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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

October 2011 • Vol. 2011 No. 8

30 Predictions on the Future of Ambulatory Surgery Centers

By Rob Kurtz

Becker's ASC Review queried a number of ambulatory surgery center physicians, administrators and company executives asking them to make predictions pertaining to the immediate, short- and long-term future of ASCs and the ASC industry. These predictions could apply to any aspect of surgery centers and the industry.

Here are 30 predictions from 14 leaders, organized by the last name of the source.

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Will There Be Enough Physician-Investors in ASCs in the Future?

By Leigh Page

At a time when some physician-owners of surgery centers enter hospital employment or contemplate retirement, there may not be enough physician-investors to take their place, some officials at ASC management companies say.

Physicians dropping ownership stakes

Brent W. Lambert, MD, founder and CEO of Ambulatory Surgical Centers of America, says baby boomers nearing retirement may lead to a considerable sell-off of shares in surgery centers. "These physicians face

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Finding the 'New Spine': 7 Procedures Moving Into the ASC Setting

By Rachel Fields

If surgery center leaders can identify and add an up-and-coming procedure to their list of approved procedures prior to their competitors doing such, they may be able to corner the market and profit tremendously before the surgery becomes widespread. Lori Vernon, regional vice president of operations for Health Inventures, and Goran Dragolovic, senior vice president of operations for Surgical Care Affiliates, discuss seven procedures and subspecialties that could provide expansion opportunities for ASCs.

1. Unicompartmental knee replacements. According to Ms. Vernon, unicompartmental knee replacements were performed in the inpatient setting about 10 years ago, but quickly fell from popularity because of adverse outcomes. As implant technology has

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Publisher's Letter

We are seeing a tremendous amount of positive and negative activity in the ASC industry. Here are a few quick observations:

1. On the negative side:

A. Increased competition and litigation regarding physicians who are being acquired and/or employed by hospitals.

B. Increased peer review actions by centers regarding physician quality issues.

C. More compliance review efforts regarding billing and coding.

D. More consolidation among payors and more aggressiveness against payors — at times, they act like nipping or baying dogs.

E. Increased acquisitions of practices by hospitals.

F. Increased competition for a limited number of doctors.

2. On the positive side, we see:

A. Strength and backbone from the leading ASC specialties as to remaining independent — i.e., not becoming employed by hospitals.

B. Continued profitability at a great number of centers.

C. Great interest in buying centers by hospitals and national companies.

D. The possibility of a changing attitude in Congress — and, in the long run, the White House (albeit after 2012) — towards entrepreneurial healthcare.

E. Some hospital systems again looking seriously at ASC cluster strategies.

F. The periodic movement of new types of procedures into ASCs.

G. ASCs smartly managing their margins, given the pressure on revenues in some places.

H. Several management companies greatly streamlining and improving their own shops.

We hope you find this issue helpful. Should you have any questions or can we be of any help, please contact Scott Becker, publisher of Becker's ASC Review, at sbecker@beckershealthcare.com or call (800) 417.2035.

Very truly yours,

Scott Becker

30 Predictions on the Future of Ambulatory Surgery Centers
(continued from page 1)

John D. Brock, administrator of NorthStar Surgical Center in Lubbock, Texas:

1. Procedures will continue to migrate from ASCs from hospitals. "ASCs will more and more be doing cases traditionally done in the hospital. At NorthStar, we are once again doing total joint procedures. To be able to offer the appropriate patient an outpatient procedure (overnight for knees and ankles and same-day for shoulders) that has historically required a multiple-day hospital stay is in the best interest of the patient, the payor and the system. This is also consistent with our mission, and the mission of ASCs, of providing unparalleled medical expertise and cost-effective care."

Jack Egnatinsky, MD, president of the AAAHC board and retired anesthesiologist:

2. ASCs will not benefit from participating in ACOs. "Hospitals, which will dominate ACOs, will not let the two-tiered payment approach for ambulatory surgery exist within their ACOs. They will siphon off all of the profitable cases to the HOPD by being able to direct referrals. ACOs will prove to be a failure — many more of them will cost the providers money than will bring in 'bonus' payments for efficiency and cost savings."

3. Web-based accreditation/certification in healthcare will lead to a lower standard of care. "ASCs that accept web-based training and re-certification, for example in ACLS and PALS, have no assurance that their staff and/or medical staff has demonstrated proficiency in the use of an AED, cardiac compression or airway management. Simple reliance on EMRs and written policies does not validate what actually takes place in the centers and is observed in on-site visits, whether it be ASCs or medical homes."

4. Natural orifice and other 'gimmick' surgical approaches to avoid scarring will gradually disappear. "There are still scars, just not visible ones, which can lead to adhesions and other future problems. They will become unnecessary as new mini- or micro-fibers and tubes, which pass through barely visible incisions, are developed to allow sampling of tissue for pathologic examination, precise 'cutting' and cauterization and vaporization with removal of the tissue vapors in a closed-filtered system. This may seem very radical, but as I think back to 1966 and my first anesthetic for a cataract extraction — general anesthesia with deep extubation so the patient would not cough and extrude vitreous, sand bags on each side of the head, 45 minutes of operating time and 7-10 days in the hospital for recovery. This does not at all seem far fetched to me."

Sandra J. Jones, MBA, MS, CASC, FHMA, executive vice president and COO of ASD Management and president of Ambulatory Strategies:

5. Same-store growth will be one of the most significant factors for ASCs to maintain success. "With decreasing or flat reimbursement and increasing operating expenses, ASCs will need to focus on improving volume. Adding new physicians to the surgery center medical staff and being sure those physicians are not "one and done" when they make the commitment to try the surgery center are critical to the surgery center's long-term financial health."

6. Quality outcomes will finally be rewarded. "Insurers are using claims data to determine who should be in a network. Some already have de-

veloped a super restricted provider network that rewards physicians who have a history of an acceptable treatment program and excellent patient outcomes. Pain management is one specialty that insurers are targeting. More insurers will mine their claims data to select providers, which means surgery centers will need to be aligned with the right providers as payors continue to advance their analysis of payment for episodes of care."

Brent W. Lambert, MD, founder and CEO of Ambulatory Surgical Centers of America:

7. Reimbursement will continue to decline. "Out-of-network arrangements are going away and CMS is not allowing Medicare increases to cover their true inflationary costs. Surgery centers are falling more behind year after year. ASCs will remain the low-cost, high-quality providers for outpatient surgery. That means their future is basically bright. The only thing that can dim it is more cuts in reimbursements."

8. ASC industry will continue consolidating. More ASCs are joining larger organizations, such as management companies, hospitals and health systems. Small ASC management companies without an equity stake in their centers will have difficulties growing. They will have less access to bank loans and private equity. "One key contributing factor is their inability to finance a pipeline of projects."

9. Private equity funds are losing interest in ASCs. The new equity funds are showing declining interest in the ASC space. There are exceptions like H.I.G., which is buying NovaMed and taking it private. "Virtually no new funds are entering the ASC market, and some of the funds that have been there are getting out."

10. Healthcare reform carries a cloud of uncertainty. "Nobody knows how healthcare reform will work out." Congress, the courts and regulators could significantly change it. "What healthcare reform finally looks like is anybody's guess." The challenges in healthcare reform for ASCs include the Independent Payment Advisory Board, the influx of millions of more low-paying Medicaid patients and the introduction of accountable care organizations. "There is no incentive to start an ACO and plenty of disincentives not to."

Amy Mowles, president and CEO of Mowles Medical Management:

11. Failure to remain flexible, aware of industry changes will lead to problems. "Slowed reimbursement and tighter regulations means ASCs will have to work smarter, not harder. They must be acutely aware of what is going in the ASC industry, with their own specialties and with Medicare and Commercial payor activities. They must have a plan in place to address immediate, short- and long-terms goal and be flexible. They must also be ready for ACOs, as this could affect physician referral patterns."

Scott Palmer, president and COO, ambulatory surgery center division of SourceMedical:

12. Cloud computing will continue expansion into ASCs. "Another way to view cloud computing is the shift of your server hardware and software from on-premises to off-premises. The question is not whether this shift will occur for most healthcare providers but when and how. The business case for cloud computing is driven by lower total cost of ownership, reduced risk, improved performance, anywhere/anytime access, improved interoperability and agility. Independent ASCs and networked facilities will welcome not having to worry about performing backups, equipment failure, periodically replacing hardware and software, installing software updates and other worries associated with maintaining an in-house IT solution."

13. Increasing use of social media will impact utilization and referrals. "Twenty-three percent of social media users reporting discussing their healthcare experience and seeking advice through their linked contacts. With the continuing rapid expansion of social media utilization into daily life, you can be sure that there will be a meaningful impact on how people share their experiences and recommendations. This bodes well for physicians and ASCs that provide a great patient experience."

14. Clinical automation will see continued increase in ASCs. "We are continuing to see steady growth in adoption of an electronic health record into ASCs. Growth is driven by proven ROI, pressure from surgeons who no longer expect to be using a paper-based chart and an interest to get ahead of the curve before a government-mandated solution. Most facilities and corporate accounts are still in an evaluation phase but many facilities are now installing with great success."

Thomas J. Pliura, MD, JD, PC, physician, attorney at law and founder of zChart:

15. Private practice of medicine will continue to flourish. "Many people in the healthcare industry believe the end of the private practice of medicine is at hand. I predict the private practice of medicine will continue to flourish for essentially all medical providers, especially physicians. Many 'experts' predict the demise of physician groups which are not affiliated with large hospital systems. I predict that is all hogwash. I do not believe hospitals know how to practice medicine. Physicians practice medicine. Hospitals are frantically trying to develop healthcare delivery models that protect their status quo — that is, their revenues. I believe all healthcare providers need to be able to adapt to a rapidly changing environment.

"It is my belief that hospitals, by their very nature, are examples of an inefficient delivery system. Traditional large medical providers such as large hospital systems are plagued by multi-levels of inefficient middle management. I think traditional medical providers will need to adapt and change to accommodate the forces that are driving the changes in medicine. The greatest force is the need for economic efficiencies, in my opinion."

16. Outpatient settings will drive efficiency in healthcare. "I predict outpatient delivery systems, including ASCs, will be one of the drivers in forcing the healthcare system to become more efficient. Historically the payors (federal, state and commercial) have reimbursed hospitals at a higher rate than outpatient surgery centers. I predict that in the not-to-distant future these payment disparities will begin to evaporate. There is no valid reason why two medical providers should be paid differently for providing the exact same type of service. I do not believe society will continue to approve of these disparate reimbursement methodologies simply based on an argument that the hospital delivery system is more costly, thus society should pay a higher price."

17. Insurance companies will continue efforts to align with health systems to obtain price breaks. "I predict insurance companies will continue to attempt to try and align with large health systems to obtain pricing breaks on certain inpatient services such as ICU pricing, neonatal pricing and other high-cost service centers. The U.S. Department of Justice has begun to look at these relationships as being anticompetitive and driving up the cost of healthcare. As an example, the DOJ has filed and antitrust lawsuit against Blue Cross Blue Shield of Michigan, challenging Blue Cross of practices which are alleged to be anticompetitive and cause increases in the cost of healthcare, to the detriment of society. I predict in the not-to-distant future many of the larger insurance companies will be forced to change many of their policies which are in effect today. I believe this will result in ASCs playing an even larger role in the delivery of outpatient medicine.

Blayne Rush, MHP, MBA, president of Ambulatory Alliances:

18. Financial investors will assume a larger role. "While it is well noted that we are seeing increased consolidation up and down the ASC vertical with individual centers, multi-center groups and ASC management companies, I believe in the near term we will see more financial investors playing a larger role in the ASC market. Historically speaking, ASC management companies have lead the way as far as highest purchase price paid for surgery centers, then came the hospitals competing with the ASC management companies around price paid. I believe that now and in the

near future, financial buyers (i.e., private equity groups) will outpace all of them as far as price paid.

"To understand this, you need to understand a little bit about private equity groups. PEGs obtain money for the most part from intuitional investors, and high net worth families/individuals. Generally speaking, they are typically paid on a two and twenty basis: two percent on the amount under management and 20 percent of the gain in the value of the fund. Funds are typically set up with a 10-year fund life and 6-year investment duration. Think 10 years to invest for six.

"The catch is that the typical agreement is that if they do not deploy the money, they will have to give back the 2 percent management fee. So if they have a $100 million fund and are in year three of the fund, they have taken $6 million in management fees. If they have 6-year investment, they must deploy the money by the end of year four or give back the $2 million per year that they have taken out of the fund for management fees. Knowing that, and that PitchBook found a $418 billion overhang (dry powder/undeployed funds) in 2010, increasing more than $211 billion since 2007, what does that tell you? The vast majority of the funds will not want to return money they have already spent and are on the prowl for investments. All that dry powder has a deadline, and firms are very aware of that which could stimulate some to think getting the deal is more important than getting the best deal, which is good for ASCs.

"The majority of PEGs look for deals bigger than the one ASC deals, but because they are attracted to the ASC space, are facing increasing pressure to invest and there is more money than deals, financial buyers are looking to buy one-off centers and the smaller regional ASC companies to consolidate them. They will do this in a motivated way and in a not so disciplined manner."

19. Local community bank lending will grow. "For single ASC project debt sources, I believe local community bank lending will grow. To many people's disbelief, banks have cash to lend and need to place debt. Regional and national banks are very tight when it comes to placing debt on smaller projects; they perceive there is less risk lending on larger projects. Many banks have taken a bath with the downturn in real estate and the overall economy. With all banks being overly cautious in placing debt for real estate, they are in search of alternatives to lend on.

"Some national experts have published that historically as much 80 percent of small community bank's debt portfolios have been held in real estate. Thus, they are in search of safer alternative non-real estate projects and they see physician-centric surgery centers as a strong alternative. Even though you believe you have a strong relationship with a regional bank, search the market local to the project for funding for your next ASC; you just might be surprised."

Mike Russell, MD, of Azalea Orthopedics in Tyler, Texas, and president of Physician Hospitals of America:

20. ASCs will integrate with hospitals in the short and intermediate-term, but the ASC model will experience resurgence in the long-term. "ASCs have been an integral part of the evolution of procedures out of the high-cost and inefficient arena of full-service hospitals. Unfortunately the government's policies are driving independent ASCs to sell to hospitals, where they are losing their independent spirit and are becoming more costly to society. These policies will drive short- and intermediate-term decisions, forcing many ASCs to sell and integrate with full-service hospitals. I believe, however, that in the long-term medicine will have to be disrupted, so that more procedures will become outpatient, even office-

based, and therefore there will be a resurgence of the ASC model."

Bob Scheller, CEO and COO of Nikitis Resource Group :

21. To preserve the physician-owned model, more ASCs will consider co-management. "We see the co-management model as the way to continue a successful physician-owned venture — one with a hospital partner but following the co-management rules. That is all driven by reimbursement. If we were in the environment of the old age of reimbursement, we probably wouldn't be doing this but third-party payors look at hospitals and give them a much higher payment for the same procedure. They pay for hospitals for parts; they don't pay for parts in the ASC. To preserve physician participation and physician management, that's where you'll continue to get your efficiencies. If the hospital is allowed to 'hospitalize' the project, that seems to be where inefficiencies arise."

22. Hospitals and payors are increasingly eyeing surgery center partnerships. "With the advent of accountable care organizations, many hospitals are looking for an efficient surgery center right now. And if I were a payor group, I'd be looking for a couple of surgery centers as well. If I were running a health plan, I would have physicians enrolled and would be looking to work out real estate partnerships and things for the docs and still keep that efficient ASC model, even though I would have to add a substantial number of specialists. It seems like it's all going to be driven by efficiency, and isn't that the reason ASCs were started in the first place?"

John Seitz, CEO of ManageMyASC.com and chairman and CEO of Ambulatory Surgical Group:

23. There will be growing reliance on benchmarking tools and resources for sustainability. "Physicians and owners will begin to rely more on analytical and business intelligence tools to measure and tune the business of their surgical center, to quickly identify problems before they impact the bottom line and to recognize and capitalize on opportunities. While it has always been critical to set targets, measure results and benchmark data, the ability to do this in a quick and efficient manner will change the way owners and managers interact and respond on a real-time basis, and those ASCs that do not take advantage of available resources will fall behind."

24. "Closed networking" will change the practice of business. "Physicians, operators and patients will take more advantage of "closed networking" (such as LinkedIn and "peer-to-peer" websites) to gather information and to make decisions. On the provider side, we will use these tools to discuss reimbursements and contracts, review/rate equipment and vendors and explore other opportunities and partnerships. For patients, they will use these tools to learn about treatment options, payments and charges, quality measurements and results."

David Shapiro, MD, CASC, CHC, CH-CQM, CHPRM, LHRM, co-chair of the Ambulatory Surgery Center Quality Collaboration, chair of the Ambulatory Surgery Center Association and partner in Ambulatory Surgery Co.:

25. ASCs' role in the healthcare system is set to change. "Broadly, what I do see changing in the near future is the ASCs' place in the healthcare system. Things are changing around us and I think ASCs, more than ever, need to be aware of what's going on in the healthcare community, particularly their own community. That includes physicians, hospitals and health plans. This does not necessarily mean forming an accountable care organization tomorrow but it's about becoming aware of what kind of changes are occurring, what alliances are being built, the growing role of primary care providers in determining the course of a patient's healthcare. ASCs really need to know what's going on in their local area, as well as nationally."

26. Use of electronic medical records will increase. "ASCs need to continue evolving, and that includes the area of electronic medical record usage. We know we have a notoriously low penetration of ASCs using EMRs but we really need to start thinking about getting up to speed on that if not only to improve patient care in our own ASCs but really to allow us to participate in the larger healthcare communities — surgeon groups, hospitals we may form alliances with and even insurers."

27. Quality reporting is going to happen. "It looks like we will be starting some quality reporting system in 2012. We're less than six months away from doing something significantly different for ASCs. Physicians have been doing it for a long time, hospitals as well. Clearly it's something that has been a long time coming. It's something we've asked for and is something we've worked very hard to prepare ourselves for. ASCs need to stay tuned to their state and national societies. We have a lot of unanswered questions about the quality reporting system. As CMS rolls out more specifics, ASCs need to have a place to go to and get that information so they can have their own internal reporting systems.

Vivek Taparia, director of Regent Surgical Health:

28. Industry consolidation will continue. "Last year marked the first year in which the net growth of ASCs fell to zero, representing

for the industry a transition from a phase of growth to one of maturity as evidenced by recent consolidation in the industry. With Surgery Partners' acquisition of NovaMed and AmSurg's acquisition of National Surgical Care, 2011 has represented a watershed year of consolidation for the ASC industry, marking a trend that will continue in the intermediate future.

"In order to continue to achieve economic gains, surgery centers and management companies consolidate to achieve cost synergies. Tangible evidence suggests that such consolidation-linked synergies can be realized. For example, average case volume levels per OR per day have fallen meaningfully over the past few years. Over the long run, it would not be surprising if the ASC industry resembles the current dialysis industry in which a few large players such as Davita and Fresenius control the vast majority of the market. In the short term, however, smaller chains continue to proliferate. According to VMG Health's 2008 Intellimarker, 24 ASC chains managed 988 facilities. In the same study for 2010, VMG reported that 44 chains managed 1,302 ASCs."

29. There will be a necessity to embrace robust information systems. "In order to for ASCs to stay competitive, I anticipate the necessity for ASCs to embrace robust IT platforms which thoroughly capture cost and quality data. The Affordable Care Act requires that, starting in Oct. 2012, Medicare reduce hospital DRG reimbursements by a small percentage and reward these funds to providers with high quality and efficiency measures. Earlier this year, HHS presented a plan to Congress to implement a similar value-based purchasing program for ASCs. Draft regulations for accountable care organizations indicate that providers must track 65 different quality metrics in order to participate in the program. While it is still very unclear the traction ACOs will gain amongst providers, it is very clear that robust information systems that track quality, efficiency and cost will be paramount to success in tomorrow's reimbursement environment."

Jeff Thompson, MS, MBA, MSHA, CEO/administrator of New Mexico Orthopaedic Surgery Center in Albuquerque, N.M.:

30. Challenges will continue, but the role of ASCs in healthcare will be solidified. "In recent years, the ASC industry has experienced significant transformation. It's no secret that we are operating in a more highly regulated, legally restrictive and politically sophisticated environment. Overall, the industry has responded well, and from my perspective, is stronger and more relevant than ever. However, the challenges and day-to-day hurdles are greater than ever, as well. We do have momentum and traction as an industry and I think that will continue. I also think that we will see some favorable legislation in the short term. Although, at the end of the day, the challenges we currently face pertaining to legal and regulatory requirements, reimbursement rates and physician employment will no doubt be the challenges of tomorrow. I do believe that our contribution to and position within the national healthcare delivery system will become more defined and solidified within the next two years. Thus, it is vital that we reach out to policymakers and actively participate in the process." ■

Contact Rob Kurtz at rob@beckersasc.com.

Will There Be Enough Physician-Investors in ASCs in the Future?
(continued from page 1)

a very hostile workplace out there," Dr. Lambert says. "We have some places where the Medicare contractor isn't paying its bills on time. Obamacare creates so much uncertainty, surgical volumes are down and malpractice insurance costs are rising."

However, Goran Dragolovic, senior vice president at Surgical Care Affiliates, has not seen a big wave of physician retirements yet. "We have not noticed an unusual uptick in the retirement of baby boomer physicians," Mr. Dragolovic says. "The recent economic events are forcing many to delay their original retirement plans and continue their practice well into their 60s."

A more significant trend right now, Mr. Dragolovic says, is physicians opting for hospital employment, which usually means they cannot use the surgery center any more. "We are seeing the physician pool shrinking more as a result of hospital employment than retirement," he says. "In such instances the physicians are expected to move their activity away from the ASC and into the hospital and divest their ownership in the ASC."

Mr. Dragolovic says these cases can cause headaches for ASC owners who have to take action on physician divesture without much direction from their operating agreements. "While ASC operating agreements typically address death, disability or retirement of physicians, they may not have appropriate provisions on how to deal with partners who become employed," Mr. Dragolovic says. "These ambiguities can pose divestiture challenges for the partnership."

Who will take exiting investors' place?

As some physicians drop their ownership stake, "ASCs across the country are wrestling with this issue," Mr. Dragolovic says. "In certain markets, there is a shrinking the pool of potential new partners for ASCs."

For example, there are not as many young physicians available to buy shares, because this generation is caught up in the trend toward hospital employment. "Many of the younger physicians coming out of fellowships and residencies are pursuing the employment model and going to work for hospitals," Mr. Dragolovic says.

Dr. Lambert, however, still expects some interest among younger physicians who have not sought employment. He says they would need to invest $50,000-$100,000 in the center, which can be hard to scrape together, what with hefty medical school debts and little savings accrued yet. But Dr. Lambert says young physicians could quickly amass the funds in a few years. "How long it takes to accumulate the necessary funds depends on what your lifestyle is," he says. "If you are frugal, you could accumulate that much money in a year."

Dr. Lambert adds that shares in the ASC might also be sold to hospitals, management companies and surgeons who have become disillusioned with hospital employment. Mr. Dragolovic agrees that some employed physicians will grapple with issues such as the possibility of reduced payments by hospitals and come running back to ASCs. "Will hospital-employed physicians be as productive as they were on their own?" he asks. "Will the hospital be able to maintain the current payment levels to their physicians over a longer time horizon?"

Dearth of de novo ASCs provides new source of investors

Despite the possibility that problems with hospital employment may drive physicians back to the ASC, it would take several years for disillusioned employed physicians to break their multi-year hospital contracts and return to private practice. Meanwhile, Mr. Dragolovic has identified another source of new ASC investors: physicians who would have built new centers if the times were different. With fewer unaffiliated physicians to partner with and more difficulty getting financing in some markets, these physicians are now more likely to join existing centers than build new ones, he says.

"We are seeing diminished interest on the part of unaffiliated physicians without ASC ownership to build their own ASCs," Mr. Dragolovic says. "As a result, we are still able to identify independent physicians in a number of markets who can be syndicated into existing facilities." However, Mr. Dragolovic concedes there are not enough busy unaffiliated physicians to fill all the vacated spots on ASC boards. Without new investors coming on board, some struggling ASCs may be forced to close their doors, he says. ■

Contact Leigh Page at leigh@beckersasc.com.

Finding the 'New Spine': 7 Procedures Moving Into the ASC Setting
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improved, however, she has seen a resurgence of unicompartmental knees. "They've developed new implants, and it seems that the success rate for the new implants has really improved," she says. "There are physicians that are beginning to think they have a very valuable physiologic impact."

She says unicompartmental knees are not appropriate for all patients. The surgery is most appropriate for a younger group of patients whose health makes them eligible for outpatient surgery. Unlike some other emerging orthopedic procedures, unicompartmental knees are approved by Medicare. She adds that because the implant costs $3,500-$4,000, surgery centers must ensure profitable payor contracts before adding the procedure.

Mr. Dragolovic says while payors in some markets are open to the cost-saving opportunity in unicompartmental knees, others simply do not regard the procedure as a priority. "Surprisingly enough, we have some markets where we can't get the payor's attention about the savings," he says. "In some markets, we are told that while they recognize the savings, they have much bigger items to tackle that have a much bigger total dollar."

2. Baha and cochlear implants. Historically, Baha and cochlear implants were performed in an inpatient or HOPD setting, Mr. Dragolovic says. "ENT physicians are expanding their use of ASCs, and we see an opportunity to provide a cheaper alternative to the patient and payor on cochlear and Baha implants," he says.

Since ENTs have been working in surgery centers for years, he says payors are the biggest challenge in moving these cases into the ASC setting. The procedures have high implant costs, so surgery center leaders must negotiate strong payor contracts to make them profitable. "The objective is to get in front of the payor and offer a cheaper alternative to the HOPD for these types of procedures," Mr. Dragolovic says.

3. Women's health procedures. Ms. Vernon says there may be an opportunity for surgery centers to add more women's health procedures, including laparoscopy-assisted vaginal hysterectomies, partial mastectomies and other breast procedures. "In general, I think women would prefer an environment like an ASC as opposed to an acute-care hospital," Ms. Vernon says. "The ASC represents an opportunity to widen the spectrum of women's healthcare providers because they are more private, more intimate and smaller." She says while payment from commercial payors can vary widely, reimbursement for lumpectomies and partial mastectomies are generally robust, and supply costs are insubstantial.

Mr. Dragolovic says gynecology poses a challenge for surgery centers because gynecologists have historically maintained strong ties with hospital. "In many instances, these physicians are OB/GYNs rather than just gynecologists, and they're wedded to the hospital because of the OB nature of their practice," he says. "Because of this, any surgical activity — even if it's outpatient — is done in the hospital setting." He says Surgical Care Affiliates has been successful in recruiting younger physicians to perform laparoscopy-assisted vaginal hysterectomies — partly because younger physicians are more likely to be trained on laparoscopic approaches, and partly because they haven't spent 20 years building loyalty to the hospital.

Ms. Vernon says certain breast surgery procedures may not be appropriate for all outpatient setting because, depending on location, some ASCs cannot provide the same ancillary services as hospitals. "If the surgeon wants to do any sentinel node work, there has to be a way

to access a radioactive isotope," she says. "If they want to use mammography and needle localization, patients have to be able to access those ancillary services." She says these associated components present the biggest obstacles to performing women's health procedures in a surgery center.

4. General surgery. Ms. Vernon says there are opportunities in general surgery for surgery centers if physicians are available for recruitment. "The biggest obstacle is the general surgeon," she says. "They are usually so closely tied to an acute-care hospital because of the need to be available for call coverage."

She says she sees opportunities for increased laparoscopic cholecystectomies, especially in markets where lap choles are not performed in the ASC setting. She says she has also seen some surgery centers performing laproscopic nissen fundoplication procedures to treat gastroesophageal reflux disease, but those are "few and far between."

"In the case of general surgery, it's mostly related to the surgeons," she says. "They've always done general surgery in the hospital and they feel comfortable there." If the ASC can convince general surgeons to move into the center, she says, there may be potential to expand the ASC's list of approved procedures.

5. Hip arthroscopies. Ms. Vernon says technological improvements may enable more surgery centers to perform hip arthroscopies in the future. "There are champions of hip arthroscopy out there," she says. "If there is an orthopod who works in the facility who believes in hip arthroscopies and wants to improve their technique and trial some of the new techniques, they can be performed in the outpatient setting." She says the use of a scope in these procedures has been limited so far, but the technique may become more popular as more physicians pursue minimally invasive surgery.

6. Sling procedures. Mr. Dragolovic says Surgical Care Affiliates has started looking at urology for expansion opportunities. "We see sling procedures as having potential in both volume and margin," he says. "We're seeing less of a resistance [from urologists] because they have historically used ASCs more frequently than gynecologists." He says in the case of sling procedures, ASCs may face contract issues because the tape required can cost over $4,000. Surgery center leaders must negotiate contracts that account for tape and mesh implants prior to adding the procedure.

7. Cardiac rhythm procedures. Cardiac rhythm procedures, including pacemaker battery changes and replacements, may have a place in surgery centers in the future, Mr. Dragolovic says. Patient population issues are the biggest deterrent for physicians and payors when it comes to cardiac rhythm procedures, as the majority of patients are elderly and thus more likely to present significant comorbidities. In addition, interventional cardiologists have not traditionally used ASCs.

Mr. Dragolovic says ASCs must establish a very rigorous patient selection process and staff training program prior to adding cardiac rhythm procedures. "In this case, both the physician and the contracting are going to be real critical," he says. Identify cardiologists who are enthusiastic about moving these procedures into the outpatient setting, and work with those providers to acquire necessary equipment and staff and demonstrate clinical safety to payors. ■

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135 of the Leading Ophthalmologists in America

By Leigh Page

135 of the Leading Ophthalmologists in America

Here are profiles of 135 leading ophthalmologists in the United States. They were selected for this list based on the awards they received from major organizations in the field, leadership in those organizations, work on professional publications and their positions of service. The surgeons are listed in alphabetical order by last name. All physicians placed on this list have undergone substantial review from our editorial staff. Physicians do not pay and cannot pay to be selected as a leader to know. The list is not an endorsement of any individual's or organization's clinical abilities.

Maria M. Aaron, MD (Emory University, Atlanta). Dr. Aaron is director of the ophthalmology residency program at Emory. Her clinical interests include adult comprehensive ophthalmology, particularly diabetic retinopathy and cataract surgery. She has been president of the Program Directors' Council of the Association of University Professors of Ophthalmology, vice chair of the Ophthalmology Residency Review Committee and an associate examiner for the Oral Board Examination of the American Board of Ophthalmology.

Richard L. Abbott, MD (University of California, San Francisco). After spending two years as a young physician running a community health clinic on the Navajo reservation, Dr. Abbott decided to pursue a career in ophthalmology. Today he is a professor of ophthalmology at UCSF and current president of the American Academy of Ophthalmology. He has been a member of the FDA Ophthalmic Devices Panel and the National Eye Institute coordinating committee for the development of a patient assessment instrument for refractive error correction. He is research associate at the Francis I. Proctor Foundation and an emeritus director of both the American Board of Ophthalmology and the Castroviejo Cornea Society.

David H. Abramson, MD (Memorial Sloan-Kettering Cancer Center, New York). Dr. Abramson is an ophthalmic oncologist with special interest in retinoblastoma and uveal melanoma. With a joint appointment in surgery, pediatrics and radiation oncology, he is first chief of the ophthalmic oncology service at Memorial Sloan-Kettering, the only service of its kind dedicated to ophthalmic oncology in a cancer hospital in the United States. In addition to developing novel approaches for treating retinoblastoma, he has studied second cancers in retinoblastoma, focusing on the effect of genes and the environment on the genesis of these cancers.

Lloyd Paul Aiello, MD, PhD (Joslin Diabetes Center, Boston). Dr. Aiello dedicates 80 percent of his time to ophthalmology research, particularly on biochemistry and molecular mechanisms of retinal vascular disorders, such as diabetic eye disease and vascular retinal tumors. He is director of the William P. Beetham Eye Institute and head of the Section of Eye Research at the Joslin Diabetes Center. He holds an appointment at Harvard Medical School in Boston and is on the editorial board of the American Journal of Ophthalmology and Retina.

Anthony J. Aldave, MD (Jules Stein Eye Institute, Los Angeles). Dr. Aldave is director of the cornea service, the refractive surgery fellowship program and the Corneal Genetics Laboratory at Jules Stein Eye Institute. His NIH-funded laboratory research focuses on the molecular genetics of the corneal dystrophies.

Eduardo C. Alfonso, MD (Bascom Palmer Eye Institute, Miami). Dr. Alfonso's research interests include bacterial and fungal sensitivity and the development and clinical applications of keratoprosthesis. He is director of Bascom Palmer Eye Institute and chairman of the ophthalmology department of the University of Miami Miller School of Medicine. He has served as medical director of Anne Bates Leach Eye Hospital and vice chair of its board.

David J. Apple, MD (Apple Laboratories, Sullivan's Island, S.C.). Dr. Apple is director of the Apple Laboratories for Ophthalmic Devices Research. He is an expert in ocular pathology, cataract surgery and intraocular lens implantation and both corneal and IOL refractive surgery. He has been inducted into the Ophthalmology Hall of Fame and was selected to give the Binkhorst Lecture, Kelman Lecture and European Guest Lecture at the Oxford Ophthalmological Congress. He was previously chairman of the Department of Ophthalmology at the Storm Eye Institute at the Medical University of South Carolina.

Sophie J. Bakri, MD (Mayo Clinic, Rochester, Minn.). Dr. Bakri is associate professor of ophthalmology and director of the vitreoretinal surgical fellowship at Mayo Clinic. Dr. Bakri is a principal investigator on numerous multicenter clinical trials on novel drugs for retinal disease. She is editor-in-chief of the book, "Mayo Clinic on Vision and Eye Health," an editor of the American Journal of Ophthalmology, and on the editorial board of Retina, Seminars in Ophthalmology and Clinical and Surgical Ophthalmology.

Laurie G. Barber, MD (Jones Eye Institute, Little Rock, Ark.). Dr. Barber is professor of ophthalmology at the Jones Eye Institute at the University of Arkansas for Medical Sciences University of Arkansas for Medical Sciences in Fayetteville and chairs the American Academy of Ophthalmology's Surgical Scope Fund Committee. She was chair of the academy's OPHTHPAC and is past president of the Arkansas Ophthalmological Society.

George B. Bartley, MD (Mayo Clinic, Rochester, Minn.). After serving as CEO of Mayo Clinic Florida and vice president for quality for Mayo Clinic

nationwide, Dr. Bartley has resumed his surgical practice at Mayo Clinic Rochester. A trustee of the American Academy of Ophthalmology, he has been editor-in-chief of Ophthalmic Plastic and Reconstructive Surgery and on the editorial board of Ophthalmology, American Journal of Ophthalmology, and Archives of Ophthalmology.

Eliot L. Berson, MD (Massachusetts Eye and Ear Infirmary, Boston). Dr. Berson and colleagues developed the first treatment regimen for adults with typical retinitis pigmentosa. He is director of the electroretinography at the Massachusetts Eye and Ear Infirmary and director of its Berman-Gund Laboratory for the Study of Retinal Degenerations. His major clinical interest is in hereditary retinal degenerations, especially retinitis pigmentosa.

Mark S. Blumenkranz, MD (Stanford University, Palo Alto, Calif.). Dr. Blumenkranz has been involved in translational research for several new therapies that were approved by the FDA. He is chairman of ophthalmology at Stanford University School of Medicine, with a main area of interest in vitreoretinal diseases. His research focuses on new forms of imaging, laser delivery systems, microsurgical tools and new drugs and drug delivery systems that inhibit new blood vessel growth, scarring and intraocular inflammation. He is former president of the Retina Society and an associate examiner for the American Board of Ophthalmology.

Thomas J. Bombardier, MD (Ambulatory Surgical Centers of America, Hanover, Mass.). Dr. Bombardier is the chief operating officer and one of the three founding principals of Ambulatory Surgical Centers of America. Before founding ASCOA, he established the largest ophthalmic practice in Western Massachusetts, two ASCs and a regional referral center. Dr. Bombardier earned his MD from Albany (N.Y.) Medical College and completed his residency at Louisiana State University in Baton Rouge, La.

Kraig Scot Bower, MD, (Wilmer Eye Institute, Baltimore). Dr. Bower is director of refractive surgery at the Wilmer Eye Institute and previously served in that role at the Walter Reed Army Medical Center in Washington, D.C. A retired Army colonel, he was the Army's refractive surgery subject matter expert and managed the Army's Warfighter Refractive Eye Surgery Program.

David S. Boyer, MD (Retina-Vitreous Associates Medical Group, Beverly Hills, Calif.). Dr. Boyer has been involved in extensive clinical trials for age-related macular degeneration, diabetic retinopathy and cytomegalovirus retinitis. He is a senior partner at Retina-Vitreous Associates Medical Group and holds an appointment at the University of Southern California. He has been on the advisory boards for Alcon, Novartis, Eyetech/Pfizer, Genentech, Neurotech and the Macular Degeneration Partnership. He is also a reviewer for the Archives of Ophthalmology, American Journal of Ophthalmology, Diabetes Care and Ophthalmology.

David M. Brown, MD (Retina Consultants of Houston). Dr. Brown is interested in diseases of the macula, including macular surgery, age-related macular degeneration and diabetic retinopathy. He is a partner in Retina Consultants of Houston and a peer reviewer for all five major ophthalmology and retina journals as well as the New England Journal of Medicine. A former president of the Houston Ophthalmological Society, he has served on the board of directors for the Greater Houston Area American Diabetes Association as well as the Gulf Coast Juvenile Diabetes Research Foundation.

Alexander J. Brucker, MD (Scheie Eye Institute, Philadelphia). A successful ophthalmologic inventor, Dr. Brucker has developed surgical instruments and procedures such as scleral buckles, scleral needles, a retinal cryoprobe, the vitreous air infusion pump and a tech-

nique for draining subretinal fluid. He is professor of ophthalmology at Scheie Eye Institute at the University of Pennsylvania in Philadelphia and has served as president of the Macula Society, Retina Society and Vitreous Society.

Joseph Caprioli, MD (Jules Stein Eye Institute, Los Angeles). Dr. Caprioli is chief of the glaucoma division, director of the glaucoma photography laboratory and glaucoma director of the ophthalmology diagnostic laboratory at Jules Stein Eye Institute. He is the glaucoma section editor for Duane's Ophthalmology and book review editor for Ophthalmic Surgery.

Keith Carter, MD (University of Iowa, Iowa City). Dr. Carter is head of the Department of Ophthalmology and Visual Sciences at the Carver College of Medicine and the University of Iowa Hospitals and Clinics. He was director of the university's ophthalmology residency program, has been a trustee of the American Academy of Ophthalmology and served as AAO meeting committee chair for ocular tumors, pathology and orbit and lacrimal plastic surgery.

David F. Chang, MD (Peninsula Eye Surgery Center, Mountain View, Calif.). Dr. Chang was the first U.S. surgeon to implant the light-adjustable artificial lens and the first dual-optic accommodating IOL. He is managing partner of the Peninsula Eye Surgery Center and is in private practice in Los Altos, Calif., focusing on cataract and intraocular lens implants. Dr. Chang has designed a number of popular cataract surgical instruments that bear his name and are used worldwide. He served as program chairman for the American Academy of Ophthalmology's annual meeting from 2004-2009.

Stanley Chang, MD (Harkness Eye Institute, New York). Dr. Chang developed several revolutionary surgical approaches to treat complicated forms of retinal detachment. He is chairman of the Harkness Eye Institute at Columbia University and on staff at Columbia University Medical Center and New York-Presbyterian Hospital in New York. He was the first to use perfluoropropane gas in the management of retinal detachment worsened by scar tissue proliferation and made a major contribution to the development of perfluorocarbon liquids for vitreoretinal surgery.

Steve Charles, MD (Charles Retina Institute, Memphis, Tenn.). Dr. Charles is a mechanical and electrical engineer who holds 103 patents or pending patents and is founder of the Charles Retina Institute. Ocular Surgery News named him one of the top ten innovators in the past 25 years. He holds appointments at the University of Tennessee in Knoxville, Columbia College of Physicians and Surgeons in New York and the Chinese University of Hong Kong. He is on the editorial board of Retina and a reviewer for Ophthalmology, Archives of Ophthalmology and American Journal of Ophthalmology.

Emily Y. Chew, MD, PhD (National Eye Institute, Bethesda, Md.). Dr. Chew is deputy director of the Division of Epidemiology and Clinical Applications at the National Eye Institute in the National Institutes of Health. She is currently president of the Macula Society and chairs the NEI Age-Related Eye Disease Study 2 and the Action to Control Cardiovascular Risk in Diabetes Eye Study. Dr. Chew has also analyzed, designed or chaired several landmark clinical trials, including the Age-Related Eye Disease Study and the Early Treatment Diabetic Retinopathy Study.

Robert Cionni (Eye Institute of Utah, Salt Lake City). Dr. Cionni was one of the first surgeons in the Midwest to perform sutureless cataract surgery. He is now medical director of the Eye Institute of Utah, where he continues to design implants and new surgical techniques. His specialties include ocular injuries, traumatic cataract, congenital lens subluxation and disease-induced zonular weakness.

Anne L. Coleman, MD, PhD (Jules Stein Eye Institute, Los Angeles). Dr. Coleman is the principal investigator of a multi-site study on the incidence of AMD in elderly women, funded by the National Eye Institute. She is director of the Jules Stein Eye Institute Mobile Eye Clinic and is a professor of ophthalmology at the David Geffen School of Medicine at UCLA. She is a consultant to the FDA's ophthalmic devices panel and chairs the glaucoma subcommittee of the National Eye Health Education Program of the NIH.

Stephen C. Coleman, MD (ColemanVision, Albuquerque, N.M.). Dr. Coleman is among a select few eye surgeons in the United States instructing other physicians on the use of the VISX laser system. He practices at ColemanVision, focusing on LASIK surgery, and has been part of an ongoing FDA study evaluating Wavefront technology for nearsightedness, farsightedness and astigmatism.

Scott W. Cousins, MD (Duke Eye Center, Durham, N.C.). Dr. Cousins has been developing blood tests and imaging technologies to identify patients at high risk for macular degeneration. He directs the Duke Center for Macular Diseases in the Duke Eye Center. He earned his MD from Case Western Reserve University School of Medicine in Detroit and completed a residency in ophthalmology at Washington University in St. Louis and a vitreoretinal fellowship at Bascom Palmer Eye Institute. He focuses on age-related macular degeneration, diabetic retinopathy and retinal vascular diseases.

Alan S. Crandall, MD (University of Utah School of Medicine, Salt Lake City). For the past nine years, Dr. Crandall has traveled to Africa once a year to teach local physicians and perform free cataract and other eye surgeries. He is director of glaucoma and cataract services and senior vice chairman of ophthalmology and visual sciences at the University of Utah School of Medicine in Salt Lake City. He is a past president of the American Society of Cataract and Refractive Surgery. Dr. Crandall earned his MD from the University of Utah. He completed a surgery internship at the University of Pennsylvania Medical Center, an ophthalmology residency and glaucoma fellowship at the Scheie Eye Institute, both in Philadelphia.

Donald J. D'Amico, MD (New York Presbyterian Hospital, New York). An internationally recognized leader in the field of vitreoretinal surgery, Dr. D'Amico is ophthalmologist-in-chief at New York Presbyterian Hospital and chairman of Ophthalmology at Weill Cornell Medical College, both in New York. His major interests include vitreoretinal surgery, diabetic retinopathy, macular degeneration, experimental lasers and other technologies for the surgical treatment of vitreoretinal disorders such as retinal detachment, macular holes and epiretinal membranes and endophthalmitis and intravitreal drug therapy.

Elizabeth A. Davis, MD (Minnesota Eye Consultants, Minneapolis). Dr. Davis was an early investigator in phakic IOLs for myopia. She is medical director of the surgery center at Minnesota Eye Consultants and holds an appointment at the University of Minnesota in Minneapolis. She is chair of the refractive committee of the American Society of Cataract and Refractive Surgery, sits on the editorial board for several journals and has edited six textbooks.

James A. Davison, MD (Wolfe Eye Clinic, Marshalltown, Iowa). Dr. Davison started the vitrectomy surgery service at Wolfe Eye Clinic. He is chair of the practice management committee of American Society of Cataract and Refractive Surgery and is a member of the editorial board for the Journal of ASCRS. Dr. Davison received his MD from Mayo Clinic Medical School in Rochester, Minn. He completed his ophthalmology internship at Los Angeles County-University of Southern California and an ophthalmology residency at Mayo Graduate School of Medicine. He is recipient of the Surgicus Golden Hands Award from Surgicus III.

Susan H. Day, MD (California Pacific Medical Center, San Francisco). Dr. Day chairs the ophthalmology department and is residency program director at California Pacific Medical Center. She is a past president of the American Academy of Ophthalmology and has chaired the Residency Review Committee for Ophthalmology.

Steven J. Dell, MD (Texan Eye, Austin). Dr. Dell is the inventor of the Dell Astigmatism Marker, Dell Fixation Ring and Dell PlumeSafe Ophthalmic Evacuation System and Handpiece. He is director of Refractive and corneal surgery for Texan Eye, which focuses on cataract and LASIK surgery. Dr. Dell is an award-winning lecturer, textbook author and editor. He has performed more than 20,000 surgical procedures and conducted research on the latest advances in eye surgery, often serving as an investigator for FDA-sponsored studies.

Joseph L. Demer, MD, PhD (Jules Stein Eye Institute, Los Angeles). Dr. Demer is a pioneer in the use of imaging to understand strabismus and double vision about the neuroanatomy of the eye socket. He is chief of pediatric ophthalmology and strabismus division and director of the Ocular Motility Laboratory at the Jules Stein Eye Institute.

Uday Devgan, MD (Devgen Eye Surgery, Los Angeles). Dr. Devgan has a special interest in cataract, refractive lens implant and LASIK surgery. In addition to his private practice, he holds an appointment at the Jules Stein Eye Institute at the UCLA School of Medicine and is chief of ophthalmology at Olive View-UCLA Medical Center. He earned his MD at the USC School of Medicine and trained at the Jules Stein Eye Institute at UCLA, where he won awards for outstanding achievement and research.

Eric D. Donnenfeld, MD (LASIK Long Island, Rockville Centre, N.Y.). Dr. Donnenfeld was one of the original investigators of the excimer laser. He has performed among the most refractive surgeries and has trained a large number of surgeons to perform refractive surgery. He designed and patented four instruments for refractive surgery use.

Pravin U. Dugel, MD (Retinal Consultants of Arizona, Phoenix). **Dr**. Dugel was co-investigator in National Eye Institute research studies and in several multicenter studies. He is managing partner of Retinal Consultants of Arizona and founding member of Spectra Eye Institute in Sun City, Ariz. Dr. Dugel has authored more than 30 papers and book chapters and is the first person to receive both the Heed Foundation and the Ronald G. Michels Vitreo-Retinal Surgery Fellowship awards.

Daniel S. Durrie, MD (Durrie Vision, Overland Park, Kan.). Dr. Durrie is founder of Durrie Vision, specializing in LASIK and cataract surgery and one of the few centers in the country to conduct FDA clinical trials. He serves is clinical professor and director of refractive surgery services at the University of Kansas Medical Center in Lawrence.

Harry W. Flynn Jr., MD (Miller School of Medicine, Miami). Dr. Flynn has edited or co-edited four books including Diabetes and Ocular Diseases: Past, Current, and Future Therapies and Vitreoretinal Disease: The Essentials. He is chair in ophthalmology at the Miller School of Medicine at the University of Miami and has a special interest in diabetic retinopathy and complications of cataract surgery. Dr. Flynn has authored or co-authored more than 300 publications as well as 53 book chapters.

Richard K. Forster, MD (Bascom Palmer Eye Institute, Miami). Dr. Forster specializes in corneal diseases, corneal transplant surgery, anterior segment reconstruction and secondary intraocular lenses. He is chair in corneal and external ocular diseases at the Miller School of Medicine in Miami. He earned his MD at Boston University School of Medicine and completed an ophthalmology residency at Bascom Palmer Eye Institute in Miami and a fellowship in corneal and external diseases at the Francis I. Proctor Foundation for Research in Ophthalmology in San Francisco. He was guest of honor at the American Academy of Ophthalmology's 2011 meeting.

Gary Foster, MD (Eye Center of Northern Colorado, Ft. Collins). Dr. Foster was one of the first in the Rocky Mountains to adapt Lasik, perform femtosecond cataract surgery and to implant premium intraocular lenses. He is a physician trainer for the VISX laser system and is frequently teaches advanced surgical techniques at meetings of the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgeons. He also moderates the comprehensive list serve for Eye Connect, a website where ophthalmologists can post challenging questions on their field.

K. Bailey Freund, MD (Vitreous-Retina-Macula Consultants of New York). Dr. Freund is an expert in rare conditions that have been difficult for other specialists to diagnose. He holds an appointment at New York University School of Medicine and is on staff at New York Presbyterian Hospital, Manhattan Eye, Ear & Throat Hospital and Lenox Hill Hospital, all in New York. His chief interests are retinal disorders including macular degeneration, diabetic retinopathy and retinal vascular and inflammatory diseases. He recently authored a guide for macular degeneration patients and their families, using narration and animation to explain diagnosis, treatment and rehabilitation.

David S. Friedman, MD (Wilmer Eye Institute, Baltimore). Dr. Friedman undertakes eye-care development projects in China and other countries for Helen Keller International in New York. He is director of the glaucoma fellowship program at the Wilmer Eye Institute at Johns Hopkins University. He is a member of the American Academy of Ophthalmology's Glaucoma Preferred Practice Patterns Panel, co-chairman of the World Glaucoma Association Research Committee and chairman of the American Glaucoma Society Practice Guidelines Subcommittee. He is also on the editorial board of Ophthalmology and Journal of Glaucoma.

James Gills, MD (St. Luke's Cataract & Laser Institute, Tampa, Fla.). Dr. Gills was one of the first eye surgeons in the United States to dedicate his practice to cataract treatment through the use of intraocular lenses. The founder and director of St. Luke's Cataract & Laser Institute, he was a front-runner in adopting intraocular antibiotics to prevent post-surgical infection, no-stitch cataract surgery and intraocular medicines to reduce inflammation and to prevent needles for anesthesia.

David B. Glasser, MD (Patapsco Eye MDs, Columbia, Md.). Dr. Glasser holds privileges at Howard County General Hospital in Columbia, Md., and works at the hospital's ambulatory surgery center. He s the current president of the Cornea Society. Dr. Glasser earned his MD for Albany (N.Y.) Medical College, completed his internship at Albany Medical Center Hospitals, his ophthalmology residency at Jules Stein Eye Institute in Los Angeles and fellowships in cornea and external disease and corneal physiology at Medical College of Wisconsin in Milwaukee. He has received the R. Townley Paton Award from the Eyebank Association of America.

David S. Greenfield, MD (Bascom Palmer Eye Institute, Miami). Dr. Greenfield is the recipient of a National Eye Institute consortium grant studying advanced imaging technology in glaucoma. He is director of the glaucoma fellowship program at the Bascom Palmer Eye Institute at the University of Miami Miller School of Medicine. Dr. Greenfield has served as chair of the AAO glaucoma subspecialty day committee and chair of the bylaws and strategic planning committee of the American Glaucoma Society, as well as vice chair of the society's Scientific Program Committee.

Barrett G. Haik, MD (University of Tennessee, Memphis, Tenn.). Dr. Haik is chair of the ophthalmology department at the University of Tennessee College of Medicine. During his tenure, he has transformed the department from with fewer than ten academic faculty members into the Hamilton Eye Institute, with more than 40 academic faculty members. He is immediate past president of the Association of University Professors of Ophthalmology and was president of the American Eye Study Club and American Society of Ophthalmic Ultrasound.

Julia A. Haller, MD (Wills Eye Institute, Philadelphia). Dr. Haller is ophthalmologist-in-chief of the Wills Eye Institute and professor and chair of the department of ophthalmology at Thomas Jefferson University in Philadelphia. She is past president of the American Society of Retina Specialists and serves on the editorial boards of RETINA, Retinal Physician, Ocular Surgery News, Ophthalmology Times and Evidence-Based Ophthalmology.

Sadeer B. Hannush, MD (Wills Eye Institute, Langhorne, Pa.). Dr. Hannush is an attending surgeon on the cornea service at Wills Eye Institute and holds an appointment at Thomas Jefferson Medical College in Philadelphia. He is chair of the scientific program at the Cornea Society and served on the FDA's ophthalmic drug and devices panels. His interests are full and partial thickness corneal transplantation, complex cataract and anterior segment reconstructive procedures including permanent keratoprosthesis and laser vision correction.

Seenu M. Hariprasad, MD (University of Chicago). Dr. Hariprasad is co-founder of

the CONNECT Network, a collaborative association of academic vitreoretinal specialists. He is chief of the vitreoretinal service, director of ophthalmic clinical research and director of the surgical retina fellowship program at the Pritzker School of Medicine at the University of Chicago. He has been principal investigator or sub-investigator in more than 30 national clinical trials evaluating new drugs, devices, surgical innovations and drug delivery for age-related macular degeneration, retinal vascular occlusion, endophthalmitis and diabetic retinopathy.

Jeff Heier, MD (Ophthalmic Consultants of Boston). Dr. Heier is an advisor or consultant to more than 20 biotechnical or pharmaceutical companies and is on the protocol committee of the National Eye Institute's AREDS 2 study. A partner at Ophthalmic Consultants of Boston and co-director of its vitreoretinal fellowship, he holds appointments at Tufts School of Medicine and Harvard Medical School in Boston. A former president of the Center for Eye Research and Education Foundation, he has been secretary of online education and e-learning for the American Academy of Ophthalmology. His specialty is retinal diseases such as macular degeneration, diabetic retinopathy and venous occlusive disease.

Bonnie Henderson, MD (Ophthalmic Consultants of Boston). Dr. Henderson has been principal investigator for the development of a computer software program simulating surgery for training purposes. She is one of 26 ophthalmologists at Ophthalmic Consultants of Boston, which cares for more than 150,000 patients each year in all categories of eye disorders and visual system diseases. She holds an appointment at Harvard Medical School in Boston and is author of Essentials of Cataract Surgery.

Allen C. Ho, MD (Wills Eye Institute, Philadelphia). Dr. Ho is a member of the FDA Ophthalmic Device Panel and a principal investigator of several clinical trials at Wills, where he is a professor of ophthalmology and a vitreoretinal surgeon. Dr. Ho is editor-in-chief of Current Opinion in Ophthalmology, on the editorial boards of several other ophthalmic publications and also serves on scientific advisory boards at Alcon, Genentech, Novartis and Eyetech.

Edward J. Holland, MD (Cincinnati Eye Institute). Dr. Holland is president of the American Society of Cataract and Refractive Surgeons and has served on the ASCRS executive committee. He is the director of cornea services at the Cincinnati Eye Institute and a professor of ophthalmology at the University of Cincinnati, where his focuses is corneal conditions, stem cell transplantation, corneal transplantation, cataract surgery, ocular surface transplantation and refractive surgery.

Gary N. Holland, MD (Jules Stein Eye Institute, Los Angeles). Dr. Holland was among the first to describe the ophthalmic manifestations of AIDS. He is director of the Ocular Inflammatory Disease Center and the Clinical Research Center at Jules Stein Eye Institute and is chief of the cornea-external ocular disease and uveitis division in the ophthalmology department at David Geffen School of Medicine at UCLA. Dr. Holland is a past president of the American Uveitis Society and has served as associate editor of the American Journal of Ophthalmology.

Mark Humayun, MD, PhD (Doheny Eye Institute, Los Angeles). Dr. Humayun leads a consortium of engineers and scientists from more than 10 national laboratories and universities who are refining the Argus artificial retina, commercialized by Second Sight Medical Products. An associate director of research at Doheny Eye Institute at the University of Southern California, he developed the retinal chip, restoring partial sight to those who have been blinded by retinitis pigmentosa.

Mark W. Johnson, MD (University of Michigan, Ann Arbor). Dr. Johnson is director of the retina service at the University of Michigan. He has been a member of the update and special focus course committee and the basic and clinical science course committee of the American Academy of Ophthalmology and has served as associate examiner for the American Board of Ophthalmology. He has also served on the board of the American Society of Retina Specialists and Retina Society.

Randolph L. Johnston, MD (Cheyenne Eye Clinic, Cheyenne, Wyo.). A third-generation ophthalmologist, Dr. Johnston is past president of the American Academy of Ophthalmology. He is in private practice at Cheyenne Eye Clinic, a consultant to the Cheyenne VA and holds appointments with the University of Wyoming Family Practice Program and the University of Utah department of ophthalmology in Salt Lake City.

Albert S. Jun, MD, PhD (Wilmer Eye Institute, Baltimore). Dr. Jun researches corneal diseases such as keratoconus using molecular biology and genetic techniques. He is associate professor of ophthalmology at the Wilmer Eye Institute at Johns Hopkins University School of Medicine in Baltimore and co-director of the Wilmer Openshaw Keratoconus Research Group. He also specializes in Fuchs dystrophy, refractive surgery, cataract and external eye diseases.

L. Jay Katz, MD (Wills Eye Institute, Philadelphia). **Dr**. Katz is director of the glaucoma service at Wills Eye Institute and professor of ophthalmology at Thomas Jefferson University in Philadelphia. He has published numerous peer-reviewed articles, authored three books on ophthalmologic surgery and participated in collaborative studies at the National Eye Institute.

John H. Kempen, MD, PhD (Scheie Eye Institute, Philadelphia). Dr. Kempen was vice chair of the Multicenter Uveitis Steroid Treatment Trial and is founding director of the ocular inflammation service and ophthalmic epidemiology at the Scheie Eye Institute at the University of Pennsylvania. He helped coordinate the Eye Diseases Prevalence Research Group, which serves as a referral center for the management of ocular inflammatory diseases in Pennsylvania, New Jersey, Delaware and nearby states.

Terry Kim, MD (Duke University Health System, Durham, N.C.). Dr. Kim is associate director of cornea and refractive surgery services at Duke Health and chair of the cornea clinical committee at the American Society of Cataract and Refractive Surgery. He earned his MD from Duke University School of Medicine, performed his residency in ophthalmology at Emory University School of Medicine in Atlanta and his fellowship in cornea and refractive surgery at Wills Eye Hospital in Philadelphia. His clinical interests are corneal transplantation, PK, DSEK, cataract surgery, the multifocal intraocular lens, ReSTOR, laser refractive surgery, LASIK, LASEK, PRK, thin-flap LASIK, IntraLASIK, Intralase, femtosecond laser, phakic intraocular lens, Verisys and Visian ICL.

Douglas D. Koch, MD (Baylor Vision, Houston). Dr. Koch is medical director of Baylor Vision at Baylor College of Medicine and professor of ophthalmology at the Cullen Eye Institute at Baylor. He is past president of the International Intra-Ocular Implant Club and the American Society of Cataract and Refractive Surgery, as well as a charter member of the executive committee of the Refractive Surgery Interest Group of the American Academy of Ophthalmology.

Paul S. Koch, MD (Koch Eye Associates, Warwick, R.I.). Dr. Koch was one of the first physicians in America to practice refractive surgery, one of the first to use phakic lens implants and one of the first to use accommodating lens implants to correct presbyopia. He is the founder and medical director of Koch Eye Associates and he has written seven textbooks on eye surgery, six of which are on cataract surgery and one on corneal refractive surgery. He is medical editor emeritus of Ophthalmology Management Magazine.

Colman Kraff, MD (Kraff Eye Institute, Chicago). Dr. Kraff was the first refractive eye surgeon in the Midwest to perform LASIK and is one of three primary excimer laser trainers in the United States. He is a member of the Kraff Eye Institute and was principal investigator for eight FDA studies for laser manufacturers as well as co-investigator for four more studies. In addition to his work as reviewer for the Journal of Cataract and Refractive Surgery, he has written more than five textbook chapters.

Ronald R. Krueger, MD (Cleveland Clinic). Dr. Krueger is co-medical lead for the concept OptoQuest, a Cleveland Clinic spin-off company. He is a co-editor of the first book on Wavefront customized LASIK surgery and was a founding organizer of the first conference on Wavefront. The medical director of the department of refractive surgery at Cole Eye Institute at the Cleveland Clinic, Dr. Krueger has served as board member of the International Society of Refractive Surgeons before it merged with the American Academy of Ophthalmology.

Brent Lambert, MD (Ambulatory Surgical Centers of America, Hanover, Mass.). Dr. Lambert is chairman of the board and a founder of Ambulatory Surgical Centers of America. He is currently responsible for business development at ASCOA. Prior to founding ASCOA, Dr. Lambert developed and owned three ASCs, including one of the first eye ASCs in the Northeast. He earned his MD from Columbia University College of Physicians and Surgeons and completed his residency at the Massachusetts Eye and Ear Infirmary in Boston.

Stephen S. Lane, MD (University of Minnesota, Minneapolis). Dr. Lane was one of

the original clinical investigators for the FDA trial examining the use of the excimer laser. He is clinical professor of ophthalmology at the University of Minnesota. His expertise is in cornea and external disease, anterior segment surgery and refractive surgery. In addition to his practice at Associated Eye Care in Minneapolis, he has participated in more than 20 national clinical trials in cataract and refractive surgery.

Paul Daniel Langer, MD (UMDNJ-New Jersey Medical School, Newark). Dr. Langer is chief of the division of ophthalmic plastic and reconstructive surgery and director of the residency program at the Institute of Ophthalmology and Visual Science at UMDNJ-New Jersey Medical School. He also serves as co-chair of the ophthalmology committee at the Accreditation Council for Graduate Medical Education.

Andrew G. Lee, MD (Methodist Hospital, Houston). Dr. Lee is chair of the department of ophthalmology at the Methodist Hospital. He is editor-in-chief of the Journal of Academic Ophthalmology. His specialties include neuro-ophthalmology, optic nerve disorders and optic nerve tumors.

Jerome H. Levy, MD (New York Eye Surgery Center, Bronx). Dr. Levy is co-founder, president and surgeon director of New York Eye Surgery Center and the Ambulatory Surgery Center of Greater New York. He is an attending surgeon at Lenox Hill Hospital in New York and the Ambulatory Surgery Center of Greater New York and past president and board member of the Outpatient Ophthalmic Surgery Society.

Paul R. Lichter, MD (Kellogg Eye Center, Ann Arbor, Mich.). Dr. Lichter is chair of the department of ophthalmology and visual sciences and director of the Kellogg Eye Center at the University of Michigan. He is past president of the American Academy of Ophthalmology and Association of University Professors of Ophthalmology, past chair of the American Board of Ophthalmology and past editor-in-chief of Ophthalmology.

Thomas J. Liesegang, MD (Mayo Clinic, Jacksonville, Fla.). Dr. Liesegang is a professor of ophthalmology at Mayo Clinic Florida. He has practiced at the Mayo Clinic for 28 years, first in Rochester, Minn. Dr. Liesegang has been chair of the American Academy of Ophthalmology's ophthalmic clinical education committee and CME committee. He serves on the International Council of Ophthalmology's Task Force on Ophthalmology Continuing Education and is a director of the Pan American Association of Ophthalmologists.

Richard L. Lindstrom, MD (Minnesota Eye Consultants, Minneapolis). Dr. Lindstrom has developed a number of solutions, intraocular lenses and instruments. He is founder and attending surgeon at Minnesota Eye Consultants and is chief medical editor for Ocular Surgery News and medical director of TLC Vision, Sightpath Medical and Refractec. He spent 10 years on the active faculty at University of Minnesota in the department of ophthalmology in Minneapolis.

Parag A. Majmudar, MD (Chicago Cornea Consultants). Dr. Majmudar has served as American Academy of Ophthalmology meeting committee chair for refractive surgery and optics, refraction contact lenses and is on the international council of the International Society of Refractive Surgery. He has private practices in Chicago, Hoffman Estates and Highland Park, Ill., specializing in laser and non-laser vision correction procedures, cataract surgery and complications stemming from refractive surgery. He is associate professor of ophthalmology at Rush University in Chicago and was co-director of the corneal fellowship at Rush.

Robert K. Maloney, MD (Maloney Vision Institute, Los Angeles). Dr. Maloney was among the first surgeon on the West Coast to perform LASIK surgery as part of the original FDA

clinical trials. He is director of the Maloney Vision Institute and has trained more than 700 surgeons for the excimer laser. He has personally performed more than 40,000 vision-correction surgeries. In addition to an appointment at UCLA, he has appeared frequently on TV as the exclusive LASIK surgeon for the ABC series "Extreme Makeover."

Richard Mackool, MD (Mackool Eye Institute, Astoria, N.Y.). Dr. Mackool developed the first combined microsurgical system for performing both phacoemulsification and either posterior or anterior segment vitrectomy. The founder of the Mackool Eye Institute, he performed one of the first human implantation of an acrylica intraocular lens.

Mark J. Mannis, MD (UC Davis Health System, Sacramento, Calif.). Dr. Mannis' research includes development of experimental antimicrobial agents and growth factors that affect the corneal wound healing rate, skin diseases that affect the eye and outcomes of corneal transplants and artificial corneas. He is chair of ophthalmology at UC Davis Health System Eye Center and past president of the Cornea Society.

Steven L. Mansberger, MD, MPH (Devers Eye Institute, Portland, Ore.). Dr. Mansberger is director of ophthalmic clinical trials for the Devers Eye Institute and director of glaucoma services at the Veterans Hospital. He holds appointments at Oregon Health Science University and has research grant support as principal investigator from the National Eye Institute, CDC and American Glaucoma Society. He is on the editorial board for *Journal of Glaucoma* and *American Journal of Ophthalmology*.

Samuel Masket, MD (Advanced Vision Care, Los Angeles). Dr. Masket is author of the *Atlas of Cataract Surgery*, an overview of the current state of cataract and related surgery. He is a partner in Advanced Vision Care and clinical professor of ophthalmology at UCLA's Jules Stein Eye Institute. He chaired the cataract special interest committee of the American Society of Cataract and Refractive Surgery and was on the board of the American Academy of Ophthalmology.

Peter J. McDonnell, MD (Wilmer Eye Institute, Baltimore). Dr. McDonnell is director of the Wilmer Eye Institute at Johns Hopkins University School of Medicine. He is a leader in corneal transplantation, laser refractive surgery and treating dry eye. His research interests include the causes and correction of refractive error, corneal wound healing and microbial keratitis.

Aaron M. Miller, MD (Houston Eye Associates). Dr. Miller is editor-in-chief of Eye Wiki, an ophthalmic wiki with content written by ophthalmologists. A member of Houston Eye Associates, Dr. Miller emphasizes patient communication. He strives to answer any question that may arise during the visit. Research projects include thestudy of retinopathy of prematurity and pediatric orbital infections.

Joan W. Miller, MD (Massachusetts Eye and Ear Infirmary, Boston). Dr. Miller was the first woman to be named a full professor of ophthalmology at Harvard Medical School in Boston. She is now chief and chair of the department of ophthalmology at Massachusetts Eye and Ear Infirmary at Harvard. Dr. Miller's clinical interests include diseases and surgery of the retina and vitreous, age-related macular degeneration, diabetic retinopathy and photodynamic therapy. Her research interests involve neuroprotection and ocular neovascularization, particularly as it relates to macular degeneration and diabetic retinopathy.

Kevin M. Miller, MD (Jules Stein Eye Institute, Los Angeles). Dr. Miller works with industry to bring products to market in the area of intraocular lenses and ophthalmic optics. He is comprehensive ophthalmology division chief at the Jules Stein Eye Institute at UCLA and holds his own humanitarian device exemption from the FDA to implant Morcher artificial iris segments in eyes with congenital or acquired iris defects.

Richard P. Mills, MD, MPH (University of Washington, Seattle). Dr. Mills is in a private glaucoma practice and holds an appointment at the University of Washington. He is editor of *Eye Net*, a publication of the American Academy of Ophthalmology, and chairs the steering committee for EyeCare America at AAO.

Bartly Mondino, MD (Jules Stein Eye Institute, Los Angeles). Dr. Mondino is chairman of the UCLA Department of Ophthalmology and director of the Jules Stein Eye Institute. He is executive vice president of the Association of University Professors of Ophthalmology and on the medical advisory board of the Braille Institute in Los Angeles.

Timothy Murray (Bascom Palmer, Miami). Dr. Murray is an expert in treating eye cancer in children. He is director of the Ocular Oncology Service at Bascom Palmer and holds an appointment at the Miller School of Medicine at the University of Miami. His research interests include ocular oncology, with a focus on combined modality focal therapies, tumor responses to periocular chemotherapy and external beam radiotherapy. Dr. Murray earned his MD from Johns Hopkins University School of Medicine in Baltimore. He completed an ophthalmology residency at University of California School of Medicine, San Francisco and retinal and vitreoretinal fellowships at the Medical College of Wisconsin in Milwaukee.

Peter A. Netland, MD, PhD (University of Virginia, Charlottesville). Dr. Netland has published five textbooks, most recently *Pediatric Glaucomas* and the second edition of *Glaucoma Medical Therapy*. He is chairman of the ophthalmology department at the University of Virginia in Charlottesville. With research interests primarily in the pharmacologic effects and surgical techniques in glaucoma, he is an active clinician caring for glaucoma patients.

Timothy W. Olsen, MD (Emory Eye Center, Atlanta). Dr. Olsen collaborates with mechanical engineers at Georgia Tech in Atlanta for the development of new surgical instrumentation to address advanced AMD. His research team has described novel methods of drug delivery, such as the suprachoroidal route using small microcannulae. Dr. Olsen is director of the Emory Eye Center and is on the board of the Emory Clinic. He holds leadership positions in the Macula Society, American Ophthalmologic Society, American Academy of Ophthalmology and Association for Research in Vision and Ophthalmology.

Randall J. Olson, MD (Moran Eye Center, Salt Lake City). Dr. Olson has been researching intra-ocular lens complications, teleophthalmology and corneal transplantation techniques. He is CEO of the John A. Moran Eye Center at the University of Utah in Salt Lake City, an ophthalmology professor at the University of Utah and author of more than 300 professional publications. Having earned his MD at the University of Utah School of Medicine, Dr. Olson completed a residency at Jules Stein Eye Institute in Los Angeles and fellowships at the University of Pennsylvania in Philadelphia, University of Florida in Gainesville and Louisiana State University Eye Center in New Orleans.

James C. Orcutt, MD, PhD (University of Washington, Seattle). Dr. Orcutt chairs the American Board of Ophthalmology and has interests in neuro-ophthalmology, orbital disease and oculoplastic surgery. He is a professor of ophthalmology and adjunct professor of otolaryngology, head and neck surgery at University of Washington. He has done research in teleretinal imaging for diabetic eye disease and has developed a national registry for tracing soldiers with ocular injuries.

Robert H. Osher, MD (Cincinnati Eye Institute). Focusing on cataract and implant surgery, Dr. Osher has designed many of the contemporary intraocular lenses and instruments used in cataract surgery. He is professor of ophthalmology at University of Cincinnati College of Medicine and has been the ophthalmic consultant for the Cincinnati Reds since 1990. Dr.

Osher has co-authored five books on cataract and implant surgery and is editor of the *Video Journal of Cataract & Refractive Surgery*, *Video Textbook of Viscosurgery* and *International Advances in Phacoemulsification*.

Mark Packer, MD (Drs. Fine, Hoffman & Packer, Eugene, Ore.). Dr. Packer works with the ophthalmic industry on the development of new technology for cataract and refractive surgery. He is in private practice with Drs. Fine, Hoffman & Packer and holds an appointment at Oregon Health & Sciences University in Portland. He serves as consultant to Abbott Medical Optics, Advanced Vision Science, General Electric Company, Rayner Intraocular Lenses, Transcend Medical, TrueVision Systems, Visiogen and WaveTec Vision Systems.

Kirk Packo, MD (Illinois Retina Associates, Chicago). Dr. Packo has invented more than 25 surgical instruments, holds two U.S. patents and collaborated on the development of the artificial silicon retina. In addition to being a partner in of Illinois Retina Associates, Dr. Packo chairman of the ophthalmology department and the retina section at Rush University Medical Center in Chicago and cofounder of Rush's vitreoretinal fellowship. He also founded the journal *Retina Times* and has produced over 20 award-winning medical films.

Larry E. Patterson, MD (Eye Centers of Tennessee, Crossville). Dr. Patterson has done extensive medical mission work in Central America and the South Pacific, and is chief medical editor of *Ophthalmology Management* magazine. He is medical director of the Eye Centers of Tennessee and the Cataract and Laser Center and past president of the Outpatient Ophthalmic Surgery Society. Dr. Patterson built and operated a multispecialty surgery center in 1998 and an ophthalmic surgery center in 2002. He earned his MD from the University of Tennessee in Knoxville and completed his ophthalmology residency there as well.

Jay S. Pepose, MD, PhD (Pepose Vision Institute, Chesterfield, Mo.). Dr. Pepose is director of Pepose Vision Institute, director of the Midwest Cornea Foundation and holds an appointment at Washington University in St. Louis. He is a subspecialist in refractive surgery, cornea and external diseases and is an editor of the *American Journal of Ophthalmology*.

Jean E. Ramsey, MD, MPH (Boston University Eye Associates). Dr. Ramsey has developed specialty clinics for adults with cognitive and intellectual disabilities. She holds an appointment at Boston University School of Medicine and directs the ophthalmology residency program at Boston Medical Center. She specializes in pediatric ophthalmology and strabismus.

J. Bradley Randleman, MD (Emory University School of Medicine, Atlanta). Dr. Randleman is associate professor of ophthalmology at Emory University School of Medicine and is director of the Emory Corneal Fellowship program. He is editor of the *Journal of Refractive Surgery* and associate editor for the *Journal of Cataract and Refractive Surgery*.

Christopher J. Rapuano, MD (Wills Eye Institute, Philadelphia). Dr. Rapuano was instrumental in reintroducing refractive surgery to Wills Eye Institute. He is co-director of the cornea service and the refractive surgery department at Wills and professor of ophthalmology at Thomas Jefferson Medical College in Philadelphia. As a resident, he co-authored a best-selling textbook in ophthalmology, *Wills Eye Institute Manual*. He recently published the *LASIK Handbook — A Case-Based Approach*.

Philip J. Rosenfeld, MD (Bascom Palmer Eye Institute, Miami). Dr. Rosenfeld pioneered the use of Avastin, the first drug that actually reverses vision loss for patients with age-related macular degeneration. He is professor of ophthalmology at Bascom Palmer Eye Institute and is principal investigator for nine prospective studies investigating pharmacotherapies for the treatment of neovascular age-related macular degeneration.

Stephen J. Ryan, MD (Doheny Eye Institute, Los Angeles). The founding president of the National Alliance for Eye and Vision Research, Dr. Ryan is president of Doheny Eye Institute, affiliated with the University of Southern California, and has authored or edited nine books and more than 270 peer-reviewed articles. Dr. Ryan received his MD from Johns Hopkins University School of Medicine in Baltimore. He completed his ophthalmology residency at the Wilmer Eye Institute at Johns Hopkins. He previously served as dean of the Keck School of Medicine at USC and is a recipient of the American Academy of Ophthalmology Senior Honor Award.

Thomas W. Samuelson, MD (Minnesota Eye Consultants, Minneapolis). Dr. Samuelson is founding partner and attending surgeon of Minnesota Eye Consultants and holds an appointment at the University of Minnesota in Minneapolis. He is chair of glaucoma clinical committee at ASCRS and past chairman of the medical staff at the Phillips Eye Institute in Minneapolis. Dr. Samuelson is an examiner for the American Board of Ophthalmology and past president of the International Society of Spaeth Fellows. He serves on the Basic Clinical Science Course Committee for the American Academy of Ophthalmology.

Andrew P. Schachat, MD (Cole Eye Institute, Cleveland). Dr. Schachat is vice chairman of clinical affairs and director of clinical research at the Cole Eye Institute at the Cleveland Clinic. He has served on many committees with the American Academy of Ophthalmology, including the Bylaws and Rules committee, Outcomes Program committee and Basic and Clinical Science Course committee.

Carol Shields, MD (Wills Eye Institute, Philadelphia). Dr. Shields is involved in numerous research projects centered on tumors of the conjunctiva, eyelids, orbit and intraocular areas. She is associate director of the oncology service at Wills and holds an appointment at Thomas Jefferson Medical College in Philadelphia. She has been writing recently on conjunctival melanoma, conjunctival nevi and conjunctival squamous cell carcinoma. In the area of intraocular tumors, her main focus is on choroidal melanoma, choroidal metastasis and retinoblastoma.

Jerry Shields, MD (Wills Eye Institute, Philadelphia). Dr. Shields established the ocular oncology service at Wills in 1974. He is director of the oncology service at Wills and holds an appointment at Thomas Jefferson Medical College in Philadelphia. With a main interest in choroidal melanoma and retinoblastoma, he pioneered new therapies and was instrumental in popularizing plaque radiotherapy for choroidal melanoma to save the patient's eye. He is former president of the International Society of Ocular Oncology.

Bradford J. Shingleton, MD (Ophthalmic Consultants of Boston). A glaucoma and cataract specialist with Ophthalmic Consultants, Dr. Shingleton has performed among the most cataract, glaucoma and laser operations in New England. He holds an appointment at Harvard Medical School in Boston and was president of the American Society of Cataract and Refractive Surgery from 2008-2009. An avid sports fan, he is team ophthalmologist for the Boston Bruins, Boston Red Sox, New England Patriots and the New England Revolution.

Carla J. Siegfried, MD (Washington University School of Medicine, St. Louis). Dr. Siegfried is associate professor of ophthalmology and visual sciences at Washington University School of Medicine. She is AAO meeting chair forglaucoma and ad hoc reviewer for the *American Journal of Ophthalmology* and *Journal of Glaucoma*. After earning an MD from the University of Missouri, Kansas City School of Medicine, she completed an ophthalmology residency at University of Illinois Eye and Ear Infirmary and a glaucoma fellowship at Northwestern University, both in Chicago. Her specialty areas are glaucoma and general ophthalmology.

Stephen G. Slade, MD (Slade & Baker Vision Center, Houston). Dr. Slade was among the first surgeons in the United States to perform LASIK. A partner in Slade & Baker, he was also among first in the United States to implant the Crystalens, a phacoemulsification lens for presbyopia, and is among the most experienced physicians with INTRALASE, a "bladeless" Lasik. Dr. Slade has directed LASIK training of more than 8,000 other refractive surgeons worldwide.

Ronald E. Smith, MD (University of Southern California, Los Angeles). Dr. Smith is chairman of the ophthalmology department at the University of Southern California. He served as president of the American Academy of Ophthalmology and was the AAO's chair of the Lifelong Education for the Ophthalmologist Planning Committee and the Master Plan for Education Committee. He was also national project director of the Elimination of Preventable Blindness from Diabetes by the Year 2000.

Kerry Solomon, MD (Carolina Eyecare Physicians, Charleston, S.C.). Dr. Solomon is the first director of the Carolina Eyecare Research Institute at Carolina Eyecare Physicians and is chair of the FDA liaison committee for the American Society of Cataract and Refractive Surgery. He was director of cataract, refractive and cornea services at Storm Eye Institute, medical director of the Magill Vision Center and director of the Magill Research Center, all in Charleston.

Richard F. Spaide, MD (Vitreous-Retina-Macula Consultants of New York, New York). Dr. Spaide has developed numerous surgical instruments that were named after him. He was involved in developing combined photodynamic therapy and intravitreal triamcinolone for age-related macular degeneration. His current research interests include development of autofluorescent photography of the eye using a fundus camera.

Walter J. Stark, MD (Wilmer Eye Institute, Baltimore). Dr. Stark is director of the Stark-Mosher Center for Cataract and Corneal Diseases of the Wilmer Eye Institute at Johns Hopkins Medical Institutions. He is also medical director of the Medical Eye Bank of Maryland, former chairman of the Ophthalmic Devices Panel of the FDA and former associate editor of *Archives of Ophthalmology*.

Roger F. Steinert, MD (UC Irvine Ophthalmology Group, Irvine, Calif.). Dr. Steinert was involved in the first stage of excimer laser refractive surgery and LASIK development. While a visiting scientist at Massachusetts Institute of Technology in Cambridge, his laboratory group was the second in the world to begin studying the applications of the excimer laser in 1983. He was among the first group of surgeons in FDA trials of phototherapeutic keratectomy and photorefractive keratectomy.

Paul Sternberg Jr., MD (Vanderbilt Eye Institute, Nashville, Tenn.). Dr. Sternberg is chair of the Department of Ophthalmology and Visual Sciences at Vanderbilt Eye Institute, Vanderbilt University School of Medicine. He is member of the board of trustees of the American Academy of Ophthalmology and Association for Research in Vision and Ophthalmology. He chaired the NIH Study Section on Retinal and Choroidal Diseases and is a reviewer for the *American Journal of Ophthalmology*.

Edwin M. Stone, MD, PhD (University of Iowa, Iowa City). Dr. Stone is director of the Carver Family Center for Macular Degeneration at the University of Iowa. He specializes in molecular genetics of inherited eye diseases, including age-related macular degeneration, hereditary glaucoma, autosomal dominant RPE dystrophies, Leber's hereditary optic neuropathy, familial exudative vitreoretinopathy and hereditary corneal dystrophies.

R. Doyle Stulting, MD, PhD (Woolfson Eye Institute, Atlanta). Dr. Stulting is director of Corneal Disease and Research at Woolfson Eye Institute. An immediate past president of the American Society of Cataract and Refractive Surgery, he served as a member of the FDA Ophthalmic Devices Panel for 10 years and chaired that panel for three years. He has served as editor-in-chief of the journal *Cornea* and as a board member of the Eye Bank Association of America.

William S. Tasman, MD (Mid Atlantic Retina, Philadelphia). While serving in the U.S. Air Force in Germany, Dr. Tasman worked with Professor Meyer-Schwickerath at the University of Bonn, who was developing the xenon arc photocoagulator for treating diabetic retinopathy. Dr. Tasman founded Mid Atlantic Retina, which is affiliated with Wills Eye Hospital in Philadelphia. Aside from retinopathy of prematurity, Dr. Tasman has had a strong interest in other pediatric vitreoretinal conditions, such as Stickler's syndrome. He has been president of the Retina Society and American Board of Ophthalmology.

John T. Thompson, MD (Retina Specialists, Towson, Md.). In addition to his practice at Retina Specialists, Dr. Thompson holds appointments at Johns Hopkins University in Baltimore and the University of Maryland in College Park. He has served as vice president of the American Society of Retina Specialists and president of the Maryland Society of Eye Physicians and Surgeons. Dr. Thompson earned his MD from Johns Hopkins Medical School and completed an ophthalmology residency and surgical and medical retina specialty training at the Wilmer Institute in Baltimore. He has been American Academy of Ophthalmology meeting chairman for retina, vitreous and intraocular inflammation and uveitis.

Richard Tipperman, MD (Ophthalmic Partners of Pennsylvania, Bala Cynwyd). Dr. Tipperman is part of Ophthalmic Partners of Pennsylvania, specializing in refractive surgery, cataract surgery and management of complications of cataract surgery. He has authored numerous publications and twice won the Best Paper of Session award at the American Society of Cataract and Refractive Surgery annual meeting. Dr. Tipperman received his MD from the University of Rochester (N.Y.) School of Medicine and Dentistry.

Michael T. Trese, MD (Associated Retinal Consultants, Royal Oak, Mich.). Dr. Trese is an expert in retinopathy of prematurity and pediatric retinal disease. In addition to being a partner of Associated Retinal Consultants, he currently is Clinical Professor of Biomedical Sciences at The Eye Research Institute of Oakland University (Rochester, MI), and Clinical Associate Professor at Wayne State University School of Medicine in Detroit. He is also chief of Pediatric and Adult Vitreoretinal Surgery at William Beaumont Hospital, based in Royal Oak, Mich.

Russell N. Van Gelder, MD, PhD (University of Washington School of Medicine, Seattle). Dr. Van Gelder chairs the ophthalmology department at the University of Washington School of Medicine and director of UW Medicine Eye Institute. He has been president of the American Uveitis Society and chair of the commercial relations committee of Association for Research in Vision and Ophthalmology. He is a reviewer for the *American Journal of Ophthalmology*, associate editor of *Ocular Immunology and Inflammation*, and serves on the editorial boards of*IOVS*, *Journal of Biological Rhythms* and *Molecular Vision*.

Woodford Van Meter, MD (University of Kentucky, Lexington). Dr. Van Meter directs the Cornea and External Disease Service at the University of Kentucky School of Medicine and is a consultant for the Ophthalmic Devices Panel of the Medical Devices Advisory Committee at the Center for Devices and Radiological Health at the CDC. He currently serves as president of the Kentucky Academy of Eye Physicians and Surgeons.

Rohit Varma, MD, MPH (Doheny Eye Institute, Los Angeles). Dr. Varma has received among the top amount in grant funding from the National Eye Institute of the National Institutes of Health. He is director of the glaucoma service, ocular epidemiology center and clinical trials at Doheny Eye Institute at the University of Southern California.

George A. Violin, MD (Medical Eye Care Associates, Norwood, Mass.). Dr. Violin was one of the early investigators of epikeratophakia, a precursor of LASIK technology. He is the founder of Medical Eye Care Associates and devotes most of his practice to cataract surgery, LASIK and related surgeries. He is one of the three founding principals of the Ambulatory Surgery Centers of America and is affiliated with Caritas Norwood (Mass.) Hospital, Faulkner/Brigham and Women's Hospital, Massachusetts Eye and Ear Infirmary and New England Medical Center, all in Boston.

John A. Vukich, MD (Davis Duehr Dean Center for Refractive Surgery, Madison, Wis.). Dr. Vukich twice served as program chairman of the largest refractive surgery meeting in the world, the ISRS/AAO Refractive Surgery Subspecialty Day. He is the surgical director of Davis Duehr Dean Center, holds an appointment at the University of Wisconsin Medical School in Milwaukee and is an associate editor of the *Journal of Refractive Surgery*. Dr. Vukich earned his MD from Emory University in Atlanta and completed an ophthalmology residency at the University of Illinois Eye and Ear Infirmary in Chicago.

R. Bruce Wallace III, MD (Wallace Eye Surgery Center, Alexandria, La.). Dr. Wallace is the founder and medical director of Wallace Eye Surgery Center. He holds appointments at LSU Medical School and Tulane School of Medicine, both in New Orleans. The current president of the Outpatient Ophthalmic Surgery Society, he has been AAO meeting chair for cataract and president of the Society for Excellence in Eyecare and American College of Eye Surgeons.

Robert S. Weinberg, MD (Johns Hopkins Bayview Medical Center, Baltimore). Dr. Weinberg chairs the department of ophthalmology at the Johns Hopkins Bayview Medical Center and is associate professor of ophthalmology at the Wilmer Eye Institute at Johns Hopkins. A specialist in corneal and external diseases of the eye, uveitis and ocular manifestations of systemic disease, he previously served as director of the cornea service at the Medical College of Virginia in Richmond.

Robert N. Weinreb, MD (Hamilton Glaucoma Center, San Diego). Dr. Weinreb is director of the Hamilton Glaucoma Center, known for its cross-disciplinary investigative programs. He has served as president of the American Glaucoma Society, Association for Research in Vision and Ophthalmology and World Glaucoma Association. He has written or edited more than 16 books, including *Essentials in Ophthalmology*, and is co-editor of *Graefe's Archive for Clinical and Experimental Ophthalmology* and research editor of *Survey of Ophthalmology*.

Jon-Marc Weston, MD (Weston Eye Center, Roseburg, Ore.). Dr. Weston introduced the now standard "no needle, no stitch" cataract procedure to Southern Oregon and was among the first in the Pacific Northwest to use endoscopic laser for glaucoma and multi-focal lens implants. In addition to his practice at Weston Eye Center, he founded Vision Surgery & Laser Center and Oregon Laser Eye Center. He is secretary of the Outpatient Ophthalmic Surgery Society.

Charles P. Wilkinson, MD (Greater Baltimore Medical Center). Dr. Wilkinson is chairman of the ophthalmology department at Greater Baltimore Medical Center. He is past president of the American Academy of Ophthalmology and chaired its preferred practice patterns retina panel. He also was chair of the American Board of Ophthalmology and the FDA Ophthalmic Devices Panel.

George Williams, MD (William Beaumont Hospital, Royal Oak, Mich.). Dr. Williams has a special interest in advanced vitreoretinal surgery for complex retinal detachment and diabetic retinopathy. The chair of ophthalmology at William Beaumont Hospital, he is also director of the Beaumont Eye Institute, holds an appointment at Oakland University William Beaumont School of Medicine in Rochester, Mich., and is a partner with Associated Retinal Consultants. He is currently the principal investigator of several research trials sponsored by the National Eye Institute and the pharmaceutical industry.

Ruth D. Williams, MD (Wheaton Eye Clinic, Wheaton, Ill.). A glaucoma consultant and partner at the Wheaton Eye Clinic, Dr. Williams serves on the executive committee of this practice of 26 ophthalmologists. She is president-elect of the American Academy of Ophthalmology and serves on the academy's board of trustees.

M. Edward Wilson Jr., MD (Albert Florens Storm Eye Institute, Charleston, S.C.). Dr. Wilson chairs the pediatric committee of ASCRS and was pediatric issues consultant to the FDA Ophthalmic Devices Panel. He is director of the Albert Florens Storm Eye Institute and chairman of the department of ophthalmology at the Medical University of South Carolina in Charleston. Dr. Wilson serves on the board of the South Carolina Society of Ophthalmology and has been president of the Costenbader Society, a pediatric ophthalmology group. He is an executive editor of the *American Journal of Ophthalmology* and serves on the editorial board of the *Journal of the American Association for Pediatric Ophthalmology and Strabismus*.

Lawrence A. Yannuzzi, MD (Manhattan Eye, Ear & Throat Hospital, New York). Dr. Yannuzzi is a pioneer in angiography, having helped coin the term "idiopathic polypoidal choroidal vasculopathy" for a particular type of hemorrhagic maculopathy. He is vice chairman and director of the Retinal Research Center of the Manhattan Eye, Ear & Throat Hospital and founder and president of the Macula Foundation. He holds an appointment at Columbia University College of Physicians and Surgeons in New York.

Terri L. Young, MD (Duke Eye Center, Durham, N.C.). Dr. Young is professor of ophthalmology and pediatrics at Duke Eye Center. She is the American Academy of Ophthalmology meeting chair for pediatric ophthalmology and strabismus. Dr. Young earned her MD from Harvard Medical School in Boston and completed an ophthalmology residency at the University of Illinois, Chicago, and a fellowship in pediatric ophthalmology and strabismus at the University of Pennsylvania in Philadelphia. She has received honor awards from the American Academy of Ophthalmology and American Association of Pediatric Ophthalmology and Strabismus. ■

Contact Leigh Page at leigh@beckersasc.com.

From Surgery Center Administrator to Executive: 4 Industry Leaders Discuss Their Transition

By Rob Kurtz

Many of today's ambulatory surgery center management and development company leaders made a name for themselves as administrators before moving into the role of executive. The following four executives discuss their transition from administrator to executive:

- Sandi Baber, RN, MHA, vice president of operations for Blue Chip Surgical Partners
- Susan Kizirian, RN, MBA, chief operating officer for Ambulatory Surgical Centers of America
- Sarah Martin, RN, MBA, CASC, vice president of operations for Meridian Surgical Health
- Robert Welti, MD, senior vice president of operations and medical director for Regent Surgical Health

Note: Responses are listed in alphabetical order of respondent's last name.

Q: Where did you serve as administrator, when did you make the change to company executive and what was the position you moved into?

Sandi Baber: I have held several administrator positions within the St. Louis area in both large and small centers. I originally worked with physicians to develop de novo single specialty centers with emphasis in orthopedics and ENT. In 1998, I moved into an executive position as a vice president of six surgery centers for a large management company.

Susan Kizirian: My last position as the administrator of an ASC was at University of Virginia Health Systems. I was a medical center director. UVA purchased a freestanding ASC and I was hired to convert it to an HOPD while keeping its ASC efficiencies. I moved into a vice president of operations [position] with ASCOA in 2005.

Sarah Martin: I was in a unique position as the administrative director for four freestanding surgery centers in the Memphis, Tenn., area, which were joint ventures with a local hospital system. Two were multi-specialty surgery centers, one was urology and one was all pediatric. I learned about coding, how to bill, schedule, about collections and still assisted in staffing in all areas, preop, operating room and PACU. It was a wonderful experience as I had overall responsibility for the clinical, financial and quality aspects of four centers, which set me up for taking on a regional role with an additional volume of centers.

My first executive role was with Symbion as a regional director of operations for their Midwest Region, and I had six facilities of varying specialties: several multi-specialty centers, a surgical hospital and an imaging center, so it was an eclectic mix of facilities.

Dr. Robert Welti: I was a practicing anesthesiologist in Santa Barbara (Calif.). We opened an ASC in 2001. I went over as medical director and on-site anesthesiologist. I did that until 2006. The administrator at Santa Barbara Surgery Center then left for another location. I was very involved as medical director, so the management company of the ASC and physicians asked me to go ahead and try to be an administrator. I had done a lot as medical director, more than usual, and learned from the job from the administrator there. I was administrator from 2006-2008. In 2008, after we were able to orchestrate a turnaround of the surgery center and get it to a stable and profitable situation, Regent Surgical Health asked me if I'd be interested in becoming an executive with the company. I became the senior VP of operations to provide regional oversight for their Western U.S. surgery centers.

Q: What was the motivation or circumstances which led to your move from working as an administrator to an executive?

Ms. Baber: I found that I was very interested in development and recruitment of physician-partners. The reimbursement climate and increased competition has dramatically changed the healthcare industry. The key is staying competitive by focusing on our patients and our physician partnerships while enhancing our revenue and product lines. I found this balance very exciting and challenging.

Ms. Kizirian: As administrator I had run the gamut of experiences including writing the business plan, obtaining financing and getting one off the ground to converting an ASC to an HOPD. The challenge of learning, moving fast through multiple and/or complex operational issues with top results, managing multiples, creating process and protocol to obtain systemwide improvements and the big picture focus getting even bigger were primary motivators.

Ms. Martin: I love to be challenged and to continue to grow and learn. I was ready for a change from day-to-day operations. I left the hospital system to become a consultant for ASCs. In the process of consulting for Symbion, I was asked to interview for the RVP position when it came available.

Dr. Welti: I had practiced anesthesiology for 27 years, and it was through the administrator experience that this opened up a whole new career, a whole new world. I had practiced anesthesiology for a long time, and my kids were out of the nest — they were all grown up. It seemed like an opportunity to try something new. I really enjoy the organizational aspects of business and helping centers to turn them into good places for physicians to work.

Q: How is life different on the "other side of the fence"?

Ms. Baber: The work is focused more on the business of ASC life rather than the patient focus of an administrator. Administrators face the daily challenge of creating a quality environment for patient care while maintaining the essential and sometimes monumental tasks required for licensure and accreditation.

Ms. Kizirian: The details are different. Administrators deal in the day-to-day, much of it mixing components of human, materials and financial management with good communications for great outcomes.

While I don't deal in center-specific details, I do deal in the who, what, when, where and why of the changing ASC industry and market impact for all our facilities. And that is, in essence, a much broader field involving finding the right formula of mixing human, materials and financial management with clear, concise communications that translates with high consistency to excellent results. Fundamentally, [it's] a bigger laboratory and bigger test tubes to create an exponentially significant impact.

Ms. Martin: I see the biggest difference is the face-to-face interchange with physicians and staff. The administrator is on-site daily and has to be the first line of interaction with angry physicians, or difficult issues that arise. I don't get involved with those unless they escalate to a point where the adminis-

trator can't handle them. Also, the accountability is certainly increased, as I am required to ensure that all facilities are successful in all areas of the operations.

Dr. Welti: Going back to the transition from being a physician to administrator, what I learned is that when physicians come into a center, do their cases and leave, it's very rare for a physician to have any idea of how much it really takes to run an ASC. They come in, do a case and get that snapshot view, but they have no idea how much it takes to run the center in terms of regulatory issues, clinical issues, supply issues, labor issues. Having held both the role of physician and administrator, I thought I was in a pretty good position to understand these organizations from the ground up, but what I needed was then financial education that a company like Regent could give me.

Funny thing I learned was that I thought that going to the executive position would be more relaxing than being in the trenches as a practitioner/administrator, but in reality it's just multiplied by six (for the six ASCs he oversees) and I end up working harder and more hours (factoring in the travel as well) then even when I was practicing full-time anesthesia. It's a seven-day-a-week job.

Q: What do you miss about working as an administrator?

Ms. Baber: Patient contact. As an RN, patient care is always at the forefront of my mind. As an administrator, I found that daily contact is an essential component of management.

Ms. Kizirian: Patient care and mentoring new employees fresh out of school.

Ms. Martin: Working with patients. When there were staffing shortages, I would jump in and help and that always gave me the personal touch "fix" working with patients gives me. It also reminded me of how hard my staff work and gave me a renewed appreciation of their work ethic. It was also fun working in my hometown and being able to see and take care of friends and family when they were having surgery. Now that I travel, that aspect is gone.

Dr. Welti: When I was administrator, you really did create a sense of a family. I would know the nursing staff, the business staff, and having worked for 27 years as a physician in the community, we were really a close-knit family. It takes awhile to penetrate the culture of each new center and to be accepted as not an outsider. I do miss really knowing the people on a day-to-day basis.

Q: For individuals working in surgery centers considering this career change, what advice or recommendations would you offer them?

Ms. Baber: Making the transition from a clinical mindset to a business mindset is often challenging. I recommend that they find a mentor and learn as much as they can. Don't be afraid to ask questions. The ASC business changes rapidly and it is extremely important to keep up with all of the new regulations. Keep the old motto "never stop learning" in mind.

Ms. Kizirian: Once you have gotten your ASC as good as it can get, then this is the next step. Master's degree preparation in business is an enormous advantage. Participation in industry associations on the state and national level, pursuing public speaking on ASC specific topics and writing for ASC publications are all excellent stepping stones to expanding ones horizon from one facility and the day-to-day to a much bigger forum. You have to like confrontation and conflict management. And you have to thrive on new and different. To get to this next step it is

about successfully motivating others and creating and implementing fast and efficient protocols to achieve all goals en masse.

Ms. Martin: Develop your time management skills so that you will be able to handle multiple facilities. Focus on details, as many times the new centers I am introduced to are mature and well run, but can still use my experience and knowledge of where to look for money-saving opportunities or how to implement clinical best practices. Conversely, I have also had to go into centers and make many corrections, so learn everything you can about your business when an administrator from how to use your software system in all modules to performing life safety checks in your facility. Last, but not least, look for opportunities to learn new things and help other centers within your organization. This exposes you to your executive management team more and you get to observe how other facilities are run. One thing that changes once you step into an executive role is you learn that there are many ways to run facilities and you need to have an open mind to this. Be open to constructive criticism.

Dr. Welti: I think you have to have — and you probably already do if you're an administrator — excellent organizational skills because now you're trying to keep up with handling the information of not just one center, but you're trying to keep on top of multiple centers.

I think you need to really like people because you're constantly meeting new and diverse people you may have never met in your old center. You just have to know the business inside out so you can walk into a new place and convey the confidence that you're really there with the knowledge to help them develop the center. The travel from covering multiple centers can be exhausting. I could not have done this when I had small kids. You better not [dislike] like travel. ■

Contact Rob Kurtz at rob@beckersasc.com.

Top 10 Orthopedic Procedures in Surgery Centers by Volume

By Rob Kurtz

Here are the 10 most-performed orthopedic procedures in freestanding outpatient surgery centers in 2009, according to SDI's *Free-standing Outpatient Surgery Centers Database* (2009 data year). Procedures are listed by CPT code, long name description and total volume.

CPT code	Long name	Total volume
29881	Arthrs Kne Surg W/meniscectomy Med/lat W/shvg	342,903
29826	Shoulder Scope, Bone Shaving	256,477
29877	Arthrs Knee Debridement/shaving Artclr Crtlg	195,212
29848	Ndsc Wrst Surg W/rls Transvrs Carpl Ligm	150,914
29880	Arthrs Knee W/meniscectomy Med&lat W/shaving	132,800
29827	Arthroscopy Shoulder Rotator Cuff Repair	117,341
28285	Correction Hammertoe	112,648
29823	Arthroscopy Shoulder Surg Debridement Extensive	110,287
26055	Tendon Sheath Incision	109,201
29824	Arthroscopy Shoulder Distal Claviculectomy	102,311

Source: SDI's *Free-standing Outpatient Surgery Centers (FOSC) Database, 2009* Data Year. To learn more about SDI, go to www.sdihealth.com or contact James Doyle at (484) 567-6538 or jdoyle@sdihealth.com.

Note: SDI distinguishes between HOPs (hospital outpatient surgery centers which are on the same campus as a hospital) and FOSCs (outpatient surgery centers which are not on a hospital campus). ■

The information provided should be utilized for educational purposes only. Please consult with your billing and coding expert. Facilities are ultimately responsible for verifying the reporting policies of individual commercial and MAC/FI carriers prior to claim submissions.

100 Surgery Center Benchmarks

By Rachel Fields

Here are 100 benchmarking statistics on processes and outcomes at ambulatory surgery centers across the country. Data is compiled from ASC Association surveys, VMG Health's Multi-Specialty Intellimarker and SDI's Outpatient Surgery Profiling Solution.

Net revenue, OR time and outcomes

The following statistics on net revenue are based on data from VMG Health. The statistics on surgery center OR time and outcomes are based on data from the ASC Association's Outcomes Monitoring Project 2nd Quarter 2010 Report.

Average surgery center net revenue: $6,833,000
Average total operating expenses: $4,881,000
Average EBITDA: $2,001,000

Median operating room time per patient encounter: 50.2 minutes
Average procedure room time per patient encounter: 34.2 minutes
Median rate of unscheduled direct transfers: .6 transfers per 1,000 patient encounters

ASCs using a patient satisfaction survey: 99.5 percent
ASCs completing 90 percent of medical records in 30 days: 78.5 percent
ASCs reporting 0 wrong site, side, procedure, implant, patient procedures: 94.7 percent

Case volume, payor mix and staff hours

The following statistics on case volume, payor mix and staff hours per case are based on data from VMG Health's Multi-Specialty Intellimarker 2010.

Case volume

Total cases per center: 4,698
Cases per day: 18.8
Surgical cases per OR (annually): 705
Surgical cases per OR (daily): 2.8
Non-surgical cases per procedure room (annually): 1,169
Non-surgical cases per procedure room (daily): 4.7

Payor mix

Medicare: 25 percent
Medicaid: 5 percent
Commercial: 59 percent
Workers' comp: 6 percent
Self-pay: 5 percent
Other: 7 percent

Staff hours per case

Nurse hours per case: 6.2
Tech hours per case: 2.6
Administrative hours per case: 4.4
Administrator hours per case: 0.6
Total hours per case: 11.0

Affiliated physicians

The following statistics on affiliated physicians are based on data from SDI's Outpatient Surgery Center Profiling Solution, which profiles 81,597 physicians performing procedures at ASCs.

Number of affiliated physicians per ASC

1-5 physicians — 47 percent
6-10 physicians — 18 percent
11-15 physicians — 9 percent
16-25 physicians — 10 percent
26-50 physicians — 10 percent
More than 50 physicians — 6 percent

A/R and Compensation

The following statistics on surgery center accounts receivable and compensation are based on data from the ASC Association's 2010 ASC Employee Salary & Benefits Survey and the ASC Association's Outcomes Monitoring Project 4th Quarter 2010 Report.

Accounts receivable

All reporting ASCs — 39.7 days
Multi-specialty ASCs — 40.3 days
Single-specialty ASCs — 39.2 days
Gastroenterology single-specialty ASCs — 30.1 days
Ophthalmology single-specialty ASCs — 37.0 days
Orthopedic single-specialty ASCs — 52.8 days

Average 2010 Salaries

Certified registered nurse anesthetist: $156,000
Administrator: $93,870
Registered nurse: $60,500
Business office manager: $53,000
Anesthesiologist: $275,000
Instrument technician: $33,280
Operating room technician: $40,000

Managers eligible for bonuses:

- Administrators – 75 percent
- Business office managers – 63 percent
- Directors of nursing – 64 percent
- Materials managers – 53 percent
- Medical directors — 10 percent

Specialties

The following statistics on surgery center specialties are based on data from VMG Health's Multi-Specialty ASC Intellimarker 2010. Specialties are listed in alphabetical order.

ENT
Case volume mix as percent of total cases: 8 percent
Net revenue per case: $1,742
Gross charges per case: $7,066
Discount to charges: 73.6 percent

GI/Endoscopy
Case volume mix as percent of total cases: 24 percent
Net revenue per case: $746
Gross charges per case: $3,216
Discount to charges: 72.3 percent
Average number of cases for single-specialty ASCs: 5,641

General Surgery
Case volume mix as percent of total cases: 8 percent
Net revenue per case: $1,545
Gross charges per case: $5,534
Discount to charges: 68.4 percent

OB/GYN
Case volume mix as percent of total cases: 3 percent
Net revenue per case: $1,757
Gross charges per case: $6,404
Discount to charges: 69.1 percent

Ophthalmology
Case volume mix as percent of total cases: 19 percent
Net revenue per case: $1,227
Gross charges per case: $5,395
Discount to charges: 74.7 percent
Average number of cases for single-specialty ASCs: 2,640

Oral Surgery
Case volume mix as percent of total cases: 1 percent
Net revenue per case: $1,041
Gross charges per case: $3,024
Discount to charges: 65.4 percent
Average number of cases for single-specialty ASCs: 3,036

Orthopedics
Case volume mix as percent of total cases: 17 percent
Net revenue per case: $2,443
Gross charges per case: $8,973
Discount to charges: 70.0 percent

Pain Management
Case volume mix as percent of total cases: 14 percent
Net revenue per case: $898
Gross charges per case: $3,835
Discount to charges: 73.2 percent
Average number of cases for single-specialty ASCs: 4,234

Plastics
Case volume mix as percent of total cases: 5 percent
Net revenue per case: $1,415
Gross charges per case: $6,198
Discount to charges: 68.9 percent

Podiatry
Case volume mix as percent of total cases: 3 percent
Net revenue per case: $1,664
Gross charges per case: $7,061
Discount to charges: 72.7 percent

Urology
Case volume mix as percent of total cases: 3 percent
Net revenue per case: $1,435
Gross charges per case: $5,937
Discount to charges: 68.6 percent
Average number of cases for single-specialty ASCs: 3,487 ■

Sources:
VMG Health at www.vmghealth.com
ASC Association at www.ascassociation.org
SDI at www.sdihealth.com

10 Metrics for Measuring Physician Performance

By Leigh Page

Measuring physician performance in an ambulatory surgery center has become essential, says Sandy Berreth, administrator of Brainerd Lakes Surgery Center in Baxter, Minn. "It is the only way we know if we have been effective and if we need to change behavior," she says. "You don't know how well you are doing unless you can measure."

Data collected on physicians can direct budgeting, staffing and financial policy. Results can be put into their credentialing files and reported to the ASC board. "We want to make sure that the physician is falling within a certain standard," Ms. Berreth says.

When presented to physicians in the form of blinded comparisons of in-house colleagues, she says this data can be a powerful motivational tool. "You can benchmark very nicely with doctors within the same ASC because they are competitive," she says.

When there is a choice of metrics, "you want to pick measurements that are near and dear to your heart," she says. ASCs can use required metrics or choose their own to report to physicians, Ms. Berreth says. Some metrics are mandatory but not very useful, such as hair removal on patients, and others are both mandatory and useful, such as completing medical records within 30 days.

Here are 10 physician performance metrics chosen by Ms. Berreth and Ann O'Neill, director of clinical operations at Regent Surgical Health in Westchester, Ill.

1. On-time starts. When one surgeon or anesthesiologist frequently starts late, it creates a pattern of inefficiency across the schedule and the ASC, leading to increased costs. "Late starts can have a domino effect on the surgery center and can be a patient dissatisfier," Ms. O'Neill says. Regent tracks physicians' surgery starts that are at least 15 minutes later than the scheduled time. She says this can easily be measured through the scheduling component of standard business software that many ASCs have.

Ms. Berreth warns that for on-time starts to be comparable between physicians, the metric has to be measuring the same thing for all physicians. If the start of surgery is measured as the point when the physician walks into the OR or when the patient is put under sedation, the metric may be lopsided, because it could include extra steps that some physicians do after this point and some do before it. This could throw off the start times.

For example, some plastic surgeons may mark the patient in the pre-op hold area while others mark patients after sedation. To create a fair measurement, Ms. Berreth identifies the start time as when the physician "makes knife," when the first incision is actually made.

2. Utilization of block time. Blocking out surgery schedules is no good if block times are not being used. "We want make sure our OR is being utilized to its full potential," Ms. Berreth says. "As a rule, the surgeon should be using 80 percent of his OR block time." If the surgeon is using less than that amount, he may be asked to cut back to a shorter block time. For example, "if he is blocked for whole morning and puts in just two cases, then maybe he should end his cases at 10 a.m. rather than noon," she says.

3. Case volume. The ASC reviews each physician's volume from quarter to quarter, looking for early warning signs of changes in his practice. For example, a reduction might be a sign that the physician is preparing for retirement or is sending more cases to the hospital. Current volume could determine whether young physicians will be able to fill the shoes of older physicians. However, Ms Berreth does not compare one physician's volume with another's. "Physicians are not being held accountable for this, but this information does go into their credentialing file," she says.

4. Cost of staff per case. Measuring the cost of labor per case can identify surgeons who are taking longer to complete a case, using more staff per case or using more expensive staff, such as all RNs and no techs. "This metric explains variances and provides opportunity for improvement," Ms. O'Neill says. She again advises being careful to compare the exact same procedure when comparing physician performance.

To compare this metric with other ASCs, this metric can also be measured as RN hours per case or tech hours per case, which avoid regional variations in labor costs, she says. Cost of staff per case should cover all labor costs for a case, including pre-op and post-op, as well as staff costs in the OR, Ms. Berreth adds.

5. Cost of supplies per case. Ms. O'Neill says prices of supplies can be entered either manually or by using automated software, such as through the inventory management software that is part of many ASCs' business software package. "Make sure you enter the supplies the physician actually used, rather than what is on the preference card," she says. Again, be careful that comparisons are equal, she says. For example, one surgeon may be doing an additional procedure that would boost his supply costs.

Ms. Berreth says showing physicians blinded comparisons is a particularly good motivational tool with supply costs per case. "All cataract surgeons, for example, want to have similar case costs," she says. "If one of them costs $1,000 per case and the other just $650, it will be noticed."

6. Infection rates. Reviewing physicians' cases, Ms. Berreth says she follows skin infections based on the CDC definition, which involves such factors as redness, swelling and heat at the site. "The CDC has four different levels of infection and we count them all," she says. A case is also included in her center's infection rates if the physician puts the patient on an antibiotic afterwards. Infections will be detectable by the time the patient makes the post-op visit to the physician, which generally occurs 7-10 days after the operative procedure.

In addition, when ASC representatives make their 30-day post-op call to patients, "we ask them how their follow-up appointments have gone and infections can be reported in that way," she says. That information is then verified with the physician's office.

7. Surgical complications. Ms. Berreth says her ASC also measures surgical complications, which can often be found in the physician's dictated operative record. For instance, the physician might report he accidently cut a nerve in carpal tunnel surgery. But if the complication involves the staff instead of the physician, she is careful not to put it on the list, she says. For example, "when the surgical staff electrically grounds a cautery device with a gel pad on the patient's skin and a sore develops, it would not be put on the list," she says.

Ms. O'Neill uses a similar statistic, called the unexpected complication rate. As of Jan. 2010, Medicare will require all ASCs to report surgical complications 30 days after the procedure and one year afterwards for implants. She says the information has to be collected manually from the physician's office after surgery.

8. Handwashing compliance. Ms. O'Neill says Medicare requires that centers track handwashing practices of physicians as well as staff. "This is one of the areas that a lot of ASCs are getting dinged on in Medicare surveys and, in many cases, it's the physicians who are not properly handwashing," she says. Surveying handwashing compliance requires periodic observation by a designated staff members and filling out a standardized form. Being careful not to look obvious, the monitor watches how others handwashing and makes sure they are using the proper technique" she says.

9. On-time completion of medical records. This metric is not only mandatory — Medicare surveyors use it to judge centers — but is also useful to improve operations. Physicians are the very appropriate to measure here, because a medical record cannot be turned in until the physician completes it. "We track this with all physicians," Ms. Berreth says.

Ms. O'Neill says Medicare sets three different deadlines in this area: The patient's history and physical must be updated and documented within 24 hours of the procedure, the post-operative report must be completed within 72 hours and the full medical record must be completed within 30 days. Even though the history and physical is generally done at the physician's office, it impacts the ASC, Ms. Berreth says. Her ASC measures five components of the H&P while some centers measure as many as eight components.

10. Patient satisfaction. Ms. O'Neill says this metric is important because it influences whether patients will use the facility again. "Everybody measures patient satisfaction in some way or another," she says. "Whatever measurement is used, you want to determine whether the physician has a top-box rate," the highest level of the rating. Since patient satisfaction surveys are standardized, results can be compared across the industry and with national benchmarks.

In addition to scrutinizing survey results, Ms. Berreth tracks every patient complaint about a physician. She says the complaint usually has to do with the physician not conversing with the patient enough about the procedure or what to expect afterwards. "Sometimes the physician said he did talk to the family, which does count for something," she says. The metric is reported to the ASC board. "No physician has more than two or three of these a month, but we don't want them to have even one," she says. ■

Contact Leigh Page at leigh@beckersasc.com.

10 Key Financial Metrics to Measure in a Surgery Center

By By John J. Goehle, COO of Ambulatory Healthcare Strategies

John J. Goehle, COO of Ambulatory Healthcare Strategies, identifies 10 key financial metrics to measure in an ambulatory surgery center.

Revenue side

1. Number of days in accounts receivable. One mistake ASCs often make is not reviewing reports on accounts receivables on a regular basis. "This is one the most important metrics you should follow," Mr. Goehle says. "The administrator should oversee various reports from the business department monthly." The figure may creep up gradually, month by month. "If it starts climbing above 35 or 40 days, it's time to start taking action," he says. During the month, when this metric is not being measured, look at collections as an indicator of where A/R might be heading.

2. Review collections during the month. Compare payments coming in each week with the center's goal for the month. "By mid-month, you should have collected about half of your goal," Mr. Goehle says. If payments fall below that level, it may be time to check the entire collection cycle to identify where the hold-up might be.

3. Estimated net revenue for the month. When monitoring revenue, one mistake ASCs make is to survey how much they billed rather than how much they will actually be paid, based on contracts or rate schedules. "It isn't that hard to collect data on what you will actually be paid," Mr. Goehle says. Most billing systems can be set up to automatically calculate what net revenue would be, based on contract data entered into the ASC's computer system. All the major billing systems have this function, including SourceMedical, Vision and Experior.

Even though the automation is available, a lot of centers do not measure estimated net revenue, or they may do it manually, which can be very time-consuming for a high-volume facility. Mr. Goehle visited one ASC where the staff was manually calculating estimated net revenue, steps away from a computer system that could have done it for them. Small centers may not have such automation and will have to keep making manual estimates, but this may not be so challenging if the center is single-specialty with a limited number of procedures to bill for.

4. Net revenue per case. This metric might pick up a shift in case mix or a shift in volume toward lower-paying insurers, which could affect decisions on appropriate cases and staffing levels. For example, in a multi-specialty ASC, the metric might reveal a rise in lower-paying GI volume or a drop in higher-paying orthopedic volume. "Compare net revenue per case with your budgeted net revenue," Mr. Goehle says. "Identify the cases that

are bringing down net revenue per case and decide whether expenses for these cases can be cut back or whether they should be covered at all." This metric also affects staffing. If the ASC is doing more lower-paying, less time-consuming cases like GI, then staffing should be cut back.

Balance sheet side

5. Number of days cash on hand. The standard for ASCs is 30 days cash on hand, which means the center can go for a month without taking in any revenue. Some centers aim for 35-60 days cash on hand. To calculate this metric, take the amount of cash the center has and divide it by average daily expenses, not including depreciation or amortization. This points the focus on supplies and wages.

Why do you need to know this? "There are several scenarios when you would need to have very generous cash on hand," Mr. Goehle says. "For example, when I was working at an ASC, Medicare implemented a change in the electronic billing protocol, creating a problem with claims processing. All revenue stopped for 2-3 weeks while the Medicare intermediary worked on the problem." In a more mundane example, the billing officer goes on vacation for two weeks, with no one assigned to cover her work.

Even happy situations, like adding more physicians, can force a center to dip into its cash reserve. Adding a practice would suddenly increase volume, a cause for celebration, but it comes with a temporary downside. The added volume would substantially increase expenses before the increased revenue comes in to pay for them. "In this situation, it is going to take 30-60 days to collect revenues to cover those expenses," Mr. Goehle says. Of course, accumulating enough cash to cover 30-60 days of operation requires withholding a larger part of distributions, which physician-owners may resist. "This can be challenging because many physician-owners like to take out most of the cash in the ASC as it accumulates," he says.

6. Number of days in accounts payable. "This figure will show you how long it takes the center to pay its bills," Mr. Goehle says. Accounts payable, of course, represents the amount of money the ASC owes its vendors. To calculate days in accounts payable, take the amount in accounts payable and divide it by daily operating expenses such as supplies, but not salaries, depreciation or amortization.

This figure tends to hover somewhere below 30 days because ASCs, like other businesses, tend to wait until they get near the due date to pay a bill. Vendors typically want to be paid within 30 days, but a drug vendor, for example, might provide a discount if the bill is paid within 15 days. If the number of days in accounts payable creeps up and starts to exceed payment deadlines, angry vendors may start putting the center on credit hold, refuse to ship new supplies or require cash on delivery. That can bring an ASC to its knees.

Expense side

7. Salaries and wages divided by net revenue. This figure helps the ASC adjust staffing as revenue changes. Salaries and wages should equal 20-25 percent of net revenue. "Changes in this figure are usually an early warning indicator that staffing changes are needed," Mr. Goehle says. For example, a busy physician exits the ASC and case volume plummets. The ASC would then have to reduce staffing. On the other hand, a drop in this metric may simply mean that one or more employees are on vacation and it can be ignored. When this metric starts creeping up, some physician-owners may resist laying off employees, hoping that it is just a temporary blip, but as the realization seeps in that the change is permanent, staffing cuts will have to be implemented.

8. Total clinical hours per case. This is another way to determine whether staffing levels are correct. Determine the total paid clinical hours of the tech and nursing staff and divide it by the number of cases. To look for trends, track this metric every month or look at a three-month rolling average. Compare the figure to the center's past performance or to a national benchmark, which is available from the ASC Association. The association's figure is not yet broken out by specialty, but that is planned. "Keep in mind that total clinical hours per case will vary substantially by specialty," Mr. Goehle adds. For example, the figure would be around 5-6 hours for GI and pain and around 10-12 hours for orthopedics.

9. Supply costs per case. This figure can identify changes in supplies, such as an anesthesiologist switching to a more expensive product without telling anyone or a surgeon deciding to use a different type of implant. Because contracted prices and physician preferences vary widely, it is almost impossible to benchmark this metric using outside sources, but it can be compared to previous months within the ASC.

10. Maintenance and repair expenses. This metric can help the center decide how much money to set aside to cover routine maintenance. However, identifying a useful figure can be quite challenging. "This is a tough one," Mr. Goehle says. "Machines don't break down on schedule. They often follow Murphy's Law and break down all at once, when you have the highest caseload and the least cash in the bank." With so much variability, it takes some thought to come up with a useful number. "You could go nine months out of the year and there will be virtually no problems at all, then you'll get walloped all at once," he says.

Because of the unpredictability, Mr. Goehle recommends using rolling averages over many months. Compare maintenance and repair expenses each year or on a 12-month rolling average. A larger ASC with lots of equipment might be able to use quarterly rolling averages. "If maintenance and repair expenses are going up, you might want to ask why," Mr. Goehle adds. "If a machine is constantly being repaired, it may be time to buy a new one." ■

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50 Benchmarks of 5 Top ASC Specialties

By Rachel Fields

Here are 50 benchmarks of five top ASC specialties. Statistics come from various sources identified at the end of the column and specialties were chosen based on the top five most desirable specialties as ranked by HealthCare Appraisers. Orthopedic spine was excluded from this list due to lack of available data.

GI/Endoscopy

1. Mean gross charges per case: $3,216
2. Mean gross net revenue per case: $746
3. Percentage of total ASC cases: 24 percent
4. U.S. region with highest net revenue per case: Southwest ($831)
5. U.S. region with lowest net revenue per case: Midwest ($629)
6. Number of cases performed annually: 3,744
7. Mean gastroenterologist salary: $496,139
8. Percentage of gastroenterologists investing in ASCs: 40 percent
9. Percentage of single-specialty centers driven by GI: 27 percent
10. Average number of GI cases in single-specialty surgery centers: 5,641
11. Percentage of ASC rooms designed for endoscopy: 9 percent
12. Growth in market share from 2000-2009: 23 percent

Pain Management

13. Mean gross charges per case: $3,835
14. Mean gross net revenue per case: $898
15. Percentage of total ASC cases: 14 percent
16. U.S. region with highest net revenue per case: Southwest ($831)
17. U.S. region with lowest net revenue per case: Midwest ($629)
18. Number of cases performed annually: 1,365
19. Mean pain management physician salary: $383,377
20. Percentage of single-specialty centers driven by pain management: 5 percent
21. Average number of pain management cases in single-specialty ASCs: 4,234

Orthopedics

22. Mean gross charges per case: $8,973
23. Mean gross net revenue per case: $2,443
24. Percentage of total ASC cases: 17 percent
25. U.S. region with highest net revenue per case: Southwest ($2,855)
26. U.S. region with lowest net revenue per case: Midwest and Northeast ($2,012)
27. Number of cases performed annually: 1,236
28. Mean orthopedic surgeon salary: $524,259
29. Percentage of single-specialty centers driven by orthopedics: 5 percent
30. Average number of orthopedics cases in single-specialty centers: 2,486

Ophthalmology

31. Mean gross charges per case: $5,395
32. Mean gross net revenue per case: $1,227
33. Percentage of total ASC cases: 19 percent
34. U.S. region with highest net revenue per case: Southwest ($1,329)
35. U.S. region with lowest net revenue per case: Southeast ($1,158)
36. Average number of cases performed annually: 876
37. Rate of incorrect procedures in the operating room: 1.8 per 10,000
38. Average ASC procedure time for cataracts: 14 minutes
39. Average ASC recovery time for cataracts: 22 minutes
40. Percentage of single-specialty centers driven by ophthalmology: 22 percent
41. Average number of ophthalmology cases in single-specialty centers: 2,640
42. Mean ophthalmologist salary: $376,943
43. Percentage of ophthalmologists investing in ASCs: 27 percent

ENT

44. Mean gross charges per case: $7,066
45. Mean gross net revenue per case: $1,742
46. Percentage of total ASC cases: 8 percent
47. U.S. region with highest net revenue per case: Southwest ($2,109)
48. U.S. region with lowest net revenue per case: Southeast ($1,407)
49. Number of cases performed annually: 779
50. Percentage of surgery centers performing ENT: 17 percent ■

Sources:

1-5, 13-17, 22-26, 31-35, 44-48: VMG Health's *Multi-Specialty ASC Intellimarker 2010*
6, 18, 27, 36, 49: SDI's *Outpatient Surgery Center Profiling Solution*
7, 19, 28, 42: MGMA's *Physician Compensation and Production Survey*
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4 Things You Should Know About the ASC Quality and Access Act of 2011

By Rob Kurtz

In June, Reps. Pete Sessions (R-TX) and John Larson (D-CT) and Sens. Ron Wyden (D-OR) and Mike Crapo (R-ID) introduced the Ambulatory Surgery Center Quality and Access Act of 2011 into the U.S. Congress. It has since been endorsed by almost 20 more members of the House and Senate, as well as a number of organizations, including the American Academy of Ophthalmology, American College of Surgeons, American Society for Gastrointestinal Endoscopy, American Society of Interventional Pain Physicians and Outpatient Ophthalmic Surgery Society.

Here are four things you should know about the bill, as identified by the Ambulatory Surgery Center Association.

1. Legislation would change the way ASC payments are updated in the Medicare system. Currently, CMS uses the Consumer Price Index for All Urban Consumers (CPI-U), but the legislation would give ASCs the same update factor as hospitals — the hospital market basket.

2. Legislation would provide the secretary of the U.S. Department of Health and Human Services with the authority to implement a value-based purchasing program for ASCs. VBP programs are designed to reward high-performing facilities with bonus payments generated from savings that accrue to the Medicare system. The savings would be generated by surgeries migrating from hospital outpatient departments to ASCs.

3. Legislation would level the playing field on patient disclosures between ASCs, HOPDs and physician offices. The bill would overturn the CMS Conditions for Coverage mandate that patients receive disclosures a day in advance of surgery being performed in an ASC.

4. Legislation would require an ASC representative be appointed to the Advisory Panel for Ambulatory Payment Classification Groups. This is the panel that determines which procedures can be performed in the outpatient department, a prerequisite for adoption on the ASC list. ■

To learn more about and view the bill, visit the ASCA webpage dedicated to it at www.ascassociation.org/ascact2011.

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12 Important Questions to Ask Before Changing Anesthesia Care

By Rob Kurtz

As ambulatory surgery centers look for ways to maintain and grow their bottom line, more centers are changing their anesthesia care services to access more revenue. On the surface, the financial reward for modifying anesthesia services can be very compelling; however if ASCs do not do their homework, there could be some unintended long-term implications.

The decision to change anesthesia care, or any ancillary service, is one that should not be taken lightly, says Mark Casner, CEO of aisthesis (formerly Safe Sedation), a provider of anesthesia service solutions to ambulatory, hospital, and office-based surgery practices nationwide. Small adjustments to anesthesia services can significantly influence an ASC's operations and relationships with patients.

Providing anesthesia in-house, rather than contracting anesthesia care services, is a trend that many ASCs have considered adopting. "I think a lot of groups hear they can set up their own anesthesia company and reap huge profits, and they take this information as gospel," says Mr. Casner. "We find many didn't stop to ask some of the critical questions that need to be asked. This isn't necessarily difficult to do, but you have to [answer these questions] before you launch" such a company.

Mr. Casner and John Kutsch, CFO of *aisthesis,* identify 12 critical questions surgery centers need to ask themselves before changing their anesthesia.

1. How will this change impact our patients? Changes to anesthesia care services can deter patients from visiting a center initially or returning for a second procedure, particularly if anesthesia becomes an out-of-network service.

"We find greater awareness in the patient population when it comes to deductibles, co-pays and the consequence of being in- or out-of-network," says Mr. Kutsch. More often, patients are asking about network coverage prior to scheduling their procedures, demonstrating that they understand the prohibitive expense of having out-of network medical procedures. These inquiries also suggest patients may be reluctant to receive treatment in a facility if the anesthesia care is not within their network.

2. Do we have the financial resources available to support a change in care? When planning new anesthesia services, ASCs should secure resources to pay for the anesthesia providers. Centers creating their own anesthesia group may need to pay their providers for a period of time before they receive any reimbursement for service, regardless of whether the group includes anesthesiologists, CRNAs or a combination of the clinicians. This assumes that payor contracts have been secured for the new entity.

"Typically it is going to be 90 days or longer before ASCs see some meaningful reimbursement, but in the meantime [centers] have to pay these providers," Mr. Casner says. "Several months of increased payroll can be expensive and cause cash flow issues." Cash flow issues can be compounded if a center has not considered the possibility that payment for services may go directly to patients, rather than the surgery center. Reimbursement for services could end up in the hands of a patient before an ASC if the center does not participate with the patient's insurance provider.

3. How will the dominant insurance carriers respond? Connecting with the larger insurance companies in your market is an important precursor to developing a pro-forma for new anesthesia services, says Mr. Casner. "The insurance providers will help you understand whether they will allow you to do so, and the ins and outs of not participating."

Offering out-of-network anesthesia care can deliver higher reimbursement rates; however, billing and collecting for service may be more difficult. Mr. Casner suggests that centers ask whether non-par services require additional documentation and if claims for these services could be delayed.

4. Do we have and will we maintain sufficient volume to justify the investment? "How variable is the volume of your center? Project out one, two, three years from now," says Mr. Kutsch. "If you're going to go for the maximum profit now, and bring in a captive group, how does that tie your hands in the future if that volume changes dramatically?"

5. Have we considered the regulatory issues? It is critical to identify any legal issues that may impact your anesthesia care plans, such as Stark and self-referral laws, especially for centers bringing anesthesia in-house.

"It does require a bit of legal due diligence," Mr. Casner says. "Might you need to form a separate professional corporation?" State regulations need to be explored when there is common ownership between the center and the ancillary provider.

6. How will this impact our patient volume? As Mr. Kutsch explained in response to question one, ASCs must determine the potential impact new anesthesia services will have on patients and their willingness to have higher out-of-pocket expenses.

Mr. Kutsch recommends that centers consider the following questions: "Have we potentially reduced the number of patients that choose to come back, or have we pushed them to other centers or providers, because of the collections processes we had to follow to chase that higher margin?"

7. How might fluctuations in patient volume change the profitability of our practice? Understanding the influence patient volume can have on an ASC's overall profitability is very important. "If volume were to change in a practice for any reason — competition, economic reasons, decreased quality, etc., — will we start losing money because of our new anesthesia arrangement?" says Mr. Casner. "Should we consider a plan that allows us to only pay for the anesthesia care service we use or need?"

8. How might this impact our administrative resources? Offering anesthesia services requires administrative resources, whether those resources are coming from an ASC's existing administrative staff or an outside party.

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If a center brings anesthesia in-house, many administrative personnel could be affected, including the business office, human resources and the quality/accreditation team. "Centers need to consider the steps that are necessary to ensure the staff they employ can handle the expanded workload, says Mr. Kutsch. "Ask yourself: Do we have the right practice management and billing software to effectively capture the anesthesia encounter and rapidly release claims?" he says. "Do we have the staff to effectively collect for anesthesia?"

9. How well do we know who we want to partner with? ASCs should put extensive time and effort into learning about the anesthesia providers they are considering as partners.

"What is their track record?" Mr. Casner says. "You should talk with their references. You're going to want to check out if these guys really know what they're doing. Bigger does not necessarily mean better, but experience does count for something."

10. Do we have a plan for addressing vacation and sick time for anesthesia providers? When an ASC hires anesthesiologists, these providers will expect a certain amount of vacation and sick time just like any physician or staff member. The surgery center will want to have a plan for how to address providers taking time off.

"Do you have a provision for filling in for those people when they're on vacation?" asks Mr. Casner. "You either need to have more providers or you have to get locums coverage, and has the pro-forma included this cost in addition to recruitment and turnover? You have to go understand the cost of activity that up until now has been invisible and handled by the traditional anesthesia firm that serviced the center."

11. Have we considered the impact of global billing? ASCs should consider what might happen in a few years if the government decides to go with global billing for ASCs much as it has with DRGs in hospitals. "There are some insurers now already doing that," Mr. Casner says. "How then will you allocate those dollars? Whereas before you might be making a profit [with anesthesia], now that might become a cost issue."

12. Do we think this model is sustainable for a long period of time? "If you set up a model where you believe you can operate in a non-par environment and keep up additional margins, can that the model be sustainable over a long enough period of time to justify the expense of setting up another practice?" Mr. Kutsch says. "We advise our clients to look long-term and think through all of the issues that can impact the center." ■

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6 Ways to Ensure Clinical Quality While Switching Anesthesia Providers

By Rachel Fields

Thomas Wherry, MD, medical director for Health Inventures and principal for Total Anesthesia Solutions, discusses six ways surgery center administrators can ensure clinical quality during a transition between anesthesia providers.

1. Educate your staff about the transition. Anesthesia groups and surgery centers part ways for a number of reasons, but chances are the transition will not be entirely amicable, Dr. Wherry says. Whether the group is leaving for financial or clinical quality reasons, there may be more tension in the surgery center in the 30-90 days between the group's decision to leave and its actual departure. For this reason, Dr. Wherry recommends administrators communicate with surgery center staff about the transition. "These transitions don't occur over night, and in that period of time it's important to do your best to educate your staff on the fact that a new group is coming," he says. "I see so many centers that don't clue the staff in and give them all the details."

This doesn't mean the administrator needs to communicate the exact reasons for the anesthesia group's departure, Dr. Wherry says. Just make sure that staff know the dates of the transition and can come to center leadership with any problems. "The staff may feel kind of put in the middle of this," he says. "Especially if these [providers] are their friends and they've worked with them for years, they need to understand that the surgeons have signed off on the change and it's being done for the right reasons."

2. Meet a few weeks before the start date to go over policies and procedures. Dr. Wherry says the center administrator should meet with the new anesthesia group a few weeks in advance to discuss the center's policies and procedures. This particularly applies to pre-op screening processes and post-operative care processes. "If you've had trouble with the old group around pre-op screening processes, this is the opportunity to make changes," Dr. Wherry says. "For example, the old group may have been too stringent on a type of patient or required too much information." He says some surgery center leaders feel their anesthesia group is not involved enough in the pre-op screening process, so this is a perfect opportunity to lay out expectations for the new providers.

The same is true for recovery care in the PACU, Dr. Wherry says. "Anesthesiologists need to clarify how patient discharge works," he says. "What is their expectation of the recovery room, and what is their willingness to participate in helping to define the standards?" He says in the past, there may not have been clarity around when patients were ready to be discharged from the PACU. Those standards should be decided in this initial meeting.

3. Make sure the group is comfortable with all equipment. Go over all the anesthesia equipment in the surgery center to make sure the new group is happy with the equipment. He says the two "big-ticket items" for anesthesia in a surgery center — the anesthesia machine and the monitors — will probably not be of concern to the anesthesiologists. "Most centers today that are adequately licensed and certified have adequate equipment," he says. He says while the anesthesia group may not be used to the monitors the surgery center uses, the providers will probably be able to adapt easily as long as the monitors have been checked and calibrated properly.

The new anesthesia group may have more requests when it comes to difficult airway equipment and equipment for peripheral nerve blocks, Dr. Wherry says. "You may have to in-

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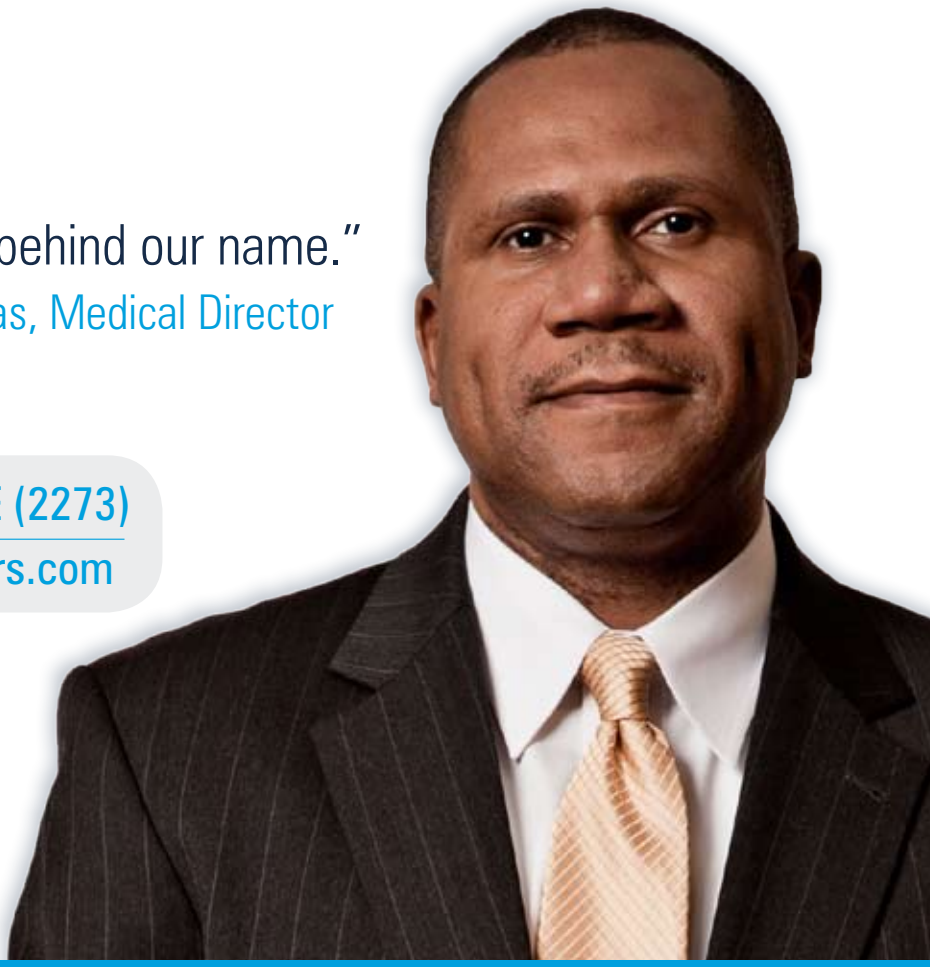

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vest in the difficult airway department," he says. "The new group may have an expectation that a GlideScope is the standard of care, but maybe the old group wanted something a little less expensive." Similarly, if your center performs a lot of orthopedic procedures, the new group may prefer an ultrasound technique.

4. Perform a comprehensive equipment check the weekend before the start date. Dr. Wherry recommends asking your biomed provider to visit the surgery center the weekend before the group's start date to perform a comprehensive equipment check. "That's the time to go over everything and make sure nothing is broken, especially things that the old group was used to that [may not have been] working properly," he says. "You want to make sure that everything is in proper working condition."

5. Ask anesthesia to review the first week's schedule. Prior to starting at the surgery center, the anesthesia group should review the first week's schedule, Dr. Wherry says. At that point, go over how you will communicate about add-on cases and cancellations, and assign a point person from the group to answer any last-minute scheduling questions. You can also go over when the anesthesia providers are expected to arrive at the surgery center for each case.

6. Identify a lead anesthesiologist who can serve as a liaison. The anesthesia group should appoint one anesthesiologist to serve as a go-between for the group and the surgery center. "It would be really nice to identify a lead anesthesiologist who will be on-site most of the time and who would be willing to go with the administrator to surgeons' offices and answer any questions they have," Dr. Wherry says. The surgeons may have had problems with the previous anesthesia group's techniques, and this lead anesthesiologist can address those concerns during the office visits. ■

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

5 Traits to Look For in an Anesthesia Group

By Rachel Fields

Beverly Kirchner, owner and CEO of Genesee Associates, discusses five traits an ASC should look for when selecting a new anesthesia group.

1. Willingness to work with an EMR. If your ASC is planning to invest in EMR over the next several years, Ms. Kirchner recommends finding an anesthesia group willing to work with an EMR. She says if the anesthesiologists and CRNAs in your anesthesia group have already made the switch to using EMR technology, it will be a lot easier to get them to use your center's system. You will save a lot of time on negotiation and compromise by finding a group that accepts EMR is a useful and inevitable part of ASC operations going forward.

2. Willingness to cooperate with your pre-admission process. In southern Louisiana, where Ms. Kirchner's center is located, many patients suffer from co-morbidities such as morbid obesity, cardiac disease and hypertension. The prevalence of health problems means the pre-admission process for Ms. Kirchner's center is necessarily extensive. "We re-pre-screened every patient, and we were on the phone doing nursing assessments on every patient before they came to the center to make sure they met our criteria," she says. "When we identified a patient that needed additional workup, the anesthesia group agreed to get on the phone and [deal with the patient] the morning of surgery."

3. Interest in participating in ASC operations outside anesthesia provision. Ms. Kirchner says ideally, an anesthesia group will be interested in sitting on ASC committees and participating in quality control programs. "[Our anesthesia group] helps us with infection control based on anesthesia input and works with us on the medical committee," she says. "Their participation helps make sure the center flows and functions based on what CMS [and accreditors] are requiring."

4. Punctuality and appropriate discharge practices. Prior to working with her current anesthesia group, Ms. Kirchner says her ASC had problems convincing anesthesiologists to comply with the center's schedule. Her previous anesthesia group frequently showed up late and then refused to stay and discharge the patient appropriately after surgery. During the interview process, she made sure that the new anesthesia group she picked would be willing to put in extra time to discharge every patient. The same standard applied to punctuality. Groups that didn't demonstrate personal responsibility for showing up on time were not considered.

5. Good professional references and contract history. Most employers find that personal references go a long way in demonstrating a potential employee's true work ethic — a trait that can be hard to gauge during a job interview. "We very carefully checked [the group's] references on how they'd worked with other surgery centers and hospitals," Ms. Kirchner says. She advises not limiting your reference check to those provided by the anesthesia group. Instead, ask for an exhaustive list and talk to everyone to make sure you get an accurate representation of the group's behavior. "We asked them for a list of all current contracts and references for contracts that had been cancelled in the last 24 months," she says. ■

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Best of Both Worlds For Your ASC: Increasing Productivity and Raising Standards in Sterilization

October 26, 2011 • 2:15 p.m. EST/1:15 p.m. CST/11:15 a.m. PST

Sterilization of surgical equipment is essential to ensuring your surgery center is providing the highest standard of care. Yet, ambulatory surgery centers (ASCs) face many real-world challenges, including:

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Adding a Total Joint Program to a Surgery Center: Q&A With John Brock of NorthStar Surgical Center

By Rachel Fields

NorthStar Surgical Center in Lubbock, Texas, began offering total knee, uni-knee, total ankle and total shoulder procedures at the beginning of the year. The ambulatory surgery center has performed approximately 10 of the procedures so far. John D. Brock, administrator for the ASC, discusses his surgery center's new program and why it was the right time for the facility to expand its offerings.

Q: What led NorthStar to consider expanding your services to offer total joint replacement?

John Brock: Several of our physician-partners expressed a desire to provide this service to their patients in an outpatient setting. The mindset is that the physicians wanted to provide the appropriate patient seeking this procedure with the same access to outpatient care as the more conventional orthopedic patient. The patient benefits not only from going home much sooner than in the past, but we can perform the procedure for a significantly lower cost. Currently we have two physicians that perform the total knee, three that perform the uni-knee, three that perform the total ankle and one that performs the total shoulder.

Q: Describe the process your ASC went through which confirmed expanding was the right decision and that the time to expand was now.

JB: Our physicians determined that the procedures are now more advanced, less invasive and patient pain is easier to control. Also, our physicians had a significant increase in demand for these procedures in an outpatient setting, which led to us working under the direction of our physicians to structure a program to meet this demand. We also met with the medical supply vendors to facilitate providing these procedures in a cost-effective manner.

Q: Why expand to offer total joint replacement rather than expand in a different direction?

JB: NorthStar Surgical Center is the premier orthopedic facility in this market. We provide sports medicine services to Texas Tech University athletes. We have nine orthopedic physician partners. On staff we have three hand fellows, three foot and ankle fellows and three sports medicine fellows. Expanding in this direction was a natural move.

Q: How have your payors responded to this expansion? What feedback have you received from patients?

JB: The payors where the procedures are allowable have responded favorably. The fact that we're able to perform these procedures at a savings to them is certainly a positive. The patients have responded favorably as well.

Q: What role do you envision your total joint program playing in the long-term financial success and sustainability of your ASC?

JB: It can only help from a multitude of reasons. First, we have found orthopedic procedures to be a great service line for us here at NorthStar. And by growing orthopedics, it can only result in sustaining the financial health of the facility. Finally, there is a halo-effect associated with high-tech procedures of this nature, which I would expect to positively impact other service lines as a result.

Q: For ASCs considering expanding into total joint replacement surgeries, what advice would you offer? For ASCs considering any type of expansion, is there other advice you would offer?

JB: Whether it's expanding into total joints or other service lines, I think the advice would be the same and that's to do your due diligence. In the case of total joints, I would first recommend that the physicians be the drivers of the process. Without their commitment, you're doomed to mediocrity. I would also recommend visiting and consulting other facilities that have successfully implemented the program — this would include learning about their policies, processes and protocols and their relationships with home health agencies for aftercare. ■

Contact Rachel Fields at rachel@beckersasc.com.

Future of the Freestanding Surgery Center: Q&A With Barry Tanner of Physicians Endoscopy

By Leigh Page

Barry Tanner is president and CEO of Physicians Endoscopy in Doylestown, Pa.

Q: What do you see as the future of the freestanding ambulatory surgery center?

Barry Tanner: I think it's brighter than it's ever been. I know that may seem to go against conventional wisdom and the immediate business interests my own company. However, I believe that physician-owned, freestanding ASCs will continue to play an important role in the healthcare delivery system. That outlook may change over time, but the fact is that as physician reimbursements continue to decline, physician ownership in ASCs has become a significant portion of overall medical practice income. It's called survival. It's going to be extremely hard for independent physician ownership of ASCs to disappear.

Consolidation of the market will continue because there are very clear benefits to affiliating with a larger, multi-site ASC management company. We have depth of management, business expertise and access to both human and financial capital, which you do not necessarily see in a wholly physician-owned ASC. However, there are lots of physician-owned freestanding ASCs left. Less than 50 percent of surgery centers, maybe just

25 percent, have a corporate partner. After all these years, are the other 75 percent of ASCs simply going to fail?

Q: Don't large organizations' economies of scale make them superior to the independent surgery center?

BT: There are most definitely economies of scale, but there are other reasons why the industry is consolidating. There is less opportunity to develop de novo ASCs and fewer available physicians to recruit as owners. Management companies that want to grow — and desire to do so quickly — have to acquire existing ASCs. The best way to achieve this is to promote market consolidation.

Sure, a larger ASC management organization can provide independent centers with access to capital and potentially better business guidance, but there are clinical factors for success that are not completely in the management company's control. These include efficient utilization of a facility's procedure rooms or ORs, staffing of those rooms and the practice patterns of physicians. One GI physician may take 45 minutes to perform a colonoscopy while another may take 30 minutes. That difference is significant, because the reimbursement for the procedure is fixed and does not accommodate the consumption of resources. There are several other factors where the differences between independent ASCs and multi-site ASC management companies are less lopsided, such as access to best pricing through group purchasing organizations.

Q: Will self-standing ASCs be able to take advantage of accountable care organizations?

BT: ASCs would make great sense for ACOs because they are clearly the low-cost, high-quality option. But it's still not clear to me that ACOs will have any broad-based success. Many ACOs may crop up in the short term, but I'm not sure they will survive the test of time. If the pilot programs that were the precursors of ACOs are any indication, this phenomenon may well prove to be a miserable and expensive failure.

But whatever happens with ACOs, I am confident we will see a trend toward some form of bundled payments. Providers will face a mandate for better coordination of care and the result will be more collaborative partnerships between them. Physicians and hospitals will continue to partner on ASCs and possibly even third-party payors will join in. The details are not yet clear. Everybody wants to know: Where will I fit into a bundled payment scenario, what will my role be and how can I best position myself to influence the outcome? ■

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Top 5 Vulnerabilities of Surgery Centers in the Next Few Years

By Leigh Page

Nap Gary, COO of Regent Surgical Health in Westchester, Ill., lists the top five vulnerabilities of surgery centers in the next few years.

1. More scrutiny of clinical quality. Surgery centers are coming under increasing scrutiny by regulators and the media, due to a few problems discovered at a few low-quality centers. "CMS surveys seem to taken on a more aggressive approach," Mr. Gary says. "In the most egregious cases, the threat of a loss of certification has become more pronounced."

Extra funds from federal stimulus spending were earmarked for stepped-up CMS inspections. "Our vulnerability in this area is as high as it's ever been," Mr. Gary says. He reports that some centers that passed inspections by accreditors have "gotten blasted" by CMS inspectors. "Obviously it's just a fundamental obligation to make sure the quality we provide is equal to or better than that available in the hospital," he says. "We now have to be very careful about crossing all our t's and dotting all our i's."

2. Out-of-network strategy slips away. "A significant out-of-network strategy is getting difficult to maintain," Mr. Gary says. "Some of the major payors are reducing out-of-network benefits to members to the point where there is no incentive any more." The loss of this option, which varies by region, reduces a center's options in negotiating with payors, giving them less leverage against payors.

3. Some leverage moves to payors. Payors' negotiating power has been enhanced, especially in markets where the number of ASCs has reached the saturation point. "When there is a surgery center on every street corner, just comparing yourself with the hospital is no longer good enough," Mr. Gary says. "You now are competing with other centers. With so many centers around, one of them might be willing to take a lower rate than you offer." In some markets, payors have further enhanced their negotiating power through consolidations.

4. Fewer Medicare dollars to go around. Ongoing efforts in Washington to cut the federal deficit are likely to slow Medicare spending, affecting ASC reimbursements in the coming years. However, this new cost-consciousness could also present a great opportunity for surgery centers, Mr. Gary says. Hospitals, which have had a lot of political clout in Washington, will have more difficulty justifying higher reimbursement rates than ASCs. "The ASC industry has to get its message out, and I think we are doing an increasingly more effective job in Washington," he says. "Now we will go back there with our sleeves rolled up, and we'll see where we come out."

5. Fewer new physician-investors. At a time when many physician-investors are nearing retirement, there may not be enough physicians to take their place. Mr. Gary notes that many — but not all — young physicians are seeking employment at hospitals, taking themselves out of the pool of eligible investors.

"The prediction that all young physicians or all women physicians seek employment is too simplistic," he says, "but it is safe to say that in the short term, at least, more physicians are trying to align with hospitals." In the long term, however, this trend may derail. "Long-term employment is incompatible with the mindset of the successful surgeons I've worked with," Mr. Gary says. ■

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Spine Surgical Innovation

Who Can Pay More for a Surgery Center: Hospital or Management Company?

By Curtis H. Bernstein, CPA/ABV, ASA, CVA, MBA, Director, Valuation Services, Sinaiko Healthcare Consulting

Like surgery center management companies, hospitals are restricted from paying above fair market value for a surgery center under the Anti-Kickback Statute because of the referral relationship between the physician-owners and the center. Since surgery center management companies are typically the more active companies purchasing controlling interests in surgery centers, the prudent seller would be better suited to understand how these companies determine value, how the purchase price converts into an earnings multiple and how hospital acquisition prices compare to those of the management companies.

Management companies as buyers

Management companies will generally purchase a 30-51 percent interest in a center with an interest in having management control of the surgery center through a management agreement paying 5-7 percent of net revenues, depending on the scope of services provided.

Overall, the management companies are looking to earn a 15-20 percent cash-on-cash return on their investment. The management companies will look to earn this return through the continuation of historical cash flows, growth in future cash flows through higher revenues and reduced costs and their management fee.

When a management company purchases a 100 percent interest in a surgery center, which is very rare, the management company will not pay top price for the surgery center because of the desire to keep the physicians locked into the future of the surgery center through ownership and non-compete agreements. Since the management companies prefer physician ownership, the management company would likely sell non-controlling interests to physicians after the purchase of the 100 percent interest. For interests that lack the ability to control surgery center operations, prices paid would be expected to be at lower multiples (e.g., a 3x multiple of EBITDA for a non-controlling interest versus potentially a 6x multiple of EBITDA for a controlling interest). The lower returns on re-syndication will result in lower returns to the buyer and, accordingly, the buyer will pay less up front.

In mathematical terms, a company would not pay a 6x multiple of EBITDA for a 100 percent ownership interest and then have to sell between 30-49 percent for a 3x multiple to non-controlling shareholders. This would be dilutive to the controlling shareholder and significantly lower the cash on cash return of the investment.

For this reason, a properly syndicated surgery center will generally sell for more money as a multiple of earnings because it removes the effort that a potential buyer has to expend and the possibility of an unsuccessful syndication.

Hospitals as buyers

When a hospital purchases a surgery center, the hospital is generally going to purchase 100 percent of the ownership interest in the center. The reason for this is that such purchases typically are made with the intent of converting a freestanding ASC to a hospital-based ASC, which must be owned entirely by the hospital. This allows the hospital to begin billing the ASC services as a hospital outpatient department, which may result in significantly higher reimbursement. Another recent trend is for hospitals to purchase a 51 percent interest in a center or create a joint-venture management company that owns 51 percent of the center. One purpose of these arrangements is to use the hospital's leverage in negotiating with payors in an effort to increase reimbursement to the surgery center.

Since a hospital is restricted by the FMV standard, the difference in hospital reimbursement cannot be considered for valuation purposes. This is the case because other hypothetical buyers, which are not hospitals, would likely have an interest in the surgery center and therefore have to be considered among the universe of hypothetical buyers. In certain cases, however, it is possible that revenue may be appropriately adjusted upwards if it is determined that the overall universe of potential buyers would have the ability to improve revenues.

If the hospital currently owns a controlling interest in the surgery center, the remaining non-controlling interest is likely not as valuable since the hypothetical buyer is unable to gain control (i.e., even though the hospital is adding to its control interest).

In certain circumstances, the hospital may enter into a management (or co-management) agreement with the former owners of the surgery center. Since this agreement is part of the overall transaction, any payments under the management agreement should likely be included as consideration as part of the transaction. Overall, the management agreement reduces the return to the potential buyer (e.g., the hospital).

The cash-on-cash return available in the market should dictate the return the hospital should expect to receive. While a hospital might actually achieve better results under its payor contracts or through a move to hospital-based reimbursement or other improvements it may make, because of the FMV requirement under Anti-Kickback, the reimbursement and other improvements specific to the hospital should likely not be used in determining the value. Also, any post-transaction management arrangements should be considered in determining the value as these agreements affect the overall return to the hypothetical buyer.

So, who can pay more?

Based on the above analysis, a hospital would likely pay a lower multiple of earnings for a 100 percent interest than a management company would pay for a 51 percent controlling interest. The amount likely would also be further reduced if the hospital does not internally manage the unit, but, instead, outsources the management to the prior owners.

Here is a mathematical example of the value of a 100 percent interest in a sample surgery center to better explain this analysis. This example is not an actual surgery center and does not represent any opinion of value as it relates to a specific surgery center's value.

	Traditional purchase	Purchase without management Fee	Purchase with co-management
EBITDA	$700,000	$700,000	$700,000
Less: Management fee	N/A	N/A	(117,000)
Adjusted EBITDA	$700,000	$700,000	$583,000
51 percent of EBITDA	$357,000	$357,000	$297,000
Multiple	7.0x	5.6x	5.6x
Purchase price	$2,499,000	$1,999,000	$1,662,000
49 percent of EBITDA	$343,000	$343,000	$286,000
Multiple	3.0x	3.0x	3.0x
Purchase price	$1,029,000	$1,029,000	$857,000
Total purchase price	$3,528,000	$3,028,000	$2,519,000
PV of future management fees	(504,000)	N/A	504,000
Adjusted purchase price	$3,024,000	$3,028,000	$3,023,000
Effective multiple of Unadjusted EBITDA	5.0x	4.3x	3.6x

As the table above illustrates, a purchaser of a surgery center is willing to pay more upfront when the purchase involves a management agreement payable to the purchaser because of the future guaranteed cash flows that will be received through management services remuneration. The management fees are negative when paid to the purchaser in the future and are positive when paid to the seller in the future.

Ultimately, assuming the same level of ownership, the same projected level of profitability and the same expected rate of return, a hospital and management company should pay the same. However, hospitals are generally looking to purchase a larger percentage than the surgery center management company. The multiple of EBITDA that can be paid on the higher percentage (e.g., 100 percent) should not be the same multiple that would be paid for a smaller controlling interest (e.g., 51 percent) in the same center.

Note that all companies may not offer the upper end of FMV and that certain parties may have different thoughts on what constitutes a market rate of return, with the party willing to accept a lower return being able to pay more for the purchase. Ultimately, the FMV of the equity interest is a range-based on the expect returns in the market for the investment. The range should be fairly precise based on the specifics of the transaction. Sellers and purchasers must be aware that synergistic factors, such as billing under a hospital's provider number or reduced billing costs, cannot be considered under the FMV standard. ■

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9 Observations on the ASC Market

By Scott Becker, JD, CPA, and Rachel Fields

ASCs are seeing more uncertainty than at any time in the last decade. This article provides several observations related to the ASC market.

1. Key questions being asked by ASCs. Three key questions we are often asked are 1) will healthcare be dominated by vertically integrated systems? 2) will reduced reimbursement of specialties drive more physicians towards employment? 3) are we seeing the extinction of entrepreneurial physicians?

2. Private equity interest. The ASC market remains of great interest to several private equity funds. There continues to be significant interest in the ambulatory surgery business. However, investors seem to be more interested in ambulatory surgery center chains with a specific focus — e.g. pain management, orthopedics, or spine — than in general surgery chains. While the ASC industry faces certain challenges, tremendous consolidation opportunities and significant cost benefits associated with moving surgeries from inpatient to outpatient venues exist. In the last 24-36 months, TPG Capital invested in Surgical Care Affiliates and H.I.G. Capital invested in Surgery Partners. One year later, in January 2011, Surgery Partners then bought NovaMed, AmSurg Corp. bought National Surgical Care and LLR Partners invested in a platform of fertility driven ASC businesses.

3. Health systems. We still see health systems with ASC strategies. As a core strategy, we see some health systems attempt to develop or acquire, often with a management company, 5-7 ASCs. There, they try and develop a broader market alternative to physician employment and use it as a means to align with physicians and earn income. In the past two months, health systems across the country have added surgery centers to their list of facilities in an attempt to expand market share and build relationships with physicians.

A joint-venture partnership between United Surgical Partners International and San Francisco-based Catholic Healthcare West added three Arizona ambulatory surgery centers to its portfolio in July, and an HCA acquisition of The Colorado Health Foundation gave the hospital operator full ownership of 13 ASCs in the metro Denver area. Kaiser Permanente San Diego recently broke ground on a new ambulatory surgery center included in a $60 million medical office building, which will house specialty care providers, nuclear medicine and a GI procedure suite.

4. Two key headwinds/three biggest challenges. The ASC industry faces two serious headwinds. First, on the revenue side cases are harder to come by as there is a reduction of available independent doctors. There are approximately 100,000 surgeons in the United States that would be available for ASC ownership. There are close to 5,000 plus surgery centers, many of those having 10 to 30 physicians per center. This means that a large number of the independent physicians are surgeons already spoken for.

Regent Surgical Health estimated in an August presentation that the number of available investors per surgery center has dropped in recent years from an average of 40-60 to an average of 12-20. The *2011 Medscape Physician Compensation Report* found that more than 25 percent of orthopedic surgeons have already invested in a surgery center; for ophthalmologists, the number jumps to 27 percent, and for gastroenterologists, to 40 percent.

On the reimbursement side, we are also seeing negative trends from out of network and general reductions in reimbursement. In states like New Jersey, surgery centers continue to move in-network as legislation threatens to impose additional requirements on out-of-network ASCs. This means physicians and surgery centers must adjust their profit expectations as they negotiate less profitable in-network contracts or face significant reductions to OON reimbursement levels.

The three biggest challenges in large part overlap with these headwinds are 1) challenges with reimbursement from payors; 2) challenges relating to physician employment by hospitals and recruitment of physicians; and 3) increased CMS and state regulation. In terms of physician employment, we are seeing key differences from market to market and specialty by specialty. In some specialties, there is rapid evolution toward employment — e.g. cardiology, primary care, obstetrics and gynecology and certain other specialties. According to Merritt Hawkins' *2011 Review of Physician Recruiting Incentives*, family practice was the most requested physician search by medical specialty last year, gaining substantial traction over its popularity in 2006. Family practice was followed by internal medicine, hospitalists, psychiatry, orthopedic surgery and OB/GYN. The recruiting incentives for these specialties are also increasing as demand spikes: The average income offered to orthopedic surgeons in 2010/11 was $521,000, compared to $519,000 in 2009/10 and $413,000 in 2006/07. Once a hospital in one county or area starts to employ physicians, the other system often needs to respond to that effort.

5. Six best specialties. It is often perceived that the six best specialties for surgery centers are orthopedics, spine, GI, ENT, ophthalmology and pain. According to the *2010 ASC Valuation Survey*, conducted by HealthCare Appraisers, general orthopedics is the most desirable specialty for ASC management companies, earning a 94 percent approval rating. General orthopedics is closely followed by its sister specialty, orthopedic spine, which received an 88 percent approval rating in the survey. ENT, ophthalmology and pain management followed close behind with 76 percent each, and GI rounded out the top six with a 70 percent approval rating. These specialties are prized for different reasons, namely profitability and efficiency. For example, both general orthopedics and spine command high reimbursement per case, whereas ophthalmology offers short case and turnover times.

6. Turnarounds. As far as the turnaround market goes, there is an increasingly number of centers that need to be turned around. However, it is harder and harder to actually turn them around due to lack of available physicians and the lack of upside reimbursement. According to HealthCare Appraisers' *ASC Survey 2010*, 29 percent of surgery center management companies prefer to acquire turnaround centers at lower multiples and asset values. However, this percentage is significantly lower than the number (41 percent) who are now looking to acquire established facilities with immediate cash flow.

7. Pricing of deals. We often see majority centers still selling at 6-7.5 EBITDA range. Out of network centers see much lower multiples, often 3-4 times EBITDA. Hospitals most often buy at reasonably high prices if they wish to convert to HOPD and/or reap higher reimbursement. Finally, hospitals recognize that every loss of an in-patient case takes six to eight outpatient cases to make up the revenues. Thus, as hospitals do see decreases in inpatient cases, they are more aggressive about trying to find outpatient cases and implant ASC strategies.

8. Co-management and 100 percent hospital-acquired ASC. There are a great number of questions as to what can be paid and is a co-management company truly needed. There are several different models that hospitals and physician groups can pursue around co-management. In a direct contract model, for example, the hospital owns the service line and enters into a management agreement with the physician group. The physician group then provides management services for a fee, and a governance committee is appointed to oversee the relationship. In this scenario, the governance committee is present only to provide oversight, not to serve as an active manager. In a joint venture model, on the other hand, the hospital and physicians form a "newco" which contracts with the hospital. The profits from the newco are then split between the hospital and the physician group. The type of arrangement sometimes depends on the number of physician groups involved.

Compensation for co-management services is generally divided into two levels of payment: a base fee and a bonus fee (based on quality and performance). Both fees must be consistent with fair market value, and to meet safe harbors for the Anti-Kickback Statute, compensation must be set in advance. This means hospitals can only reward physicians with bonuses if the minimum and maximum bonus amount is decided in advance, rather than based on a percentage of collections. Physicians should also not be compensated for clinical duties through a co-management arrangement.

9. Accountable care organizations. It remains unclear whether ASCs will have a positive role with ACOs. On the one hand, the development of ACOs will tend to favor lower cost providers such as ASCs. However, many of the ACOs will be driven by hospital systems that are much more focused on steering all possible cases to hospitals. ■

Contact Scott Becker at sbecker@beckershealthcare.com or Rachel Fields at rachel@beckersasc.com.

ASCs Take on Lap-Band Surgery, But Payors Still Have to Catch Up

By Leigh Page

Laparoscopic gastric band surgery, buoyed by an obesity epidemic and improved clinical outcomes, has become a viable option for ambulatory surgery centers, but payors have been slow in extending coverage to surgery centers.

In San Diego, a hotbed of lap-band surgery in outpatient centers, ASCs operated by Surgery One still have to rely on cash-paying patients. Payors only cover lap-band patients in the hospital, says Scott Leggett, CEO of Surgery One. "Centers such as our own have gained substantial experience and great outcomes with cash-paying lap-band patients, but many payors still have not caught up," he says. "It is rare to find any payor that will cover lap-bands in surgery centers right now." Basically the same situation exists in other parts of the country, Mr. Leggett and others say.

There are reasons why payors have been leaving ASCs out in the cold. Traditionally, bariatric surgery could only be done in the hospital, but innovations like laparoscopic surgery, used in lap-bands, have made outpatient bariatric surgery possible. Lap-band surgery involves non-invasively placing an inflatable silicone device around the top portion of the stomach. This surgery is also a less costly option. Gastric bypass, which still can only be done in a hospital, costs about $23,000-$25,000 per case, while lap-band costs about $14,000-$15,000.

In addition to lower prices, improved complication rates have made lap-bands an important option, says Julie Ellner, MD, a bariatric surgeon who performs lap-bands at both Alvarado Hospital in San Diego and at Physician's Surgery Center at Alvarado, a joint venture with the hospital. "The surgery center is really the ideal venue for the low-risk band patient," Dr. Ellner says. "It's better from the patients' standpoint because it is a more streamlined, more personal experience. And for patients paying cash, it's a less expensive option."

Future growth opportunities

Since lap-band surgery in the ASC has to be paid out-of-pocket, centers offering the procedure took a beating in the economic downturn, but volume has been slowly recovering, Mr. Leggett says. While the number of lap-band cases at Surgery One fell when the recession started, volume has been inching back up lately, he says.

One key factor in recent growth was the FDA's decision in February to lower the patient body mass requirement for lap-band surgery. The decision has expanded the potential market of weight-loss surgery patients by 11 million people, says Goran Dragolovic, a senior vice president for Surgical Care Affiliates.

"The FDA decision bodes particularly well for ASCs, because candidates with a lower BMI are better suited for an outpatient setting," Mr. Dragolovic says. Specifically, the FDA reduced the body mass limit required for lap-band eligibility from at least 40 BMI to 30 BMI, provided that diets and weight-loss drugs were not successful and patients do not have an obesity-related condition such as diabetes or high blood pressure. "As the obesity epidemic continues, the demand for bariatric procedures, including lap-bands, will continue to grow," Mr. Dragolovic says.

ASCs still have to win over insurers

Few payors, however, have yet to cover lap-bands in surgery centers. Reacting to the possibility of complications from bariatric surgery, they typically require that the hosting facility be designated as a bariatric center of excellence. Basically, this involves meeting minimum volume levels, using appropriate equipment and following patients both before and after surgery. Mr. Dragolovic says the requirement addresses payor anxiety about expensive complications after surgery. "Treating lap-band complications can have a price tag that can be 15 times greater than the original cost of the procedure," he says.

Centers of excellence are designated either by the American Society of Metabolic and Bariatric Surgery or the American College of Surgeons. On its website, the ASMBS said it has designated more than 450 facilities nationwide as centers of excellence. To qualify, facilities must host at least 125 bariatric surgeries per year and establish procedures for care of patients. Each surgeon must have performed at least 125 bariatric surgeries and at least 50 per year, and the facility must have a dedicated multi-disciplinary bariatric team, including surgeons, nurses and medical consultants, report long-term outcomes and submit to an on-site inspection.

Several ASCs have reportedly been designated centers of excellence but have not been recognized by insurers yet. Insurers can be very choosy even about the hospital sites they'll allow, says Robert Zasa, managing partner of ASD Management, which is a partner in Physicians Surgery Center at Alvarado. "The payors don't want too many people undergoing bariatric surgery," he says. "They're trying to pick the place for this to be done that gives the best price and quality results."

As demand for bariatric procedures increases, Dr. Ellner says some payors are tightening quali-

fication standards for patients. "We're seeing a pushback from a great number of insurers that, just plain and simple, want to avoid paying for this type of surgery, no matter where the patient has it done," she says. "Insurers are pushing patients toward the cash payment route." Dr. Ellner reports some insurers are starting to require six months to two years of monthly visits to their physician before they will consider covering a bariatric procedure. She says Premera Blue Cross in California will initiate this kind of policy on Jan. 1, 2012.

Looking for new ways to gain payor coverage

Despite payor push-back, California ASCs are looking for new opportunities for coverage of lap-band procedures in surgery centers. Mr. Leggett says the California Ambulatory Surgery Association has been in discussions with several major payors in California on extending coverage to qualifying ASCs. "CASA has been working hard to convince payors to extend coverage beyond hospitals," he says. "It has been a lengthy process, and some key insurers still are not showing any movement." Still, he says there have been encouraging signs from WellPoint and UnitedHealthcare, and Blue Shield of California has started allowing several California ASCs to apply for lap-band coverage.

Even when payors allow applications, Mr. Leggett says it could take months before an ASC could receive lap-band coverage. "There would have to be a call for applications, and then applications have to be reviewed," he says. And, of course, applications would be limited to centers that have met the ASMBS or ACS designation, which includes sufficient volume of procedures, a difficult hurdle for many ASCs.

Meanwhile, centers affiliated with hospital centers of excellence are asking to share the hospital's designation. Mr. Zasa says ASD Management is asking payors to recognize Physicians Surgery Center at Alvarado as a center of excellence through its relationship with Alvarado Hospital. "At this point, payors have not recognized that the center should come under the hospital center of excellence Mr. Zasa says. "ASD Management is processing that now with multiple payors in the San Diego area."

Dr. Ellner says sharing the designation with an affiliated hospital makes clinical sense. The Alvarado ASC is right across the parking lot from the hospital, and Dr. Ellner and other bariatric surgeons at the ASC already work in the hospital center of excellence. She says with the hospital as a partner, the surgery center can share expensive equipment, such as a bariatric laparoscope and monitors and longer cameras to use in the abdomen of obese patients. She adds that the Surgical Review Corp., which administers the ASBMS centers of excellence program, said an ASC should qualify for inclusion under the hospital's designation if the hospital is an owner and is less than one mile away from the center.

"There is a great deal of demand for bariatric surgery," says Mr. Zasa, who underwent Roux-en Y gastric bypass several years ago and has lost a great deal of weight. As a patient, he says he can understand the need for high standards and appropriate follow-up. "The surgery is a tool, not the solution," he says. "It changes your body drastically. You have to maintain your diet and regimen of exercise."

Steps an ASC should take to prepare for lap-bands

Mr. Dragolovic recommends surgery centers take the following steps before introducing lap-band surgery.

Select excellent clinical staff. Pick experienced surgeons whose historical complication rates meet national standards. Make sure that the anesthesiologist is experienced with intubating obese patients and choose nurses who have experience with this patient population.

Choose the right patients. Set up a selection protocol for patients to identity appropriate choices for the ASC setting. For example, obese patients with serious comorbidities are not good candidates for outpatient surgery.

Ensure appropriate post-op follow-up. The surgeon should follow the patient postoperatively for at least one year, regularly following the patient's progress. The patient should participate in support groups and follow a diet. "ASCs generally see little of this activity, but lack of these steps will adversely impact the long-term success of the procedure and may affect the reputation of the ASC," Mr. Dragolovic says. ■

Contact Leigh Page at leigh@beckersasc.com.

Laparoscopic Bariatric Procedures Increased From 2003-2008

By Leigh Page

The number of laparoscopic bariatric procedures increased from 2003-2008, partly due to wider use of laparoscopic techniques and patients' greater acceptance, according to a report in the *Journal of the American College of Surgeons*.

Based on data from the Nationwide Inpatient Sample, the number of bariatric operations peaked in 2004 at 135,985 cases, or 63.9 procedures per 100,000 adults.

Laparoscopic procedures rose from 20 percent of bariatric operations in 2003 to more than 90 percent in 2008, while inpatient mortality for these procedures decreased from 0.21 percent to 0.10 percent. ■

Contact Leigh Page at leigh@beckersasc.com.

Debridement Most Confusing ICD-9-CM Subcategory Among Coders

By Rachel Fields

Debridement is the ICD-9-CM subcategory that causes the most confusion among coders, based on a study published in the summer issue of *Perspectives in Health Information Management*.

According to the report, debridement can be performed on skin, muscle and bone, as well as other tissues. Appropriate ICD-9-CM code assignment depends on the documentation provided in the medical record.

According to the study authors, confusion stems from inaccurate or lacking medical documentation. They recommended a further study aimed at improving coding accuracy and variation.

The study determined three criteria to identify a problematic ICD-9-CM subcategory for further study, including cost, volume and level of coding. The researchers used the Medicare Provider Analysis and Review of 2007 fiscal year data as well as expert suggestions to identify coding subcategories.

The researchers identified a list of 13 unique ICD-9-CM code categories and found that excisional debridement was the associated with the most confusion. Other confusing subcategories included complications and congestive heart failure. ■

Contact Rachel Fields at rachel@beckersasc.com.

Trends & Developments Shaping IT in Surgery Centers: Q&A With Scott Palmer of SourceMedical

By Rachel Fields

Scott Palmer, president and COO of SourceMedical's surgery division, discusses the effect of information technology on ambulatory surgery centers.

Q: Where does the ASC industry stand in terms of IT utilization currently?

Scott Palmer: I think a problem in our industry is that people are somewhat technology-adverse. We're not on par with other industries or even with other sectors within healthcare in terms of technology utilization. I think this is for a couple of reasons. First of all, there is a lack of IT resources internally. A typical ASC has a nurse administrator and a physician board, and they're not thinking about the latest [developments] in technology and applying new technologies to their business. They're focused on patient care. That's also true in of the case of some small management companies; they're focused on day-to-day operations.

There is an opportunity for IT in the ASC industry, especially in these times where there are going to be top-line revenue challenges and pressures on cost. Surgery centers may be able to maintain or even improve margins with expanded IT utilization.

Q: What would you say to surgery center leaders who believe the upfront capital expense of IT outweighs the possibility of long-term cost savings?

SP: Let me give you some short-term and long-term recommendations. First of all, a number of vendors in the market today have incremental products that improve efficiency. An example is online patient follow-up surveys. There's no reason that anybody today should be surveying patients on paper. Not only is an online survey less expensive, but electronic surveying can provide immediate alerts to patient care problems and improved insight and benchmarking. The same is true with patient intake — why do we ask people to come in a day before surgery and fill out paperwork? That can be done online with tools that exist from any number of vendors. There are many more examples of short-term recommendations for incremental ways to improve efficiency and reduce cost.

Long-term, the number one technological development is cloud computing. The simplest way to explain cloud computing is to say that you're taking your server out of your facility and putting it in a professionally-managed data center. You're doing that to achieve some well-defined benefits today: anywhere, anytime access, reduced risks, access to improved web-enabled applications, improved interoperability and significantly lower total cost of ownership over time.

Q: How does cloud computing reduce the cost of ownership over time?

SP: Software as a service, or SaaS, should not typically involve a significant upfront cost. However, your vendor will ask you for an extended commitment of 3-5 years to recover their investment. The vendor will also allocate cost using a metering approach — a per-case, per-user or per-OR cost, for example. This is an appropriate way to allocate cost as well as to provide a graduated pricing scale for small surgery centers.

Total cost of ownership will also include labor and other soft costs. Vendors guarantee almost 100 percent uptime, as well as managing all the patches, upgrades and backups. Security risks are better managed as well.

Q: Are there other benefits to cloud computing in terms of access?

SP: Surgery centers and management companies also have access to more applications. In a license model, vendors tend to charge for each module. In an SaaS module, you get access to all the applications for the [per-case, per-user or per-OR] fee. We're seeing a big shift. We like selling our modules, but we want our clients to use our software, so that's not happening today. For example, we have a surgeon scheduling portal that, in a traditional model, we would sell as an optional module. In our Vision On-Demand package, it's included and you can have your doctors scheduling appointments remotely. This goes back to driving efficiency and increasing utilization of the facility.

Q: In your experience, how many ASC companies and centers are already taking advantage of cloud computing?

SP: Utilization of cloud computing, as currently defined in the market, is very low. However, management companies and large accounts have typically traditionally hosted applications on behalf of their centers, so they've started moving them into a data center somewhere. I would estimate that 20 percent of the market has a server managed by a third party.

Another point on cloud computing is the move to an enterprise solution. Right now, large national accounts with 50-plus centers have the opportunity to combine all their facilities into one database. Whereas previously you actually maintained separate facility databases, in a true cloud environment, it's an enterprise database. Large companies have longed for that kind of solution. It makes on-boarding a facility really easy because you have a standardized [database] across your company, and all you have to do is add some locally relevant data, such as doctors and employees. You can be up and running very quickly.

Enterprise solutions also provide enterprise reporting, which combines data from all centers and makes it available at the push of a button.

Q: How is the movement toward electronic health records impacting surgery centers?

SP: Clinical automation is shifting from a paper-based record to an EHR [in surgery centers]. Today, about 18 percent of the ASC market uses an EHR, and a lot of those aren't true EHRs. They're just scanning systems. The centers are taking a paper chart, scanning it and referring to it as an electronic chart. We're seeing [EHR implementation] as a growing trend, driven by the need for efficiency, doctors expecting an electronic medical record in any facility they participate in, and, of course, the government's current and future mandates.

Q: Why do you think surgery centers have lagged behind hospitals in terms of EHR implementation?

SP: I think it's comfort with a paper chart, first of all. Also, vendors in the traditional model were expecting a significant upfront investment. I think that will shift. In some cases, the EHR software wasn't that advanced, and facilities were waiting for the software to improve. Also, physicians and hospitals were provided with stimulus funds to shift to an EHR, and that has dramatically increased utilization, whereas we are just starting to see the rollout of those rules that will impact ASCs.

Q: With many vendors competing for a surgery center's EHR business, where should ASC leaders start looking? How do they know what they need in terms of functionality?

SP: We see three general categories of software vendors in the ASC market today: vendors serving the ASC market specifically, vendors specializing in physician practice management software claiming to have an ASC solution and acute care vendors. I would suggest to any ASC that you look to the vendors serving and supporting the ASC industry. [These vendors should] provide guarantees to support any current and future government requirements specific to ASCs. The vendor should fully understand the nuances of the ASC market, and the software should follow the workflow of an ASC.

Also, keep in mind that EHR applications are very complex, require lots of product development resources and take years to develop and integrate properly, so potential buyers will want to carefully consider their options.

Q: Meaningful use criteria have not yet been developed for ASCs, and surgery centers also are ineligible for stimulus funding to implement EHRs. Do you predict that the government will involve ASCs in meaningful use and available funding in the future?

SP: Indications are that ASCs are included in the Stage 2 Meaningful Use requirements that will be available later this year. Overall, the government cannot achieve its objectives for leveraging [EHR without involving ASCs].

Q: How do you predict social media will affect surgery centers specifically?

SP: "Word of mouth" is shifting to the web, and 23 percent of social media users have noted that they use their online contacts to discuss their healthcare experience and seek advice. Along these lines, 74 percent of all adults now use the Internet, and 61 percent report having used the internet to research medical information and treatment options. These numbers will continue to grow, and users will embrace social media as a means to share experiences and be better educated consumers. It's a great opportunity for ASCs to speak to [their] advantages in providing top quality care in a safe and comfortable environment.

Q: How should surgery centers use social media to market most effectively?

SP: How social media users and patients interact is not something a facility or industry can control. However, you can facilitate providing positive information and making your facility visible to social media users. Also, having a strong online presence will assist you in promoting your local business and helping educated legislators to the value of our industry.

First, track your quality metrics and consider posting them to your web site periodically. For example, [you could post], "Over 98 percent of our patients report that they would recommend our facility to their friends and family" and consider adding some patient quotes to your facility — de-identified, of course. Your website is the first contact that most patients will have with your facility, and you will want to make a favorable and lasting impression.

Secondly, open Facebook and Twitter accounts for your facility, and add this as a connection within your website to help users connect and provide positive feedback. With 750 million users on Facebook, you are getting an inexpensive second website for users to access. You should be prepared for some negative feedback since unhappy consumers are more vocal than satisfied users, but the overall benefits should prevail in the long run.

Third, use metadata in your web pages to help search engines list your facility for key services you provide. Your webmaster can assist you with these simple and inexpensive tasks.

Q: What else can we expect for future trends?

SP: Interoperability is a hot topic in healthcare, but unless your facility is part of an IDN it probably hasn't impacted yet. Moving forward, be prepared to be connected to a health information exchange, accountable care organization and other parties. Be sure your vendor and applications have a well-defined strategy for supporting interoperability to meet internal and external requirements. ■

Learn more about SourceMedical at http://sourcemed.net.

6 Out-of-the-Box Ideas to Cut Costs on Surgery Center Supplies

By Leigh Page

Tom O'Bannon, director western alliance value optimization at Amerinet, discusses six out-of-the-box ideas for ambulatory surgery centers to cut costs on supplies.

1. Centralize supply ordering. Many ASCs lose out on potential savings by spreading supply chain duties among two or more people. A scrub tech might do the surgical supply ordering, a post-op nurse might order the pharmaceuticals and an executive assistant might be in charge of office supplies. Each person simply orders what is needed, rather than crafting a coordinated strategy where products are standardized and savings are identified with distributors or group purchasing organizations. "Supply ordering is too important an activity to be left uncoordinated," Mr. O'Bannon says. "This work should be overseen by one person at the ASC."

At smaller centers, the person doing this work would still retain her original duties, such as working as a scrub tech, but must be given sufficient time to do her supplies work. Also appoint a backup supply person and give both of them training on the basics of supply chain management. "The people ordering supplies do not need to have a complete knowledge of the products they are ordering, but they do need to be good facilitators," Mr. O'Bannon says.

2. Use supply ordering software. Many ASCs are just paying the supply bills and not inputting their order data into a software system to help automate ordering and keep tabs on spending. "Without supply data, you have no history to track," Mr. O'Bannon says. "You don't know how you're doing." Most of the major distributors offer customers free software using bar codes and a hand-held device to read them. This information is downloaded onto a PC and then sent to the distributor.

ASCs can also buy their own software to manage inventory. "Prices for this technology have dropped significantly over the past few years," Mr. O'Bannon says. "This requires a relatively small investment and there are unlimited benefits, from paying invoices to tracking what you are ordering." The ASC might already have inventory management software, as part of a larger financial software package, and simply not be aware of it.

3. Partner with a distributor. A surgery center can save money by developing a close partnership with one distributor. Hoping to get the best price on one particular item, some centers work with several distributors at once, but multiple distributors dilute the potential volume discount and are more difficult to keep track of. "Talk with people at the distributor and get their advice, in coordination with GPO," Mr. O'Bannon advises.

A representative at the distributor can help the center get a better price. He can say, "We offer five different brands for this particular product and you use the highest-priced one. Do you have to use that one?" Also, the distributor rep might review the ASC's orders to see if anything jumps out, such as mistakenly ordering too many items. "If you hit the wrong button and ordered 100 items instead of 10, this person would be reviewing your order and could give you the heads up," Mr. O'Bannon says.

4. Keep working with physicians on new items. Identify surgical items where lower prices can be obtained and ask physicians to trial these lower-cost items. "Basically anything going into the physician's hands needs to be trialed by them first," Mr. O'Bannon says. "The trialing can take time, but it's worth it."

Before starting trials, make sure the physicians are on board. "They have to truly want cost savings," Mr. O'Bannon says. Ask them to sign-off on a cost-savings strategy and remind them of it later if they balk at trialing new products. When a physician wants to stay with a higher-cost item, be prepared to show him just how much more it will be costing the ASC. The distributor or GPO can provide data on potential savings. "You can hold your physicians accountable in a subtle way," Mr. O'Bannon says. "Pitch it back them. Tell them, 'You want us to be more cost effective and here's a great opportunity to actually do it.' "

5. Don't overcustomize packs. Stocking a custom pack to meet all the needs of just one physician is convenient for him or her but not economical for the ASC. The most economical way to use custom packs is to have them stocked so they almost meet the needs of at least several physicians, then add the missing items. For example, if a custom pack is stocked for gynecological procedures, "you might need to pull just one item for a particular physician rather than make 20 pulls," Mr. O'Bannon says.

6. Review purchase history with GPO and distributor. ASCs should review all purchase history with the GPO and the distributor. "Look at what you are buying that is not on contracts for discounts," Mr. O'Bannon says. Can any of these products be substituted with a contracted item? Also, be on the lookout for pricing discrepancies. "It's good to check," Mr. O'Bannon says. "Sometimes the distributor forgets to charge the contracted price and is charging you the full price." These reviews should be done at least twice annually, but they could even be done monthly, he says. ■

Learn more about Amerinet at www.amerinet-gpo.com/.

MDs, CRNAs and Care Teams: The Ins and Outs of 4 Anesthesia Care Models

By Rachel Fields

Surgery centers have several options for anesthesia provider models, depending on surgeon preference, local anesthesia market conditions, surgery center size and revenue and federal or state regulatory requirements. Thomas Wherry, MD, founder of Total Anesthesia Solutions and medical director with Health Inventures, discusses the details of several anesthesia models — all-MD, all-CRNA, the anesthesia care team and the MD/CRNA model.

"When it comes to staffing an ASC, there is really no one perfect model," Dr. Wherry says. "There is no cookie cutter approach. Each situation is unique and one must weigh all the pros and cons."

All-MD model: Dr. Wherry says the all-MD anesthesia model is often seen in one- or two-room surgery centers. The small size of one- or two-room ASC makes it inefficient to staff with both MDs and CRNAs. However, he says the all-MD model is less common in larger ASCs because of the cost required to staff the center with multiple anesthesiologists. "An all-MD model can be cost-prohibitive in a larger surgery center, especially if the group is expected to provide a 'floating' anesthesiologist to cover pre-op and PACU," Dr. Wherry says. "If you have four rooms, it's really hard to have five MDs there."

Clear-cut policies for patient handoff are important in any model, but particularly important when using a model that does not have a 'floating provider.' Surgery center leaders should also explore how the staff handles problems in pre-op or the recovery room. If there is any question about the patient's condition, the anesthesiologist must remain with the patient in the recovery room, precluding him or her from starting another case.

This can be a source of frustration if there are frequent case delays. If any patient suddenly becomes unstable, the nurses in the recovery room must be fully trained to handle such problems. Dr. Wherry says all PACU nurses should be ACLS-trained for this reason.

All-CRNA model: An all-CRNA model allows certified registered nurse anesthetists to function independently without the assistance of an anesthesiologist. Certain states require CRNAs to be supervised a physician, but not by an anesthesiologist. "The surgeon could be considered the supervising physician," Dr. Wherry says. "There are CRNAs that function independently in the ASC setting. This is a broad level of supervision and there is little to no risk of the supervising physician being vicariously liable. This model will run in to the same problem as the

all-MD model: no 'floating provider.'" Thus, the ASC must have all the proper protocols in place to handle any emergencies if the CRNA is tied up in the operating room.

Furthermore, Dr. Wherry says ASCs that use an all-CRNA model should be sure to discuss emergency care and transfer procedures, including what will happen if the patient has a "life or death" issue. Dr. Wherry adds that these issues should be discussed during the quality review process, and any complications should be tracked and analyzed.

Care team model: The "anesthesia care team model" or "ACT" is a term coined by the American Society of Anesthesiologists to describe "anesthesiologists supervising resident physicians in training and/or directing qualified non-physician anesthesia providers in the provision of anesthesia care wherein the physician may delegate monitoring and appropriate tasks while retaining overall responsibility for the patient."

According to Dr. Wherry, the care team involves the anesthesiologist in all key elements of anesthetic provision but allows CRNAs to administer the anesthetic themselves. "The anesthesia care team model is a highly supervised environment where the MD is involved in all aspects of the care," he says. This means the anesthesiologist is present for pre-, intra- and post-operative processes and must be available at all times to consult with the CRNAs.

Dr. Wherry says for the care team model to work, the anesthesiologists must be invested in the model's efficacy. If the anesthesiologist believes that only MDs should treat patients, he or she may create a hostile environment for the CRNAs and the patient. This type of anesthesiologist might also be a poor CRNA supervisor.

Anesthesiologists who use the care team model may have different billing requirements than anesthesiologists who participate in a less-strict MD/CRNA model. When billing Medicare for services, anesthesiologists must determine whether they should bill for medical direction based on their level of supervision over the CRNA. "Seven steps of supervision are required to meet medical direction, making it more of a billing term than a medical term," Dr. Wherry says.

MD/CRNA model: The MD/CRNA model functions much like the care team model but with fewer supervision requirements, and it allows the CRNAs to function according to their full scope of practice, Dr. Wherry says. In this looser supervision model, the MD is present in the surgery center to supervise the CRNAs but may leave the operating room to attend a meeting, staff another room or answer another provider's questions. "It depends on the physician's comfort level, as well as the local and state requirements [governing CRNA practice]," Dr. Wherry says. This model marries the advantages of anesthesiologist involvement in patient care, the skills and scope of practice of the CRNAs and the cost efficiency of CRNAs.

Dr. Wherry says the MD/CRNA model provides larger facilities with more flexibility when the center needs to cover an extra room. If the center is consistently running three rooms and occasionally needs to cover a fourth room, the MD/CRNA model is useful because the center can choose between an MD and a CRNA for coverage. "If it's all MD, you've got to find another MD," he says. "With this model, you can pull one or the other, and you have a greater chance of finding someone to cover that room." ■

Learn more about Health Inventures at www.healthinventures.com and Total Anesthesia Solutions at http://totalanesthesiasolutions.com/tas.

New Regulations for Reporting Anesthesia Time Start Jan. 2012

By Rachel Fields

A universal system for reporting anesthesia time to payors will go into effect Jan. 1, 2012, as part of the transition to HIPAA 5010, according to an ASA release.

According to the release, the new standard will require anesthesia time to be reported in minutes instead of units. Some commercial payors use this system currently, but the implementation date will expand the requirement to all payors.

The change may cause some payors to move from a full unit to fractional unit payment system, which could benefit some anesthesia providers and cost others money depending on when individual contracts permit rounding to the next unit. Any change to commercial payment contracts should be negotiated between commercial payors and providers.

According to the report, the change does not stop contracts from rounding to the nearest whole unit when determining payments. ■

Contact Rachel Fields at rachel@beckersasc.com.

What Management Companies Want: 10 Statistics on Surgery Center Owners and Operators

By Rachel Fields

Here are 10 statistics on surgery center management companies, according to HealthCare Appraisers' 2010 ASC Valuation Survey.

1. Six percent of management companies are public, while **94 percent are private**.

2. Most ASC management companies — **72 percent — have 10 or fewer ASCs under ownership**. Eleven percent own 11-20 ASCs, six percent own 41-50 and another 11 percent own more than 51.

3. **Forty percent** of management companies have **performed due diligence on 1-5 acquisition candidates** in the last year. The rest of the responses were split relatively evenly, with 18 percent of candidates saying they had performed due diligence on no candidates and another 18 percent reporting more than 16 candidates.

4. At 65 percent, **most management companies purchased no new ASCs last year**. Eighteen percent purchased 1-2 centers, 12 percent purchased 5-6 and 6 percent purchasd more than seven.

5. **The majority of companies (52 percent) expect to purchase 1-2 ASCs next year**. Another 18 percent say they have no plans to purchase centers; 12 percent say they will buy 3-4, 12 percent say they will buy more than seven and 6 percent say they will buy 5-6.

6. **The most popular specialty with management companies is general orthopedics**, which received a 94 percent "desirable" rating in the survey. The next most popular was orthopedic spine (88 percent), followed by ophthalmology (82 percent), ENT (76 percent) and pain management (76 percent).

7. **The least popular specialty with management companies is plastic surgery**, which received a 0 percent "desirable" rating on the survey. The second least popular was GYN (29 percent), followed by urology (47 percent), podiatry (59 percent) and general surgery (65 percent).

8. Most management companies (72 percent) **prefer 6-10 physician owners in single-specialty ASCs**.

9. Most management companies (52 percent) **prefer 11-15 physician owners in multi-specialty ASCs.**

10. Preferences on equity ownership were split among management companies: **Thirty-one percent desired 11-29 percent ownership**, while another **31 percent preferred 30-50 percent ownership**. Another 19 percent wanted a 51-75 percent ownership, and 19 percent also desired less than 10 percent. ■

Read more about HealthCare Appraisers at www.healthcareappraisers.com/ASC_Survey_2010.pdf.

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