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INSIDE

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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

Novmeber/December 2012 • Vol. 2012 No. 9

433 People in the ASC Industry to Know

By Rachel Fields

This list of leaders within the ambulatory surgery center industry was created as a result of extensive research by our editorial staff. The list is arranged in alphabetical order. Leaders do not pay and cannot pay for placement on this list. Inclusion on this list is not an endorsement of a provider's or organization's clinical abilities.

David J. Abraham, MD. Dr. Abraham is a physician at the Reading Neck and Spine Center in Wyomissing, Pa.

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10 Strategic Questions to Ask for Long-Term ASC Success

By Rachel Fields

Healthcare is in a time of transition, and surgery centers are not exempt from reimbursement pressures, acquisition opportunities and increasing expenses. Joyce (Deno) Thomas, senior vice president with Regent Surgical Health, discusses 10 tactics for surgery centers to prepare for the next 10 years.

1. What is the condition of your physical plant? Ms. Thomas says strategic planning should start with a consideration of your physical plant. "If you look at the physical plant, it will tell you what immediately needs to be done within the next year, as well as what needs to be done within three to five years," she says. If you have a brand-new facility, Ms. Thomas says your immediate task is maintenance. Make sure the facility stays pristine in order to attract physician-investors and patients. "It's a matter of waxing the floors and washing the baseboards every quarter

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Will Medicare Ever Reimburse ASCs for Spine Surgery? Q&A With Dr. Brian Gantwerker

By Laura Miller

Brian R. Gantwerker, MD, of The Craniospinal Center of Los Angeles, discusses the quality and cost benefits of performing spine surgery in ambulatory surgery centers and what it will take for Medicare to reimburse for these procedures in the future.

Q: When will Medicare approve reimbursements for spine surgery in ambulatory surgery centers?

Dr. Brian Gantwerker: I think it will be necessary for Medicare to start covering outpatient spine surgery in terms of a viable business model for healthcare. Surgery centers can perform minor spine operations, such as a minor spinal decompression and cervical procedures,

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

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FEATURES

Publisher's Letter

This issue of *Becker's ASC Review* covers several topics, including surgery center leadership, reimbursement strategies and growth opportunities in the future. It contains expertise from several of today's leading experts in the ambulatory surgery center arena.

Please save the date for the date for the Becker's Hospital Review Annual Meeting May 9-11, 2013, in Chicago. The conference will feature several sessions led by hospital CEOs and industry experts. Key note speakers at the conference will include:

1. Lou Holtz, a legendary football coach and ESPN analyst.
2. Bret Baier, anchor of FOX News Channel's "Special Report with Bret Baier."
3. Patrick Lencioni, author of *The Five Dysfunctions of a Team*, among other books.

Also save the date for the 11th Annual Orthopedic, Spine & Pain Management-Driven ASC Conference on June 13-15, 2013, in Chicago. The conference will feature several sessions led by surgeons and industry CEOs covering key business and legal issues for orthopedic and spine surgeons. Key note speakers at the conference will include:

1. Mike Krzyzewski (Coach K), former basketball player and head coach at Duke University.
2. Brad Gilbert, former professional tennis player, TV tennis commentator, author and tennis coach.
3. Geoff Colvin, senior editor-at-large for *Fortune Magazine* and author of *Talent is Overrated.*
4. Forrest Sawyer, TV journalist and entrepreneur in innovative healthcare and founder of FreeFall Productions, an award-winning documentary production company.

Should you have any questions or comments, please contact myself at sbecker@beckershealthcare.com or co-editors Rachel Fields at rfields@beckershealthcare.com and Laura Miller at lmiller@beckershealthcare.com, or president and CEO Jessica Cole at jcole@beckershealthcare.com.

Very truly yours,

Scott Becker

8 Points of Survival for Surgery Centers After ACOs

By Laura Miller

Hospitals and physician-groups in several markets are exploring accountable care organizations, and many are choosing to participate. As a result, surgery centers are assessing whether they should join or if it would make more sense to go in a different direction.

"I think the healthcare reform has really been a great catalyst for clinical transformation," says Akram Boutros, MD, founder and president of BusinessFirst Healthcare Solutions. "ACOs are Medicare-specific designated entities that are really focused on population management, cost reduction and quality improvement. At the heart, certainly ASCs can meet this challenge. They cannot become an ACO, but they can become a member of an ACO group, and they should be focused on the idea of overall clinical transformation."

This change in the healthcare environment will force ASCs to confront ACOs, even if they choose not to become part of one.

"I would think that surgery centers would minimally want to think about how to connect with ACOs," says James Fox, director and senior CFO consultant at Warbird Consulting Partners. "If ACOs are streamlining care to patients, that would include referrals to the highest quality and hopefully best priced care going forward. Anybody who relies on referrals from physicians or maintaining business will, at some point, have to consider how to connect with ACOs as more patients will flow through those mechanisms."

The structure of accountable care organizations is left fairly open and ambulatory surgery centers have been left to carve out their own role. "The legislation doesn't speak about ASCs and we don't know where they will end up," says Jodi Laurence, partner at Florida Health Law Center. "We do know there will be healthcare reform in some way and I would think ASCs need to figure out how they will survive in this new healthcare regime."

Here, industry experts discuss eight points of survival for surgery centers in a post-ACO market, whether they decide to participate or not.

1. Show your ASC can meet ACO goals.

Accountable care organizations strive to improve the quality and lower the cost of care by promoting care coordination and asking providers to assume risk for their care. Whether your surgery center participates in an ACO or not, proving quality and cost of care meet ACO standards will be important.

"What I would advise ASCs to do is to no longer look at themselves as standalone entities with separate and distinct relationships with their physicians," says Dr. Boutros. "Become part of a healthcare delivery system where patients and physicians can move easily between sites. They will need to demonstrate they can improve quality and reduce costs better than surgeries done in inpatient hospital departments."

Once you are able to demonstrate these goals, make sure patients and referring physicians know about your facility. "Communicate with primary care physicians about how you can be cost effective for their patients," says Ms. Laurence. "Build a relationship with payors and be smart about your IT system."

2. Implement data-tracking systems.

As it becomes more important to track data — with or without an ACO — surgery centers should prepare by implementing electronic medical records or other electronic systems to track their outcomes and cost data.

"Surgery centers need to get their EMR in order if they want to become part of an integrated delivery system structure because they need to track what they do," says Ms. Laurence. "They will need to have data showing they provide good quality care and communicate with the other part of the network when a patient comes in."

Integrating electronic health systems is an onerous task, but it will benefit surgery centers far into the future. "Spend the money now on developing your IT systems so you are in the position to better coordinate care," says Ms. Laurence. "When you are talking with payors, you can show your performance and that you can provide several services at competitive costs with low complication rates. Be able to sell yourself to the payor."

Even in markets where ACOs aren't present, it will be helpful for surgery centers in the future to implement data management. "An underlying current is getting your ducks in a row for data management, because if you jump on board with an ACO, bundled payments or some other form of risk sharing provisions will follow," says Dan Connolly, vice president of payor contracting with Pinnacle III. "It's obvious that ASCs add to their preparation for these opportunities by managing their reimbursement and cost data. Having the information available at the outset to handle bundled payments or other forms of risk sharing arrangements will provide an ASC with an edge."

It's important to track both cost and quality data. "Cost and quality are the two key reasons why ACOs will want to include the right ambulatory surgery centers," says Reed Martin, COO


Dr. Akram Boutros


James Fox


Jodi Laurence

of Surgical Management Professionals. "We are gathering this information now to show quality advantages; any work that can be done to improve outcomes and infection rates needs to be reviewed so the ASC can identify how they are better than their competitors."

3. Examine your geography before proceeding with ACOs. Whether your surgery center is leaning toward becoming part of an ACO or seeking another way to grow within the market, it's important to understand your geography. In some markets it makes more sense for surgery centers to become ACOs than others.

"Geography usually trumps everything else," says Dr. Boutros. "Look at the hospitals and health systems closest to you; they are the ones with strongest relationships to the medical staff. That will determine the patient population that is part of CMS and commercial ACOs."

The hospital's presence in the community will have a huge impact on how surgery centers will interact with current and future ACOs.

"If the ACO in a given market includes the hospital that is a substantial employer of physicians who integrate their care, then certainly the surgery center will have to work with the hospital to balance that out," says Mr. Fox. "Hospitals


Dan Connolly


Reed Martin

should be incentivized to provide the highest quality, lowest cost care possible, so they will partner with surgery centers for an economic sharing possibility, or build ASCs of their own."

However, if the ACO is driven by physicians in the community, surgery centers will be able to compete with hospitals as a lower-cost provider because the physicians are incentivized to bring cases to the highest quality, lowest cost setting.

"If hospitals aren't a huge part of the ACO, they might be more interested in working with ASCs to provide more surgeries at a lower cost assuming the quality is high, than working with the hospital at a higher cost base," says Mr. Fox.

4. Develop relationships with payors and providers. There are several models ACOs could take over the next few years depending on the relationship between physicians, providers and payors in your community. Physicians and surgery centers that already have a relationship with others are more likely to build on that foundation for an ACO or ACO-like payment model in the future.

"Surgery center administrators should begin by developing a closer relationship with health systems and beginning to manage commercial payor risk models," says Dr. Boutros. "I think the relationship models that the freestanding ASCs should think about developing are participating in a program that puts some dollars at risk but has significant upside potential because it reduces overall cost and improves patient satisfaction and outcomes."

When approaching the hospital about a partnership, Dr. Boutros advises working through a surgery center physician who also has privileges at the hospital. "See who has the best relationships with the hospital administration on your staff and they can help you navigate the process," he says. "I would look for a progressive health system that has had some risk contracting and pay-for-performance experience because their executives understand the value of integration and collaboration."

In some communities, surgeons and surgery centers are concerned that close relationships with hospitals could lead to hospital ownership in the future. In this case, surgery centers could partner with primary care physicians or payors involved in an ACO that would benefit from ASCs as a low cost provider.

"I think it makes sense for surgery centers to align with primary care physicians because they are going to be the new gatekeeper in this system," says Ms. Laurence. "They have to figure out how to compete by finding hospitals that don't have an ASC and working with them as well as finding primary care physicians to network with."

5. Become part of the continuum of care. Many surgery centers only see patients when surgeons bring them in for their procedures — not providing additional care such as imaging services, physical therapy or follow-up visits. As providers in the market move toward a continuum of care model, surgery centers that aren't able to become part of that global care could be in trouble.

"Overall, I would think it's important that ASCs begin thinking of themselves as a part of the healthcare services continuum," says Dr. Boutros. "We have to integrate the processes so consumers are more satisfied because they see improved outcomes and lower costs."

ACOs encourage providers to work together on a cost-containment platform so anything the ASC can do to build a relationship outside of their own walls will be helpful.

"Regardless of their platform going forward, all stakeholders know we are all in this together. The only way we are going to impact change is to form a collaborative relationship where everyone has skin in the game and works together effectively," says Mr. Connolly. "First, target the gaps in service to form a partnership that will help in the future, such as physical and occupational therapy for orthopedic-focused surgery centers, and connect the dots for referral patterns to develop relationships with primary care physicians."

In addition to cost and quality metrics, payors and ACOs will be looking for patient satisfaction levels. "Patient satisfaction will be very important for ACOs because providers want to know their patients are satisfied," says Mr. Martin. "We think that the use of an outside, unbiased third party to send the information and gather information tabulated electronically is very helpful."

6. Move more procedures into the surgery center. The more types of procedures that can be performed in the outpatient surgery center, the more cases an ACO will bring them. Surgery center administrators should consider expanding services to higher acuity cases that were traditionally done in the hospital, as long as the patients would be good candidates for the outpatient setting.

"The more surgeries that can be moved out of the expensive acute care setting into an ambulatory setting, the more money that will be saved," says Mr. Fox. "That will benefit the ACO as well as the surgery center."

In some cases, this will mean purchasing new equipment and recruiting new surgeons who perform cases such as minimally invasive spine surgery or total joint replacement.

"ASCs are seeking opportunities for their affiliated surgeons to move high cost procedures out of hospitals and into ASCs," says Mr. Connolly. "The potential cost savings could lead to reward sharing among the involved entities. We've been negotiating fee for service rates for spine and total joint cases with payors who are eager to identify opportunities to save money. There is a dual effect — costs are contained and the overall system benefits."

Some payors will be familiar with bringing these cases into the ASC while others will be more skeptical. Meet with the medical directors who work for wary payors to educate them about the safety and effectiveness of these procedures. "Convince them this is safe by pointing out all the criteria that is set up to ensure only appropriate patients are seen for these procedures in this setting," says Mr. Connolly. "Educate them about the cost savings as well as how making this kind of move will benefit the system, the payors and their members. Many times this starts with the surgeon who will be performing the procedures having a 'collegial talk' with a payor's medical director."

7. Protect yourself from taking on too much risk. Being part of an ACO will require surgery centers to take on a portion of the risk

for providing care. This could mean capping the cost of an episode of care so the surgery center would have to cover the cost of care associated with complications. However, don't take on too much risk.

"Many providers are going into ACOs with eyes wide open so they are not taking full capitation risk," says Mr. Fox. "They are gain sharing or if they take risk it's often a tacked risk so they aren't fully exposed."

The contract shouldn't push too much risk onto the surgery center, or eat up too much of the surgery center's costs. "One of the things to be concerned about is if the ACO is trying to shift too much of the risk or costs onto the surgery center," says Mr. Fox. "Our concerns are primarily the financial ones."

Additionally, you don't have to fully enter into the ACO right away.

"You don't have to do an 'all-in' relationship," says Dr. Boutros. "You can pick one carrier with one product and work to establish the relationship to test the water and see how well things work out with the organization, and expand if it works."

Some surgeons are skeptical or ill-informed about ACOs, but it seems they are trending as the way of the future. "If there is a movement toward ACOs in your community, surgeons need to figure that patients will be part of the ACO," says Ms. Laurence. "Some surgeons don't want to join, but you want to be on the cutting edge of healthcare reform; be in a situation where you can profit and not die by the wayside."

It's important to know your cost data so you can negotiate rates that aren't too tight for the surgery center to handle. "We look at the variable costs associated with the case," says Mr. Martin. "We want to make sure we'll still make an acceptable profit, so we have to understand what the costs are. ACOs will want ASCs for lower costs and higher quality, so for ASCs to negotiate effectively they need to understand their own costs by procedure."

8. Avoid red flags that would have a negative impact on ASCs. Before taking the leap into an ACO, make sure the organization will provide the right type of patients at a healthy volume. You also want to make sure that ACO surgeons will use your facility.

"Getting the right types of patients is important," says Mr. Fox. "Also be aware of who else in the network is providing the same types of services as you are and how those mixed incentives are balanced. You don't want the ACO to play you off of the other providers; you want to be the primary ambulatory setting of the ACO because at some point capacity will have to be managed and you don't want to be excess capacity."

Additionally, if the ACO is primarily concerned with Medicare or Medicaid patients, or another type of charity care, they may not be beneficial for the surgery center in high volume. "Have an understanding of the payor mix that will come through the ASC and payments attached to them," says Mr. Fox.

Finally, consider whether you will be able to communicate with the other providers in the system through several channels, including electronic health records. "It will be important to evaluate the size and capability, as well as technical abilities and interactive abilities, of the ACO to distribute information," says Mr. Martin. "Choose your partners well and identify throughout agreements if there are any risks or costs in joining the ACO. Also think about the potential upside with respect to potential patient volume growth." ■

Most Beneficial Payment Models for ASCs in the Future: Q&A With Lloyd Guthrie

By Laura Miller

Lloyd Guthrie, vice president of accountable health networks at Lutheran Medical Center in Wheat Ridge, Colo., discusses accountable care ACOs and the beneficial payment models for ambulatory surgery centers in the future.

Q: What payment models will be most beneficial for ASCs in the wake of healthcare reform?

Lloyd Guthrie: Healthcare reform means enhancing the value of care and services that ASCs provide. As financial pressures increase, it would seem that ASCs are in a good position to offer services that have historically been provided at a hospital. An example would be total joint replacements. But to be really competitive, and better differentiated in its local market, an ASC would practically want to develop comprehensive service bundles so there is the perception on the part of the purchasers — insurance plans, government coverage or self-insured employers — that the ASC is showing a leap in value.

In addition to combining the ASC facility with physician professional and therapy services, the bundles would have a warrantee or guarantee, so there are assurances that patients are financially aware the bundle exists, and know what their role within the successful bundle. That is, that patients are incented to keep their post-procedure follow-up care, take their meds and receive therapies as prescribed. Then, ASC physicians could make the assumption that patients will be engaged in their care or postoperative care in a way that reduces complications.

Q: How would this model work for ASCs? Are there any examples for providers doing it today?

LG: An example of an organization that provides bundles with guarantees is the Geisinger Proven Care model. They may not currently provide guarantees for ASC procedures, but the construct is directly applicable to ASCs. For instance, if a patient is having a knee procedure there would be a scheduled series of documented activities — pre-procedure, during the procedure and follow up to the procedure, for a prescribed period of time. If all parties, the patient and providers alike, engage in the continuum of care delivery per their individual part of the agreement, the patient has a guarantee that complications will be covered.

Part of the advantage of having an ASC that is a joint venture between a group of physicians and hospital is the pre-existing care continuum that can be wrapped in as part of the guarantee package. If there is not a venture between physicians and the hospital, the ASC will need to determine where the physicians' typical hospital referral patterns are and negotiate with those hospitals on behalf of the bundle.

Q: By guaranteeing outcomes, the providers are also assuming some risk. Is it possible for surgery centers to mitigate this risk while still providing appropriate care?

LG: As part of the due diligence necessary to build profitable bundles, there should be an actuarial assessment of the population the ASC typically cares for, and some additional "risk amount" can be added to the package price to cover complications and other events. Alternatively, there may be opportunity to negotiate stoploss coverage with private insurers if the volumes are significant.

From the ASC's position, to drive volumes, value-based bundles may be attractive for several purchasers, including health plans looking for new subscribers by offering narrowed networks. Another significant group would be self-insured employers that take risk for the total expenditure for their employees. To some extent, I think this second group may be the biggest opportunity. The third group would be local provider-based accountable care organizations that are looking to enhance the value for their covered lives. If you have a physician's ACO comprised of primary care doctors that had assumed financial liability for medical services risk, they will necessarily be in the ASC market to find a high quality, low cost provider.

Q: If there is a place for ASCs in markets with ACOs, where do ASCs fit into emerging ACO models?

LG: The ASC could be either a direct participant in the ACO or in a network participant rather than a core participant. If the ACO has a broad catchnet area, the ASC could be part of the overall ACO consortium. Those ASCs that stay on top of technology developments, particularly those that provide opportunities to move procedures from the inpatient setting to the outpatient setting, stand to benefit from ACOs.

Q: Where do you see ASCs headed in the future? Where is the biggest opportunity for growth?


Lloyd Guthrie

LG: There are some additional things that make sense for ASCs to consider, such as getting engaged with providers who are in the clinical decision-making positions across the expanded treatment continuum. That is, aligning with providers who determine whether or not a surgical procedure or a referral to a surgeon is necessary. Be engaged with providers in the path of conservative treatment versus limiting the ASC's reach to providers of procedures or interventions. For instance, in spine care you can become involved in the non-surgical aspects of care.

Another aspect is getting more involved in the continuum of care after patients have their procedure. Have more contact with sports medicine physicians, therapists and others that would be engaged in the 90 day postoperative period with the idea that if you are engaged in the complete care continuum discussion, the ASC can potentially show greater value than the historic one-stop procedure provider.

Catering to the value equation is critical: better access, higher quality, enhanced satisfaction and lower costs. That's really what healthcare reform and ACOs are all about, and when an ASC looks to growing the local market, it should have a plan to address all those components. ■

8 Steps to Promote Growth & Innovation at Surgery Centers

By Laura Miller

Here are eight steps for surgery center administrators to create a culture of growth and innovation at their facilities.

1. Be proactive with your decisions. Many surgery centers boast high efficiency and some profitability now, but you have to look to the future to make sure growth and development is always happening at the ASC. Don't be content with where you are now, because as the healthcare landscape evolves you'll be forced to change.

"The first thing is you need to be proactive," says John McConnell, MD, an orthopedic surgeon in Greenville, Texas. "The facility always has to be accommodating to bring in new blocks and more people who are involved in the growth and development at the ASC. They should be driving the change as opposed to reacting to it."

For example, a surgeon's retirement could have a big impact on your center if you haven't been actively recruiting new surgeons in. An economic downturn in your community could also spell disaster if you don't have a strategic plan to accommodate for lower case volume.

2. Understand the surgeon dynamic at your ASC and constantly recruit. Administrators must be keenly aware of the macro and micro elements of the healthcare market as they relate to their physicians and the daily activities at the ASC. "There is no shortcut for honest discussion with surgeons about how things are going and what they need to make the surgery center a better experience," says Joseph Zasa, co-founder and managing partner of ASD Management. "When the surgeons stop talking to you, you have a problem."

Surgery centers should always be in the development mode, which means identifying new surgeon recruitment opportunities. Current physicians may be retiring or becoming employed by hospitals, so it's good strategy to continuously recruit new surgeons.

"We appreciate surgeons that are doing cases at our center, but we always need to bring more surgeons in," says Charles Dailey, vice president of development at ASD Management. "We are constantly looking to refill that funnel. We are constantly out there looking for new partners to join our centers."

3. Control costs for future growth. Surgery centers must operate at a high level in their current state before seriously considering change for the future. The first step might be focusing on materials management to control cases and make room for growth.

"We are actively educating our centers to stay with their group purchasing contracts because the more compliant they are and the more they adhere to them, the more money we save," says Mr. Dailey. "When we buy within the contracts, we save money. We are also focusing on volume buying because the power of volume allows us to get better deals."

ASD is focusing on how they can save on medication and supplies through alternative programs and resources to drive better pricing for their surgery centers and physician offices.

4. Grow internally with new procedures in emerging medical markets. Administrators can also look for opportunities to grow internally by adding new procedures that benefit a larger patient population than in the past. When considering a new procedure, investigate whether it can be done safely in an outpatient setting and ask the surgeons whether there is clinical benefit and economic justification to move forward.

"Doing more procedures in our surgery center allows the physician to grow his practice base and ultimately the patient is being offered another surgical option that could make a difference in their lives," says Mr. Dailey. "If the surgeons are interested, we are trying to partner with industry members to certify us to perform new procedures."

For example, in the orthopedic and spine realm surgery centers can bring in compression fracture patients for kyphoplasty or interventional pain patients for neurostimulators. Gastroenterologists can bring in colon screenings as well as other procedures. However, due diligence is important to make sure this strategic move will be beneficial.

"When new procedures arrive, sometimes they are more or less efficient for the center," says Dr. McConnell. "Adding new procedures doesn't always translate to the surgery center moving forward in a typical fashion."

5. Adapt to practice pattern changes. Surgery centers must be adaptable to changes in practice patterns and trends, which includes bringing in new technology. New technology can be expensive, but smart purchases will have a high return on investment.

"The surgery center has to be committed intellectually and financially so that equipment will have the improved upgrade as better equipment rises on the scene," says Dr. McConnell. "This is a competitive edge the surgery centers have over the hospital. Bureaucratic hospitals push outpatient elective cases to the back of the queue for procurement. Commitment to staying on top of continually improving and upgrading equipment is key."


Joseph Zasa


Charles Dailey

When new technology or procedures are added, surgery centers can help market their physicians to bring new cases into the center. "We're constantly trying to market our physicians on a regular basis," says Mr. Zasa. "We try to find them patients and help them. One of the things we focus on is looking at new technology and new procedures down the pipe and promote them so they'll have a competitive edge in the market."

6. Make cost-effective decisions. Projecting efficiency and cost effectiveness is very

important because surgery centers don't have the resources to waste on a failed venture. Negotiate the best contracts possible for a new piece of equipment and make sure the case volume will be there once it is in place.

"Independent surgery centers don't have the large support basis of the hospital," says Dr. McConnell. "They have to be more cost effective and generate cases that will make money. They have to be adaptable, cost effective and customer friendly. Maintaining this commitment is important for continued growth."

7. Recognize the team culture. Surgery centers are different from hospitals because all the medical professionals work as a team, which means not all surgeons have the right personality for the surgery center. Administrators should promote working in a team environment and atmosphere, especially in a community where they are one of few surgery centers.

"Oftentimes, if the surgery center is fairly new to a community that has not be served by surgery centers in the past, patients and physicians are used to the culture of the hospital so you need to inform them and educate them about the advantage of the ASC," says Dr. McConnell. "In a hospital setting there is, to some extent, a management/labor type relationship between administration and physicians. In the hospital setting, it's almost slightly adversarial in many circumstances. In the surgery center, the administrator is collegiate, accommodating, friendly and part of the team."

In some cases, hospitals may apply pressure on surgeons and their staff to continue bringing cases to the hospital instead of an ASC. The administrator should make sure surgeons know they have the right to bring their patients to the ASC if it's the most accommodating space for treating their patient.

"You are working toward a goal of better service and working with the needs of surgeons' and patients' schedule," says Dr. McConnell. "Adapting to things that are more innate to the culture of the surgery center than the hospital fosters growth."

8. Stay open to new ideas from every source. Surgery center administrators should be open to ideas from various sources, whether they are networking with other administrators or listening to suggestions from staff members and patients. Management companies can provide some fresh perspectives as well, and surgeons can bring home new suggestions from annual meetings.

"The important thing is to look for good ideas," says Dr. McConnell. "Sometimes surgeons or staff members have ideas from their previous facilities. Other times, ask vendor representatives their opinion because they have interchanges with staff members and physicians at all of their surgery centers. There should be openness to new ideas, whatever the source, and that has to be a hallmark of the facility."

You should also solicit feedback from patients about their experience. Sometimes the idea isn't doable, but other times it is. "It's being open to innovation and advantageous ideas, whatever the source, that is the mark of an evolving surgery center," says Dr. McConnell. ■

8 Qualities of Forward-Thinking ASC Administrators

By Laura Miller

Surgery center leaders must have a forward-thinking attitude to stay abreast of healthcare changes and remain viable in this ever-evolving market. Growth has and will continue to be an important part of an ASC's survival in the future. Sarah Martin, vice president of operations for Meridian Surgical Partners, discusses eight key qualities for forward-thinking surgery center administrators.

1. Set a tone of innovation. The culture at a surgery center is set by the administrators and physician owners; if they are open to change and encourage innovation, everyone else at the center will follow. This leadership includes the central administrative team, clinical managers, physician leaders, board president and medical director.

"In order to be flexible, these persons need to stay current as to what changes are taking place in the industry to include regulatory changes, payor trends and clinical advances," says Ms. Martin. "The administrator must be a person who embraces growth and innovation personally and in the workplace. This is not a role for someone who says, 'But we've always done it this way.'"

2. Adapt to changes in local and national markets. Surgery center leaders must be flexible and react quickly to changes on a local and national level to the healthcare landscape. Sometimes, this flexibility might require sacrifices.

"Some examples of ways to stay flexible for growth is for seasoned partners to be willing to change their block schedules to accommodate new center utilizers," says Ms. Martin. "In order to move these utilizers toward partnership, there has to be willingness to dilute the current partners' shares in order to bring in the new members if there are no more shares available to sell."

One of the most important coming changes for surgery centers will be quality reporting. While initially administrators may find quality reporting extra work, it could be beneficial for ASCs in the long run.

"I believe the growth will come from performing new procedures and from a continued push towards transparency in cost and quality outcomes at healthcare facilities," says Ms. Martin. "The ASC industry has always provided quality care with positive outcomes and now the reporting requirements will allow consumers to see how we stack up against providers as compared to other healthcare facilities."

3. Look for new services and procedures. New medical technology will allow more procedures to move into the outpatient setting and surgery center administrators must be prepared for this transition. If they are able to capture more cases from existing surgeons, they could increase patient volume or open a new service line.

"The leadership group must be forward-looking to see what new procedures or service lines would be a good fit for their facility in order to continue to grow the business," says Ms. Martin. "Some areas that have seen growth in recent years include adding spine and total joint programs to a surgery center and more facilities are moving towards cardiology. As technology continues to improve, the number of procedures that can be performed safely in the ASC will continue to grow."

Orthopedic surgery centers could also expand to include complimentary services such as pain management and podiatry. Multispecialty ASCs could look into adding individual procedures such as lithotripsy or gastric band surgery.

4. Stay abreast of developments for outpatient surgery. In addition to new procedures for the surgery center, technology has also made it possible to bring in surgical patients who were excluded in the past for co-morbidities or other issues that are now safely handled in the ASC.

"A safe but forward-thinking medical director or anesthesia group can expand the pool of patients by not excluding those patients with latex allergies, sleep apnea or a history of MRSA," says Ms. Martin. "There was a time when this patient population would be performed in the hospital, however with proper screening, appropriate training and protocols in place for the staff to include needed medications and equipment on hand, these conditions can be safely handled in an ASC."

5. Network with peers. One of the ways surgery center leaders can stay abreast of the latest industry information is by networking with their peers. They can meet colleagues at meetings such as the annual Ambulatory Surgery Center Conference or ASCA meeting as well as state associations gatherings.

"If there is no state association, then create your own network of regional ASC leaders to meet with or connect with via social media and emails," says Ms. Martin. "Changes take place so quickly, so being a member of ASCA, reading online publications and attending regional and national meetings are a must."

Even missing one change, such as the requirement for billing G codes for Medicare, can be devastating for an ASC. "As an AAAHC surveyor, I see centers that are not aware of changes that directly impact them," says Ms. Martin. "They have to seek this information on their own to stay viable."


Sarah Martin

6. Keep staff informed about healthcare trends. Administrators should provide staff members with publications to read that include healthcare articles beyond just clinical information. "All employees are also consumers of healthcare, so educate them on changes that will impact their healthcare," says Ms. Martin. "There may be online resources that are free."

If you are concerned about abuse related to providing Internet access to your employees, you can limit the sites they can view, or simply provide them with a printed version and include it in required reading as part of an in-service day.

7. Encourage others to participate in promotional efforts. Good surgery center leaders are constantly involved in community and political events to promote their centers and ASC-related initiatives; great surgery center leaders motivate their staff and physicians to become involved as well.

"In order to provide growth for their employees, ASC administrators should encourage employees and physicians to participate in grass root efforts to promote their ASCs in the community and with their state legislators," says Ms. Martin. "[They can invite] them to tour their facility to see what ASCs provide and how ASCs are a safe and cost-effective alternative to hospitals."

Physicians and staff members can also participate in letter writing campaigns, such as the recent campaign notifying state leaders of drug shortages. Finally, the ASC can host an open house and invite community members to create awareness about their services.

8. Open up for innovation in key processes. Surgery centers strive for efficiency and cost-effectiveness in addition to good clinical outcomes. Benchmarking individual centers against national and regional averages will help administrators find areas for improvement.

"Benchmarking against national standards, or even benchmarking against yourself, could lead to a process change," says Ms. Martin. "For example, GI centers could track how long it takes for them to withdraw from the colon compared to others nationally. If they are too fast or two slow, they could improve on what they are doing."

Surgery centers that are already hitting the mark can keep an open mind for even further efficiencies. ■

6 Common Myths About Patient Financing in an ASC

By Rob Morris of CareCredit

This article was written by Rob Morris, vice president of marketing and new business development for CareCredit, a part of GE Capital.

Have you considered adding a third-party patient financing program to your ASC's financial policy but hesitated because you felt your patients didn't need it? Maybe you thought the program would be too hard to use or would take up too much of your ASC's valuable time? Or maybe you decided that all patient financing programs were the same, so you might as well add the cheapest one?

These are just a few of the common myths that may negatively impact healthcare professionals' perception of third-party financing programs. Let's take a closer look at these and other common myths to see if we can shed some light on the factual reality of how patient financing can be used as a tool to reduce A/R and increase cash flow.

1. Myth: "My patients don't need financing."

Some ASCs feel that because they are in an affluent area, their patients would not use a patient financing program. In reality, thousands of individuals who apply each month for CareCredit, a leading healthcare credit card backed by GE Capital, make over $100,000 per year. Some of these individuals prefer to take advantage of payment options like "no interest if paid in full" plans* not because they "need" financing — but because the options make good financial sense.

Others use these plans because they provide an easy and convenient way to fit medical expenses into their monthly household budgets. These individuals are financially savvy and like to feel as if they are "getting a deal." Financing allows them to pay over time without incurring interest charges as long as the full amount is paid within the promotional period**.

2. Myth: "All patient financing companies are the same."

If there is no real difference between patient financing companies, why not go with the one that has the lowest price? It saves money and is more profitable for the ASC. While this myth sounds good in theory, the reality is not quite as attractive. The truth is that patient financing companies that offer lowered fees are able to do so because they approve fewer patients.

These companies approve individuals who have higher FICO scores, thus taking a lower risk. While lower risk means more profit for the patient financing company, it also means fewer patients are being approved. This occurs despite the fact that financial concerns are the number one reason patients don't move forward with scheduled care.[1]

In addition, some patient financing companies can take weeks to pay your center. Over time this can negatively affect your cash flow. That's why it's important to know when your center can regularly expect payment. Some financing companies provide payment within two business days, helping to maintain a positive cash flow.

3. Myth: "Having patients apply in the office is too invasive."

Some ASCs may feel that having patients complete the application process while in the office is too personal and even a bit invasive. But most patients actually welcome the opportunity to be instantly approved for a "no interest if paid in full" plan* right in the office and don't mind supplying the few pieces of information needed to complete the simple application. In fact, the vast majority of pa-

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tients appreciate the added convenience of knowing they've secured affordable financing for their co-pay, deductible, or other out-of-pocket costs.

4. Myth: "Patients can just go to their banks for financing."

Today, patients have come to expect some level of assistance from healthcare providers when it comes to managing the cost of care. In a study conducted by Inquire Market Research, 32 percent of patients stated that without an obvious payment solution, they would ask the provider to function in the role of a financing company by billing them.[1] When patients need more extensive treatment, that requires a large deductible and higher out-of-pocket cost, and referring patients to their banks to get a loan may seem like a logical financial solution.

Unfortunately, patients who deal with a bank loan process face long delays and additional fees (application and origination). Plus, banks typically have variable interest rates (risked-based pricing) based on credit worthiness. This can often price a loan out of reach for some patients. Depending on which company you select, patient financing can allow you to offer all of your patients a "no interest if paid in full" plan* or a fixed interest rate that does not fluctuate based on credit worthiness.*

5. Myth: "I can just extend payment options in-house and not have to pay processing fees to the patient financing company."

When your ASC takes on the responsibility of billing patients, it can have a significant impact on the bottom line. In addition to billing and collection costs — which can add up to tens of thousands a dollars a year — extending credit to patients in house can be expensive to the center in terms of reduced cash flow. While waiting for fees to be collected, overhead costs including payroll, rent, supplies, and equipment can really add up. Over time, a cash flow crunch may be created, with more money tied up in accounts receivable than there is coming into the center. Using a financing company allows you to get out of the banking business. Centers can receive payment in as little as two business days, reducing A/R issues and improving cash flow.

6. Myth: "Finance companies just want practices to finance more."

This is another one of those "all companies are the same" myths. If you take a closer look, you might be surprised by the differences between patient financing companies. While most finance companies offer low interest programs, not all programs or companies are the same. Every finance company's success is directly related to the success of the practices they serve. That's why it's important to seek out a company that provides value-added tools and resources that help to maximize your success.

Adding patient financing to your financial policy is a proven way to help more patients move forward with the procedure that they need. Increased treatment acceptance, reduced A/R, and improved cash flow are all benefits that have made patient financing a positive reality for practices and patients across the nation. ■

*Subject to credit approval

**Minimum monthly payments required.

1. Inquire Market Research Study March 2006

7 Tips for Bringing Spine Cases to an Ambulatory Surgery Center

By Rachel Fields

Helene Medley, administrator of Charleston (S.C.) Surgery Center, an affiliate of Surgical Care Affiliates (SCA), recently introduced spine cases to her surgery center. Here she shares seven ideas she picked up through the process of implementing the new specialty.

1. Ask other facilities and/or your management company for guidance. Ms. Medley decided to bring spine to her facility after noticing that other surgery centers in her region had started performing the specialty. Her center was already a multi-specialty facility with orthopedics, so the addition of spine was not overly burdensome. "I started doing some research about patient safety and the kind of procedures that can be done in the outpatient setting, and I used the resources through SCA and my colleagues who were already doing spine," she says.

2. Make sure you understand your physician's implant preferences. Implant costs vary from procedure to procedure and brand to brand, Ms. Medley says. Before you add up costs to determine how much reimbursement you will need from your payors, make sure you know which implant brands your spine surgeons will be using. "One of our surgeons used a different implant than another surgeon, and it turned out to be $1,000 more," Ms. Medley says. Also make sure you are familiar with the CPT codes and that you have a good coder. A different approach to the procedure can change the CPT code and that code may change reimbursement rates.

She says, if possible, surgery centers should request an instrument list from the hospital where the physician performs his or her cases. Work with your surgeon during this step to make sure the preference list is up to date.

3. Target physicians looking for opportunities in your region. New physicians may be arriving in your city, meaning they're probably looking for opportunities to develop relationships with facilities and contribute case volume. Spine cases may not have migrated to the ASC arena in your area, so you may have to change the mind set in your community. Ms. Medley was lucky to find an enthusiastic spine surgeon who was happy to introduce some of his case volume to her facility.

She made this surgeon the focus of her new spine program, knowing she could recruit more physicians once the specialty was more established. "I brought him to the center and gave him a tour of the facility, we looked at the pre-op bays and the size of our ORs and discussed the equipment needs in relation to the room size," she says. Now that her primary surgeon has performed several procedures at the ASC, Ms. Medley says she is "actively recruiting" other spine surgeons. She says that one strategy could be to target surgeons recently out of training, who may be more comfortable with the concept of outpatient spine.

4. Pick a vendor who will work with you through implementation. Ms. Medley says it helps to choose a vendor who is willing to let you trial various instruments before choosing which to purchase. "We showed our surgeon multiple options so he could choose his preference," she says. "I was lucky I had vendors who were willing to bring in drills, instruments, positioning equipment, and retractors to let the surgeon try them out first."

She says it's tantamount to work with a vendor who is willing to spend time with the surgeon at the facility. Her vendor came for the initial cases and provided a variety of instruments for the physician to trial. "We ended up purchasing only what we absolutely needed, instead of all these extras," she says.

5. Make sure staff are ready to handle the new procedures. You may already have staff members in your facility with spine experience — but even if you do, a refresher course is always helpful when starting a new specialty. "I had some team members here who had done spine, but it had been a while," Ms. Medley says. She says she depended on her relationship with other facilities in the region to provide spine training for her team.

Her teammates visited another SCA facility and observed some spine cases there, and they sent an experienced team member to her surgery center to train and assist on the first spine cases.. You may have to hire a few nurses with spine experience if no one in your facility is familiar with the specialty.

6. Prove your worth to payors. Some payors may be hesitant to negotiate contracts for spine cases in the outpatient setting. However, Ms. Medley says SCA has helped her partnership negotiate for fair reimbursement for spine with many payors for spine procedures.

Negotiating carve-outs for spine is essential because implants are so expensive, so make sure you understand the costs of your implants for every case when going into the negotiation. It can also help to bring along a physician who can speak to the safety of the procedure in your facility. "You just have to show the payors your efficiencies, your low infection rate, and the other benefits you provide these patients," she says.

7. Ensure PACU bays are availability for longer cases. When you're starting spine cases in your facility, make sure you have the room availability to keep patients in PACU after the procedures. "Some of the spine cases would be kept longer than other cases, so we had to make sure we had adequate nutrition available for the patients. We also wanted to ensure that we had a comfortable environment for the family members who are in our center for a few hours," Ms. Medley says.

Her spine surgeon currently has block time in the center every week, and she expects him to perform two to three cases a week once the facility is accustomed to the new procedures. She recommends starting spine cases early in the morning to ensure patients have enough time to recover. ■

How ASCs Can Become a Disruptive Force in the Healthcare Market: Q&A With Adam Powell of Payer+Provider Syndicate

By Laura Miller

Payer+Provider Syndicate President Adam C. Powell, PhD, discusses the ambulatory surgery center as a disruptive force among healthcare providers and how ASCs can leverage this power in their market.

Q: What aspects of surgery centers make them a disruptive innovation in healthcare delivery?

Adam Powell: Surgery centers tend to be focused factories. Many of them are single-specialty providers, so they do only one thing and do it very well. As a result, they can have lower costs, higher quality, and more optimized support services than general institutions. Many surgery centers only perform a small number of procedures, and as a result of their focus, can perform at a higher level quality. Practice makes perfect.

Teams have been found to operate better when there is less variation in output and team composition. Employing a smaller number of people and having them work together in consistent teams rather than in teams that are frequently shuffled has been shown to produce higher quality care.

Q: How can surgery centers capitalize on these qualities to gain market share?

AP: They can market the core competencies they have, such as excellent quality in surgery "X." Many hospitals have been marketing their specialties in response to surgery centers. This has been going on for a long time, but surgery centers are taking even more volume now. Regulatory changes at CMS have enabled surgery centers to bill Medicare for a wider variety of procedures, which means they can now market more things.

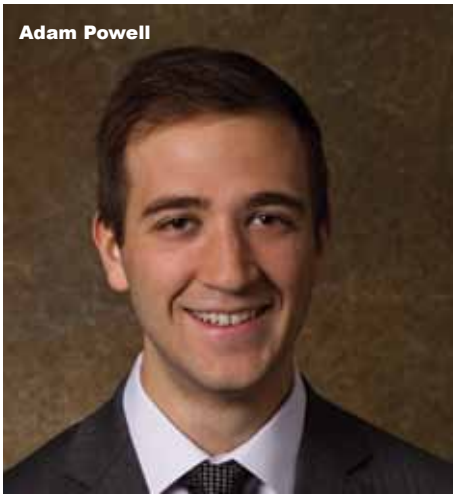
Accountable care organizations present an additional opportunity for ASCs. If surgery centers are able to provide surgeries at a lower cost than traditional hospitals, their presence within an ACO can drive down the ACO's cost of service for the patient population.

Q: What unique aspects of the healthcare industry have made it difficult to take full advantage of these qualities?

AP: Surgery centers by law need to be located near hospitals because they need to be able to transfer patients to hospitals in the event of an emergency. As a result, the number of locations in which surgery centers can be situated is somewhat constrained. Another special consideration is that there are differences in reimbursement for hospital-based care versus surgery center-based care. As a result, some of the savings that surgery centers provide accrue to the payor rather than the provider.

Q: What role do you see ambulatory surgery centers playing in the future?

AP: I see them playing a much larger role going forward. Their role has grown and will likely continue to do so. ASCs provide focused care in a potentially more comfortable setting than the general hospital. Their focus enables them to potentially achieve both higher quality and lower costs. As the population ages, there will be an increasing demand for surgery. ASCs have been innovators because they have pushed the development of surgical procedures that are less invasive and have shorter recovery times. These advances in some cases have enabled procedures to be performed in physician offices. I foresee a future in which there is an increase in both the convenience and the specialization of care. ASCs are leaders in driving these improvements. ■


Adam Powell

Evolving Strategies for Surgery Centers to Reach Savvy Healthcare Consumers: Q&A With Dr. Arvind Movva, CEO of Regional SurgiCenter

By Laura Miller


Dr. Arvind Movva

Changes in the healthcare industry, coupled with the evolving consumer mindset, are driving healthcare providers to find new and innovative ways to attract patients. Some ambulatory surgery centers, such as Regional SurgiCenter, have published pricing information online to attract patients who are comparison-shopping.

"In medicine, we've always been afraid to market ourselves," says Arvind Movva, MD, CEO of Regional SurgiCenter in Moline, Ill. "We say that if we are available, behave nicely and provide good services, patients will come to our practice. That changed with elective surgery — such as plastic surgery — where surgeons started marketing their services, but the rest of us remained on the sidelines. That was fine when the margins were high and physicians could cover their costs easily. Now with expenses increasing and reimbursement decreasing, we are reaching the tipping point to where we might not be making money practicing medicine. That's what made people say we should look into this."

Here, Dr. Movva discusses his decision to publish pricing information online and where the trend of healthcare consumer marketing is headed in the future.

Q: Why did you set up your program to publish pricing information on the website?

Dr. Arvind Movva: We all know that value is dependent on two factors, quality and cost. Initially, we realized that our website talked about quality and not about cost so we wanted to address that. It's something surgeons are not comfortable talking about with their patients, but we wanted to let consumers know that it would cost them twice as much to have their procedure done at a hospital.

There is fear in the physician community that hospitals will be upset and there might be repercussions, because they might steer primary care networks away from us, but what we are talking about here is high quality, low cost care, which is what payors, including the government have asked us to provide. For decades ASCs have provided this value, but the consumer is often unaware of this, even if they perceive higher quality, most do not know the cost savings, and some I have talked to even thought an ASC would be more expensive, since it is a superior experience.

I tell my patients that I'm the same physician and if we do the procedure at the ASC you will get charged one price and at the hospital you'll be charged more. I also tell them about the quality comparison. The endoscopes we use at the hospital are older; at the surgery center we have the latest scopes with high definition optics and improved features such as narrow band imaging. Here we get the pathology reports back within 24 hours, and at the hospital it often takes seven to 10 days. That wait can really be difficult, because we are not able to treat our patients quickly and they have anxiety about the results, especially in cases were cancer is a possibility.

In our surgery center, we use MAC sedation, which is better than using conscious sedation at the hospital. Wait times are also shorter here. Sometimes patients are only here for an hour and 15 minutes total whereas they might spend that long at the hospital just waiting to get into the procedure. Hospitals are not designed to process these types of high volume outpatient procedures — they are designed for acute care, which they do well. As a nation, we need to triage care to the most effective facilities to maximize value and ASCs are well designed to provide high value for outpatient procedures.

Q: How prevalent is it for surgery centers to post their prices online? Is that idea gaining traction in the market?

AM: Practices from around the country have been looking into it. Hospitals have billboards about coordinating care and finally now physician practices and ASCs are getting into the marketing business as well. In a consumer-driven healthcare market, it has become necessary.

Traditionally, Medicare paid the usual and customary fee; the provider submitted their bill, and as long as it was similar to others in the area it was fine. Then, we moved into the CPT world. In the future, we are looking at bundled payments, capitation, and ACOs. Now we need to move into a new role where we are talking about value as the key driver. Value is quality divided by cost. Much of the time, we talk about quality and don't address the cost aspect of care.

We are in the limbo stage with our website where we don't want to be aggressively out there because we aren't sure how well that would be received, but as time goes on and margins shrink even more, this is what everyone will be doing. I think it's a matter of time before there is a billboard outside of every hospital or HOPD (hospital outpatient department) saying, "You Could Get This Done for Half the Price Down the Road."

Q: Has posting pricing information on the website attracted patients?

AM: We've had patients notice it and tell their friends. If you are talking about people with fixed income, they don't have a choice but to comparison shop. Between their medication costs and fixed cost of living, finding the low cost provider is very important. We've had patients who underwent procedures somewhere else bring in their bills to ask why it was so much more expensive and couldn't believe there was such a difference in price, especially since they had the same or most times a better experience at the surgery center.

Every practice has a few patients who leave or decide to doctor shop; when they pick up their records from us, we have a print out of our cost information on the top of their records so they can easily make the comparison.

Q: What is driving the trend toward publishing pricing information online and focusing cost in addition to quality?

AM: In addition to payor and regulator incentives to provide the highest quality possible for the lowest cost, there is a generational change in how consumers consume everything. This is driving a change in how people choose their doctors and in what setting they consume medical care. In the future there will be data that shows cost comparisons for each doctor online and currently patients can post on websites like Yelp or other social media what they paid and whether they had a good experience. The days of costs and quality data being under a shroud are over and we have to prove to patients we will provide high quality, low cost care. In this battle ASCs win every time.

The generations under 40 shop for everything online, from books to plane tickets; why pay more for an airline when there is very little difference? They want to make advised decisions for themselves. We are really getting into the era where patients are going to pick their doctors on a lot more than just their primary care physician's suggestion. They are going to be involved in their own advocacy and primary care physicians will be questioned by their patients on why they are recommending a certain provider, whether that be a physician or facility.

That's what everyone is trying to do in healthcare: alter behavior. The alignment of both provider and consumer incentives is the goal of all changes in healthcare. HMOs didn't align incentives properly because if you didn't do anything, you ended up with the most benefit as providers. In this new era, the consumer is going to be the one who influences all of this. High deductible plans are being used to incentivize the patient to find the highest quality and lowest cost provider.

Q: How do consumers interact with this information about cost and quality at the surgery center versus the hospital?

AM: Traditionally, most people didn't see the direct cost of their healthcare, so nobody knew what it cost for anything. In other industries we would try to see what someone would pay at our facility versus the another, but due to regulations in healthcare we can't compare because we can't look at the hospital's insurance contract, but studies show that there are 54 percent lower payments across the board for ASCs when compared to hospitals or HOPDs.

As a consumer, I have to consider whether the procedure would be best at Regional SurgiCenter or the local hospital. It's like if I go to a restaurant, I can see what the price is for a cheeseburger and if it's more expensive than the place around the corner, but not a better burger, I wouldn't eat there. We are trying to empower our patients to see these facts. Insurance companies are now showing enrollees what their copay is with different providers, and using this to drive their enrollees to the lower cost settings.

We use Medicare data at our practice because it's available to everyone. When you are using Medicare data, we can show patients how much their out-of-pocket expenses are, which helps patients make an informed decision as a consumer.

Q: If patients and providers do begin bringing more patients to ASCs, how will that impact healthcare delivery?

AM: If we took just 50 percent of outpatient procedures done in hospitals that have ASC eligible codes and moved these cases into the ASC setting, CMS would have saved $2.1 billion instantly last year. In our region, we are having discussions about accountable care organizations. If we are able to take more procedures to the ASC, it will immediately save the ACO money and everyone will share in the savings. This doesn't take any extra work because we already have the facilities and infrastructure available.

Employers want to look for a cost savings too. Whoever is paying the bill will realize an immediate savings. As an employer, our health insurer for our staff continues to raise rates by double digit percentage increases year over year; at the same time they are cutting our reimbursement, which is very frustrating as mid-sized business. If I'm a large employer, I would encourage employees to get care in a low cost setting so when I have the negotiations, I can say to our insurer: we have managed to drive down the cost of care and should be rewarded with a slower rate of increase, if not a decrease in the cost of our insurance.

Q: Have you experienced cooperation from the hospital for taking more cases into the surgery center? How do you think they will react with as more cases transition into that setting in the future?

AM: I think hospitals see this as something that will have to be done, but they don't want the transition to happen until they have more control over ASCs. That's why they are getting into the market — because they need to lower their costs. I think that's going to fail because they are taking a hospital mentality into ASCs; some will succeed, but I much prefer ASCs be independent or with some hospital partnership if the local market dictates this.

More physicians are going to become involved in surgery centers as a result of ACOs. If it's going to be their skin in the game, why not move cases to the ASC and share in those savings? This is going to happen and since the ASC industry has already established itself as the low-cost, high-value provider of outpatient care, I think we can do it better than hospitals. ■

5 Steps for Surgery Center Leaders to Reverse Unhappy Surgeons Before It's Too Late

By Laura Miller

Here are five steps for surgery center administrators to identify and reverse unhappy surgeons before it's too late.

1. Notice the signs of an unhappy surgeon. Surgeons could be unhappy with their experience at a surgery center for several different reasons. Administrators must know the signs of a surgeon's unhappiness and react quickly to fix the problem. Taking cases out of the ASC is the most common sign that a surgeon is unhappy, says Daniel C. Daube, MD, founder and director of Gulf Coast Facial Plastics & ENT Center in Panama City, Fla.

"If a surgeon has a high volume of cases, they can try to hold the center ransom or they will move their cases to other centers," says Dr. Daube. "All the members need to be sensitive to the fellow physician's state of mind. If they think a surgeon is unhappy, they need to contact a managing member and have on person coordinate the solution for the real or perceived problem."

Before that stage, you can usually identify an unhappy surgeon by their conversation with other physicians and staff members. "One of the biggest signs that surgeons are unhappy is their complaining to staff members," says Joe Zasa, co-founder and managing partner of ASD Management. "The second is when their patients start complaining."

2. Proactively communicate with key physicians. Identify which physicians within the surgery center seem to have a positive relationship with most of the surgeons and communicate with them regularly to make sure everyone is happy. If someone shows signs of unhappiness, administrators will find out sooner through these conversations.

"If a surgeon has a high volume of cases, they can try to hold the center ransom or they will move their cases to other centers," says Dr. Daube. "All the members need to be sensitive to the fellow physician's state of mind. If they think a surgeon is unhappy, they need to contact a managing member and have one person coordinate the solution for the real or perceived problem."

3. Identify and confront the problem. After an unhappy surgeon is brought to your attention, sit down with the surgeon and identify the problem. If possible, find a solution. The most common problems are associated with money or scheduling at the center.

"If the surgeon feels they are doing a disproportionate amount of work but not receiving dividends that reflect what they perceive as their level of work, this could be a problem," says Dr. Daube. "Sometimes surgeons aren't sure why they are upset so the most important step is taking time to find the problem."

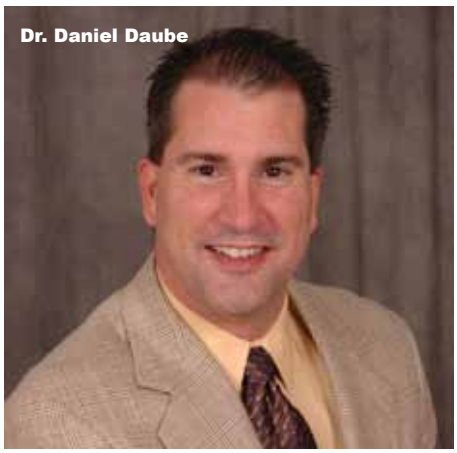
In this example, the surgeon might say he is upset about the dividends, but the real problem is his personal finances aren't in shape and he was hoping the surgery center would help him more. "The problem is often more complex than just owning enough shares," says Dr. Daube.

4. Open conversation about solutions. Find solutions for the problem and open a dialogue with all surgeons involved to accommodate their needs. "The open discourse is key," says Mr. Zasa. "Figure out what their needs are and what you can do to accommodate them. Talk to them about how they feel so at the end of the day you understand their expectations and accommodate their needs."

Ask the surgeon what you can do for them, which is part of the every day operations at the center. "These are all problems that have solutions," says Mr. Zasa. "It could be a function of staff not being prepared, patients having a bad experience or not getting on the scheduled time they want. These are fixable problems."

5. Send out a consistent message or solution. After identifying the problem and a potential solution, relay any changes to all surgeons involved so everyone has a consistent solution to the problem.

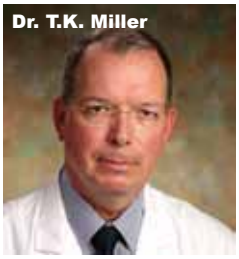

Joseph Zasa


Dr. Daniel Daube

"If the surgery center manager and a fellow surgeon are both communicating with the unhappy surgeon, they both need to know the solution so they aren't giving different varied ideas about the situation," says Dr. Daube. "You want this to be a simple process. I would liken it to a family situation where someone is having a problem because when everyone is trying to help they need to be on the same page. The key is management that is sensitive to these issues and I really give Joe Zasa the credit for helping me learn and implement all of these practices in an ongoing and consistent fashion. That is what good management does." ■

5 Steps to Maximize Utilization at Surgery Centers

By Laura Miller


Dr. T.K. Miller

T.K. Miller, MD, an orthopedic surgeon with Carilion Clinic Orthopedics and medical director at Roanoke (Va.) Ambulatory Surgery Center, recently went through a utilization analysis and found ways to make the surgery center more efficient and bring in more cases without building onto the original facility.

"We just expanded our efficiency without doing anything to the building," says Dr. Miller. "Now, we'll have to do a new assessment for any new providers who want to use our facility. We have a little wiggle room in pain management, but once those spaces are filled the facility will be truly maxed out and then expansion becomes a very realistic option."

Dr. Miller discusses five steps to accommodate additional patient volume before spending the time and money it takes to build onto your facility.

1. Bring surgeons in for a full day. If possible, schedule physicians for a full day of block time at the surgery center. Sometimes this will mean scheduling someone every first and third Wednesday or another surgeon one Friday per month, but having surgeons scheduled for one full day is more efficient than multiple half-days.

"From the perspective of getting physicians to use the facility, offering a full day to lock them in is good," says Dr. Miller. "If we can get a physician to come in and stay at the facility for a full day, even if they have one case that we would just break even on or lose money on, having that surgeon there for the full day is beneficial for us. We would rather offer someone one full day per month than two half days because nobody will want an afternoon half day to follow a surgeon who might not run on time."

However, when you assign half days to surgeons you may run into negative utilization patterns unless you allow surgeons to schedule the maximum cases per day. When utilization is based only on the percent of time the surgeon uses, they might be told they can't bring an extra case in at 2:45 pm if the full day ends at 3:30 pm; they are just credited for the full day.

"When surgeons aren't allowed to add on a last case, we look critically at what kind of cases they want to add on and whether that fits in their usual volume," says Dr. Miller. "You have to look at where everyone is and whether you need to be more efficient in order to fit that last case in."

2. Find holes in the schedule based on the provider. Even if all the block times are filled, look at the actual utilization rates to see whether there is an opportunity for consolidation. On average, your surgery center might see a 79 percent utilization rate, but when you break it down there are four days with 115 percent and one day with only 70 percent. Figure out how to fill the gaps on the 70 percent day.

"You have to see if you have consistent gaps and figure out whether somebody only consistently uses a certain number of hours on their block time," says Dr. Miller. "For example, one provider might have a day where he is consistently cutting his schedule at noon so he doesn't see anyone else after 11am. Nobody new will want to fill that afternoon space, but we can offer it to another provider who is already at the center."

Even though half days aren't ideal, this arrangement could work out if the first surgeon ends promptly and the second surgeon is already invested and present at the surgery center. "This way you can improve utilization and you don't need to add anyone to your facility," says Dr. Miller. "If you look at the gaps, you can see where moving one provider around might make a difference and the schedule starts to cascade from there."

3. Fill large gaps with a new provider. If you find there are large gaps in the schedule and consolidation leads to more open space, consider bringing on a new provider. "If you look at utilization and find consistent openings in your schedule, you can add providers without expanding the facility or purchasing more equipment," says Dr. Miller. "This is especially true if you are adding a provider from a specialty that already brings cases to the center."

If you have the opportunity to bring on a new specialty, there are several factors you have to consider. Make sure the operating rooms are the right size for the new specialty and that you have the right equipment. You also want to verify flipping the operating room between specialties won't cause inefficiencies at the center.

"You might consider this type of expansion if there are new providers coming into the center and bringing in new specialties, or if there are patient losses in other areas and there is a potential to bring cases into the facility that it wouldn't otherwise capture at all," says Dr. Miller. "If there is space available, they will come to your center based on your reputation."

4. Revise block schedule times. Dr. Miller just finished doing an analysis on their schedules and revising block schedule times. As a result, the surgery center was able to add two new groups to the surgery center that will bring in around 60 to 70 more cases per month.

"Physicians might think they are using all of their time and need more, but when you show someone their utilization for one quarter compared to the other, they most likely aren't using all of their time," says Dr. Miller. "Physicians are very protective of their block time and they don't want to give it up. At the hospital, if you give up block time, you might never get it back. We tell them we won't give up their block and if our new schedule doesn't work out they can have the block back."

Dr. Miller has found that surgeons are often open to trying the change if they know their block time will be protected. With better utilization, you can bring in new providers you didn't anticipate having space for in the past.

5. Expand to evening and weekend hours. Before expanding the facility, consider whether you will be able to benefit from evening and weekend hours. There are challenges associated with both options, but with the right surgeons and staff members it is possible.

"The risk of going to extended hours is the tendency to nudge people to work longer," says Dr. Miller. "We have high staff retention because people know when they can go home. If we are going to extend our hours, we have to define who comes in to the late hours and make sure the change happens smoothly."

Surgery centers also have the option of keeping Saturday hours, opening one or two operating rooms every Saturday.

"There is a subset of staff that only want to work one or two days per week and a patient population that doesn't want to interrupt their school and work weeks to get surgery done," says Dr. Miller. "Consider whether you have the right pool of people who want to work on the weekends — staff members, surgeons and anesthesiologists — and the right patient population. With those in place, Saturday hours will work." ■

Lowering Physician & Operating Room Costs Per Case at Surgery Centers: Q&A With Michael Abrams of Numerof & Associates

By Laura Miller

There are several ways a surgery center administrator can cut costs from materials management to revenue cycle review, but one of the least-charted territories has been cutting costs related to clinical decision making.

"Most delivery organizations have had some kind of cost efficiency activity going on for the last decade, but the general focus has been on everything except what physicians do," says Michael Abrams, co-founder and managing partner of Numerof & Associates. "A lot of cost savings have come from consolidating and negotiating more intensively with suppliers, and from outsourcing — everything but what is going on in the operating room between physicians and patients. I think it's time to take a look at that."

Here, Mr. Abrams discusses how surgery center administrators can approach cutting cost per case by working with physicians to eliminate waste and promote efficiency in the operating room.

Q: What are the essential elements of a physician-focused cost cutting program at a surgery center?

Michael Abrams: There are two broad considerations: one is analytics, or how you go about the analysis of your data; and the other, which is at least as important as analytics, is consensus management. No matter how good your analysis is, if you can't gain some consensus among the physicians who need to change their behavior, the best analysis in the world doesn't get you anywhere.

Q: What statistics should you gather to assess the efficiency of each surgeon?

MA: The analytic task is detective work; it's about identifying outliers and researching the cost drivers behind those outliers. Once you identify cost drivers, research alternative approaches that reduce or eliminate the cost drivers. Start by benchmarking internally to close the gap between the most and least cost effective physicians. If you can close that gap and get everyone to be as efficient as the most efficient physician on your staff, it will have a positive financial impact on the center.

I would start by selecting your five highest volume procedures and within those procedures calculating the cost per case for the highest volume physicians. You want to focus on that small number of physicians who make up roughly 80 percent of the cases in each procedure. The physicians you will focus on vary from procedure to procedure, depending on which surgeons do the bulk of the work in that particular area. For your highest volume procedures, know who the physicians are who do most of the work and complete a cost per case analysis for each of them.

However, you can't stop there — you have to dig deeper into the nature of the differences between charges typically generated.

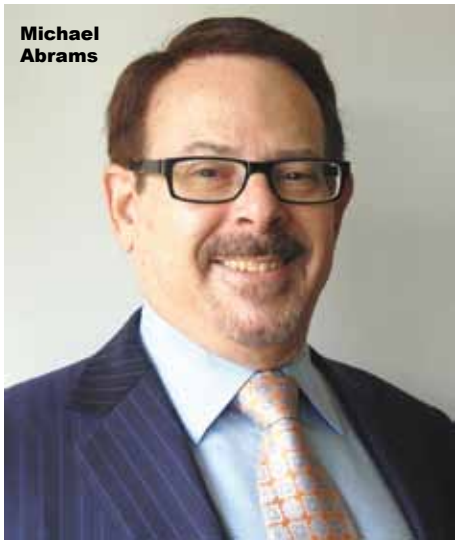
Q: What areas typically show the biggest differences between physicians?

MA: Typically, we see differences in charges for labs, imaging, supply costs, operating room and physician charges. Once you have the cost per case broken down for the handful of surgeons who account for most of the work, analyze your data for differences and discuss where those differences come from. One physician might be spending more time in the operating room, or another might have higher supply costs for some reason. Some physicians might drive up costs by using more diagnostics.

Once you've identified by category what the differences are, you need to drill down further and find out why one physician is more expensive; figure out which labs that surgeon is ordering that drives up the cost. If someone is an outlier on supplies, drill down on records to understand what supplies are driving that cost. I think it's also important to collect processes and outcomes data on cases by physician to understand the potential quality impact. If you find a physician who is more expensive than others, but has a better outcome as a result, you might want to have the other physicians copy his or her approach.

At this point, you really need to supplement your understanding of the big picture with some interviews with each of the physicians and speak about their protocols. Figure out what their plans are for doing this procedure and what considerations and evidence are driving these decisions.

Q: How do you usually approach these discussions?


Michael Abrams

MA: First and foremost, surgeons are trained to be scientists and they generally respond to data. If you can show a physician that his or her costs in a particular area or category are significantly higher than his peers, and explain why they are higher, they are typically receptive. There needs to be a discussion on whether or not their higher costs have higher value in terms of safety, recovery, or clinical outcome.

In one instance, we looked at the way a particular procedure was being done through the development of a care path that showed key activities and decisions. The care path showed routine use of three different diagnostic tests. We reviewed that with another surgeon who was also part of the group, and he said the most current scientific research showed the second two diagnostic tests were unnecessary because they didn't provide any additional information beyond the first. Sometimes surgeons need to hear that recent research offers evidence for changing their practice. They might not know some of these updates, so getting an outside point of view can help.

Q: How do you build consensus among the surgeons for cost-cutting initiatives?

MA: If you are going to manage the consensus process, identify the most influential surgeons in the group and make them leaders in the effort

to drive down cost per case. You need to bring physicians on board and make them accountable for getting it done. They should agree it needs to be done and take responsibility for driving the efforts going forward. These physician leaders should be the face of the project. You should put together a committee with influential physicians and work with them to develop a communication plan that will explain to the entire audience of physicians and other staff your strategic reason for cutting costs.

They need to understand the strategic context and objectives, and what operational path they need to follow. If you don't do a good job of communicating these things to the broader audience, they will be anxious and more resistant to it. This is part of minimizing resistant to educate them about where you are going.

Q: How do you choose the physician leaders?

MA: You can choose people as leaders because they have expertise in a particular procedure. People are more than happy to be anointed the champion based on their expertise. It is important to have one person who owns the project.

Q: How often do you meet with the surgeons to discuss the initiative and its progress?

MA: You need to have regular meetings to share findings and discuss the next steps. Surgeons need to be engaged and have the ability to talk about the next step from their point of view. Work with the committee as a whole and with individual members to prepare them for a discussion about your findings. This is really new territory, because historically physicians have had the freedom to operate the way they saw fit, as long as they didn't cause trouble. The situation in which anyone goes to physicians and presents them with data telling them where they are is oftentimes a very compelling argument itself.

Physicians by their nature are very competitive and nobody wants to look like the most expensive surgeon in the group — at least not without justification. Being able to present data and appealing to that competitive instinct will help physicians change their approach.

More broadly, you need to analyze the financial impact of the cost per case differential on the performance of the ASC and be prepared to talk about the initiative in terms of the financial impact. If you modeled out what it would mean to the performance of the ASC to close the gap between the most and least cost-effective surgeon on high volume procedures, this will translate meaningfully to the surgeons. Show them how it would impact the bottom line; that will go a long way to winning support for your effort

Q: When you apply external benchmarks, where do you ideally want your case costing benchmarks to be?

MA: Once you have utilized internal benchmarking to close the gap between the most and least effective physicians, you can complete the process using external data. The advantage of starting with internal benchmarking is you eliminate the argument that the differences that appear between the physician and benchmark data are attributable to some characteristics that aren't true of the benchmark, such as overhead structure, patient acuity, or region of the country. You might also be limited in your level of specificity by the granularity of the comparative data.

When you get external data, you are getting it from everyone — people who are efficient as well as people who are not; you are getting the average of whatever is out there. You can benchmark yourself against average and strive to be average, but what you really want to be is the best. You want to be in the top quartile, if your dataset will allow you to see that. ■

7 Revenue Cycle Best Practices for Surgery Centers

By Heather Linder

An optimally functioning revenue cycle is crucial to an ambulatory surgery center's success.

Brenda Myers, associate senior vice president of business office operations for ASD Management, works closely with ASC business offices to improve policies, procedures, coding and compliance to maximize revenue.

Here are Ms. Myers' seven tips for revenue cycle best practices.

1. Know your benefits. One of the biggest keys to collecting all due revenue is having coders be familiar with managed care contracts. Billers cannot always refer to the contracts, so Ms. Myers recommends loading the contracts into the accounts receivable software system.

"If you don't load your managed care contracts and you have your billers only post per explanation of benefits and not by looking at the contract, you can lose money," she says.

2. Avoid unlisted codes. If a physician dictates a procedure in an operative note that does not fall under a current procedural technology code, then a coder may have to resort to using an unlisted code. Since Medicare does not reimburse for unlisted codes, these codes cost centers profits.

"You could be leaving money on the table," she says.

While unlisted codes cannot be completely avoided, centers can take steps to make sure they are not unnecessarily used. For instance, Ms. Myers says, a solution could be educating a physician on a similar technique which does have an assigned code or helping the physician use proper supporting documentation in an operative report to qualify for a code.

3. Negotiate increase for frequent procedures. Surgery center administrators should periodically assess the top 25 procedures performed at the center and weigh the cost against the reimbursement. If you are not receiving enough money on a frequently performed procedure to make it profitable, then talk with commercial payors about increasing that particular code's rate.

"They won't give you an across-the-board increase," Ms. Myers says, "but you can say, 'We have increased these shoulder scopes and done 50 more this year, and it's costing us this much to do.' They may go back to the drawing board and increase a particular CPT code."


Brenda Myers

Showing your payors that you are unable to perform a frequent procedure without additional reimbursement can give them an incentive to make the surgery more financially worthwhile, thus increasing your overall revenue.

4. Encourage timely dictation. You cannot bill a claim without an operative report or it is considered fraudulent, and delayed operative notes increase the number of billing days and decrease revenue. To avoid this problem, Ms. Myers says to impress upon your physicians the importance of dictating notes quickly.

"Teach your doctors the sooner they dictate, the sooner we can generate revenue," she says. "It's important to stay on top of dictating in a timely fashion."

5. Review managed care contract coverage. Once or twice a year, an ASC's managed care contracts should be reviewed, Ms. Myers says. Staff members should look at the procedures most often performed and which payors are covering patients. You can determine any gaps in your patient coverage.

"All of a sudden you see there's a new employer in town, and he's contracting with United Healthcare," she says, of a hypothetical discovery this review can detect. "Your surgery center has never contracted with United Healthcare, so you are turning away new patients because the deductible is too high."

You may see a new payor contract could be beneficial to picking up new patients and can begin negotiations.

6. Monitor clearing house claims. Most surgery centers bill electronically for faster turnaround, but it is still important for billers to continuously monitor clearing house claims, Ms. Myers says.

Monitoring the electronic claims allows billers to discover problems before the current claims age and fix them for quicker turnaround. "If there is a glitch in a case at the clearing house level or payor level, you can catch it then, too," she says.

By monitoring these claims, billers can also read the error reports to learn which claims cause problems and how to avoid those problems in the future.

7. Schedule in advance. Attempt to schedule all cases one to two weeks in advance, if possible, Ms. Myers says. Early scheduling allows an ASC to verify a case immediately and obtain member benefits.

Also, notify the patient ahead of time how much they are responsible for paying and to bring money in the day of surgery, whether it is cash, credit or care credit.

"Collecting up front reduces bad debt turnover on the back end," she says. "Industry standards have shown bad debt is harder to collect afterwards."

To make early scheduling possible, eliminate the communication gap that can occur between surgery center and physician office schedulers. "We have a schedulers' luncheon," she says. "It's an opportunity for our schedulers in the surgery center to meet and greet with schedulers at the doctor's office and build a bond." ■

Timeline for the Transition to an EMR: During Integration (Part 2 of 3)

By Joe Macies, CEO, AmkaiSolutions

This is the second in a three-part series on the different stages an ambulatory surgery center goes through when switching to an electronic medical records system. Part one appeared in the October issue of Becker's ASC Review *and on www.beckersasc.com.*

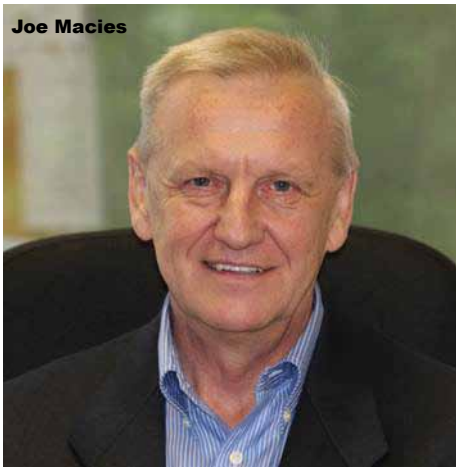
More ASCs are making the switch to electronic medical records to take advantage of the myriad benefits an electronic system provides to patients, physicians and staff. But making the switch requires more than just a flip of a switch: it requires buy-in from leadership and staff, careful planning and ongoing collaboration between the ASC and its EMR vendor.

There are three stages inherent in the transition to an EMR: before, during and after integration. In this part of the series, we will discuss the second stage, or the series of events that take place from the beginning to the completion of the system's implementation. There are 10 steps your ASC will need to take during this stage to ensure a smooth implementation that will have your facility immediately reaping the rewards of the EMR system.

1. Kick off the project. The beginning of implementation establishes a plan for the entire implementation process. The project kickoff begins with your EMR vendor meeting with the project leaders — those staff members who will work closely with the vendor during implementation. This may include a staff member designated as a project manager, or may include the clinical director, administrator, a few nurses, a physician and a representative from anesthesia. These leaders are not necessarily all of the "super users" discussed in part one of this series, but there may be some overlap.

Working with these project leaders, the EMR vendor will review any previously gathered information on your operations for accuracy, and may request additional details. Then the leaders will work with the vendor to target a feasible go-live date. This is accomplished by determining your "go-live requirements."

Go-live requirements focus on who you want using the system at go-live, which is typically a


Joe Macies

combination of nurses, surgeons and/or anesthesiologists. You will also determine what parts of the system your ASC intends to use immediately after the system goes live and those features you plan to use later. An EMR system has many components, and most ASCs choose to use only

some of them at the beginning and then slowly incorporate others.

You will then choose a go-live target date. There are two types of go-live dates: a "hard date" and a "soft date." If your ASC is a new facility under development and will open on July 1, for example, it would make sense to set a hard date of July 1 for the EMR's go-live so the day your doors open, your EMR is operational. If your ASC is already operational, a soft, flexible date is more practical as it allows for adjusting the date. It is better to delay your go-live than rush to meet an unrealistic date.

Once this date is chosen, you will work with the vendor to plan the project backwards, identifying significant target dates during implementation, developing realistic expectations for the implementation process and holding an orientation to discuss the different phases of implementation. This orientation will likely touch on many of the steps we will discuss in the rest of the column. It is important to note that these steps — the phases of implementation — are frequently concurrent.

Note: In addition to working with your EMR vendor during implementation, you will need to involve the vendor supplying and setting up new computer hardware. The date your hardware is ready will often affect the go-live date, as a number of the steps described below require use of the hardware.

2. Install software. Working with your ASC's IT staff/vendor, the EMR vendor's technical team will discuss your ASC's server capabilities and then install its software and databases to your server. This is typically a short process.

3. Perform facility assessment. Your EMR vendor will work with your staff to review information on facility workflow and personnel roles. The vendor will discuss how the system and supporting hardware will impact your operations. An EMR will improve your efficiency and reduce the time needed to perform many tasks, so you should use this discussion to start considering changes to make to your ASC's workflow and staff responsibilities to maximize the system's benefits.

4. Gather and review business and clinical documentation. If the EMR system you choose incorporates your ASC's documentation into the software's database, you will need gather all your business and clinical documentation and provide it to your vendor. These documents will likely include your ASC's consents, pre-op phone call questions, patient instructions, anesthesia records, physician orders, discharge instructions and medication formularies.

Before you provide these documents to the vendor, analyze them and determine whether these documents can be improved. If you want to change a document, this is the optimal time to make a revision so the improved document and process becomes the new standard in your EMR system.

5. Build database. Once your ASC provides the business and clinical documentation to your vendor, the documents are built into the EMR's database. The vendor will then take your ASC through the software and show how your documentation is accessed and populated in the system. During this step, your ASC may still have the opportunity to make electronic revisions to the documentation and activate some of the EMR's features to further improve your documents.

Your EMR vendor will also teach you how to add documents to the database so you understand how to maintain your database going forward.

6. Undergo training. Once the database build process is far enough along (it doesn't need to be complete), your EMR vendor will work with a team from your ASC to simulate a real case moving through the system. This team, sometimes referred to as an advisory committee, will involve individuals from throughout your ASC who can complete the documentation during each part of a case.

It is during this mock case — and perhaps throughout your training — that a staff member previously assigned to completing a task involving a paper record is no longer the most appropriate person to complete the same task using the electronic record. This is another opportunity to analyze your workflow and staff responsibilities to identify areas for improvement.

After the mock case simulation is completed, your EMR vendor will train other staff members on use of the system. This will include simulated experiences based upon the specific responsibilities of staff members and training on different EMR applications. Your vendor will work with your ASC's administration to schedule the most appropriate times to train different members of your team to limit the impact of taking staff away from other responsibilities.

7. Create charting policy. After the database build is complete and you learn more about those EMR applications that you designated for immediate use, you will create a policy that assigns completion of the different components of the patient chart and use of these applications to specific staff. While many responsibilities will not change, you may reassign some tasks to further improve workflow, and you will identify who will use new applications. For example, if you start to use a pre-admission questionnaire included in the EMR, you need to determine who will perform this new task.

8. Fix issues. Until you start to test and train on the system, it is not unusual to encounter some issues in areas like hardware, workflow gaps and improper device implementation and placement. Throughout the implementation process, you and your EMR vendor will assess your progress and identify any problems to fix or changes to further improve your operations.

Prepare your staff members for the possibility that not everything will go exactly according to plan, but if they maintain a positive attitude and assist with fixing issues that do arise, those obstacles will not hinder the implementation process.

9. Go live. The approach ASCs take to their go-live is different for each facility. It will be up to you, discussing options with your vendor, for how to proceed on the first day using your EMR for real cases. For example, you can use your EMR for all of a day's cases or a single case. You can select individual staff members who are comfortable with the technology to use the system or have all of your staff on the system. If you have multiple operating rooms, you can choose all of them to use the system or have a phased-in approach where just those you identify as having the strongest users go live on the first day.

Once these decisions are made and the go-live date arrives, you and your EMR vendor will perform a final onsite walkthrough, and the vendor will shadow users within each department to help ensure a smooth transition to the live system.

10. Celebrate! When you make the switch to an EMR, you are investing in a resource that will significantly improve your operations and the experience of your team and patients. Since the preparation for and the implementation of the EMR system requires significant time and energy from all of your staff members, celebrate their effort, and recognize the commitment of those team members who led the way to making your surgery center an even better, safer and more efficient place to work and receive care. ■

Part three of this series appears on p. 41.

Joe Macies is the CEO of AmkaiSolutions, software/services provider to the ASC industry and its affiliated practices and clinics. The company's AmkaiCharts EMR, together with the AmkaiOffice administrative program, provides a comprehensive, fully integrated solution designed for the specific needs of the ASC. Learn more at www.amkaisolutions.com.

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176 Physician Leaders in the Ambulatory Surgery Center Industry

By Heather Linder

176 Physician Leaders in the Ambulatory Surgery Center Industry

Editor's note: If you believe any of the information provided in this column to be inaccurate, please email Heather Linder at hlinder@beckershealthcare.com.

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Amir Arbisser, MD. Dr. Arbisser is an ophthalmologist and co-founder of Eye Surgeons Associates in Bettendorf, Iowa, where he also serves as board chairman. He recently finished a six-year gubernatorial appointment on the Board of Regents, the governing body of Iowa's public universities.

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Alejandro Badia, MD. Dr. Badia is the founder of the Badia Hand to Shoulder Center in Doral, Fla., and serves on the surgeon advisory panel of the DaVinci Center in Doral. He is a founding partner of the Miami Hand Center and OrthoNOW, an immediate orthopedic care center.

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Joseph Banno, MD. Dr. Banno is the founder and co-owner of the successful Peoria (Ill.) Day Surgery Center and is past chairman of the ASCA and a current executive committee member. He is a board-certified urologist with the Midwest Urologist Group.

Scott Bateman, MD. Dr. Bateman is an otolaryngologist practicing at Sheridan (Wyo.) Ear, Nose & Throat. He has served the Sheridan area in private practice since 1995. He is affiliated with the American Medical Association and American Academy of Otolaryngology.

Robert A. Berger, MD. Dr. Berger is the medical director of bariatric surgery at Flagstaff (Ariz.) Medical Center. He has special interest in minimally invasive procedures and bariatric surgery. He is affiliated with American College of Surgeons and American Society of Bariatric Surgeons.

Fernando Bermudez, MD. Dr. Bermudez is the medical director of Eastside Endoscopy Center and the physician financial executive of G.I. Medicine Associates in St. Claire Shores, Mich. He specializes in diseases of the gastrointestinal tract, liver and pancreas.

Todd Beyer, DO. Dr. Beyer is an ophthalmologist and oculofacial-plastic surgeon at Novus Clinic in Tallmadge, Ohio, where he serves as president. He also serves on the board of directors of the Ohio Association of Ambulatory Surgery Centers. He specializes in LASIK and refractive surgery.

Robert Boeglin, MD. Dr. Boeglin, an ophthalmologist, is the board president for Midwest Eye Institute in Indianapolis and co-founder of Health Venture Management, a company that develops surgery center partnerships between physicians and Clarian Health.

Thomas Bombardier, MD, FACS. Dr. Bombardier is an ophthalmologist and one of the founding principals of Ambulatory Surgical Centers of America. Prior to founding ASCOA, he established the largest ophthalmic practice in Western Massachusetts, two ASCs and a regional referral center.

Nader Bozorgi, MD. Dr. Bozorgi has been a leader and pioneer in the field of outpatient surgery since 1973, when he opened one of the first ASCs in the United States. This paved the way for a system of ASCs under Magna Health Systems in Chicago, where he is CEO.

Robert S. Bray, Jr., MD. Dr. Bray is the CEO of DISC Sports & Spine Center. DISC is an official medical services provider of the United States Olympic Team, Red Bull's North American athletes and the Los Angeles Kings. This success fueled the 2011 opening of a second DISC facility.

Richard F. Bruch, MD. Dr. Bruch practiced with Triangle Orthopedic Associates in Durham, N.C., from 1977 to 2011 when he retired. He continues to work closely with the administrative team of Triangle as a consulting physician.

Michael Bukstein, MD, FACS. Dr. Bukstein is a general surgeon who serves as the board president of the Northeast Missouri Ambulatory Surgery Center in Hannibal and practices general surgery at Hannibal Clinic. His clinical interests are general surgery and surgical oncology.

John Byers, MD. Dr. Byers has practiced otolaryngology since finishing residency in 1994 and currently serves as the Medical Director as a member of the Board of Directors for the Surgical Center of Greensboro, and SCA Affiliates.

James T. Caillouette, MD. Dr. Caillouette is a board-certified orthopedic surgeon with Newport Orthopedic Institute in Newport Beach, Calif., subspecializing in joint replacement and adult reconstructive surgery of the hip and knee. He has been in private practice for more than 20 years.

Peter A. Caprise, MD. Dr. Caprise works as an orthopedic surgeon at The Orthopaedic Center of Central Virginia in Lynchburg. He subspecializes in arm, hip, knee and shoulder surgery and provides joint replacement, arthroscopic surgery and sports medicine surgeries to his patients.

John Caruso, MD. Dr. Caruso practices as Parkway Surgery Center in Hagerstown, Md., and has more than 16 years of neurological surgery experience. Dr. Caruso completed his three-year residency at the Eastern Virginia Graduate School of Medicine in Norfolk.

Peter Cimino, MD. Dr. Cimino practices orthopedics at Omaha Orthopedic Clinic and Sports Medicine in Nebraska, a center with more than 70 years of experience in orthopedic service. He specializes in orthopedic surgery of the foot and ankle, hip, knee, shoulder and elbow.

James R. Colgan, MD. Dr. Colgan helped found Carson Urologists in Carson City, Nev., and has provided patient care to the surrounding area since 1974. Over the years, he has served as board chairman of Carson Ambulatory Surgery Center and chief of staff and chief of surgery at Carson-Tahoe Hospitals.

Christine Corbin, MD. Dr. Corbin is a GYN surgeon and medical director of the Surgery Center at Tanasbourne in Hillsboro, Ore., a Blue Chip Surgical Partners facility. She is the founder and president of Northwest Gynecology Associates.

William Crowder Jr., MD, FACOG. Dr. Crowder helped to start the Conroe (Texas) Surgery Center in 1983. A new larger facility was built in 2003 and he serves as the chair of the board of managers. He is vice president of the Texas Ambulatory Surgery Center Society Board of Directors.

Gary Cram, MD. Dr. Cram is board certified neurosurgeon practicing at the Greensboro Specialty Surgical Center, an affiliate of SCA, and is one of three inaugural directors of the SCA National Spine Advisory Panel.

R. Blake Curd, MD. Dr. Curd is chairman of the board of directors of Sioux Falls, S.D.-based Surgical Management Professionals. He serves as secretary/treasurer for Physician Hospitals of America. He is also a manager for Medical Facilities Corp.

Ray D'Amours, MD. Dr. D'Amours joined Universal Pain Management in Palmdale, Calif., in 2002, where he serves as a partner. He also works as an assistant clinical professor of anesthesiology at the Keck School of Medicine at the University of Southern California.

Christopher Danis, MD. Dr. Danis is in his twentieth year of practicing hand surgery in Dayton, Ohio. About 10 years ago, he initiated Far Hills Surgical Center, a hospital-physician joint-venture ASC where he serves on the board. He is affiliated with Dayton Children's Medical Center of Dayton.

Urfan Dar, MD. Dr. Dar is the medical director of Theda Oaks Surgery Center in San Antonio for the last seven years. The ASC performs close to 10,000 cases annually. Dr. Dar is board certified by the American Board of Pain Medicine and the American Board of Anesthesiology.

Devin K. Datta, MD. Dr. Datta is an orthopedic and spine surgeon at The B.A.C.K. Center, an affiliate of Osler Medical in Melbourne, Fla., and a Blue Chip Surgical Partners facility. He serves as the chairman of the department of orthopedics at Holmes Regional Medical Center.

Daniel C. "Skip" Daube, MD. Dr. Daube is the director and CEO of Surgical Center of Excellence in Panama City, Fla. He practices with the Gulf Coast Facial Plastics and ENT Center in Panama City and is on the clinical faculty at Tulane University Medical Center in New Orleans.

Philip A. Davidson, MD. Dr. Davidson is the founder and former CEO of Tampa Bay (Fla.) Specialty Surgery Center and now practices orthopedics with Heiden Orthopaedics in Park City, Utah. He is an official consultant of Major League Baseball and the National Football League.

Tom Deas Jr., MD, MMM. Dr. Deas is medical director of two Fort Worth, Texas, ambulatory endoscopy centers. He serves as president of the American Society for Gastrointestinal Endoscopy and participates in the Surgical Care Affiliates physicians' leadership team.

John DiPaola, MD. Dr. DiPaola is an orthopedic surgeon and occupational orthopedist who originally built his Swan Island, Ore., clinic to exclusively serve injured workers. He opened his solo practice in 2000 after deciding to focus on workers with orthopedic injuries.

Douglas R. Dodson, DO. Dr. Dodson practices orthopedics at Alamogordo Orthopaedics and Sports Medicine in New Mexico. He is the former chief of staff of Gerald Champion Memorial Hospital and serves on the board of directors for Alamogordo Physicians Cooperative.

Stephen E. Doran, MD. Dr. Doran is chairman of the board of Midwest Surgical Hospital in Omaha, and practices with Midwest Neurosurgery & Spine Specialists, also based in Omaha. Dr. Doran is a clinical assistant professor of surgery at University of Nebraska Medical Center.

Ken Drazan, MD. Dr. Drazan is a physician and partner at Bertram Capital Management based in San Mateo, Calif. He has been a leader and he is also an investor in different businesses that serve the ASC market. Previously, Dr. Drazan was the CEO and founder of Arginox Pharmaceuticals.

Jack Egnatinsky, MD. Dr. Egnatinsky is the immediate past president of the AAAHC Board of Officers. He has been a medical director for AAAHC and is on the board of directors for the AAAHC Institute for Quality Improvement.

James P. Emanuel, MD. Dr. Emanuel is an orthopedic surgeon practicing with Parkcrest Orthopedics in St. Louis. He specializes in the care of the upper extremity and has extensive experience in arthroscopic shoulder reconstruction.

Frank J. E. Falco, MD. Dr. Falco is the medical director of Mid Atlantic Spine in Bear, Del., and the executive vice president of the American Society of Interventional Pain Physicians. He has served as the president of the Delaware Society of Interventional Pain Physicians.

John Fitz, MD. Dr. Fitz is the founder of The Surgery Center of Farmington (Mo.), a 10-year-old, multi-specialty surgery center. Under his guidance, the center has operated under a very successful rural area model. He is chairman of the board for The Surgery Center of Farmington.

Donald W. Floyd, MD. Dr. Floyd is an orthopedic surgeon practicing with Texas Surgical Center in Midland. He has been in private practice since 1982 and serves as team physician for Midland College and Midland Rockhounds AA Baseball Team, an Oakland Athletics' affiliate.

John Fontana, MD. Dr. Fontana is an obstetrician/gynecologist practicing at Beaufort (S.C.) OB/GYN. He also serves on the staff at Beaufort Memorial Hospital. He has held faculty positions at Hershey Medical Center at Penn State University in Philadelphia and Dunham Army Hospital.

Thomas R. Forget Jr., MD. Dr. Forget is a neurosurgeon with the St. Louis Spine Surgery Center, a Blue Chip Surgical Partners facility. He is affiliated with St. John's Mercy Medical Center in St. Louis, where he is chief of neurosurgery, and St. Luke's Hospital in St. Louis.

John A. Foster, MD. Dr. Foster is an otolaryngologist practicing with Spartanburg Ear, Nose and Throat in South Carolina. He has been with the center since 1991. He serves as medical director and chairman of the board for the Spartanburg ASC.

Robin Fowler, MD. Dr. Fowler is chairman and medical director of Interventional Management Services. He is also the medical director of the Interventional Spine and Pain Management Center in Conyers, Ga., and an active staff member at Newton and Rockdale Medical Centers.

James L. Fox Jr., MD. Dr. Fox is the founding leader of the Ravine Way Surgery Center in Glenview, Ill., and practices at the Illinois Bone & Joint Institute. He is a board certified orthopedic surgeon who has been practicing for more than 20 years.

Eric J. Freeh, DO. Dr. Freeh practices orthopedics at Alamogordo Orthopaedics and Sports Medicine in New Mexico. He is the former team physician for the Phoenix Suns. He specializes in trauma surgery, shoulder injury and osteoporosis and has treated thousands of fractures.

Tom Fry, MD. Dr. Fry, a board-certified orthopedic surgeon, currently sits on the board of Lutheran Campus ASC in Wheat Ridge, Colo., a Pinnacle III facility. He previously acted as chief of hand surgery at Tripler Army Medical Center in Hawaii.

Robert Gannan, MD, PhD. Dr. Gannan is the founder and clinical strategies advisor for Doylestown, Pa.-based Physicians Endoscopy. He established Eastside Endoscopy Center as one of the first outpatient endoscopy centers in Washington State.

Brian R. Gantwerker, MD. Dr. Gantwerker is the president of The Craniospinal Center of Los Angeles. He previously worked at the Narrow Neurological Institute at Case Western Reserve University in Cleveland. He received his medical degree from Rush University Medical Center.

Tom N. Galouzis, MD, FACS. Dr. Galouzis is the president and CEO of the Nikitis Resource Group and currently practices as a general surgeon at Lake Park Surgicare in Hobart, Ind. He was as a clinical instructor of surgery at the University of Chicago Pritzker School of Medicine.

David S. George, MD. Dr. George is an ophthalmologist with The Eye MDs of George, Strickler and Lazer, based in Marietta, Ohio. He is a member of the board of directors for the ASCA and the Outpatient Ophthalmic Surgery Society.

Gregory George, MD, PhD. Dr. George is the founding principal of SurgCenter Development, which partners with local surgeons to create physician-owned and operated ASCs. Under his leadership, SurgCenter Development has developed more than 60 profitable, physician-owned ASCs.

Scott Gibbs, MD. Dr. Gibbs is the founder of the Brain and NeuroSpine Clinic of Missouri and also serves as director of the Southeast Missouri Hospital's Brain and Spine Center, both located in Cape Girardeau, Mo. He founded the International Brain Foundation for brain awareness.

Carlos Giron, MD. Dr. Giron is an anesthesiologist at The Pain Institute of Georgia in Macon. He's been practicing medicine for 20 years, and is the executive director of the Georgia Society of Interventional Pain Physicians.

Scott E. Glaser, MD, FIPP. Dr. Glaser is founder of the Pain Specialists of Greater Chicago in Burr Ridge, Ill. He serves as director on the national board of the ASIPP and was heavily involved in the lobbying efforts required to ensure passage of the NASPER bill.

Edward Glinski, DO, MBA, CPE. Dr. Glinski is the medical director at Heritage Eye Surgicenter of Oklahoma in Oklahoma City and is a specialist in refractive and cataract surgery. He also serves as an accreditation surveyor for the organization Healthcare Facilities Accreditation Program.

Steven A. Gunderson, DO. Dr. Gunderson is CEO/medical director of Rockford (Ill.) Ambulatory Surgery Center. He has been has a surveyor for the AAAHC since 1996, and is a member of the American College of Physician Executives and Ambulatory Surgery Center Association of Illinois.

Nameer Haider, MD. Dr. Haider is a pain management physician with Spinal & Skeletal Pain Medicine in Utica, N.Y. He has training in advanced pain treatment techniques. He is also partner of the outpatient pain practice Advanced Physician Medicine & Rehabilitation in Utica, N.Y.

John H. Hajjar, MD. Dr. Hajjar is the CEO of Urology Specialty Care in northern New Jersey. He holds an MBA from the University of Tennessee in Knoxville, where he completed a yearlong project on office-based surgery centers.

Hans Hansen, MD. Dr. Hansen is the director of the Pain Relief Centers in Conover, N.C. He serves as an executive member of American Society of Interventional Pain Physicians and a sitting member of the Medicare Carrier Advisory Committee and Physician Advisory Committee for Medicaid.

Stephen Hochschuler, MD. Dr. Hochschuler, founder of Texas Back Institute in Plano, has served as president of the International Society for the Advancement of Spine Surgery and founding member of the American Board of Spinal Surgery.

Scott Holley, MD. Dr. Holley is the president and founder of Great Lakes Plastic & Hand Surgery in Portage and Battle Creek, Mich. He is president of the Michigan Association of Hand Surgery and is a member of numerous professional societies.

Stephen Holst, MD. Dr. Holst practices urology at Big Horn Urology in Sheridan, Wyo. He is affiliated with the American Board of Urology, American Lithotripsy Society, American Urological Association and Rocky Mountain Urological Society.

Gregory Horner, MD. Dr. Horner is the managing partner of Smithfield Surgical Partners and a board member of the California Ambulatory Surgery Association. He has founded multiple ASCs and remains CEO of Hacienda Surgery Center and Pleasanton Surgery Center.

Young B. Huh, MD. Dr. Huh is a gastroenterologist with Gastroenterology Associates in Bettendorf, Iowa. He practices at the Center for Digestive Health, which was established in 2004 as a joint venture between Gastroenterology Associates and Genesis Medical Center.

Richard Hynes, MD. Dr. Hynes is a spine surgeon who has been serving as president of The B.A.C.K. Center in Melbourne, Fla., since 1996. He is also a director of TXEDAKA, a charity that helps low-income individuals gain access to the medical care they need.

Jack E. Jensen, MD, FACSM. Dr. Jensen is medical director of Athletic Orthopedics and Knee Center and the founder of a surgery center in Houston. He has a very active role in the Texas Ambulatory Surgical Center Association.

Don Johnson, MD. Dr. Johnson is medical director at Southeastern Spine Institute and ASC in Mt. Pleasant, S.C. He has been president of the South Carolina Spine Society, South Carolina Orthopedic Political Action Committee and South Carolina Orthopedic Association.

Karamjit Khanduja, MD. Dr. Khanduja is a colorectal surgeon who serves on the medical staff of Green Street Surgery Center and practices at Colon & Rectal Surgery in Columbus. He received training in colon and rectal surgery at Grant Med Center.

Douglas D. Koch, MD. Dr. Koch is medical director of Baylor Vision. He is editor of the *Journal of Cataract and Refractive Surgery* and past president of the International Intra-Ocular Implant Club and the American Society of Cataract and Refractive Surgery.

Marc E. Koch, MD, MBA. Dr. Koch is the president and CEO of Somnia Anesthesia, where he focuses on providing high-quality, cost-efficient anesthesia solutions to hospitals, ASCs and office-based facilities. Dr. Koch co-founded Resource Anesthesiology Associates in 1996.

Satish Kodali, MD. Dr. Kodali is an ENT physician and one of the physician owners of The Surgery Center in Franklin, Wis. He serves as president of The Surgery Center's board of managers and was a key player in negotiations during the joint venture process.

Peter Kosek, MD. Dr. Kosek practices at Pain Consultants of Oregon in Eugene. He served as the president of the Oregon Society of Interventional Pain Physicians as a member of the Oregon Pain Management Commission of the Oregon Department of Health and Human Services.

Donald Kramer, MD. Dr. Kramer has developed several successful ASCs in the Houston market and is the founder of Northstar Health-

care, which develops, owns and operates ASCs in concentrated markets. He is a member of the Texas Ambulatory Surgery Center Society.

Timothy Kremchek, MD. Dr. Kremchek is a physician with Beacon Orthopaedics & Sports Medicine in Sharonville, Ohio. He has developed plans and thoughts around operating surgery centers and building and marketing brands for orthopedic surgeons and for surgery centers.

Alan B. Kravitz, MD. Dr. Kravitz is a general surgeon at Montgomery Surgery Center in Rockville, Md., and advisor for Surgical Care Affiliates' supply chain team. He is chairman of general surgery at Shady Grove Adventist Hospital.

Peter R. Kurzweil, MD. Dr. Kurzweil is the founder of the Surgery Center of Long Beach (Calif.) and has a special interest in the treatment of athletic injuries. He is the fellowship director for the Southern California Center for Sports Medicine in Long Beach.

Richard Kube, MD. Dr. Kube is the CEO, founder and owner of Prairie Spine & Pain Institute and Prairie SurgiCare in Peoria, Ill. He is a fellowship-trained spine surgeon who performs minimally invasive, motion-preserving surgical techniques, including sacroiliac joint surgery.

Brent W. Lambert, MD, FACS. Dr. Lambert is the founder and CEO of Ambulatory Surgical Centers of America. He is an ophthalmologist and previously developed and owned three ambulatory surgical centers, including the first eye ASC in New England.

Gregory Lauro, MD. Dr. Lauro is the president and medical director of Laurel Surgical Center in Greensburg, Pa. He opened the center in 2004 with a group of surgeon-investors. The center has been in partnership with Meridian Surgical Partners since 2007.

Lance J. Lehmann, MD. Dr. Lehmann is an interventional pain physician who spends a tremendous amount of time studying business and healthcare. He is a physician with the Pain Consultants of Florida in Hollywood.

Jeffrey Leider, MD. Dr. Jeffrey Leider is a co-owner of Great Lakes Surgical Center in Southfield, Mich., and surgeon at the American Ear, Nose and Throat Institute in Farmington, Mich. He is a fellow of the American Academy of Otolaryngology and Head and Neck Surgery.

Brad D. Lerner, MD, FACS. Dr. Lerner is the clinical director at Houston-based Summit Ambulatory Surgery Centers. Prior to joining Summit, he served as clinical director of Urologic Surgery Associates ASCs in Baltimore for more than a decade.

Jay R. Levinson, MD. Dr. Levinson is medical director of Michigan Endoscopy Center in Farmington Hills. He was recognized by his peers as one of the region's most respected gastroenterologists in *Detroit Magazine's* "Top Doc" survey in 2005 and 2008.

Bruce Levy, MD, JD. Dr. Levy is CEO of Austin (Texas) Gastroenterology and serves on the Texas Ambulatory Surgery Center Society Board of Directors. He has been executive director of the Texas State Board of Medical Examiners and actively testified in front of the Texas Legislature on behalf of the ASC industry.

Marshall S. Lewis, MD. Dr. Lewis is an orthopedic surgeon practicing in Bakersfield, Calif. He serves as chief of orthopedic surgery for several different hospitals and also runs a private practice.

Stephen Lloyd, MD, PhD. Dr. Lloyd is a board-certified internist who has practiced in the Midlands in South Carolina for about 30 years. He practices at South Carolina Medical Endoscopy Center in Columbia, where he has trained over 100 physicians in colonoscopy.

Thomas Lorish, MD. Dr. Lorish is the medical director of the Providence Brain Institute in Portland. He is a physiatrist and tremendous leader of their efforts to move towards an ASC effort and philosophy. With his help, Providence has become one of leaders in ASC joint ventures in the country.

James Lynch, MD. Dr. Lynch is a spine surgeon and board-certified neurosurgeon and founder of SpineNevada in Reno. He also serves as chairman and director of spine programs at Surgery Center of Reno. He is director, spine services, for Regent Surgical Health.

Laxmaiah Manchikanti, MD. Dr. Manchikanti is the CEO of Pain Management Center of Paducah (Ky.) and is also chairman of the board and CEO of the American Society of Interventional Pain Physicians and Society of Interventional Pain Management Surgery Centers.

Ajay Mangal, MD, MBA. Dr. Mangal is the founder, CEO and a board member of Prexus Health Partners in Hamilton, Ohio. As a hands-on executive at Prexus, he has been instrumental in developing ASCs and assisting existing centers and hospitals to prosper

Lee James Marek, DPM. Dr. Marek is a podiatrist at North Point Surgery Center in Fresno, Calif. Dr. Marek is an associate professor with the California College of Podiatric Medicine and residency director at Delano Regional Medical Center.

Bryan Massoud, MD. Dr. Massoud is founder and head surgeon at Spine Centers of America in Fair Lawn, N.J. He received training at Texas Back Institute in Plano, and has performed more than 1,000 endoscopic spine surgeries, including endoscopic cervical spine surgery.

Alfred McNair, MD. Dr. McNair is a gastroenterologist who founded Digestive Health Center in Biloxi, Miss. He earned his medical degree at Presbyterian-St. Luke's Medical Center in Denver and has practiced at several hospitals in Mississippi, most recently being Ocean Springs Hospital.

Christopher Metz, MD. Dr. Metz is a board-certified general orthopedic surgeon at Brainerd Lakes Surgery Center in Baxter, Minn. He served as chief of surgery at St. Joseph's Medical Center, chief of staff.

Keith Metz, MD. Dr. Metz is the medical director of Great Lakes Surgical Center in Southfield, Mich., which includes four ORs and one procedure room. He is a clinical anesthesiologist and he has served on the board of directors for the ASCA.

Jeffrey Michaelson, MD. Dr. Michaelson specializes in orthopedic surgery at the Porretta Center for Orthopaedic Surgery in Southfield, Mich., as well as Providence and Providence Park Hospital in Novi, Mich., and DMC Surgery Hospital in Madison Heights, Mich.

Thomas K. Miller, MD. Dr. Miller is an orthopedic surgeon at the Roanoke (Va.) Ambulatory Surgery Center and Carilion Clinic Orthopaedics. He has specialty experience in sports medicine, arthroscopy and knee and shoulder reconstruction.

Thomas Miller, DPM. Dr. Miller is a board-certified podiatrist at the Surgery Center of Beaufort (S.C.). He is a member of the Podiatry Associates of Beaufort and affiliated with Beaufort Memorial Hospital.

Arvind Movva, MD. Dr. Movva is currently CEO of Heartland Clinic, Valley View Anesthesia and Regional SurgiCenter, an eight-OR multispecialty ASC in Moline, Ill. He also practices as a gastroenterologist and serves as co-founder and consultant with Movva Medical Consulting.

Michael J. Musacchio, Jr., MD. Dr. Musacchio is a neurosurgeon who focuses on minimally invasive spine surgery. He co-opened an ambulatory surgery center, Institute for Minimally Invasive Surgery. He also practices at the Center for Spine Care in Dallas.

Fred Naraghi, MD. Dr. Naraghi is an orthopedic spine surgeon and the director of the Comprehensive Spine Center in San Francisco. He specializes in minimally invasive cervical and lumbar disc surgery.

Robert Nucci, MD. Dr. Nucci is founder of Nucci Spine & Orthopedics Institute in Tampa, Fla. He helped develop and implement minimally invasive surgical techniques and serves as an international speaker on spine surgery.

Joan F. O'Shea, MD. Dr. O'Shea is a dually trained neurosurgeon and spine surgeon and founder of The Spine Institute of Southern New Jersey in Marlton. She is a member of the North American Spine Society and Women in Neurosurgery.

Bergein Overholt, MD, FACP, MACG. Dr. Overholt is a physician with Gastrointestinal Associates in Knoxville, Tenn. He has served as president of the ASCA and is a founding member and past president of the Tennessee Society for Gastrointestinal Endoscopy.

Burak Ozgur, MD. Dr. Ozgur is a neurological spine surgeon at DISC Sports & Spine Center, based in Marina del Rey, Calif., and he leads its new location in Newport Beach that includes an ambulatory surgery center.

Paul D. Pace, MD. Dr. Pace is a hand surgeon practicing at the San Antonio Orthopaedic Group in San Antonio, where he has worked since 1998. He previously practiced with the Hand Associates of South Texas in San Antonio from 1982 to 1998.

Allan T. Parr, MD. Dr. Parr is the medical director of Premier Pain Center in Covington, La., and president of the American Society of Interventional Pain Physicians. He is also a member of the American Pain Society.

Greg Parsons, MD. Dr. Parsons is the medical director of the Carolina Surgical Center, a joint venture with Tenet Health Systems in Rock Hill, S.C. He has been on the staff of the center since its beginning in 1989, and has been the president of the physician group for more than 10 years.

Prakash Patel, MD. Dr. Patel is CEO of Access MediQuip, a national provider of surgical implant management solutions. He was chief corporate development officer for Magellan Services. He also led operations at Magellan's National Imaging Associates.

Charles Peck, MD, FACP. Dr. Peck is the president and CEO of Health Inventures, where he actively oversees the company's growth in outpatient surgery partnerships as well as physician practice management and inpatient perioperative management with hospitals and physicians.

John H. Peloza, MD. Dr. Peloza is founder and medical director of the Center for Spine Care and founding physician partner of the Institute for Minimally Invasive Surgery in Dallas, a partnership between Meridian Surgical Partners and local physicians.

Kenneth Pettine, MD. Dr. Pettine is the co-founder of Rocky Mountain Associates in Orthopedic Medicine in Loveland, Colo., and the founder of the new Society for Ambulatory Spine Surgery. He co-invented, designed and patented the Maverick Artificial Disc.

Stanford R. Plavin, MD. Dr. Plavin has served as a member and managing partner of Ambulatory Anesthesia of Atlanta since its inception. He is immediate past president of the Greater Atlanta Society of Anesthesiologists. He practices exclusively in the outpatient setting.

Thomas J. Pliura, MD, JD, PC. Dr. Pliura is a physician and attorney at law with the company he founded, zChart, an electronic medical records-related company. He has also served as founder and manager of four ASCs. He received the first favorable Medicare Advisory Opinion in the country.

William A. Portuese, MD. Dr. Portuese is the current president of the Washington ASC Association and Washington State Chapter of Facial Plastic Surgeons. In 2008, he earned the Washington ASC Association Physician of the Year Award.

Greg Poulter, MD. Dr. Poulter is a spine surgeon at Vail (Colo.) Summit Orthopaedics. He was among the first surgeons to perform minimally invasive spinal fusion. His specialty is advanced adult and pediatric spine surgery.

Thomas E. Price, MD (R-Ga.). Dr. Price is an orthopedic physician who now serves in the U.S. House of Representatives. He developed

the Comprehensive HealthCARE Act and is now ranking Republican member of the health, employment, labor and pensions subcommittee.

Vito Quatela, MD. Dr. Quatela co-founded Ambulatory Healthcare Strategies and serves as CEO. He developed and owns two ASCs in Rochester, N.Y. He is the immediate past president of the American Academy of Facial Plastic and Reconstructive Surgeons.

David J. Raab, MD. Dr. Raab is on the board of managers at the Illinois Sports Medicine & Orthopedic Surgery Center in Morton Grove, Ill., and is a fellowship-trained sports medicine physician with Illinois Bone & Joint Institute.

Michael R. Redler, MD. Dr. Redler is a founding partner of The Orthopaedic and Sports Medicine Center in Fairfield, Conn. He is a fellowship-trained orthopedic sports medicine and hand surgeon. He serves as an orthopedic consultant to Major League Lacrosse.

Wallace Reed, MD. Dr. Reed is credited with co-founding the nation's first ASC in Phoenix and has been recognized for his "vision and tireless advocacy on behalf of ASCs," by ASCA. He continues to inspire ASC community members to reach even greater heights.

Christopher Reising, MD. Dr. Reising is president of the board of directors for Pine Ridge Surgery Center in Wausau, Wis., a Pinnacle III facility. His practice is Surgical Associates in Wausau.

J. Michael Ribaudo, MD. Dr. Ribaudo serves as CEO and chairman of Ballwin, Mo.-based Surgical Synergies. He is a pioneer in the development of physician-owned ASCs and developed one of the largest freestanding outpatient surgery center in the country.

Herbert W. Riemenschneider, MD. Dr. Riemenschneider is the principal physician and urologic surgeon at Riverside Urology in Columbus, Ohio. He performed the first prostate cryoablation in Ohio in 1993 and continues to perform the procedure today.

Steven Robinson, MD. Dr. Robinson is a board member and practicing plastic surgeon at Riverside Outpatient Surgery Center in Columbus, Ohio. He is an active member of the Aesthetic Society and the American Society of Plastic and Reconstructive Surgeons.

Paul L. Rohlf, MD. Dr. Rohlf began practicing at Urological Associates in 1969. He has served as president of the ASCA. He was the initial urologist who obtained the first surgery center certificate of need in Iowa.

L. Edwin Rudisill, Jr., MD. Dr. Rudisill is a hand surgeon and practices with The Hand Center in Greenville, S.C. He is board certified by the American Board of Orthopaedic Surgery.

James W. Rust, DPM. Dr. Rust has been in private practice since 1988. In 1991, he joined Atlantic Podiatry Associates in Daytona Beach, Fla., where he practices. He also works with Twin Lakes Surgical Center in Daytona Beach.

Kuldip S. Sandhu, MD, FACP, FACG. Dr. Sandhu is a gastroenterologist at the Sutter Roseville (Calif.) Endoscopy Center in and is president of Capitol Gastroenterology Consultants Medical Group. He completed his fellowship training in gastroenterology at LAC-USC Medical Center.

Kent Sasse, MD, MPH, FACS. Dr. Sasse is a bariatric physician, serves as the director of the Western Bariatric Institute in Reno, Nev. He founded International Metabolic Institute, which combines medical and scientific principles of physiologic weight reduction.

Donald Schellpfeffer, MD. Dr. Schellpfeffer is CEO of Medical Facilities Corp., and has almost 20 years of experience in ASC environments. He has served as medical director and a member of the management committee of Sioux Falls (S.D.) Surgical Center since he founded it in 1985.

David Schultz, MD. Dr. Schultz is a board-certified general surgeon at Surgical Associates of Neenah (Wis.). Since the 1980s, the surgical center has maintained a relationship with Theda Clark Medical Center to develop a traumatic injury program.

Bruce A. Scott, MD. Dr. Scott is the medical director of SurgeCenter of Louisville (Ky.) and serves on the physician leadership team for Surgical Care Affiliates. He is a graduate of Vanderbilt University and the University of Texas Medical Branch.

Hooman Sedighi, MD. Dr. Sedighi is a physical medicine and rehabilitation physician who has practiced as a private practice physician in Dallas since 1997. He is an equity partner in Pine Creek Medical Center in Dallas, a short-stay surgical hospital.

David Shapiro, MD, CASC. Dr. Shapiro is a partner with Ambulatory Surgery Co., an ASC consulting company. He is chair of the board of ASCA and the Ambulatory Surgical Foundation, and chaired the Florida Society of Ambulatory Surgery Centers.

Joshua A. Siegel, MD. Dr. Siegel is the sports medicine director at Access Sports Medicine & Orthopaedics in Exeter, N.H., and the founding partner and managing member of Northeast Surgical Care. He is in charge of developing new services and physician recruitment.

Khawar Siddique, MD. Dr. Siddique is a California spine surgeon with the Beverly Hills Spine Surgery. He has given many lectures on advanced spine surgical techniques and has taught many surgical dissection courses to other neurosurgeons and orthopedic surgeons.

Thomas A. Simpson, MD, FACS. Dr. Simpson is chairman of the board of directors for the Iowa City Ambulatory Surgery Center and led the board of this multispecialty ASC as it came together to plan and develop the ASC with Mercy Hospital.

Vijay Singh, MD. Dr. Singh is the medical director of Spine Pain Diagnostics Associates in Niagara, Wis., and a lifetime director of the American Society of Interventional Pain Physicians. He is a member of the International Spinal Injection Society and North American Spine Society.

Paul Slosar, MD. Dr. Slosar is a board certified and fellowship trained orthopedic spine surgeon who performs surgery at the Presidio Surgery Center, an SCA Affiliate, in San Francisco. He is also one of three inaugural members of the SCA National Spine Advisory Panel.

Keith Smith, MD. Dr. Smith, a board-certified anesthesiologist, serves as co-founder and chief medical director at Surgery Center of Oklahoma in Oklahoma City. Dr. Smith has pioneered new programs at the surgery center that focus on increasing access to affordable healthcare.

Eric J. Stahl, MD. Dr. Stahl is the president of Golden Ridge Surgery Center in Golden, Colo. He specializes in sports medicine at the Panorama Orthopedics and Spine Center and serves as vice president of the Colorado Ambulatory Surgery Center Association.

Steven Stern, MD. Dr. Stern is a Harvard-trained orthopedic physician. He is the medical director and the vice president of neurosciences orthopedic and spine of United Healthcare. He is a member of the American Academy of Orthopaedic Surgeons.

Marc Stone, MD. Dr. Stone is an associate professor of anesthesiology and a board-certified anesthesiologist at The Mount Sinai Hospital in Newark, N.J. He has also conducted clinical trials on the LIDCO System.

David W. Strege, MD. Dr. Strege specializes in orthopedic surgery at Mid County Orthopaedic – Bellevue in St. Louis. He works with St. John's Mercy Health Care, St. Mary's Health Center and Missouri Baptist Medical Center, all in St. Louis.

Lewis Strong, MD. Dr. Strong is the president of the Skyline Endoscopy Center in Loveland, Colo., a Pinnacle III facility. He was a founding member of the local physician's health organization and served as its president for four years.

Charles Tadlock, MD. Dr. Tadlock is the founder of Surgery Center of Southern Nevada in Las Vegas. He is affiliated with the Center for Pain Management in Las Vegas and CEO of Epiphany Surgical Solutions and an avid developer of surgery centers.

Kevin Tadych, MD. Dr. Tadych is medical director Northwoods Surgery Center in Woodruff, Wis., a Pinnacle III facility. His practice is Northern Wisconsin Bone & Joint in Minocqua, Wis.

Larry Teuber, MD. Dr. Teuber is the founder and physician executive of Black Hills Surgery Center in Rapid City, S.D., and president of Toronto, Canada-based Medical Facilities Corp., He has almost 20 years of experience in ambulatory surgical environments.

George M. Tinawi, MD. Dr. Tinawi is the president of Surgery Center Partners and its management subsidiary, Endoscopy Management Services Organization. As a practicing physician, he developed a clear understanding of the business issues physicians face.

William Tobler, MD. Dr. Tobler is a neurological surgeon and president and director of neurosurgery at The Christ Hospital Spine Surgery Center in Cincinnati. He is a member of North American Spine Society and Congress of Neurological Surgeons.

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Vasudevan Tiruchelvam, MD. Dr. Tiruchelvam served as chief of the division of surgery at the York Hospital. He currently serves as vice-chairman of the York Hospital department of surgery, as well as the president of the York County Medical Foundation.

George Trajtenberg, MD, FACS. Dr. Trajtenberg is a general surgeon at Turk's Head Surgery Center in West Chester, Pa., a Blue Chip Surgical Partners facility. He has served as the President of the Chester County Medical Society.

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George A. Violin, MD, FACS. Dr. Violin is the founder of Medical Eye Care Associates in Massachusetts. He is one of the three founding principals of the Ambulatory Surgery Centers of America.

Alan Villavicencio, MD. Dr. Villavicencio founded The Minimally Invasive Spine Institute in Boulder, Colo., and serves as the director of surgery. He is the director of research and development for Boulder Neurosurgical Associates.

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Robert Welti, MD. Dr. Welti is the senior vice president of operations at Regent Surgical Health in Westchester, Ill. He was previously the medical director and administrator of the Santa Barbara (Calif.) Surgery Center.

Thomas F. Winters, M.D. Dr. Winters concentrates on adult orthopedics and has been an ardent supporter of ASCs for over 20 years. He is a partner at the Orlando Center for Outpatient Surgery, an affiliate of SCA.

Thomas Wherry, MD. Dr. Wherry is co-founder of Total Anesthesia Solutions. He is medical director for the Surgery Center of Maryland in Towson and consulting medical director for Health Inventures.

Kimberly L. Wood, MD. Dr. Wood is co-chair of the ASC Quality Collaboration and founder of kmdWOOD, which provides consulting services to the ASC industry. She has served as an advocate for the industry on issues such as Medicare's coverage and payment policies.

Richard N.W. Wohns, MD, MBA. Dr. Wohns is one of the first physicians involved with the development of ambulatory spine practices. He is founder of South Sounds Neurosurgery in Puyallup, Wash. He also founded Neospine, a spine ASC development company.

Anthony T. Yeung, MD. Dr. Yeung founded Desert Institute for Spine Care in Phoenix and developed the FDA-approved Yeung Endoscopic Spine System. He was one of the first spine surgeons to utilize endoscopically guided laser for degenerative conditions of the lumbar spine.

David Zarin, MD. Dr. Zarin is senior vice president, medical affairs, for United Surgical Partners International and one of the founding partners of Texas ENT Specialists in Houston. He is the chairman of the board and serves in the Expert Group of the ASC Quality Collaboration. ■

10 Strategic Questions to Ask for Long-Term ASC Success
(continued from page 1)

right now," she says. "In the next two years, you'll need to repaint the main traffic area."

If you work in an aging facility, think about how to keep the surgery center "fresh" on a yearly basis. Ms. Thomas says she works with old facilities that will need to look at replacing their HVAC systems and vacuum compressor pumps in the next five to 10 years. In the next three to five years, you may want to install new flooring or make other improvements to assure patients and physicians that you still provide great patient care. Like it or not, an attractive facility gives an impression of clinical quality. Ms. Thomas says while you may not be able to predict exact costs for maintenance over the next 10 years, you should be able to make an educated guess as to the cost of repairs and lost case volume if the center had to close.

2. When will your current physician owners retire? Physician owners are the lifeblood of a facility; without their case volume the surgery center cannot turn a profit. Ms. Thomas advises ASC administrators to look at the age of their physicians and determine when recruitment will be most critical. "If the majority of your partners are in the 50 to 60 year old age group, they're going to be 60 to 70 years old in 10 years," she says. "Who are you going to recruit to replace them?" She says if your facility is well-run, your current physicians may want to purchase the shares sold by departing partners. Unfortunately, this does nothing to increase your revenue because the current physicians still bring the same case volume.

Ms. Thomas recommends that ASC leaders consistently look for new physicians coming into the community. A young physician may be interested in surgery center ownership but lack the funds to purchase shares in a profitable surgery center. In this case, Ms. Thomas says a relationship with a local bank can be beneficial. "Direct the new physician to a bank that can offer them a short-term, low-interest loan to buy the share," she says. "You need to have avenues and options for him."

3. Which service lines could benefit profitability in the future? You may want to add service lines to your surgery center over the next 10 years, either to make up for low reimbursement in other areas or simply to add case volume. Some specialties compliment others, so you may be able to add case volume with minimal investment.

For example, an orthopedic-driven ASC can add pain with relative ease, while a general surgery center can add gynecology because of the dual use of laparoscopic technology and video towers. She says spine is becoming more popular because of high reimbursement levels, but facilities should be careful when deciding to implement it — the specialty comes with high equipment costs and a space necessity. Surgery centers adding spine should have 400,000 square feet of room, she says.

4. What is the local hospital doing to purchase practices or employ physicians? If the local hospital is making moves to poach your physicians, you need to know about it sooner rather than later. Don't wait until the horse is out of the barn, Ms. Thomas says; talk to your physicians now about recruitment tactics by your competitors. "You need to know what's going on in your market and be upfront with your doctors," she says.

If a physician's practice is purchased by the local hospital, physicians may still be able to negotiate contracts that allow them to keep their shares in the surgery center. If hospital employment is becoming more common in your community, talk to your physicians about their plans for the future and determine where you can find a stream of independent, entrepreneurial-minded surgeons.

5. Will you need to replace critical staff in the next five to 10 years? Physicians aren't the only ones in short supply; Ms. Thomas says it's also getting more difficult to recruit OR nurses. "If you have lovely, well-seasoned OR nurses that the doctors adore, you may not be able to replace them quickly," she says. "We need to start getting our young nurses in to start shoring up our resources."

She says surgery centers can form partnerships with local surgical tech and nursing schools; surgical tech schools generally allow their techs to do clinical rotations at surgery centers, and nursing schools can provide a stream of graduating providers every year too. She says in the meantime, the surgery center should cross-train its pre-op and PACU nurses to ensure that a vacancy in the OR staff can be filled easily.

6. What are payors doing in your market? Make sure you understand whether your payors are reimbursing you well for your services, Ms. Thomas says. Start by looking at the Medicare fee schedule in your area and comparing it to your commercial reimbursement. "You never want to be reimbursed less than Medicare on your commercial contracts," she says. "There are some major payors that are offering less than Medicare, and you have to be very upfront and say no."

When negotiating payor contracts, you absolutely must know your costs; Ms. Thomas recommends breaking it down to costs per every 15 minute quadrant. This means that when you're evaluating your reimbursement, you can determine easily whether your revenue will cover your costs. She also recommends using a database to manage your fee schedule, to make sure there are no outlier CPT codes that are reimbursing the incorrect amount.

7. How will your salaries and benefits adjust over time? Surgery centers generally give standard of living salary increases on a yearly basis to keep up with inflation. In order to understand how your costs will affect your profitability over the next 10 years, Ms. Thomas asks surgery center leaders to think about how salaries will have to increase.

"Surgery centers have been very generous with salaries and benefits historically, paying 100 percent of health insurance benefits and giving an 8 percent match on the 401(k)," she says. "It's not necessarily realistic now, but in order to recruit, we have to keep our finger on what people are making in the community."


Joyce Thomas

She says the surgery center should analyze salaries and benefits annually to determine whether the surgery center can give merit increases. If raises are not an option, the ASC must determine another way to stay competitive and retain staff, such as inexpensive "perks" and a focus on a family atmosphere.

8. Would a management company or hospital partner benefit your ASC? More surgery centers are turning to hospital partners to increase market share, boost reimbursement and decrease supply costs. Ms. Thomas says hospital/physician joint ventures are certainly a good idea for many surgery centers, but that a management company can be a useful mediator in sorting out potential problems between the parties.

"There are still some hospitals that are not physician-friendly," she says. "We have found that our current model — where the hospital is the majority partner, the management company is a tiny partner and the physicians own around 49 percent — allows the physicians to maintain total control of day-to-day operations." She says in this case, the management company serves as a "buffer" between the hospital and the physicians and helps to build trust over time. "The physicians know the hospital won't try to put them under the hospital's thumb with unnecessary regulations, and the hospital knows the physicians will deliver a quality service," she says.

9. When does your lease run out? If your surgery center has a long-term lease, you need to know when it expires, Ms. Thomas says. Knowing this information will help you decide whether you want to renew the lease and stay in the current facility or move elsewhere. When the lease expires, the owner may decide to up the rent. Otherwise, you will need approximately three years to prepare for and execute a move to a new location, Ms. Thomas says. If your lease is due to expire in a few years, you should be thinking about your location now.

10. Who in your surgery center should be groomed for leadership now? It's always useful to have a few staff members at your surgery center that could move into management positions if necessary. This simplifies the hiring process and ensures that you'll hire someone trustworthy and capable.

Ms. Thomas recommends looking at your staff members to determine which have "inherent leadership qualities" — a trait she says is different than the ability to do your current job. "Look at them beyond their current level of competence," she says. "You're looking for leadership skills that you can take and improve over time." ■

Timeline for the Transition to an EMR: After Integration (Part 3 of 3)

By Joe Macies, CEO, AmkaiSolutions

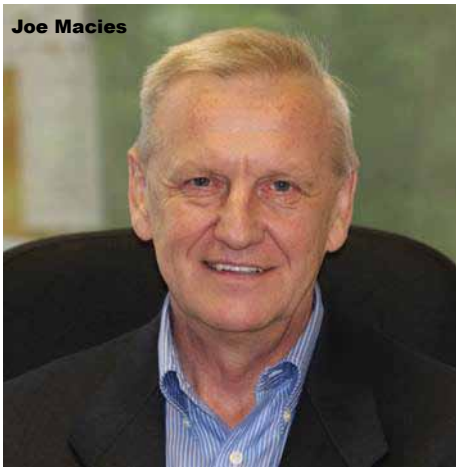
This is the third in a three-part series on the different stages an ambulatory surgery center goes through when switching to an electronic medical records system. Part one appeared in the October issue of Becker's ASC Review *and on www.beckersasc.com. Part two appears on p. 29.*

In this final part of a three-part series, we will be focusing on the third stage of an ASC's transition to an EMR — the period after integration. There are five steps your ASC should take during this stage, when you will continuously work to maximize the benefits of the investment in the EMR and ensure all staff members are using the system properly.

1. Reevaluate education and perform follow-up training. Very few ASCs will utilize every feature of an EMR on the day the system goes live. An EMR has numerous tools, and learning about these resources and how to use them effectively during initial training, and retaining this information can be a challenge.

Once you are comfortable with using the tools learned during initial training, your EMR vendor will return to your ASC to discuss your staff's experience and address any questions or redo training in specific areas. Then you will put your team, primarily the "super users" discussed in parts one and two, through training on the additional EMR features you want to incorporate into your operations.

2. Train new employees. When new employees join your team, they will need to receive EMR training. This is where your super users come in. As with any employee training, set aside sufficient time for your super users to train new employees on using the system. They should start slowly, covering the essential components at the beginning, and then gradually educate them on the specific components of the EMR that will become their responsibility.


Joe Macies

If your ASC experiences significant staff turnover and your super users are challenged to educate a large number of new team members, ask your EMR vendor to send a few representatives to your ASC to conduct on-site training.

3. Workflow remediation. When you switch to an EMR, your ASC will assign staff members to new tasks and will likely reassign some responsibilities in an effort to improve workflow. If any of these assignments do not improve your operations, work with your team to reassign responsibilities to better optimize workflow.

4. Undergo upgrades. Like most software, your EMR will undergo periodic upgrades. When your vendor informs you about a planned upgrade, learn about the improvements and new features prior to the upgrade. Request educational materials from your vendor on the changes; these materials may include documentation, pre-recorded videos, and live webinars providing a walkthrough of what will change with the upgrade.

When it's time for the upgrade, work with your EMR vendor to schedule it during off-hours. After the upgrade is completed, explore the new features as soon as possible so the education you received on the changes is fresh in your mind.

5. Expand your use of the system. As we mentioned earlier, it is worthwhile to examine the ancillary features of the EMR that are not being utilized by your ASC and determine whether these resources should become a part of your operations. This philosophy is also true for new features introduced during upgrades.

Remember not to rush incorporating new features. Ensure your staff members are comfortable using the current features first. If you introduce a new resource at the right time, your team will be ready to embrace the change and the tool will contribute to the improvement of your ASC's workflow.

Making the switch

Making the switch to an EMR is a gradual process, and one that requires an ASC-wide commitment, teamwork and patience. But once the switch is made and integration completed, ASCs will find their effort and the investment in the system pays immediate, significant dividends as an EMR allows them to work smarter, more efficiently, reduce costs and provide better care to their patients. ■

Joe Macies is the CEO of AmkaiSolutions, software/services provider to the ASC industry and its affiliated practices and clinics. The company's AmkaiCharts EMR, together with the AmkaiOffice administrative program, provides a comprehensive, fully integrated solution designed for the specific needs of the ASC. Learn more at www.amkaisolutions.com.

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5 Ways to Ensure a Healthy Hospital/ Physician ASC Joint Venture Relationship

By Rachel Fields

Surgery centers can enjoy tremendous benefits by partnering with a hospital: better managed care contracts, lower prices from vendors and greater market share. But the road to a happy hospital partnership is not always easy, and miscommunications between the parties can lead to tension and dissatisfaction. Here Robert Carrera, president and CEO of Pinnacle III, discusses five ways to build a solid partnership.

1. Choose a partner wisely. Looking back at his experience in successful physician-hospital joint ventures, Mr. Carrera indicates the most positive partnerships involve hospital systems that want the physicians to drive the project. "When the hospital system wants to be engaged in the facility, but truly understands that the physicians are the ones that will make it or break it, the arrangement is more likely to be a successful one," he says. If the relationship has been strained in the past, there may be problems in the future. The hospital system should be able to "help where it's needed and defer to the physicians on other issues," Mr. Carrera asserts.

To make this decision, it's important to assess the current relationship between the hospital and the local physician community. Mr. Carrera says he wouldn't hesitate to approach a hospital with no history of physician ASC joint ventures — but he would hesitate if there has been a history of animosity between the two groups. "What kind of relationship has been established with regard to hot button issues such as call coverage? What is the overall relationship between the medical community and the hospital system? Those are the questions to ask," he states.

2. Determine why you're pursuing a joint venture in the first place. In order to choose a partner, you need to identify the goals for seeking out a joint venture in the first place, Mr. Carrera points out. If an existing physician owned facility is stable, it needs to identify what it will gain through a joint venture relationship — better pricing, contracting or market share, for example — in order to adequately assess the benefits and drawbacks of continuing to be independent.

If you do have a reason to pursue the partnership, you need to know if the hospital will meet that need. For example, in some situations, the hospital is able to provide assistance in payor contracting which may lead to the physicians offering 51 percent ownership to the hospital. In this case, the hospital would be expected to increase contract rates by 15 to 20 percent, depending on the market.

In other situations, the hospital may not have the ability to improve contract rates because the local area is highly managed by the payors. "There are economic and strategic reasons for any joint venture. The physicians need to complete their due diligence on the benefits of having a majority or minority interest to make a sound decision," Mr. Carrera says.

3. Understand your current situation. When you approach a hospital partner, you need to have a firm grasp on your current financial and strategic situation. If your center needs to be "turned around," it may benefit from hospital assistance. If you are a well-run business, you may simply need the help of a partner with greater clout.

If you need significant help to improve, it makes sense for the hospital to be heavily involved in operations. "Many hospitals become more involved in turnaround situations and take more of a backseat in successful start-ups," notes Mr. Carrera. "Good hospital partners seem to step up in those situations where they're needed, and understand when they need to let the physicians drive the center."

4. Establish your expectations for non-competes. Before entering a joint venture both the physicians and the hospital need to have a thorough discussion of how a non-compete will work for both parties, Mr. Carrera says. For example, he has seen situations where the hospital and physicians are bound by the same non-compete terms with neither party allowed to pursue opportunities with other surgery centers in a defined area.

In other situations, they have non-compete agreements with a clause that if one party involves the other party in another project, they can go outside the non-compete. Other variations hold only the physicians to a non-compete, and in others still, there is no non-compete in place. Mr. Carrera says there simply needs to be thorough discussion and an agreement on the issue in order to avoid, as much as possible, any future bad blood between the involved parties..

5. Bring in a third-party manager. Mr. Carrera states a third-party manager is always useful to smooth out the relationship between the hospital and physicians, serving both as the representative of the center and as a liaison when problems arise. He says the management company must have positive working relationships with the physicians and the hospital to bring up sensitive issues without causing conflict and build consensus between the parties when strong differences of opinion arise. ■

5 Succession Planning Tips From Stateline Surgery Center

By Rachel Fields

Jennifer Morris, administrator of Stateline Surgery Center in Galena, Kan., discusses how her surgery center prepares its employees to move into other positions.

1. Cross-train employees in case of emergencies. You never know when you'll have to replace an employee — whether due to an unexpected departure, an illness or a family emergency. Ms. Morris says she cross-trains her business office and clinical staff members so that they can take on added responsibilities if a coworker leaves the surgery center. "We believe that people can fill in for multiple positions, so we prepare them in case they need to advance," she says. "It gives them a bigger picture of the corporation and how it works."

Cross-training will serve you well if you decide to promote an employee into a managerial position, she says. If you keep employees in silos, they can work in the same small surgery center with their coworkers every day and never really know what they do. Then if they transition into a management position, they will be unable to communicate properly with those people. For example, she says several staff members are trained on posting and billing, representative relationships and implant management. "You have to make sure your bases are covered," she says. "If someone leaves, billing still has to go out, so our biggest focus on cross-training is for employees in the revenue cycle."

2. Keep detailed standard operating procedures for every department. Ms. Morris says her surgery center stays organized by keeping binders of standard operating procedures for every department, as well as a "master list" of procedures in the administrator's office. "We have one for basically every job in the surgery center," she says. "How to void a credit card, how to check in a patient — every department has standard operating procedures for every task."

She says this helps in two ways. First, the surgery center staff finds it easier to train new individuals, since they can refer to the handbooks at any time. Second, if an employee moves up through the ranks and assumes new responsibilities, they can be taught a procedure once and refer to the handbook from then on. "They have their notebook of procedures to fall back on," she says. It also helps if an employee is absent and someone needs to fill in; for example, Ms. Morris can refer to the handbook if she needs to check in a patient and hasn't done so in six months.

3. Send transitioning employees to conferences. When Ms. Morris transitioned an employee into a new infection control position, the surgery center sent her to a state conference to brush up on infection control practices. "Any time someone is taking on a new role like that, education is key," she says. "We try to get them into conferences to help them out."

4. Use your local network of facilities. Ms. Morris says her surgery center also gets in touch with other ASCs when an employee has to transition into a new role. "We have a pretty good network of facilities we work with," she says. "My staff members can call those people in the role at the other facility and get advice from them." Don't feel you have to be alone in your education efforts just because other surgery centers are competing with you. Sharing best practices will foster strong relationships among surgical facilities in the community and make collaboration easier in the future.

5. Promote employees from within to set an example. Ms. Morris says her surgery center tries to promote from within if an employee is qualified for an open position. "It's not always possible, and if that's the case, we'll advertise it externally," she says. She says if your surgery center promotes a few staff members into management positions, employees will get the message that you will reward hard work.

"We do promote the fact that we have moved several people up from within," Ms. Morris says. "It's always someone that everyone respects and thinks highly of to begin with, so we haven't had any issues." She says it sends a positive message to other employees: "Work hard and look for opportunities, and you may be able to score a promotion as well." ■

10 Ways to Get Paid Appropriately From Commercial Payors in an ASC

By Rachel Fields

Negotiating a profitable payor contract is half the battle to receiving maximum reimbursement; the other half involves perfecting the revenue cycle at your facility. Andrea Woodell of Regent Surgical Health discusses 10 tips for surgery centers to make sure they receive appropriate reimbursement from commercial payors.

1. Ask for implants to be paid as percent of billed charges. Ms. Woodell says surgery centers should ask their payors to pay implants as a percent of billed charges, so that the payment equates to a "cost plus." This way, the payor will not request a paper invoice and slow down the payment process for the ASC.

2. State "the obvious" in writing when it comes to multiples and implants. According to Ms. Woodell, it's usually a good idea to "state the obvious" in payor contracts, in case the payor is planning on cutting reimbursement in a way the ASC does not anticipate. For example, multiples and implants should be paid in addition to facility fees, with physician professional fees excluded. She says if the contract doesn't clearly state that multiples and implants are paid in addition, the payor could say that multiples or implants don't apply to carve-outs.

3. Include contract language capping take backs on overpayments. If a surgery center accidentally receives overpayments from a payor over a period of time, the payor could subsequently collect the overpayments, causing significant financial damage to the ASC. Ms. Woodell recommends including contract language that specifies how far back the payor can go to collect overpayments.

"I might add language saying you can only go back six months and make that reciprocal — so the surgery center cannot collect on underpayments after

Andrea Woodell

six months either," she says. She says this can be helpful if the surgery center changes hands or the partnership structure shifts. This way, new physicians or owners will not be stuck paying for problems that plagued the ASC in the past.

4. Spell out in the contract which items are necessary for a clean claim. Payors may try to delay surgery center payment by requesting additional items necessary for processing, Ms. Woodell says. She recommends spelling out explicitly in the contract which items are required by the payor. "Ask for a definition of a clean claim," she says. "It should be the same for all your cases." She says this will not apply if the payor challenges the medical necessity for a procedure, but otherwise, you should not encounter as many random denials.

5. When you negotiate a new contract, push a sample claim through the system. When you start a new contract with a payor, give the payor a sample claim to make sure everything can be adjudicated without problems. "It's a nice proactive step," Ms. Woodell says.

6. Clearly define the terms used in the fee schedule. Ms. Woodell says it's important to define terms used in the fee schedule so that you are paid the amount you expect. For example, when it comes to carve-outs, the payor may reference a 'case rate,' 'global rate,' or 'per CPT rate.' A CPT rate would mean that you receive a certain amount of money — say, $2,000 — for a certain CPT code. A case rate could mean that the surgery center will not receive anything except that rate for the particular carve-out, meaning you are not reimbursed for implants or multiples. "The purpose of a carve-out is to pay you higher than the enhanced groupers of the CMS methodology you're using," she says. "If you have a case rate, you may actually end up getting less." She says a 'global rate' implies that the rate is inclusive of some type of professional fee.

7. Understand the payor's ability to adjudicate carve-outs. Ms. Woodell says some payors have an easier time adjudicating carve-outs than others. "I've worked with payors that have to go through an incredibly arduous process to get carve-outs added to the claims system so they can be adjudicated electronically," she says. "It can take six months to get added." She says in this case, it's important to plan and start early. Work with a payor as soon as you know that you'll need a carve-out for a particular procedure.

8. Specify the Medicare year if the contract pays a percent of Medicare. If your payor contract pays a percent of Medicare, the contract should specify which Medicare year the payment is based on. "If you don't know which one it is, it could be current year CMS or 2007 CMS," Ms. Woodell says.

She says there are advantages to using current CMS rates and advantages to using old ones: For example, a pain management, GI or ophthalmology center would fare better with old CMS rates because reimbursement has dropped significantly in recent years. Orthopedic and spine-driven ASCs will want payments to be based on current CMS rates.

9. Specify how the contract pays for multiples in device-intensive cases. The contract should specify how the payor pays for multiples — and specifically have a disclaimer for device-intensive cases, Ms. Woodell says. If devices are paid 100-50-50, the surgery center can lose a significant amount of money, she says.

"If you start thinking about trial simulators, where electrodes cost $1,500 each, those should be paid $1,500-$1,500-$1,500, not $1,500-$750-$750," she says. "Device-intensive cases as defined by Medicare may require a little pushback from the ASC."

10. Understand what will happen if a payor reprices through a TPA. When a payor re-prices through a third-party administrator or local regional payor, you may not have a contract with the new organization. "You need to educate your business office manager that just because [your payor] accesses this network doesn't make it okay if you don't have a contract with that network," Ms. Woodell says. ■

5 Tactics to Negotiate Bundled Payments for Surgery Centers

By Rachel Fields


Adriaan Epps

More payors are introducing bundled payment programs, giving surgery centers and hospitals the ability to accept a pre-determined rate for a procedure in exchange for higher volume from the payor. In this scenario, the payor and the facility also work together to determine quality goals that the facility will meet in exchange for additional reimbursement. Adriaan Epps, director of contracting services for abeo, discusses five steps surgery centers and physicians should take during negotiation for bundled payments.

1. Make sure all physicians have a seat at the table. Every physician who works at the surgery center should have a seat at the table when it comes to negotiating bundled payments, Mr. Epps says. Bundled payments generally mean that the facility receives a total "bucket of money" for a procedure or set of procedures, and then that bucket is divided among the providers who perform the surgery. "Typically facilities, whether hospitals or surgery centers, will recognize that a surgeon should receive more of the money versus other providers," he says. "It will end up being 75 percent to the surgeon, and the others will have to fight for the scraps." For example, if the anesthesiologists don't have a voice in the negotiation, they will most likely miss out on significant money.

Mr. Epps says it's important to demonstrate the value these other providers bring to services and procedures. "We only see, time and again, the surgeons that are bringing the patients," he says. "The patient doesn't come through the radiologist, and therefore the facility views them as a cost and a necessary evil. It's very important for all parties to come to the table and demonstrate the value they bring to the organization."

2. Make sure bundled payments are lucrative compared to current reimbursement. Healthcare costs are high in the United States at the moment — it's a common topic of conversation, and payors are all too aware of it. "They view payments to doctors as already too high, and the concept is to find additional methods to reduce compensation," Mr. Epps says. Surgery centers benefit from the movement to reduce cost because they are a high-quality, low-cost provider, especially compared with higher-paid hospitals. But despite efforts on the part of payors to lower reimbursement, surgery centers should only accept bundled payments that are as lucrative (either in terms of individual case reimbursement or volume) as their previous reimbursement.

"Facilities need to make sure that it's a financially viable methodology, and that it doesn't further reduce revenues or profitability," Mr. Epps says. He says the methodology for bundled payments is generally quite complex and varies significantly from payor to payor — some give reimbursement based on fee-for-service methodology, while others use a case rate plus carve-out codes tied to Medicare methodology. Others tie reimbursement to efficiency parameters. Either way, he says physicians should perform due diligence and determine whether a boost in volume or stable reimbursement will keep the surgery center at the same level of profitability.

3. Understand which procedures will be included. Mr. Epps says facilities and payors commonly carve out the codes that will be included in the bundled services, and it doesn't always encompass every service offered at the facility. Mr. Epps says the facility should share with the payor their data on the most commonly performed procedures (or most commonly documented codes) at the surgery center. The bundled payments should probably be based on the highest-volume procedures at the center.

4. Determine how to measure quality. Bundled payments are based on the idea that facilities can receive additional reimbursement for meeting critical quality benchmarks. For example, most payors across the United States focus on the total cost index of the hospital and how that relates to average length of stay. If quality measures show that the physicians in the facility are performing high-quality services more effectively than their competitors, the payors will reward those physicians by saying, "If you meet this certain benchmark or threshold, we'll pay a certain amount of money per procedure or group of procedures." If the physicians further prove that they have been more efficient and reduced average length of stay, they would receive a percentage of dollars captured as a reward.

Because of this methodology, Mr. Epps says you need to agree with the payor on the quality measures that will be used to determine your reimbursement. "If they can't agree on the measures, it's really difficult to negotiate the methodology and premise behind the bundled payment," he says. "The payor needs to be able to capture the same data as you."

He says reimbursement may be based on SCIP or PQRI measures and should be measured approximately every quarter or six months. "The facility needs to demonstrate their outcomes through quality improvement programs they have in place," he says. "They need to be able to sit down with key people on the payor's side and share those quality parameters."

5. Make sure you understand the contract. "It's always important to understand the terms of the agreement," Mr. Epps says. "See a copy and review what is being proposed." He says the payor may be changing contract language as a result of the movement to bundled payments. If the bundled payments only apply to certain procedures, you need to know how other services will be reimbursed if they're not included in the program. "It's so easy for payors to re-contract the doctors or for them to sign an amendment without understanding what it means to the practice or facility," he says.

Mr. Epps says the agreement should be an overall boon for your facility. "Is this cost-effective to your business, and how do you get out of the contract if it turns out not to be?" he says. There's a chance that this may not be the best time to start bundled payments — you should always be able to revisit in six to 12 months if necessary. ■

5 Tips for Collecting in Full From Out-of-Network Payors

Ronald Duperrior

By Heather Linder

Ambulatory surgery centers are at risk of losing revenue from performed procedures if the appropriate revenue cycle management principles are not performed and executed for out-of-network payors. Even if out-of-network claims are infrequent, ASCs can reduce their risk of denials or short pays by taking a few precautionary measures.

Ronald A. Duperrior, managing partner of Dallas-based Clarity Health, provides operational guidance to self-managed ASCs and their physician owners. He often handles out-of-network claims and has expertise for collecting reimbursements.

Here are Mr. Duperrior's five tips for successfully managing the out-of-network process.

1. Set reasonable rates. Problems can develop between ASCs and payors when a surgery center's charge master rate is too high. It becomes noticed and it is difficult to justify. Mr. Duperrior recommends knowing what is reasonable for your market and setting your rates two standard deviations away from the median or taking a multiple of what Medicare reimburses.

Payors know what others are submitting as charges within your geographical location, he says. If you are charging at an unreasonably high rate, you are asking for them to reject your claim because your rates are not customary and reasonable.

"It is not unreasonable to have your rates at the upper end of the scale," he says. "But don't be outrageously unreasonable. Two standard deviations can easily be justified. Perhaps your physician team is recognized with noteworthy accomplishments or has a unique education [or] your center has purchased equipment considered to be advanced technology … This is justifiable. Setting a charge master 10 standard deviations to the right is unreasonable, and you will be often challenged."

It's the responsibility of the surgery center to charge fair rates with a reasonable profit margin that does not exploit the patient or the out-of-network payor.

2. Know your rights. Each state has a state operating manual in which the state dictates to payors its insurance regulations. It's important for ASCs to know their rights according to the SOMs and to use those rights to their benefit, Mr. Duperrior says.

"If you are constantly getting denials for the same thing over and over, it may be an indication you are being harassed or payments are being unreasonably withheld," he says. "There are penalties involved. In some states [payors] will have to pay the full charge if they are wrong and delay payments."

When billers do not know their legal rights, they are more likely to be taken advantage of by payors. Citing state rules in appeals letters can also help leverage an ASC's ability to fully collect.

Always be on the lookout for improper delays or denials, Mr. Duperrior says. A surgery center knowing its rights and standing up for itself also means hiring qualified personnel to represent the center. "Know the rules; keep on top of [accounts receivable]," he says. "Have a strong billing system. Hire good people and pay them accordingly."

3. Appeal all denials. Surgery centers have a right to due process when it comes to disputes over submitted claims. It can be worth appealing a denied claim within 24 hours to maintain your due process rights, Mr. Duperrior says, which are forfeited if no appeal is submitted within an outlined timeframe.

"Even if I don't know how I will respond or I know my response will be weak, I will appeal to save the ASC's due process rights," he says. "I appeal and personally reply to every one of them, depending on what the payor tells me and why they are [denying]."

Be firm and don't allow companies to use certain tactics as a justification for withholding money. "It may be give and take, but I hold my ground, and 90 percent of the time we come to a satisfactory outcome," he says.

He warns ASCs, though, to differentiate between being firm and being a bully. If centers start by charging unreasonable amounts and demand to be paid, they will immediately put the payor on the offensive and shut down opportunities for discussion.

"If I know the rules I'm playing by, I don't need to be aggressive," he says. "Be professional. Be reasonable. Be customary. I don't need to be aggressive because I'm right."

Most payors also have subcontractors to work with appeals and negotiations who are paid to reduce your bill. Try to talk to the same person every time and share with them why your charge is what it is. "Depending on the fiscal health of the center, I typically will not accept the discounts offered for a prompt pay," Mr. Duperrior says. Consistency helps build a relationship.

4. Don't be talked down. Commercial payors are quick to negotiate your asking price down and they are good at it, but Mr. Duperrior says this can set a bad precedent for future transactions.

"Hundreds of people negotiate down," he says. "Third party payors will say, 'We'll pay quicker if you take less.' I stand firm by my price. A fiscally unhealthy ASC might take that deal because they need the money. The healthy ASCs will reject it because they can afford to wait a couple of days."

If an ASC accepts a low offer, then payors see this as a precedent and expect the center to always accept the reimbursement as it now has become an established, acceptable rate.

"If you can afford to do it," Mr. Duperrior says, "stick to your reasonably set charge master."

5. Begin your work before the procedure. ASC billers should not wait until after the procedure has been performed and the patient discharged to think about the bill. Verify insurance for each patient scheduled, identify what the out-of-network benefit will be and get authorization to do the procedure, Mr. Duperrior says.

Mr. Duperrior has encountered situations where the insurance expired between authorization and the day of surgery. For more expensive procedures, it can be worthwhile to verify the day of that the insurance is still valid.

"I understand you can't revalidate every procedure — it's an all day thing trying to validate and probably one in 300 procedures we see something like this happen — but if not done, it will make you mad if you get shortchanged on the big cases."

Identify what needs to be collected prior to the day of surgery; call patients and encourage them to stop in prior to surgery to take care of their co-pay and deductibles. Centers often wait and bill the patient later, but collecting up front can prevent losing money.

"Collect the co-pay and the deductible the day of surgery, if you can," he says. "Also have a verified credit check membership so you know there are funds in the account when you take the check, or take cash or credit card only."

Overall, ASCs should also keep an eye on weekly accounts receivable reports. Respond to denials quickly and don't always trust that the biller has already taken care of it, he says. A/R reports will verify the center is on top of all billings and appeals. ■

Will Medicare Ever Reimburse Surgery Centers for Spinal Surgery? Q&A With Dr. Brian Gantwerker of The Craniospinal Center of Los Angeles
(continued from page 1)

safely and more cost effectively than in hospitals. If Medicare is serious about cost savings, they probably need to move some of these smaller procedures in carefully selected patients to an outpatient setting. It cost almost a tenth of the amount to do a lumbar microdiscectomy in a surgery center than a hospital; this is a real cost savings.

Q: Covering spinal surgeries in outpatient ASCs seems intuitive from a cost and quality standpoint. Why are there still barriers for Medicare coverage? Will surgeons be able to overcome these roadblocks in the future?

BG: Unfortunately, there may be various reasons why it will be difficult to gain Medicare coverage for spinal surgery in ASCs. There is a lot of pressure for hospitals to create accountable care organizations to keep physicians in an organized, managed fashion. The hospitals probably stand to lose considerable business if Medicare moves spine to an outpatient setting.

Q: Medicare patients often have higher comorbidities and other special considerations. Will surgery centers be able to accommodate for this population if Medicare does reimburse for them?

BG: I think surgery centers could support them. It would behoove Congress to look at supporting the surgery center model to maintain the viability of the entire Medicare system. Obviously, patients need to be very carefully selected for. Not just in spine, but spine is a great place to start.

Upper endoscopies, angiograms, and kyphoplasty are already done in an outpatient setting. It may be that doing a single level microdiscectomy or minimally invasive decompression would allow these patients to get their care in a safe setting and show real cost savings to the federal program.

Another aspect is that hospitals can and have done joint ventures with physician-owned surgery centers. Essentially, everyone wins in this model. The hospital can get the services done and get their facility fees, Medicare gets their patients taken care of at a lower cost and the physician has the satisfaction of a job well done in an outpatient setting.

Q: What will prompt this change? Is there anything spine surgeons or surgery centers can do to promote this change more quickly?

BG: We have to go to Congress and show them the numbers. I don't think there is any other way they are going to understand it unless they see what it really costs to have a patient treated in the outpatient setting. I think it's mandatory that we have to show them these costs and establish a relationship with Congress.

By working within our professional organizations, such as North American Spine Society and the American Association of Neurological Surgeons, and creating a lobby for outpatient spine. We need to show them the cost savings and help them realize the impact of performing carefully selected spinal cases in surgery centers.

Q: Are physicians ready to perform these types of procedures in the surgery center? In the immediate future, will they be able to advocate for Medicare reimbursement?

BG: Maybe all it takes is a conversation; it just takes a group of individuals who could present a brief and codified statement that says outpatient spine surgeries are just as safe and effective as in the hospital and realize the cost savings. There may be obvious hesitations and concerns about patient safety, but there are higher morbidity procedures being performed in the outpatient setting. The obvious caveat is the patients — how old? Is there a cutoff? What is an acceptable risk? How do we stratify these patients?


Brian Gantwerker

It's going to require a very strong group of individuals who will go to Congress and present hard data on cost savings.

As a whole, a lot of surgery centers are able to access what their fee schedules are for certain procedures and provide that to Medicare with a cost analysis. Compare the procedure in both settings, including anesthesia, and I think it would demonstrate a tremendous cost savings. There is a lot of motivation to return patients home comfortably and provide very good care for them.

As physicians, we all want Medicare to work; nobody wants the system to fail. We want patients to be able to afford their healthcare and have a certain level of confidence in their physicians and system they paid into for the past 50 years. Physicians are willing to make this work but we need partners in Congress and surgery centers to show it is a viable option to have spine surgery in the outpatient setting when it is safe, appropriate and most importantly, when it's in the patient's best interest. ■

433 People in the ASC Industry to Know (continued from page 1)

Margaret Acker, RN, MSN, CASC. Ms. Acker is the administrator of Southwest Surgical Center, a multi-specialty freestanding ASC, and the chair of the Michigan Ambulatory Surgery Association Membership Committee.

Clifford G. Adlerz. Mr. Adlerz is president, COO and director of Symbion, a position he has held since May 2002.

Traci Albers. Ms. Albers is administrator of North Memorial Ambulatory Surgery Center at Maple Grove (Minn.) and High Pointe Surgery Center in Lake Elmo, Minn.

Ross Alexander. Mr. Alexander is administrator at The Surgery Center of Fort Collins (Colo.), a multispecialty ASC owned and managed by a group of surgeons, Poudre Valley Health System and SCA.

Amy Allard, BSN, MPH, RN. Ms. Allard is administrator of Ramapo Valley Surgery Center in Ramsey, N.J.

Kathleen Allman, CASC. Ms. Allman is the administrator of Millennium Surgery Center in Bakersfield, Calif.

Robert Andersen. Mr. Anderson is vice president of ASC development for Foundation Surgery Affiliates and has over 20 years in all areas of sales and development.

James Andrews, MD. Dr. Andrews is founder of Andrews Orthopaedic & Sports Medicine Institute in Gulf Breeze, Fla.

Kim Andry, CASC. Ms. Andry, the administrator at Great Lakes Surgical Center in Southfield, Mich., serves as business manager and administrator of her multispecialty physician-owned facility.

Amir Arbisser, MD. Dr. Arbisser is an ophthalmologist and co-founder of Eye Surgeons Associates in Bettendorf, Iowa, where he also serves as board chairman.

Robyn Archer. Ms. Archer joined Salt Lake Surgical Center in Utah as a nurse over 30 years ago and moved through various positions until rising to the administrator role in 2006.

Richard G. Areen, MD. Dr. Areen is a highly experienced otolaryngologist who has been in practice with Sacramento Ear, Nose & Throat since 1982, where he serves as president.

Jennifer Arellano. Ms. Arellano began her career with Pueblo (Colo.) Surgery Center in 1998 and has been its administrator for the past 13 years.

Vickie Arjoyan. Ms Arjoyan is administrator of Specialty Surgical of Beverly Hills which is affiliated with Symbion.

Dale A. Armstrong, MD. Dr. Armstrong is chairman of the board of Mason City (Iowa) Surgery Center and the president of the Mason City Clinic, where he has visionary ideas for his center.

Steven Arnold, MD, MS, MBA, CPE, FHIMSS. Dr. Arnold joined Access MediQuip in January 2012 to direct clinical programs and the development of medical management policies and procedures.

Brent Ashby, CASC. Mr. Ashby is the administrator of two surgery centers — Audubon Surgery Center and Audubon ASC at St. Francis, both located in Colorado Springs, Colo.

Cathy Atwater. Ms. Atwater is the administrator of Banner Health-Union Hills Surgery Center and Banner Thunderbird Surgery Center in Peoria, Ariz.

John Atwater, MD. Dr. Atwater is a spine surgeon at Downstate Illinois Spine Center and McClean County Orthopedics, both in Bloomington, Ill.

Kenneth Austin, MD. Dr. Austin is an orthopedic surgeon at Rockland Orthopedics & Sports Medicine in Airmont, N.Y.

Lisa A. Austin, RN, CASC. Ms. Austin serves as vice president of operations for Pinnacle III and has served on the executive board of the Colorado Ambulatory Surgery Center Association.

David Ayers. Mr. Ayers is the CEO of U.S. operations for Nueterra Healthcare and has 30 years of experience in the ASC industry.

David F. "Buddy" Bacon, Jr. Mr. Bacon is a founder and the CEO of Meridian Surgical Partners and has more than 22 years of experience in the healthcare sector.

Alejandro Badia, MD. Dr. Badia is the founder of the Badia Hand to Shoulder Center in Doral, Fla., and serves on the surgeon advisory panel of the DaVinci Center in Doral.

Beverly Baker. Ms. Baker has served as the administrator of the Timberlake Surgery Center in Chesterfield, Mo., since 2008 and has been an administrator in the ASC field for over seven years.

Norman Douglas Baker, MD, FACS. Dr. Baker is a surgeon at the Ophthalmic Surgeons and Consultants of Ohio in Columbus.

Carl Balog, MD. Dr. Balog practices with Oregon Pain Management Associates.

Joseph Banno, MD. Dr. Banno is the founder and co-owner of the successful Peoria (Ill.) Day Surgery Center and is past chairman of the ASC Association and a current executive committee member.

Robert O. Baratta, MD. Dr. Baratta is partner and CEO of Ascent Surgical Partners in Nashville, Tenn. He is an ophthalmologist who has more than 25 years of experience managing surgery centers.

John Bartos, JD. Mr. Bartos is the CEO of Collect Rx and previously served as executive vice president for Prematics.

Rob Bashore. Mr. Bashore is the administrator of Same Day SurgiCenter in Orlando, Fla.

Nora Bass. Ms. Bass is vice president of surgery at Parkview Health in the greater Detroit area.

Scott Bateman, MD. Dr. Bateman is an otolaryngologist practicing at Sheridan (Wyo.) Ear, Nose & Throat.

Tracey Baughey. Ms. Baughey is the administrator of Laser Spine Institute in Wayne, Pa.

Gregary W. Beasley. Mr. Beasley is the president of the ambulatory surgery division of HCA and served as COO and senior development office, Western region, for the division.

Linda Beaver, RN, MSN, MHA. Ms. Beaver serves as administrator of Gateway Endoscopy Center, managed by USPI.

Christine Behm, BSN, CASC. Ms. Behm has been administrator of San Buena Ventura Surgery Center in Ventura, Calif., since 1991.

Timothy Beluscak II. Mr. Beluscak is the administrator of Jacksonville Beach (Fla.) Surgery Center, part of the Symbion Healthcare family of surgery centers.

Kelly Bemis, RN, BSN. Ms. Bemis is a director of clinical services for Surgical Care Affiliates, where she oversees 35 outpatient facilities.

Sean Benson. Mr. Benson is the co-founder of ProVation Medical and has been involved in the company's operations since its inception in 1994.

Robert A. Berger, MD. Dr. Berger is a general and bariatric surgeon and the medical director of bariatric surgery at Flagstaff (Ariz.) Medical Center.

Fernando Bermudez, MD. Dr. Bermudez is the medical director of Eastside Endoscopy Center and the physician financial executive of G.I. Medicine Associates in St. Claire Shores, Mich.

Sandy Berreth, RN, MS, CASC. Ms. Berreth serves as the administrator of Brainerd Lakes Surgery Center in Baxter, Minn.

Todd Beyer, DO. Dr. Beyer is an ophthalmologist and oculofacial-plastic surgeon at Novus Clinic in Tallmadge, Ohio, where he serves as president.

Chris Bishop. Mr. Bishop is senior vice president of acquisitions and business development for Blue Chip Surgical Center Partners.

Stephen E. Blake, JD, MBA, CPA. Mr. Blake serves as the administrator of Central Park Surgery Center in Arlington, Texas, a 100-percent physician-owned facility accredited by the AAAHC.

Jeff Blankinship. Mr. Blankinship is the CEO and president of Surgical Notes, which provides transcription services to more than 500 surgery centers and 20,000 physicians nationwide.

Steven Blom, RN, MAHSM, CASC. Mr. Blom is the regional director for National Surgical Care, which was acquired by AmSurg Corp., and executive director of Specialty Surgery Center in San Antonio.

Henry H. Bloom. Mr. Bloom is the founder of The Bloom Organization, a healthcare-consulting firm that provides project-related services to healthcare providers.

Robert Boeglin, MD. Dr. Boeglin, an ophthalmologist, is the board president for Midwest Eye Institute in Indianapolis and co-founder of Health Venture Management.

Tim Bogardus. Mr. Bogardus is the director of ASCs for Community Health Systems.

Dotty Bollinger. Ms. Bollinger currently serves as COO of Laser Spine Institute, where surgeons perform minimally invasive spine surgery.

Tom Bombardier, MD. Dr. Bombardier is an ophthalmologist, and one of the three founding principals of ASCOA, an ASC management and development company.

Regina Boore, RN, BSN, MS. Ms. Boore is the principal and CEO of Progressive Surgical Solutions, a company that specializes in business solutions for outpatient surgery centers.

Todd Borst. Mr. Borst is CEO of Smithfield Surgical Partners and manages the company along with principals Gregory Horner, MD, and Steve Mohebi.

Nader Bozorgi, MD. Dr. Bozorgi has been a leader and pioneer in the field of outpatient surgery since 1973, when he opened one of the first ASCs in the United States.

Robert S. Bray, Jr., MD. Dr. Bray is a neurosurgeon and the CEO of DISC Sports & Spine Center.

Brett Brodnax. Mr. Brodnax is president and chief development officer of United Surgical Partners International, which has ownership interests in or operates more than 200 surgical facilities.

Ben Brouhard, MD. Dr. Brouhard is senior vice president of Cejka Executive Search.

Brian Brown. Mr. Brown is regional vice president of operations for Meridian Surgical Partners.

Robert Brownd. Mr. Brownd is director of business development at Surgical Notes, a full-service medical transcription and coding provider to over 500 ASCs.

Richard F. Bruch, MD. Dr. Bruch practiced with Triangle Orthopedic Associates in Durham, N.C., from 1977 to 2011 when he retired.

Michael Bukstein, MD, FACS. Dr. Bukstein is a general surgeon who serves as the board president of the Northeast Missouri Ambulatory Surgery Center in Hannibal.

Danny Bundren. Mr. Bundren is vice president of acquisitions and development for Symbion.

T. Taylor Burnett. Ms. Burnett is CEO and administrator of The Plastic Surgical Center of Mississippi, a physician-owned surgery center in Flowood.

John Byers, MD. Dr. Byers is an otolaryngologist with the Surgery Center of Greensboro (N.C.) and Greensboro Ear, Nose and Throat Associates, where he has practiced since 1994.

Jason B. Cagle. Mr. Cagle is general counsel for United Surgical Partners International, a healthcare facilities management and development company.

James T. Caillouette, MD. Dr. Caillouette is a board-certified orthopedic surgeon with Newport Orthopedic Institute in Newport Beach, Calif.

Joe Cappiello. Mr. Cappiello is the chief operating officer for Healthcare Facilities Accreditation Program.

Peter A. Caprise, MD. Dr. Caprise works as an orthopedic surgeon at The Orthopaedic Center of Central Virginia in Lynchburg.

Robert J. Carrera. Mr. Carrera is the president and CEO of Pinnacle III. He was promoted to the top executive position in August.

John Caruso, MD. Dr. Caruso practices at Parkway Surgery Center in Hagerstown, Md., and has more than 16 years of neurological surgery experience.

Arthur E. Casey. Mr. Casey is senior vice president of business development for Outpatient Healthcare Strategies, a healthcare consulting firm based in Houston.

Frank J. Chapman, MBA. Mr. Chapman is the COO of Asheville (N.C.) Gastroenterology Associates and past president of Medical Group Management Association Gastroenterology Administrators Assembly.

John Cherf, MD. Dr. Cherf is an orthopedic surgeon, president of the Chicago Institute of Orthopedics, president of OrthoIndex and clinical advisor to Sg2.

Thomas Chirillo. Mr. Chirillo is a principal at Chirillo Consulting and previously worked at NOVA and Surgery Partners.

Ajay Chokshi. Mr. Chokshi serves as vice president of strategy and implementation at Surgical Care Affiliates, a leading ASC management and development company.

Rajiv Chopra. Mr. Chopra is a principal with The C/N Group, which develops, owns and operates healthcare facilities.

Raman Chopra. Mr. Chopra is principal for The C/N Group. He oversees the firm's diagnostic imaging and hospitality operations and all marketing and technology related activities.

Ravi Chopra. Mr. Chopra is the president and CEO of The C/N Group where he holds a variety of operational responsibilities.

Richard N. Christie, MD. Dr. Christie is a vice president of operational development at Ambulatory Surgical Centers of America and an OB/GYN with a private practice in Newport Beach, Calif.

Monica Cintado-Scokin. Ms. Cintado-Scokin is the senior vice president of development for United Surgical Partners International, and she has been with USPI since 1998.

Joe Clark. Mr. Clark serves as executive vice president and CDO for SCA. Previously, Mr. Clark served as the president and CEO of HealthMark Partners and as CEO of Response Oncology.

James H. Cobb. Mr. Cobb is founder, president and CEO of Orion Medical Services. He has more than 38 years of experience in management.

Larry Cohen, MD. Dr. Cohen works with Frontier Healthcare alongside Jordan Fowler, CEO.

James R. Colgan, MD. Dr. Colgan helped found Carson Urologists in Carson City, Nev., and has provided patient care to the surrounding area since 1974.

Chris Collins, RN, BSHCA. Mr. Collins has been with Metropolitan Surgery Center in New Jersey since January 2012, when the facility was acquired by USPI.

Daniel Connolly. Mr. Connolly is the vice president of payor contracting for Pinnacle III.

Mary Ann Cooney, RN. Ms. Cooney is the administrator of Riverside Outpatient Surgery Center in Columbus, Ohio, an ASC managed by Health Inventures.

Christine Corbin, MD. Dr. Corbin is a GYN surgeon and medical director of the Surgery Center at Tanasbourne in Hillsboro, Ore., a Blue Chip Surgical Center Partners facility.

Rebecca Craig, RN, CASC. Ms. Craig is CEO of Harmony Surgery Center in Fort Collins, Colo.

Bill Cramer. Mr. Cramer co-founded Access MediQuip in 1997 and developed the business model which serves as the foundation for the company's current portfolio of strategic medical device solutions.

Deborah Lee Crook. Ms. Crook is the administrator of Valley Ambulatory Surgery Center in St. Charles, Ill.

Jimbo Cross. Mr. Cross is a vice president of acquisitions and development with ASCOA.

William Crowder Jr., MD, FACOG. Dr. Crowder helped to start the Conroe (Texas) Surgery Center in 1983 with 16 other physicians.

R. Blake Curd, MD. Dr. Curd is chairman of the board of directors of Sioux Falls, S.D.-based Surgical Management Professionals.

Ray D'Amours, MD. Dr. D'Amours joined Universal Pain Management in Palmdale, Calif., in 2002, where he serves as a partner.

Christopher Danis, MD. Dr. Danis is in his 20th year of practicing hand surgery in Dayton, Ohio. About 10 years ago, he initiated Far Hills Surgical Center.

Urfan Dar, MD. Dr. Dar is principal, manager and medical director of Theda Oaks Surgery Center in San Antonio, which performs close to 10,000 cases annually.

Devin K. Datta, MD. Dr. Datta is a spine surgeon at The B.A.C.K. Center, an affiliate of Osler Medical in Melbourne, Fla., and a Blue Chip Surgical Partners facility.

Daniel C. "Skip" Daube, MD. Dr. Daube is the director and CEO of Surgical Center of Excellence in Panama City, Fla.

D. Paul Davis, CPA, CMA. Mr. Davis is founder and serves as the president and CEO of Broomfield, Colo.-based Amblitel.

Anne Frey Dean, RN, BSN, LRM. Ms. Dean has been actively involved in the ambulatory surgery world since 1976, and has spoken internationally on the ASC industry.

Tom Deas Jr., MD, MMM. Dr. Deas has served as medical director of two Fort Worth, Texas, ambulatory endoscopy centers since their development in 1995 and 2002.

Greg DeConciliis, PA-C, CASC. Mr. DeConciliis serves as the administrator of Boston Out-Patient Surgical Suites in Waltham, Mass.

Troy DeDecker. Mr. DeDecker is the official CEO of Bartow Regional Medical Center, where he served on an interim basis since July 2011 before being named to the permanent position.

Richard DeHart. Mr. DeHart is the previous CEO and co-founder of Pinnacle III and has more than 18 years of experience in the outpatient healthcare industry.

Vicki Dekker. Ms Dekker is the director of business development at Blue Chip Surgical Center Partners.

Joan Dentler, MBA. Ms. Dentler is president and founder of both ASC Strategies and Out-patient Strategies, providing consulting services related to strategy

Ann S. Deters, MBA, CPA. Ms. Deters is CEO and co-founder of Vantage Outsourcing (formerly Vantage Technology), which provides cataract outsourcing to hospitals and ASCs.

John DiPaola, MD. Dr. DiPaola is an orthopedic surgeon and occupational orthopedist who originally built his Swan Island, Ore., clinic to exclusively serve injured workers.

Douglas R. Dodson, DO. Dr. Dodson practices orthopedics at Alamogordo Orthopaedics

and Sports Medicine in New Mexico.

Gina Dolsen, RN, BSN, MA. Ms. Dolsen serves as vice president of operations for Blue Chip Surgical Center Partners.

Lorri A. Downs, BSN, MS, RN, CIC. Ms. Downs is vice president of infection prevention and patient safety at Medline Industries.

Michael Doyle. Mr. Doyle is CEO of Surgery Partners where he is responsible for overseeing the firm's day-to-day operation and expansion through partnerships.

Ken Drazan, MD. Dr. Drazan is a partner at Bertram Capital Management based in San Mateo, Calif., which includes GENASCIS among its portfolio companies.

Stephen Dresnick, MD. Dr. Dresnick has been the chairman, CEO and president of Internal Fixation Systems, Inc., since April 2009.

Tom Ealey, CPA. Mr. Ealey is a professor and consultant at Alma (Mich.) College. He has been in healthcare for more than 30 years.

Vicki Edelman, RN, BSN, CASC. Ms. Edelman is the administrator of Blue Bell Surgery Center and currently is employed by ASCOA.

Marie Edler, MPH. Ms. Edler is a senior director of reimbursement for Surgical Care Affiliates, based in Birmingham, Ala.

Jack Egnatinsky, MD. Dr. Egnatinsky is the immediate past president of the AAAHC Board of Officers for 2011/12.

Rose Eickelberger. Ms. Eickelberger is the director of surgical services at Beacon Orthopaedic Surgery Center in Sharonville, Ohio.

Stephanie Ellis, RN, CPC. Ms. Ellis is the owner and president of Brentwood, Tenn.-based Ellis Medical Consulting and has provided healthcare consulting services to ASCs in that capacity since 1992.

Christian Ellison. Mr. Ellison is senior vice president at Health Inventures. He has formed numerous physician/hospital joint-venture partnerships.

Alice L. Epstein. Ms. Epstein is a risk control consulting director with CNA Health Pro.

Pamela J. Ertel, RN, BSN, RNFA, CNOR, FABC, CASC. Ms. Ertel oversees daily operations at The Reading Hospital SurgiCenter at Spring Ridge.

Fawn Esser-Lipp, RN. Ms. Esser-Lipp has been an RN for 14 years, and serves as a certified operating room nurse, infection preventionist and OR manager at The Surgery Center in Franklin, Wis.

James "Jay" Etheridge Jr. Mr. Etheridge is the CEO of Implantable Provider Group.

Gayle Evans, RN, BSN, MBA, CNOR, CASC. Ms. Evans is president of Continuum Healthcare Consultants, a firm that specializes in the planning, development and operation of ASCs.

Carolyn Evec, RN, CNOR. Ms. Evec has served as the administrator at The Surgery Center of Beaufort for over 10 years.

Paul G. Faraclas. Mr. Faraclas is president and CEO of CTQ Solutions. Since 2003, CTQ has provided healthcare providers with solutions to optimize patient feedback.

Azadeh Farahmand. Ms. Farahmand is the founder and CEO of GHN-Online and principle business architect for its products.

Mark Farrow. Mr. Farrow is founder, president and CEO of Tulsa, Okla.-based Orthopedic Resources, a licensed, accredited and Medicare-approved durable medical equipment provider.

Allan Fine. Mr. Fine is the senior vice president and chief strategy and operations officer at The New York Eye & Ear Infirmary.

John Fitz, MD. Dr. Fitz is the founder of The Surgery Center of Farmington (Mo.), a 10-year-old, multi-specialty surgery center, where he works as a physician.

Donald W. Floyd, MD. Dr. Floyd is an orthopedic surgeon practicing with Texas Surgical Center in Midland.

Thomas R. Forget Jr., MD. Dr. Forget is a neurosurgeon with the St. Louis Spine Surgery Center, a Blue Chip Surgical Partners facility.

Robin Fowler, MD. Dr. Fowler is chairman and medical director of Interventional Management Services. He is also the medical director of the Interventional Spine and Pain Management Center in Conyers, Ga.

James L. Fox Jr., MD. Dr. Fox is the founding leader of the Ravine Way Surgery Center in Glenview, Ill., and practices at the Illinois Bone & Joint Institute.

Richard Francis Jr. Mr. Francis has served the chairman of Nashville, Tenn.-based Symbion Healthcare since March 2002 and as CEO of the company since its inception in 1999.

Janet Nau Franck, RN, MBA, CIC. Ms. Franck is a well known infection preventionist and consultant to healthcare with over 30 years of experience.

Brandon Frazier. Mr. Frazier is the vice president of development and acquisitions at Ambulatory Surgical Centers of America, with a focus on development of de novo ambulatory surgery centers.

Tom Fry, MD. Dr. Fry, a board-certified orthopedic surgeon, currently sits on the board of Lutheran Campus ASC in Wheat Ridge, Colo., a Pinnacle III facility.

Jennifer Fuqua. Ms. Fuqua is director of marketing and business development for Meridian Surgical Partners and has more than 15 years of experience.

Tom N. Galouzis, MD, FACS. Dr. Galouzis is president and CEO of the Nikitis Resource Group. He is also a practicing general surgeon in northwest Indiana.

Nap Gary. Mr. Gary is the COO of Regent Surgical Health, where he is responsible for all operations and physician relations at the company's centers.

Ann Geier, RN, MS, CNOR, CASC. Ms. Geier is a senior vice president of operations for ASCOA, with over 20 years of experience in all aspects of ASC operations.

David Geier, Jr., MD. Dr. Geier is an orthopedic surgeon and the director of MUSC Sports Medicine in Charleston, S.C.

David S. George, MD. Dr. George is an ophthalmologist with The Eye MDs of George, Strickler and Lazer, based in Marietta, Ohio.

Gregory George, MD, PhD. Dr. George is the founding principal of SurgCenter Development, which partners with local surgeons to create physician-owned and operated ASCs.

Scott Gibbs, MD. Dr. Gibbs is the founder of the Brain and NeuroSpine Clinic of Missouri and also serves as director of the Southeast Missouri Hospital's Brain and Spine Center.

Bill Gilbert. Mr. Gilbert is the vice president of marketing at AdvantEdge Healthcare Solutions. In that role, he oversees product management and marketing.

Carlos Giron, MD. Dr. Giron is an anesthesiologist at The Pain Institute of Georgia in Macon.

Scott E. Glaser, MD, FIPP. Dr. Glaser is a well-respected pain specialist and founder of the Pain Specialists of Greater Chicago in Burr Ridge, Ill.

Tamar Glaser, RN. Ms. Glaser is the founder, CEO and principal consultant for Accreditation Services in Rolling Hills Estates, Calif.

Eric Gleichman. Mr. Gleichman is chief development officer for Nueterra. He previously served as executive vice president and chief development officer for Foundation Surgery Affiliates.

Edward Glinski, DO, MBA, CPE. Dr. Glinski is the medical director at Heritage Eye Surgicenter of Oklahoma in Oklahoma City and is a specialist in refractive and cataract surgery.

John J. Goehle, CASC, MBA, CPA. Mr. Goehle founded Ambulatory Healthcare Strategies alongside Vito Quatela, MD, where he is COO.

Robert C. Goettling. Mr. Goettling is a principal with The Bloom Organization, a commercial industrial and office real estate development firm.

Douglas Golwas. Mr. Golwas is senior vice president of ASCs for Medline Industries and is responsible for the strategic direction, growth and sales leadership of the business unit.

Brett Gosney. Mr. Gosney is a founder and CEO of the Animas Surgical Hospital in Durango, Colo., the first physician-owned hospital in the state.

Michael Gossman, BSBA, CASC. Mr. Gossman is the administrator at the Cedar Lake Surgery Center in Biloxi, Miss., a multi-specialty center.

Judy Graham. Ms. Graham is administrator of Cypress Surgery Center in Wichita, Kan., a freestanding, multi-specialty ASC that opened in December 2000.

Donna Greene. Ms. Greene is a vice president of acquisitions and development for ASCOA, with over 20 years experience in healthcare.

Nicole Gritton. Ms. Gritton, vice president of nursing and ASC operations at Laser Spine Institute, is based at the organization's headquarters in Tampa, Fla.

Michael Guarino. Mr. Guarino is an administrator and consultant for North Shore SurgiCenter in Smithtown, N.Y.

Steven A. Gunderson, DO. Dr. Gunderson is CEO/medical director of Rockford (Ill.) Ambulatory Surgery Center.

John Hajjar, MD, FACS, MBA. Dr. Hajjar, a urologist, is the chief medical officer and chairman of Surgem.

David Hamilton. Mr. Hamilton is the president and CEO of Mnet Financial, which provides healthcare collections services for ASCs, imaging centers and outpatient hospitals.

John H. Hammergren. Mr. Hammergren is chairman, president and CEO of McKesson Corporation. He was elected president and CEO in 2001 and chairman in 2002.

Marilyn Hanchett, RN. Ms. Hanchett is the senior director of clinical innovation at the Association for Professionals in Infection Control and Epidemiology.

Kenneth N. Hancock. Mr. Hancock is the president and chief development officer of Meridian Surgical Partners.

Tracey Harbour. Ms. Harbour is an administrator at Nueterra Healthcare in Pinehurst, N.C.

Karen Harris. Ms. Harris is the administrator of GNS Surgery Center in Georgia.

Andrew Hayek. Mr. Hayek is the president and CEO of Surgical Care Affiliates, where he also serves on the board of directors.

Tom Hearn, MBA. Mr. Hearn is managing principal for Novarus Healthcare, which hired him and changed its name from Novarus Mobile Technologies in January 2012.

Robert Henry. Mr. Henry joined Symbion in 2011 and serves as senior vice president of development.

Edward P. Hetrick. Mr. Hetrick, the founder and president of Facility Development & Management, has more than 30 years of experience in the healthcare industry, with over 20 years of ASC experience.

Carol Hiatt. Carol Hiatt is a registered nurse, certified operating room nurse, licensed healthcare risk manger and certified surgery center administrator.

Bo Hjorth. Mr. Hjorth is the vice president of business development at Regent Surgical Health. More than half of his 20-plus years in healthcare have been dedicated to the outpatient industry.

Stephen Hochschuler, MD. Dr. Hochschuler, founder of Texas Back Institute in Plano, has served as president of ISASS and founding member of the American Board of Spinal Surgery.

Tracy Hoeft-Hoffman, RN, MSN, MBA. Ms. Hoeft-Hoffman is the administrator of Fremont Surgical Center.

Jeremy Hogue, JD, MBA. Mr. Hogue is co-founder, president and CEO of Sovereign Healthcare, which operates surgery centers in California and Arizona.

Christopher Holden. Mr. Holden joined AmSurg in October 2007 as president, CEO and director. Mr. Holden is a healthcare industry veteran of more than 21 years.

Scott Holley, MD. Dr. Holley is the president and founder of Great Lakes Plastic & Hand Surgery in Portage and Battle Creek, Mich.

Tracey Hood. Ms. Hood is the administrator of Ohio Valley Ambulatory Surgery Center, which is managed by Ambulatory Surgical Centers of America.

Gregory Horner, MD. Dr. Horner is the managing partner of Smithfield Surgical Partners, a national ASC management and development firm.

Severko Hrywnak, MD. Dr. Hrywnak is founder and co-chairman of Project H.U.G.S. — Helping Uninsured Get Surgery.

Joseph W. (Woody) Hubbard. Mr. Hubbard is vice president of ambulatory care for Novant Health, a North Carolina Health System that includes 12 hospitals and 12 ASCs.

Richard Hynes, MD. Dr. Hynes is a spine surgeon who has been serving as president of The B.A.C.K. Center in Melbourne, Fla., since 1996.

Thomas Jacobs. Mr. Jacobs has served since 2003 as CEO and co-founder of MedHQ, a business office solutions provider for outpatient healthcare businesses.

Richard K. Jacques. Mr. Jacques, president and CEO of Covenant Surgical Partners, has more than 18 years of experience in the ASC industry.

Marion Jenkins, PhD. Dr. Jenkins is founder and CEO of QSE Technologies, an IT systems integrator in Denver.

Jack E. Jensen, MD, FACSM. Dr. Jensen is a board-certified orthopedic surgeon and medical director of Athletic Orthopedics and Knee Center.

Beth Ann Johnson, RN. Ms. Johnson is vice president of clinical systems for Blue Chip Surgical Center Partners.

Don Johnson, MD. Dr. Johnson is the medical director at Southeastern Spine Institute and Ambulatory Surgery Center in Mt. Pleasant, S.C.

Douglas V. Johnson, MBA. Mr. Johnson is COO of RMC Medstone Capital and has served on the board of directors of Physician Hospitals of America.

Jen Johnson, CFA. Ms. Johnson is a partner with VMG Health and oversees the professional services agreements division.

Sandra J. Jones, MBA, MS, CASC, FHMA. Ms. Jones is the executive vice president and chief operating officer of ASD Management.

Mike Karnes. Mr. Karnes is the CFO and co-founder of Regent Surgical Health. He oversees the financial aspect of all the Regent facilities.

I. Naya Kehayes, MPH. Ms. Kehayes is managing principle and CEO of Eveia Health Consulting & Management, based in Issaquah, Wash.

Wendy Kelley, CASC. Ms. Kelley serves as the administrator of Cool Springs Surgery Center in Franklin, Tenn., a five-OR, one-procedure room, multi-specialty facility.

David Kelly, MBA, CASC. Mr. Kelly is the administrator of Samaritan North Surgery Center, a multispecialty center with four ORs and two procedure rooms in Dayton, Ohio.

R. Matthew Kilton, MBA, MHA. Mr. Kilton is principal and COO of Eveia Health Consulting & Management, based in Issaquah, Wash.

Beverly Kirchner, RN, BSN, CNOR, CASC. Ms. Kirchner is the owner and CEO of Genesee Associates.

Susan Kizirian, RN, MBA. Ms. Kizirian is the chief operating officer of ASCOA. Ms. Kizirian has over 17 years experience in all aspects of ASC operations.

Chris Klassen. Mr. Klassen is the vice president of supply chain for Surgical Care Affiliates and s4. Mr. Klassen has more than 20 years of supply chain leadership experience in the healthcare industry.

Douglas D. Koch, MD. Dr. Koch is medical director of Baylor Vision, the refractive surgery clinical and research group at Baylor College of Medicine in Houston.

Marc E. Koch, MD, MBA. Dr. Koch is the president and CEO of Somnia Anesthesia.

Satish Kodali, MD. Dr. Kodali is an ENT physician and one of the physician owners of The Surgery Center in Franklin, Wis.

Greg Koonsman, CFA. Mr. Koonsman is a senior partner and founder of VMG Health, where he specializes in providing valuation, transaction advisory, feasibility and operational consulting services.

Peter Kosek, MD. Dr. Kosek practices at Pain Consultants of Oregon in Eugene. He most recently served as the president of the Oregon Society of Interventional Pain Physicians.

Lawrence E. Kosinski, MD, MBA. Dr. Kosinski has been in the practice of gastroenterology since 1984. He is currently one of the managing partners of the Illinois Gastroenterology Group.

Matthew Kossman. Mr. Kossman is a senior director at SCA. He has previous experience as a senior healthcare consulting manager at Pershing Yoakley & Associates.

Catherine W. Kowalski, RN. Ms. Kowalski is executive vice president and chief operating officer of Meridian Surgical Partners.

Donald Kramer, MD. With a medical practice spanning more than 25 years, He has developed several successful ASCs in the Houston market and is the founder of Northstar Healthcare.

Alan B. Kravitz, MD. Dr. Kravitz is a general surgeon at Montgomery Surgery Center in Rockville, Md., and advisor for Surgical Care Affiliate's supply chain team.

Timothy Kremchek, MD. Dr. Kremchek is one of the leading shoulder surgeons in the country and is a physician with Beacon Orthopaedics & Sports Medicine in Sharonville, Ohio.

Richard Kube, MD. Dr. Kube is the CEO, founder and owner of Prairie Spine & Pain Institute in Peoria, Ill.

Michael Kulczycki. Mr. Kulczycki is the executive director for the Ambulatory Accreditation Program at The Joint Commission.

Peter R. Kurzweil, MD. Dr. Kurzweil is the founder of the Surgery Center of Long Beach (Calif.) and is an internationally recognized orthopedic

surgeon with expertise in arthroscopic and reconstructive surgery.

Brent W. Lambert, MD, FACS. Dr. Lambert is a founder of Ambulatory Surgical Centers of America and was the developer and owner of three ambulatory surgical centers.

Luke M. Lambert, MBA, CFA, CASC. Mr. Lambert came to ASCOA, first as its CFO in 1997 and then becoming its CEO in 2002, with a broad background in finance, strategy, and operations.

Linda M. Lansing. Ms. Lansing serves as senior vice president of clinical services for Surgical Care Affiliates.

Matt Lau, CPA. Mr. Lau, corporate controller for Regent Surgical Health, uses his 16 years of finance and accounting experience to oversee the corporate accounting and cash management duties.

Gregory Lauro, MD. Dr. Lauro is the president and medical director of Laurel Surgical Center in Greensburg, Pa.

John W. Lawrence Jr. Mr. Lawrence joined Surgery Partners as senior vice president and general counsel in May 2011 when Surgery Partners acquired NovaMed, Inc.

Scott Leggett. Mr. Leggett is CEO of Surgery One and has more than 17 years of experience in orthopedics.

Lance J. Lehmann, MD. Dr. Lehmann is an interventional pain physician who spends a tremendous amount of time studying business and healthcare.

Jeffrey Leider, MD. Dr. Leider is a co-owner of Great Lakes Surgical Center in Southfield, Mich., as well as a physician and surgeon at the American Ear, Nose and Throat Institute in Farmington, Mich.

Jeff Leland. Mr. Leland is the CEO of Blue Chip Surgical Partners. He previously served as executive director of Lutheran General Medical Group and as a senior-level executive with Advocate Health Care.

Brad D. Lerner, MD, FACS. Dr. Lerner is the clinical director at Houston-based Summit Ambulatory Surgery Centers.

Jay R. Levinson, MD. Dr. Levinson serves as medical director of Michigan Endoscopy Center in Farmington Hills.

Bruce Levy, MD, JD. Dr. Levy is CEO of Austin (Texas) Gastroenterology and serves on the Texas Ambulatory Surgery Center Society Board of Directors.

Michael J. Lipomi. Mr. Lipomi is president and CEO of Surgical Management Professionals.

Stephen Lloyd, MD, PhD. Dr. Lloyd is a board-certified internist who has practiced in the Midlands in South Carolina for about 30 years.

Thomas Lorish, MD. Dr. Lorish is the medical director of the Providence Brain Institute in Portland, Ore.

Rodney H. Lunn. Mr. Lunn is the principal of the Surgical Health Group. Over the past 17 years, he has developed more than 150 ASCs throughout the United States.

James J. Lynch, MD, FACS. Dr. Lynch is a fellowship-trained spine surgeon and board-certified neurosurgeon and founder of Spine-Nevada in Reno.

Scott T. Macomber. Mr. Macomber joined Surgery Partners as executive vice president and chief financial officer in May 2011, when Surgery Partners acquired NovaMed, Inc.

Neal Maerki, RN, CASC. Mr. Maerki is the administrator of Bend (Ore.) Surgery Center. He started his career with BSC in 1997 as a nurse, then nurse manager and finally as administrator.

Anthony Mai. Mr. Mai is the senior vice president of healthcare finance at Sun National Bank.

Tom Mallon. Mr. Mallon is co-founder and CEO of Regent Surgical Health.

Laxmaiah Manchikanti, MD. Dr. Manchikanti is the CEO of Pain Management Center of Paducah (Ky.) and is also chairman of the board and CEO of ASIPP.

Ajay Mangal, MD, MBA. Dr. Mangal is the founder, CEO and a board member of Prexus Health Partners in Hamilton, Ohio.

Becky Mann. Ms. Mann is the director of Houston Orthopedic Surgery Center in Warner Robins, Ga.

Lee James Marek, DMP. Dr. Marek is a podiatrist at North Point Surgery Center in Fresno, Calif.

Lori Martin. Ms. Martin, administrator and director of nursing at SUMMIT Surgery Center.

Reed Martin. Mr. Martin, COO of Surgical Management Professionals, has more than 28 years of healthcare management experience.

Sarah Martin, MBA, RN, CASC. Ms. Martin is a vice president of operations for Meridian Surgical Partners.

Bryan Massoud, MD. Dr. Massoud is founder and head surgeon at Spine Centers of America in Fair Lawn, N.J.

Brian Mathis. Mr. Mathis is vice president of strategy at SCA, where he has served since 2009.

Theresa Mazzitti, MHA, MBA, CASC. Ms. Mazzitti is the administrator of Eastside Surgery Center, a multi-specialty surgery center.

Sara McCallum. Ms. McCallum is administrative director of Sheboygan (Wis.) Surgery Center, a multispecialty surgery, endoscopy and pain management center.

Rob McCarville, MPA. Mr. McCarville is a principal with Medical Consulting Group.

Kevin McDonald. Mr. McDonald is senior vice president of revenue cycle solutions division of SourceMedical Solutions.

Kevin McDonough. Mr. McDonough is a senior manager at VMG Health and is based out of the Dallas office.

Mike McKevitt. Mr. McKevitt offers Regent more than 20 years of senior management experience in developing ASCs and physician-focused joint ventures.

Dawn Q. McLane, RN, MSA, CASC, CNOR. Ms. McLane is vice president of consulting, development and integration for Health Inventures.

Bernard McDonnell, DO. Dr. McDonnell is a physician surveyor and team captain for Hospital Facilities Accreditation Program.

Alfred McNair, MD. Dr. McNair is a gastroenterologist who founded Digestive Health Center in Biloxi, Miss.

Cathy Meredith, RN, BS, CASC. Ms. Meredith serves as vice president of finance for Ambulatory Surgical Centers of America.

Todd Mello. Mr. Mello is a partner and co-founder of HealthCare Appraisers and manages the firm's Colorado office.

Douglas C. Melton. Mr. Melton is the finance director for Helena (Mont.) SurgiCenter, a position he has held since June 2010.

Tyler Merrill. Mr. Merrill is a vice president of operational development for ASCOA. Prior to joining ASCOA he worked as a sales representative for Pfizer Pharmaceuticals.

John Merski. Mr. Merski leads MedHQ's HR services area. With more than 30 years of experience, he is a highly experienced human resource executive.

Christopher Metz, MD. Dr. Metz is a board-certified general orthopedic surgeon at Brainerd Lakes Surgery Center in Baxter, Minn.

Keith Metz, MD. Dr. Metz is the medical director of Great Lakes Surgical Center in Southfield, Mich., which includes four ORs and one procedure room.

Thomas A. Michaud, CPA. Mr. Michaud is the CEO of Foundation Hospital Affiliates.

Ann Sells Miller. Ms. Sells Miller, partner and chief operating officer with Advanced Healthcare Partners.

Evelyn S. Miller, CPA. Ms. Miller is the vice president of operations for United Surgical Partners International.

Steve Miller. Mr. Miller is the director of government and public affairs with the ASCA.

T.K. Miller, MD. Dr. Miller is an orthopedic surgeon at the Roanoke (Va.) Ambulatory Surgery Center and Carilion Clinic Orthopaedics.

Charles Militana, MD. Dr. Militana is director of anesthesia at the Dorothy & Alvin Schwartz Ambulatory Surgery Center and director of ambulatory surgery centers for North American Partners in Anesthesia.

Krystal Mims. Ms. Mims is president of Texas Health Partners.

Kristian M. Mineau II. Mr. Mineau is the president and CEO of Constitution Surgery Centers, based in Newington, Conn., which operates 12 ASCs in the surrounding area.

Amy Mowles. Ms. Mowles is president and CEO of Mowles Medical Management.

Steve Mohebi. Mr. Mohebi is chief development officer of Smithfield Surgical Partners in Rocklin, Calif., and co-manages the company.

Jarod Moss. Mr. Moss is the vice president of strategy at USPI. He has held his current position since September 2007.

Arvind Movva, MD. Dr. Movva is currently CEO of Heartland Clinic, Valley View Anesthesia and Regional SurgiCenter, an eight-OR multispecialty ASC in Moline, Ill.

Tom Mulhern, MBA. Mr. Mulhern is the executive director of Limestone Medical Center, a large medical office building complex and ASC in Wilmington, Del.

Rob Murphy. Mr. Murphy is founder, president and CEO of Murphy Healthcare Group in Montvale, N.J., and New York City.

James E. Mutrie. Mr. Mutrie serves as vice president, assistant general counsel and compliance officer for United Surgical Partners International.

Jessica Nantz. Ms. Nantz is the president and founder of Outpatient Healthcare Strategies and has worked in the healthcare field for 25 years, 15 years focused in the outpatient setting.

Fred Naraghi, MD. Dr. Naraghi is an orthopedic spine surgeon and the director of the Comprehensive Spine Center in San Francisco.

Thomas "Tom" Newman. Mr. Newman is executive vice president and COO of Foundation Surgery Affiliates. He has seven years of experience in the ASC industry.

Robert Nucci, MD. Dr. Nucci is a fellowship-trained spine surgeon and founder of Nucci Spine & Orthopedics Institute in Tampa, Fla.

David W. Odell, CPA. Mr. Odell leads finance and partnership management for MedBridge. In addition, he is executive vice president and chief financial officer of TynanGroup, Inc.

Joan F. O'Shea, MD. Dr. O'Shea is a dually trained neurosurgeon and spine surgeon and founder of The Spine Institute of Southern New Jersey in Marlton.

Jon O'Sullivan. Mr. O'Sullivan was a senior principle and founding member of VMG Health and recently launched HealthEconomix.

Michael Orseno. Michael Orseno, Regent Surgical Health's revenue cycle director, maintains and enhances the revenue cycle process for all Regent facilities.

Bradford "Brad" Ottwell, CPA. Mr. Otwell is the CFO of Foundation Surgery Affiliates and has over 30 years of experience in financial, operational and managerial healthcare.

Bergein Overholt, MD, FACP, MACG. Dr. Overholt is a physician with Gastrointestinal Associates in Knoxville, Tenn.

Burak Ozgur, MD. Dr. Ozgur is a neurological spine surgeon at DISC Sports & Spine Center, based in Marina del Rey, Calif., and he leads its new location in Newport Beach.

Michael Pankey, RN, MBA. Mr. Pankey is the administrator of the Ambulatory Surgery Center of Spartanburg (S.C.).

Colin Park. Mr. Park is a manager at VMG Health in the Dallas office. He specializes in providing financial, valuation and transaction advisory services to the firm's healthcare clients.

Charles Peck, MD, FACP. Dr. Peck, an internist and rheumatologist, serves as president and CEO of Health Inventures. The company currently manages approximately 30 ASCs and surgical hospitals.

John H. Peloza, MD. Dr. Peloza is founder and medical director of the Center for Spine Care and founding physician partner of the Institute for Minimally Invasive Surgery in Dallas.

Jeff Péo. Mr. Péo is the vice president of acquisitions and development for the Ambulatory Surgical Centers of America.

Linda Peterson. Ms. Peterson is the CEO of Executive Solutions for Healthcare, based in Chandler, Ariz.

Kenneth Pettine, MD. Dr. Pettine is the co-founder of Rocky Mountain Associates in Orthopedic Medicine in Loveland, Colo., and the founder of the new Society for Ambulatory Spine Surgery.

Stanford R. Plavin, MD. Dr. Plavin has served as a member of Ambulatory Anesthesia of Atlanta since its inception and has been the managing partner for the last several years.

Thomas J. Pliura, MD, JD, PC. Dr. Pliura is a physician and attorney at law with the company he founded, zChart, an electronic medical records-related company.

John Poisson. Mr. Poisson joined Physicians Endoscopy in September 2000 and is now executive vice president of strategic partnerships.

William A. Portuese, MD. Dr. Portuese is the current president of the Washington ASC Association and Washington State Chapter of Facial Plastic Surgeons.

Marti Potter. Ms. Potter is the administrator of Jersey Shore Ambulatory Surgery Center, a position she has held since September 2008.

Greg Poulter, MD. Dr. Poulter is a spine surgeon at Vail (Colo.) Summit Orthopaedics. He was among the first surgeons to perform minimally invasive spinal fusion.

Stefan Prada, MD. Dr. Prada is an orthopedic spine surgeon with Laser Spine Institute where he performs minimally invasive spine surgery procedures.

William Prentice. Mr. Prentice is the chief executive officer of the ASCA and Ambulatory Surgery Foundation.

Vito Quatela, MD. Dr. Quatela co-founded AHS and serves as CEO. He developed and owns two ASCs in Rochester, N.Y.

David J. Raab, MD. Dr. Raab is on the board of managers at the Illinois Sports Medicine & Orthopedic Surgery Center in Morton Grove, Ill.

Terry Rajendran, MHA. Ms. Rajendran is co-founder and CEO of Johnstown, Colo.-based LaClaro, a revenue cycle software company that specializes in the ASC market.

Lori Ramirez. Ms. Ramirez is the founder, president and CEO of Elite Surgical Affiliates, which was founded in 2008.

Lesley Raskin. Ms. Raskin joined Surgical Care Affiliates in March 2011. In her current role as director of strategy, she divides her time between regional and enterprise initiatives.

Michael R. Redler, MD. Dr. Redler is a founding partner of The Orthopaedic and Sports Medicine Center in Fairfield, Conn.

Karen Reiter. Ms. Reiter is the administrator at D.I.S.C. Sports & Spine Center in Marina Del Ray, Calif., a position she has held since 2006.

Chris Revell. Mr. Revell manages project and implementation services for Surgical Notes MDP, LP.

Blair Rhode, MD. Dr. Rhode offers practices with Orland Park Orthopedics as a solo practitioner that specializes in orthopedic sports medicine. He owns 100 percent of his own surgery center.

J. Michael Ribaudo, MD. Dr. Ribaudo serves as CEO and chairman of Ballwin, Mo.-based Surgical Synergies.

Gary A. Richberg, RN, ALNC, CRN-A/C, CASC, CAPPM. Mr. Richberg is the administrator at Pacific Rim Outpatient Surgery Center in Bellingham, Wash.

Patrick Richter. Mr. Richter is the vice president of business development for United Surgical Partners International.

Herbert W. Riemenschneider, MD. Dr. Riemenschneider is the principal physician and urologic surgeon at Riverside Urology in Columbus, Ohio.

Anne Roberts, RN. Ms. Roberts is the administrator at the Surgery Center at Reno.

Will Roberson. Mr. Roberson serves as vice president of Medical Facilities Group.

Beverly Robins. Ms. Robins serves as director of accreditation services for Healthcare Facilities Accreditation Program.

Regina Robinson. Ms. Robinson is the director and administrator at Peninsula Surgery Center in Newport News, Va.

Steven Robinson, MD. Dr. Robinson is a board member and practicing plastic surgeon at Riverside Outpatient Surgery Center in Columbus, Ohio.

Lisa Rock. For the past 10 years, Ms. Rock has served as president of National Medical Billing Services, one of the largest ASC billing companies in the country.

Jay Rom, MBA, CPA. Jay Rom, MBA, CPA, is president of Blue Chip Surgical Partners, an ASC management and development company.

Stephen Rosenbaum. Mr. Rosenbaum is CEO for Interventional Management Services. He has more than 15 years of healthcare experience working with physicians and physician-owned facilities.

Kenneth L. Rosenquest. Mr. Rosenquest is the senior vice president of operations at Constitution Surgery Centers, based in Newington, Conn.

Jason Ruchaber. As a partner in HealthCare Appraiser's Colorado office, Mr. Ruchaber is head of the company's business valuation services.

Michael Rucker. Mr. Rucker is the executive vice president and COO of SCA. He has previous experience as a divisional vice president of operations at DaVita.

Cathy Rudisill. Ms. Rudisill is a partner at Nelson Mullis Riley & Scarborough, with more than 20 years of experience in commercial real estate and financial transactions.

L. Edwin Rudisill, Jr., MD. Dr. Rudisill is one of the leading hand surgeons in the country and practices with The Hand Center in Greenville, S.C.

Blayne Rush. Mr. Rush is president of Ambulatory Alliances, a boutique investment banking, business brokerage and strategic advisory firm for surgery and radiation oncology centers.

Michael E. Russell II, MD. Dr. Russell is a spine surgeon at Azalea Orthopaedics in Tyler, Texas.

Mary Ryan, RN. Ms. Ryan is the administrator of Tri State Surgery Center, a multispecialty facility in Dubuque, Iowa.

Karen Sablyak, CPA. Ms. Sablyak is CFO and executive vice president of management services at Physicians Endoscopy, which develops and manages endoscopic ASCs.

April K. Sackos. Ms. Sackos is vice president of revenue cycle management. She has over 24 years of healthcare experience.

Nader J. Samii. Mr. Samii is CEO of National Medical Billing Services, a leading revenue cycle outsourcing company focused strictly on ASCs.

Kuldip S. Sandhu, MD, FACP, FACG. Dr. Sandhu is a gastroenterologist at the Sutter Roseville (Calif.) Endoscopy Center in and is president of Capitol Gastroenterology Consultants Medical Group.

Bobby Sarnevesht. Mr. Sarnevesht is at Bay Area Surgical Management, one of the largest and fastest growing ambulatory surgery center providers in the San Francisco Bay Area.

Marcy Sasso. Ms. Sasso is currently the director of operations at Ambulatory Surgical Center of Union County in the greater New York City area.

Tona Savoie, RN. Ms. Savoie is administrative director of Bayou Region Surgical Center in Thibodaux, La.

Yousuf Sayeed, MD. Dr. Sayeed practices at The Spine Center of DuPage Medical Group.

John Schario, MBA. Mr. Schario is CEO of Nueterra Healthcare and brings together the extensive resources that let Nueterra develop, operate and nurture ambulatory care facilities.

Bob Scheller Jr., CPA, CASC. Mr. Scheller is the COO of the Nikitis Resource Group. In the past 15 years, he has been involved in the development and management of more than 50 surgery centers.

Donald Schellpfeffer, MD. Dr. Schellpfeffer is CEO of Medical Facilities Corp., and has more than 18 years of experience in ambulatory surgical environments.

Robert M. Schwartz, JD. Mr. Schwartz is managing director of strategic resources with Proliance Surgeons.

Simon Schwartz. Mr. Schwartz joined Pinnacle III in April 2010, where he works on new client development for the operational development, management and billing of ambulatory surgery centers across the country.

Bruce A. Scott, MD. Dr. Scott is the medical director of SurgeCenter of Louisville (Ky.) and serves on the physician leadership team for SCA.

Matt Searles. Mr. Searles is the managing director of Merritt Healthcare, a company he has served with for more than 10 years.

Phenelle Segal, RN, CIC. Ms. Segal is the president of Infection Control Consulting Services.

Ken Seip. Mr. Seip serves as a vice president of the Project, Structured and Leverage Finance/ Healthcare business of Siemens Financial Services, a wholly owned subsidiary of Siemens, AG.

John Seitz. Mr. Seitz is the co-founder, chairman and CEO of Ambulatory Surgical Group. He also serves as CEO of MMX Holdings, which includes the Manage My ASC platform.

Caryl Serbin, RN, BSN, LHRM. Ms. Serbin is executive vice president and chief strategy officer for SourceMedical, which provides clinical and business software solutions for ambulatory surgery centers.

David Shapiro, MD. Dr. Shapiro is a partner with Ambulatory Surgery Co., an ASC consulting company.

Jeffrey Shanton. Mr. Shanton is the director of billing at Journal Square Surgical Center in Jersey City, N.J.

Carla Shehata, RN, BSN. Ms. Shehata is vice president of operations for Regent Surgical Health. She is responsible for daily operations in addition to clinical survey readiness.

Joshua A. Siegel, MD. Dr. Siegel is medicine director at Access Sports Medicine & Orthopaedics in Exeter, N.H., and the founding partner and managing member of Northeast Surgical Care.

Patrick Simers. Mr. Simers is executive vice president of Principle Valuation. He has valued all tangible and intangible assets associated with healthcare enterprises.

Jeffrey Simmons. As chief development officer for Westchester, Ill.-based Regent Surgical Health, Mr. Simmons is responsible for overseeing the company's acquisition and development of surgery centers.

Lynda Dowman Simon. Ms. Simon is the administrator at St. John's Clinic: Head & Neck Surgery in Springfield, Mo.

Bill Simon. Mr. Simon is co-founder and vice president of Innovative Healthcare, which he founded in 1995.

Thomas A. Simpson, MD, FACS. Dr. Simpson is chairman of the board of directors for the Iowa City Ambulatory Surgery Center and led the board of this multispecialty ASC.

Carol Slagle, CASC. Ms. Slagle is the administrator of Specialty Surgery Center of Central New York, managed by ASCOA.

John Smalley. Mr. Smalley is a current special consultant and former principal with Healthcare Venture Professionals.

Brooke Smith. Ms. Smith is administrator of the Maryland Surgery Center for Women in Rockville, a center affiliated with Ambulatory Surgical Centers of America.

Daren Smith. Mr. Smith is responsible for clinical activities associated with development of Surgical Management Professionals sites.

Brendan Snyder. Mr. Snyder, president of Healthcare Strategy & Research Consultants, has over 28 years of experience in the acute care hospital market, consulting, and physician engagement.

Sheldon S. Sones, RPh, FASCP. Mr. Sones is president of Sheldon S. Sones and Associates, a pharmacy and accreditation consulting firm based in Newington, Conn.

Kenny Spitler. Mr. Spitler is senior vice president of development at Nueterra in Nashville.

Donna St. Louis. Ms. St. Louis currently serves as a vice president for ambulatory services at BayCare Health System.

Jimmy St. Louis III, MBA. Mr. St. Louis is the CEO of Advanced Healthcare Partners as well as a strategic advisor to Laser Spine Institute.

Donald E. Steen. Mr. Steen founded United Surgical Partners International in February 1998 and served as its CEO until April 2004.

Marc Steen. Mr. Steen is market president in Atlanta for United Surgical Partners International, where he oversees six USPI ambulatory surgery centers in the Atlanta market.

John C. Steinmann, DO. Dr. Steinmann treats traumatic spinal injuries as well as degenerative problems of the neck and low back.

Steven H. Stern, MD, MBA. Dr. Stern is vice president for Cardiac & Orthopedics and Neurosciences at UnitedHealthcare.

Jim Stilley. Mr. Stilley is the CEO of Northwest Michigan Surgery Center, a multispecialty surgery center in Traverse City, Mich.

Debra Saxton Stinchcomb, RN, BSN, CASC. Ms. Stinchcomb is a consultant at Progressive Surgical Solutions.

Stephanie L. Stinson, RN, BSN, CASC. Ms. Stinson is administrative director for Strictly Pediatrics, a pediatrics-only ASC in Austin, Texas, managed by ASD Management.

Lewis Strong, MD. Dr. Strong is the president of the Skyline Endoscopy Center in Loveland, Colo., a Pinnacle III facility.

Michael Stroup. Mr. Stroup serves as USPI's vice president in development and has over 16 years of healthcare experience.

C. Scott Stone. Mr. Stone is the executive vice president and chief financial and administrative officer for SourceMedical Solutions.

Shaun Sweeney. Mr. Sweeney is the vice president of sales at Cygnus Medical, a company that specializes in products and services.

Alsie Sydness-Fitzgerald, RN, CASC. Ms. Sydness-Fitzgerald is on the board of directors for the ASCA and participated in the develop-

ment of the Certified Administrator Surgery Center credential.

Kevin Tadych, MD. Dr. Tadych is medical director Northwoods Surgery Center in Woodruff, Wis., a Pinnacle III facility.

Keri Talcott. Ms. Talcott joins Surgical Management Professionals with over 10 years of healthcare management experience.

Barry Tanner. Mr. Tanner has been president and CEO of Physicians Endoscopy since 1999. The company currently manages 17 endoscopy centers.

Vivek Taparia. Mr. Taparia is director of business development for Regent Surgical Health.

Larry Taylor. Mr. Taylor is president and CEO of Practice Partners in Healthcare.

Larry Teuber, MD. Dr. Teuber is the founder and physician executive of Black Hills Surgery Center, one of the country's most successful small surgical hospitals.

David Thoene. Mr. Thoene is a founder of Medical Surgical Partners. He was previously the vice president of business development for Titan Health.

Dan Thomas. Mr. Thomas is the president of Provista, a group purchasing company. He is the former CEO of VIant, a large independent PPO network.

Joyce (Deno) Thomas. Ms. Thomas is senior vice president of operations for Regent Surgical Health.

George Tinawi, MD. Dr. Tinawi is a co-founder of Surgery Center Partners and its management subsidiary, Endoscopy Management Services Organization.

William Tobler, MD. Dr. Tobler is a neurological surgeon and president and director of neurosurgery at The Christ Hospital Spine Surgery Center in Cincinnati.

Daniel J. Tomes, MD. Dr. Tomes is a neurological and spine surgeon and president of Southwest Lincoln (Neb.) Surgery Center, a Blue Chip Surgical Partners facility.

Kimberly L. Tude Thuot, MAOM, CMPE. Ms. Tude Thuot is the administrator and executive of Yakima (Wash.) Ambulatory Surgical Center.

Rebecca S. Twersky, MD. Dr. Twersky is the vice-chair for research and professor of anesthesiology at SUNY Downstate Medical Center at Brooklyn.

Arnaldo Valedon, MD. Dr. Valedon is the chief ambulatory division and managing partner of First Colonies Anesthesia Associates in Baltimore.

LoAnn Vande Leest, RN. Ms. Vande Leest is the administrator at The Surgery Center, a large, multispecialty ASC located in Franklin, Wis.

Pedro Vergne-Marini, MD. Dr. Vergne-Marini is founder and managing member of Physicians' Capital Investments, which is based in Plano, Texas.

Jonathan Vick. Mr. Vick is founder and president of ASCs Inc., which is based in Valley Center, Calif., and has assisted in development, merger and acquisition transactions.

George A. Violin, MD. Dr. Violin is the founder of Medical Eye Care Associates in Massachusetts. He devotes most of his practice to cataract surgery, LASIK and related surgeries.

Alan Villavicencio, MD. Dr. Villavicencio founded The Minimally Invasive Spine Institute in Boulder, Colo., and serves as the director of surgery.

Jeffrey L. Visotsky, MD, FACS. Dr. Visotsky is a member of Illinois Bone and Joint Institute and founder of the Morton Grove (Ill.) Surgery Center.

Kara Vittetoe. Ms. Vittetoe is the administrator of a one-OR, two-procedure room, multispecialty surgery in a growing rural area.

Brice Voithofer. Mr. Voithofer leads the anesthesia, pain management and surgery center division of AdvantEdge Healthcare Solutions.

Jack Wagner. Mr. Wagner is president and CEO of Micro-Scientific Industries, a company focused on producing products to prevent microbial transmission in the healthcare industry.

Dianne Wallace, RN, BSM, MBA. Ms. Wallace is the executive director of the Menomonee Falls (Wis.) Ambulatory Surgery Center, a multispecialty ASC.

Randy Ware. Mr. Ware is the president and founder of West Coast Medical Resources, a medical supplies surplus company.

Michelle Warren, RN, BBA. Ms. Warren is the executive director of Powder River Surgery Center in Gillette, Wyo.

Michael Weaver. Mr. Weaver is vice president of acquisitions ambulatory network with Vanguard Health Systems, which owns and operates 28 acute-care and specialty hospitals and complementary facilities.

Suzanne Webb. Ms. Webb is the COO of ASC Billing Specialists, a billing company that serves surgery centers and physician practices.

Drigan Weider, MD. Dr. Weider is a board member of Boulder (Colo.) Surgery Center, a Pinnacle III facility.

Thomas Wherry, MD. Dr. Wherry is co-founder of Total Anesthesia Solutions.

Robert Westergard, CPA. Mr. Westergard is the chief financial officer for ASCOA.

Kathleen Whitlow, RN, BS, CASC. Ms. Whitlow serves as COO for Blue Chip Surgical Center Partners. She joined the company as a partner and vice president of operations.

Carolyn Whitsel. Mr. Whitsel has more than 35 years in healthcare, including 23 years of ASC experience.

William H. Wilcox. Mr. Wilcox is the founder and chairman of United Surgical Partners International, which was established in 1998.

Donald Wilson. Mr. Wilson founded a predecessor to Cirrus Health in 1996 and now serves as Cirrus' CEO.

Kimberly L. Wood, MD. Dr. Wood is co-chair of the ASC Quality Collaboration and founder of kmdWOOD, which provides consulting services to the ASC industry.

Kim Woodruff. During Ms. Woodruff's tenure with Pinnacle III, her role has evolved from vice president of business office operations to her current role as vice president of corporate finance and compliance.

Tom Yerden. Tom Yerden is the owner of TRY Health Care Solutions in North Fork, Idaho, an outpatient surgery management consulting firm.

Cindy Young, RN, CASC. Ms. Young is the administrative director of the Surgery Center of Farmington (Mo.), where she started as a staff nurse and moved into the administrator position.

David Zarin, MD. Dr. Zarin is senior vice president, medical affairs, for United Surgical Partners International and one of the founding partners of Texas ENT Specialists in Houston.

Joseph Zasa, JD. Mr. Zasa is a managing and founding partner ASD Management, where he works with existing ASCs that require turnaround expertise as well as developing new outpatient surgery centers.

Robert Zasa, MAHHA, FACMPE. Mr. Zasa is a managing and founding partner of ASD Management. His career spans more than four decades of managing and developing ASCs.

J.A. Ziskind, JD, MBA, PhD. Mr. Ziskind is the founder, president and CEO of Global Surgical Partners, which focuses on developing and managing hospital/physician and physician-owned joint-ventured ASCs.

Greg Zoch. Mr. Zoch is managing director and a partner with Kaye/Bassman, where he has marketed healthcare organizations and been involved in recruitment.

Chris Zorn. Mr. Zorn is vice president at Spine Surgical Innovation, global distributor of the Swivel Port MIS System. ■

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