons and Pain Management Physicians, ASC Physician Owners, Administrators and Others
- Immediately useful guidance plus great keynote speakers
- New and Advanced Procedures for ASCs — Spine, Intradiscal Biologics Injections for Mild to Moderate Degenerative Disc Disease, Lumbar Fusions and More
- Have an outstanding time in Chicago
- Earn Your CME, CASC, CEU Credits - 15.25 CASC credits and 15 CME and CEU credits
- Big Thoughts Combined with Practical Guidance
- Legal Issues for ASCs and Physician Owned Hospitals
- Great Networking
- Understand the Impact of Healthcare Reform on ASCs
- Orthopedics, Spine and Pain Management
- Benchmarking, Cost Cutting, Safe Harbors, Billing and Coding, Revenue Growth and more

For more information, call (800) 417-2035 or email sbecker@beckershealthcare.com

If you would like to sponsor or exhibit at the program, please call (800) 417-2035.

To Register, Call 800-417-2035 • Fax 866-678-5755 • Email registration@beckersasc.com
Register Online at http://www.regonline.com/10thorthopedicspineASC

Lou Holtz has established himself as one of the most successful college football coaches of all time. Born Louis Leo Holtz on January 6, 1937, Holtz grew up in East Liverpool, Ohio, just up the Ohio River from his Follansbee, West Virginia, birthplace. He graduated from East Liverpool High School, earned a Bachelor of Science degree in history from Kent State in 1959 and a master's degree from Iowa in arts and education in 1961. He played linebacker at Kent State for two seasons before an injury ended his career. He has received 4 honorary doctorate degrees.

COACH

Holtz is the only coach in the history of college football to: 1) Take 6 different teams to a bowl game. 2) Win 5 bowl games with different teams. 3) To have 4 different college teams ranked in the final Top 20 poll. Despite never inheriting a winning team, he compiled a 243-127-7 career record that ranked him third in victories among active coaches and eighth in winning percentage. His 12 career postseason bowl victories ranked him fifth on the all-time list. Holtz was recently selected for the College Football Hall of Fame, class of 2008, which places him in an elite group of just over 800 individuals in the history of football who have earned this distinction. Approximate 1 in 5,000 people who played college football or coached it make it into the Hall of Fame.

ESPN Sports Analyst

Currently, Holtz serves as a college football studio analyst on ESPN. He appears on ESPNEWS, ESPN College GameDay programs, SportsCenter as well as serves as an on site analyst for college football games.

Sam Donaldson, a 44-year ABC News veteran, served two appointments as chief White House correspondent for ABC News from January 1998 to August 1999 and from 1977- 1989, covering Presidents Carter, Reagan and Clinton. Donaldson also co-anchored PrimeTime Live with Diane Sawyer from August 1989, until it merged with 20/20 in 1999. He co-anchored the ABC News Sunday morning broadcast, This Week With Sam Donaldson & Cokie Roberts, from December 1996 to September 2002. From October 2001 to May 2004, he hosted The Sam Donaldson Show - Live in America, a daily news/talk radio program broadcast on ABC News Radio affiliates across the country. In the three hour show, Donaldson tackled the day's top stories and important issues-taking comments from newsmakers, engaging listener calls and, of course, inserting his own unique experience and opinion.

Most recently, Donaldson hosted the show Politics Live on ABC News Now, the ABC News digital network. From 1999 to 2001, Donaldson also hosted SamDonaldson@abcnews.com, the first regularly scheduled internet webcast produced by a television network. On it, he interviewed former Presidents Jimmy Carter, Gerald Ford and George Bush, along with such diverse personalities as actor Sean Connery, comedian Janeane Garofalo, tech company CEO Jeff Bezos and sports great Willie Mays.

Donaldson has covered every national political convention since 1964 with the exception of the 1992 Republican Convention in Houston. He reported on the presidential campaigns of Senator Barry Goldwater, Senator Eugene McCarthy, Senator Hubert Humphrey, President Jimmy Carter, President Ronald Reagan and Governor Michael Dukakis. He also reported as an eye-witness on Spiro Agnew's no contest plea in a Baltimore courtroom that forced Agnew's resignation from the Vice Presidency.

In 2008, Donaldson received the AFTRA Media and Entertainment Excellence Award as well as the RTNDA Paul White Award. In 1998, Donaldson received the Broadcaster of the Year Award from the National Press Foundation. The Washington Journalism Review named him the Best Television White House Correspondent in the Business in 1985 and the Best Television Correspondent in the Business in 1986, 1987, 1988 and 1989. Donaldson has won many other awards, among them four Emmy Awards and three George Foster Peabody Awards.

Tucker Carlson is a veteran journalist and political commentator, currently working for the Fox News Channel. Carlson is also the editor-in-chief of TheDailyCaller.com, a news and opinion site. Carlson joined Fox from MSNBC, where he hosted several nightly programs. Previously he was the co-host of *Crossfire* on CNN, where he was the youngest anchor in the history of that network. During the same period, Carlson also hosted a weekly public affairs program on PBS. A longtime writer, Carlson has reported from around the world, including dispatches from Iraq, Pakistan, Lebanon and Vietnam. He has been a columnist for *New York* magazine and *Reader's Digest*. He currently writes for *Esquire* and *The New York Times* magazine. Carlson began his journalism career at the *Arkansas Democrat-Gazette* newspaper in Little Rock. His most recent book is entitled, *Politicians, Partisans and Parasites: My Adventures in Cable News*. In 2006, he appeared on ABC's Dancing with the Stars. Carlson is currently working on his third book.

TO REGISTER, CALL (800) 417-2035

REGISTRATION FORM

Photocopies are acceptable. Please print or type below. Please use a separate registration form for each attendee.

10th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

Improving Profitability and Business and Legal Issues

THE 10TH ANNUAL CONFERENCE FROM ASC COMMUNICATIONS

JUNE 14-16, 2012

WESTIN HOTEL • CHICAGO, ILLINOIS

REGISTRATION INFORMATION

First/Last Name: _____

Degree (As you wish it to appear on your badge): _____

Title: _____

Facility/Company: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

REGISTRATION FEES

ANNUAL CONFERENCE & EXHIBITS

Receive multiple registrant discount(s). The more people you send, the greater discount you receive. The prices listed below are per person. Your registration includes all conference sessions, materials and the meal functions.

MAIN CONFERENCE ONLY

	FEES (Before 5/1/11)	AMOUNT	FEES (After 5/1/11)	AMOUNT
1st Attendee	$625	$ _____	$725	$ _____
2nd Attendee	$575	$ _____	$675	$ _____
3rd Attendee	$525	$ _____	$625	$ _____
4th Attendee or more	$500	$ _____	$600	$ _____

(Ask about larger group discounts)

MAIN CONFERENCE + PRE-CONFERENCE

	FEES (Before 5/1/11)	AMOUNT	FEES (After 5/1/11)	AMOUNT
1st Attendee	$725	$ _____	$825	$ _____
2nd Attendee	$675	$ _____	$775	$ _____
3rd Attendee or more	$625	$ _____	$725	$ _____
4th Attendee or more	$600	$ _____	$700	$ _____
Add $100 to subscribe to Becker's ASC Review or Becker's Orthopedic & Spine Review			(+$100)	$ _____

TOTAL ENCLOSED $ _____

PAYMENT INFORMATION

❑ Enclosed is a check, payable to ASC Communications, Inc. Check #: _____

❑ I authorize **ASC Communications, Inc.** to charge my: ❑ VISA ❑ MasterCard ❑ American Express

Credit Card Number: _____ Expiration Date: _____

Printed Cardholder Name: _____ Zip Code: _____

Signature: _____ CVV#/3-digit #: _____

TO REGISTER

COMPLETE REGISTRATION FORM AND MAIL OR FAX AS FOLLOWS:

Mail: **Make checks payable to ASC Communications** and mail to: ASC Communications June Meeting, 315 Vernon Avenue, Glencoe, IL 60022

Fax: Fax registration form with credit card information to (866) 678-5755

Call: Call (800) 417-2035 to register by phone

Email: registration@beckersasc.com

Web site: www.BeckersASC.com

Cancellation Policy: Written cancellation requests must be received by May 1, 2012. Refunds are subject to a $100 processing fee. Refunds will not be made after this date.

REGISTER ONLINE AT:
http://www.regonline.com/10thorthopedicspineASC

Multi-Attendee Discount Policy: To be eligible for the discount, your ASC must be registered at one time and work at the same address. Just copy the registration form for each attendee. Employees from a 2nd location are not eligible for the discount.

GENERAL INFORMATION

HOTEL RESERVATIONS

Westin Hotel has set aside special group rates for conference attendees. To make a reservation, go to **http://www.starwoodmeeting.com/Book/ascjune2012**

The Westin
909 N. Michigan Avenue
Chicago, IL 60611
(312) 943-7200
Group Room Rates: $289

CONFERENCE QUESTIONS

For additional information or questions regarding the conference please contact

ASC Communications
Phone: (800) 417-2035
Fax: (866) 678-5755
Email: registration@beckersasc.com

For *Becker's ASC Review* and exhibitor/sponsorship questions contact (800) 417-2035

ADA REQUEST

If you require special ADA accommodations, please contact us at (800) 417-2035

ONLINE REGISTRATION

http://www.regonline.com/10thorthopedicspineASC

Register before May 1, 2012, and SAVE on registration!

For information on exhibiting and sponsorships, call (800) 417-2035

Visit www.BeckersASC.com.

5 Things to Know About Successful Spine Surgery Center Joint Ventures

By Laura Miller

Jeff Leland, CEO of Blue Chip Surgical Center Partners, has been involved in the management and development of several spine-focused ambulatory surgery centers, including joint ventures between hospitals and physician groups. He discusses five core concepts for achieving and maintaining success with joint venture spine ASCs.

1. Joint venture spine surgery centers can be beneficial for hospitals and physicians. Physicians are often eager to hold ownership in joint venture surgery centers because they are able to reap obvious benefits of faster turnaround times, lower infection rates and additional ancillary income. Hospital and health system executives are often more cautious about committing to the project because they fear an ASC will mean a lower case volume of spine procedures in the hospital. However, in his experience, Mr. Leland has found the opposite is true.

"Hospital and health system executives have some trepidation about doing these projects because they are fearful of giving up cases that would be done in the hospital," he says. "We created a spine surgery center with a hospital and the hospital tracked its inpatient spine work for two years before the project and three years afterward. The hospital found its inpatient spine case volume actually went up because surgeons were more productive in the ASC, which allowed them to take on more inpatient cases."

In this particular example, the hospital was in a community where there weren't enough surgeons to meet patient demand. However, with the efficiency of the surgery center — where there was only 10 to 11 minutes between cases — they were able to close the coverage gap and increase market share.

2. The project builds stronger relationships between physicians and hospitals. In many communities, physicians and hospital executives have an adversarial relationship from decades of battling over business and clinical issues. However, success in today's healthcare market is dictated by the ability of different providers to work in tandem. Launching a joint venture spine surgery center can help bridge the gap between providers so both groups are working toward the same goals and both have skin in the game.

"Hospital executives and orthopedic spine surgeons and neurosurgeons come to know each other better when they are working on a joint venture ASC together," says Mr. Leland. "As a result of the relationship around the surgery center, they build more loyalty to one another and the surgeons who are "splitters" often, in time, begin bringing more inpatient cases to the partner hospital."

It's also easier for hospital executives to obtain physician support for cost-cutting and business measures if the physicians have financial investment in the project. A hospital's aligned surgeons often are difficult to motivate or recruit to work on the hospital's business opportunities like a Spine Center of Excellence program because the surgeons aren't appropriately incentivized or effectively motivated to participate in the program.

"When doctors have a key interest in the surgery center, they have an interest in standardizing implants and instrumentation, which translates to the hospital," says Mr. Leland. "Our hospital partners have experienced the benefit of surgeons changing preference cards once they understand the cost of instruments and supplies."

3. Initiate conversations about starting a joint venture intelligently. Whether the hospital executives or physician group initiate the conversation, a great deal of preparation should go into joint venture plans before even mentioning the partnership to the other side.

"If the project is initiated by surgeons, the best way to proceed is to agree on all of the key points among the partners and create legal documents before the project is introduced to the hospital," says Mr. Leland. "Tell hospital executives the train is pulling out of the station — the surgeons are creating this ASC — and there is a seat on the train for the hospital, and it will depart soon." Physician groups should be prepared to give hospital executives 30 to 60 days to make a decision about the project. Unfortunately, without a deadline, some hospital executives will move in hourglass time when the surgeons expect to move in nano-second time.

"On the other side of the coin, when the hospital initiates the idea of the project, we will often negotiate and agree upon key terms with the hospital well in advance of presenting the idea to the physicians, and things can move more quickly from there," says Mr. Leland.

4. Physician control of the surgery center is important. Mr. Leland feels it's important for physicians to hold majority ownership in the surgery center while hospitals and management companies hold minority shares. Generally speaking, in the joint ventures Blue Chip invests in, physicians hold 51 percent equity while hospitals and management companies each hold 24.5 percent equity. Generally, each physician involved holds an equal amount of the equity owned by the physician group.

"Typically, I believe the best surgery centers are the ones where physicians have control," says Mr. Leland. With majority ownership, the physicians can make decisions about care delivery processes and protocols, while still benefiting from hospital contracting power and the community reputation and status of the hospital.

5. Physician work on spine centers of excellence is more feasible. Creating a "Spine Center of Excellence" is difficult and often requires physicians to spend extra time with administrative duties, agreeing protocols, designing clinical pathways and clinical coordination. Physicians are often busy with their clinic and in the OR, leaving little time for meetings where they aren't directly compensated. However, if physicians are able to accrue additional income from the joint venture surgery center, they will often make time to focus on helping create a meaningful program.

"Spine centers of excellence are entities created by the hospital to help facilitate the ease with which patients can access the system," says Mr. Leland. "Surgeons have to be involved to standardize protocols and processes. It's expensive for surgeons to spend three hours in a meeting to sort that out, but when they are taking in $15,000 to $20,000 more per month with ownership in the ASC, they are more relaxed about becoming involved." Once a spine surgeon helps create and expand a "Spine Center of Excellence," the surgeons are often pleased with increased volume of patients and the ease with which the patients transition through the delivery system — the ancillary income from the ASC makes it much easier for the surgeons to "be fully committed" to the project. ■

Contact Laura Miller at laura@beckershealthcare.com.

10 Reasons Physicians Take Cases Out of Surgery Centers

By Rachel Fields

Blayne Rush, MHP, MBA, president of Ambulatory Alliances, and Stuart Katz, MBA, FACHE, director of TMC Orthopaedic Outpatient Surgery in Tucson, Ariz., discuss 10 reasons physicians take ASC-eligible cases to other facilities.

1. Preferences for equipment or instruments not available at the surgery center. Mr. Rush says physicians may decide to take cases elsewhere because the surgery center does not stock the supplies or equipment they need. This may be a budgetary issue, but in all likelihood, it comes down to failed communication between your staff and the physician's office. "You have to have a relationship with everyone in the doctor's office — the practice manager, the scheduler, the doctor himself," he says. "If you have a relationship with all those people, you'll get to the heart of the issues." Talk regularly with your physicians' office staff and ask about supplies that are no longer used or any requests that have not been met.

2. Patients are inappropriate for surgery at the ASC. Mr. Katz says sometimes cases go elsewhere simply because the surgery center can't perform them safely. "The biggest reason that physicians take patients out of surgery centers is the presence of co-morbidities," he says. Before every procedure is scheduled, his surgery center performs pre-anesthesia testing on the patient and scores them on an ASA scale of 1-4. "Anybody with more than ASA III doesn't come," he says.

He adds that patients also go to the hospital if they have had problems with anesthesia in the past. This is one issue that surgery center leaders can't do much about; just make sure the physician and ASC are on the same page about which patients are appropriate for ASC surgery and which aren't.

2. Investments in another facility or a treatment suite at their office. Mr. Rush says it is becoming more common for physicians — especially pain and OB/GYN physicians — to house surgery and procedure suites in their offices. "They'll set up that procedure room in their office and then take what they can't do in their office to the ASC," he says.

He says he also sees physicians with investments or affiliations with multiple surgery centers and hospitals, meaning cases are divided among several facilities. "Sometimes the physician will have investment in an out-of-network center and an in-network center, and they'll bring any patients with out-of-network benefits to the out-of-network center and will bring Medicare and other lower-reimbursed insurance plans to the other ASC," he says. Mr. Rush says scheduling difficulties can easily drive a physician to another surgery center, so surgery center staffers must make sure that scheduling is easy.

3. Hospital politics and pressures. Mr. Rush says some physician offices are located on hospital campuses, meaning there's a hospital representative in their office multiple times a week. "The hospital rep will go and influence where the patients are referred, and sometimes it's the squeaky wheel that gets the grease," he says. He says while an ASC may not be able to compete in terms of proximity, ASC leaders can do their best to make the ASC an efficient, comfortable place to work. "Create positive pressure rather than negative pressure," Mr. Rush says. "Make sure they want to leave the hospital and drive down the street to your center because they're wanted there, the staff is happy and it's efficient in a way the hospital can't necessarily imitate," he says.

4. Cases that require after-hours treatment. Most surgery centers are only open during normal business hours, meaning a midnight fracture will probably need to be treated at the local hospital or emergency care center. "If it's after hours on a weekend, the physician will probably take care of the problem at the hospital," he says. He says in some instances, a case can be delayed until Monday or Tuesday, but the priority here should be the safety and comfort of the patient.

5. Confusion about third party payor contracts. If a center is out-of-network, physicians may be hesitant to bring their cases to the center because of payor pressure. "Some insurance carriers have sent out letters to physicians and essentially made a soft threat that if they take a patient to an out-of-network facility, they're in technical violation of their agreement with the insurance company," Mr. Rush says. He adds that physicians may simply be confused about which patients can be treated at the center based on their insurance contracts.

If a patient comes to the surgery center and later receives an unexpected bill, he or she is likely to complain to the physician who performed the surgery. "If one irate patient comes to the physician's office about billing, then the physician starts getting upset," Mr. Rush says. Make sure to communicate clearly with the physician's office about which types of insurance the surgery center accepts, and communicate with patients about their predicted financial responsibility prior to the procedure.

6. Scheduling/block time non-compliance. Use of block time can cause conflicts among physicians, all of whom want their cases to start and end on time. Mr. Rush says sometimes one physician will start his cases late and bump into another surgeon's block time, effectively squeezing the latter surgeon's block time because he still has to finish to make room for the next provider. He says he has also seen surgery centers that split a block down the middle because two physicians wanted the time and could not agree. "That didn't solve the problem," he says. "You had two upset people because they tried to split the baby instead of accommodating both of them and creating an incentive for one of them to change block times."

7. Lack of adherence to start times. There are various reasons surgery can be delayed in the morning, including a late arrival from the physician or a late start by anesthesia. If the physician has to wait for other staff members to be ready to start his case, he will likely be annoyed and consider taking his cases elsewhere. Mr. Rush says the key is to isolate each problem causing late starts and deal with them individually, rather than just resolving to "start on time." "Only one issue is not a big issue, but when you add them all together, you often don't get the surgery started until 8:30 a.m.," he says.

8. Lack of familiarity or comfort with ASC staff. It's simple: If a physician doesn't know or respect the surgery center staff, he is less likely to bring cases to the center. Try to match the same staff members with each physician on a regular basis to improve efficiency and physician satisfaction. An operating room where everyone knows each other will move faster than an OR full of strangers. In addition, physicians like to be comfortable with their staff and don't want to constantly work with new people who don't understand their preferences.

9. Lack of transparency — both financially and with executive decisions. If a center plays favorites with physician investors and discloses information to particular partners, other physicians are likely to be annoyed. "If you have a group of partners within a surgery center and one partner controls most of the center's stock, often the center will accommodate that physician in a certain way that no one else receives," Mr. Rush says.

Mr. Rush says all physicians should be invited to be involved in surgery center operations — a move that benefits the surgery center too, since dedicated physicians usually mean better outcomes and higher profits. Every significant decision at the surgery center should be run by the physician-investors, and no physician should be treated differently because of the amount of stock he owns in the center.

10. Lack of partner enthusiasm and partner frustration. When partners initially join a surgery center, they will probably be excited to bring cases and get involved with surgery center projects, Mr. Rush says. Over time, however, they may notice that another partner who brings more cases to the center receives preferential treatment. He recommends treating every partner, even younger ones, with the same amount of respect, keeping in mind what the physician could do for the surgery center in the future. "The person who's doing 20 cases a month now could be doing 50 cases a month in five years," Mr. Rush says. "You need to look at them and see where they're going," he says.

He says that a lack of enthusiasm from physicians can be the death knell of a center, since someone else is almost certainly recruiting your physicians to another facility. Make sure to keep your partners excited about the opportunities at your center, even after they've been with you for a number of years. ■

Contact Rachel Fields at rachel@beckershealthcare.com.

What Can Football Teach Us About Surgery Center Management?

By Rachel Fields

"As I watched Alabama win this year's national championship in college football as well as the national championship in 2009, it struck me how similar running a surgery center is to coaching a football team," says Joe Zasa, co-founder of ASD Management. Mr. Zasa grew up in Birmingham and attended the University of Alabama, an institution with an abiding love of football and a storied past in the sport.

"I have had a particularly unique window with respect to the football program, and particularly the head football coaches, from Bear Bryant to the current coach, Nick Saban," he says. "Over this time, Alabama had three very good coaches and several mediocre coaches. There are similarities between the coaches who succeeded."

According to Mr. Zasa, the "rule of three" applies to both sports programs and to business. The most successful programs have:

1. A system. Establishing a system of operations is the core of a surgery center and a sports program, Mr. Zasa says. "The next time you watch Monday Night Football, listen to the starting lineup," he says. "You will find that most of the players did not play on championship teams, or even the historic great college football programs. They were excellent players in mediocre systems."

He says the system for a surgery center has three components: 1) clinical systems, 2) business office and 3) risk management. Each area of the surgery center must have a strict adherence to center culture and strategic direction in order to succeed. Mr. Zasa says when his company approaches a surgery center in need of a turnaround, the problems often lie with systematic failures. For example, the surgery center may not load their contracts into a computer system to track their accounts receivable. The supply area may look like a McKesson warehouse — full of supplies that will never be used but have already been purchased, effectively throwing money away. Employees don't have a defined process for doing their jobs, so they end up dropping claims and forgetting to follow up on collections.

The surgery center should have a pervasive culture that touches every area of the facility, Mr. Zasa says. This doesn't just mean purchasing and printing out generic policies and procedures for a small business; it means truly understanding how each role in the ASC contributes to profitability and advising staff members on how their tasks should be performed. Staff members should know how to answer the phone, how to drop claims and how to audit processes to track progress. Mr. Zasa says the surgery center should also have an employee bonus program in place that provides tangible financial rewards for good work. The bonus program should not be a "guessing game": Employees should understand they will reap exactly what they sow.

2. Recruitment. According to Mr. Zasa, the Alabama football program has had a top five recruiting class for the last five years — and they have won two national championships. "This is not a coincidence, but it is a mistake to believe that recruiting players is the solution," Mr. Zasa says. "You must have a superior system and superior execution."

This doesn't necessarily mean recruiting "stars" if they won't work with the other members of the surgery center, Mr. Zasa says. "We spend a lot of time with staff members, and we have pre-screening tests to make sure they're a good fit for the center," he says. While a small surgery center can't necessarily implement full-time training for each employee, Mr. Zasa says it helps to have regular on-site training and presentations about the center's culture.

Physicians and anesthesia providers should be similarly recruited to work within the "system" of the center, he says. Anesthesia groups should be able to turn rooms quickly, choose appropriate drugs for the surgery center and have a strong interest in the quality aspects of the ASC. "You want anesthesiologists and CRNAs who have an interest in outpatient surgery," he says. The same is true for physicians: Every physician recruited to the center should fit within the center's strategic plan, bringing a needed specialty and an eye towards quality improvement. The physician should also get along well with the other providers at the center.

3. Execution. Execution is about completing a series of small tasks that create success in the long run, Mr. Zasa says. A football team can't win a championship just by thinking about it; the team has to run drills during every practice and concentrate on every individual play in order to succeed. Your surgery center might have a good system and great players but fail because of poor execution, Mr. Zasa says.

He says execution comes down to what your staff does on a daily basis. The big picture is useful to keep in mind, but every staff member should primarily be focused on his or her daily tasks. If a team member is distracted by thinking about their upcoming vacation or a fight with their spouse, they will jeopardize the success of the ASC just as a football player would jeopardize the potential to win. "Every day, your staff should be thinking, 'This is the job I need to do today,'" he says. "It's about focusing on what's important now." Over time, completing those small daily tasks will add up into long-term success. ■

Contact Rachel Fields at rachel@beckershealthcare.com.

Learn more about ASD Management at www.asdmanagement.com.

5 Observations on Physician Employment & Recruitment From Dr. Richard Kube

By Rachel Fields

Richard Kube, MD, CEO, founder and owner of Prairie Spine and Pain Institute in Peoria, Ill., discusses five trends impacting physician employment and surgery center investor recruitment this year.

1. Employed primary care physicians are cutting off referrals to surgery centers. Dr. Kube says in his area, hospital employment has concentrated mainly on primary care physicians, posing a threat to specialist referrals in the long term. He says that while hospitals should technically not be able to dictate where treatment occurs, employed primary care physicians frequently push specialists to perform cases at the hospital.

"It's more physician-driven than facility-driven, even though the facility is still probably behind it at the end of the day," he says. He says physicians who bring their cases to the local surgery center are likely to receive a call from the referring primary care physician, asking why the case was not brought to the hospital. Dr. Kube says he has even seen primary care physicians threaten to pull referrals from specialists who choose to take their cases elsewhere.

2. Direct-to-consumer marketing can improve volume in heavily employed areas. Dr. Kube says direct-to-consumer marketing can help to offset limited referrals from primary care physicians. "If patients are coming to us directly, hospitals and employed physicians have less control over where we can do the procedure," he says. "It has required us to be a lot more active in marketing so that we can get those referrals on our own instead of having to rely on primary care physicians to send cases to us." Marketing your practice or surgery center can involve making and regularly updating a website, posting ads in the local newspaper and advertising in local hotspots to build patient traffic.

3. Large, private physician practices are less susceptible to employment. Dr. Kube says subspecialists are generally resisting hospital employment in his area due to the presence of large specialty groups. "A lot of facilities don't have the resources to replace these large, private groups," he says. "It's much easier for the hospitals to chip and chisel away at primary medical offices, because there are dozens of those. If they want to target ENT, there's one major powerhouse group here." He says the larger groups still have a lot of autonomy in delivering services because they control most of the physicians in a particular specialty.

4. Physicians may be moving away from employment. Though many physicians are moving towards hospital employment for the security of an annual salary, Dr. Kube says others are moving back to private practice after hospitals fail to "follow through" on their promises. "There are some doctors who are now very regretful that they ever got involved with the hospital, and they are trying to get out of the hospital system and branch out on their own," he says.

He believes some employed physicians are realizing that after receiving an attractive sign-on bonus from the hospital, their compensation has decreased compared to what they were making in private practice. "Doctors that are doing the same type of work in a private setting may not do as well early on, but once they get established five or 10 years later, they're making substantially more," he says. Surgery centers should watch for physicians leaving the local hospital or health system and target those physicians for investment, as they may be looking to supplement their income with ancillary revenue.

5. Younger physicians are hesitant to invest in surgery centers because of risk. Dr. Kube says while most physicians are interested in ancillary revenue from surgery center investment, younger physicians are frequently hesitant to pursue investment because of the risk. "In the era of so many doctors wanting to be employed by a hospital, there's an incredible aversion to risk," Dr. Kube says. "Even when you're offering them a guaranteed return on investment, they don't want to buy into anything. They don't want to take that capital risk — which is, of course, the hallmark of business." He says six years ago, almost none of his graduating colleagues had any interest in working for a hospital, but today's young physicians seem to be prioritizing security over profitability. ■

Contact Rachel Fields at rachel@beckershealthcare.com.

Dr. John Byers: 4 Priorities for ASC Physician Investors in 2012

By Rachel Fields

Physician leaders are a crucial part of any surgery center. Far from just being a source of cases, physicians can help with managed care contracting, vendor negotiations, quality improvement projects, financial analysis and physician recruitment — and any great surgery center should have a few physicians involved in operations. John Byers, MD, medical director of the Surgical Center of Greensboro (N.C.), managed by Surgical Care Affiliates, discusses four priorities for ASC physician investors this year.

1. Work to decrease implant costs. Dr. Byers says surgery centers can only do so much to increase reimbursement; the real task ahead is controlling costs. He says this year, his surgery center has decided to focus on reducing implant costs. "We need to try and get the implant companies to ratchet down their unbelievably high margin," he says. "As far as I can tell, this is the only remaining industry in healthcare that makes such a high margin on their products." He says the surgery center plans to hold a meeting with all its orthopedic physicians to discuss how much the center spends on implants and how costs break down per surgeon.

He says part of the challenge is convincing physicians to change implant brands, which can be a tough sell for an ASC administrator. "Surgeons have big egos, and they're not necessarily going to listen to an administrator," he says. While a surgeon might tell an administrator that he can't use an implant due to clinical reasons, he might not be so confident in using this excuse with another physician. With the surgeons on board and willing to use alternatives, Surgical Center of Greensboro can utilize SCA's economy of scale and S4 program to analyze case and surgeon cost in order to bring competition into the mix and hopefully lower spend.

2. Control your relationship with vendor representatives. Vendor representatives can have an adverse effect on surgery center costs by convincing physicians to adopt more expensive products, Dr. Byers says. He says one of his center's priorities this year is to loosen vendors' grip on physicians.

The center will create an implant committee to increase transparency around implant costs in the center, then present the data to vendor representatives. "We're going to go to these specific reps and show them we're organized, that they can't go to Doctor A, B and C separately and whisper in their ear that they need a certain product," he says. He says presenting a unified front should demonstrate the center is serious about negotiating lower costs. Also limiting the general entry of the sales representatives into the center can be helpful and our general partner provides a web based access solution that manages some of this problem.

3. Concentrate on quality issues at your center. Dr. Byers says Surgical Care Affiliates, the surgery center's general partner, is actively involved in the process of developing quality measures for the ASC industry. "[SCA CEO] Andrew Hayek has made a positive spin on these requirements by working with the government

from the ground up and proposing some of these quality measures to the government," he says. "Thus they have accepted many of them as legitimate, good measurements of quality, and the centers that are already measuring this are going to be way ahead of the game."

He says his surgery center is currently measuring falls, transfers, burns, wrong-site surgery, infection rates and time of antibiotic infusion. He says the center recently discovered it had a fairly high hospital transfer rate of children undergoing simple adenoid surgery. "When we dug into it and analyzed the data, we found it was a screening issue and that we were admitting an abundance of poorly treated reactive airway children into the ASC." He says the surgery center has since created parameters for its screening process to account for children with asthma.

Dr. Byers recommends surgery centers emphasize quality by forming a subcommittee through the medical executive committee. His surgery center chose several anesthesiologists, ENT physicians, and a nurse anesthetist to review the charts and formulate a strategy which helped the team work together to improve the screening process.

4. Plan for drug shortages at your center. Dr. Byers says many of his colleagues are suffering from nationwide drug shortages, which have plagued the healthcare industry for the last several years. The greatest shortages are affecting anesthesia and cancer drugs —a problem for surgery centers since anesthetics are critical and many ASCs lack the resources to stockpile drugs. "Physician leaders need to get in touch with the FDA, because that's the only way the pressure gets built up to take care of these shortages," he says. "What I perceive as the problem is that nobody really wants to make a big deal out of this locally, because nobody wants patients to hear there's a shortage of anesthetics."

He says his surgery center has held several meetings with its anesthesia group to educate the providers about "best practices" during the shortage. "There were a lot of anesthesiologists and CRNAs that were still drawing up 15 different drugs and laying them on the back table, where they sometimes had to be discarded," he says. "We really emphasized that you don't need to draw a drug up ahead of time — it only takes 10 seconds and we want to save it if it's not used." He says the surgery center has already saved money by being careful with anesthesia drugs, and in some cases has substituted safe alternatives for anesthetics in short supply. ■

Contact Rachel Fields at rachel@beckershealthcare.com.

Learn more about Surgical Care Affiliates at www.scasurgery.com.

6 Ways to Keep Eligible Cases at Your ASC: Advice From Dr. Brad Lerner of Summit Ambulatory Surgery Centers

By Rachel Fields

Brad D. Lerner, MD, FACS, clinical director at Baltimore-based Summit Ambulatory Surgery Centers, discusses six ways to keep all ASC-appropriate cases in your surgery center.

1. Look at top procedures by CPT code and break down where cases are taken. Dr. Lerner says his surgery centers look at their top procedures by CPT code and determine how many cases each physician brings to the surgery center versus the hospital. "I can look at the breakdown and say, 'Let's look at laser vaporization of the prostate. You did two in the surgery center but 20 in the hospital. Can you help me understand why you are performing such a high number of these cases in the hospital instead of the ASC?'"

Dr. Lerner says he and his nursing director look at these statistics on a quarterly basis and compares the data to the previous year to determine how case volume is shifting. He says these statistics are essential to know where your "problem areas" lie. Once you know a physician is taking a particular procedure to the hospital more often than the ASC, you can sit down and talk to him about his reasoning.

2. Consult with physicians about which cases are appropriate for the ASC. Some cases simply aren't appropriate for surgery centers, including those where the patient has a high BMI, significant co-morbidities or historic problems with anesthesia. The level of case acuity that surgery centers are willing to accept varies — some won't perform anything above an ASA II, whereas others are willing to consider ASA IIIs and even IVs under special circumstances.

Dr. Lerner says it's important to have a conversation with your physicians about which cases are appropriate for the ASC. He says this is particularly crucial with younger physicians, who have spent years training in a hospital setting and may be somewhat gun shy about bringing cases to the ASC. "Part of my job is to educate them," he says. "If a patient has co-morbid issues of concern but they are stable and treatment has been optimized, the patient may still be a candidate to have their procedures performed in an ASC setting. If there is any doubt concerning suitability for the ASC, a consultation is obtained with the anesthesia medical director." He says this is particularly true for a specialty like urology (which makes up the majority of case volume for Dr. Lerner's centers), where cases are generally low-risk.

3. Don't be afraid to use outside vendors that may charge for their technology, technician or disposable supplies. Physicians may take cases outside the surgery center if they feel the ASC does not stock the supplies and equipment they need. Especially if they've practiced in the same hospital for many years, they may not even stop to inquire as to whether the ASC has a certain supply or piece of equipment. Dr. Lerner says this is another area where physicians need additional education.

There may be certain lines of service that are suitable for the ASC but lack the critical volume to justify purchase of the equipment. If a proper cost analysis is performed and it is still cost-effective to perform a certain procedure in the ASC, it should be done. Examples in Summit ASC include laser treatment of bladder stones and prostate cryoablation. Over time, if case volumes increase, alternate arrangements can be investigated to purchase the equipment and train existing personnel in the technology.

4. Re-evaluate block time on a quarterly basis. You may need to re-assign block times if your physicians need more or less room than you've allocated. If a physician doesn't have enough block time at your ASC to handle all his cases, he may tell his scheduler to start moving them elsewhere. Dr. Lerner recommends looking at block time regularly to make sure no cases are being unnecessarily shifted to other facilities.

"We may have a doctor whose practice is growing and who is running close to 100 percent of block time," he says. "I would need to have a conversation with this doctor and discuss whether we need to give him more. At the same time, if we see a doctor with chronically low utilization, we may reduce their amount of block time. We encourage the physicians to contact their respective nursing manager or the medical director if they are experiencing difficulty scheduling cases within a reasonable period of time."

5. Hold monthly meetings between physician schedulers and ASC leadership. Dr. Lerner says his administrative staff holds monthly meetings with physicians' surgical posters to strengthen the relationship and go over which cases are suitable for the ASC. They also address any concerns that the posters may have related to scheduling of cases and issues with block or open time availability.

"We're in constant communication with our posters about what can and can't be done in the ASC — and then within certain lines of service, which insurance plans should and shouldn't be done in the ASC," Dr. Lerner says.

6. Decide which procedures are not financially feasible for your center. In order to schedule appropriate cases at the ASC, you need to know which procedures are profitable or not profitable based on your insurance contracts, Dr. Lerner says.

"For certain lines of service or procedures, some insurance carriers will reimburse differently in the ASC while others may not reimburse at all," Dr. Lerner says. "It is important to perform regular cost analyses and try to renegotiate contracts with insurance carriers and even look for carve-outs when applicable." ■

Contact Rachel Fields at rachel@beckershealthcare.com.

8 Characteristics of Highly Successful Surgery Centers

By Rachel Fields

Nap Gary, COO of Regent Surgical Health, Joe Zasa, co-founder of ASD Management, and Connie Casey, administrator of highly profitable Northpoint Surgery and Laser Center in West Palm Beach, Fla., discuss eight characteristics of highly successful surgery centers.

1. Well-organized leadership. In Mr. Gary's experience, success in surgery centers "seems to flow from outstanding leadership and outstanding administrators." He says an outstanding administrator is at once well-organized, reliable and communicative — someone who anticipates issues and isn't afraid to face them head on. For example, a successful administrator will approach the local hospital to discuss partnership strategies long before the other surgery centers in the area start thinking about joint ventures. A successful administrator will start recruiting physicians before he or she notices gaping holes in the schedule. A successful administrator will contact payors six months before the contract renewal date, to make sure negotiations aren't delayed by logistical issues on the payor's end.

Ms. Casey is a good example of a well-organized administrator: For every procedure her surgery center considers adding, she writes down every associated code and checks to see how her insurance companies reimburse for each one. "I write down every code and put it in the system, and I look to see exactly what they're going to pay for those codes side-by-side," she says. "If an insurance company isn't going to pay well, we go to them immediately and let them know we're starting new procedures and need to negotiate better rates."

2. Clear strategy around reimbursement. Mr. Gary says in his experience, the most financially successful centers are those that think carefully about their reimbursement strategy based on their market. He says there is no "one-size-fits-all" policy for ASC reimbursement. For example, while a large percentage of Medicare is generally considered risky for surgery centers, centers can make Medicare work if they rely heavily on orthopedics and other well-reimbursed specialties. "Similarly, there are specialties that don't typically get reimbursed well by commercial payors, but the right mix of them can work in particular markets," says Mr. Gary.

He says successful administrators will understand how much money they make from each payor and how their managed care contracts affect their profitability. For example, surgery center administrators should break down reimbursement rates by procedure and payor. He says the best administrators also have an "enormous bundle of tricks" when it comes to reimbursement. They have educated themselves on negotiation tactics and understand when to walk away from the table, when to accept an offer and when to end a relationship with an insurance company.

3. Physicians that "get it." Physician involvement is one of the easiest ways to improve profitability, Ms. Casey says. For example, when she realized medical supply costs were increasing, she printed out preference cards for all her orthopedic physicians and presented them at the board meeting. "One doctor would be opening two shaver tips and another would be opening one, "she says. "One would be using four anchors and one would be using two. They had absolutely no idea how much money they were spending." She says to save money, the administrator has to educate his or her physicians and get them involved in surgery center operations.

Mr. Gary says physicians that "get it" will sacrifice their own needs for the good of the center. "We have partners who say, 'Give the best [time slots] to the non-owners because we need to keep their case volume,'" he says. "The more involvement from our physicians, the better our centers are." He says surgery center administrators should involve physicians in recruitment and make sure they are recruiting more partners who are committed to the center's profitability.

4. Close contact with vendor and payor representatives. "Your [vendor] rep should be your best friend," Ms. Casey says. She says she has worked with several local vendors that give her surgery center much better pricing than the national companies because they've been working together for so long. "You need to have a relationship where you can say, 'Look, we have this case that's not going to pay us anything because the insurance company won't carve out implants. You need to give us a lower price on implants,'" she says. Form an honest, open relationship with your vendors and communicate that you will keep buying from them as long as they work to provide the best pricing for you. She says it also helps to regularly present data on the number of cases performed in the facility, so the vendors know how much work they will get out of you.

When handling payor representatives, Ms. Casey recommends providing precise detail on where the physicians will take their cases if you don't achieve better reimbursement rates. Ms. Casey gives the payor rep the physician's name and the name of the hospital that will take the cases if the surgery center can't afford to. "The payors want to know where the physician is doing the procedures, and they don't really believe you until you give them the name of the hospital," she says. "Once they have that, they come back and say, 'We'll give you a better rate.'"

5. Commitment to quality. As of Oct. 1, 2012, surgery centers will be required to report data on patient burns, falls, wrong-site/side/patient/procedure/implant, hospital admissions and transfers and prophylactic IV antiobiotic timing — with more measures to come in 2013. This industry-wide commitment to quality means that surgery centers must prioritize

QI studies and physician involvement in quality initiatives. "I've never seen a successful center that didn't have outstanding commitment and follow-through with respect to quality issues," Mr. Gary says. That means isolating several quality issues at your center every year and conducting a thorough study into how your center is performing, where your weaknesses lie and how you can improve them. These results should be presented to the board and physicians to achieve involvement at every level of the ASC.

6. Active case recruitment. Ms. Casey says physician recruitment is difficult in her area because, as she puts it, "no one moves to south Florida unless their mother or their wife's mother lives here." She says instead of focusing strictly on new surgeons, her facility focuses on existing physicians and their potential to bring more cases. "We have a scheduler happy hour once every six months," she says. "That's the person who gives you those cases, who says, 'I can send this to North Point.'" She says she also makes sure to build relationships with her physicians' practices so that when a new physician joins the practice, he or she "falls into place" in the surgery center.

7. Paying attention to benchmarks. Mr. Zasa says surgery centers can excel in supply and staffing costs, efficiency and volume by operating the center to industry benchmarks. ASC administrators should have a keen awareness of where their center stands in relation to other surgery centers, both in the area and nationally. If a center is way outside the established industry benchmark, center leadership should be able to give a reason that fits with the ASC's strategy.

Mr. Zasa says that operational issues can be improved by assigning a different person to each area of the ASC. "The problem with most centers is that no one person can be an expert in risk management, financial operations, business office, managed care and clinical [issues]," he says. "If a center is safe and meeting quality criteria, assuming reasonable volume, its issue is typically weakness in management systems and execution." Assign an expert to cover each critical area of the ASC, then pay attention to internal and external benchmarks to keep every department on track.

8. Follow-through from administration. Mr. Zasa says a great administrator follows through with plans. If the center plans to recruit a new physician, the administrator follows through and works with the practice to bring new cases to the center. If the administrator has promised employees a coffee machine for the break room, he or she promptly provides one. He says the administrator should also provide "clear and concise direction" to employees on every task that needs to be accomplished. ■

Contact Rachel Fields at rachel@beckershealthcare.com.

10 Steps to Improve ASC Profitability Through Benchmarking

By Rachel Fields

The following article was written by David Kelly, administrator of Samaritan North Surgery Center in Dayton, Ohio, a Health Inventures facility.

Access to the comparative benchmark data for surgery centers within the Health Inventures network highlighted that Samaritan North Surgery Center was one of the lowest (bottom five) in the performance metric, in terms of percent of accounts receivable greater than 120 days. The center was sitting at 20 percent, and the national benchmark is 8 percent. Patient responsibility balances (self-pay) accounted for most of the "A/R 120 or more days old," which consisted of a great many payment plans where the center had previously accepted minimal monthly payments over a long time horizon. For all intents and purposes, patients were receiving interest free loans for whatever time period they desired.

The center initiated a Continuous Quality Improvement study to discuss the barriers to collections and brainstorm potential solutions to the problem. The CQI study was truly a collaborative effort that garnered commitment and support among all stakeholders in the surgical continuum: the physician offices, scheduler, pre-admission testing nurse, insurance verifier, registrar, business office staff working the self-pay lists and our collection agency partner.

After lengthy discussions and data analysis, the group defined the problem as a lack of a standardized method for verifying insurance benefits to estimate patient out-of-pocket expense and inconsistent procedures for collections follow up. The problem was significant to the center because the inability to collect estimated patient financial responsibility on the date of service decreases cash flow and increases the amount of time spent and expense on collection follow up efforts. Additionally, the team felt it was important for patients to be educated on their out-of-pocket expenses so they could make an informed decision regarding their elective procedure.

To improve collectability on accounts and reduce the A/R, the team defined the performance goal for the project as increasing collections on the day of service by 75 percent over the prior year to reduce the open A/R on the books for more than 120 days to less than 15 percent.

There were several corrective actions taken:

1. Developed a template in Excel to calculate the estimated patient responsibility. The insurance verifier enters the scheduled CPT code, the allowed amount based on the contract, the patient coinsurance, deductible, out of pocket maximum, and the template returns an estimate of the patient's total financial responsibility.

2. Updated the scheduling information request to include the CPT code for the scheduled procedure to determine the allowed amount.

3. Altered the insurance verifier's role to involve contacting every patients prior to date of service to request the entire estimated patient responsibility, offering various alternatives for payment. There is some room for negotiation from collecting the entire amount, but there are specific and consistent guidelines that are followed.

4. Entered the expected patient payment amount into the patient management system and collected by the registrar the day of service.

5. Tasked the pre-admission testing nurse with reminding patients at the end of the health assessment call to bring any co-pay or deductibles on the day of service.

6. Implemented Care Credit as another source for patients to pay their out of pocket expenses. The center also limited the center's interest free payment plan option to three months, and, if not paid in full, began to consistently turn over to collection agency for follow up.

7. Scheduled patients unable to meet financial responsibility to another time — after enlisting and receiving support from the physician's offices. After enlisting and receiving support from the physicians' offices, patients unable to meet the financial responsibility were scheduled to another time.

8. Created more user-friendly self-pay collector work lists and divided the accounts by alphabet among the business office team members who are responsible for the account form inception to close.

9. Developed verbal scripts and standard procedures for consistent follow up for the business office staff. For example, after three statements and one call, if no response or payment is received, patient account is turned over to collections.

10. Attended a vendor seminar on collection strategies to gain insight into what works well and what doesn't.

We knew that for this to be successful, everyone had to buy into the new model and everyone involved needed to be consistent in their message to patients. While the harsh reality of the patient's out-of-pocket expense is a difficult pill to swallow in these economic times, we found that patients do appreciate understanding their personal financial impact up front. We were quite frankly surprised that the center only had four patients out of 5,000 total cases who chose to cancel in the calendar year due to inability or unwillingness to pay their out of pocket expense up front. The project was very successful, exceeding the team's goals significantly.

It has been 10 months since the start of the CQI study, and Samaritan North's outstanding self-pay balances over 120 days have dropped by 50 percent. Up front or day of service collections have increased by 93 percent compared to our goal of 75 percent. Open A/R on the books for more than 120 days has dropped from 20 percent to 12 percent against a goal of 15 percent.

Access to external benchmarking data revealed to this administrator that his center was falling way behind. That's all it took and then the competitive spirit kicked in. While Samaritan North Surgery Center is still not quite leading the pack within the Health Inventures network of ASCs, we are making continued and consistent improvements each month and are no longer bringing up the rear! ■

Contact Rachel Fields at rachel@beckershealthcare.com.

Learn more about Health Inventures at www.healthinventures.com.

5 Strategies for Administrator Succession Planning From ASC Administrator Lori Martin

By Taryn Tawoda

When Lori Martin, RN, administrator and clinical director at SUMMIT Surgery Center at Saint Mary's Galena in Reno, Nev., found herself battling cancer and needing to scale back her full-time work schedule for several months, she fully realized the value of consistent succession planning with her employees.

For Ms. Martin, the point wasn't so much to prepare employees to be next-in-line for the administrator position, but to equip them with the skills necessary to handle unexpected absences and changes in responsibility without shifting focus away from effectively running the center. Ms. Martin was able to accomplish this by ensuring that every employee had an understanding of her day-to-day responsibilities from day one.

"If I had just kept all of that information to myself, my absence would have been a disaster," said Ms. Martin. "I've seen other administrators try to hoard all information, but when something like this happens, what does everybody do?"

Ms. Martin shared five strategies for succession planning as an administrator, with a continuous focus on grooming all employees to be well-versed in the administrative tasks that enable the center to function.

1. Lead by example. Ms. Martin's priority as an administrator is to exemplify the qualities she wanted to see in center employees and in a future administrator. She would emphasize openness and approachability, for instance, by encouraging employees to contact her via calling or sending text messages to her cell phone if questions arose while she was out of the office.

To maintain an upbeat environment in the center, Ms. Martin will often approach and greet patients with the hope that employees will observe and mimic the behavior. Smiling is a crucial part of how she impacts her environment, even on days following chemotherapy when she finds it difficult. Ultimately, a consistent smile can send a strong message of expectations to her staff.

"If the administrator looks stressed out, everybody thinks, 'Something bad is going on, we should be stressed out, too, '" Ms. Martin said. "It's about having that attitude, knowing the seriousness of what we do, and approaching it in a calm and confident manner. The staff are treated and respected as professionals, but it's not like the atmosphere has to be so serious and bogged down. If you're prepared, you don't have to approach things in such a stressful way. We enjoy what we do, so my approach is to enjoy being at work."

2. Walk employees through every step of the administrative process. Ms. Martin would also groom employees on key aspects of the administrative processes necessary to keep the center running smoothly. She would begin by accompanying a staff member to a meeting with a vendor representative, for example, and explain each step of the meeting and the necessary questions to ask.

"A big part of grooming someone in leadership is feeling comfortable to delegate things, meeting with reps, gather information," Ms. Martin said. "A lot of the staff are from a nursing background, so asking questions about money, profit costs and disposable items is foreign to them," said Ms. Martin. "But they have to get comfortable with that. They have to know how much things cost, how to finance a for-profit organization. The comfort level they've built with managing those items has allowed us to continue to be successful."

3. Use an employee's strengths to determine which skills to build. Though she emphasized the skills behind key tasks such as marketing, vendor meetings and payroll with all employees, Ms. Martin also assigned particular tasks based on an employee's personal strengths. When potential physician partners would visit the center for a tour, for example, Ms. Martin would give the task to a more extroverted employee who was familiar with the concept of promotion.

"Many of the staff members weren't used to interacting with doctors and trying to sell the center," said Ms. Martin. "It's all personality-based — you don't want your introverts trying to push their comfort level to sell something."

4. Organize regular leadership meetings. Ms. Martin and the center staff meet each month to discuss the importance of delegating responsibilities and building leadership qualities within the center. The center's monthly quality meeting dovetails into a monthly

leadership meeting, which includes pre-op and PACU supervisors, the business office manager and the OR supervisor. During this time, Ms. Martin said, the key staff members discuss current leadership and development needs within the center, and Ms. Martin often reads a quote or excerpt from recent news that highlights an example of leadership.

5. Ensure that the center can function well in the administrator's absence. When Ms. Martin was unable to come into the office due to her illness, center staff members were able to work to resolve conflicts without having to turn to her for assistance. The center recently faced a need for a radiology technologist, for example, but was unable to place any per diem technologists in the position.

In normal circumstances Ms. Martin, an X-ray technologist, would have completed the task herself or coordinated the hiring of a new employee. But in her absence, center staff instead coordinated the search, interview and hiring of a new technologist with the help of the center's HR company.

Having been thoroughly trained in the center's values and goals, the staff was able to hire an employee with mutual team values who has fit in seamlessly with the center, Ms. Martin said. ■

Contact Taryn at taryn@beckershealthcare.com.

30 New Statistics on Surgery Center Acquisition & Valuation

By Taryn Tawoda

More surgery centers are considering acquisition or partnership with a management company or hospital as reimbursement rates decline and profitable strategies such as out-of-network billing become unfeasible. Here are 30 new statistics on surgery center acquisition and valuation, according to data from VMG Health's *2011 ASC Valuation Survey*. The following questions were answered by representatives from major surgery center management and development companies.

1. Do you target ASCs for acquisition in markets where you already have a presence?

Yes, not exclusively: 58 percent
Targeting new markets: 26 percent
Yes, exclusively: 16 percent

2. Physicians' expectations regarding ASC multiples have:

Increased: 13 percent
Decreased: 25 percent
Remained unchanged: 63 percent

3. Which model of ASC operator ownership does your company prefer?

Majority equity ownership: 41 percent
Minority equity ownership: 29 percent
Minority equity ownership with hospital partner: 29 percent

4. How does your company determine offering price when approaching ASC acquisitions?

Discounted cash flow analysis: 26 percent
Standard multiple of EBITDA: 7 percent
Risk adjusted multiple of EBITDA: 41 percent
Third party fair market value opinion: 26 percent

5. Are you considering any ASC mergers to boost efficiency and returns?

Yes: 37 percent
No: 63 percent

6. What impact on ASC value do the following traits or situations have:

High level of ownership by physicians in competing centers

Very low: 0 percent
Low: 0 percent
Medium: 7 percent
High: 33 percent
Very high: 60 percent

Low number of physician investors in the ASC

Very low: 0 percent
Low: 7 percent
Medium: 20 percent
High: 33 percent
Very high: 40 percent

High reliance on out-of-network payors

Very low: 0 percent
Low: 0 percent
Medium: 0 percent
High: 7 percent
Very high: 93 percent ■

Contact Taryn at taryn@beckershealthcare.com.

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

How the ASC Industry Can Succeed in the Future: Q&A With ASCOA CEO Luke Lambert

By Laura Miller

Luke Lambert, CEO of Ambulatory Surgery Centers of America, discusses the current state of the ambulatory surgery center industry and how it can succeed in the future.

Question: What are the biggest challenges ASC industry leaders are facing right now?

Luke Lambert: In my view, hospitals have been effective in really skewing the reimbursement systems in their favor so that now everything in our health system does better if it is owned by a hospital. For example, physician practices and surgery centers can achieve higher reimbursement if they are owned by hospitals than if they are independent because hospitals have market dominance and the power to demand more from commercial payors. Hospitals are also effective at lobbying Medicare and Medicaid. If a hospital buys a surgery center and owns it, or turns it into a hospital outpatient department, on day one they can increase Medicare reimbursement close to 70 percent; with commercial payors it's not atypical to see 100 percent improvement in reimbursement.

Profits of hospital-owned facilities are dramatically higher and with the squeeze on independent ASCs, they feel they are at a comparative disadvantage and many are wondering whether they should sell to a hospital. It may be financially advantageous to sell to a hospital, but in the long run I think it will be a detriment to the healthcare system to have less competition.

Q: What steps are being taken to level this playing field?

LL: From an industry standpoint, the Ambulatory Surgery Center Association is advocating for improvement in reimbursements and expanding the list of reimbursable cases with government payors and removing regulatory barriers, to the extent possible, for physician-led projects. In many states, the department of health exists to protect hospitals against competitors. This stance against others stifles competition and limits the growth of our industry.

Q: Why is it so important for ASCs to maintain physician ownership?

LL: If you look at various markets, many hospitals could be described as local monopolies. In their local geography, a physician-owned surgery center might be the only competition and if the hospital purchases that, they own the whole market. That position of dominance doesn't lead to cost-effective care or improved quality. Major metropolitan areas tend to have more competition with multiple hospitals and physician-owned facilities.

Q: Where do opportunities exist for physician groups to partner with hospitals?

LL: There are a lot of opportunities for hospitals to partner with physicians in surgery centers. What you are trying to do there is capture both the benefits hospitals can bring — including greater reimbursements — and the benefits physicians can bring — such as efficient and cost-effective provision of care. The reality of our industry is such that a lot of our growth in the coming years will be in that type of joint venture. My own company is involved in those types of ventures and we see more of that happening. Around the country, hospitals are reaching out to surgery centers to see if there is an opportunity to partner. When these partnerships are done right, I think they make a lot of sense.

Q: How can surgery centers become a stronger force politically?

LL: I think the ASCA has done a great job at forging those relationships with legislators. When biased studies come out, I think they are taking an effective stand against them. I think we need to persist and continue educating those who are setting policy. With enough education, the day may come when policy makers look to the ASC industry to become a larger part of the solution — by providing incentives for physicians and patients to make greater use of ASCs.

Q: How can single ASCs and ASC advocates make a difference at the local level?

LL: It's a grassroots effort. The ASCA has been effective in organizing events where surgery centers invite elected representatives to visit centers. These visits go a long way in educating law makers as to the quality and cost advantages of ASCs. Having surgery center owners and managers visiting elected representatives and communicating what their needs and priorities are is also important. We need to do more of this type of activity. ■

Learn more about ASCOA at www.ascoa.com.

Contact Laura Miller at laura@beckershealthcare.com.

When Hospital Employed Physicians Own a Joint Venture ASC: 4 Points From Dr. Thomas Miller of Carilion Clinic Orthopaedics

By Rachel Fields

Thomas K. Miller, MD, serves as the medical director and a physician owner of Roanoke Ambulatory Surgery Center, a 50/50 joint venture project of Carilion Roanoke Memorial Hospital and what had been a number of independent physician practices. While surgery center joint ventures are increasingly common, the set-up for this ASC is rather unusual: According to Dr. Miller, about half the physician owners at the surgery center — including Dr. Miller — are employees of the corporation that owns Carilion Roanoke Memorial Hospital. In April 2010, Dr. Miller's former practice, Roanoke Orthopaedic Center, merged with hospital-employed physician group Carilion Bone and Joint to form Carilion Clinic Orthopaedics. The employed physicians still maintain ownership in the surgery center, with the other surgery center investors remaining independent and performing their hospital-based cases elsewhere.

According to Dr. Miller, there was some initial concern about whether the employed physicians' ownership would be contrary to the Clinic's mission and structure, as the original hospital group did not have access to supplemental income streams in addition to their hospital incomes. However, Dr. Miller says the arrangement has provided an efficient setting to perform outpatient cases and has decompressed the hospital's issues of insufficient OR access and case backlogs. Here he discusses four points on owning interest in an ASC as a hospital-employed physician.

1. Current OR capacity in the community dictates the relationship between employed physicians and ASCs. According to Dr. Miller, the feasibility of this model depends largely on the current OR capacity and wait times in the community. "If you're in a community where the OR access is maxed out, the process is completely different than in a community where there is excess OR capacity," he says. When the surgery center started as a 50/50 joint venture between the hospital and local physicians, the hospital was at capacity and was suffering from a backlog of cases. The community was primed for a new surgical facility, and it was in the hospital's best interest to move outpatient cases to a lower-cost, high-efficiency setting. The surgery center was originally owned by solely independent physicians, but when Dr. Miller's group decided to merge with the hospital-based group, physicians moved to system-based employment while maintaining ASC investment.

Dr. Miller says issues with OR capacity at the hospital make the arrangement feasible. If the hospital ORs were not full, he says the hospital would likely object to losing cases to the surgery center. As it is, the surgery center simply provides a location for the "run-off" cases. "The hospital system might be losing cases to this surgery center, but if they don't have anywhere to do the cases — or if they have to do them after hours at increased cost — the patients are going to go somewhere else anyway," he says. "It's better for all involved to have patients cared for efficiently by the employed physicians than to see patient care delays or loss to other facilities and providers."

2. Employed physicians must have production targets. Dr. Miller says the clinic providers' contracts are structured to include production targets that determine their base salary and total income. "It's a pretty common perception that when you transition to hospital employment, you don't have to work as hard because you have a guaranteed income," he says. "In at least the short-term where we are, we have a base salary and then a production-based bonus program, so we are incentivized to be productive and efficient."

He says the clinicians are also incentivized to hit budget targets every year, creating an environment similar to an independent practice because physicians' actions directly impact their compensation. He says this creates an incentive for physicians to work to improve hospital profits just as they work to improve ASC profits. "If you have a system with a guaranteed salary and no incentive for the provider to use your facility, it won't work," Dr. Miller says.

3. Investment arrangements may not be able to continue long-term. Dr. Miller says while the arrangement with the hospital works for the time being, it might not be realistic in the long-term. "The hospital has raised the question of whether new hires should be allowed to invest in the surgery center, and I understand that point completely," he says. "How do you apply that equitably to other providers who are willing to take fiscal risk with other systems? It's a very valid question on their part, and the answer is that long-term, I don't think you would see an arrangement like ours continue."

He says in the long-term, he thinks there will be a "transition strategy" that moves physicians away from surgery center investment after they reach a certain number of years of employment. He says the group is currently in a "pleasant limbo" because while the surgery center takes cases from the hospital, it also serves as a valuable resource: a test bed for pilot programs at the hospital and an example of how to improve efficiency.

4. Physicians at the surgery center must be treated equitably, regardless of employment. Not all the physicians at Roanoke Ambulatory Surgery Center are employees of the corporate umbrella of the hospital — in fact, many of them use a different primary hospital base in town. "It's kind of an interesting arrangement that we have providers who take call at a competing hospital, who use a surgery center co-owned by a competing hospital," Dr. Miller says. When the surgery center started, he says the center offered all outpatient surgery providers access to the facility as investors, and that policy has continued despite his group's move to employment.

He says a policy of equal treatment has been essential to the surgery center's success. "Even though we have become employed, they still maintain their block times," he says. "We made sure nobody was going to get squeezed, and that everyone was going to be treated equitably. Open access was not going to be based on whether a physician was employed or not employed." He admits the ownership model is a work in progress: As medical director, he sits down with the non-employed investors and hospital system on a regular basis to hash out surgery center policies and discuss any problems. ■

Contact Rachel Fields at rachel@beckershealthcare.com.

5 Mistakes Surgery Centers Make When Dealing With Payors

By Rachel Fields

Dan Connolly, MHS, ARM, vice president of payor contracting for Pinnacle III, discusses five mistakes surgery centers make in payor negotiations.

1. Treating the payor as an adversary. Many surgery center leaders tend to view their payors as adversaries rather than allies, observes Mr. Connolly. He encourages ASC leaders to build effective working relationships with their payors. Payor representatives respond positively to individuals who have taken the time to establish a rapport with them, Mr. Connolly says. When ASC leaders create common ground and build upon that foundation during each interaction, payor representatives are more inclined to create mutually beneficial contractual terms, points out Mr. Connolly. It helps to remember that payor representatives are people, too.

He encourages ASCs to keep in touch with their payors throughout the year rather than only contacting them when a reimbursement increase is desired. "You shouldn't wait until you need something to knock on the door," he says. "Offer yourself as a resource to the payor, so they will call you and say, 'Hey, I know this doesn't have anything to do with you, but I'm seeing this with other surgery centers and I want to know your thoughts.'"

2. Waiting several years to renegotiate a contract. Insurance company negotiation teams generally operate under strict guidelines about the increases they can offer based on each year's budget. If you let your contract lapse, rolling over under the evergreen clause from one year to the next, then ask for several years' worth of increases, the payor will simply not be able to afford your request. "If you let your reimbursement lapse for five years, it's going to be hard — if not impossible — for the payor to absorb five years of increases in a one-time rate adjustment," Mr. Connolly states. "Poor planning on your part creates a crisis on the payor's end and can easily lead to hard feelings."

Mr. Connolly recommends looking at each contract every year and exercising some form of renegotiation if feasible. He says if the contract has a 12-month term, the surgery center should assemble its renegotiation plan and start the renegotiation process no later than 120 days prior to the contract's anniversary date. This will allow the payor the necessary time to assemble historical reimbursement and utilization data, for both parties to analyze proposed reimbursement scenarios and, ultimately, for the payor to load and execute the new rates upon renewal.

3. Assuming the payors know your business. Mr. Connolly notes many surgery center leaders make the mistake of assuming the payor understands their business. "Imagine you are a payor who deals with hundreds of different types of providers," he says. "It's the surgery center's responsibility to educate the payor, because you know your business better than they do." This means educating payors about the general value surgery centers bring to the health care marketplace — providing high quality care in a cost-effective manner — as well as the specific nuances of your individual center.

For example, you may want to explain that your physicians have privileges at hospitals in the local community and will take their cases to those facilities if the payor cannot provide an increase to the surgery center. "They will start connecting the dots and see that if they don't bring the ASC on board, the payor will more than likely end up paying more for the surgeries at the hospital," he says.

4. Making the first offer — or accepting theirs. Mr. Connolly advises surgery center leaders to avoid making the first offer. "This is typical negotiation 101, but it's so common to go in and tell someone what you want," he remarks. In most cases, he tries to get the payor to send him a proposal. He observes that if you ask for a proposal, the payor may offer something you would not have asked for or expected to receive. Even if you know the payor won't reimburse for implants, you can gain more leverage by pointing out that their proposal did not include implant coverage and that you will need another amenity to make up for it.

Similarly, Mr. Connolly points out negotiators should rarely, if ever, accept the payor's first offer. "If the ASC administrator is not a seasoned negotiator, hire someone who is," he remarks. A professional will understand when and how to effectively push for an increase and when to accept an offer.

5. Negotiating over the phone or email. Mr. Connolly recommends surgery center leaders negotiate in person rather than over the phone. In some cases, your payor will be located far away and the expense of travel will outweigh the potential increase; however, whenever face-to-face negotiation is possible, this is the manner in which you should proceed. "If you are trying to build or improve a relationship with the payor, you will more effectively accomplish that task in person," he says. "Face-to-face meetings allow you an opportunity to pick up on non-verbal communication that can assist you in determining whether you should push for higher rates." ■

PINNACLE III

Aligning Performance and Prosperity

VISIT US AT
EXHIBIT BOOTH 36

1658 Cole Blvd, Suite 100
Lakewood, CO 80401
(720) 359 - 2660

www.pinnacleiii.com

PROVEN PRACTICES THAT DELIVER RESULTS

pinnacle III
SURGERY CENTER EXCELLENCE
SPECIALTY BILLING SOLUTIONS

Thursday, June 14, 2012
2:55pm - 3:25pm

Infection Control in ASCs
10 Best Key Practices

Jean Day, RN, CNOR
Director of Clinical Operations
&
Clinical Education

Jean has adeptly become the point person to Pinnacle III directors and mid-level management for policy development, regulatory compliance, accreditation interpretive specialist, operations advisor and special projects. Each month she presents webinar programs on a wide range of topics including but not limited to: clinical best practices, business operations, quality assurance, infection prevention, risk management, supply chain management, and the artful skills required in managing people.

5 Best Practices for Appointing an Infection Prevention Nurse at an ASC

By Rachel Fields

Surgery centers are placing a greater emphasis on infection prevention as the healthcare industry turns an eye to quality measures and their future ties to reimbursement. Jean Day, RN, CNOR, director of clinical education for Pinnacle III, discusses five things to know about appointing, training and overseeing an infection prevention nurse in a surgery center.

1. Choose a staff member who volunteers for the position. Ms. Day indicates selecting a staff member for the position of infection preventionist can be "a bit of a challenge." Surgery center leaders are often forced to choose from a cadre of nurses who may not want to branch out into infection control, she says. "Most staff nurses like being staff nurses," she comments. "They like the direct patient care, and they are not inclined to seek a job that asks more in terms of job responsibilities. If they were so inclined, they would likely already be climbing the career ladder in search of a leadership position."

She recommends asking for volunteers among ASC staff. Ms. Day maintains, "If nurses are forced into the infection prevention role, they tend to not perform well." She recommends supporting the staff member by providing funds for professional development and education, such as attendance at infection prevention conferences. The surgery center should also set clear expectations about the amount of time spent on infection prevention duties — Ms. Day estimates around 10 percent of total work time is required to effectively accomplish the related tasks.

2. Hold the infection preventionist responsible for evaluation of policy. The infection prevention nurse should be held responsible for evaluating the surgery center's policies to determine the center's level of compliance, Ms. Day suggests. "That doesn't mean authoring them, but being granted an authoritative voice when it comes to enforcing those policies," Ms. Day asserts.

For example, if the IP nurse observes a coworker using his or her personal protective equipment incorrectly, intervention and correction with that colleague must occur. Every staff member should understand that the infection prevention nurse is responsible for reviewing and enforcing policy to create a sense of trust and respect. "A teachable moment is lost when the IP nurse feels they have responsibility but not authority," says Ms. Day.

3. Assign the IP nurse to provide staff education. Ms. Day believes the IP nurse should also be held responsible for providing staff education on a quarterly basis at minimum. For example, the IP nurse can sit down with staff members and provide an overview of hand hygiene policies. "On a quarterly basis, we do expect some kind of staff education, even if that's just reporting the quarterly infection rates to the staff," she states.

Education doesn't have to involve a sit-down lesson, either; the IP nurse can pull a current article out of print material and place it in an educational notebook for personnel to read. Asking the IP nurse to provide staff education helps connect the staff member to the remainder of the ASC's employees. Colleagues will be more likely to listen to and respect the IP professional if they receive education about the center's progress on a regular basis.

4. Go over statistics basics with your new IP professional. IP nurses will have to use statistics to track infection rates and uncover trends in patient safety issues — a potential problem because ASC staff members may not have recent experience with statistics. "Some nurses have never been asked to collect and report data, and they may not know how to calculate infection rates based on total population or by specialty," Ms. Day says. The IP nurse at a surgery center may need a refresher course in statistics, or an overview of how to track and record adverse events in the surgery center's computer system, Ms. Day adds.

5. Expect ASC surveillance on a regular basis. Most of the IP nurse's responsibilities should center on surgery center surveillance, Ms. Day emphasizes. She indicates the nurse may spend up to eight hours a month conducting concurrent surveillance for surgical site infections (SSI). When SSI are reported by the attending surgeon, the IP nurse is required to conduct an investigation to determine if the infection is attributed to breaches of best practices. Ongoing surveillance includes observing direct patient care and determining whether staff members are in compliance with infection control policies. For example, the IP nurse may conduct hand-washing surveillance to determine how many staff members are washing their hands (a significant concern since national hand-washing compliance falls around 50 percent, according to Ms. Day). Verifying consistent use of personal protective equipment (PPE) which minimizes an employee's risk exposure is an additional surveillance activity that ought to be conducted on a routine basis

Ms. Day expects IP nurses to conduct a "walkabout" throughout the work environment on a monthly basis. She notes Pinnacle III provides a surveillance checklist to ensure every IP nurse reviews the same set of criteria. Surveillance may include reprocessing of surgical instruments, medication storage, medication administration, donning and removal of gloves and direct patient care, she adds. ■

---

pinnacle III
SURGERY CENTER EXCELLENCE

PINNACLE III is a Colorado-based company, just outside of Denver, which provides ASC management and development as well as billing services. Since 1999, PINNACLE III has served multiple clients from single-specialty practices, physician-owned ASCs to multi-specialty joint ventures with hospital partners across the country. The company's leadership team includes Rick DeHart, CEO; Rob Carrera, president; and Scott Thomas, executive vice president. Its vice presidents are Kim Woodruff (corporate finance & compliance), Carol Ciluffo (revenue cycle management), Lisa Austin (operations), Kelli McMahan (operations) and Dan Connolly (payor contracting). Simon Schwartz is the director of marketing and sales. PINNACLE III offers ASC development, management and billing along with consulting services in the area of facility auditing, payor relations and contract work. While PINNACLE III offers equity models, non-equity models are accessible as well. PINNACLE III also provides auditing and billing services to physician practices.

PINNACLE III PROVIDES CONSULTING SERVICES TO ASCS AND PHYSICIAN PRACTICES THROUGHOUT THE COUNTRY

PAYOR CONTRACTING:

Does getting paid for your services feel entirely too complicated? Quite simply, it is. From ever-changing reimbursement parameters to increasingly restrictive and complicated processes, healthcare reimbursement has become a frustrating and time-consuming system fraught with sweeping changes. It's time to overcome those complexities. Count on the proven expertise of Pinnacle III to not only decipher, analyze, and fully comprehend terms third party payors cite in their contracts, but also create reimbursement scenarios that actually address your business needs.

FACILITY OR PRACTICE AUDIT:

Our team of experts represents over 150 years of combined experience and a wealth of knowledge assessing and evaluating processes in ASCs and physician practices across every major specialty. We can assist you in employing processes that result in a more prosperous ASC. While we monitor the changes in the healthcare system, you can focus on what you do best – treat patients. We work behind the scenes to improve the viability and strength of your ASC.

Managed Care Contracting: Strategies for Success

By Rebecca Overton, Director of Revenue Cycle Management, Surgical Management Professionals

Reprinted with the permission from Surgical Management Professionals.

Effective initial negotiation and ongoing maintenance and renegotiation of provider contracts play an essential role in revenue streaming and overall profitability of service lines. Developing aggressive strategies and refined negotiation and renegotiation techniques to ensure that reimbursement is optimal, can prove to be the most profitable revenue strategy at your disposal.

Optimal managed care contract negotiation begins with evaluation and interpretation of all current contracts as well as evaluation of contracting needs now and in the future. Doing your homework on targeted payers can prove to make a difference in all phases of negotiation — understanding payer covered lives in the provider's demographic area and payer mix volumes of providers is essential data as you begin negotiations. To properly evaluate and assess contracts and contracting needs, the following items should be reviewed:

• Contract terms and historical reimbursement patterns of payors

Contract interpretation and how that is applied to provider billing processes is essential to ensuring that reimbursement outlined in current contracts is being effectively captured. Appropriate capture of implants, supplies, imaging and other revenue generating items as it applies to specific contracts is crucial to revenue capture. Too often, misinterpretation of contract terms and reimbursement language by billing staff can lead to missed revenue opportunities for your facility.

In addition, review of historical payor reimbursement patterns aids in providing the data necessary to identify trends or issues with current contracts that may not be apparent from the contract itself. Bringing these issues to the table is an important aspect in renegotiations, if there are trends that you can determine clarity on at the time of renegotiations, it may change your approach or tactic in getting the most out of it. For example, if you have implant reimbursement carved out in your contract but see a trend of denials stating the implant reimbursement is included in the payment for the primary procedure — you will want to clarify contract interpretation. If clarification leads to the implants not being paid separately, it is advantageous to account for this in your request for increased reimbursement on procedures.

• Provider demographic payor contracting trends

Researching payer reimbursement trends in your demographic area can be very helpful in evaluating how your contracts compare. This information is used to leverage the provider and ensure reimbursement expectations are set within competitive market ranges. This information is not always easily accessible. If that is the case, just make sure you do adequate homework so that you ensure a reasonable profit margin for your service lines.

• Procedure cost vs. reimbursement analysis and proactive pursuit of strong reimbursement for future volume

Compiling detailed analysis of procedure cost compared to reimbursement is very important in preparing to enter negotiations or renegotiations. This information is useful defense in substantiating a need for higher reimbursement than what is being offered. Also be sure to identify future trends in outpatient services to forecast future needs in contract reimbursement. This can prove very effective in getting aggressive rates for procedures such as sinuplasties, uni-knees, discectomies, emerging technologies and new service lines. Query your providers to ensure that you are fully armed with as much information regarding future service lines or emerging technologies so that proactive reimbursement strategies are put into place. This will save you time in the long run as you shouldn't need to come back to revisit these items later or have them fall into reimbursement patterns that are not advantageous to your facility.

Once you have fully assessed your needs, current reimbursement, payer trends and performed detailed data analysis, you are ready to begin negotiations. It's important to remember that when beginning negotiations or renegotiations, the payer is providing the initial proposal or renegotiation proposal so that you know what you are starting with and can effectively counter with reimbursement that makes sense for your facility. Allowing the payer to drive the negotiations is the last thing you want to do, if they see your starting point first, you could be cutting yourself out of reimbursement that the payer may initially offer.

Many times working with a consultant can prove to be money well spent as reimbursement rates have long lasting effect on cash flow and overall profitability. SMP works with its clients to ensure that they have leverage in negotiation. Leverage comes in many forms from facility association or partnerships to special services provided by the facility or physician staff. Our objective is to know and understand the client and its needs, so that we are able to strategically work as an extension of the client to increase overall reimbursement, ensure competitive rates are obtained and educate staff on interpretation so that maximum reimbursement is attained for all service lines. ■

Learn more about Surgical Management Professionals at www.spmsd.com.

Contact Rachel Fields at rachel@beckershealthcare.com.

5 Strategies for Cutting Costs in an Out-of-Network Surgery Center

By Taryn Tawoda

Long-term cost management is among the greatest challenges for out-of-network ASCs. As the administrator of an out-of-network surgery center that performs more than 300 cases per month in a one-room OR, Toni Rambeau, CASC, has developed the necessary cost management strategies her center requires to sustain long-term profitability.

"Cost containment is how we are able to thrive and expand as an out-of-network-only center," said Ms. Rambeau, administrator of SurgCenter in Glen Burnie, Md. "Orthopedics can be very costly, but we work well together to find what the surgeon needs and also provide a price that makes us profitable at the same time."

Ms. Rambeau shared five essential strategies for eliminating unnecessary costs, securing reimbursements and educating center staff on the importance of cost containment in an out-of-network center.

1. Encourage physicians to test less expensive surgical tools. Though physicians may be partial to the surgical tools used during training and medical school, nudging them in the direction of less expensive alternatives with the help of a vendor is an effective cost-cutting strategy for the long term.

Ms. Rambeau will ask a sales vendor to come to the office with surgical tools ready to sample. She can then sit down with the vendor and the physician to compare two items side by side, allowing the physician to personally handle and assess the potential alternative.

"Ultimately it's their decision, but nine times out of ten they see that it's less expensive to go this route, and we'll move toward a less expensive item," said Ms. Rambeau.

2. Reprocess single use items. By using a consistent medical supply reprocessing company, surgery centers can save around 50 percent per item by sending in single use items and purchasing them back. SurgCenter uses Medisiss for its reprocessing needs, according to Ms. Rambeau.

"Once a procedure is finished, we clean the products and ship out a box of single use items every week to Medisiss," Ms. Rambeau said. "They run items through a battery of tests and clean and process them before sending them back to us. We purchase the products back from them, paying only half of what they initially cost."

Some items — including ENT shavers, blades, arthroscopic shavers and trocars for endoscopy — can be used many times over with this process.

3. Train other employees to be cost-conscious. Passing on cost cutting strategies to other employees in the center is crucial for maintaining a cost-conscious culture. When Ms. Rambeau and her employees perform equipment price comparison searches online, for instance, she ensures that the employees are aware of drastic price differences between companies and the need to persist in a search for a less expensive option.

For example, a company may be selling a simple shoulder traction kit for $400. But after several Internet searches and phone calls to other companies, Ms. Rambeau will find that the same item is sold for $200, and then, eventually, $100. Throughout this process, it's important to emphasize to employees that money saved will benefit them in the long term.

"I try to explain to an employee that spending the center's money is like spending her own money," Ms. Rambeau said. "The less you spend, the more benefits you get in the center in terms of raises and merit increases."

4. Work with a device management company to recover implant costs. When insurance companies such as Medicare and Blue Cross Blue Shield do not reimburse surgical centers for implant costs, a device management company such as Implantable Provider Group can be used to recover some of these funds, Ms. Rambeau said. IPG contracts with Blue Cross Blue Shield, for instance, and is able to negotiate for lower pricing due to its size and scope as a national company.

"If a patient with Blue Cross Blue Shield has a fractured ankle and comes to our center, the insurance company won't reimburse for the plate and screws," Ms. Rambeau said. "But IPG will bill Blue Cross Blue Shield for the cost and reimburse us."

5. Ensure staff is cross-trained and able to work flexible hours. On lighter case days, center staff should have the flexibility to leave when work is done to save money on staffing — a policy that can be established as early as during the initial job interview.

"It's the first thing out of my mouth in the interview – they have to be flexible," said Ms. Rambeau. "We can't guarantee 40 hours because there might be a couple of slow days here and there. I also cross-train my whole staff so that everybody can do everybody else's job if necessary." ■

Contact Taryn Tawoda at taryn@beckershealthcare.com.

How to Collect More Often on Spine Cases

By Barbara Cataletto, MBA, CPC, Chief Executive Office Business Dynamics Limited.

It is amazing to me that we still have the propensity to lose earned revenues due to customer failures that are the result of our own business associates. This includes the physician, ancillary support staff, coders and reimbursement teams that are put into place to ensure a collective and successful process. Now before you get into a tiff and think that I am speaking about the other Spine ASC's and practices in your community, you may want to take a closer look at your Quality Assurance programs before dismissing this article. With over 25 years of engaging in revenue cycle management for spine facilities and practices, I have come to take QA as the utmost critical component of our business. The QA factor forces the staff, both executive and clerical alike to answer to a higher authority other than themselves, and it is here, in this venue that we are able to critique and improve our financial position by way of improving the financial position of the spine institutions we represent.

Yes, I know that there are so many issues to contend with in the area of spine procedure: federal and state guidelines, regulatory mandates, coding and reimbursement changes, independent carrier and state policy positions and last, but not least, is the patient and their experience with your facility. How does the staff and administration keep tabs on the continuously difficult and often adversarial conditions that keep the spine business afloat?

The only way to continue to improve your financial platform is to focus on the basics of service delivery at every turn. This may seem near impossible and most administration or executive personnel will say that there is not enough time in the day to qualify and quantify all levels of service. Our challenge is to find steps that will support a strong QA based company. If not, I can guarantee that managing from 10 thousand feet without looking at your QA failures will surely result in denied procedures, lost revenue and a diminished patient experience.

It is not possible to discuss all of the elements involving QA for an ASC, facility or spine practice in just one article, so I will focus on the basic requirements for the immediate improvement in the revenue cycle and present a series of questions that you can ask yourself about your particular situation. Once you complete the question and answer session, you can think about your own personal experience and begin to determine if your QA protocols are providing you with the information and tools necessary to make the necessary positive adjustments to secure future growth in both the quantity and quality of your services.

Do you have a QA that guarantees that all services performed in your business are billed each month?

Seems like a ridiculous question, but what measures do you take to ensure that all services are billed out each month. We recommend a series of QA techniques, most are pretty unsophisticated, but hit the mark.

- *First*, each day's services should result in a productivity listing of all procedures booked and provided.
- *Secondly*, there should be an associated check of services not billed due to cancellation or discontinued service. How often is the calendar of scheduled procedures reviewed for billed services and the collection on these same services?

We recommend that this become part of your month end protocols, as this will surely increase your billings since most facilities and practices miss several claims submission opportunities more times than you think. You may find that surgeons have not dictated a medical note or that an emergency or "squeezed in" case has not been accounted for or that the surgical listing for the facility does not match that of the surgeons' calendar; these can all identify missed billing opportunities. If you think these issues don't apply in your case, do your own audit of services and respective submission for the past year and look at your results.

Do you have a protocol that reviews canceled cases/appointments?

Well, most booking staff think that a canceled patient will reschedule at a later time, but the ability to capture information about the cancellation may be pretty revealing. Most patients cancel due to personal or scheduling reasons, but others cancel for reasons that require a "fix" in your business. We have found that asking patients why they are canceling can provide the QA necessary to evoke changes in the presentation, positioning and overall personality of the business. You would be interested to note that cancellation issues reveal scheduling difficulties, staff interaction concerns, insurance and financial difficulties, etc., that can be assessed and revamped, depending on the situation.

Let's look at these different scenarios

- Cancelled appointments due to scheduling may be due to the fact that your schedule is full for the next six weeks and patients/physicians are not interested in waiting that long to have their procedures completed so they look elsewhere to accommodate their needs. If you know this may be the situation in your business, you may want to consider expanding your office hours to reduce the risk of lost opportunities.
- If we look further into the reason for cancellations and note that certain representatives have a higher cancellation rate than others, it may be time to evaluate their customer service skills. Perhaps consider whether the patient that cancels after booking their service had an issue with the insurance carrier.
- If your preauthorization or financial team cannot emulate a positive business environment and secure the required documents specific to patient financial responsibility and translate that information adequately to the patient, you may lose that service opportunity, thus resulting in a cancellation.

Are you able to review your reimbursements and improve your coding and reimbursement process?

So let's look at your revenue cycle management QA from the most basic understanding of how your RCM department works.

- The claims are coded, submitted and collected upon. How often do you review your payments on each case, not account, but each case?
- Are all codes accounted for, all line items paid and all billable medical materials reimbursed?
- If yes to the above, how do you ensure that all items are paid at contract or at the expected reimbursement level for non-contracted or out of network services?

Well, there are several factors that may inhibit the level of reimbursement expected. First, let's start with the coding and documentation.

- Is the documentation complete, concise and timely?

The last thing you want is to lose revenue due to a timely filing issue with the carrier. Secondly, how is the coding?

- Is it up to date and accurate, and has it been checked by a second staff member that is qualified to critique the first coder.

Just because your surgeon or physician codes a case, doesn't mean that it is complete and accurate. So to that end, it is recommended that at least two coding experts review the coding to be

submitted to ensure accuracy and coding compliance. It is interesting to note that about 20 percent of all spine claims are coded incorrectly when only one coder is involved and this number drops to about 1 percent if two coders review each case. Calculate out those numbers and you will be able to get sense of what you are losing.

Now let's look at the reimbursement end of this cycle.

- Have you reviewed each account to ensure payment is received in a timely manner;
- Follow up on your claims not later than four weeks after submission of your claim; do you follow through to completion every two weeks or so after that to push for your payment?

You may be thinking "*Who has the staff for that*" or "*Once I have proof of filing from my electronic submission, I will get paid eventually.*" If that is your thought process, I guarantee that your business is losing money. The ability to collect on spine cases in a timely and complete fashion requires the right staff and the right amount of staff to stay on top of your claims. Reducing staff to save money in a spine business will surely result in a much higher financial loss of income when compared to the cost of hiring the proper number of trained staff for your volume. The continuance of spine education for your staff will also prove to benefit your bottom line.

Following the above statement, how many of you review "zero" pays? Many spine businesses get to the "zero" pays when they have a free moment, and keep in mind that free moments really don't exist in a busy spine business! Managing "zeros" provides a wealth of information if you have a QA policy of assessing them. Many zero payments are the result of incorrect coding or poor documentation that can be adjusted internally to correct such deficiencies.

But many "zero" pays are also the result of inappropriate insurance denials as well. Examining these issues will allow the organization to improve their documentation and coding process and look to improve their appeals position to ensure that the revenue cycle team is successful in securing denied payments. We have found that an aggressive appeals department is worth its' weight in gold in resolving unwarranted denials, retractions and can actually produce a significant increase in income. This will require properly positioned and trained staff capable of studying specific carrier expectations in coding, reimbursement and preauthorization processes for specific carrier coverage guidelines and provide the necessary implementation processes to ensure successful reimbursements.

So I have only asked three basic Quality Assurance questions, followed by challenging statements to push you to consider your own business application:

- Are you pushing the QA requirements to improve your overall financial position?
- Are you critical of the processes in your business to push for change when the opportunity presents itself via your QA results?
- And at the very least, are you interested enough in those operating requirements below 10,000 feet to push to make a difference to enhance the overall business financial foundation?

A positive answer to all of the above questions is the only path one should to take to ensure the continued success with your spine business. ■

Learn more about Business Dynamics Limited at www.businessdynamicsllc.com/screens/index.htm.

ASC Administrator Connie Casey: 5 Fresh Ideas for Cutting Costs in 2012

By Rachel Fields

Cost-cutting is a continual task for surgery center administrators. Here Connie Casey, administrator of North Point Surgery & Laser Center in West Palm Beach, Fla., discusses five fresh ideas to stay within a tight budget this year.

1. Demonstrate cost savings to payors by providing details about where physicians take their cases. Most surgery center leaders agree that payors are more likely to increase your reimbursement rates if you can demonstrate that your ASC is less expensive for the payor than the local hospital. Unfortunately, making this claim without evidence might not be enough.

Ms. Casey says she recently started presenting the payor with clear evidence about where her physicians take their cases if they can't be performed at the ASC due to reimbursement issues. "I say, 'I have this doctor taking his cases to the hospital right now. This is his name; this is the hospital's name. You can look at his cases at the hospital and see what you're paying for the procedure,'" she says. She says when the payor can actually see where the patient is going, they are more likely to offer a reimbursement increase.

2. Consolidate suppliers to give them higher volume. The more volume you can give a supplier, the better pricing you can achieve, Ms. Casey says. If you use one vendor for a certain supply, you can give them monthly case volume numbers and demonstrate how much money they will make from you in a month. "They really have to know how much work they're going to get out of the facility," she says. "You can say, 'We love the anchors you're putting in the shoulders, but we can't pay that much. If we're going to do this many cases a month, we will need a lower price.'"

If you consolidate suppliers, you will also likely build a better relationship with the vendors you use, Ms. Casey says. It's important that you stay close with your vendor representative to hear about discounts and negotiate deals. Ms. Casey says she has been able to achieve significant cost savings by working with local companies rather than national ones. When you have a relationship with a supplier, she says, "you can explain to them that some payors won't pay for implants, so you need a discount on the implant from the supplier."

3. Hold a scheduler "happy hour" to bring more cases to the ASC. Schedulers are the gatekeepers of physician cases, and without them, your ASC volume can suffer. Ms. Casey says she holds a scheduler happy hour every six months to refresh their relationship with the ASC.

"The scheduler is the person who gives you those cases, who says, 'I can send that to North Point,'" she says. "We put a lot of emphasis on keeping schedulers and physicians happy so that when a new physician joins the

practice, they fall into place at the ASC and you don't have to work hard for their cases." If your surgery center, like Ms. Casey's, is in an area that suffers from low population growth, you may want to focus on getting more cases from your existing physicians rather than on new physician recruitment.

4. Promote from within. Promoting an employee from within can save money in hiring and training — and you won't have the same lag time as the new employee gets used to your surgery center. Ms. Casey says her materials manager has been with her for 16 years and started at the ASC as a receptionist. "I saw she had much more potential, and she started building relationships with the local companies whose contracts beat out corporate contracts," she says. "I took her and started teaching her, and she caught on so fast that I can give her other jobs as well." Don't limit your employees by deciding they can only do one job from the start; watch for particular strengths and determine if they could benefit your ASC in a different area.

5. Target insurance companies with low reimbursement immediately for new procedures. When starting a new procedure, Ms. Casey says it's essential to approach your payors immediately to start negotiating reimbursement increases. When Ms. Casey's surgery center started performing urology last year, she went to her insurance companies to explain the situation and ask for carve-outs for the procedures. "All but one really helped us," she says. "They know it's a lot more money if the case goes to the hospital."

She says it's important to target insurance companies with predictable low reimbursement in particular. "I have to see if I'm going to be profitable or not," she says. "I write every code down and put it in the system so I can look and see exactly what payors are going to pay for a procedure side-by side." ■

Contact Rachel Fields at rachel@beckershealthcare.com.

5 Strategies for Successful Orthopedic ASCs From ASC Administrator Karen Cannizzaro

By Taryn Tawoda

With new procedures, varying payor reimbursements and rising implant costs to consider, running a profitable, orthopedic-driven ASC can often be a delicate balancing act of conflicting demands. Karen Cannizzaro, CASC, administrator at Physicians Day Surgery Center in Naples, Fla., provides five strategies for satisfying physicians, patients and payors while maintaining a profit-driven and increasingly efficient ASC.

1. **Keep track of competing ASC closures**. ASCs looking to recruit orthopedic physicians in scarcely populated markets should keep an eye on the status of competing ASCs nearby, as a business closure could present an ideal opportunity to acquire new physicians.

When a nearby ASC ceased operations last year, several orthopedic physicians from the competing center joined Physicians Day — a first in the center's 15-year history, Ms. Cannizzaro said. This transition proved effective in increasing the center's caseload by more than 50 percent in the latter half of 2011, she said, and the center's five orthopedic surgeons now perform a combined 150 cases per month.

"We knew that the other center had some business issues, and the surgeons began discussions about coming over to our center as business was winding down," Ms. Cannizzaro said. "They were the closest center to us in specialty mix and size, and we felt very fortunate to be able to do that."

The recruitment opportunity was particularly welcome at a center like Physicians Day, where the majority of the owners have been with the center since its inception in 1997, and in a market like that of Naples, Fla., where available physicians are rare.

"Our local market is such that there are virtually no physicians that are not currently invested somewhere," Ms. Cannizzaro said. "When there is a new face in town, the courting begins."

2. **Cross-train nursing staff and emphasize collaboration with physicians**. A center's efficiency level and overall quality of care can be heightened with a cross-trained staff. Specifically, nurses can be cross-trained to float between pre-op, OR and recovery, said Ms. Cannizzaro. From a practical standpoint, this also means that staff members are able to substitute for one another during vacations and can coordinate shorter or longer days depending on the surgery schedule.

Employees are also trained to avoid unnecessary financial burdens for the center 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 or supplies if you're not sure that you need them," said Ms. Cannizzaro. "They may suggest an alternative product to physicians, or wait to open something so that different trays and implants aren't opened unnecessarily for one procedure."

3. **Coordinate block time schedules with busy physicians**. Orthopedic surgeons with heavy case volumes should aim to schedule their cases according to a block time system, Ms. Cannizzaro said. To implement this, she tracks the amount of weekly and monthly cases each surgeon brings to the center and works to allocate consistent OR times, such as every Monday afternoon or all day every Thursday, for each surgeon.

"It helps physicians schedule and fill their days efficiently," Ms. Cannizzaro said. "It prevents us from having cases scattered all over the place, where the staff is waiting on the next surgeon to come in. Everybody's expectations are very clear."

4. **Develop a consistent formula for evaluating new products and procedures**. In the midst of what can be an overwhelming influx of sales proposals for new products and instruments, it's important to carefully and systematically evaluate the cost effectiveness and efficiency that each one can bring to the center.

Medicare patients are susceptible to wrist fractures, for instance, but wrist plating systems tend to be cost prohibitive, Ms. Cannizzaro said. When considering fixation systems for fractures, a center must pick products based on a comparison of how much money could be lost on a case.

The same rules apply when considering new procedures. It's important to consider which surgical procedures require things like video towers — orthopedic and gynecological procedures typically do, for example — and whether the center can accommodate that without any conflicts.

"We look at the overall cost of the procedure or supplies and whether we have everything here or will need to acquire more instrument trays or equipment to accommodate it," she said. "We also look at the length of time in OR, the anticipated recovery time, the reimbursement from payors. We need to analyze if it will impact other cases we do, or negatively affect our patient flow on certain days. Mixing many specialties together can be challenging."

5. **Work to control implant costs**. Surgical implants require a continuous balance between choosing the right implant for the patient, getting the implant at the best possible cost and securing adequate reimbursement from payors. This can be particularly complex when orthopedic surgeons within the same practice each have their own practice habits and the ASC wants to standardize supplies, said Ms. Cannizzaro.

"As an administrator, you really have to nurture relationships with physicians, patients and payors," she said. "We have also nurtured our relationships with our vendor reps and feel confident that our pricing is competitive and they have provided all of the value added incentive that they can. If we all don't make a little bit of money, none of us can stay in business. That's reality." ■

Contact Rachel Fields at rachel@beckershealthcare.com.

4 Simple Steps to Improved Supplier Contracting, Negotiations and Costs at Your ASC

By Rachel Fields

Andy Davis, director of development for S4, and Chris Klassen, vice president of supply chain for Surgical Care Affiliates and S4, discuss contract terms every surgery center leader should understand and four steps to achieving cost savings in supplier negotiations.

S4 was developed and designed to help independent ASCs of various sizes save on supplies and services. Through S4, non-SCA-affiliated surgery centers can access SCA supply chain to improve pricing on facility supplies and vital services, such as medical waste, linen, anesthetic gas, and others. S4 also provides competitive pricing with an easy-to-use web-based purchasing system and it is designed to improve surgery centers' competitive stance in their marketplace.

Important contract terms

Mr. Klassen began the presentation by explaining that cost control for ASC supplies is important because supplies account for around 30 percent of an ASC's cost structure. On average, SCA centers spend $1.6 million per year on supplies and services — a benchmark that Mr. Klassen has seen echoed throughout the industry. To help ASC administrators understand what they're getting into when they sign contracts with suppliers, Mr. Klassen gave an overview of various terms commonly seen in supplier contracts.

Breach — Failure of a party to perform a contract obligation.

Damages — Details within the contract that describe whether parties will compensate each other for loss, consequence of breach or expense of breach

Term — Duration of the contract; the term includes the possibility for automatic renewal, which lets surgery centers lock in price without re-negotiation for multiple years

Price — Price or discount for agreement term; language about price might detail whether prices will increase every year or remain fixed

Payment — Payment requirements, including stipulations that payments to the supplier will incur a late fee if not paid on time

Freight — Defines who is responsible for goods transfer and who is liable for freight

Inventory consignment — Supplier's agreement to place inventory they own in your center; includes details about how expired/obsolete products are managed, what happens when supplier inventory balancing occurs, liability for lost/damaged/opened products and ownership of physical inventory

Limitation of liability — Limits liability of either party to each other, and should be based on the "worst case scenario" for the surgery center

Mr. Davis continued the presentation by discussing four steps that should be part of any ASC supplier contract negotiation.

1. Identify savings opportunities. Before you move into negotiations with your supplier, you need to understand the ripest areas for cost savings in your ASC. Mr. Klassen notes that many surgery centers use group purchasing organizations for their contracting. SCA and s4 contract direct with manufacturers and utilizes a GPO. He says it's common practice to perform GPO comparisons and recommends that surgery center leaders consider the other services GPOs offer in addition to pricing. Certain GPO contracts also include data services, reimbursement assistance and other services.

In order to know where you can save money, you need to know where you spend money, Mr. Klassen says. "Don't boil the ocean," he says. "Look at the items you're buying the most and where you're spending the most money. This is your biggest opportunity to offset price increases over time as well as enjoy savings." He says surgery center leaders should gather and document a 6-month purchase history, using last price paid and organizing a matrix that includes manufacturer, part number, description, UOM, quantity per UOM, UOM price, quantity ordered, total and category.

Mr. Klassen says surgery centers should identify highest spend and savings opportunities, particularly for supplies that are not contracted with suppliers or are fragmented between multiple suppliers. "If you're buying drapes and gowns from four different suppliers, I might want to consider pulling that spend into one supplier," he says. He says supplier consolidation should be a priority for all your high-spend items. "Suppliers really want your market share," he says. "If you can demonstrate to a supplier that you can give more business to them and that they can enjoy a larger share of your supplies expense, they will work with you on better discounts on your supplies."

Mr. Klassen says there are several benefits to consolidation: lower price, less storage space needed, and reduced confusion for nursing staff and improved purchasing efficiency. He recommends that ASC leaders create a comparison template to compare competitive bids from different suppliers. To do this, pull six months worth of purchase history and organize by category, then create areas to input information and quotes from other suppliers. Turn that into an excel document and delete the "price paid" section before sending to suppliers — you don't want to share pricing information among competitors. Your suppliers can use this template to fill in their quotes based on your volume.

2. Cost savings analytics. Cost is not just about the purchase price of a particular supply, Mr. Klassen says. There are many other factors that affect total cost, including repair costs, disposables cost, warranty cost, maintenance expense and freight. As you consider analytics, consider all costs that affect your total cost.

Mr. Klassen recommends breaking down costs from your current supplier and then analyzing costs from several competitors. Break down costs into purchase price, repair costs, dispos-

able costs, etc., and compare each supplier to see where costs are driven up for each one. If you can acquire competitive pricing information from several different suppliers, you may be able to convince your original supplier to offer you a lower cost. Mr. Klassen says in SCA's experience, capital can account for surprisingly little of total cost — in his example, capital ended up totaling 27 percent of the total three-year cost, and savings on disposables and services costs actually paid for half the capital.

3. Negotiation planning and strategy. Mr. Klassen recommends allowing 60-90 days for the sourcing process, since your team and supplier representatives are busy. He recommends engaging surgeons and physicians early to determine if preferences exist for certain supplies. "The best opportunity to negotiate an effective contract is while the supplier is trying to earn your business," he says. Start talking immediately about terms and conditions that are desirable to you and make them important to the negotiation.

He recommends creating a "negotiation plan" for the ASC, or a document that lists the objectives for negotiation. This might include cost targets you want to hit, the length of commitment from the supplier, rebates, payment terms, freight terms and other objectives. For each objective, outline a "best", "better" and "acceptable" scenario so that you know what you're aiming for and know the minimum offer you will accept.

He says collaboration and buy-in from your surgery center team is critical when negotiating a new contract. Surgeons and team members should be involved in product evaluations and should understand your savings objectives and negotiation plan. They should be informed about the timeline of the process and should be included in celebration if you achieve your desired cost savings.

4. Decision/contract award. Mr. Klassen says the decision about a supply often comes down to product trials. He says when trialing products, concentrate on the supplies that are used most frequently and will cause the most problems if you select an inferior product. As you move through the trial, provide staff members with a sheet to mark off whether the item is superior, acceptable or unacceptable. Also include the question, "Would you convert to this product?" for each supply.

When you receive feedback from your product trials, don't hesitate to share it with your suppliers. "If you communicate as transparently as possible, [suppliers] can be more competitive in winning your business," Mr. Klassen says. "We recommend very candid feedback with suppliers." However, remember not to disclose pricing information among different suppliers.

Once you have gone through product trials, update your negotiation plan and comparison template and make a final decision. Once that's finished, your only task is to finalize contract terms and award the business.

Overview of S4

Mr. Davis shared several features and benefits of the S4 program. According to Mr. Davis, SCA has an aggregate of greater than $200 million in surgical spend, and S4 clients benefit from that volume of spend by saving money on supplies and services. The company has 24 supply chain experts on the team dedicated to reducing costs for our partners. "The idea here is that this is a partnership," Mr. Davis says. "We're in this together to solve some of these problems." S4 uses a web-based system called SmartSystem that lets ASC staff members save time by using electronic ordering and templates for reoccurring orders. According to Mr. Davis, the system has an "Amazon.com feel to it," allowing users to place items in a shopping cart and review ordered items. Users can also compare prices on different supplies. The system also provides robust monthly reporting that shows order compliance and provides continued savings opportunities. When using SmartSystem, ASCs only receive one consolidated invoice rather than having to manage various invoices independently.

According to Mr. Davis, S4 can put together a value analysis savings report and provide a demo of SmartSystem for interested facilities. ■

Learn more about Surgical Care Affiliates at www.scasurgery.com and S4 at www.s4sca.com.

Contact Rachel Fields at rachel@beckershealthcare.com.

7 Best Practices for Driving Spine Center Profitability With Marketing

By Kathleen Roney

In order for a spine center to be successful, it is important to procure and maintain a high volume of patients. Marketing, advertising and other forms of outreach can attract patients to the center. However, developing relationships with local physicians and specialists is also an effective method for increasing patient traffic. Both methods work to bring patients to the center thus, both methods should be utilized — patients equal profits.

Unfortunately, not many spine centers have a great amount of time to put toward patient outreach and building physician relationships. Any marketing materials and time spent needs to be cost-effective, time-effective and produce positive outcomes.

Here, Daniel Goldberg, director of business development for New Jersey Spine and Rehabilitation in Pompton Lakes, a spine practice founded by Richard A. Kaul, MD, in 2003, discusses seven best practices for handling marketing and business development to increase profitability and patient volume:

1. Dedicate a position to marketing and business development. The first best practice is simple. Hire an individual to focus all their efforts on public relations, media relations, marketing and business development for the spine center or practice. As a physician, running the clinical and business operation aspects of a spine practice or center may be too time-consuming to focus on patient outreach and laying the foundation for physician relationship building, especially alone. An employee can share some of the burden. Hiring a marketing director will also increase the changes that the methods used will be effective and produce results.

2. Write for your patients. Writing blogs for your practice's website and submitting to national and/or local publications is a great way to reach a specific patient population. It brands the practice as an informative and knowledgeable source while also increasing brand recognition. Mr. Goldberg uses this best practice at NJSR and it is effective.

"I identified potential patient populations such as what groups have high incidents of spine injuries and then looked for local and national publications that are suited to that population. For instance, if your patient population is older then AARP magazine might be a great avenue for reaching that patient base," says Mr. Goldberg. A key is to take larger national stories and make them relatable to your audience.

"If there has been a story in the news about a famous athlete who was injured, you could write a story about that and how a certain spine procedure or treatment treats that injury and how your practice can help," says Mr. Goldberg.

3. Focus on wording. Give some thought to how you phrase your marketing. According to Mr. Goldberg, while offering complementary consultations to bring patients into the office is a great idea, be careful how you word the advertisement or flyer. "Free has been overviewed and overused, it is now a taboo word," says Mr. Goldberg. "Nothing in this world is free so patients may think there is a catch. Also, 'free' may lead patients to believe that the spine center is lackadaisical in its efforts or not as accomplished as others." Use words like "complementary" or "no cost" to be more effective, says Mr. Goldberg.

4. Differentiate your practice. No matter where a practice is located, a goal should be to create a unique brand to differentiate from competition. In New Jersey and New York, there is a lot of competition in the spine industry. "I would consider it a failure to think that people believe NJSR and another practice offer similar levels of care," says Mr. Goldberg. "You have to make it known that your practice can offer a higher level of care. What do you do that is special? What do you do that is above and beyond. It is important to share that information so patients know."

5. Use social media to target a specific audience. Whether you have 1,000 or 10,000 followers if your social media outreach is not reaching quality individuals than it is not effective. "[NJSR's] age demographic is 30-60 year olds," says Mr. Goldberg. "It would not be a good idea for the practice to follow an 18 year-old on Twitter because an 18 year-old does not need our information and will most likely not be a patient for many years."

You do not need to deny a friend or a follower, but do not waste time seeking out individuals who do not fit your patient population. Mr. Goldberg also recommends trying new things with social media and staying up-to-date. "The science of social media is not a science. While everyone has their tricks and tips, it is all very subjective and still evolving," says Mr. Goldberg. "Things may change tomorrow so it is best to try to stay current with trends and adapt."

6. Do not give medical advice online or via social media. It is very common for individuals to ask specific medical questions online or on social media. It is better to direct them to the practice's website or give them a phone number to call. Giving out wrongful advice in response to a patient's question online can be detrimental to a practice or a physician.

"It would be misleading and confusing to a patient if I were to respond to a question if later one of our physicians gave the patient a different diagnosis," says Mr. Goldberg. "You do not want to be inconsistent."

Every patient is different and every case is different. It is better to use social media to direct patients to your practice's website. "You want your social media to be educational and an avenue for increasing patient volume."

7. Track your return on marketing and advertisements. As for any organization or company, it is important to track the return on investments in marketing and advertising. If you place an advertisement in a magazine, newspaper or even on a website, you want to compare the advertisement's cost to what it generated for the practice.

"An advertisement costs a low amount of money so if it generates one patient, the patient's treatment more than covers the cost of the advertisement," says Mr. Goldberg. "However, you should still set benchmarks. The ad may have paid for itself a thousand times over due to the one patient but that does not mean it was effective."

It is not always possible to determine how many views or impressions a print advertisement received. A benchmark for success could be the amount of inquiries the practice receives per week. Even if an individual calls and references the ad, you know that it was effective. Encourage your receptionist or secretary to ask individuals who call the practice to ask how they heard about the practice, which will give you an idea of where your referrals come from. ■

Contact Kathleen Roney at kathleen@beckershealthcare.com.

5 Strategies for Physician Recruitment in Competitive Markets

By Taryn Tawoda

Christy Franck, administrator at Montgomery Surgery Center in Rockville, Md., knows that understanding the competition in one's market is crucial to effective physician recruitment. Located just half an hour out of Washington, D.C., Ms. Franck's surgery center is in a market with a plethora of single- and multi-specialty surgery centers that often vie for the same physicians. Here she shares five strategies for approaching the physician recruitment process in a way that meaningfully distinguishes a surgery center in a challenging market.

1. Research and assess the competition from other centers. According to the Maryland Healthcare Commission, there are more than 300 licensed surgery centers in the state, which means that an individual center must make a compelling case in order to convince a surgeon to move. In order to do this, Ms. Franck first determines which type of centers may also be trying to recruit the same physicians.

Because Montgomery Surgery Center is multi-specialty, Ms. Franck is mindful of any single-specialty centers nearby — she knows that certain physicians may be more attracted to a smaller center that focuses exclusively on one type of case, and she adjusts her specialty recruitment targets accordingly.

"If there are several GI centers right around you, you probably will not recruit GI physicians because they'll love going to a GI-only center," Ms. Franck said.

2. Anticipate a new physician's priorities. In a market where surgery centers are hungry to recruit a limited number of physicians, a willingness to compromise and accommodate is a helpful asset. Ms. Franck recommends having an open discussion with potential new physicians about their preferences and any difficulties they've had with past surgery centers in order to increase their comfort level with the center.

Topics of discussion may include frustrations with case scheduling, out-of-network insurance plans, preferences for particular brands of products or a center's ability to handle a high case volume. To anticipate issues ahead of time, Ms. Franck will consult the center's current partners about their own experiences.

"We try to find out from surgeons that already come here, 'What are your obstacles somewhere else? What can we do to make things easier?'" said Ms. Franck. "We'll also emphasize that we have an experienced staff. Physicians have to be comfortable with their clinical team and know that they'll been taken care of once they're here."

3. Offer to make concessions. Approaching the physician recruitment process with a "customer service" mindset is important in distinguishing oneself from a competing center, and this includes a willingness to make concessions to satisfy the physician.

Once a physician's preferences and concerns are on the table, Ms. Franck said, it's up to the center to weigh the cost of accommodating a physician against the revenue that his or her cases will bring to the center. If an ENT surgeon expresses a preference for a certain type of ear tubes, for example, the center is typically willing to purchase that product in order to bring the physician in.

The act of accommodating a physician often requires significantly less effort than the benefits it reaps, Ms. Franck says. By spending some money to accommodate a new physician, the surgery center can increase profit through additional case volume and build physician loyalty.

"From a business standpoint, it's beneficial to accommodate a physician if you can," said Ms. Franck. "Physicians appreciate us listening to them and finding out what it is that they would like to see happen in the center. If we can help them, they'll bring their business to us."

4. Ask current employees to recommend new physicians. Existing physicians should play an active, ongoing role in the recruitment process. With more than 100 physicians performing cases, Montgomery Surgery Center uses its staff as a crucial resource for insight on which physicians to contact.

It's often ideal for physicians to communicate directly with potential recruits, Ms. Franck said. Longstanding social ties and mutual backgrounds between physicians create an automatic sense of trust and credibility.

Ms. Franck also asks the support staff, including the OR team and surgical technicians, for information on physicians they've previously worked with who may be interested in bringing cases to the center.

5. Make recruitment an ongoing priority. A center that continually works to attract physician talent will be more likely to weather future blows to case volume, including physician retirement or unanticipated moves. Ms. Franck tries to maintain an ongoing awareness of the recruitment climate in the state, knowing full well that an ideal physician partner is not something she is likely to stumble upon solely in a moment of need.

Maryland prints a physician directory book, which Ms. Franck uses for reference in addition to regular Internet searches to monitor physicians near the center's location in Rockville.

"I try to use anything I can to compile," said Ms. Franck. "If I'm focusing on ENT, I try to find a list of all ENT surgeons in the area, then go to our current medical staff and ask if they know or can recommend any of them. Anything that's on the table for us to use, we take advantage of.." ■

Contact Taryn Tawoda at taryn@beckershealthcare.com.

Healthcare Reform's Day in Court: 8 Experts Weigh In

By Laura Miller

In late March, the Supreme Court heard arguments over the legality of the Patient Protection and Affordable Care Act. In June, they will announce if the individual mandate is or is not legal under the Constitution. Here, industry experts share their thoughts on how the Court will rule and what impact the ruling will have on healthcare delivery and consolidation.

Chuck Lauer, Author, Public Speaker, Career Coach, Former Publisher of Modern Healthcare: The Supreme Court hearing on the healthcare law challenge begins next week. However, the issue could be delayed until 2014 because of what is called the Anti-Injunction Act. It is a federal law that says courts cannot consider a challenge to a tax law until that tax is actually assessed. If the high Court actually rules that the AIA applies to the healthcare law then no challenge to the individual mandate can be heard until after 2014. That is unless the Congress was to act on the measure. Neither the government nor the challengers feel that the law necessarily applies, but the Court has hired a lawyer to argue a position that neither of the parties would argue, which is that the challenge to the individual mandate is premature and can only be brought once it goes into effect in 2014.

The individual mandate is really the key provision of the law, and it requires most people to buy health insurance by 2014 or pay a penalty. The government argues that the Congress had the authority to pass the law under the Commerce Clause. The opponents, however, consisting of 26 states, four individuals and a small business group say that Congress does not have the authority to force someone into the marketplace. They argue that if Congress has the power to pass the mandate that would mean that the scope of its power is unlimited.

I believe the opponents of the individual mandate will prevail and the Supreme Court will rule in their favor. If in fact, if I am correct in my assessment, the Court will then have to rule on what happens to the rest of the law. Opponents of the law contend that if the mandate is struck down the entire law should be in turn struck down. The government takes the position that if the mandate is struck down, only two popular provisions of the law (that would include the one that deals with insurance companies dealing with preexisting conditions) would have to fall but the rest of the law can stand. This whole matter is complicated and very few people are willing to predict the actions of the Court relative to this matter. Predicting the outcome is a little like throwing the dice on a craps table in Las Vegas.

Peter R. Kongstvedt, MD, FACP, Senior Health Policy Faculty, George Mason University/Principal, P.R. Kongstvedt Company: Despite the SCOTUS having a 5/4 conservative majority, the only vote that is perceived to be locked in is that of Justice Clarence Thomas who will vote to repeal the mandate and may even argue against severability since that would overturn the entire ACA. It's also good odds that the more liberal Justices, itself a highly relative adjective, will support the ACA in its current form. But the remaining Justices are a cipher at this point. The arguments on both sides are logical, whether or not you agree with them. The reasons one or more might support the mandate are that the uninsured still consume services, so it isn't a clear cut case of requiring people to buy something they would otherwise never, ever use; and overturning the mandate sets a precedent that might be applied in unknown ways in the future (you can argue the exact point to support overturning it). In a way, it's a balance between societal good — spreading the risk, and an individual good — and freedom to not pay for something even if you end up using it later.

Said another way, they must affirm or deny that famous philosophical dictum "The needs of the many outweigh the needs of the few" uttered by Leonard Nimoy's Spock in "Star Trek II: The Wrath of Khan" (OK, utilitarianist philosopher and auto-icon Jeremy Bentham [1748-1832] had a similar quote: "It is the greatest good to the greatest number of people which is the measure of right and wrong.")

Bruce Berg, Associate Professor of Political Science, Fordham University: The question for the court is whether the federal government has the authority to mandate that an individual purchase health insurance. The federal government contends that it has this authority under the commerce clause since individuals purchasing or not purchasing health insurance has an impact on interstate commerce. This is an area of public policy traditionally regulated by the states and there is a federal law recognizing this power. However, there have been sufficient mergers and expansions in the healthcare industry of late, meaning that even though states have the power to regulate insurance, healthcare insurances cross state lines on a regular basis.

We also have to look at whether the federal government has the power to regulate individual actions with the commerce clause. There have been cases were the Supreme Court ruled the federal government did have the power to tell an individual which course of action to take, but there are different circumstances surrounding each case. In this instance, does the Supreme Court really want to get into a tussle with the legislative and executive branches? This is a major piece of national legislations and the judges need to decide whether they want to challenge legislation on a piece of law that is relatively narrow.

John Cerasani, Owner, Northwest Comprehensive (Chicago): There are many aspects of HealthCare Reform that are quite unpopular to people that truly understand the economics of how health insurance works. Whether or not aspects of the bill are unconstitutional will be decided by the Supreme Court; those challenging the bill's constitutionality are doing so as a means to get rid of it, as it does not fix anything that it set out to fix.

There is no affordability of care and the people that put this bill in place know that the provisions represented in it will increase health insurance premiums to businesses, not do the opposite. If the bill falls apart due to the unconstitutionality of it, which it should, then we are back where we were a couple of years ago with two main concerns still needing to be addressed: 1) access to healthcare for uninsured Americans, and 2) unaffordable insurance premiums. My hope is that we start from scratch and work on a bill to address both of these priorities, not just one.

Lynn Massingale, MD, FACEP, Executive Chairman, TeamHealth: Obviously the court could go either way on this issue, based the "swing votes" of a few of its members. As you know, if they decide the mandate is unconstitutional, then the question will be whether that makes the entire act unconstitutional or whether the mandate can be severed from the rest of the provisions. If it can be severed as unconstitutional, I'm confident the administration will have already considered others ways to pay for the broadened coverage...one can only speculate as to those additional funding sources.

Paul Summerside, MD, MMM, CMO, BayCare Clinic (Green Bay, Wis): I believe they will uphold the law. The government clearly has a compelling interest in healthcare. A patchwork series of payment/insurance law does not serve interstate commerce and the government remains the payor of last resort and needs an equitable mechanism of funding. I believe a negative ruling will slow consolidation but not stop the trend. All the current insurers want consolidation so payment rends are forcing physician/hospital consolidation.

Bill Woodson, Senior Vice President, Sg2: There is a lot of uncertainty about what the Supreme Court justices will take into account as they make their decisions. We advise our clients not to let this decision become too much of a distraction because the issues that confront them today are the same issues that will be there over the next decade — the toothpaste that is healthcare reform is already out of the tube and you can't put it back in. There will be press and politics about the individual mandate, but there are other things like reimbursement pressures and new care delivery models that will truly transform health care over the next five years.

The number one thing to focus on is the combination of new types of risk sharing arrangements and broader concepts of value-based purchasing, which puts the onus on creating new strategies for reducing the total cost of care. This is a gradual shift, but there is a building urgency to examine the value and efficiency of your healthcare delivery model. There are certainly providers for whom Medicaid payment is a huge part of their revenue stream and the Supreme Court decision may indeed impact those facilities, but others should focus on developing a response to the narrowing gap between commercial and Medicare reimbursement.

We see industry consolidation from several different angles. There is no doubt, however, that the combination of reimbursement pressure and the capital and operating costs associated with information technology and new regulations will cause an industry shakeout.

For providers who wonder how they should respond locally to the Supreme Court decision, we remind them that there is a great deal of confusion among patients, physicians, employers and other stakeholders about what healthcare reform really means. Ongoing education and communication about how healthcare is evolving and the value that providers are delivering to the local community is critical.

Jay Warden, Senior Vice President, The Camden Group: 1) Provider partnerships with local and regional health plans and the huge momentum behind CMMI programs in bundled payment and shared savings will continue to help providers prepare for achieving the "triple aim" regardless of the Supreme Court ruling.

2) Improving primary care access and designing primary care practices to more efficiently and effectively manage care for populations will continue to be one of the biggest challenges facing provider organizations. The Supreme Court ruling will impact the specifics of how care is paid for, and by whom, but the need for local providers to improve access to primary care will remain a constant.

3) No matter what happens with the health reform law and the federal insurance mandate, provider organizations need to incorporate payor strategy and network development strategy into their strategic planning activities, and they need to continue operations improvement efforts to reduce readmissions and manage the cost of care. Many of our clients have been having proactive discussions with local and regional health plans for several months regarding narrow networks, bundled payment, and accountable care organizations. In many cases, payors are "taking sides" and forming significant partnerships with large health systems at the expense of other providers. As a result, competing payors are funding ACO infrastructure development to help smaller health systems develop the networks and care management capabilities they need to compete with the bigger systems. ■

Contact Laura Miller at laura@beckershealthcare.com.

20 Statistics on Physician Compensation for 5 Key Surgery Center Specialties

By Rachel Fields

Here are 20 statistics on compensation for physicians in five common surgery center specialties, based on data from Medscape's *Physician Compensation Report 2011.*

Gastroenterology

Median income: $300,000

Highest-paying region of U.S.: North Central ($542,500)

Highest-paying practice setting: Private practice (partner)

Percent who feel fairly compensated: 53 percent

Ophthalmology

Median income: $248,500

Highest-paying region of U.S.: Great Lakes ($333,000)

Highest-paying practice setting: Single specialty group

Percent who feel fairly compensated: 55 percent

Orthopedic surgery

Median income: $350,000

Highest-paying region of U.S.: North Central ($537,500)

Highest-paying practice setting: Hospital employee

Percent who feel fairly compensated: 47 percent

OB/GYN

Median income: $225,000

Highest-paying region of U.S.: North Central ($290,000)

Highest-paying practice setting: Multi-specialty group

Percent who feel fairly compensated: 50 percent

General surgery

Median income: $300,000

Highest-paying region of U.S.: North Central ($341,579)

Highest-paying practice setting: Hospital employee

Percent who feel fairly compensated: 45 percent ■

Learn more about Medscape at www.medscape.com/sites/public/physician-comp/2011.

Contact Rachel Fields at rachel@beckershealthcare.com.

Advertising Index

Note: Ad page number(s) given in parentheses

WestCMR
West Coast Medical Resources, Inc.
Your Surplus Surgical Specialists since 1997
www.WestCMR.com
1-800-565-6385

Would you like to turn your NON-MOVING Inventory into $$$?

DO YOU HAVE NON-MOVING SURGICAL INVENTORY DUE TO:

- ***UNREASONABLE RETURN POLICIES?***
- ***POOR INVENTORY MANAGEMENT?***
- ***PRODUCT CONVERSIONS?***
- ***SURGEON PREFERENCE?***
- ***BUDGET CUTS?***
- ***TURNOVER?***

WE PURCHASE SURGICAL SUPPLIES FOR THE FOLLOWING PROCEDURES:

- ***ARTHROSCOPY / ENDOSCOPY***
- ***GYN / WOMEN'S HEALTH***
- ***ENDO-SURGERY***
- ***HERNIA REPAIR***
- ***ORTHOPEDICS***
- ***UROLOGY***
- ***TRAUMA***
- ***E.N.T.***

Come visit us at:

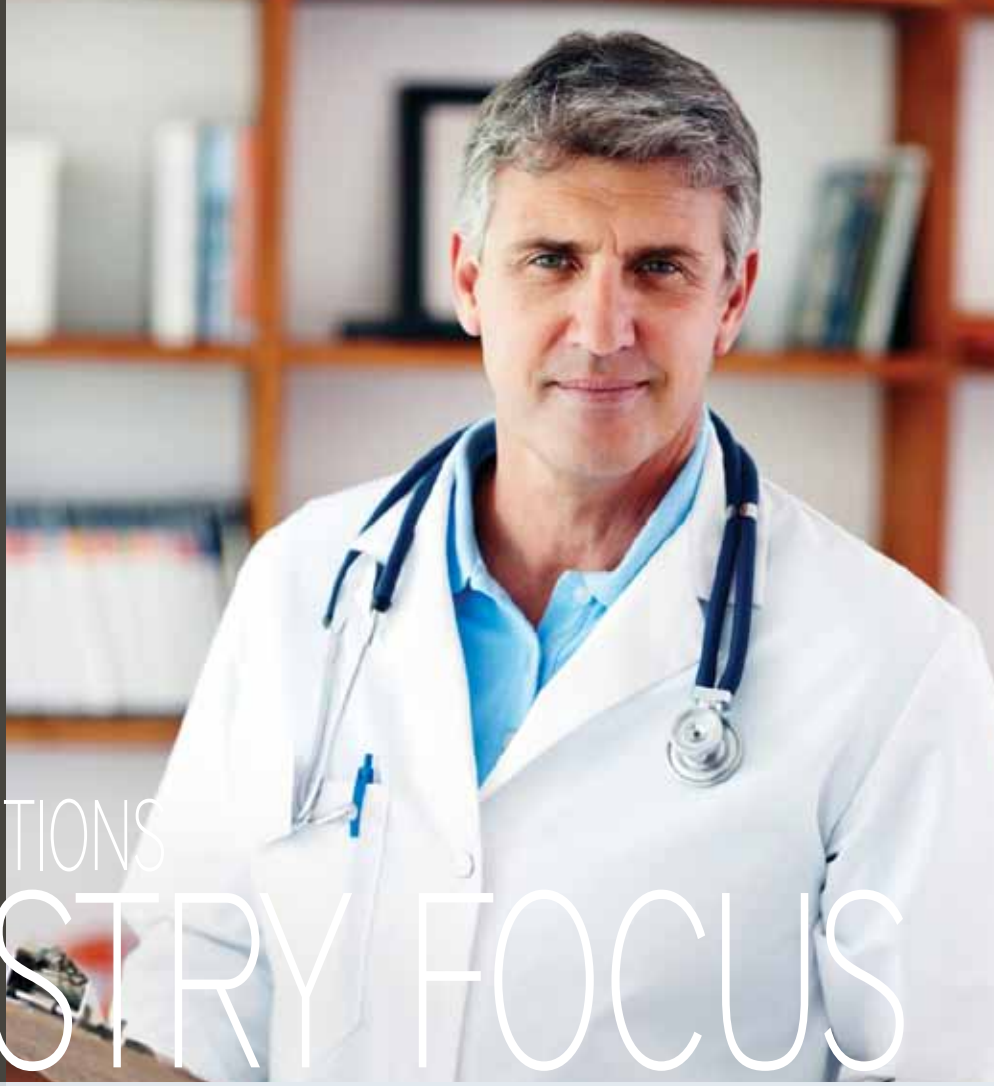
ASCA 2012
Booth 729
May 9-12, 2012

AHRMM12
August 5-8, 2012

To find your regional representative visit:
WestCMR.com/SellSurplusNow.html
or CALL TODAY!

Toll Free: 800-565-6385
www.WestCMR.com

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



INNOVATIVE SOLUTIONS
INDUSTRY FOCUS

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