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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

September/October 2012 • Vol. 2012 No. 7

Hospital Ownership, Out-of-Network and Other Pressing ASC Issues: Q&A With Luke Lambert of ASCOA

By Rachel Fields

Luke Lambert, CEO of ASCOA, discusses the biggest issues facing the ASC industry, the growth of hospital ownership and power, and where growth opportunities exist for surgery centers in the next few years.

continued on page 42

Rising Stars: 32 ASC Industry Leaders Under 40

By Rachel Fields

Here are 32 surgery center industry leaders who — despite their continued success, far-reaching influence and deep knowledge of the industry — have yet to reach age 40. Note: If you would like to be included on this list in the future, please email Rachel Fields at *rfields@beckershealthcare.com*.

Joshua Billstein, The Polyclinic in Seattle (38). Mr. Billstein spent 10 years as a clinician and practice manager at a busy physician clinic before joining The Polyclinic in June 2010. He currently serves as practice manager for the three-OR, multi-specialty ASC, where he has helped integrate cardiology cases into the center's caseload.

continued on page 9

12 Keys to Financial Success – Ambulatory Surgical Centers

By Scott Becker, David Pivnick and Lindzi Timberlake of McGuireWoods

This article discusses 12 ideas and tactics that are critical to ASC success today and over the next 24 to 36 months. To stay effective and profitable, ASCs must both block and tackle effectively and approach the market in certain new ways.

ASCs face two substantial threats. First, payors are increasingly looking at all avenues to cut costs and stay relevant in the insurance business. In an article in the *Wall Street Journal*, entitled "Medical Care Time Warp," dated August 2, 2012 it states:

"Under pressure to squeeze out cost, some of the U.S.'s biggest health insurers are quietly erecting more hurdles for patients seeking medical care. The companies are in many cases reaching

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Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

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Publisher's Letter

6 Key Issues Facing Healthcare in the Second Half of 2012

The first half of 2012 has been an incredibly busy and momentous one for healthcare. Most notably, the Patient Protection and Affordable Care Act was upheld by the Supreme Court, cementing the law's changes to healthcare coverage and delivery — at least until the outcomes of the November elections are decided.

Other events this year impacting the industry may not have been as closely watched, but they were certainly numerous and far-ranging. From the battle over the Medicare sustainable growth rate for physician payments, to the naming of more than 150 Medicare accountable care organizations, to the release of CMS' meaningful use stage 2 requirements, the changes announced for the industry so far this year are significant. Yet, the year is far from over. As we move to the second half of 2012, here are six key issues to watch.

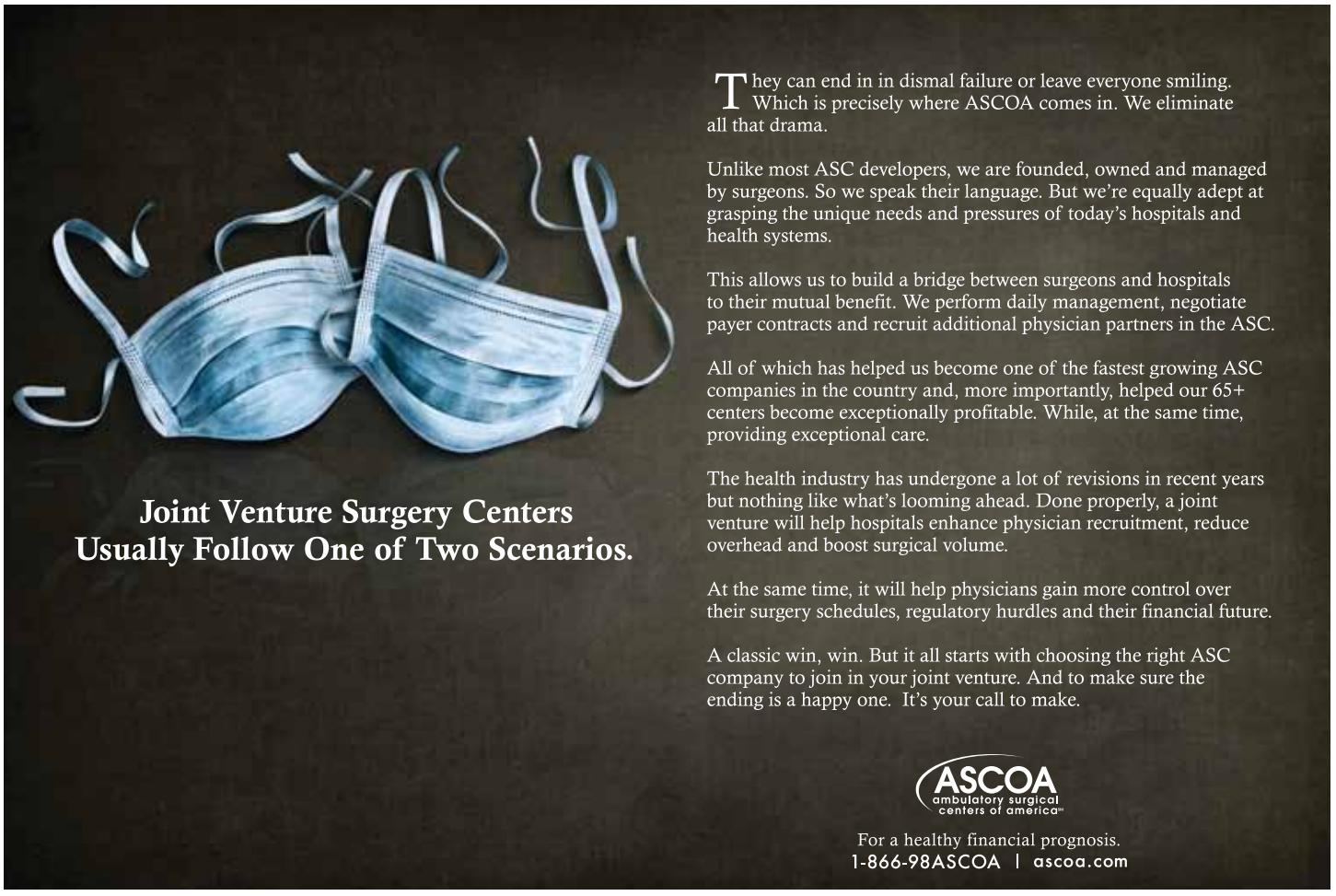
1. Healthcare reform. Now that the Supreme Court has ruled the PPACA largely constitutional, this leads to several interesting questions for the second half of the year.

- Will the implementation of the law move quickly?
- Will the declaration of the Supreme Court that the individual mandate included in the Act is in effect a tax have an impact on the presidential election?
- Will the decision that the Act is constitutional give new legitimacy to President Obama in the face of the independent and the middle of the voting public?
- How much will this issue strengthen the resolve of the Republican party? Will it matter?
- How will funding of much of the Act be achieved, especially if Republicans take control of the Senate?

Healthcare certainly seems to be a key issue in campaigning, which could lead to an absolutely fascinating election. Becker's Healthcare is pleased to be hosting a debate on healthcare reform and the election featuring former Democratic presidential candidate Howard Dean and former press secretary for George W. Bush Ari Fleisher at the 19th Annual Ambulatory Surgery Centers Conference to be held Oct. 27-29 in Chicago.

2. Integration of healthcare systems in preparation for risk products. While clinical integration has been increasing among hospitals, physicians and other providers for several years, the next iteration of this strategy for advanced systems appears to be an entrance into the risk-bearing market.

Certain healthcare systems have gotten well ahead of others in preparing for risk products on the commercial side. For example, in June, closely watched for-profit Vanguard Health Systems announced it would acquire Medicaid HMO ProCare, and in February for-profit Steward Health Care, backed by private equity firm Cerberus, launched Steward Community Care, a limited network plan for small businesses.



A great question revolves around how much of an advantage these systems will have in the market and how quickly will the acceleration of risk sharing products happen. For example, while the country remains largely fee-for-service, will the acceleration lead to a tipping point where there is a much quicker movement towards alternative methods of delivering/paying for care?

We expect integration and the role of health systems in taking on risk to be a topic of discussion at the Becker's Hospital Review Annual CEO Strategy Roundtable to be held Nov. 1 in Chicago. The event features a panel of 12 outstanding healthcare leaders, including Charlie Martin, CEO of Vanguard. For more information on the event, visit http://www.beckershospitalreview.com/novhospitalevent.html.

3. Impact on consolidation. The pace of consolidation of independent hospitals and practices had vastly accelerated over the last few years. In 2011, 86 hospital merger or acquisition deals occurred in 2011, the highest number in the past decade, according to data from Irving Levin Associates. For the first quarter of 2012, hospitals had 23 deals worth $129 million, while physician groups had 20 deals. Numbers for the second quarter of 2012 are not yet available, but the uncertainty of the Supreme Court decision is expected to have caused a slight slowing of consolidation efforts. The question now is whether the decision will cause further acceleration of consolidation, particularly with smaller hospitals and with practices.

4. Investment in healthcare. Over the next few years, we expect there to continue to be tremendous interest in investment in healthcare. Aging of the baby boomer population is expected to drive demand for a variety of healthcare services and products, and if the expansion of health coverage called for by the PPACA does indeed come to fruition, the newly insured are expected to further positively impact volumes. Despite the consolidation of healthcare that has and is anticipated to occur, we have not yet seen a reduced amount of opportunities for investment in healthcare.

5. Information system requirements. We continue to see health systems at all levels suffer in their ability to implement technology related to healthcare. Whether this is in the payor processing world or with regard to electronic medical records, it is not clear whether there is a systematic structural weakness or issues in the labor force that will not allow systems and companies to use the type of technology that has been so broadly encouraged by the government. It will be interesting to see whether there is sufficient talent needed to implement and run such concepts effectively.

For example, in February, CMS released its proposed requirements for stage 2 of meaningful use under the Electronic Health Record Incentive Programs for Medicare and Medicaid. While the requirements are intended to improve interoperability and data exchange — both important elements for using electronic data to better coordinate care — many in the industry voiced concerns over several elements of the requirements, such as making providers responsible for patient engagement with their electronic health information.

6. Increased tension between payors and providers. While we expect large, integrated providers to work more collaboratively with payors on new payment models in the future, pressures on payors to lower premiums may also lead to contentious negotiations or even litigation for providers who aren't willing to come to the table and help payors lower costs.

As consolidation increases, we see more tension between the non-consolidated provider groups and large payors. The payors may need to accommodate large systems but are more willing to play hard ball with less critical providers. As discussed in the *Wall Street Journal* report *"Aetna, Doctors Face Off on Costs"* (July 5, 2012) :

> "Under pressure from cash strapped customers, including large employers, managed-care companies are increasingly focused on limiting their physician and hospital networks to rein in costs, and calling out doctors who rack up big charges. Analysts say the trend reminds them of 1990s-era managed-care strategies that helped constrain health spending, but that frustrated doctors and patients.
>
> In a separate suit filed in February, Aetna alleged that Los Angeles-area physicians it contracted with intentionally sent patients to six of the outpatient surgery centers that are plaintiffs in the current filing, all run by a company called Bay Area Surgical Management. The centers aren't part of Aetna's network. According to the court records in February case, the doctors were investors in the outpatient centers and stood to profit. The first hearing in the case is scheduled for July 20. The management company didn't respond to requests for comment. Because the surgery centers were out-of-network, they could charge higher prices. Aetna alleged that the doctors agreed to waive copays the patient would face as a result of receiving out-of-network treatments. Their bills to Aetna totaled $23 million for 1,900 procedures the insurer says were worth only $3 million, according to the suit."

While smaller provider groups may be more at risk for this type of situation, larger providers who are unwilling to meet payor demands can also expect contentious situations. Take University of Pittsburgh Medical Center and insurer Highmark who were at a head for most of the year over the renewal of their contract until Pennsylvania Governor Tom Corbet stepped in, with the help of a mediator, to negotiate a deal. When negotiations began, Highmark refused the rate increases initially requested by UPMC. As the battle ensued, Highmark announced it would acquire UPMC competitor West Penn Allegheny Health System — a competitor that in 2009 had actually filed suit against UPMC for anticompetitive behavior. The suit is still playing out in court. Following Highmark's announcement, UPMC President Jeffrey Romoff told legislators the health system would refuse further negotiations with the insurer. While the two eventually agreed to the deal after lawmakers got involved, the drama garnered close attention from the national business press and suggests just how combative providers' relationships with payors can become.

With an eye on these six key issues, we are expecting an extremely interesting second half of the year.

Very Truly Yours,

Scott Becker

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Rising Stars: 32 ASC Industry Leaders Under 40 (continued from page 1)

Chris Bishop, Blue Chip Surgical Partners (39). Mr. Bishop is a partner and senior vice president of acquisitions and business development for Blue Chip Surgical Center Partners. In his current role, he is responsible for optimizing performance at ASCs within the Blue Chip network and acquiring and "turning around" underperforming surgery centers. Prior to joining Blue Chip in 2010, Mr. Bishop served as vice president with ASCOA.

Jennifer Butterfield, RN, BSN, CNOR, Lakes Surgery Center (39) Ms. Butterfield is the administrator of Lakes Surgery Center, a multispecialty, Joint Commission-accredited ASC that performs over 5,600 cases per year. She has worked in the ASC industry for over seven years.

Michael Doyle, Surgery Partners (39). Mr. Doyle is CEO of Surgery Partners, where he is responsible for overseeing the firm's day-to-day operation and continued growth. He has experience developing and managing hospitals, surgical centers, rehabilitation facilities and imaging centers. In 2012 he led the Surgery Partners team in the successful acquisition and integration of NovaMed.

Jill Dowe, Blue Chip Surgical Partners (35). Ms. Dowe was appointed director of business office operations for Blue Chip Surgical Partners in 2011, joining the company from a position as business office manager of Surgery Center Cedar Rapids (Iowa). She has also worked as a consultant for Health Inventures, where she trained new business office managers in daily and monthly tasks.

Viva Elia, Surgical Care Affiliates (35). Ms. Elia serves as a Vice President of Operations for Surgical Care Affiliates (SCA), where she is responsible for six ASCs in Southern California. Ms. Elia originally joined SCA in 2003 in a marketing role and later became an administrator before being given responsibility for the Southern California region.

Andrea Fann, Orthopaedic South Surgical Center in Morrow, Ga. (39). Ms. Fann serves as the administrator of Orthopaedic South Surgical Center, a United Surgical Partners International facility. She has served in the position since 2005, before which she worked as business office manager for Buckhead (Ga.) Ambulatory Surgery Center and as director of front office operations for Atlanta Outpatient Surgery Center in Sandy Springs, Ga.

John Gol, Borland-Groover Clinic in Jacksonville, Fla. (39). Mr. Gol is the CFO for Borland-Groover Clinic, which owns two endoscopy ASCs. He also serves as executive administrator for the Fleming Island Surgery Center in Orange Park, Fla., and is Borland-Groover Clinic's representative for ownership interest in St. Augustine (Fla.) Surgery Center.

Bill Heath, Practice Partners in Healthcare (37). Mr. Heath is the chief development officer at Practice Partners in Healthcare in Birmingham, Ala., an ASC management and development company. He has had more than 10 years of experience in the healthcare field, previously serving as the director of development for a large provider of ASC services where he assisted in acquisitions, de novo projects and syndications.

Steve Henry, MBA, CASC (35). Mr. Henry serves as administrator at Surgery Center at Liberty (Mo.) Hospital. Previously, he served as administrator of Fremont (Neb.) Surgical Center, where he enjoyed a 4 percent case volume growth and 9 percent increase in net revenue during the his last year. His has spent time as a financial analyst, business office director and administrator of a start-up surgery center.

Jennifer Hunara, MHA, MBA, Surgery Center of Allentown (Pa.). Ms. Hunara has managed the Surgery Center of Allentown for the

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last five years. She began her healthcare career at the age of 24 as a business manager of perioperative services at Lehigh Valley Health Network, in Allentown, and moved on to the role of executive director of surgical services for Robert Wood Johnson University Hospital Hamilton (N.J.).

Emilie Keene, Parkridge Surgery Center in Columbia, S.C. (32). Ms. Keene is the administrator of Parkridge Surgery Center, and president-elect of the South Carolina Ambulatory Surgery Center Association. She earned her MHA at the University of South Carolina in Columbia and was promoted to administrator just eight months after joining Parkridge as an assistant to the vice president and administrator.

Tony Kilgore, Surgical Care Affiliates (36). Mr. Kilgore serves as a Group Vice President of Operations for Surgical Care Affiliates (SCA), where he is responsible for 21 ASCs and six health system partnerships in a 17 state territory. Since joining SCA in 2011, Mr. Kilgore has been influential in creating, implementing and optimizing SCA's growth and operating strategies.

Heidi Kruger, Laser Spine Institute in Scottsdale, Ariz. (32). Ms. Kruger is the executive director for Laser Spine Institute in Scottsdale, which recently celebrated its three-year anniversary. The surgery center has experienced tremendous growth and success, achieving accreditation from the AAAHC in March 2010.

Angela Laux, Bellin Orthopedic Surgery Center in Green Bay, Wis. (38). Ms. Laux started as the administrator of Bellin Orthopedic Surgery Center in June 2010 and brings over 10 years of experience working in an ASC. The center opened in March 2010. Since then Ms. Laux has led her team to accomplish doubling the number of ORs, case volume, and net revenue annually.

Jared Leger, Arise Healthcare (33). Mr. Leger is a co-founder and managing partner of Arise Healthcare. The company currently owns and operates various healthcare-related businesses with a focus on ASCs. His past experience includes healthcare finance, mergers and acquisitions, development and operations.

Colin McDermott, CFA, CPA/ABV, VMG Health (33). Mr. McDermott is a senior manager with VMG Health and is based in the Dallas office. He specializes in providing financial, valuation and transaction advisory services to clients in the healthcare industry. He leads VMG's financial reporting valuation services team and has presented and published articles on healthcare valuation issues, including in the ASC industry.

Kevin McDonough, VMG Health (32). Mr. McDonough is a senior manager with VMG Health, a leading provider of valuation services to the surgery center industry. Mr. McDonough began his career with VMG in 2003 and now leads the firm's ASC business valuation department. He provides valuation services to over 100 ASCs each year.

Christina McDonald, Tampa Outpatient Surgical Facility (33). Ms. McDonald serves as the administrator of Tampa Outpatient Surgical Facility, where she is responsible for overseeing facility operations and strategically increasing volume. Since joining the center in August 2008, she has increased monthly case volume from an average of 200 to an average of 700.

Amy McKiernan, Louisville Surgery Center in Kentucky (36). Ms. McKiernan joined Louisville Surgery Center, an ASD Management facility, in Jan. 2005, three months after the center opened. She says the center has grown tremendously since her first day; in the first year, the ASC performed 814 cases, and in 2010, the number jumped to 3,431 cases.

Aaron Murski, VMG Health (31). Mr. Murski is a senior manager at VMG Health, based in the Dallas area. He focuses on developing client relationships and providing valuation, transaction advisory and operational consulting services in the healthcare services industry.

Amber Patterson, Westside Surgery Center in Douglas, Ga. (27). Ms. Patterson is practice administrator of Ear Nose & Throat Clinic and Westside Surgery Center. She came to Westside Surgery Center in Dec. 2008, when she inherited the administrator position. In her first three years with the center, she completed the state survey and Joint Commission accreditation and maintained compliance with federal regulations.

Rebecca Overton, Surgical Management Professionals (36). Ms. Overton brings more than 15 years of healthcare receivables and revenue cycle experience to her role as director of revenue cycle management for Surgical Management Professionals. Previously, she served as director of A/R and materials management for SurgCenter Development and worked as the business director for two surgery centers in Florida.

Jason Reese, Health Inventures (34). Mr. Reese currently serves as Health Inventures' vice president of operations for Ohio, overseeing operations at three ASCs and 11 sleep diagnostic centers. He previously spent time as a management consultant with McKinsey & Co., concentrating on strategy and business turnaround management.

Chris Revell, Surgical Notes (37). Mr. Revell manages project and implementation services for Surgical Notes, a leading provider of EMR, transcription, coding and value-added healthcare IT services. As a certified project management professional, Mr. Revell has 14 years of experience managing projects in the healthcare and IT sectors.

Jason Ruchaber, CFA, ASA, HealthCare Appraisers (37). Mr. Ruchaber, partner at HealthCare Appraisers, leads the company's business valuation team in valuing ASCs, transactions in the ASC industry and a variety of healthcare compensation, management and service arrangements, as well as intangible assets.

Simon Schwartz, Pinnacle III (29). Mr. Schwartz joined Pinnacle III in April 2010. In his role at the company, he works on new client development for the operational development, management and billing of ambulatory surgery centers across the country. He is also responsible for all advertising materials, communications, articles, materials for trade journals and website management.

Brooke Smith, Maryland Surgery Center for Women in Rockville, Md. (36). In her two years with Maryland Surgery Center for Women, Ms. Smith has successfully taken a struggling ASC and turned it into a profitable facility. She has worked to increase collections from an average of $70K per month to an average of $240K per month, all while decreasing the center's days in A/R significantly to an average of 25 days.

Jason Strauss, Surgical Care Affiliates (32). Mr. Strauss serves as a Vice President of Operations for Surgical Care Affiliates (SCA), where he is responsible for ASCs in the greater Los Angeles area. During his time with SCA, his combination of analytical and interpersonal skills helped him achieve the highest improvements in physician satisfaction scores across SCA's entire enterprise while delivering bottom line growth of 10-12 percent over three years.

Neil Walker, Surgical Care Affiliates (35). Mr. Walker serves as Vice President of Acquisition Management for Surgical Care Affiliates (SCA). Currently, Mr. Walker leads the company's M&A process by working with both internal teams and external clients to ensure that SCA's capital is being deployed efficiently and effectively as SCA and its 30 health system partners continue to grow each year.

Philipp Wall, MD, RPVI, Arizona Vein and Vascular Center (38). Dr. Wall is the founder of Arizona Vein and Vascular Center, a specialist practice devoted to the treatment and practice of vascular disease. He single-handedly turned a two-exam room office into a 6,500 square foot center in two years.

Parth A. Zaveri, MHA, MBA, The Endoscopy Center of St. Louis (33). Mr. Zaveri is the administrator of The Endoscopy Center of St. Louis, located in St. Louis and St. Charles, Mo. During his time as administrator, Mr. Zaveri's team has been able to undertake several successful initiatives: the ASC has a capsule endoscopy program that was started last year, as well as a new in-house pathology department for patients. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

Ambulatory Surgery Centers – 11 Key Legal Risk Areas

By Scott Becker, Partner, McGuireWoods

There are several different legal issues that face the surgery center industry. This article briefly outlines 11 core legal risk areas.

1. Share Sales. Here, a key issue relates to selling shares at below fair market value in order to obtain or bring in cases. It is also problematic where physicians are offered more or less shares based on the volume or value of their business.

2. Out of Network Business with Payors. Increasingly, payors are attempting to bring all kinds of different actions against centers related to out of network business. At the same time, out of network business remains an important part of the profit component of many surgery centers.

3. Safe Harbors for Redemption. There are strong arguments that it is appropriate to use safe harbors to redeem a physician who is not meeting the safe harbor due to the fact that the center wants to be safe harbor compliant. There are also evolving interesting arguments as to how to use the safe harbors lawfully and whether they are being used for the right purposes legally. Where not used for the right purposes, there is a risk in redeeming physicians.

4. Minimum Case Numbers. Some centers attempt to set high minimum case numbers for physicians to remain owners of the surgery center based on a number of different theories. There remains significant risk that this will not be enforceable and/or that this might be viewed as inappropriately conditioning ownership or referrals. Surgery centers have some risk of being faced with qui tam or false claim cases brought by employees or competitors based on a number of different issues including case requirements or usage requirements.

5. Anesthesiology and Pathology Relationships. Many surgery centers and owners attempt to profit from anesthesiology and pathology relationships. Many of these may be legal. However, the more that these are focused on providing physicians with profits and the physicians are not actively engaged in the work, or supervising the work, and to the extent that this is intended to provide profit in exchange for referrals, the more concerning these relationships can be.

6. HIPAA and Data Breach Issues. Increasingly, centers have to spend money working on or responding to data breach or security breach issues, for example, where certain amounts of patient medical records are inadvertently disclosed or lost.

7. Physician Owned Distributorships. In many situations, physician owned distributors can actually save a center or hospital a great deal of money. At the same time, because so much of the business is often based solely on that physician's referrals, there can be the appearance that the physician is being paid for something that is really not his core business and that it is really an excuse to pay him or her money in exchange for cases.

8. Equipment Lease and Lithotripsy Relationships. There are situations where physicians own equipment and then rent it to a surgery center on an annual basis or per click basis. These can be argued to be in exchange for business development as opposed to for actually being the best distributor or renter. The lithotripsy business continues to be almost wholly tied to urologists owning the lithotripters that are used for their procedures.

9. Overnight Stay and Recovery Care Facilities. Increasingly, surgery centers look to handle more complex cases that require some level of recovery care and overnight stay. Here, there is nothing fundamentally wrong with this. However, it is generally not permissible for Medicare patients and many states have limitations on what kind of cases can be done in a surgery center that may require recovery care.

10. Medical Staff Privileges Issues. Increasingly, ASCs face disputes over medical staff and privileges issues as centers and providers get more cautious about medical quality at their facilities. This often can also tie into ownership issues and there can be accusations that medical staff privileges issues are used as a means to pressure a physician as to ownership issues.

11. Co-Management and Relationships Coupled with HOPD Conversions. Increasingly, centers may convert to a hospital outpatient department with the intent to increase reimbursement and then provide co-management responsibility to a physician company. Here, it is critical that the co-management agreement be entered into for reasonable purposes and at fair market value. In essence, that it not an excuse to provide the physicians with funds to continue bringing cases to the center. ■

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6 Surgery Center Administrators on Best Leadership Tactics

By Taryn Tawoda

Six ambulatory surgery center administrators discuss effective leadership strategies for boosting staff morale, organization, efficiency and profitability.

Steve Corl, Mackinaw Surgery Center (Saginaw, Mich.): We implemented a rounding protocol for managers. Once a month, they will round on each employee for five to 10 minutes to see how things are going. Rounding must be done privately and at a time convenient for the employee. This program helps identify employees that are doing an outstanding job — not from just the management's point of view, but from their peers. Recognition of those employees can be given in the form of a thank-you card mailed to their home, an "employee of the month" parking spot up front in the parking lot, or a gift card. We also will have potlucks that can be sponsored by all employees bringing something or by the organization if they meet certain patient satisfaction or quality initiative goals.

Chris Doyle, Riddle Surgical Center (Media, Pa.): We conducted an employee satisfaction survey, and I was anxious to present the excellent staff scores at our monthly team meeting. To kick off the summer, my leadership team and I served water ice and pretzels, Philadelphia-style, to our team members. At the end of the meeting, we provided Riddle Surgical Center T-shirts. As a follow-up to that meeting, I formed an employee satisfaction committee to further improve team morale. This committee includes five team members from each area of our facility. The steering committee is meeting monthly and will present their results to the entire team at the end of the year. A second initiate to improve morale is my monthly "lunch with the administrator," where I provide lunch for four team members. I deliver a facility report to the group and ask them for feedback about their experiences.

Sandy Berreth, Brainerd Lakes Surgical Center (Baxter, Minn.): Staff morale is based on perceptions. I believe by recognizing, by encouraging, by being "present" and finally by rewarding, the staff will appreciate the efforts of the leadership team, and therefore staff morale will increase. I participate daily in the managing of the surgery center, and I know the work schedule and the workload of each employee. In recognition of jobs well done, we give gift certificates to Target and the local movie theater, as well as having lunches and breakfasts as rewards.

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Anita Roper, Viewmont Surgery Center (Hickory, N.C.): One of a leader's most important resources is their staff. Invest in your staff; listen to them; engage with them; ask them what is working and what is not working. During our staff meetings, I always go around the room and give each employee at the meeting time to ask any questions, voice any concerns, or mention any topics they believe need to be discussed. If you as a leader decide to implement this opportunity for employees, you can plan on a long first meeting. But the staff members will get accustomed to the process, and they will learn how to bring up important conversations. If they bring up a topic that you plan to discuss in your agenda, thank the employee for bringing that up and let them know you will address it.

Arvind Movva, MD, CEO, Regional Surgicenter (Moline, Ill.): The most important factor in improving non-provider productivity is boosting employee efficiency. This is accomplished through increased morale and personal buy-in. Recently, we began disseminating information via intranet postings and e-mail, replacing our previous methods of paper postings, mailings and word of mouth. We also launched several new service lines, which include interventional pain and ENT. Because we were a GI predominant multispecialty center, our staff was very well educated on all things GI, but they were less familiar with these newer specialties. An educated staff is a productive staff. So, how can we improve the knowledge level of our staff while at the same time giving them a feeling of ownership and improving morale? Answer: Trivia game with prizes via e-mail and intranet that revolve around new service line offerings. We tied these to sports tickets, but anything fun can work. This created significant interaction among the staff and physicians regarding their procedures and also fostered some healthy competition about knowing more than others.

Brooke Day, Hastings Surgical Center (Hastings, Neb.): There is a difference between hearing what an employee is telling you and actually listening to what an employee is telling you. It is important to approach each individual conversation with openness to their feelings, opinions and perceptions. Listening involves paying attention to the non-verbal cues, being aware of their feelings and in return being sensitive. Leaders always have to consider the business, surgeons, employees and patients and although the appropriate decision may not be the preferred choice by staff, you can always approach the staff with an honesty and awareness of their feelings. ■

5 Qualities to Look for in a Surgery Center Third-Party Patient Financing Program

By Rob Morris, vice president of marketing and new business development at CareCredit

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

Many patients today are facing higher out-of-pocket costs, including increased deductibles and co-pays that can make moving forward with surgical procedures a challenge. To help patients get the care that they need, every ASC should review its financial policy and ensure that it provides a variety of payment options that patients can take advantage of — including patient financing. With a comprehensive financial policy, an ASC can provide patients with a payment solution that fits both their budget and lifestyle, improve the ASC's cash flow, and reduce A/R.

Most ASCs have a financial policy that requests payment at the time of treatment by cash, check, or major cards such as VISA or MasterCard. However, studies show that most Americans have only $300 of available credit on consumer cards, and find it difficult to write a check for more than $500 out of their monthly budget. With facility fees ranging from $400 to $7,000 and the popularity of elective procedures in ASCs growing, it's not unusual for patients to have large out-of-pocket costs that put a real strain on finances.

In today's economic environment, patients appreciate and have even come to expect some level of assistance from healthcare providers when it comes to managing the cost of care. In a study conducted by Inquire Market Research, 32 percent of patients stated that without an obvious payment solution, they would ask the provider to function in the role of a financing company by billing them. Unfortunately, when a facility takes on the responsibility of billing, they also incur the cost and risk associated with it as well — including late payments, bad debt and uncollected accounts. A better solution that has proven more effective for both healthcare professionals and their patients is to add a financing program through a third-party financing provider.

Manageable monthly payments

Over the last 25 years, healthcare professionals in nearly every field, including dentistry, ophthalmology, cosmetic surgery, podiatry, bariatrics, and even veterinary medicine, have increasingly used third-party patient financing programs to help patients pay for out-of-pocket costs and treatment not covered by insurance. In fact, many patients prefer using this payment option instead of their consumer credit cards because the availability of promotional offers.

Choosing a program for your practice

With a third-party financing program, you can offer patients both deferred interest and low-interest payment options without assuming the risk and expense of billing and collections. Patients complete a short credit application, which is submitted to the third-party financing company. The patient quickly receives a credit decision and credit line. If approved, patients can schedule their procedure immediately and pay over time with a manageable monthly payment.

The cost of offering this option comes out to about the same as giving a courtesy discount of 5 percent for cash payments. In today's economic environment, most patients don't have the cash on hand to take advantage of a courtesy discount, so having a monthly payment option can motivate patients to schedule their procedure or move forward with care. One of the biggest benefits is that once approved, the financial arrangement is between the patient and the financing company. The center receives immediate payment via an electronic transfer in about two business days, improving cash flow and reducing A/R.

When you offer additional payment options through a third-party financing company, you must be able to trust them with your patient relationships. In other words, the finance company must treat your patients as well as you do. Here are a few things to look for when selecting your third-party financing partner.

1. Experience. Experience does count. Find out how long the company has been in business and how many healthcare providers offer the program. Also ask how many patients have used the program to get care.

2. Flexibility. Does the company offer a wide range of payment options? Can patients apply at home and in your office? Can they apply over the phone and over the internet?

3. Customer service. Can patients get help 24/7? Does the company provide your team and your patients with high-quality information and service?

4. Efficiency. Can your patients complete the application in just a few minutes? Can you receive a credit decision within seconds?

5. Value. Does the company provide marketing and presentation materials? Do they offer other value-add services to help your ASC become more financially healthy?

Adding the program to your financial policy

Your patient financing program should be included as part of your financial policy and presented as an option along with cash, check, and Visa and MasterCard. Your policy will be most effective if it is written and specific, leaving little room for interpretation or misunderstanding. For example, the policy should outline the patient's responsibility if their insurance company does not cover care, if there are fees for missed appointments or returned checks, or if you offer a courtesy discount for payment with cash or check. It's also important that the policy be embraced by your entire team and consistently communicated to all patients.

A written financial policy will increase patient satisfaction by minimizing confusion and miscommunication. Patients often become unhappy when their expectations are not met, either clinically and financially. Without a specific written financial policy, both your team and patients run the risk of incorrectly interpreting both payment responsibility and options.

A written financial policy will also help patients understand how their insurance benefits work within the financial system of your center. Patients may not understand how insurance benefits are applied to treatment. Your financial policy should detail the expected insurance benefit and the patient's out-of-pocket expense. Most importantly, a clear financial policy will help you to increase treatment acceptance by eliminating "fear of cost." A patient may hesitate to move forward with care because of prohibitive cost. A financial policy enables patients to quickly identify the payment option that works best for their situation, addressing the issue of cost before it can become a concern.

Adding patient financing to your financial policy makes it easy to offer patients a payment solution that fits both their budget and lifestyle. Improved cash flow, reduced A/R and more scheduled procedures are all benefits that can improve your center's financial health and help more patients get and stay healthier. ■

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Leading a Surgery Center During a Time of Change: Q&A With John Wipfler and Linda Ruterbories of Orthopaedic Surgery Center

By Taryn Tawoda

John Wipfler, CEO of OA Centers for Orthopaedics in Portland, and Linda Ruterbories, ANP, director of OA's Orthopaedic Surgery Center, discuss the process and challenges of leading an ambulatory surgery center through times of change.

Q: How do you approach change as a surgery center leader?

John Wipfler: As leaders, we need to be very focused on how to be creative and adaptive, and create organizations that are very fluid. Change is the new "normal." We have to be constantly moving our organization and seeing the change as an opportunity — you can't allow it to overwhelm you or view it as something that's fearful.

Q: What significant sources of change do you face in your practice today?

JW: Our payor relationships are all related to our clinical practice. We want to partner with businesses looking for greater value in healthcare and figure out how to deliver that. Under the "tiering and steering" model, large employers are talking about identifying providers and facilities that provide high quality and a lower cost, and then "steering" their beneficiaries to those providers. Healthcare is increasingly defined by the relationship of cost and quality, and surgery centers have a leg up all around on both of those items.

We have to think about how we position ourselves so that people who are sending patients to us realize we provide that great value and high quality. We're building those kinds of partnerships by working with other physician practices in Maine and aligning ourselves with other specialists. We want to be able to compete as specialists in the new accountable care organization world as it evolves — we created an alliance through a specialty Independent Practice Association that puts us in a good position to compete for contracts.

Q: How do you motivate your employees to adapt in times of change?

JW: You need to manage your staff and physicians so that they can come along with you. You need a high level of communication, and you need to be as transparent as possible with everybody.

Linda Ruterbories: We're lucky to have creative individuals in leadership positions and employees who are excited about challenges and change, and they feel accountable when we're making a change and want to be a part of it.

JW: A piece of this is creating an organizational culture, where all of the staff are engaged in knowing that change is necessary and part of our expectation. That allows them to really throw themselves fully into whatever the initiative is. When we're hiring and training, we're creating an environment and an expectation where people understand that there needs to be a lot of adaptability. If you have that underlying culture, managing the change gets easier. In our surgery center, which Linda directs, they're really great at identifying how to drive costs down, how to serve the patients better and how to make the patient experience higher quality — they're always looking for a better way.

Q: What qualities do you look for in prospective employees to ensure that you are building an adaptable team?

LR: I'm constantly interviewing to find the right candidate, even if there is not a position open. If I'm sent a resume, I'll bring them in and say, "While there's no position available right now, I'd like to interview you and in the event that something comes up, we will call you. During the interview process we'll discuss our different ideas and mindsets related to change and the important aspects of patient care. If a position opens up, I'll call the candidate who was the best fit and ask if they would like to start per diem full time.

During that time we can gauge their work ethic and mindset, and at the same, they can evaluate us. So that after spending about 12 weeks here, we determine whether or not it's a good fit. I get the majority of the full-time employees that way — I would say the per diem employees work out 80 percent of the time.

JW: Also, somebody who's willing to step into a per diem position has more ability to take on risk. A per diem position is riskier because you're not in a locked-down employed position, and if you're willing to do that, you probably have a more fluid mind and approach in terms of being able to step out of the normal construct of how you do things.

LR: When you have per diem employees, if a full time employee leaves, you know you'll always have somebody in training to replace them — there are no gaps in time where the other employees are stretched to cover the open positions.

Q: What have been some of your greatest leadership challenges and how have you overcome them?

JW: When leaders face resistance from employees, it can feel like they're being challenged. Resistance often means we are not communicating the change effectively enough or not engaging everybody effectively enough. Maybe we're moving too fast and not giving enough information, and people don't understand why the change is happening. Resistance allows us to slow down, communicate more and really ask people where the resistance is coming from.

LR: Our expectation is that we're going to have a period of resistance going on regardless. It's just a matter of whether that period is going to be longer or shorter.

JW: You have to expect it and put it in the right context. You have to think, "This is telling us something about how we're not doing this as effectively as we could be, so let's figure out where we're dropping the ball." Any sort of change is a complicated process, but it's rewarding when you can boost it effectively and create an organization that's fluid. ■

6 Good Ideas to Grow Single-Specialty Surgery Center Case Volume

By Laura Miller

Here are 10 ways for single-specialty surgery centers to increase case volume.

1. Attract the majority of specialists in your area. In large metropolitan areas, it may be difficult to attract the majority of specialists to your surgery center because some groups will already have competing affiliations; however, in small markets with fewer specialists, you may be able to attract a majority of available surgeons to your surgery center.

"In suburban centers, there is an opportunity to attract the majority of surgeons in a single specialty," says Catherine Sayers, director of operations at Pinnacle III. "That doesn't apply as much in large metropolitan areas where there are more specialists; you will have a harder time attracting them because they are already involved in other ventures."

However, in either situation, attracting more physicians will grow your case volume. The best place to begin physician recruitment efforts is within your current physician base. "Start with your current group and ask them to refer colleagues so you have a good basis for whom to speak to in the market," says Amanda Kane, manager of business development at Blue Chip Surgical Partners. "The most effective way to attract new physicians is through physician referrals."

2. Make sure surgeons are bringing all possible cases to the surgery center. If surgeons aren't bringing all their ASC-appropriate cases to the surgery center, you are losing patient volume and revenue. The success of a surgery center depends on the physician partners and credentialed physicians performing cases there, so make sure you are accommodating the special needs of each surgeon.

"If you've got a busy surgeon who is bringing only some of his eligible cases to the center and taking the remainder to the hospital, have a conversation about why that is and what you can do for him," says Ms. Sayers. "Figure out why those cases aren't coming your way — maybe the surgeon doesn't have enough block time — and see what you can do to bring those cases into your center."

Sometimes, physicians may be taking cases to the hospital instead of the surgery center because they aren't aware of advancements in technology making those procedures appropriate in the outpatient setting.

"With careful patient selection many more complex, higher acuity cases are being done safely in the surgery centers today," says Ms. Kane. "Surgeons are bringing ACL cases to the surgery center, as well as unicompartmental knee replacements, which haven't been done in the past. Expanding the breadth of cases really helps drive ASC volume without having to recruit additional surgeons."

However, make sure the surgeon is comfortable performing these more complex cases in the surgery center.

3. Engage in direct-to-patient marketing for patient-referred specialties. Other specialties, such as endoscopy, depend more on patients scheduling their own visits. "In an endoscopy center, patients don't usually see the gastroenterologist first; they just know they need a

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colonoscopy and contact a center to schedule the procedure," notes Ms. Sayers. "Promote yourself as an open access endoscopy center and make it easy for patients to schedule with you directly."

Surgery centers focused on driving patient volume from direct-to-patient marketing can also participate in community outreach events to let potential patients know about their services. The physicians can host educational presentations or sponsor health fair functions.

"Our center is sponsoring a walk organized by the Crohns and Colitis Foundation. Our physicians are involved, which raises awareness for us in the community," says Ms. Sayers. "This works especially well in a smaller community where your visibility is high. In a larger community, you might not get as big of a bang for your buck, but your patients see you out there and may be more likely to head your direction when the need arises."

Ms. Kane has also worked on campaigns to send mailings out to potential patients by zip codes advertising colonoscopies at the center. "We are doing direct-to-consumer marketing for colonoscopies, which allows the patients to call the center and schedule instead of going through PCPs," she says. "The nurses do the pre-screening and give patients the instructions over the phone. We have found that the direct access program makes it easier for patients to schedule their colonoscopies, which then leads to increased patient compliance for colon cancer screening."

4. Maximize efficiency for surgeon referral-driven centers. For surgery centers driven by specialties where surgeons are usually responsible for bringing in the patients, such as orthopedics or general surgery, it's important to keep the surgeons happy. One of the best ways to make the physicians happy is by increasing efficiency, which will also allow more cases within an allotted timeframe at the ASC.

"You have to actively promote your surgery center to physicians by highlighting the efficiencies they will experience there," says Ms. Sayers. "Have on-time starts, well-trained personnel, educated staff members and good turnaround times, so things run smoothly. You also want to provide great customer service to patients, which will help attract those surgeons."

Fast turnover times are key for the surgeons because the more cases they can fit into their schedules, the more likely they are to use the center. "If the operating rooms are turned over efficiently and quickly, you are allowing for more cases to be done in a given day," says Ms. Kane.

5. Close the gaps in operating block schedules. When surgeons have block time, make sure they are regularly using all of it. If they often have extra time, consider shortening their block to extend time for another physician or bring in a new surgeon who could use that time for additional cases. "Take a look at your schedule and make sure it optimizes times physicians are in the operating room," says Ms. Kane. Efficiency within the schedule optimizes time that physicians are in the OR, and leaves unused OR time as an opportunity to bring in new surgeons.

6. Negotiate implant carve-outs. Single-specialty surgery centers should understand how to negotiate contracts for all their procedures, especially newer procedures, to make sure costs are covered; if they aren't, bringing those cases into the ASC isn't beneficial for the surgeon or surgery center from an economic standpoint. For example, in orthopedic or spine driven surgery centers, implants are among the biggest expenses per case and if they aren't carved out, a large chunk of the reimbursement will be spent to cover those costs.

"It's important to negotiate contracts that include carve outs for implants," says Ms. Kane. "Failing to do so will result in the loss of high revenue cases where the implants can be very costly." ■

12 Keys to Financial Success – Ambulatory Surgical Centers
(continued from page 1)

back to the 1990s and boosting the use of techniques that categorized patients and doctors alike. Today's approaches are tweaked, but many feel familiar to many: Insurers are rolling out plans with more restricted choices of doctors and hospitals, and weighing new requirements for referrals before patient can see specialists." It also states that payors are using "Narrow Networks: Often "tiered," so patients get bigger out-of-pocket charges if they go to providers that aren't in the top category, then even larger bills if they go completely out of the insurer's network." The WSJ also states that "Insurers are creating plans built around particular healthcare providers that they own or partner with. WellPoint is "rolling out a number of narrow and tiered networks" across its markets, said Ken Goulet, executive vice president. These networks involve around 30 percent to 70 percent of the company's full list of providers, he said."

In a Bain & Company report entitled "Healthcare 2020" it states:

> "Payers are searching for all available tools to stunt the growth of a sector that has successfully resisted cost containment for decades. The net result will be an unprecedented decline in the share of the overall healthcare profit pool captured by innovation-driven companies in favor of lower-margin sections like generic manufactures and providers."

Second, competitors are increasingly becoming vertically integrated and attempting to buy up and control physicians that are the lifeblood of surgery centers. Here, Bain uses dialysis as an example of vertical integration and states:

> "Companies like Fresenius Medical Care, which started out producing dialysis machines, have emerged to "own" an entire segment of care – vertically integrated with machines, clinics and drugs. With global government spending estimated at about $50 billion for dialysis products and services, but with shrinking reimbursement per treatment, the vertically integrated model may be an effective path to capture a very specific part of the profit pool"

With this background, here are 12 concepts ASCs should consider.

1. Become Great in an Area and at Consumer Branding and Marketing. As surgery centers compete with vertically integrated systems to attract physicians and patients, they will increasingly need to be masterful at finding an area to excel in and in making the effort to be really known for that area. They can attempt to, for example, (1) become dominant in a specific specialty or procedure or (2) be low cost to consumers and payors in a high volume area. Increasingly, ASCs will need to excel in an area and be able to fully market and brand themselves as outstanding in that area. We view a surgery center as needing to both be profitable and to attempt to be a leader in certain areas. Whether it is in a specialty niche area, as a low cost provider, or in having the best surgeons, it is critical that a center be known for quality and greatness in certain areas to succeed in the long run.

2. Great Billing and Collections. As margins decrease throughout healthcare, it will be critical to fully and properly collect on ASC billings and collections. This includes increasingly from patients as well as payors. Financial success is highly dependent on great revenue realization.

3. Managed Care Contracts. A center must really work to obtain favorable contracts and it must be careful not to sign a bad payor contract even if the payor is a small percent of its business. Over the past several years, centers have often signed unfavorable payor contracts with small percentage payors only to find that those payors then rent their networks to other payors and that they are actually setting their pricing for a broad variety of payors.

4. Out of Network. Out of network is increasingly criticized. That stated, providers still make a disproportionate amount of earnings from a small percentage of patients that are paying via payors out of network rates. It may be necessary to take some risk and work with out of network patients in order to stay successful.

5. Examine Bundling Mechanisms. Increasingly payors are very receptive to and often seeking to pay for an entire procedure via one contract. Here, if a center can become a leader in bundling together all aspects of a procedure, particularly high volume or high cost procedures and develop contracts with payors that are attractive to physicians, they can possibly retain a core spot in the market.

6. Constantly Be Recruiting Surgeons. A center must constantly be looking to recruit additional surgeons who can work at the center and help add capital to the center. Recruiting should not be an every few years type effort, but rather should be a constant activity to find the best surgeons to join the center.

7. Consider a Hospital Partner. Centers in many markets may benefit from a hospital partner particularly with respect to physician issues or managed care contracts. However, not all partnerships with hospitals are destined for success. It often depends on the true interests of the hospital in such partnerships and its willingness to really devote efforts to help the surgery center.

8. Recruiting Great People. There is no substitute in business for extremely smart and focused people. Particularly with the changes in business, there is a real premium on smart, agile, focused persons as leaders and at every level.

9. Standardizing Costs. A center must be able to measure cost per surgery and to bring the cost within reason so they can focus more time on recruiting more cases and better cases.

10. The Best Boards are Highly Engaged Boards. A Board of the center should be focused constantly on greatness and on high profits and be regularly in touch and view the surgery center as a critical part of their daily existence. The best boards are highly engaged and meet often.

11. Be Alert to Risk. A center must be very cognizant of what its key risks are. Whether the risks relate to the loss of a key employee, regulatory risk, a key surgeon, infection risks or a specific payor situation, the centers' leadership must be highly attuned to core risks.

12. Continued Failure. If a center has failed six times, it is often the case that you can try and buy that center and turn it around. However, it is likely that the center suffers from systemic problems that will not be solved with any new operator. ■

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12 Steps to More Robust Reimbursement in a Surgery Center

By Rachel Fields

Jessica Nantz, president and founder of Outpatient Healthcare Strategies, discusses 12 strategies to improve reimbursement processes in your surgery center.

1. Monitor your revenue cycle processes. A profitable surgery center depends in part on a functional revenue cycle, Ms. Nantz says. Since the revenue cycle has many moving parts, every part has to be working properly in order to achieve maximum reimbursement. "Once the case is actually completed and the op note is dictated, the revenue cycle kicks in," she says. "It goes from transcription to coding to charge entry to billing to posting, and you need to monitor every one of those processes."

She says monitoring revenue cycle processes includes the following tasks:

- **Ensure transcription is completed in 24 hours.** Look at your transcription processes to determine whether you have a "problem physician" who isn't turning in his or her dictation on time. If you have a consistently late physician, sit down and explain the importance of timely transcription for timely payment.
- **Ensure coding is completed in 48 hours.** "Coding is the first step to bringing the cash in," Ms. Nantz says. Audit your coders on a regular basis to make sure coding is completed within 48 hours of the procedure. You should also conduct semi-regular aduits to ensure coding accuracy, which can be performed by an outside consultant. Ms. Nantz says you should also have a backup plan if your regular coder is out, which may mean cross-training other members of the business office team to understand coding basics.
- **Ensure billing is sent in 72 hours.** Billing should be sent out within 72 hours of the procedure to ensure timely reimbursement, Ms. Nantz says.
- **Receive updates on OTC and A/R collections.** You should have a good idea of your month-to-date OTC and A/R collections, Ms. Nantz says. You should also understand which areas your ASC has the most trouble collecting from. Are you struggling to collect from patients because your collector only calls in the morning, when patients are at work? Are you receiving denials from payors because of coding issues? Knowing your problem areas will help you target specific employees and processes for improvement.

2. Ensure collection goals are met. Make sure your staff members know your collection goals on a daily basis, Ms. Nantz says. For example, you might set an over-the-counter collection goal of $6,000. This means that you have totaled each patient's expected co-pay and co-insurance and added the totals together for the day. Once receipts come in at the end of the day, you can compare the total collected to your collection goal. "If you set a goal of $6,000 and collected $3,000, why were you at 50 percent?" Ms. Nantz says. "What happened, and what issues are you having?" She says it's important to make sure goals are met for both over-the-counter collections and A/R.

- **Review A/R accounts with your business manager.** On a regular basis, review you're A/R accounts with your business manager and determine which "buckets" are doing well and which have problems. For example, you may have a lot of claims in your "over 120 days" bucket, meaning you're still waiting for payment 120 days later. If those claims are from payors that take a long time to reimburse you — such as workers' comp — this may not be a problem.
- **Discuss reasons for claim denials.** Talk to your business manager about the reason for claim denials, Ms. Nantz says. She recommends performing a quality improvement study around your percentage of claim denials. Once you understand how many claims are denied, you can dig deeper to determine the cause. "Is there a certain payor that always returns claims for a certain reason? Is there an employee who's transposing incorrect data? Is there something that's not attached?" Ms. Nantz says. She says if you outsource any of your revenue cycle processes, you should still be having this conversation with your revenue cycle company.

3. Track your implant reimbursement. Implant reimbursement is essential to profiting from your cases — especially orthopedic cases, which carry high implant costs. Ms. Nantz recommends tracking implant reimbursement to determine how much your payors are reimbursing you for your implants. "Some people have implants at cost, and some people have them at cost plus — the point is, how do you know what implant revenue is coming back if you're not tracking that?" she says.

She says you should keep a spreadsheet that details how payors pay for implants, because the methodology will probably differ from payor to payor. For example, some payors pay the ASC per implant, whereas others just lump the payment into the total reimbursement for the case. You need to analyze your implant reimbursement separately from total case reimbursement to make sure you're receiving enough money for your high-dollar items.

4. Monitor your payor contracts. Every administrator should understand reimbursement for their top CPT codes by specialty and payor, in order to predict the center's profitability, Ms. Nantz says.

- **Review payor mix monthly by contract and by physician.** Look at the rates you're receiving from your payors on a monthly basis, Ms. Nantz says. "You should look at the rates you're being paid by contract and by physician," she says. "That predicts your net revenue — in a month, there's a huge difference in net revenue depending on whether you're reimbursed at $400 or $600 for GI cases, or $2,000 or $3,000 for shoulder cases."
- **Review top 12 payor contracts (one per month).** Review one payor contract a month to determine whether the payor is reimbursing your center in a timely fashion, and whether you could stand to re-negotiate the contract for a payment increase. For example, if the cost of your supplies has gone up in the past year, you will see upon reviewing the contract that your payor no longer reimburses an adequate amount to cover your costs. ■

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7 Ways for Surgery Centers to Make More Money Now

By Taryn Tawoda

Arthur E. Casey, CASC, senior vice president of business development for Outpatient Healthcare Strategies, discusses seven ways to foster surgery center culture that emphasizes cost cutting, innovation and profitability.

1. Create a money-saving mindset among staff members from day one. Before any cost cutting measures can take place, it is important to first encourage a willingness to participate among every physician and staff member in the process to save money throughout the center, says Mr. Casey. "It should definitely be part of the culture and philosophy of the facility. In every situation in which you can be talking about the goals of the facility — upon hire, during evaluations, in weekly or monthly staff meetings — you should be driving that home," he says.

It is also important, however, to incentivize staff members without necessarily incorporating a cash bonus program, which may cancel out any cost savings achieved. Alternative ways to recognize staff efficiency and cost cutting include public recognition and smaller rewards. "You should also be highlighting and recognizing your staff members when they are doing what you're asking," he says. "Everyone wants to be acknowledged for doing a good job, and it's extremely important that staff members are publicly recognized or thanked at every opportunity.

Staff members can also be given small incentives, such as a $15 gift card to a coffee shop or a pot luck lunch. "With those sorts of things, you're motivating your staff to do the job that they're supposed to be doing," he says.

2. Quantify the effect of savings achieved. Creating simple reports that illustrate the facility's cost savings is often an effective way of communicating the importance of even the smallest cuts over time, says Mr. Casey. "If you go from spending $8 to $6 on a supply item that you use 50 times a month, show on a chart that you're saving $1,200 per year with that change," he says. "The savings become impressive when you add those numbers up." Reports that focus on each cost saving opportunity on an annualized basis are often the most clear and effective way to communicate this information.

Quantified reports also allow physicians to comprehend the importance of switching to less expensive but equally effective supplies. "When you've got really good data, you can go to your physicians and show that doctor A is more expensive than B, C and D, and you can ask doctor A to switch to different products," says Mr. Casey. "Whenever you can utilize the same product across the board, it's less expensive and can help start realizing savings."

3. Tighten the facility's insurance verification process. Improving the patient insurance verification process is one of the few ways to see a meaningful boost in profitability before the year's end, says Mr. Casey. "If you're doing very good insurance verification, identifying the patient's portions up front and are rigorous about collecting that money up front, that will keep many of those accounts out of the collections process and has the potential to help improve profitability," he says.

It is typical for a facility fail to collect the patient's portion of the payment at the time of the procedure, instead accepting smaller payment amounts over the next six months after the insurance portion is paid. "If you arrange for payments upfront, you have a reduced amount of potential claims that will go to bad debt," he says.

4. Challenge your vendor to offer consistent cost cutting opportunities. Many facilities are locked into a longstanding relationship with their current supply vendors, and over time, they can become blind to the possibility that the vendor may not be offering the most competitive supply rates. "If you're not seeing continued reductions and if your rep isn't coming to you consistently with money saving suggestions, then that person may not be looking out for your best interest," says Mr. Casey. "If you have a really good rep, that person will be trying to make your job easier and find you opportunities to save. But if they're not going to bring you ideas, you need to look for your own."

Leveraging one vendor against competing vendors for supply cost quotes will often cause an existing vendor to lower costs. "If your vendor knows you're shopping a product, they'll come back with their own proactive ways of saving money," he says. "The vendor gets to keep the business, and you have reduced your costs."

5. Keep a tight rein on supply inventory. Over-ordering supplies is among the most common sources of overspending. A rule of thumb is to only stock what the facility will need and use within the next week or two at most, says Mr. Casey. The facility should be able to move 100 percent of the value of its inventory in no more than 30 days. "Don't have standing orders, and don't automatically order supplies just because they're what you order every week," he says.

"Focus on ordering the minimum amount that you need to get you through the week."

It is also helpful to keep all supplies in one centralized location to avoid overstocking in multiple places throughout the facility, such as built-in OR cupboards and recovery rooms. "You can end up having supplies in six different places instead of one or two," says Mr. Casey. "I often recommend to not let the staff stock the cupboards in the ORs — we instead have all of the supplies in one location so that we know how much we have in the facility and that we're not over-ordering for that week."

It is common for staff members to fear running out of a particular supply item because of a past incident, and to over-order that supply in the future to avoid a repeat scenario, says Mr. Casey. But rather than making assumptions, he recommends closely watching the procedure schedule. "You will most likely have at least a day or two of advanced notice for which supplies you'll need," he says.

6. Eliminate unnecessary service contracts. Knowing the difference between essential and non-essential service contracts, and abandoning the latter in the right circumstances, can help facilities cut costs over time. "If you look at your service contract and see that it's not something you've actually utilized, or only had to have the equipment serviced one time, don't renew contract because you're not using it frequently enough to justify the cost," says Mr. Casey.

Equipment less than three years old that does not serve "life crucial" functions, such as blood pressure machines, monitors and lightboxes, should not need a full service contract because the likelihood that they will require significant, costly maintenance is low, he says. For some pieces of equipment, six-month biomed checks

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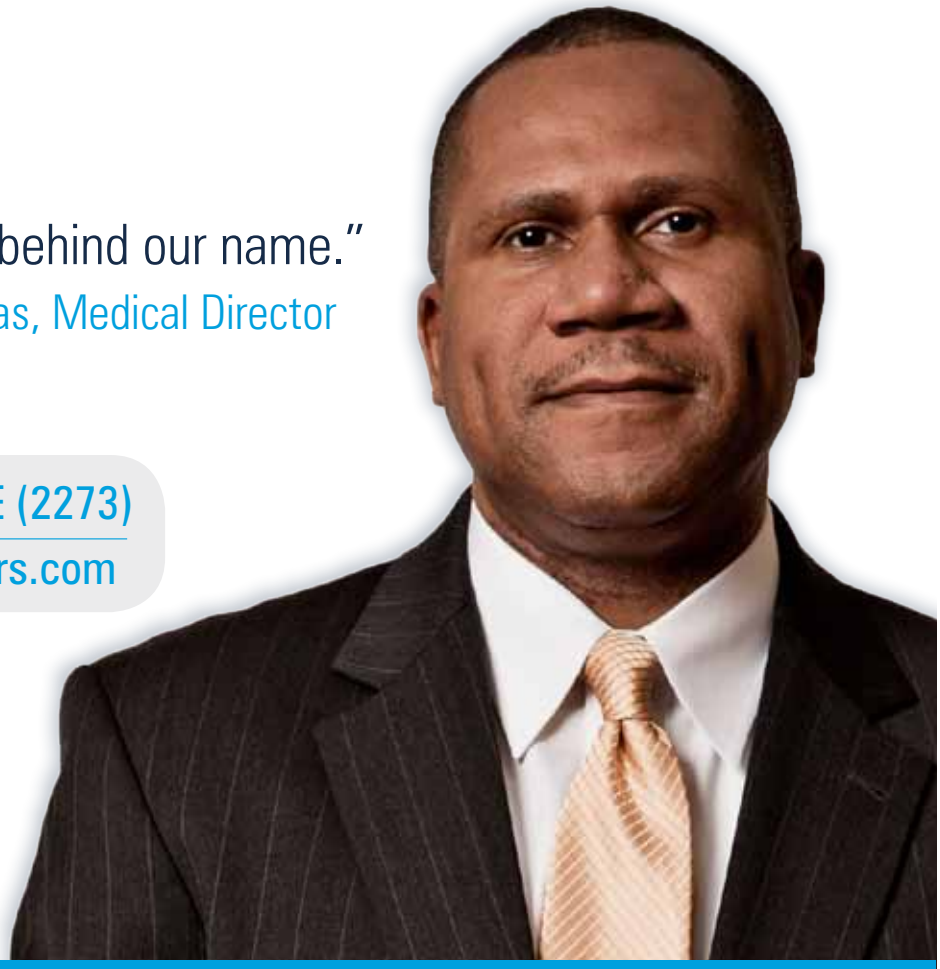

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will serve to identify problems in place of a costly long-term service contract. "If you find that there's a problem with a blood pressure machine, it's most likely not an expensive piece of equipment to repair, which doesn't make it worth it to maintain a service contract for all 12 of your blood pressure machines throughout the facility," he says.

7. Avoid stagnation in the facility's cost saving policies. Among the worst justifications that a staff member can give for continuing a particular policy is that it has "always been done that way," says Mr. Casey. "You have to be smart about how you deal with ingrained policies. If there's not a significant clinical or operational reason why it's done that way, you should be looking at whether there is a way we can make it better."

The idea of continuous improvement in operational efficiencies and cost reduction stems back to the idea of creating and fostering a culture of change in the facility, he says. "Ultimately, the biggest factor is the culture and the willingness of those involved, employees and physicians, to participate in identifying ways of reducing their expense, thereby improving the facilities bottom-line profitability." ■

9 Points for ASCs on Achieving Financial Solvency

By Laura Miller

Financial solvency is important for surgery centers as they consider their options for long-term growth and viability. "The recent global financial crisis has shown the importance of maintaining solvency and a healthy balance sheet," says Rajiv Chopra of The C/N Group. "When most people think of solvency, they relate to financial measures, which are quantitative in nature. When you want to evaluate the quantitative aspects of long term financial stability, the best place to start is the surgery center's financial statements. However, there is a qualitative aspect to solvency, and you must look beyond the financial statements to predict what the future may hold."

Mr. Chopra discusses the key aspects of achieving financial solvency.

1. Beware large debt. When surgery centers have a high level of debt, they are under intense pressure to make debt service payments — this could mean financial distress, much like we saw in the housing market during the recent debt crisis for homeowners. "If an ASC is carrying a lot of debt, chances are they will have trouble making investments in the center going forward," says Mr. Chopra. "Existing centers often need a fresh coat of paint, new OR lights or replacement of aging equipment. If there is a lot of debt on the balance sheet, it becomes a challenge for an ASC to invest in its future."

Some centers have a fair amount of debt because they have borrowed money for strategic purposes in recent years due to generationally low interest rates. In this case, having a big cash balance on the books is good because when they hit a rough spot down the road — such as a wave of capital investment or physicians retirements — they'll be able to weather the storm. One key metric to consider is "Net Cash," which is defined by cash minus long-term debt.

"One reason Ford survived the recent financial crisis better than General Motors is because it made a strategic move to establish a huge cash balance by drawing on its credit lines well before the crisis hit," says Mr. Chopra. "GM didn't have that option or didn't make that strategic move and ultimately filed for bankruptcy."

2. Pay attention to accounts receivable. On the assets side, look at how quickly the center is collecting its receivables. "Consistent cash flow is the mother's milk of a surgery center. If you aren't collecting on a timely basis from Medicare and private payors, you don't have any cash coming in the door," says Mr. Chopra. "If you don't have cash flow, you can't meet your obligations. You want to see 30 days to 40 days receivables turnover."

3. Take the liquidity test. The liquidity test compares your cash and accounts receivable to short term liabilities. The dollars you have in cash and receivables represent the numerator of the equation and the short term liabilities (vendor payables, bills for the cleaning company, etc.) are the denominator.

"If you have less in the numerator than the denominator, that means the center doesn't have enough cash on hand to meet its current liabilities," says Mr. Chopra. "The liquidity test is short term assets over short term liabilities and really is a nice indicator of whether or not an ASC can make ends meet."

Having a large accounts payable balance is a red flag. If an ASC takes 90 days to 120 days to pay its bills to vendors that could spell trouble. "This says the centers don't have the cash flow to keep up with the vendors and may experience a disruption in obtaining basics such as medical supplies," says Mr. Chopra.

4. Know what banks are looking at. Banks and other institutions which lend to ASCs have a set of solvency measures they typically utilize. Debt service coverage ratio is typically defined by EBITDA over principle and interest payments on your debt. "Banks are looking for 1.25 to 1.5 for a healthy operation," says Mr. Chopra. "A ratio of 1:1 means the ASC is generating just enough cash to cover its bank payments. You should have more than that to maintain a cushion to continue your operations."

Banks are also looking at leverage ratios: Bank Debt over EBIDTA. Take the outstanding debt you owe to the banks and finance companies in the numerator and EBIDTA is the denominator, which is proxy for cash flow. "If you are over 3:1, that's when the banks start getting nervous," says Mr. Chopra. "In go-go times, banks become more relaxed and you may see them lending at 3:1 or 4:1. However, when the economy is in trouble they tighten evaluations and underwriting standards."

5. Comb your income statement for red flags. The income statement or "P&L" will tell you what has happened with the surgery center over a period of time, including the patient volume trend. Red flags on the bank statement include:

- Declining volume
- Margins going down

"If you are looking at long term solvency, you are going to look at the income statement for trends to extrapolate the future," says Mr. Chopra. "If your margins go down but case volume goes up, that means you are probably taking on cases that aren't profitable."

6. Examine your surroundings to predict future trends. Financial solvency isn't just an exercise about where you were and where you are now, but also where you are going in the future. Look broadly at industry

trends to forecast what challenges lay ahead and how you will meet them. One of the biggest challenges today is dealing with declining reimbursements, but that isn't the only thing to consider.

"Look at what is going on in the local market," says Mr. Chopra. "If I drive by the surgery center and see another surgery center going up across the street, or the hospital is opening a surgery center and just acquired the largest orthopedic practice in town, you're going to have challenges competing with them."

Another factor to consider in the marketplace is the number of payors available. "If you are evaluating a center with five big commercial payors, and then there is a big wave of mergers that result in two major payors, the ability to achieve good rates will be hampered," says Mr. Chopra. "If the combined payor represents 40 percent to 50 percent of your business, the payor has more leverage in negotiations."

7. Consider the dynamics within the center. Internal factors of the organization will have as big of an impact as the external market on the future of the surgery center. Right now, many surgery centers include several physician partners who are nearing retirement age and several who are just coming out of training, with fewer physicians in between.

"You have a set of experienced physicians who are looking to retire in the next three to five years, but they are also the ones who are generating a big chunk of your volume," says Mr. Chopra. "You also have a lot of young physicians coming into the practice who don't have the experience or patient base to carry the center. If you look at a center that has the vast majority of its volume coming from physicians who may retire in the next few years, numbers may be great now, but solvency for the future may be challenged."

When looking around the center, you should also consider future capital expenditures. If the surgery center has worn carpet, old equipment or hasn't painted the walls in a few years, you can predict those costs coming down the pipe.

"Look at when the surgery center opened and see how much money they have spent on capital expenditures," says Mr. Chopra. "If they haven't spent much in the past few years, they will need to spend more in the future. If they don't have much cash on hand and a lot of debt, that's one of those 'uh-oh' moments."

8. Innovate and take risks on up-and-coming specialties. Projecting long term solvency is difficult because it means not only calculating the past and current state but also considering the future. "When considering long term solvency, a center might want to add new procedures or specialties that are not profitable today but represent the future of where outpatient surgery is going," says Mr. Chopra. "Spine might be one of those areas. If you are conservative, you might wait until reimbursement is up and the cost of supplies comes down. However, if you wait too long the physicians may go to another clinic or hospital and establish a long-term relationship. Long-term solvency also means taking calculated risks."

If you can't immediately incorporate a new specialist or procedure, develop a relationship with those physicians anyway and discuss your plans for the future. These conversations will build loyalty to your center that could be useful when you are able to bring on someone new.

It's important to continually consider what the next big ASC procedure will be in the future to stay financially solvent. By comparison, companies com-

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peting in the pharmaceutical industry like Pfizer must invest in research and development — even though the company is currently generating a lot of cash flow and is very solvent as a result of Lipitor — because if they don't chances are they won't develop the next blockbuster drug.

"Solvency is how the center reinvents itself," says Mr. Chopra. "We talk to the ASC management and physicians to get a sense of the market and how they are preparing themselves for the future."

9. Re-focus your mindset for the long-term. Whether an ASC's leaders are long-term or short-term focused has a big impact on financial solvency. "You can learn a lot by seeing how managers run their business," says Mr. Chopra. "If they don't take on debt, have a clean balance sheet and don't spend on things they don't need, they'll be more financially solvent. Financial solvency is driven by decisions made by the governance team."

The best managers have a long-term mindset and are constantly looking at their environment and what their competitors are doing. "These managers don't get too excited when things go well by giving bonuses and huge dividends," says Mr. Chopra. "But when things are bad, they don't panic either. These managers are always thinking about how to grow the center, but in the back of their minds they are preparing for rainy days."

Some centers have experienced success with the short-term focus, but they are left more vulnerable when challenges such as reimbursement cuts come along. "You've got to prepare for the worst, hope for the best, but always expect success," says Mr. Chopra. ■

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Navigating Regulations, Reimbursements and Growth: Q&A With Minnesota Valley Surgery Center Administrator Sharon Richmond

By Taryn Tawoda

Since opening in 2006, Minnesota Valley Surgery Center in Burnsville has aimed to improve the quality of patient care, maximize efficiency and reduce costs. Despite persistent regulatory and reimbursement challenges, the multispecialty center has largely succeeded in meeting these goals.

"Our patient satisfaction scores are extremely high," says administrator Sharon Richmond. "Over the past five years, we've been successful in dropping cost considerably, and we've been able to pass those savings to the insurance companies."

Ms. Richmond discusses the surgery center's most successful pursuits, challenges and plans for the future.

Q: What have been some of the surgery center's most profitable developments in recent years?

Sharon Richmond: We opened a total joint program in 2007. Since that time, we've trained other centers throughout the state and nation on developing their own programs. We've done over 400 total joint surgeries, including hips, knees, elbows, ankles and shoulders, with the most frequent being hips and knees. The program has been hugely successful in terms of patient satisfaction (1:1 nursing care), reducing infection and complications. Above all, there has been a huge cost reduction to the insurance companies as well.

We also built an extended day surgery center that was patterned after a Hilton environment. We'd found that some people who spent three to four hours in the post-anesthesia care unit just aren't ready to leave at that point due to pain or blood pressure issues. Extended day recovery allowed them to be in a room with all of the amenities of a post-anesthesia care unit and be with their family and an RN for an additional amount of time. We staff two ACLS registered nurses in that unit.

As our volume grew, keeping a patient in a total joint bed was taking a lot of our post-anesthesia care unit space — we could have three to four patients per day for total joints. The extended day recovery was a great alternative to provide a relaxing, comfortable area for continued recovery.

Q: Can you talk about the major operational challenges the center has faced?

SR: Managed care contracts are a huge challenge. As an ASC, you don't usually have the bargaining power of a large health system, so contract negotiations can become a challenge. One payor in our state delivers our updated contract after the effective date of our contract, which leaves us with no time for negotiation as far as the reimbursement. This particular insurer consistently significantly decreases our reimbursement every contract renewal.

Being a predominantly orthopedics-focused ASC, my other challenges are rising implant costs, supply costs and staffing costs.

Although reimbursement may decrease, there are additional costs associated with new regulations. ASCs offer patients a valuable service and alternative environment for surgical procedures as well as provide healthcare at a significant cost savings.

Most third party payors have eliminated carve-outs in their contracts. Total joint replacement in an ASC can offer a cost savings of 35 to 50 percent compared to a hospital, but one particular payor is still lowering the ASC reimbursement to the point it becomes a break even procedure for us right now. If all payors were to move to the reimbursement methodology of taking Medicare rate and adding a small amount on top of that, it would not cover our costs.

Another challenge is drug and medication shortages. Critical medications like fentanyl and propofol are becoming more and more difficult to obtain, and demand for these medications is driving an increase in pricing.

Q: How have you worked to address these challenges?

SR: The center looked at negations for sole vendor pricing for implants and supplies. We also pursued an aggressive standardization of products and supplies used based on cost. We have a very active Supply Value Analysis committee that reviews comparable products and costs every month, and we do alternative searches for supplies as we see costs increase.

You also need physician buy-in on products. Physicians may have preferences to a particular product or implant. We may ask them to trial a comparable product in order to reduce cost.

Q: How has the center dealt with increasing regulatory demands?

SR: Regulatory changes have brought increased cost to the center as additional staff and resources are needed. The state quality reporting and measurement system requires a significant amount of data collection and reporting. We have hired a patient safety officer, a radiology medical director and an infection control officer to name a few.

The required conversion to the 5010 billing system was a huge challenge for all of us this past year. Compliance dates were issued, however payors and clearinghouses were not prepared. This resulted in delayed facility payments.

I'm also concerned about pay for performance. Although our patient satisfaction scores run consistently high, a low patient response rate can affect the overall outcome if one negative comment is received. We have received comments such as "you don't have a cafeteria on site." If there is a day when the surgery centers get a reduction in reimbursement because we didn't have a cafeteria on site, that is concerning. We should be looking at a variety of things — infection rates, turnover times, efficiency and case costing.

Q: What region-specific challenges has the center faced?

SR: One of our challenges in the Twin Cities is the hiring and retaining of RNs and surgical techs. Twin Cities is a highly competitive market with hospitals and ASCs within a small radius. It's difficult to remain competitive in wages and benefits when the ASC is not receiving the same reimbursement for the same procedure as the hospital.

Q: What new developments is the center planning in the near future?

SR: Since 2006, this facility has undergone two expansions and is in the process of planning a third. We look forward to adding additional surgeons, procedures and product and service offerings. We are expanding our outpatient total joint program and we added a spine surgeon and a periocular plastic surgeon. ■

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8 Steps to Build a Cash-Pay Program at Surgery Centers

By Laura Miller

With reimbursements declining and business expenses rising, surgery centers are looking for new ways to cover costs. For some surgery centers, the answer might be building a program for cash-pay patients to attract and accommodate for people without insurance or with high-deductible plans that are looking for more affordable healthcare options.

"I think as the effects of ObamaCare begin to play out, we will see a skyrocketing of medical costs," says Keith Smith, MD, anesthesiologist and chief medical director at Surgery Center of Oklahoma in Oklahoma City, which has a cash-pay program. "The costs are going to be very high and the premiums for insurance will be high, but surgery centers with a cash-pay program can intercept some of those patients with low costs that are transparent and fair. The ability to embrace the free market and adopt a model like this has a much greater chance of being successful than facilities that sign a lot of insurance contracts, go in-network and deal with government payors."

Here are eight steps to build a cash-pay program at ambulatory surgery centers.

1. Determine your goals for the cash-pay program. In the very beginning stages of the discussion about cash pay, make sure you define your goals for the program and discuss them among the physician partners. Reed Martin, COO of Surgical Management Professionals, recommends surgery center administrators consider these questions to reach the heart of their goals:

- Do you want a reasonable price for cash pay?
- Can you accommodate those patients who pay cash?
- Do you have a charity or hardship plan developed?
- Can you be flexible for individuals within the cash pay structure?

Considering these points will help administrators and physician partners reach their goals and begin planning the structure of their program. Dr. Smith began quoting prices to patients in 1997 and later published their prices online to reach a wider audience.

"We began quoting prices to primarily uninsured people who needed elective procedures and then decided to put those prices online so that people outside of our area could see them and bring their business our way," says Dr. Smith. "This was also an attempt to break the strangle hold big insurance companies and hospitals have on the healthcare business."

2. Set a discount for cash-pay. Surgery centers can offer cash-pay patients a discount on services, but you must make sure the discount is acceptable. "The price must be higher than Medicare payments but still reasonable," says Mr. Martin. "The suggestion is a percent above Medicare."

Dr. Smith says prices at Surgery Center of Oklahoma are listed anywhere from an eighth to a tenth of the prices charged at local non-profit hospitals, which is attractive for patients who are paying out of pocket. "By virtue of the price difference, our practice is in the range people can afford," he says. "The price includes the surgeon, anesthesia and facility charges so we are able to attract business because our prices are much lower and more affordable for people with no insurance or high deductible plans."

There are several factors coming together to reach an acceptable and competitive price for procedures, and surgeon partners should work together to arrive at the appropriate price. "At our surgery center, we had to come to a consensus with the surgeon partners on what the price should be for their professional services," says Dr. Smith. "We had to calculate the average time it took to complete cases, figure out anesthesia charges and compile costs incurred for each surgery to determine the facility component. A lot of things have to be pulled together to come to a rational price."

After calculating each price you can attract patients by posting those prices on your surgery center's website or distributing them to patients upon request.

3. Develop a process for traveling patients. If patients are traveling long distances for your services, have a plan ready for their pre-surgical examination and post-surgical follow up. This might include some long-distance communication to make sure they are an appropriate surgical candidate before they travel many miles to your facility.

"Typically there is a telephone consultation prior to making the trip and that gives us a good idea if they are a candidate for outpatient surgery and the procedure they need," says Dr. Smith. "After surgery, they stay for the appropriate number of days as decided by the physician and patient before traveling back home. Their follow-up depends on how far away they are, and patients that are too far to travel back to us see their primary care physicians in their hometown."

There are currently three primary care surgeons from across the country that have developed a relationship with surgeons at Surgery Center of Oklahoma because their patients chose to travel

for surgery and then do the follow up at home; now, those primary care physicians recommend their cash-pay patients travel to Surgery Center of Oklahoma for an affordable procedure.

"We have referrals from these people who aren't even affiliated with us and we have seen multiple patients from them," says Dr. Smith. "These primary care physicians have large cash pay practices and they are a good resource for us."

4. Communicate payment plans with patients. Decide which payment methods your surgery center will accept and how to communicate these methods to patients. The surgery center may want to accept promissory notes or another form of credit so patients can make payments over an extended period of time instead of paying on lump sum.

"One acceptable area of flexibility might be accepting half of the payment upfront and the other half over six months or a year," says Mr. Martin. "This method could cover the variable costs of the facility while affording patients a reasonable payment plan."

Flexibility within these plans should be available to accommodate for individual patients.

5. Appoint an authority figure to exercise payment flexibility. Every unique pa-

tient situation can't be predicted beforehand, so appoint someone within the program's structure to have authority over how much payment flexibility will be given. This can be done within the surgery center's board of directors.

"The board needs to decide who has the authority at the facility to exercise this flexibility," says Mr. Martin. "This person can decide how much flexibility exists, which could range from no upfront cash and full promissory note over a two or three year period to the least flexible payment option, which would be full payment at the time of service."

This person should be appointed early in the process before the program is launched. "There needs to be a good understanding of who has the authority and what the level of authority is," says Mr. Martin. "Everyone should know where the facility is on the flexibility continuum."

6. Develop a charity care policy. Make sure you are ready to provide a charity care policy for patients who need those services. "The charity and hardship policy development and utilization will be important," says Mr. Martin. "These are often based on guidelines for federal hardship and poverty cases, and are relatively easy to calculate."

Having the charity care policy in place before launching the cash pay program prepares the surgery center to accept those patients and educate them about their options as soon as they arrive.

7. Market your services online for increased exposure. In addition to posting the surgery center's prices online, ASCs can attract more cash-pay patients by participating in marketing efforts and enhancing their online presence. Dr. Smith has a blog where he writes almost daily about different issues in the healthcare space and is able to reach potential patients through that forum.

"My blog has gained some national attention and helped us get more exposure to the website," says Dr. Smith. "The blog posts are like op-ed pieces on the healthcare industry. I have also appeared in numerous journals or magazines, including the journal for the Association of American Physicians and Surgeons, talking about my ideas. I'm writing articles about the free market medical practice, with a free market bias not just in medicine but in all aspects of the economy."

To attract the local audience, Dr. Smith also serves as an expert source for newspapers and at town hall meetings in his community. "I would encourage any surgery center that is inclined to do this to try it and I think they'll find it won't hurt the business they have and may bring in extra business," he says.

8. Prepare for national and international patients. Once your cash pay program goes public, patients will begin coming from across the country and all over the world to receive affordable healthcare at your surgery center. You should be able to accommodate this medical tourism when necessary.

"When we put our prices online, the first thing that happened was Canadians started showing up," says Dr. Smith. "We also bring in people from all over the country. The price list was a huge project to go through, but since we finalized it there has been almost no change."

Since these patients are traveling, they will be looking for a hotel to stay in for several nights and other attractions around the city. The surgery center can help these patients make those arrangements as well as provide the medical care.

"We actually help patients with their lodging arrangements when they travel," says Dr. Smith. "We don't pay for them, but we assist them in finding a location. We help patients with flight arrangements and have directions on our website about how to get to the surgery center. It's a reverse of medical tourism." ■

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5 Steps to a Better-Run Surgery Center Revenue Cycle

By Rachel Fields

Michael Orseno, revenue cycle director for Regent Surgical Health, shares five strategies to improve your ASC's business office processes.

1. Arrange for payment from patients up front. Mr. Orseno recommends arranging for payment prior to the procedure, which doesn't necessarily mean collecting the payment up-front. "The patient should be called prior to the appointment, and their benefits should be reviewed with them," Mr. Orseno says.

Prior to calling the patient, Mr. Orseno says the front desk coordinator should determine how much the patient owes the facility, so the center can present a clear, understandable financial responsibility with an explanation according to the patient's insurance. "The staff member might say, 'In our experience, this procedure will be X amount of dollars, and you have this much remaining on your deductible. You have an 80/20 policy, so you're going to owe $2,700'," he says.

The patient would then submit his or her credit card information and sign a credit card authorization form upon arrival at the center. Once the claim is adjudicated, the center would call the patient and say, "I just want to let you know that your claim has been adjudicated, and per your EOB, you owe $2,700. We'll be charging that to your credit card." This process keeps the patient informed about his or her payment and eliminates any 'surprises' about the amount owed.

2. Take advantage of technology. Surgery center leaders are frequently hesitant to adopt information technology because of costs, time constraints and employee push-back, but Mr. Orseno says technology can significantly improve business office functions if implemented correctly. He recommends the following technological upgrades to an ASC:

- **A quality desktop scanner.** Mr. Orseno says a good desktop scanner will run your ASC around $500. He says his company has scanned around 18,000 documents with the new scanner and has never experienced a problem. "We're completely paperless," he says. "It saves us money in storage costs, and all my billers and collectors are much more efficient."

He says to make sure the scanner helps your business office, you need to have a plan as to how your files will be stored in a hierarchy. He says before Regent implemented the scanner, he talked to the business officer staff to ask how they wanted the charge tickets and EOBS stored. "Some of them wanted them stored by date received; some wanted by date of service," he says. "As long as you get staff buy-in and they know the hierarchy of the storage, you should be fine." He says the company also hired a part-time employee to scan all the old documents and get Regent "up to date" as the company implemented the new scanner.

- **Electronic payment and attachment posting.** Mr. Orseno says many billing software programs allow the ASC to post payments and attachments electronically. He says this technology has helped improve efficiency and accuracy in the Regent business office. "Staff members are much quicker at posting payments and much more accurate," he says. "The file comes in electronically from the payor, so it just populates into the software and they can review it." He says the payment posting process now takes a few minutes instead of up to an hour. He says it's also much quicker to send attachments electronically rather than physically attaching claims on paper.

- **Dual monitors.** Mr. Orseno recommends investing in two computer monitors per staff member. He says while the investment seems like a luxury, an extra computer monitor actually costs around $100, and the ASC can make up for that in efficiency in a week. He says an extra monitor allows staff members to pull up all the files they need without having to print anything out, which cuts down on paper costs and saves time.

3. Lay out expectations ahead of time — and then monitor performance. Make sure staff members understand the goals for their performance, Mr. Orseno says. For example, for your ASC collector, set a goal for the number of accounts they need to work every day. Mr. Orseno says a collector should be expected to work about 25-30 accounts — and the definition for "working" an account should be established ahead of time. "Working an account is not just making a call to the payor and then hanging up when no one answers," he says. "Working an account is a completed action — they've got to receive and post a payment, get confirmation that the payment will be sent, or rebill a customer if they weren't billed correctly initially."

Once you've established your expectations, perform weekly and monthly audits of your staff, Mr. Orseno says. For a collector, the supervisor should go through the accounts and make sure the collector is working them thoroughly. "If you monitor your collector, for example, you won't be surprised by huge spikes in A/R that occur because the collector isn't doing their job," he says.

He also recommends setting collection goals for the whole team every month. He says a collection goal might be calculated by taking the average of the last three months' net revenue, minus 2 percent for bad debt. The team should receive a tangible award for meeting collection goals, such as a pizza party or gift cards.

4. Meet regularly with staff and be open to their suggestions. Mr. Orseno says some of the best suggestions for business office improvement will come from staff members. For this reason, ASC leadership should meet regularly with business office staff and ask for suggestions for improvement. "The idea for dual monitors in our business office came from one of our billers and collectors," Mr. Orseno says.

He says his office holds bi-weekly meetings, where they discuss specific business office issues for their centers, as well as issues that affect the ASCs as a whole. "For instance, the new Medicare changes in billing — that's something we would bring up as a general announcement," he says.

5. Cross-train all business staff. All business office staff members should be trained to perform duties outside their main job description, Mr. Orseno says. "Make sure your person who's posting payments knows how to schedule, perform follow-up and work the front desk," he says. Ideally, each staff member should spend some time every month performing another job function, to make sure they maintain their skills in other areas. "That way, if anyone is out or absent, you don't miss a beat," Mr. Orseno says. ■

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How Do ASCs Increase Case Volume in the Current Healthcare Environment? Q&A With Jared Leger of Arise Healthcare

By Rachel Fields

Jared Leger, president and CEO of Arise Healthcare, discusses major issues facing the ASC industry, as well as what surgery centers can do to combat challenges like hospital employment, declining reimbursement and the disappearance of out-of-network.

Q: What, in your opinion, are the most significant issues facing the ASC industry at the moment?

Jared Leger: ASCs face two significant and intertwined challenges right now: recruiting and retaining physicians while simultaneously increasing case volume at a time when new talent is tough to attract. With more and more physicians integrating into hospital systems, either through direct employment or alignment models, independent physicians are becoming harder to find. ASCs in a specific market often find themselves targeting the same pool of prospective physicians.

ASCs need to focus on:

1. Increasing procedures from their existing physician utilizers.

2. Seeking and finding new opportunities to bring inpatient surgeries into their outpatient environments.

3. Assisting ASC physicians in building their referral patient base at the ASC, in a legally compliant manner.

4. Measuring the ASCs costs and working to reduce them in ways that doesn't compromise patient care.

Q: Surgery center experts talk a lot about the death of out-of-network reimbursement, and recent legal battles between insurers and surgery centers seem to back that up. What do you think is driving the decline of out-of-network reimbursement, and do you believe it has a future for ASCs?

JL: Out-of-network reimbursement is not dead; however, we are seeing reduced payments and maneuvers by the insurance carriers to make it difficult to treat patients on an out-of-network basis. It's being driven by the pressures insurance companies and employers are facing to contain costs. Higher out-of-network deductibles and co-insurances, increased HMO-only insurance products being sold to employers, and reasonable and customary fee schedule payment maximums will continue to make the out-of-network model difficult.

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Q: What do you see as the most profitable areas of growth, in terms of procedures, for ASCs? Where could centers be expanding that has yet to be realized?

JL: Adding new cases — whether by increasing volume or new procedures — is the only area of growth for ASCs, in my opinion. Trying to show even moderate growth by increasing net revenue per case on the same book of business is very difficult. Payment rates are not going up.

We have focused on looking for cases that are routinely performed in an inpatient setting and focus on the barriers preventing them from moving them to an outpatient setting. We look at the clinical side: Is it clinically safe and appropriate to be done at an ASC? Do we have the proper equipment? Since oftentimes these are more intensive procedures, we analyze the economics as well. We measure the case costs and ask ourselves if each payor's reimbursement rate is enough to cover our costs.

Q: The last few years have seen a wave of hospital-ASC joint ventures, as ASCs seek greater negotiating clout and hospitals seek market share. Is there a life for independent surgery centers in the next 10 years, and if so, what does it look like?

JL: While there will always be independent surgery centers, their numbers will continue to decrease, in my opinion. It is very difficult for an independent surgery center to obtain favorable managed care reimbursement rates. The decision for an ASC to sell to a national company or hospital is often based on a better reimbursement structure post-transaction.

Sometimes revenues on the same book of business will dramatically increase because the reimbursement rate per case is higher with the hospital or national company's contract. Since hospitals and national companies will continue to receive more favorable payor contracts than independent ASCs, I think we will continue to see the trend of aligning with hospitals.

Q: More and more physicians are choosing hospital employment rather than independent practice. How can ASCs attract this new generation of physicians, if they are indeed different from the entrepreneurial physicians of the past 50 years?

JL: I agree we are seeing a trend of physicians accepting hospital employment. The concept is pitched as safe, secure and stable. For many new physicians in particular, the arrangement has appeal. However, I believe some physicians are born with an entrepreneurial spirit – and with that, a desire to build something of value both clinically and economically.

The hospital employment model will not work long-term for an entrepreneurial-minded physician. Time and experience often builds confidence and a loyal patient for a physician. It's often at that point in a physician's career they feel ready to strike out and build something of their own. ASCs should constantly be working to nurture relationships with physicians even before they might seem ready to become independent, then recruit such physicians as quickly as possible if they decide to strike out on their own.

Q: How do you believe the Supreme Court's decision on healthcare reform affects the ASC industry?

JL: Overall, I think the Supreme Court's decision to uphold the healthcare reform bill will strengthen the ACO model. ACOs can hurt ASCs if we are not demonstrating our value. As long as ASCs have a seat at the ACO table, and are able to show our cost-savings and quality data, there's no reason to think there won't always be an appropriate place for us within the healthcare system. With the big push to lower healthcare costs and the fact that ASCs provide lower cost surgery care with better outcomes, ASCs are positioned quite well as an industry. ■

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6 Ways to Boost ASC Business by Saying 'Yes' to Surgeons

By Heather Linder

As the ASC market becomes more and more competitive, surgery center administrators must take viability into their own hands.

Lexa Woodyard, administrator for Cabell Huntington (W.Va.) Surgery Center, knows that keeping surgeons happy and at ease is crucial to increasing business and profits for her center.

That's why she and her staff have worked to implement a strategy of saying "yes" to surgeon requests and needs.

"It's time to change the culture of how we think of surgeons and our relationship with them," she says. "We have to remember the surgeons are our customers. Without surgeons, we don't have patients, and without patients, we don't have jobs."

Ms. Woodyard shares her top tips for attracting and retaining surgeons.

1. Make it easy to post patients with poor payor/case combinations. Many surgery centers will turn away patients with poor payor and case combinations for fear of losing money, but creating barriers for surgeons to post their patients could end up deterring a physician from working with an ASC.

"We let them post whatever, regardless of payor and case combinations, and we earn their trust," Ms. Woodyard says.

Letting the surgeons post the cases they have regardless of payor and case combination will build their trust and your capacity. Meanwhile, monitor the profit and loss by a surgeon for their total cases for a year. You may find that a surgeon may bring your ASC some cases that lose money in a year but they also bring profitable cases which outweigh the loss from less-profitable cases; don't let the minority prohibit your ASC from capturing the profitable cases.

"You might find they only bring a handful of cases that are a loss and they are bringing you far more cases to break even or make you money," she says.

2. Keep anesthesia availability and surgery times convenient and consistent. Ms. Woodyard says she and her staff notice that inconsistent or inadequate anesthesia coverage or start times for surgery can affect their patient volume. Sticking to a predetermined schedule can put surgeons at ease. "Surgeons are creatures of habit," she says. "If they know they can't do surgery without changes or surprises, they won't use your surgery center."

She recommends staying flexible and keeping in mind how busy each surgeon's schedule already is. "They can't just change their schedule at a moment's notice to accommodate the center's schedule," she says. "It's important to periodically reevaluate block times to monitor staffing and anesthesia availability."

By always working on the same timetable, ASCs build a positive rapport with surgeons. "Consistency is key," she says. "That's what they look for."

3. Treat surgeons as individual customers. When ASCs don't treat their surgeons like individual customers, it's easy for the physician to become disengaged and take his or her patients elsewhere. Meeting a physician's needs and requests, no matter how small, can make all the difference.

Taking care of surgeons can mean having the most up-to-date surgical equipment, or it can mean making small gestures to show the center's appreciation. "It could be as simple as having Dr. X come in and knowing he likes to use his favorite blue pen in pre-op, so we'll have that ready."

Ms. Woodyard advises not to compare surgeons with their peers, since each one works differently. Instead, help them see their preferences are important. "Just remembering to treat each as an individual is important," she says. "Don't try to fit them into a mold. You'll see the surgeons you are targeting will use your center more often if you're catering to them like you want them to come back."

4. Remove unnecessary patient admission barriers. Some ASCs may have patient admission requirements that are outdated or create unnecessary barriers for surgeons trying to post patients. For example, an ASC's anesthesia admission criteria might mandate the surgery center does not permit patients with latex allergies to be scheduled at the surgery center. In many centers, this decision was made years ago due to the cost of some latex free items, Ms. Woodyard says. She says most items are now latex-free, and while the new items are sometimes more expensive, surgery centers can assemble a latex-free kit to be used on a case-by-case basis to save money. A special latex screening questionnaire should be put in place for the pre-operative call to detect potential allergies or sensitivities.

"If a surgeon has a patient with a potential latex allergy and your ASC isn't receptive to this population of patients, the surgeon will likely end up scheduling a day's worth of cases elsewhere to provide care to the patient with the latex allergy," Ms. Woodyard says.

"Review the anesthesia admission criteria annually to see if it needs to be updated to adequately provide service to a patient population that you might be missing," she says, adding, "If a surgeon has a patient with a latex allergy and your center isn't receptive to these patients, they may take that case and an entire days worth of cases elsewhere."

Work to detect allergies or other similar challenges ahead of time, and find ways to accommodate patients' particular needs rather than refusing admittance.

5. Allow surgeons to work with their preferred team members. Since surgeons work habitually, surround them with the same team for the entire surgical process. "If you don't have a surgeon's team in pre-op, in the OR and post-op, you'll have a dissatisfied surgeon. Anything new or different, especially surprises they consider undesirable, creates dissatisfaction," Ms. Woodyard says.

Not only will familiar teams keep surgeons happy and returning to an ASC, but patients will also reap the benefits of having a staff that has built a comfortable rhythm with each other.

"We want to have the same staff pre-op and in the OR that the surgeon is used to working with so they can be familiar with their team," she says. "A surgeon with the same staff in pre-op can get a patient into the OR more quickly. And in the OR, they can even shave minutes off of the surgery time, which makes everyone happy."

6. Be kind to a surgeon's office staff. While catering to a physician's needs is important, surgery center leaders shouldn't forget the importance of building a good relationship with the physician's office staff. "They are really the gatekeepers when it comes to where surgeon's post cases," Ms. Woodyard says. "Unless a surgeon has a really strong opinion about the facility, they just let the office staff post cases wherever. That's why anything we can do to make it easier on them makes it easier on everyone and gives us the opportunity for more business."

When Ms. Woodyard's staff treats a physician's staff respectfully and avoids pestering them with unnecessary phone calls or requests, the surgeon's office will likely book more procedures with her center. "If a center is requiring an office to jump through more hoops to list patients or is calling the office more than the competition, you'll see that surgeon's number drop off," she says.

If your ASC is calling the surgeon's office to inquire about alternate phone numbers for patients and insurance information, determine whether your facility can be granted permission to have access to the surgeon's practice patient database. If your ASC is calling the surgeon's office to order or track down pre-admission testing results required by your admission criteria, this might deter the surgeon and their staff from posting cases at the ASC. Since the pre-admission testing is required to give anesthesia providers the information they need to make decisions about patient appropriateness, the surgery process will flow better if anesthesia staff orders the testing as needed. They should also have designated personnel to relay orders to the pre-admission testing facility of the patient's choice and retrieve the results prior to surgery.

"Volume is the key to success," she says. "If you don't have a high volume of cases with a good payor mix, you'll struggle to keep your head above water. Anything a surgery center can do to make their center more accessible, attractive and more reliable than the competition to surgeons and patients is necessary for survival." ■

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Where Minimally Invasive Spine Surgery Is Headed: Q&A With Dr. Frank Phillips of Midwest Orthopaedics at Rush

By Bob Spoerl

Frank Phillips, MD, co-founded the Midwest Orthopaedics at Rush Minimally Invasive Spine Institute in Chicago. There, he works with spine surgeon colleagues to treat a wide variety of spinal conditions. He has served as president and is a board member of the Society of Minimally Invasive Spine Surgery.

Question: What is one or two of the most exciting things happening in minimally invasive spine surgery on your radar right now?

Dr. Frank Phillips: From my point of view, having been involved in this space for some time, it is exciting to see minimally invasive surgery gaining widespread acceptance. With the development of enabling technologies as well as enhanced surgeon training — in particular exposure of young surgeons to MIS during their formal training — the procedures can be done more reliably, reproducibly and effectively. Spine surgeons and the public are starting to see it as something that is mainstream and effective. It's really taking off, and that's exciting.

On a personal level, having been involved in lateral interbody fusion (XLIF) since its inception, it is gratifying to see the outstanding outcomes being achieved with this procedure for a variety of surgical indications.

Q: What difficulties are there in the minimally invasive spine market right now?

FP: Payors are pushing back on lumbar fusion surgery in general, putting up as many roadblocks as they can. Also, the FDA process has slowed and getting approval for new technologies has become more expensive and less predictable. These uncertainties have led to the efflux of capital from the spine market and as a result innovation has slowed considerably.

Q: What effect will the excise tax have on innovation?

FP: In my opinion, the 2.3 percent medical excise tax in the Patient Protection and Affordable Care Act will decrease spine companies' appetite for innovation. These companies that will be paying the excise tax off their top-line will no doubt look for ways to reduce expenses and spending. I am concerned that this will result in scaling back on potentially game-changing but higher-risk product research and development.

Q: What will it take for more spine surgeons to adopt minimally invasive techniques?

FP: I believe that the biggest limiting factor has been surgeons questioning whether the downside of struggling through an initial learning phase is commensurate with the clinical advantages of minimally invasive spine surgery. Minimally invasive surgery involves a different skill set and anatomic appreciation to open spinal surgery. Not all "open" spine surgeons have the ability or aptitude to make this transition.

Ultimately, I think adoption of minimally invasive surgery will have to be driven by high-quality evidence and high-quality independent training programs. Traditionally, hands-on training has been done primarily by device companies. This is not an ideal training venue to help surgeons become facile with procedures and get them over the learning curve. But, the training process is evolving. There is a strong push now in surgeon education, to train surgeons through each step of a procedure with the surgeon being required to demonstrate competency throughout.

As far as the evidence goes, studies repeatedly show at least equivalent clinical outcomes can be achieved with certain minimally invasive procedures when compared to their open counterparts, with reduced lengths of stay, blood loss, surgical time, complications, morbidity and expenses. In my own practice, there are certain procedures, such as a TLIF, in which I can't honestly justify doing that procedure open. On the other hand, other questionable "fringe" minimally invasive procedures will not withstand the scrutiny of quality studies.

Q: What are some of the biggest challenges with reimbursement for minimally invasive surgery?

FP: The challenges with reimbursement, in the world we are in today, are a battle over lumbar fusions in general. There's an effort to reduce the number of lumbar surgeries being done. Only occasionally have there been unique minimally invasive challenges, unless the procedures involve a deviation from well-accepted, validated spine surgical principles.

However, spine surgeons do run into issues with denials. In many instances health coverage guidelines cited in these denials are non-transparent, involve little input from clinicians in the field and selectively cite articles to reach pre-determined conclusions. Further, the guidelines are often dated. Lumbar fusion is expensive and payors don't want to pay for it.

Q: How can surgeons overcome those denials?

FP: In the end, it comes down to data and studies. To be fair, up until the last decade, we probably haven't done a great job of collecting data using metrics that matter to the various constituents. Spine surgeons traditionally focus on metrics like rates of fusion, correction on deformity or detailed radiographic parameters that are irrelevant to payors. They care about the cost and the value. The more studies we do on broader issues of cost and value, the more clout we'll have moving forward. We have many studies supporting the effectiveness and value of many spinal procedures, but have done a poor job of getting this message out.

Q: Where is minimally invasive spine surgery headed?

FP: It's going to become more mainstream, the standard for many procedures. I think minimally invasive techniques will move spine surgeries to outpatient or overnight stays, which is already happening. Minimally invasive technique will also keep costs down and improve patient satisfaction. ■

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10 Tools to Bring to an 'Evidence-Based' ASC Payor Contract Negotiation

By Rachel Fields

Earlier this year, Dan Connolly, MHS, ARM, vice president of payor contracting for Pinnacle III, noticed something had changed. Like everyone else in the industry, he had heard for years that payors were cracking down on providers, pushing cripplingly low rates for new contracts or refusing to discuss increases for established centers. But he had never personally experienced it — until now.

At the beginning of the year, the consistent message received from payor after payor was the same: We're not looking to increase rates. You're already paid better than most. Our budget doesn't allow for additional reimbursement. It became clear that the old contract negotiation tactics, which had served him well in the past, were no longer sufficient. He decided to take a new approach — a system he calls "evidence-based negotiation."

"Evidence-based negotiation" means never going into a contract negotiation without substantial backup, in the form of hard data. For every contract he negotiates now, Mr. Connolly lays out a formal presentation that clearly defines his objectives. "Even our principals have asked at points, 'Is this necessary? Is it worth it?'" he says. From his perspective, the answer is absolutely. Without hard data to convince them otherwise, payors are increasingly telling surgery centers they're already paid enough — or in some cases, too much.

Here, Mr. Connolly discusses 10 tools to bring to an evidence-based negotiation.

1. A clear objective. Go into the negotiation knowing what you want, Mr. Connolly suggests. He indicates a formal presentation will go a long way toward convincing a payor representative that you are serious. In your presentation, define your objective right away, and let the payor think about it while you argue your case. For example, you might want to change the methodology of your reimbursement to a process that's easier to administer for both parties. You might want to stop providing invoices for implants. You might want to narrow the gap between the payor and the market. Whatever your goal, write it down and present it up-front.

He recommends presenting the objective as a "win-win opportunity" for the payor. "When you define your objective, say something like, 'I want to bring more of your members to the ASC and take them out of the higher-cost HOPD setting, and to do that, I need a higher reimbursement rate to accept those cases,'" Mr. Connolly says. In your formal presentation, your objective and supporting data should be laid out clearly, in case your proposal is passed on to a staff member who didn't hear your initial presentation. Mr. Connolly points out that you might not be there to fill in the gaps with someone else; make sure your goal speaks for itself.

2. Knowledge of current Medicare rates. You should understand how reimbursement has changed in the market since you last spoke to the payor. If ASC payment updates based on the CPI-U have dropped in the last year, you need to know how that drop has affected your center. You should also know how the payor's rates compare to Medicare rates, which are generally lower than commercial insurance rates.

"Look at where Medicare is currently, and tell the payor when they're paying less than Medicare," he says. This information may be useful to the payor representative, who may honestly not know that the payor's rates are significantly under market expectation.

3. An understanding of the payor's peers. "Who is the payor's main competition?" Mr. Connolly recommends asking yourself. There's no point bringing data to your payor on insurance companies they don't compete with directly, because your representative won't care that they offer higher rates. "There are major league payors and minor league payors," Mr. Connolly says. "If you're comparing a major league to a minor league, that won't lend any credibility to your comparison." He suggests isolating the top four to six payors in your payor's classification, which can be found by consulting the state Division of Insurance about payor market share.

For proprietary reasons, if you're going to present hard data from other payors, you need to blind the data. Mr. Connolly recommends presenting the data in a graph to demonstrate how the payor differs from the market average, rather than comparing one payor to another. He says it's useful to determine how the payor views its market. In some cases, a payor's market could be a city; in others, an entire state. Once you understand how the payor's rates compared to the going market rate, you can ask, "What can we do to narrow that gap?"

4. Data on reimbursement rates at the local hospital. One of the greatest tools an ASC has in payor negotiation is the ability to save the payor money. If your ASC is located near a hospital, your payor is probably losing money every time a physician takes an ASC-appropriate case to the higher-reimbursed hospital outpatient department. Emphasize this fact. "I recently reminded a payor that the cost of having a case in the hospital was 2.5 times greater than the cost of having a case in the ASC," Mr. Connolly remarks.

In your presentation, numbers will have the greatest effect. List the hospital's reimbursement rate, your requested reimbursement rate, the difference between them, and the number of cases you could perform every year if they were sent to the ASC. Multiply the number of cases by the difference in reimbursement, and present the payor representative with a hard estimate of their cost savings.

5. A list of your physicians and their affiliated facilities. If your physicians aren't taking cases to your surgery center, they're probably taking them to the hospital. Mr. Connolly recommends giving the payor a list of affiliate physicians and, by physician, where the physician has privileges. "I'll show them that three-quarters of the ASC's surgeons have privileges at the hospital," he says. "By doing that, I can demonstrate that by not reimbursing well enough for high-cost implants, the payor is allowing those cases to go to the hospital."

6. Evidence of your cost-saving approach. Surgery centers are low-cost, high-quality providers, and those characteristics should be first and foremost in a payor contract discussion. Show the payor the measures you have taken to cut costs in your surgery center, and present hard numbers on the difference between your reimbursement rates and your expenses. ASCs operate on a thin margin, which makes the case of a negotiator more sympathetic. "Give the payor a comparison between your center and other facilities," he says. "Most ASCs can be proud of their cost-effectiveness."

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Thursday, October 25, 2012
4:00pm - 4:40pm

The Use of Social Media by ASCs and Practices

Kim Woodruff
Vice President of Corporate Finance & Compliance

Friday, October 26, 2012
9:40am - 10:20am

Panel A. The Best Ideas and Biggest Threats to ASCs

Contributing to panel:
Robert Carrera
President

7. Data on your costs. Mr. Connolly says as more payors move to APC methodology — which eliminates the process of paying for implants separately — the importance of cost data increases. "If we don't have the data at the primary CPT level to know what we're getting paid for implants, we're severely handicapped," he states.

He points out most ASCs collect data at the implant log level for billing purposes, but don't necessarily use it for contracting purposes. He says your center should know your costs down to the CPT level. For an orthopedic ACL procedure, you should know exactly how much the procedure is going to cost you, as well as how that cost is divided. "As we move to a new platform where payors are transferring more risk, which is the tenet of managed care, we've got to be able to slice and dice the data so that we know we're fighting the right battle."

8. Details on patients who have to be turned away. Don't just say, "I think we have had to turn away patients because our rates are too low," Mr. Connolly asserts. You should know exactly how many patients have been turned away in the last few months, and you should be able to provide names if necessary. "It puts a burden on the center to proactively collect information up front," he says. "Collect the information as you go. When your schedulers are working with the physician schedulers and turning down cases you can't afford, record that data so that you have something specific to reference in your negotiation."

9. A value proposition. Your presentation should wrap up with a value proposition, or an "if-then" statement that tells the payor what you expect and what you will give in return. "'If you pay us better, then we're going to save you money as a result of having these patients,'" Mr. Connolly gives as an example. "It's got to be balanced, because if it's self-serving, it won't work." He says this approach will build a solid long-term relationship with your payor because the representative will understand you desire to forge a sustainable partnership.

10. Plan B. Sometimes the payor will simply say no. "You have to have a back-up plan," Mr. Connolly says. "Give the payor as many opportunities to step up as possible." He notes more often than not, payor representatives are operating under strict guidelines about what they can offer. He indicates you may not get increases in the areas you expected, but you can effectively "mix and match" rate changes to achieve the necessary bottom line. ■

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ASC Forensic Collections: Unearthing Hidden Treasures

By Carol Ciluffo, vice president of revenue cycle management for Pinnacle III

It doesn't matter where you stand on the ongoing healthcare debate; the unavoidable fact is healthcare providers must continue to pare down costs without sacrificing quality. Creating efficiencies while simultaneously adhering to regulatory mandates is a challenge every ASC must successfully navigate to ensure the center's future viability. Wouldn't it be nice to unearth a hidden treasure in your search for a sustainable profit margin?

High-quality care is practically a given in the ASC industry, but capturing every dollar the ASC is owed is not. If you suspect money is being left on the table, it may behoove you to outsource your coding, billing and collections or retain the services of a new revenue cycle management company.

When a revenue cycle management company assumes responsibility for your existing accounts receivable, they should begin by performing a forensic collections analysis — digging below the surface to ascertain which actions did, or did not, occur that led to the concerns being faced today. Analyzing the patient accounting system set up, reviewing the existing charge master, and thoroughly examining the aging are essential components of the process.

A patient accounting system that is not set up properly is inefficient and ineffective. If contracts are not loaded into the system, it is difficult to determine at time of posting whether or not a claim has been processed correctly. Additionally, using an outdated charge master can lead to a payor with a "lesser of" contract clause remitting a much lower dollar amount than you were entitled to according to their fee schedule.

An inquiring mind and critical thinking skills are necessary to dissect an aging. When were accounts last billed? Is documentation available to determine why account balances are outstanding? Is it necessary to drop claims a second time to avoid timely filing penalties? Were secondary payors billed? Did patient balances get transferred properly and were they billed to the guarantor timely? How often were patient statements generated and when were they last dropped? Have denials been properly investigated? Were appeals filed?

Finding "old" money is an arduous time-consuming process, but the result could net significant revenue for your ASC. Align yourself with a revenue cycle management partner who not only provides you with the "obvious" services but is also willing to expend the time and energy necessary to stake claim to the maximum reimbursement owed to you. Additional money can be found in the strangest places — leave no stone unturned when you embark on this treasure hunt. ■

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PINNACLE III is a Colorado-based company, just outside of Denver, which provides ASC management and development as well as billing services. Since 1999, PINNACLE III has served multiple clients from single-specialty practices, physician-owned ASCs to multi-specialty joint ventures with hospital partners across the country.

The company's leadership team includes Rick DeHart, CEO; Rob Carrera, president; and Scott Thomas, executive vice president. Its vice presidents are Kim Woodruff (corporate finance & compliance), Carol Ciluffo (revenue cycle management), Lisa Austin (operations), Kelli McMahan (operations) and Dan Connolly (payor contracting). Simon Schwartz is the director of marketing and sales.

PINNACLE III offers ASC development, management and billing along with consulting services in the area of facility auditing, payor relations and contract work. While PINNACLE III offers equity models, non-equity models are accessible as well. PINNACLE III also provides auditing and billing services to physician practices.

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-Albert Einstein

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- Poor revenue cycle management
- Waning physician confidence

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Thomas Fry, MD
Colorado Hand and Arm, PC
Lutheran Surgery Center

"Pinnacle III was initially contracted to do an in-depth evaluation and help determine if the surgery center should be closed. Their evaluation was thorough, concise, accurately identified significant problem areas and left no doubt as to the questionable viability of the center. Their straightforward detailed plan was presented to the board of directors and they were subsequently asked to implement that plan and take over management of the center. Since that time, debt has been restructured, costs have been brought under control, quality and satisfaction of employees has markedly improved and the number of surgeons and volume of cases has significantly increased."

Hospital Ownership, Out-of-Network and Other Pressing ASC Issues: Q&A With Luke Lambert of ASCOA **(continued from page 1)**

Q: What do you believe are the biggest issues affecting the ASC industry at this time?

Luke Lambert: One of the biggest drivers I see in our industry has been the divergent compensation that hospitals are getting paid for outpatient surgery, compared to what freestanding surgery centers are getting paid. Because that gap has been increasing over time, it's now reached the point where hospitals find it attractive to buy surgery centers 100 percent and turn them into HOPDs, and thereby reap very attractive returns on investment. That's also driving a big part of the push for surgery centers to partner with hospitals, so that they can pursue better reimbursement.

I think that underlying reality of compensation is driving a lot of the dynamics in the industry. If you go back six years, there were some people pursuing hospital joint ventures, but today, virtually everybody is — and they're doing so quite aggressively to position themselves for the future. Without that hospital association, payors aren't going to pay us well. As a result of that, we're not seeing that many de novo ASCs starting in the industry anymore. It used to be there were hundreds.

Q: Do you believe the rise of hospital ownership of ASCs is a negative trend?

LL: It's bad from some perspectives. It's bad for the consumer, because once the hospital owns the surgery center, the consumer is likely going to pay more. I would say it's bad for physicians because their centers, which were once viable as stand-alone entities, might not be anymore, so they're compelled to seek that strategic partner. Most physicians started their surgery centers because they wanted independence from their local hospitals, and now the economics are bringing them together again. If surgery centers were getting paid the same as hospitals, I don't think you'd see hospitals and surgery centers coming together. I think physicians would be happy to be independent.

Q: Would it solve the problem if ASCs were reimbursed based on the Hospital Market Basket, rather than the CPI-U, as advocated by ASCA?

LL: Even if they correct the index by which our reimbursement rates are updated by the government it won't close the gap. To close the gap, the government would need to make some corrective adjustments. Without an adjustment, the position we're in with a big gap [between reimbursement levels] will persist even if they put us on the same inflation index as the hospitals.

Q: As a management company, how do you view the opportunity for joint ventures between ASCs and hospitals? Do you recommend seeking out those partnerships?

LL: We're oriented towards forging those relationships, and where we have independent, stand-alone centers, we're seeking out hospital relationships. It's a strategy that we have given the realities of our environment, and it's a strategy that we think is important to our future. I think in stand-alone centers, it's often hard for physicians to come to grips with the reality, but they need to look carefully at their situation and say, "Look, in the current environment with healthcare reform, we need to be part of a larger system."

Part of what healthcare reform has driven is greater integration of care by the big health systems, meaning hospitals are employing more surgeons and more primary care physicians. That can put a squeeze on a surgery center, where the leaders are looking around, saying, "Where are we going to find our next group of young doctors to come into the surgery center?" In some instances, there are none because they're going to work for the hospital. Unless the hospital owns the surgery center, the physicians won't take cases to the surgery center. Hospitals recognize that they're getting paid a lot more, that way they keep care from escaping their system is by employing the people who make the referrals. It keeps the business in their system, drives up healthcare costs and grows their market share.

Q: Some people believe hospital employment will see a reversal in a few years, when physicians and hospitals start to express dissatisfaction about their relationships. What do you think?

LL: One motivation for hospital employment is hospitals desiring to control the referrals of the physicians they employ. An orthopedist sends out lots of imaging referrals, and where he does the surgery makes a big difference. If the physician is employed by the hospital, those referrals stay within the system.

But the other motivation for employment is that the independent orthopedic surgeon doesn't get paid very well being independent. They're just a small player in a large market, and they don't have any leverage with payors. The hospital comes in, and they may have hundreds of millions in revenue — hospitals are getting paid more for the same physician services, if the hospital employs the physician than if the physician is on his own. Let's say the hospital gets paid 30 percent more. In that case, the hospital can turn around and pay the surgeon more than he could make being independent.

There is some backlash occurring against this sort of thing. Take, for example, Partners HealthCare in Boston. They've been getting paid substantially more than the rest of the market for many years, and their presence was growing and driving up healthcare costs. Providers are saying, "If I'm going to be in this market, I might as well get paid the best I can," and that means being employed by Partners. The hospitals have been very effective in lobbying government and helping shape policy that supports their institutions, and

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much more effective than the other players in the healthcare market. As a result, they've been successful in translating that into bigger dollars and more work. The rest who haven't been effective in that lobbying effort are getting paid relatively less. It's a natural consequence that these institutions that are getting paid more are going to grow.

Q: In the surgery centers you've seen succeed, what factors are key to their profitability?

LL: The operational basics are the same as they've always been. The key to controlling surgery center costs, for the most part, is schedule compression, meaning doing as much throughput as possible in your center within any given day that you're open. The other piece is just making sure when your center is created that you build it in a cost-effective way. No one pays you extra because you're in a fashionable location or because you have beautiful paneling on the walls or marble or a fountain out front. Insurance companies don't pay you extra for that. When you created your center, if you did so in an economical way, that positions you long-run for being profitable.

The third key to profitability is making sure you have the volume that is well reimbursed. In most cases, the strong reimbursement comes from having been effective in payor negotiations. The most important thing you can do to increase leverage is to control where the cases go. If you're working with a group of physicians, they need to be willing to take those cases to the higher-cost hospital if your negotiations haven't gone well. For example, let's say you're negotiating with a payor and you have 1,000 cases a year being done at the hospital. Maybe that payor is paying $3,000 per case at the hospital, but at your surgery center, you could do well at $1,500 a case. If you can say to the payor, "We'll move these 1,000 cases from the hospital to the surgery center if you pay us $1,500, whereas so far you've only proposed that you're willing to pay us $1,000. At $1,000, we're not doing well enough to take those cases into the center." If you say that to a payor, they'll run the numbers and realize they'd save a lot of money.

Q: What do you think about the future of out-of-network reimbursement for ASCs? How fast is it dying, and where does it persist?

LL: It's going to persist in certain locations. For example, sometimes in isolated geographies, the hospital might have the payors over a barrel. We see this sometimes. The hospital is getting paid $20,000 a case in-network, for cases that we're doing out-of-network for $3,500. Unfortunately,

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often when we try to contract, the payors offer us only $1,200. The payors are happy that we're there competing with the hospital, even if we're out-of-network.

Q: How do hospitals gain that much power over a payor, in terms of setting rates?

LL: Like I said, it's isolated geography. The hospital says, "If you want to be in this market, you have to accept what we're asking. If we no longer accept your insurance, if we drop your contract, you're out of this market." Because there's nowhere else for the patients to go. It's what I would call a segmented monopoly; in that little market, the hospital has monopolistic power, and that's why they get paid so much in isolated geographies.

If you're a surgery center in that market, the payor might not offer you a decent contract but will be content for you to be out-of-network, and that situation might persist indefinitely. In other places, it's different. We've been seeing real pressure from payors for probably six years or more, where payors will write nasty letters to physicians, saying, "If you take our patients out-of-network, we'll drop you from our plan," and the physicians will often get intimidated by that. They also put in requirements about taking the beneficiary — the patient — to an out-of-network facility. There are certain approvals that the patient has to go through, and there are hurdles that the payor puts in the way. In addition to that, payors do things like send the reimbursement to the patient rather than the surgery center.

Q: Where do you see growth opportunities for ASCs right now?

LL: I see hospital partnership as the primary opportunity right now. If some states liberalized their CON regulations, that would also provide significant opportunities for growth. There are a lot of states that have restrictions, and if they liberalized them, it would unleash entrepreneurial activity in developing new surgery centers. It would benefit the industry as a whole, because there would be more surgery centers, which saves the health system money and puts a check on hospital dominance.

Unfortunately, we're in a world where what a service gets paid depends on who owns the service provider. That's driving all kinds of changes, including physician employment and hospitals buying surgery centers. I think it's the overriding theme in our current market, and the reason we're in this situation is because of the effective lobbying and control of healthcare policy that hospitals have had.

ASC advocates are making an effort, but it's tough when you're up against these big guns who do great fundraisers for political candidates, employ huge numbers of people, and, as a result, are very influential. As health systems come to grapple with lowering cost of care through ACOs or other arrangements with payors, it seems surgery centers should be a part of that. We're such a cost-effective and high-quality way to deliver these services. But I think we're still a long way from many hospitals realizing that surgery centers are important to their strategy. There are some enlightened ones getting their ducks in a row, in so that they can be cost-effective providers. They see surgery centers as important to that strategy, but I don't think that vision is widespread yet among hospitals. ■

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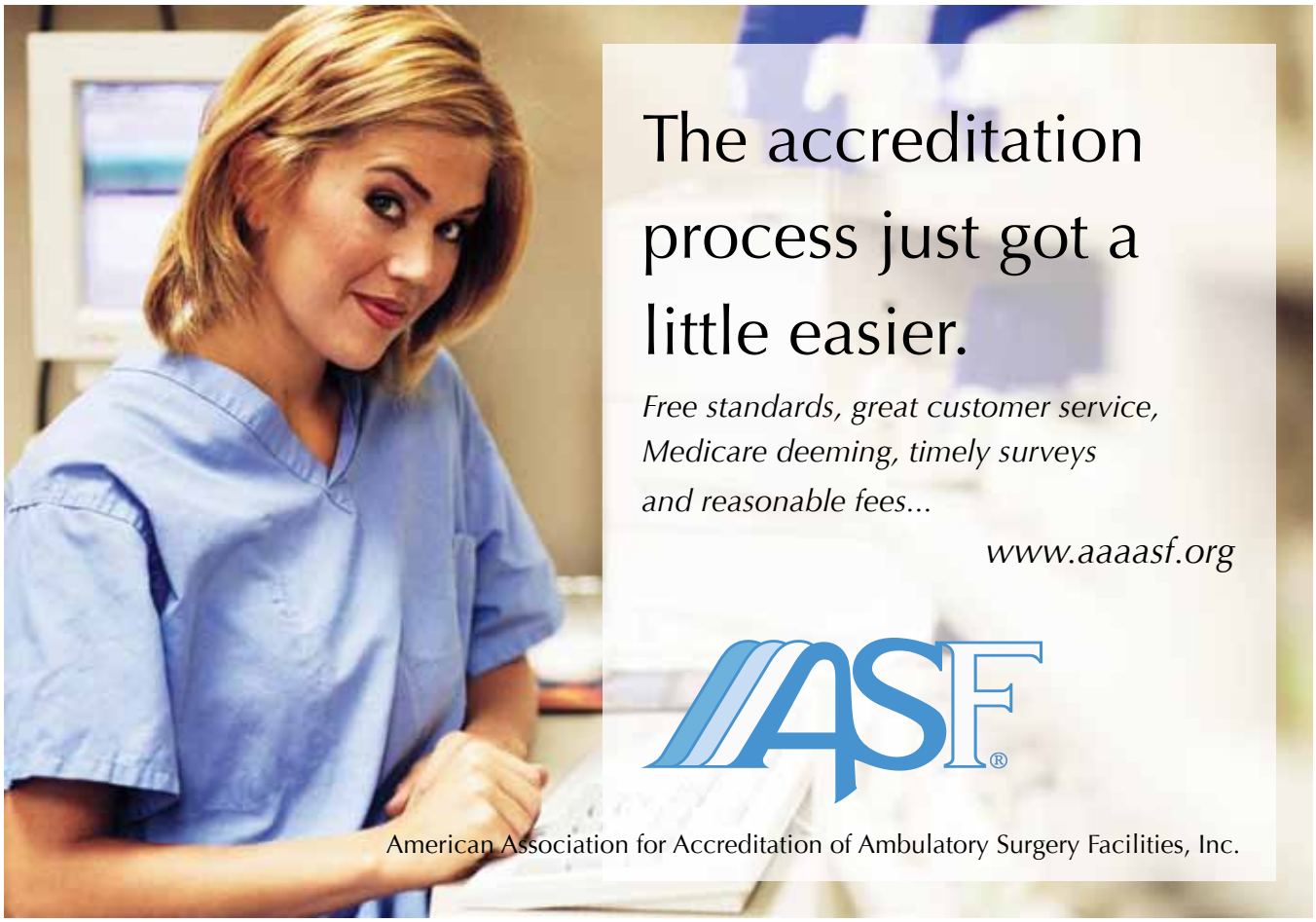

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10 Top Reasons to Invest in Surgery Centers Now

By Laura Miller

There are several reasons why surgeons should invest in surgery centers today. The market is prime for investment, and surgeons can position themselves at the forefront of delivering high quality, low cost care through their involvement with an ASC.

"The future right now is unknown; the only thing we know is there will be fewer physicians, more patients and less money to provide care," says David Ayers, CEO of Nueterra Healthcare. "However, investment in a surgery center can be the first step surgeons need to prepare for what is coming their way."

Here, industry experts discuss the top 10 reasons why now is a great time for surgeons to invest in ASCs.

1. Ambulatory surgery centers are still profitable. Despite the turbulent healthcare market and declining reimbursements, investment in an ambulatory surgery center can still be a profitable venture.

"There is a tremendous profit margin in surgery centers; even though it's less than it has been in the past it's still much larger than the vast majority of all investment opportunities and limited risk if you are a physician because you are the one who is generating the business," says Mike Lipomi, President and CEO of Surgical Management Professionals. "The options for investing with a reasonable rate of return right now are few, and this remains a great investment."

Surgeons who invest in an ASC where they regularly bring cases are able to make additional revenue based on the success of the center. "Surgery centers are still profitable and if someone is going to make a profit off a surgeon's activity, why not it be the surgeon?" says Bruce Kupper, CEO of Medarva at Stony Point Surgery Center in Richmond, Va.

Given the benefits of surgery center investment, surgeons may want to jump on the opportunity now while it's still available to them. "There's a potential risk for future legislation that would make it more difficult for surgeons to invest in surgery centers," says Mr. Lipomi. "Surgeons who waited to build physician-owned specialty hospitals are now out of luck, which has become a huge problem. With the pending election, and the uncertainty of what will happen with taxes and capital gain, surgeons may want to put their money somewhere that it will be protected by capital gains instead of regular income."

2. Surgeons can remain economically independent. In an era where increasing regulations and decreasing reimbursement makes it difficult to remain financially independent, and hospitals are eager to employ physicians, surgeons who want to remain independent may find themselves running out of options. Investing in an ASC can provide them the financial return necessary to remain independent.

"Whenever you have an investment where you can control the cost and revenue stream through patient flow, you have an ability to affect the margin," says Mr. Ayers. "Today we are seeing every provider getting hammered on their reimbursement and the specter of nationalized healthcare — which was purposefully set up with the PPACA to limit access or deny care if it can't be provided at a reduced cost — there is no way providers are going to make more money on per unit of business unless they have other revenue streams like this. ASC investment helps to ensure the financial viability of the surgeons."

In many states, surgeons and surgeon groups aren't allowed to have ownership of ancillary services, but surgery centers remain a safe investment for physicians. "ASCs may be one of the few investment opportunities physicians have within their own scope of business," says Mr. Lipomi. "They can no longer invest in labs, physical therapy, imaging or hospitals, but they are specifically allowed to invest in ASCs where they practice. Investment experts say you should invest in something you know about; if you are a physician, you know about medical practice and this is one of the limited investments you have."

3. Loans are still available. While banks have been holding their funds close over the past few years due to the recession, new loan opportunities are beginning to surface again. Since ambulatory surgery centers have been proven as a safe and effective investment, many lenders are more willing to fund those projects than others.

"There has been along period when we could not get loans and now the purse strings are starting to loosen up and the banks are looking for solid, quality investment," says Mr. Lipomi. "The healthcare sector is the number one market right now, so banks are willing to invest in those types of facilities."

Venture capitalists may also be willing to work with physicians to invest in surgery centers. "When you look at the financial markets, they are accepting with ASCs because they are familiar with it," says Mr. Ayers. "There are

a lot of lenders out there willing to invest in ASCs. They are proven and easy ventures to finance, which makes it attractive right now."

4. Surgeons have control over their surgical environment. One of the reasons why surgeons originally began taking cases from the hospital and to the outpatient surgery center setting was to have more control over the surgical environment. Surgeons who have ownership in the ASC can participate in the decision making about surgical supplies and equipment along with other daily activities that impact the quality of their outcomes and patient satisfaction.

"An investment in the surgery center gives surgeons more control and greater input in what happens here on a day to day and policy basis than in a hospital bureaucracy," says Mr. Kupper. "In an ASC you are going to find surgeons who are more entrepreneurial, who are intelligent risk-takers. They aren't going to be satisfied in an institution trying to balance the needs of a lot of different people. In the ASC, the surgeon and patients are the priorities."

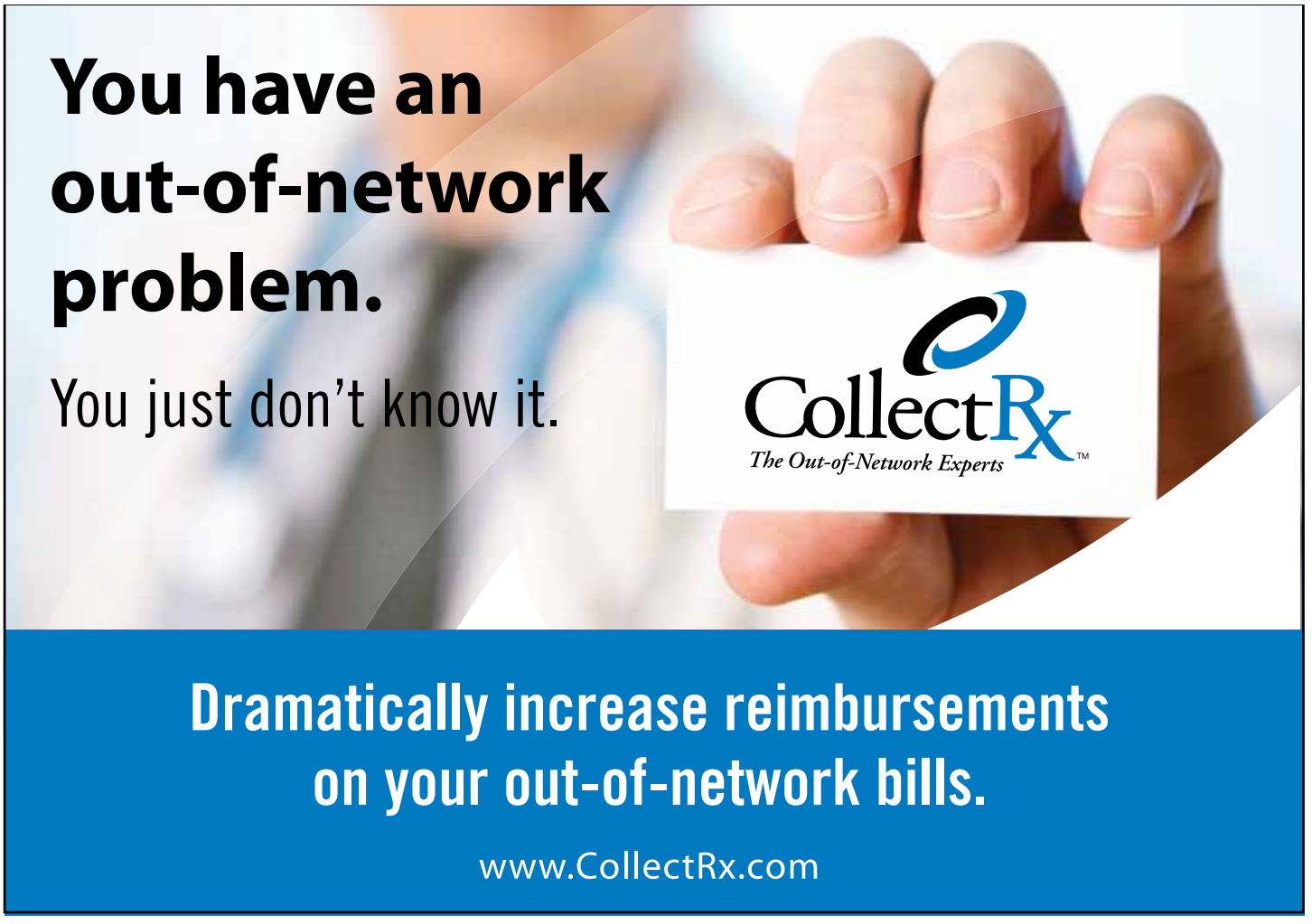
Control over the surgery center can have an impact on how the surgeon practices and outcomes for their patients. "The ASC was developed to provide an environment where physicians could control their working environment for the benefit of the patient," says Mr. Ayers. "A lot of people take that for granted, but that reason hasn't lessened over time. Understanding the patient flow, purchased supplies, patient selection and how employees are treated helps provide better outcomes for the patient and livelihood for the physician."

5. Investment positions specialists as low cost providers. The healthcare industry is shifting to a pay-for-performance model of care and looking to reduce costs at every corner, which makes ASC investment ideal for surgeons. Surgery centers receive a lower reimbursement than hospitals and many boast an infection rate lower than the local hospital. As a result, surgery centers are going to be attractive to accountable care organizations.

"I think freestanding ASCs have a place in the healthcare system going forward," says Mr. Kupper. "ACOs are going to be looking for low cost providers, particularly for high volume procedures like GI, ENT and pain management. If you are responsible for providing care to patients, you are going to be looking for high quality, low cost providers."

While early ACO pilots and payment programs have involved hospitals, the advantage surgery centers bring to the market could be disruptive. "Whenever you are looking at the formation of ACOs or medical homes, many of those groups are looking for low cost opportunities for their patients," says Mr. Ayers. "A surgery center can very easily be a plug in piece for those ACO groups if you can make that happen."

6. Surgeons can do more cases in ASCs because of the efficiency. The staff members at surgery centers are much more efficient than at hospitals because they are focused on working with surgeons to perform the same procedures every day. This is especially true if the surgery center is single-specialty, such as an orthopedics-focused ASC.



"The reason surgery centers are so successful is because they focus on doing one thing and doing it well," says Mr. Ayers. "Any time you do one thing repeatedly, you get better at it, and when you are better at it you can think about how to cut costs."

Once surgery centers are efficient and focused on cost cutting, surgeons can operate with only the staff members they need in the room. Surgery centers can also get supplies at a lower price because they are ordering large quantities from fewer suppliers, which is another way surgery centers cut costs.

"Physicians have to be efficient in their practice and they can't be waiting for the hospital OR to turnover," says Mr. Lipomi. "It's much quicker in the surgery center and they can do more cases, which is important with the reduced reimbursement."

7. Administrators are easy to access. The surgery center environment is very different from the hospital environment, especially when it comes to accessing leadership at the top. Hospital CEOs may seem out of reach for surgeons who need to discuss an issue or make a change, but surgery center administrators are often right around the corner and able to address requests quickly.

"In a hospital setting, there are a number of layers before you get to the CEO, and in an ASC there is not," says Mr. Kupper. "My office is right down the hall from the ORs and the clinical director is right there as well. Surgeons don't have to go far to find us; most administrators are very visible in the ASC for physicians."

8. Surgery centers are flexible for innovative technology and ideas. Since surgery centers are often physician-led and administrators are easily accessible, they can be on the forefront of new ideas and technology in the field. "If managed properly, a surgery center should be prepared to respond to innovative ideas much faster than a hospital or institutional-based surgery program," says Mr. Kupper. "We make decisions on technology acquisitions much faster than hospitals."

In addition to the flexibility afforded by physician management, surgery centers are driven to experiment with cutting-edge business models and collaborations by their need to maintain efficiency and cut costs. "We are going to be much more innovative because we are looking for new ways to generate revenue," says Mr. Kupper. "We are underwriting programs or developing new programs to draw patients and surgeons to the surgery center. We must create an environment that surgeons want to operate in and patients enjoy coming to."

9. Surgeons learn more about business which translates to their practice. Surgeons who invest in surgery centers become more aware of the economic and financial aspects of running the business, which they can also use in their individual practices and careers.

"When once-employed surgeons take ownership in an ASC, that investment brings them back to reality with financial systems," says Mr. Kupper. "If they are employed, they don't pay attention to cost, payor mix, reimbursements or other financial metrics. In a surgery center, those numbers become real very quickly and refocus the surgeon on their impact in the ASC."

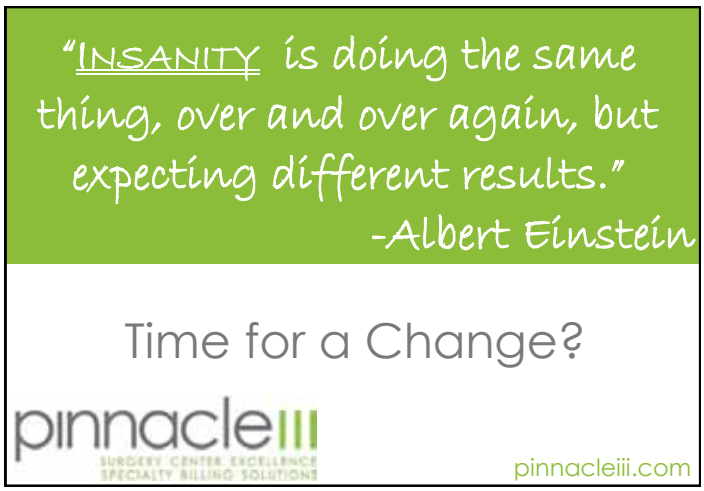
Surgeons also get a crash-course in areas such as employment law and malpractice when they become investors in a surgery center, which is important for their practice as well. "By having an investment in an ASC, surgeons are able to better understand the business of healthcare and relate it back to their practice," says Mr. Ayers. "If they are part of a multispecialty ASC that is governed by their peers and a professional management company, that allows them to learn how to strategically plan for the future."

10. Enables partnerships with other physicians and new physician recruitment. Investment in a surgery center can bring together several small physician groups within the community — whether they are competing groups or from different specialties — to rally around an alternative option to hospital use and employment.

"If there are several small groups in the community that don't want to be employed by the local hospital, an ASC is a place they could rally around so they don't feel separate from their peers," says Mr. Ayers. "They aren't isolated on an island by themselves in healthcare. The surgery center also breaks down competitive barriers between practices and gives them a mutual goal to succeed; that can be a stepping stone for the future because they might want to share services to lower cost and that wouldn't happen without the ASC."

A physician group's investment in a surgery center can also attract new physicians who may want to remain independent. "The additional revenue stream helps them recruit partners to their practices," says Mr. Ayers. "Without the ASCs, it's very difficult to maintain independence from health systems that are buying up practices left and right." ■

Contact Laura Miller at lmiller@beckershealthcare.com.



How Does Your ASC Income Statement Compare? 20 Statistics

By Rachel Fields

Here are 20 statistics on ASC patient revenues and operating expenses, according to VMG Health's *Multi-Specialty ASC Intellimarker 2011*. All numbers are averages.

Patient Revenues

Gross charges: $29,979,000

Adjustments: $10,288,000

Net revenue: $7,736,000

Operating Expenses

Employee salary and wages: $1,552,000

Taxes and benefits: $359,000

Occupancy costs: $477,000

Medical and surgical: $1,530,000

Other medical costs: $111,000

Insurance: $53,000

Depreciation and amortization: $349,000

General & Administrative

Bad debt: $162,000

Management fees: $360,000

Other general and administrative: $662,000

Total general and administrative: $1,123,000

Total operating expenses: $5,222,000

Operating Income: $2,165,000

Other income: $86,000

Net interest expense: $110,000

Earnings before taxes: $2,052,000

EBITDA: $2,513,000 ■

Contact Rachel Fields at rfields@beckershealthcare.com.

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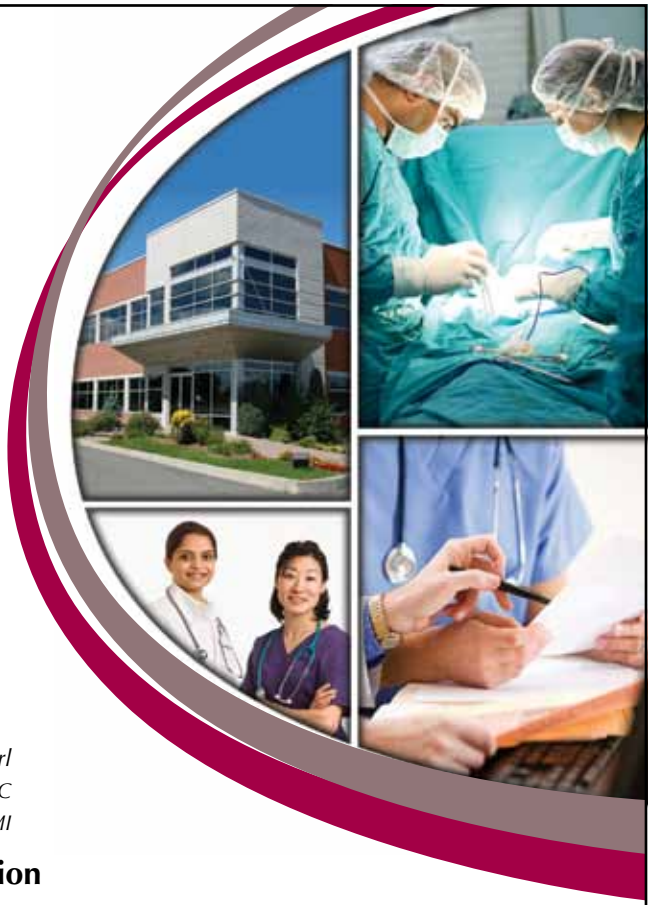

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-Steve Corl
Administrator, Mackinaw Surgery Center, LLC
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Visit our Web site www.hfap.org for more information or email info@hfap.org

5 Trends in Modernizing Surgery Centers

By Laura Miller

Ambulatory surgery centers being built and upgraded today focus on both the clinical aspects of care and the experience of patients and their families. "We are approaching ambulatory surgery center design as a way to create a less institutional feel and more a sense of 'home' and comfort," says Barbara Dokulil, IIDA, LEED AP, an interior designer at BJAC. "This is happening in new surgery centers as well as in retro-fit projects where new materials bring facilities up-to-date."

1. Build flexibility into public spaces. Public spaces, such as waiting rooms, should be flexible — not just open spaces with chairs. Family members need options for more private compartments of space within a larger public area, as well as opportunities to take advantage of positive distraction.

"We can create private compartments to promote family-centered spaces," says Ms. Dokulil. "Many surgery centers have a TV for positive distraction, which can be helpful, but you also want to accommodate quiet moments."

Furniture in the public space should add to the surgery center's aesthetic quality and be functional. "The furniture must be appropriate for public use," says Ms. Dokulil. "We find that a mixture of self seating, tables and motion pieces like swivel chairs reflect the different ways people occupy a public space. Some folks prefer to sit and read while others work on laptops. A good mix of coordinated pieces throughout can easily accommodate these different needs."

2. Expand pre- and postoperative areas. One trend is the expansion of pre- and postoperative areas to make them more private and allow family members to spend time with patients before and after a procedure. "Larger and more private pre- and postoperative areas allow family members to become more involved, which leads to better outcomes," says Ms. Dokulil. "These spaces used to be small bays with curtains, but now we are configuring spaces so family members can become part of the healing process."

Pre- and post-op areas are also being designed for patient comfort and privacy. Beds are often positioned sideways, so patients aren't exposed to others walking by in the hallway. This requires spaces be configured properly and include special furnishings such as chairs for family seating.

With some surgery centers providing 23-hour stay rooms, interior designers must again respond to new regulatory requirements. Twenty-three-hour stay rooms are typically private and must be sized correctly with a window for natural light, which promotes higher patient satisfaction and faster recovery.

The surgery center must also clearly indicate where patients and families are able to go and which areas are restricted to staff only. "When there is limited family access to the patient, the design must clearly communicate where family members can go," says Ms. Dokulil. "This type of wayfinding can be accomplished with floor patterns, color and signage."

3. Added services for family members. Surgery centers are now adding unique spaces to their facilities, such as retail or refreshment options, for family members who have a long wait. "The addition of an element such as a coffee bar to a renovation or update project has become an important component for some clients," says Ms. Dokulil. "This can help family members with longer wait times."

These areas can also positively distract the family members by giving them work space or WiFi access beyond just the waiting room environment. In addition, they provide a welcome respite from what can often be a stressful time.

4. Create a positive and efficient working environment. Staff members are a vital part of the culture of a surgery center. Thus, the design and operation of their spaces promote ergonomics, efficiency and a positive working atmosphere. "Spaces for staff and back end operations are critical to the success of a surgery center," says Ms. Dokulil. "Workspaces must be ergonomically designed with furniture that optimizes efficiency and flexibility. For example, decentralized nursing stations allow for easy patient monitoring, shorter travel distances for staff, and clearer sight lines. Making a facility work well for staff, such as nurses, has proven to result in better patient outcomes."

Furniture is an important aspect of all staff areas. "As designers, we look at how to help staff members with the various tasks of their work, such as nursing and administrative support," says Ms. Dokulil. "Administrative staff needs easy access to system components such as printers and records, so we install furniture to facilitate their work flow."

Designers must be equally sensitive to the experience of patients, visitors and staff. Locating staff break areas away from the patient and visitor flow can allow staff a necessary reprieve from the demands of the clinic.

5. Consider function in designing green. Ms. Dokulil says designers and planners can help owners select the best sustainable features for their facilities. Green design is not limited to LEED certification. Thoughtful sustainable design decisions can positively impact the owner's bottom line by reducing maintenance and life cycle costs of finishes and furnishings. For example, one of the most important elements of the building or upgrade is flooring. Flooring doesn't change often, but can have a big impact on functionality of the surgery center space.

"We often use resilient flooring with lower maintenance option," she says. "Some resilient floors don't require waxing and utilize neutral cleaners that are far less harmful for the environment and also less costly for the facility than what is needed for other surfaces."

Some surgery centers are considering their environmental impact in other areas as well and using environmentally friendly upholstery, utilizing low Volatile Organic Compounds finishes, and making their centers PVC-free. "Green design for surgical centers requires more than just a consideration of trends," says Ms. Dokulil. "It's about providing your clients with a facility that will function well in the long term, be easy to maintain, provide a good return on their investment, and, ultimately, enhance and improve the patient experience." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

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- **Keynote - Tony La Russa, former Major League Baseball Manager and Infielder, 3 Times World Series Manager**
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- Development and Business Model for Outpatient Spine and Sports Centers - Where the Future of Minimally Invasive Surgery will Lead - Robert S. Bray, Jr., M.D. and Karen Reiter, of D.I.S.C. Sports & Spine Center


Howard Dean

- Debate on Healthcare Reform and More - Governor Howard Dean, Physician and former Six-term Governor of Vermont, former Chairman of the Democratic National Committee vs. Ari Fleischer, former White House Press Secretary and primary spokesperson for President Bush
- Joint Ventures - What Works and What Fails - Brent W. Lambert, MD, FACS, Principal & Founder, Nora Bass, VP of Surgery, Parkview Health, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP
- Chaos or Transformation? Healthcare Trends 2013 - David Jarrard, President & CEO, Jarrard Phillips Cate & Hancock, Inc., Michael E. Russell II, MD, President, Physician Hospitals of America, Texas Spine and Joint Hospital, Robert Henry, Senior Vice President Development, Symbion, Inc., Steve Miller, Director of Government and Public Affairs, ASC Association, moderated by Stephanie A. Kennan, Senior Vice President Government Relations, McGuireWoods Consulting, LLC
- The Future of The ASC Industry - Andrew Hayek, President & CEO, Surgical Care Affiliates


Suzy Welch

- The Best Ideas and Biggest Threats to ASCs - Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America, Robert Carrera, President, Pinnacle III, William M. Prentice, JD, Chief Executive Officer, Ambulatory Surgery Center Association, Susan Kizirian, Chief Operations Officer, Ambulatory Surgical Centers of America, moderated by Suzy Welch, Author, Television Commentator, and Noted Business Journalist
- A 75 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, CFO, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, SVP of Operations, Ambulatory Surgical Centers of America


Ari Fleischer

- Shifting of Total Joint Surgery to an Outpatient Basis - Best Practices - John R. Moore, IV, MD, Orthopaedic & Joint Replacement Center, and, Tracey Harbour, RN, Administrator, Surgery Center of Pinehurst
- The Most Challenging Issues Facing ASC Administrators and How to Handle Them - Douglas G. Melton, CPA, Finance Director, Helena Surgicenter, Marti Potter, Administrator, Jersey Shore Ambulatory Surgery Center, Melissa Szabad, Partner, McGuireWoods LLP
- Key Business and Clinical Issues for Endoscopy Centers - Larry Cohen, MD, and Jordan Fowler, CEO, Frontier Healthcare Management Services
- Orthopedics, Spine and Pain Management in ASCs - Michael R. Redler, MD, The OSM Center, Sev Hrywnak, DPM, MD, CEO, AASC, Inc, Yousuf Sayeed, MD, The Spine Center of DuPage Medical Group, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP
- How to Profit from Ophthalmology in ASCs - Danny Bundren, CPA, JD, Vice President Development/Operations, Symbion, Inc., Vickie Arjoyan, Administrator, Specialty Surgical of Beverly Hills
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PROGRAM SCHEDULE

Pre Conference – Thursday October 25, 2012

11:30am – 1:00pm	Registration
1:00pm – 5:40pm	Pre-Conference
5:40pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Main Conference – Friday October 26, 2012

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 4:45pm	Main conference, Including Lunch and Exhibit Hall Breaks
4:45pm – 6:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 27, 2012

7:00am – 8:15am	Continental Breakfast
8:15am – 12:00pm	Conference

Thursday, October 25, 2012

11:30 – 4:30 PM
Registration and Exhibitor Set up

Concurrent Sessions
Track A - Improving Profits, Leadership and Transaction Issues

Track B - Costs, Benchmarking, Marketing, Social Media, and More

Track C - Key Specialties

Track D - Managed Care, Recruiting, Revenue Cycle

Track E - JVs, Physician Owned Hospitals, Selling Your ASCs

Track F - Quality, Infection Control, Accreditation, Management

1:00 – 1:40 PM

A. ASC Roundtable: Outlook for Investment and M&A Activity in the ASC Sector
Jason Cagle, SVP & General Counsel, United Surgical Partners International, Inc., Matt Searles, Managing Director, Merritt Healthcare, and Todd J. Mello, ASA, AVA, MBA, Partner, HealthCare Appraisers, Inc., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Out-Of-Network to Participating Provider
Bobby Sarnevesht, Managing Partner, Bay Area Surgical Management, Inc.

C. Moving Spine Procedures to ASCs – Key Business and Clinical Issues

D. Hospital Relationships - JVs, HOPDs and Co Management
Michael Weaver, VP Acquisitions Ambulatory Network, Vanguard Health, Donna Greene, Vice President Acquisitions & Development, Ambulatory Surgical Centers of America, and Robert Scheller, Jr., CPA, CASC, CEO, Lake Park Surgery Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP

E. Selling Your ASC; What Price Can You Expect; What Are The Deal Terms?
Blayne Rush, MHP, MBA, President, Ambulatory Alliances, Robert C. Goettling, Principal, The Bloom Organization, Thomas J. Chirillo, Partner, Chirillo Consulting, Inc., and Patrick Simers, EVP, Principle Valuation, moderated by Scott Downing, Partner, McGuireWoods LLP

F. Creating a Culture of Clinical Accountability
Kelly Bemis, Group Director of Clinical Services, Surgical Care Affiliates

1:45 – 2:25 PM

A. What Can Football Teach Us About Surgery Center Management? Essentials for ASC Improvement
Joseph Zasa, JD, Partner, ASD Management

B. Perspectives from Great Administrators
Lori Martin, RN, BSN, R.T.(R), Administrator, Summit Surgery Center at Saint Mary's Galena, Karen Harris, Administrator, Clinical Manager, GNS - Surgery Center, Anne Roberts, RN, Administrator, Surgery Center of Reno, and Gary Richberg, Administrator, Pacific Rim Outpatient Surgery Center, moderated by Laura Miller, Editor-In-Chief, Becker's Spine Review, Managing Editor, Becker's ASC Review

C. The Future of Pain Management - Bullish or Bearish?
Stephen Rosenbaum, CEO, and Robin Fowler, MD, Chairman, Medical Director, Interventional Management Services

D. Managed Care Contracting - 10 Key Steps
I. Naya Kehayes, MPH, Managing Principal and CEO, Eveia Health Consulting & Management

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E. JVs - Can Your Center and An Aggressive Hospital Thrive Together?
Jeff Peo, VP Acquisitions & Development, Ambulatory Surgical Centers of America, and Troy DeDecker, CEO, Health Management Associates, Inc.

F. How Do We Care For & Discharge Higher Acuity Patients in the Ambulatory Setting?
Gina Dolsen, RN, BSN, MA, Vice President of Operations, Blue Chip Surgical Center Partners

2:30 – 3:10 PM

A. Orthopedics and Spine- The Best Opportunities and Biggest Threats
Carl Balog, MD, and Stephen J. Dresnick, MD, President, Internal Fixation Systems, Robert S. Bray, Jr., MD, Neurological Spine Surgeon, D.I.S.C. Sports & Spine moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. What Makes a Great Physician Leader
Deedra Hartung, Senior VP, and Ben H. Brouhard, MD, Senior Vice President, Senior Search Consultant, Cejka Executive Search

C. Key Trends in Ambulatory Anesthesia
Rebecca S.Twersky. MD, MPH, Professor, Vice-Chair for Research, Dept. of Anesthesiology, Medical Director, Ambulatory Surgery Unit, SUNY Downstate Medical Center

D. Adding Cases and Recruiting Doctors
Brandon Frazier, Vice President of Development and Acquisitions, and Jeff Peo, VP Acquisitions & Development, Ambulatory Surgical Centers of America

E. What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements, Valuations and Other Issues
Jen Johnson, CFA, Managing Director, VMG Health

F. Key Issues in HFAP Accreditation
Beverly Robins, RN, BSN, MBA, Director of Accreditation, Healthcare Facilities Accrediation Program

3:15 – 3:55 PM

A. Investing in Healthcare - How PE Views ASCs and Different Sectors
Geoffrey C. Cockrell, Partner, McGuireWoods LLP, Joseph P. Nolan, Senior Advisor, GTCR, David Pegg, Principal, Enhanced Equity Funds, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. ASC Direct Marketing Strategies
Ann Sells Miller, Partner, Advanced Healthcare Partners, and Peter S. Cunningham, President, CCO Healthcare Partners, LLC, Moderated by TBD

C. Great Specialties - How to Profit From ENT in ASCs?
Stephen Blake, CEO, Central Park ENT & Surgery Center

D. ICD-10
Kevin McDonald, SVP of Sales, Revenue Cycle Solutions Division, SourceMedical Solutions

E. Key Business Issues for Physician Owned Hospitals
R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

F. Making the Business Case for Infection Prevention to Key Stakeholders
Lorri A. Downs BSN, MS, RN, CIC Vice President of Clinical Services, Infection Prevention and Patient Safety, Board Certified, Medline Industries, Inc.

4:00 – 4:40 PM

A. Joint Ventures - What Works and What Fails
Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, Nora Bass, VP of Surgery, Parkview Health, Jon O'Sullivan, Principal, HealthEconomix, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. The Use of Social Media by ASCs and Practices
Kim Woodruff, VP of Corporate Finance & Compliance, Pinnacle III

C. Development and Business Model for Outpatient Spine/Sports Centers - Where the Future of Minimally Invasive Surgery Will Lead?
Robert S. Bray, Jr., M.D. and Karen Reiter, of D.I.S.C. Sports & Spine Center

D. Healthcare Real Estate Roundtable: Opportunities in Healthcare Properties: The Role of Real Estate in Healthcare Deal Making
John T. Thomas, EVP Medical Facilities, Health Care REIT, Inc., Gordon A. Soderlund, SVP, Director - Business Development, Lend Lease Healthcare Development, Kenneth E. Seip, Vice President, Siemens Financial Services, Inc., Pedro J. Vergne, CEO and President, Physician's Capital Investments, moderated by Geoffrey C. Cockrell, Partner, McGuireWoods LLP

E. The Best Ideas Now; Key Ways to Improve Physician Owned Hospital Profits
Alex Rintoul, CEO, Medical Center at Elizabeth Place, Michael J. Lipomi, President & CEO, Surgical Management Professionals, moderated by Melissa Szabad, Partner McGuireWoods LLP

F. Evaluating Your Facility's IP Education Program
Janet Nau Franck, RN, MBA, CIC, APIC - Association for Professionals in Infection Control and Epidemiology

4:45 – 5:40 PM

KEYNOTE: Leadership and Management in 2012
Tony La Russa, former Major League Baseball Manager and infielder, 2011 World Series Manager, St. Louis Cardinals

5:40 – 7:15 PM
Networking Reception, Cash Raffles and Exhibits

Friday, October 26, 2012

7:00 – 8:00 AM – Registration and Continental Breakfast

8:00 – 8:10 AM – Introductions

8:10 – 8:50 AM

A. The Future of The ASC Industry
Andrew Hayek, President & CEO, Surgical Care Affiliates

B. Trends in the Employment of Key Specialties
LeeAnne Denney, Executive Vice President, iVantage Health Analytics

C. Adding Podiatry Residency Programs to ASCs
Robert Zasa, MSHHA, FACMPE, Founder, ASD Management

D. Key Business and Clinical Issues for Endoscopy Centers
Larry Cohen, MD, and Jordan Fowler, CEO, Frontier Healthcare Management Services

8:55 – 9:35 AM

A. ASCs and The Next Four Years
Barry Tanner, President and CEO, Physicians Endoscopy, W. Michael Karnes, CFO and Co-Founder, Regent Surgical Health, Jim Stilley, MHA, FACHE, CEO, Northwest Michigan Surgery Center, Greg Koonsman, Senior Partner, VMG Health, moderated by Suzy Welch, Author, Television Commentator, and Noted Business Journalist

B. Orthopedics, Spine and Pain Management in ASCs
Michael R. Redler, MD, The OSM Center, Sev Hrywnak, DPM, MD, CEO, AASC, Inc, Yousuf Sayeed, MD, The Spine Center of DuPage Medical Group, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. 10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them
Brian Brown, Regional Vice President Operations, Meridian Surgical Partners

D. Clinical Benchmarking in ASCs - How to Compare and Improve Quality
Carol Hiatt, RN, LHRM, CASC, Consultant and Accreditation Surveyor, Healthcare Consultants International

9:40 – 10:20 AM

A. The Best Ideas and Biggest Threats to ASCs
Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America, Robert Carrera, President, Pinnacle III, William M. Prentice, JD, Chief Executive Officer, ASCA, Susan Kizirian, Chief Operations Officer, Ambulatory Surgical Centers of America, moderated by Suzy Welch, Author, Television Commentator, and Noted Business Journalist

B. How ASCs fit with ACOs
Jarod Moss, SVP Business Development, James Jackson, SVP Operations and Scott Nordlund, SVP of Strategic Growth, United Surgical Partners International

C. Maximizing ASC and Anesthesia Group Relationships
Charles Militana, MD, Director of Ambulatory Surgery Centers, North American Partners in Anestheisa, Director of Anesthesia, Dorothy & Alvin Schwartz Ambulatory Surgical Center, North Shore University Hospital North American Partners in Anesthesia

D. The 5 Measures of Success - Where Clinical, Financial and Operational Management Intersect
John Seitz, CEO MMX Holdings (ManageMy ASC), and Tamar Glaser, RN, CEO, Accreditation Services, Inc. and AccredAbility, Inc.

E. The Myth of the Multiple
Jason L.Ruchaber, CFA, ASA, Partner, HealthCare Appraisers

F. Re-Evaluating Your Revenue Cycle
Sarah Martin, MBA, RN, CASC, Vice President of Operations, and April K. Sackos, CASC, Director of Business Operations, Meridian Surgical Partners

10:20 – 10:50 AM
Networking Break & Exhibits

10:50 – 11:30 AM

A. Double Digit Profit Growth in ASCs - How to Increase Profits in Challenging Times - Panel
Lisa Rock, President, National Medical Billing Services, Tom Mallon, CEO, Regent Surgical Health, Michael Doyle, CEO, Surgery Partners, Doug Golwas, SVP Ambulatory Surgery Center Sales, Medline Industries, Inc., moderated by, Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. The Most Challenging Issues Facing ASC Administrators and How to Handle Them
Douglas G. Melton, CPA, Finance Director, Helena Surgicenter, Marti Potter, Administrator, Jersey Shore Ambulatory Surgery Center, Melissa Szabad, Partner, McGuireWoods LLP

C. Orthopedic Implants and Technology Adoption for Physicians
John Cherf, MD, MPH, MBA, President, OrthoIndex

D. Key Issues in Managing the Supply Chain
Chris Klassen, VP Supply Chain, Surgical Care Affiliates

E. HR and Other Key Issues for ASCs
Thomas H. Jacobs, President, MedHQ

F. Clinical Quality in ASCs
Carla Shehata, RN, BSN, Vice President, Operations, Regent Surgical Health, Daren Smith, Director of Clinical Services, Surgical Management Professionals, Nicole Gritton, Vice President of Nursing and ASC Operations, Laser Spine Institute, moderated by Helen Suh, Associate, McGuireWoods LLP

11:35 – 12:30 PM – KEYNOTE
Healthcare Reform and More
Governor Howard Dean, Physician and Former Six-Term Governor of Vermont, Former Chairman of the Democratic National Committee vs Ari Fleischer, former White House Press Secretary and Primary Spokesperson for President Bush

12:30 – 1:30 PM
Networking Lunch & Exhibits

Concurrent Sessions
Track A - Improving Profits, General Sessions

Track B - Co-Management, Supply Costs, Management

Track C - Key Specialties

Track D - Benchmarking, Out-of-Network

Track E - Joint Ventures, Managed Care and Contracting for ASCs

Track F - Quality, Infection Control, Accreditation, Management

1:30 – 2:10 PM

A. Chaos or Transformation? Healthcare Trends 2013
David Jarrard, President & CEO, Jarrard Phillips Cate & Hancock, Inc., Robert Henry, Senior Vice President Development, Symbion, Inc., Steve Miller, Director of Government and Public Affairs, ASCA, moderated by Stephanie A. Kennan, Senior Vice President Government Relations, McGuireWoods Consulting, LLC

B. Improve Physician Alignment through "Nontraditional" Hospital Joint Venture Surgery Centers
Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners, and Nathan VanGenderen, CFO, Sentara Northern Virginia Medical Center

C. Endoscopy - The Keys to a Highly Successful Endoscopy Center
Barry Tanner, President & CEO, Physicians Endoscopy, John Poisson, EVP New Business Development, Physicians Endoscopy

1:30 – 2:50 PM

D. A 75 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits
Robert Westergard, CPA, CFO, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, SVP of Operations, Ambulatory Surgical Centers of America

1:30 – 2:10 PM

E. Key Aspects to Relationships Between ASCs and Hospitals
Larry D. Taylor, President & CEO, Practice Partners in Healthcare, and Sean McNally, CEO, Moore Clinic

F. 10 Key Legal Trends in Infection Control
Dotty Bollinger, RN, JD, CASC, LHRM, Chief Operating Officer, Laser Spine Institute

2:15 – 2:50 PM

A. How to Recruit Orthopedics - Key Steps and Timelines
Jimbo Cross, Vice President Acquisitions & Development, Jeff Peo, Vice President Acquisitions and Development, and Brandon Frazier, Vice President of Acquisitions and Development, Ambulatory Surgical Centers of America

B. Implement Spine to Drive Higher Performance of your Surgery Center
Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners, and John Caruso, MD, FACS, Neurosurgeon, Parkway Surgery Center

C. How to Profit from Ophthalmology in ASCs
Danny Bundren, CPA, JD, Vice President, Development /Operations, Symbion, Inc., Vickie Arjoyan, Administrator, Specialty Surgical of Beverly Hills

E. How to Structure a Great Joint Venture
Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

F. The Challenges Facing ASCs to Capture, Track and Report on Key Quality Indicators and Outcomes Data
Jennifer Brown, RN, Endoscopy Nurse Manager, Gastroenterology Associates of Central Virginia, and Tim Meakem, MD, Medical Director, ProVation Medical

2:50 – 3:20 PM
Networking Break & Exhibits

3:20 – 4:00 PM

A. How to Maintain Practice Independence While Effectively Partnering with Hospitals
Charles "Chuck" Peck, MD, FACP, President & CEO, and Christian Ellison, Vice President, Health Inventures, LLC

B. Co Management and Converting to an HOPD Model - How Does it Work - A Case Study
Tom Yerden, CEO, TRY Healthcare Solutions

C. Value Priced Implants for Spine and Orthopedic Surgery
Blair Rhode, MD, ROG, Sports Medicine, Orland Park Orthopedics

D. Handling Out of Network Successfully From a Billing and Coding Perspective
Lisa Rock, President, National Medical Billing Services

E. ASCs - How to Negotiate with Payors
I. Naya Kehayes, MPH, Managing Principal and CEO,Eveia Health Consulting & Management

F. Health Insurance Plans Are Taking Notice in Fraud and Abuse of Surgical Implants - What Are They Figuring Out and How to Prevent It
Steven Arnold, MD, Chief Medical Officer, Access MediQuip

4:05 – 4:45 PM

A. The EMR Challenge...
- The right Surgery Center Strategy
Chris Revell, PMP, Project Manager, Surgical Notes, Wendy Kelly, Administrator, Cool Springs Surgery Center, moderated by Robert Brownd, Director of Business Development, Surgical Notes

B. Small Scale Materials Management Success
Daren Smith, Director of Clinical Services, Surgical Management Professionals

C. Emerging Issues in ASC and Healthcare Litigation
Jeffrey Clark, Partner, Angelo Russo, Partner, Christina Egan, Partner, McGuireWoods LLP Moderated by David Pivnick, Associate, McGuireWoods LLP

D. Key Strategies for Out of Network
Suzanne Webb, Owner, ASC Billing Specialists, LLC

E. ASC Transaction Valuation Issues
Kevin McDonough, Senior Manager, and Colin Park, Manager, VMG Health

F. 8 Keys to a Successful AAAHC Survey
Gina Dolsen, RN, BSN, MA, Vice President of Operations, Blue Chip Surgical Center Partners

Roundtable Discussions

1:30 - 2:10 PM
Investment Trends in Healthcare
Joseph M. Scandariato Jr., CIMA, Managing Director - Wealth Management, Wealth Management Advisor, The Scandariato Group, Merrill Lynch

2:15 - 2:50 PM
Maximizing EASC Value and Sales Price
John Poisson, EVP New Business Development, Physicians Endoscopy

3:25 - 4:00 PM
Physician Hospital JVs - Key Issues
Jon O'Sullivan, Principal, HealthEconomix, and Michael Stroup, Vice President Business Development, United Surgical Partners International

4:45 – 6:00 PM
Networking Reception, Cash Raffles & Exhibits

Saturday, October 27, 2012

7:15 – 8:15 am – Continental Breakfast

8:15 – 8:55 AM

A. ASC 2012 - Perspectives from Physicians Leaders
David Shapiro, MD CHC CHCQM CHPRM LHRM, Red Hills Surgical Center, Adam J. Locketz, MD, Health East Media Director of Spine Care, HealthEast Spine Center, Lawrence R. Kosinski, MD, MBA, AGAF, FACG, Elgin Gastroenterology, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Shifting of Total Joint Surgery to an Outpatient Basis - Best Practices
John R. Moore, IV, MD, Orthopaedic & Joint Replacement Center, and, Tracey Harbour, RN, Administrator, Surgery Center of Pinehurst, Nueterra Healthcare

C. Co-Management Arrangements
Brendan Snyder, President, Healthcare Strategy & Research Consultants, Nicholas Colyvas, MD, Chief Medical Officer, Healthcare Strategy & Research Consultants

D. Essentials of the Life Safety Code - How To Assure Compliance
Alice Epstein, Director, Risk Control, CNA HealthPro

8:55 – 9:35 AM

A. Develop a Great Same Story Growth Strategy
Chris Bishop, SVP Acquisitions & Business Development, and Amanda Kane, Business Development Manager, Blue Chip Surgical Center Partners

B. The Best Practices for Business Office Operations
Carolyn Whitsel, Senior Director Business Office Operations, United Surgical Partners International, Sharon Benson, MBA, MSN, RN, CASC, Vice President of Operations, Ambulatory Surgical Centers of America, moderated by Holly Carnell, Associate, McGuireWoods LLP

C. JVs with Academic Medical Centers
Bo Hjorth, Vice President Business Development, and Mike McKevitt, Senior Vice President, Regent Surgical Health

D. What Should Great Medical Directors, Administrators, and DONs be Paid?
Ann Geier, RN, MS, CNOR, CASC, Vice President, Ambulatory Surgical Centers of America, Thomas H. Jacobs, President, John Merski, Partner, EVP of Human Resources, MedHQ, Christopher Collins, RN, BSHCS, Administrator, Metropolitan Surgery Center

9:40 – 10:20 AM

A. Benchmarking the Financial Solvency of an ASC
Raj Chopra, CFO, The C/N Group, Inc.

B. Sell Your ASC or Stay the Course - Key Considerations
Scott Downing, Partner, Helen Suh, Associate, McGuireWoods LLP

C. Key Practices to Improve Infection Rates and Clinical Quality
Sandra Jones, MBA, MS, CASC, FHFMA, Executive Vice President, ASD Management

D. $3MM Verdict in Chatham Surgicore v. HCSC, Insight from an Out of Network, Unlicensed Facility Case
Doug Prochnow, Partner, Edwards Wildman Palmer, LLP

10:25 – 11:05 AM

A. Critical Benchmarking Steps for ASCs
Lesley Raskin, Director of Surgery, Surgical Care Affiliates

B. Analytics Behind Physician Integration
Jeffrey Mason, CEO, BayCare Health System

C. Converting an ASC to an HOPB
Robert W. Scheller, Jr., CPA, CASC, CEO, Lake Park Surgery Center

D. Critical Communication Skills for ASC Administrators and Physician Leaders
Keri Talcott Director of Corporate Communications, and Traci Albers, Executive Director, High Pointe Surgery Center & North Memorial Ambulatory Surgery Center

11:10 – 12:00 PM

A. Conducting a Compliance Review of Your ASC or Physician Owned Hospital - Key Legal Issues for 2012 - 2013
Holly Carnell, Associate, Katherine Lin, Associate, Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:00 PM – Meeting Adjourns

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Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners
Stephen Blake, CEO, Central Park ENT & Surgery Center
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Ben H. Brouhard, MD, Senior VP, Senior Search Consultant, Cejka Executive Search
Brian Brown, Regional VP of Operations, Meridian Surgical Partners
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Jason Cagle, SVP & General Counsel, United Surgical Partners International, Inc.
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5 Operating Agreement Considerations for ASCs Pursuing Joint Ventures With Hospitals

By Heather Linder

Nap Gary is chief operating officer of Regent Surgical Health, a leader in surgery center management and development since 2001. Mr. Gary oversees operations and physician relations at more than 20 Regent centers across the country. He and Regent have been involved with numerous joint ventures with ambulatory surgery centers and hospitals. He weighs in on key considerations for ASC owners prior to pursuing a hospital joint venture.

1. Pick partners wisely. In a joint venture, each partner needs to recognize that the goal is to satisfy objectives of all involved. Selecting a hospital partner that fits your surgery center's goals and philosophies helps ensure you will work well together in the long run.

"Often it's not that difficult to agree you want to have assurance of high quality of clinical care and be successful financially," Mr. Gary says. Rather, choosing business partners come down to more specific details. "It's a delicate thing to gauge," he says, "but it's crucial to pick a hospital partner that is genuinely committed to the success of the center."

He encourages physician groups to make sure the hospital is supportive of making the joint venture successful in its own right.

"You can write all the provisions you want," he says, but it often comes down to the hospital's motivation for pursuing the venture. "Ask yourself, 'Does this hospital have demonstrated willingness to work with physicians in this regard?"

He also recommends using non-compete clauses to keep both partners interested in the venture. If the physicians are barred from working with a competing hospital or medical group, then hospitals can be held to the same standards. "Broad non-compete clauses may need to be tailored more carefully to restrict of hospitals from investing in other surgery centers," Mr. Gary says.

2. Allow hospitals to have majority ownership. Though it may seem counterintuitive to an ASC looking for the joint venture to be a partnership, allowing the hospital to have a majority ownership stake can be helpful in several ways.

Hospitals can often negotiate lower rates with payors because of their size and broader presence in the local healthcare market. If the hospital has majority ownership of the surgery center, payors may treat the center as an affiliate of the hospital, and may be willing to increase reimbursement to the center as a result.

Non-profit hospitals also often conclude that majority ownership is necessary if they are to demonstrate the ability to assure that their charitable objectives can be accomplished.

"One thing we want to do is make sure the operating agreement contains provisions that give the hospital the right to do what's necessary to maintain its mission and not jeopardize tax-exempt status," Mr. Gary says. "That typically involves including some reserve powers in the operating agreement.

3. Maintain a majority board vote. If you choose to sell the hospital majority ownership, you can keep physicians from being overruled in day-to-day operational decisions by giving them a majority board voting power with respect to that category of decisions.

Set up different classes of membership for the hospital, physician or management group. The operating agreement could create a five-member board in which the hospital gets to appoint one board member. This allows physicians to control daily operations, with reserve powers written in so physicians cannot unilaterally authorize actions that might threaten the hospital's charitable mission.

"Typically what we also do," Mr. Gary says, "is to specify in the operating agreement certain actions that can only be authorized pursuant to a supermajority vote. That approach can benefit both the majority-owner hospital and the physicians by assuring that certain important decisions will require broad support among all owners.

Mr. Gary also suggests physicians form a separate corporate entity rather than owning separate individual stakes in the venture. "It's a bigger hassle, but they are able to put their voices together and speak collectively," he says.

4. Get specific with the agreement. Physicians should make sure to thoroughly review the operating agreement prior to signing because there tends to be little recourse if a deal goes sour. One option to protect a physician's interest would be to add a clause that unwinds the agreement if certain objectives aren't met within a specific amount of time.

For instance, if a surgery center affiliates with a hospital to obtain better reimbursement rates from payors, then the surgeons could demand a certain percent improvement in payments within the first 12 months or else the contract would be terminated.

However, Mr. Gary says, "We haven't done it, and I don't know how prevalent these clauses are. You get a lot of push-back from hospitals. Ultimately, there's no substitute for doing due diligence on the hospital in advance of entering into any joint venture, and being as confident that it shares the center's philosophy about how the facility is to be run."

5. Make it about more than money. While many surgery centers pursue joint ventures with hospitals to obtain better rates from commercial payors, a substantial reimbursement increase is not always guaranteed. ASCs cannot assume that payors will raise reimbursement rates dramatically just because of a hospital affiliation.

"It's realistic to expect insurers are going to limit the upside to this as time goes on," Mr. Gary says. "We've encountered some of those efforts already. Some insurers are trying to add language to contracts that gives them the option, in the event that the surgery center adds a new majority partner, of retaining the old agreement instead of entering into a new one. It's not clear how effective those provisions are likely to be, but they nevertheless reflect efforts pay insurance companies to limit rate increases."

It's best if there are reasons beyond reimbursement increases to pursue a joint venture, he advises.

"For example, partnering with a hospital that is highly respected in the community can greatly enhance the surgery center's own reputation," Mr. Gary says. "It can also facilitate better communication among physicians and hospitals, which may lead to other opportunities to coordinate care more effectively and efficiently. Those efforts, of course, are consistent with the direction of healthcare statutes and regulations." ■

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Is Out-of-Network Reimbursement Disappearing for ASCs? Q&A With John Bartos of Collect Rx

By Rachel Fields

Out-of-network has suffered from an increasingly poor reputation in recent years, as payors put pressure on physicians and patients to choose in-network providers for their referrals and encounters. Here John Bartos, CEO of Collect Rx, a company that specializes in helping surgery centers increase reimbursements on out-of-network bills, discusses how out-of-network has changed in the last 10 years, and whether the strategy has a future given the changing healthcare market.

Question: Let's discuss changes in out-of-network reimbursement over the last 10 years. How has the strategy changed for surgery centers?

John Bartos: Most out-of-network claims come from PPO members with out-of-network benefits. Up to 20 percent of PPO members have an out-of-network experience each year. Over the past 10 years, the number of people enrolled with PPOs has increased significantly as HMOs have declined. The number of members covered by a PPO plan was approximately half of the market 10 years ago, and is now over 70 percent. As such, the number of out-of-network bills has risen correspondingly over that time period.

In response to this increase in out-of-network bills, payors have taken various steps during the past 10 years to reduce payments on such bills. So, for example, during the past 10 years, we've seen a gradual increase in patient responsibility (higher deductibles and co-pays) on out-of-network bills. We've also seen the emergence of limited benefit insurance policies, which typically limit reimbursements to a percentage of Medicare. Examples of such policies include the United Healthcare MNRP and Cigna MRC policies. The good news, contrary to what some people seem to think, is that these policies have not been widely adopted in the marketplace. In spite of these efforts by the payors, reimbursements for out-of-network bills today are higher — and frequently much higher — than a provider's reimbursements on their in-network bills. And with the proper expertise, strategy and execution plan, there's an opportunity for providers to increase those reimbursements on these bills even higher.

Q: In what situations is OON still viable? How can surgery centers determine if the going out-of-network will be more profitable than staying in-network?

JB: Candidly, many in the industry think that being out-of-network is an "all or nothing" strategy. This is what payors want surgery centers to think as part of their efforts to steer them away from an out-of-network strategy. Our view, and the view of the hundreds of ambulatory surgery centers we service, is that a hybrid out-of-network/in-network strategy puts surgery centers in the best position to maximize revenue.

With rare exceptions, in most geographies, it is financially prudent for an ambulatory surgery center to have a portion of their revenue come from out-of-network patients. This can range on the low end from 20 to 25 percent of revenue from out-of-network patients up to 75 to 80 percent depending on a number of factors. These factors include the local payor and employer mix, the comparable reimbursement levels for their most common procedures, and the relative market share of the ambulatory surgery center as compared to other providers. If ambulatory surgery centers are prudent in picking and choosing the payors with which they are out-of-network, and are prepared to engage payors on the unique parameters related to out-of-network reimbursements, they will maximize total revenue and profits.

Q: Are certain specialties more appropriate for an OON strategy than others?

JB: Our experience is that all types of specialties can benefit from an out-of-network strategy. With that said, because of the growth of patient responsibility in policies with out-of-network benefits, the facilities that will reap the greatest benefits are those in specialties with higher billed charges. Examples include orthopedics, neurosurgery, spine, and other similar higher dollar specialties. But even lower-dollar specialties can benefit from the greater reimbursements from out-of-network bills.

Q: Do you think there's a future for out-of-network?

JB: Absolutely. For starters, with ObamaCare, there will be 30 million more insureds in the U.S., which means the number of insureds with out-of-network benefits will increase correspondingly. Even setting aside ObamaCare, we believe that PPO policies will continue to grow.

For more than 10 years now, the industry has been predicting the imminent demise of out-of-network business. Yet it doesn't go away. We think the fundamental reason is that consumers want choice — simply put, they want the ability to choose where they receive care. Consumers want access to the value that ambulatory surgery centers offer — the service orientation, the higher quality, the personalized care, and the state-of-the-art equipment. Consumers are even checking on the hospital versus the ambulatory surgery center on quality of care measures like infection rates in making decisions. We just don't see these kinds of consumer demands going away.

Q: What steps should a historically out-of-network surgery center take in order to move in-network?

JB: A substantial mix of out-of-network business is essential to maximizing total reimbursements. With few exceptions, adopting a 100 percent in-network strategy doesn't make sense. Blue Cross Blue Shield plans in some markets would be an example of a payor with which an ambulatory surgery center may want to be in-network.

We hear ambulatory surgery centers express concern that they will lose patients if they go out-of-network with a given payor. This is typically not the case. Most referrals to surgery centers are made by physicians and are not driven there because of the payers or their patients. For the reasons stated above, patients want to be treated at ambulatory surgery centers, and generally follow the advice of their physician. As a result, going out-of-network should not significantly affect patient volume. Payors, of course, would like providers to believe to the contrary. ■

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6 Points on Medicare Reimbursement Trends in Surgery Centers

By Taryn Tawoda

Cathy Weaver, senior manager at Somerset CPAs in Indianapolis, discusses five trends in Medicare reimbursement in the ambulatory surgery center setting over the past several years.

1. Medicare is adding more procedures, particularly for orthopedics and spine. Medicare is adding more procedures that are typically inpatient level, and surgery centers — particularly those specializing in orthopedics — are gaining case volume as those procedures are approved, says Ms. Weaver. "Medicare continues to add CPT each year, and the spine procedures especially come into play," she says. "There are also discussions going on with the ASCA about the possibility of doing joints, and those are very positive."

2. Medicare is examining ASC procedures that are successful with commercial payors. ASCs across the country are doing total joint and partial joint replacements on non-Medicare patients — a promising step toward seeing Medicare add the procedures as well, says Ms. Weaver. "We are seeing this in ASCs in pockets across the country, including in Indiana, Wisconsin and Nevada — it's really coast to coast, but they're definitely popping up," she says. The success of these procedures with commercial payors is "setting the trend to have that discussion with Medicare."

3. Medicare's fee schedule increase has been fairly flat. ASCs will not see revenue increases based on increases on the fee schedule alone, says Ms. Weaver. "One cannot typically survive on Medicare alone in a center," she says. However, facilities can enhance Medicare reimbursement by ensuring that they are submitting clean claims. "Centers should conduct reviews to assure they are capturing all appropriate procedures on the claim, as a start," she says.

4. Medicare has added codes that accommodate high-cost supplies. According to Ms. Weaver, some of the medical surgical supplies being reimbursed by Medicare include J codes (drugs and pharmaceuticals), Q codes (including grafts) and P codes (including Albumin). "This is a positive trend over the past four to five years, and they continue to add to the list of items that can be reimbursed given the appropriate billing criteria," she says. "Medicare has become more flexible in terms of taking into account what we can do at surgery centers, how we need to bill and how we need to be reimbursed."

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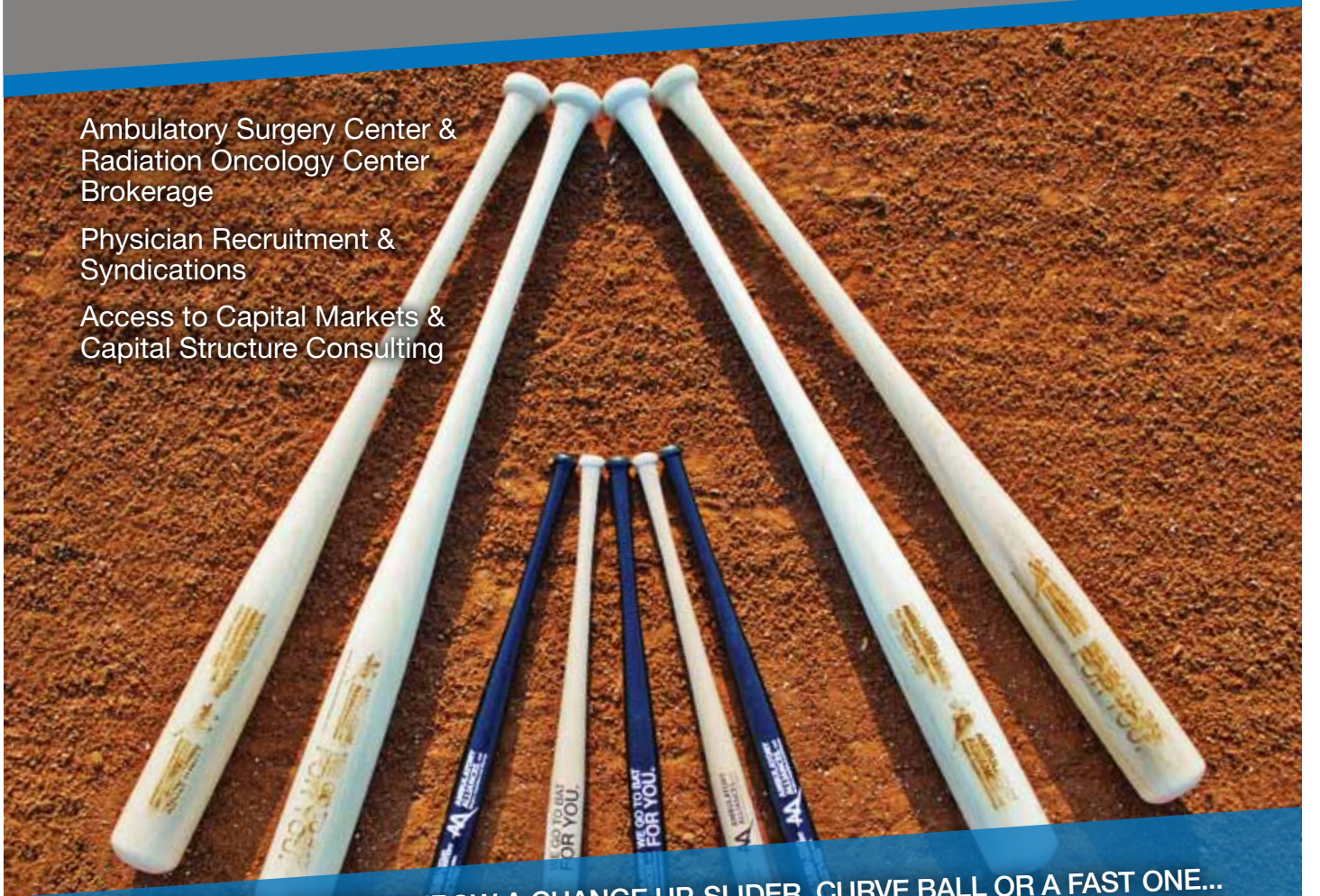

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5. Medicare is reimbursing more device-intensive procedures. Ms. Weaver says that cardio simulator and pacemaker procedures, urology procedures, neurostimulator-related spine and pain management procedures and some ophthalmic and ENT device-intensive procedures are seeing greater reimbursement from Medicare in the ASC setting. This type of reimbursement began when we transitioned to the APC model, and continues to be enhanced to account for the high cost of performing these surgeries, she says.

6. ASCs should negotiate more aggressively with commercial payors. If a surgery center is struggling with Medicare reimbursement, another option is to take a second look at commercial payor contracts. "Be smarter and more aggressive with payor contracts if [the ASC] is in-network — I think that's where the opportunity is," says Ms. Weaver. "I've found that most payors, if you ask them in the appropriate way, will work with you on negotiating something within the reimbursement. People tend to sign their contracts and then they tend to forget about them — there has to be more of an active management of the payor contracts throughout the years." ■

Are Bundled Payments Near for Surgery Centers? Q&A With Dr. Jason Hwang of Innosight Institute

By Laura Miller

Jason Hwang, MD, co-founder and executive director of healthcare at the nonprofit think tank Innosight Institute and co-author of *The Innovator's Prescription: A Disruptive Solution for Health Care* with Harvard Business School Professor Clayton Christensen, discusses bundled payments and the trend extending to ambulatory surgery centers.

Q: Will bundled payments be a viable option for ambulatory surgery centers in the future?

Dr. Jason Hwang: I think it could extend into ambulatory surgical centers. We differentiate between intuitive types of work — which is dependent on the type of people doing the work and their skill — and precise medicine where the care is understood and outcomes are based on the process. Optimize your process and you can plug in different people. In that model, you can price based on outcomes instead of inputs. If we have things done in ASCs down to a science, we should want to price through bundled payments because the outcomes are so predictable. In effect, the bundled payment represents a warranty on our services.

Q: What should surgery center administrators know when considering bundled payments?

JH: You absolutely want to align your incentives properly; make sure all the providers and clinics involved have a strong interest in quality care and aligned interest so there is no overuse or over prescribing. We've seen that dynamic in dialysis centers, so they need to reign in their over prescribing before moving to bundled payments.

Q: What challenges will surgery centers have when taking on bundled payments?

JH: Whenever a provider takes on a bundled payment, you are assuming some level of risk for the outcomes. Providers must make sure it's a situation where they can prepare for outliers, which could eat into their profit margins. One case gone awry could cancel out all the successes they've had up to that point. It has to be a process-based type of care where things are manageable and predictable.

If there is a high level of unpredictability, you are taking on too much risk and could come out unfavorably.

Q: Where do you see the trend of bundled payments heading in the future?

JH: The prevailing trend seems to be bundled payments for discrete services, but it's part of an overall larger trend of capitation at the systemic level. I think we are going to see bundles

of bundles as accountable care organizations get fleshed out. Larger systems may then decide to dole out smaller bundled payments in the outpatient setting. We will see them come out with a high level capitation plan for most people.

The reason for this trend is it's difficult for patients and employers to compare pricing, even when we move to bundled payments. We can try to increase the value of healthcare, but it's impossible to sort out the price of each and every service that goes into a whole episode of care, much less an entire lifetime of a patient. I think we're going to move increasingly toward capitated plans as the real basis of competition among providers. ■

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7 Core Concepts to Leverage ASC Data in Payor Negotiations

By Laura Miller

Steve Arnold, MD, chief medical officer at Access MediQuip, discusses seven core concepts for leveraging surgery center data during payor negotiations.

1. Compare the old contract to actual rates received. One of the first things surgery center administrators should do is to examine their old contracts and make sure that they have been receiving full reimbursement. "If the contracts call for percentage increases over time for annually renewed evergreen contracts, they need to ensure those reimbursement increases are actually being paid," says Dr. Arnold.

When you are negotiating a new rate for an old contract, it's still important to know whether the payor has adhered to the old contract. "If the contract says the surgery center should get $5,000 for the procedure and sometimes the company only reimbursed $4,000, you need to ask why," says Dr. Arnold. "If the payor doesn't give you a reasonable answer, then you need to recoup the money that was not paid before you move into a new contract."

Those losses from the previous contract can be applied to the new contract through various arrangements.

2. Know the data better than the insurance companies. Surgery center administrators must have a firm grasp on national benchmarks as well as their individual center's data going into contract negotiations. "They really need to enter into negotiations armed with better data and analysis than the payor has," says Dr. Arnold. The data they must know includes:

- Surgery center utilization
- Total costs and unit costs
- Physician alignment with the facility
- Hospital readmissions — unexpected and due to revision surgeries — broken into 30 day readmissions, 90 day readmissions and 365 day readmissions
- Capacity management
- Implant and device use on- and off-label
- Quality and safety

"If surgery centers don't have these data analytics abilities, they need to partner with an organization such as ours to supply that analysis," says Dr. Arnold.

3. Align physicians with payors and the center. Physician alignment with the payor is important because when physicians aren't aligned with the payor, they aren't aligned with the center and their procedures won't be paid. Physicians who aren't aligned with the center often have up to a 20 percent denial rate. They tend to perform surgeries without achieving prior authorization or use materials not covered in their contract.

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"Surgeons must understand their contracts and perform procedures based on coverage," says Dr. Arnold. "We want to show payors that our physicians are aligned with them and us on quality, utilization and administration."

4. Compare your data with others. Once you have your data sets available, compare your numbers with others from your local market and against national benchmarks. "The payor is going to compare your ASC to others and if yours performs twice as many knee surgeries, they are going to ask whether you actually run a better facility or if you are doing the procedure inappropriately," says Dr. Arnold.

Another data point to highlight is readmission rates for problems associated with surgeries, like infection rates and implant failure. You need to compare your numbers with others in your market. It can be difficult for surgery centers to track hospital admission rates after patients leave the ASC, but these numbers could be an invaluable tool when negotiating contract rates. Companies like Access MediQuip can help surgery centers track these data and compare them with your competitors.

"When surgery centers can give this data to the payor, the surgery center becomes more valuable," says Dr. Arnold. "These data add tremendous value because if your ASC can show that your surgeons provide patients with higher quality outcomes than at hospitals by more appropriately utilizing resources and lowering costs for the payor, you can leverage this information to achieve bundled payments or pay for performance reimbursements."

5. Propose participating in new payment programs. Participating in a pay-for-performance or bundled payments program rewards surgery centers for raising quality and lowering costs by adding volume and revenue to your center. "Bundled payments can actually raise revenue when the center is able to utilize Access MediQuip's ability to buy the implants at a lower cost," says Dr. Arnold.

There aren't many surgery centers participating in these types of programs today, and most aren't ready to participate at this point. "It's very new, but there are more surgery centers looking at it," says Dr. Arnold. "The surgery centers who should be looking at it are the ones who are most efficient or becoming more efficient. If an ASC is not aligned with their surgeons, then they should not be seeking bundled payments."

6. Factor future capacity into negotiations. If you aren't currently performing cases at full capacity, but expect to increase volume in the future, negotiate those contracts accordingly. "If surgery centers have capacity for more surgeries, they need to find a way to negotiate for increased volume through either better pricing or bundled pricing," says Dr. Arnold.

7. Know your costs so contracts will cover them. One of the biggest risks going into contract negotiations is accepting a rate that won't allow you to cover the average costs for your surgery center. Have an understanding of your overhead and fixed costs, as well as case volume per specialty, before going into contract negotiations so you can ensure those costs will be covered by the final rate.

"Administrators need to be armed with their data so they know what is reasonable and what isn't," says Dr. Arnold. "Otherwise, they might accept a rate that is too low to sustain." ■

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5 Ways to Attract Superstar Surgeons to Your ASC

By Taryn Tawoda

The quality of a surgery center's reputation is a key factor in attracting and successfully recruiting committed, talented physician investors. "I would hope that the center itself is known as being extremely efficient and well-run with top-notch customer service," says Paul King, president and CEO of DoctorsManagement, a healthcare consulting firm based in Knoxville, Tenn. "One of the main reasons surgeons go to a different surgery center is because they're not getting those things at their current setting."

Several industry leaders highlight ways to boost a surgery center's reputation in the eyes of the most sought-after physician recruits.

1. Maintain a strong, open communications policy between the administrator and physician partners. Having frequent discussions with physician partners about the surgery center's priorities will enable the administrator to stay updated on the center's recruitment needs and anticipate changes, says Janet Gordon, administrator of St. Luke's Surgicenter in Lees Summit, Mo.

"We have 39 physician investors, and we've worked hard to maintain a good working relationship with them and their practices," she says. "When they get to the point where they're ready to start recruiting, we know about it soon in the process. While we may not be doing a lot upfront, it enables us to keep the conversation open and be available with information, to meet doctors and give tours of the facilities, and to fast-track credentialing in certain circumstances. It's really about trying to stay in tune with what all of our investor groups are doing."

Communication with physician investors at St. Luke's Surgicenter is maintained through regular board meetings and strategic planning, says Ms. Gordon. "Recently, for example, we had an extensive strategic planning process where we invited members from every physician group in the ownership for a meeting, and we talked about what we could do to help them."

2. Emphasize qualities that make the center efficient and accommodating. While a surgery center's reputation is important, demonstrating that the center is organized and well-run is also crucial, says Mr. King. "Even if the money was good, a physician will not be drawn to a center if it isn't ethical and well-run with great customer service," he says. "If outside surgeons know that, then they're probably knocking on the surgery center's door instead of the other way around."

One way to demonstrate a center's operational capability is to emphasize its efficiency, he says. If the center outsources an anesthesia group, for example, it is important to ensure that the anesthesiologists arrive on time. "The surgeons are going to value their time immensely," says Mr. King. "When they arrive, they want to make sure that they're going to work efficiently and with good specialists."

Accommodating requests for specific equipment is also attractive to prospective surgeons, because well-known surgeons will expect equipment that will enable them to perform the procedures on which their reputation is based. "If the center can show them that they can bring in equipment to makes their surgeries more efficient, that's a definite selling point," says Dale Rothenberg, executive vice president of DoctorsManagement.

3. Make sure the center is not associated with "difficult" employees. A "bad apple" in the center can complicate the recruitment process because physicians may not want to associate their business with him or her, says Mr. King. In particular, a surgery center's physician partner or administrator may develop a reputation among OR staff members who spend time in multiple centers, he says. "The OR staff knows which doctors are clinically talented and which ones aren't so sound, and this can influence the opinion of someone thinking about coming on board and joining the surgery center."

Additionally, an inflexible administrator would present a drawback to a potential recruit. "Oftentimes the administrators have many years of experience, but they need to be flexible," says Mr. King. "I talked to one ophthalmologist who was using a multispecialty center run by an administrator who would only allow him to get five or six cases done in the morning — the center was so structured, and the administrator was trying to run it more like a hospital OR than an ambulatory surgery center. So the physician went and started his own surgery center, and he now does 35 cases in the morning."

4. Harness the attributes of the surrounding area. Emphasizing the attractiveness of the surrounding community and region — including how the physician's family can seamlessly integrate into the community following a move — can give the surgery center an advantage in the recruitment process. Ms. Gordon says that the area's expanding population is often a draw for prospective physicians. "We're in an area that is very lucrative in that there's a lot of land, a lot of development and great demographics," says Ms. Gordon. "It's a booming area for residential and small business growth."

The surgery center is also close to an interstate and provides easy access to eastern Jackson County, an area with substantial residential and small business growth in recent years, she says. Emphasizing the location in a fast-growing region can be appealing for physicians with spouses and families seeking to adapt to new schools, jobs and activities.

5. Present patient testimonials to prospective surgeons. Patient testimonials are often an effective way to communicate the efficiency and quality of the ASC, which will not go unnoticed by potential physician investors during the recruitment process. "You could approach some of the physicians to nominate patients to talk about their experience — it's pretty easy to get testimonials from patients when they've had a 'wow' experience," says Mr. King.

In addition to discussing the quality of medical care, patients can also highlight any administrative or logistical factors, such as convenient parking, few stairs required to access the center, elevator access and online preregistration. Surgeons appreciate knowing their patients will have a good experience at the center.

Unique or memorable customer service practices can also build patient loyalty and boost the center's reputation, says Mr. Rothenberg. "One doctor told me about a surgery center where they were doing biopsies on women for breast cancer, and the administrator made it his duty to give a rose to women after the procedure," he says. "Women in that town didn't want to go anyplace else." In that case, says Mr. King, patients are more likely to spread the word and provide testimonials. "You're the surgery center in town that all the others want to be."

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Biggest Impact Factors in Surgery Center Supply Chain Management Today: Q&A With Lori Pilla of Amerinet

By Laura Miller

Lori Pilla, vice president of Amerinet Clinical Advantage and Supply Chain Optimization, discusses potential cost savings in supply chain management and where the relationship between providers and device companies is headed in the future.

Q: What is the value of standardizing and streamlining supplies and instrumentation at surgery centers today?

Lori Pilla: There are several benefits for surgery centers, whether they are wholly physician owned or in a joint venture, to standardize supplies. For surgeons who have an investment in the surgery center, controlling supply costs will have a positive impact on their returns. Even in a multispecialty surgery center, there are plenty of opportunities to streamline supply vendors.

For example, if you have orthopedic surgeons and podiatric surgeons, there are many supplies that overlap; if you can get those supplies streamlined from five or six vendors down to one or two suppliers, you can reduce your costs. In return for agreeing to move to a couple of suppliers instead of several, the surgery center is able to reduce costs and increase profits for each surgeon.

Q: Is there room for new technology and innovation that has a clinical benefit after surgery centers decide to standardize?

LP: Yes — we are always open to looking at new technology and often there are benefits for length of stay and recovery. If the new technology initially costs more but allows patients to leave earlier and recover more quickly, there is a cost reduction on the back end. When you look at how new technology affects surgeon practices, we look at whether the surgeon will be able to perform more cases throughout the day as a result of time savings, in addition to clinical benefits.

If the surgeon can be more efficient with new technology and see more patients per day with the same or better clinical outcomes, you will be able to fill your schedule and keep staff busy instead of flexing their time. It would make for more consistent labor practices.

Q: What are the big factors that are making an impact on surgery center supply chain management today?

LP: Healthcare reform legislation is one of the biggest factors making an impact on surgery center supply chain. Over the next few years, there will be a lot going on with more people entering the pool of insured patients and the baby boomer population growing and needing medical care. This is especially true this year when it comes to spine implants; we will see an 8.8 percent increase in 2012, based on the aging population. The impact of these patients will depend on how CMS is regulating payments. Bundled payments are also coming into play and more surgeons are aware of truly utilizing a patient matching system for the implants.

Years ago, surgeons might use Stryker's total joint in all patients, whether it was a 30 year old or a 90 year old patient. Now they are putting patients through a baseline treatment and incorporating the use of therapies more often. I really think that everyone has felt the change in revenues and payments, and I think its obvious based on the number of physician practices being bought by hospitals that healthcare reform is having an impact.

As surgeons educate themselves more on the business of healthcare, they are realizing that even though it might be easy to perform the same top-dollar procedure for every patient, it might not be the best route for quality or cost.

Q: Where are physician and provider relationships with device companies headed, given the current emphasis on managing supply chain costs?

LP: As we see more consolidation with the industry, with smaller providers being merged with or acquired by larger ones, I think physicians are really going to end up partnering with the provider on cost savings. They might be best friends

with their Stryker representative, but they have to side with the facility on making implant decisions because that's who will employ them or share cost savings with them in the future.

I also think we are going to see CMS, suppliers and providers come to some level of agreement about supply costs. As a result, there will be consolidation among the suppliers, who will merge or acquire each other.

Q: How are these changes in the market impacting physician preference items?

LP: There are a lot of things that are going to impact the physician preference item industry. The Office of the Inspector General has really brought to light the lack of transparency for a lot of suppliers. The more bad practices they expose, the bigger impact there will be on price.

Going forward, I think we are going to see more things that were once a specialty carve-out become commoditized, especially in cardiology. This will change the entire landscape of physician preference items. I don't see this commoditization moving as quickly in the spinal arena, but I certainly see it beginning to happen in the joint replacement space. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

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8 Tactics to Bring Surgeons Onboard for Implant Standardization at Surgery Centers

By Laura Miller

Standardizing and streamlining implants can help a surgery center realize significant cost savings, but convincing physicians to cooperate with the initiative can be a challenge. Lori Pilla, vice president of Amerinet Clinical Advantage and Supply Chain Optimization, discusses eight tactics to bring surgeons on the same page for supply chain standardization.

1. Involve the physicians early on in the process. Engage the physicians early on in the process to standardize equipment so they are involved in making decisions. Gather all of the surgeon partners together to discuss standardization.

"Allowing them the opportunity to participate at the beginning of the process gives them a choice about which device to choose and how their decisions impact cost savings and overall profitability at the surgery center," says Ms. Pilla. "If the surgeons want to continue using the high dollar items then their monetary benefit will be reduced. It's important within the surgery center market to establish standardization for implants and other products."

2. Appoint a physician champion. The physician champion should be someone who is in a senior position at the surgery center and interested in promoting future cost savings through standardization. To appoint this person, bring all high volume surgeons from each specialty in one room to discuss supply chain management, liability and their commitment to success at the surgery center. During this meeting, a leader should come forward to really advocate for reducing costs by streamlining implants.

"Typically, physicians will listen better to their fellow surgeons than to someone from the outside," says Ms. Pilla. "Keep the physician champion in the loop about steps you are taking to standardize implants and communicate with them on a consistent basis. Additionally, if you come across someone who isn't willing to change, ask the physician champion to help stand with you from a united perspective to discuss the issue."

The physician champion will play the key role of influencing other surgeon partners to participate in the process and provide insight into the best method for standardization. Remind them that standardization of products in the market today does not necessarily mean "one" as it did historically. It could be just reducing the multiple suppliers to a much smaller number.

3. Establish a formal process for gathering information. Surgery center administrators looking to standardize and streamline implant purchasing and utilization should establish a formal process to gather information about surgery center cases and present potential cost savings to surgeon partners. The information should include the number of cases currently done at the center, cost per case and where the surgery center stands with multiple suppliers. Once the information is gathered for the surgery center as a whole — as well as individual surgeons — present that information in a formal setting such as the board meeting.

"When you show them moving from their current situation into a more streamlined approach and highlight the variable cost, they will consider moving to a more middle-of-the-road product that will cut costs at the surgery center without forgoing quality of care," says Ms. Pilla. "Often, they are not aware that there is a less expensive product available that provides the same clinical value as the newest and most expensive items."

You can provide the surgeons with blinded individual data describing the outliers, but not revealing who they are. "That generates a very excitable conversation because everyone is wondering who the outlier is," says Ms. Pilla. "By just sparking that curiosity, we can usually convince surgeons to move forward with some form of standardization."

4. Encourage discussion among the surgeons. When the data is presented at the board meeting, encourage surgeons who are outliers to discuss with their partners what they are doing differently and how they could stay in line with the pack. These meetings could spark new ideas not only for supply chain management but overall quality and efficiency at the surgery center.

"Having this data available opens up an opportunity for the surgeons to discuss and network," says Ms. Pilla. "There might be a conversation between a more senior person asking a more junior person as to what they are doing to achieve more efficiency or better cost savings with the same quality outcomes. They will talk about which method or techniques work the best and whether one surgeon is getting better outcomes than another."

With the chance to discuss the differences in their practice, most surgeons are willing to try something new to improve outcomes, efficiency and cost savings.

5. Engage suppliers in competitive standardization options. It's important to open up your options to several suppliers and do a formal Request for Proposal (RFP) asking them to bring you the best prices possible to share with your surgeons. When the suppliers have delivered the best deals they have, share this information with surgeons and discuss whether the products will meet the needs of their patient base.

"Surgeons know which products are the best, so make sure you ask them whether these new products are clinically acceptable, not just preferred," says Ms. Pilla. "Look at the data for surgeons who are using this product compared to those that are using more expensive products for similar procedures with the same case volume so surgeons can see what they are actually costing the facility. When they see their peers getting the same clinical outcomes, they don't want to be the outlier for price."

6. Narrow down your pool of candidates. When you have the best price from all suppliers and input from the physicians, remove the companies that won't work within the scope of your surgery center's needs. Begin by considering which specialties are at the surgery center and who requires more than just general surgical supplies; choose the suppliers that offer depth and breadth in these specialized areas which will prevent you from having to contract with multiple suppliers; then move forward by considering the quality and cost from the remaining companies.

"The goal is to streamline the number of suppliers and in order to do that we need a supplier who offers everything," says Ms. Pilla. "For example, if you have an orthopedic hand surgeon at your surgery center, not all suppliers will have the instruments and hardware the surgeon needs. You might be doing carve outs for this surgeon's instruments right now, and that's where you want to focus."

In this process, you will likely limit the number of suppliers down to a few key companies who offer what you need. Talk with these companies to see

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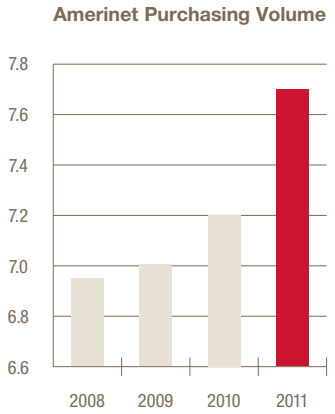

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if you can get an even better contract in partnership with them. "The cost reduction comes when suppliers are willing to partner with you," says Ms. Pilla. "If you demonstrate your willingness to partner with them, they'll want to provide the best deals for you."

7. Work with senior leadership to convince skeptical surgeons. In a large group of surgeons, there will likely be one or two surgeons who are more skeptical than the others about standardization. If you show surgeons the data and they still aren't convinced, work with senior leadership to achieve alignment.

"If there is one surgeon who is truly adamant about not moving to a streamlined approach, we will engage the medical director or chief of that specialty and ask them to help us," says Ms. Pilla. "We work together to help the surgeon understand the benefits of committing to a reduced cost. If they are still adamant, we will present the unblinded data about supply costs per physician at the board meeting; showing each surgeon, by name; no one wants to be the outlier. This typically will help establish collaboration amongst the group and support our efforts."

If even peer pressure from the unblinded data doesn't work, take your case to senior leadership of the surgery center. Discuss the surgeon outlier in terms of how many cases he brings into the surgery center, his patient population and payor mix.

"Show the senior leaders what the cost per case is for him to work there," says Ms. Pilla. "When you get down to the granular details of all of this, they might determine that keeping him at the center is not profitable. Senior leaders are getting more serious about cost and they realize that even if the surgeon brings in a lot of cases, it might cost too much to keep him on staff. When surgeons know that senior leaders are taking that seriously, they are much more willing to cooperate."

8. Allow surgeons to make the final decision. After narrowing down the list of potential suppliers, allow the surgeons to make the final decision. The surgeons should make an informed decision about their supplies based on the cost and quality of the devices.

"Surgeons are becoming more educated now and they are recognizing that, with all the changes to CMS and hospitals purchasing physician practices, it's necessary to understand and partner with others on the business side of medicine," says Ms. Pilla. "I think this is where you are going to see some collaboration."

If the surgeons have a hard time making that final decision, remind them of the monetary benefit they will realize as well. "It's much easier to get all the surgeons on the same page about standardization when you point out that if they continue to use the high dollar items, they are reducing not only their monetary benefit, but the long term viability of practicing as well," says Ms. Pilla. "It's important within the surgery center market to standardize, but that doesn't mean you have to use just one company; standardization and streamlining through two or three companies will also realize cost savings." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

FDA Proposes Medical Device Unique Device Identification System

By Rob Kurtz

FDA has announced it has proposed that most medical devices distributed in the United States carry a unique device identifier, according to a news release.

The announcement comes in response to requirements in legislation that passed Congress.

A UDI system has the potential to improve the quality of information in medical device adverse events reports, which will help the FDA identify product problems more quickly, better target recalls and improve patient safety, according to the FDA.

The FDA is seeking comment on the proposal for 120 days.

"The safety of medical devices is a top priority for the FDA, Congress, industry and patients," said FDA Commissioner Margaret A. Hamburg, MD, in the release. "The unique identification system will enhance the flow of information about medical devices, especially adverse events and, as a result, will advance our ability to improve patient safety."

With certain exceptions, under the proposed rule, a UDI would include a device identifier, which is a unique numeric or alphanumeric code specific to a device model, and a production identifier, which includes the current production information for a device.

The FDA is proposing a risk-based, phased-in approach to implementation, focusing on the highest-risk medical devices first and exempting low-risk devices from some or all of the requirements. The FDA is proposing to exempt over-the-counter devices sold at retail; these devices generally have UPC codes in place. ■

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145 Great Women Leaders in the ASC Industry

By Rachel Fields

Here are 145 women leaders in the surgery center industry who work tirelessly to oversee surgery center operations, orchestrate ASC purchases and partnerships, improve clinical quality, advocate for surgery centers on the political stage or otherwise benefit the industry. *Note: To be included on this or any other Becker's ASC Review list, please contact Rachel Fields at rfields@beckershealthcare.com.*

Margaret Acker, RN, MSN, CASC. Ms. Acker is the administrator of Southwest Surgical Center, a multi-specialty freestanding ASC, and the chair of the Michigan Ambulatory Surgery Association Membership Committee. She was formerly CEO with Blake Woods Medical Park Surgical Center in Jackson, Mich. She has worked in the ASC industry for over a decade.

Traci Albers. Ms. Albers, administrator of North Ambulatory Surgery Center and High Pointe Surgery Center in Minnesota, has over 15 years of ASC and healthcare management experience. During her tenure with her current facilities, she has added a new specialty, managed a major expansion project and achieved excellent patient and physician satisfaction scores.

Kathleen Allman, CASC. Ms. Allman is the administrator of Millennium Surgery Center in Bakersfield, Calif. She came to Bakersfield after retiring from trauma and, within two years, was opening seven cost centers at Mercy Southwest Hospital. Ms. Allman was on the board of the California Ambulatory Surgery Association for two years ending December 2011.

Cathy Atwater. Ms. Atwater serves as the administrator of Banner Health-Union Hills Surgery Center and Banner Thunderbird Surgery Center, positions she has held since January 2010 and February 2005, respectively. Prior to joining Banner, she worked as a gynecology practice manager at North Valley Obstetrics and a manager of operations at Argent Healthcare/Paralign Revenue Management.

Lisa A. Austin, RN, CASC. Ms. Austin serves as vice president of ASC operations for Pinnacle III. She has acted as a board member of the Colorado Ambulatory Surgery Center Association and currently serves as president of the organization. Ms. Austin also serves on the surgery center advisory board of MedAssets. Ms. Austin has been a registered nurse for over 29 years and has served in the ambulatory care arena for the majority of those years.

Sandi Baber, RN, MHA. Ms. Baber serves as regional vice president of operations for Meridian Surgical Partners, where she brings 25 years of healthcare experience in clinical and leadership roles to her position. Prior to joining Meridian, she worked as president and CEO of Baber Healthcare Consulting, a business she founded to assist physicians with development and management of outpatient surgery centers and ambulatory care facilities.

Beverly Baker. Ms. Baker has served as the administrator of the Timberlake Surgery Center since 2008 and has been an administrator in the ASC field for over seven years. Prior to joining Timberlake Surgery Center, she worked as a healthcare consultant specializing in practice operations and an administrator for private physician practices. She currently serves on the board of Missouri Ambulatory Surgery Center Association.

Tracey Baughey. With more than 27 years of administration and management experience, Ms. Baughey is administrator of Laser Spine Institute in Wayne, Pa. She was instrumental in the opening Laser Spine Institute's Pennsylvania and Oklahoma facilities, assisting the teams in achieving state licensure and AAAHC accreditation.

Linda Beaver, RN, MSN, MHA. Ms. Beaver serves as administrator of Gateway Endoscopy Center, an endoscopy facility in western St. Louis County managed by United Surgical Partners International. Under Ms. Beaver's leadership, Gateway Endoscopy Center obtained accreditation by AAAHC, recertification by CMS and successfully completed multiple quality improvement projects.

Christine Behm, BSN, CASC. Ms. Behm has served as the administrator of San BuenaVentura Surgery Center since 1991. She works closely with her business office, clinical manager and physicians to evaluate every case to ensure payment will cover the cost of the case. Net revenue per case more than doubled in 2011, and the center performed its first spine procedure in 2011.

Kelly Bemis, RN, BSN. Ms. Bemis is a director of clinical services for Surgical Care Affiliates, based in Birmingham, Ala., where she oversees 35 outpatient facilities. She has more than 22 years of healthcare experience in the surgical environment, both in hospitals and ASCs. She is also responsible for developing company-wide clinical quality strategies for SCA.

Cristina Bentin, CCS-P, CPC-H, CMA. Ms. Bentin is the president and founder of Coding Compliance Management, a healthcare consulting company specializing in business office and revenue cycle assessments, reimbursement audits, coding support and education. She has more than 21 years of experience in the ASC industry and currently serves on the Education & Programs Committee for ASCA.

Sharon Benson, RN, MSN, MBA, CASC. Ms. Benson is a vice president of operations at ASCOA with over 25 years of management and healthcare experience. Prior to joining ASCOA, Ms. Benson worked for eight years with AmSurg Corp in all aspects of ASC operations. Most recently she worked as associate vice president of operations for the multispecialty division of AmSurg Corp.

Sandy Berreth, RN, MS, CASC. Ms. Berreth serves as the administrator of Brainerd Lakes Surgery Center, a multi-specialty ASC that performs approximately 5,000 cases a year. She has been in the ambulatory surgery management arena for 13 years and has worked at her current center since 2004. Ms. Berreth has been an AAAHC surveyor for two years and is currently juggling being an AAAHC surveyor with her accountability to her own organization.

Julie Berzins, RN, BSN, CASC, CNOR. Ms. Berzins is the director and CEO of North Meridian Surgery Center in Carmel, Ind. She has more than 20 years of clinical, administrative, teaching and consulting experience in ambulatory surgery and acute care surgical settings.

Dotty Bollinger, RN, JD, LHCRM, CASC. In just three years with Laser Spine Institute, Ms. Bollinger, senior vice president of medical operations, has established processes and procedures that improved efficiency of care at the facilities. Under her leadership, Laser Spine Institute has successfully acquired AAAHC accreditation status for three of its clinic and ambulatory surgery facilities.

Regina Boore, RN, BSN, MS, CASC. Ms. Boore is the principal and CEO of Progressive Surgical Solutions. She has more than 30 years of clinical, administrative, teaching and consulting experience in ambulatory surgery and currently serves as the administrator of Newport Bay Surgery Center. She is a frequent presenter on ambulatory surgery topics at national meetings and has published numerous articles in industry publications.

Betty Bozzuto, RN, MBA, CASC. Ms. Bozzuto is executive director of Naugatuck Valley Surgical Center and former president and a founding member of the Connecticut Association of Ambulatory Surgery Centers. She is a former board member of FASA. Ms. Bozzuto is also a surveyor for AAAHC and president of Connecticut's Ambulatory Surgery Center Patient Safety Organization.

Jennifer Butterfield, RN, BSN, CNOR. Ms. Butterfield is the administrator of West Bloomfield Surgery Center, a multi-specialty, Joint Commission-accredited ASC that performs over 5,600 cases per year. She has worked in the ASC industry for over seven years, serving as OR manager and director of nursing prior to becoming an administrator.

Karen Cannizzaro, CASC. Ms. Cannizzaro started her career in ambulatory surgery in 1992, working as a surgery scheduler. She was recruited to the newly-opened Physicians Day Surgery Center in 1998, and other than a two-year break to pursue another interest, she has been there ever since. In the last year, case volume at Physicians Day Surgery Center rose 50 percent due to the recruitment of several new physicians.

Connie Casey. Ms. Casey is the administrator of Northpoint Surgery and Laser Center, the first physician-owned surgery center in the West Palm Beach area. The surgery center staffs 80 employees and features five ORs, two endoscopy procedure rooms and a pain management center. The center entered into an equity partnership with AmSurg this year.

Carol Ciluffo. Ms. Ciluffo joined Pinnacle III in Sept. 2008 to launch a physician billing division within Specialty Billing Solutions and to oversee the operations of the ambulatory surgery billing division. She leads a staff of 19 employees in four departments and serves as a critical member of Pinnacle III's executive management team.

Monica Cintado. Ms. Cintado is the senior vice president of development for United Surgical Partners International, and she has been with USPI since 1998. Prior to joining USPI, Ms. Cintado provided development and operations support with the international group at HCA.

Rena Courtay, RN, BSN, MBA, CASC. Ms. Courtay is a regional vice president of Operations for Birmingham, Ala. based Surgical Care Affiliates, where she oversees the operations of five SCA partner ASCs. She has worked in the ASC industry for more than 20 years and served on committees for both the ASCA and the Florida Society of Ambulatory Surgery Centers.

Cynthia Condron. Ms. Condron serves as the administrator of South Shore Surgery Center, a facility that opened in collaboration with ASCOA in December 2010. The newly constructed facility is an 11,000-square-foot center with three operating rooms and two procedure rooms. Ms. Condron holds an MBA from Palm Beach Atlantic University in West Palm Beach, Fla., and has over 15 years of experience in healthcare.

Mary Ann Cooney, RN, CASC. Ms. Cooney is the administrator of Riverside Outpatient Surgery Center in Columbus, Ohio, a multispecialty facility with six ORs and one minor procedure room. ROSC performs over 6,000 cases per year. The surgery center became a joint venture with OhioHealth and physicians in 1997 and is currently managed by Health Inventures.

Rebecca Craig, RN, CNOR, CASC, CPC-H. Ms. Craig is CEO of Harmony Surgery Center, a multispecialty, Joint Commission-accredited ASC. Ms. Craig helped to open the joint-venture center 12 years ago. Ms. Craig served as president for the Colorado Ambulatory Surgery Center Association from 2004 to 2007 and was elected to serve on the ASCA and ASC Foundation Board of Directors.

Tracy Cregg, CASC. Ms. Cregg was initially hired as the Surgery Center of Silverdale (Wash.)'s business manager before it opened in May 2007. Ms. Cregg was promoted to administrator in February 2009 and is very active in the Washington ASC Association and serves on the ASC Leadership Assembly for the Medical Group Management Association.

Deborah Lee Crook, RN, CASC. Mrs. Crook's ASC, Valley Ambulatory Surgery Center & Valley Medical Inn, is a seven-OR, multispecialty surgical facility. Since assuming her role as administrator in 2006, she has implemented improvements and changes in communication, staffing patterns, teaching, use of technology, change in processes and expense management to increase the efficiency of the center.

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Mary Cunningham, RN. Ms. Cunningham serves as the administrator of Surgical Institute of Monroe (Mich.), an organization she has served since January 2011. Prior to joining Surgical Institute of Monroe, Ms. Cunningham served as administrative and nursing director for Mercy Memorial Outpatient Surgery Center, where she was responsible for directing and coordinating all aspects of operations at the surgery center.

Carla (Daley) Shehata, RN, BSN. Ms. Shehata is director of clinical operations for Regent Surgical Health. In her current role, Ms. Shehata, supplies each center with her in-depth clinical knowledge daily as clinical director of operations. She has maintained high customer satisfaction scores and passed JCAHO Stroke Certification.

Susan Curtis, RN, BSN, CASC. Ms. Curtis is the administrative director at the Surgical Center for Excellence in Panama City, Fla., an ASD Management-affiliated facility.

Louise DeChesser, RN, CNOR, MS. As administrator of Middlesex Surgery Center for Advanced Orthopedics and clinical director for Healthcare Venture Professionals, Ms. DeChesser has over 40 years of perioperative healthcare leadership experience. Ms. DeChesser has served as president of her own surgery center consulting company, Surgical Solutions.

Linda Deeming, RN, BSN, MBA/HCM, CNOR, CASC. Ms. Deeming has served as the administrator of Longmont Surgery Center since January 2009. The multi-specialty surgery center, which opened in October 1996, has grown to include five ORs, two endoscopy suites and one procedure room. This year she will serve as the committee chair for the 2012 CASCA Annual Spring Education Conference.

Roxanne Degnan, RN. Ms Degnan has been administrator at Riverview Ambulatory Surgical Center in Kingston, Pa., since November 2009. She has been a surveyor for AAAHC since 2000 and is on the Board of Ambulatory Surgery Certification and the Pennsylvania Ambulatory Surgery Association. Over the past 2.5 years, she has recruited 12 new physicians and added a GYN specialty to Riverview.

Vicki Dekker. Ms Dekker is the director of business development at Blue Chip Surgical Center Partners. Prior to joining Blue Chip, she was responsible for the business office supporting the ENT, neurosurgery and neurology departments at the University of Minnesota. Ms. Dekker also managed an ENT group in Atlanta, where she developed and managed a single-specialty ENT surgery center that included facial plastic surgeries.

Jody Delahunty, RN, CNOR. Ms. Delahunty started at Heartland Surgery Center in Kearney, Neb., as clinical director when it opened in May 2001 and was asked to move into the administrator role one month later. Ms. Delahunty was instrumental in attracting a large orthopedic group to Heartland, as well as purchasing instruments, supplies and implants.

Pamela Dembski Hart, BS, MT (ACSP), CHSP. Ms. Dembski Hart serves as principal for Healthcare Accreditation Resources LLC, based in Boston. She previously served as the senior health and safety compliance specialist for MedSafe/TCS.

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LeeAnne Denney. Ms. Denney is the executive vice president of iVantage Health Analytics, where she helps the company strengthen its core products while introducing new products to meet market demands. She previously served as CEO of Health InfoTechnics, and has has more than 25 years of experience with major healthcare corporations.

Joan Dentler, MBA. Ms. Dentler is president and founder of both ASC Strategies and Outpatient Strategies, providing hospitals and health systems consulting services related to strategy, project design and due diligence focusing on acquiring, partnering or developing outpatient facilities. She serves on the advisory board for Community Hospital 100 and SurgiStrategies and Texas ASC Society Benchmarking Committee.

Meena Desai, MD. Dr. Desai serves as the founder, president and CEO of Nova Anesthesia Professionals, which provides physician and CRNA anesthesia services to endoscopy centers, ambulatory surgery centers and specialty hospitals. Dr. Desai also serves in numerous leadership positions for the Society of Ambulatory Anesthesia and the AAAHC.

Ann S. Deters. Ms. Deters is CEO of Vantage Outsourcing, a cataract outsourcing service serving hospital and surgery center clients throughout the country. Ms. Deters draws on her experience operating an ASC in Missouri and consulting with hospitals and ASCs. Under her leadership, Vantage has saved healthcare organizations more than $93 million in capital and supply costs to date.

Gina Dolsen, RN, BSN, MA. Ms. Dolsen serves as vice president of operations for Blue Chip Surgery Center Partners. With more than 30 years in healthcare, Ms. Dolsen has broad expertise and deep experience in ASC development and operation. She came to Blue Chip after holding a regional management position with Health Inventures.

Jill Dowe. Ms. Dowe serves as director of business office operations for Blue Chip Surgical Partners. In her previous role as business office manager of Surgery Center Cedar Rapids (Iowa), Ms. Dowe supervised office teams and worked with other members of the management team.

Lynda Dowman Simon. Ms. Simon is the administrator at St. John's Clinic: Head & Neck Surgery in Springfield, Mo. Ms. Simon has been at her center since 1994. Prior to coming to St. John's, she worked for 13 years at a local hospital in the open heart center and urology.

Vicki Edelman, RN, BSN, CASC. Ms. Edelman is the administrator of Blue Bell (Pa.) Surgery Center and currently employed by ASCOA. The four-room, multispecialty ASC operates with 22 surgical partners and an additional five affiliated physicians. She has been with Blue Bell since May 2008, during the center's construction phase.

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Marie Edler, MPH. Ms. Edler is a senior director of reimbursement for Surgical Care Affiliates, based in Birmingham, Ala. She is responsible for all reimbursement and contract negotiations for 30-plus SCA partner ASCs as well as strategic planning with regard to rate growth for the region she serves.

Teva Eiler. Ms. Eiler joined UPMC Hamot (Pa.) Surgery Center in 2006 and worked as the surgery center's purchasing manager and human resources coordinator for three years. In 2009, she was named administrative director of the surgery center.

Stephanie Ellis, RN, CPC. Ms. Ellis is the president of Ellis Medical Consulting, and has worked with most surgical specialties, assisting ASCs, physician practices, hospitals and outpatient clinics around the country in her consulting work. Prior to starting the company, she worked as a fraud investigator for the Medicaid program.

Alice L. Epstein, MHAA, DFASHRM, FNAHQ, CPHQ, CPHRM. Ms. Epstein, with CAN HealthPro, has over 30 years of consulting, operational and clinical experience serving a broad array of healthcare clients with risk management and quality consulting. Prior to joining CNA HealthPro, she developed and directed healthcare risk management consulting practices for an international insurance brokerage firm.

Pamela J. Ertel, RN, BSN, RNFA, CNOR, FABC, CASC. Ms. Ertel oversees daily operations at The Reading (Pa.) Hospital SurgiCenter at Spring Ridge, a multispecialty ASC that includes eight operating rooms, 10 pre-operative bays, 19 post-operative bays and one special procedure room. She also serves as president of the Pennsylvania Ambulatory Surgery Association.

Allison Estes, RN, BSN. Ms. Estes is the administrator of Lakeview Surgery Center in Warner Robbins, Ga. She entered the pain management field in 2006 as a founding administrator for an interventional pain management facility with an in-house procedure suite that grew into Lakeview Surgery Center.

Carolyn Evec, RN, CNOR. Ms. Evec has served as the administrator at The Surgery Center of Beaufort (S.C.) for over 10 years, after opening a surgery center in Missouri where she served as nurse manager. She has served as president, president-elect and is currently secretary for the South Carolina Ambulatory Surgery Center Association

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Andrea Fann. Ms. Fann serves as the administrator of Orthopaedic South Surgical Center, a United Surgical Partners International facility in Morrow, Ga. She has served in the position since 2005, after working for Buckhead Ambulatory Surgery Center and Atlanta Outpatient Surgery Center (both HCA facilities).

Judy Fladeboe. Ms. Fladeboe serves as the administrator of Willmar (Minn.) Surgery Center. During her career, Ms. Fladeboe has accumulated 25 years of experience working in emergency departments and GI/endoscopy units, including 15 years as manager. She has also helped the center achieve AAAHC accreditation.

Kerri Gantt. Ms. Gantt has been employed by Gastroenterology Associates of S.W. Florida and Barkley Surgicenter in Fort Myers for over 19 years. As administrator of the two organizations, she oversees business and clinical operations. She has served as past president of Health Management Association.

Ann Geier, MS, RN, CNOR, CASC. Ms. Geier, senior vice president of operations for ASCOA, has been involved in the ambulatory surgery industry in management roles since 1985. She has worked in all areas of freestanding ASCs and HOPDs, including pre-assessment, pre-op, OR, and PACU. She serves as an AAAHC surveyor.

Michelle George, RN, MSN, CASC. Ms. George is a group director of clinical services, quality and safety, for Birmingham, Ala.-based Surgical Care Affiliates. Her group includes all of the company's West Coast partner ASCs and surgical hospitals. She is a member of the American Heart Association Board of Directors.

Nancy Goldbranson. Ms. Goldbranson, practice administrator of The Virginia Spine Institute in Reston, Va., committed herself to the institute for nearly 13 years. According to her colleagues, Ms. Goldbranson ensures the six-physician practice runs seamlessly day in and day out.

Judy Graham. Ms. Graham is administrator of Cypress Surgery Center in Wichita, Kan., a freestanding, multi-specialty ASC that opened in December 2000. In 2006, the physicians that founded Cypress entered into a joint venture with Symbion Healthcare. She has kept the center successful during the changing economic and healthcare environments.

Julie Greene. Ms. Greene is the CEO of Muskegon Surgery Center in Muskegon, Mich., and Regional Healthcare Management Solutions, LLC, a consulting organization. A longtime member of the Michigan Ambulatory Surgery Association Board, Ms. Greene has been involved in several projects including working with BCBS of Michigan.

Kelly Grier. Ms. Grier, senior vice president of business operations for ASD Management, fo-

cuses on maximizing the profitability of surgery centers by managing, developing and training their business staff. She developed a business office procedures manual, regularly updated with billing and coding rules of the AMA and CMS.

Jovanna R. Grissom, BSN, CASC. Ms. Grissom is regional vice president of operations for Meridian Surgical Partners. She has experience developing new programs in bariatrics, joints and spine. She is founder and current president of the Nevada ASC Association and past chairperson of the Ambulatory Surgery Foundation.

Debra Hagendorn. Ms. Hagendorn, administrator of South Shore Ambulatory Surgical Center in Lynbrook, N.Y., started her career at South Shore as the OR nurse manager and was promoted to the administrator position. Under Ms. Hagendorn's leadership, the AAAHC survey was passed on the first attempt.

Marilyn Hanchett, RN. Ms. Hanchett is the senior director of clinical innovation at the Association for Professionals in Infection Control and Epidemiology. She is dual-certified in infection control and healthcare quality and has spoken and written on the topic of infection control on numerous occasions.

Deedra Hartung. Ms. Hartung is the senior executive vice president and managing director of Cejka Executive Search, the fifth largest healthcare executive search firm in the United States. Ms. Hartung brings over two decades of healthcare executive experience and 11 years of healthcare and academic executive search experience to her clients.

Kimble Hatridge. Ms. Hatridge serves as administrator of Texarkana Surgery Center, a Symbion Healthcare facility. She has 20 years experience in the healthcare industry, and her track record includes successful recruitment and retention of physician partners, strong financial growth and the development of a strong team of healthcare professionals.

Colleen Heeter. As senior vice president of operations design for Nueterra Healthcare, Ms. Heeter provides leadership for a broad range of clinical and operational services. Before assuming her current role, Ms. Heeter served as a group vice president for Nueterra.

Carol Hiatt, RN, LHRM, CASC. Ms. Hiatt is a licensed risk manager in Florida and AAAHC surveyor who joined the consulting team of Healthcare Consultants International, a subsidiary of AAAHC, in 2011. Ms. Hiatt specializes in building effective risk management programs for surgical facilities and emphasizes the importance of risk management for surgery centers.

Carolyn Hollowood, RN, BSN, CNOR, RNFA, CASC. Ms. Hollowood is the administrator of City Place Surgery Center in Creve Coeur, Mo., a four-OR, orthopedic-driven surgery center. She has been with the center for almost 12 years and helped design the new center.

Karen Howey, CASC. Ms. Howey is administrator of Matrix Surgery Center in Saginaw, Mich. During her time at the center, MSC has received Joint Commission accreditation, added five more specialties and grown to over 32 full-time employees.

Beth Ann Johnson, RN. In 2005, Ms. Johnson joined Blue Chip Surgical from LCA Vision, where she served as vice president of operations, responsible for the growth of the ophthalmic surgery center business. Previously, she was with Aetna as director of provider relations, recruitment and contracting for the tri-state region.

Ellen M. Johnson. Ms. Johnson is the chief operating officer of Facility Development and Management and has more than 25 years experi-

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ence within the healthcare arena. Prior to joining FDM in 2001, she held management positions with a physician/hospital organization.

Jen Johnson, CFA. Ms. Johnson is a partner with VMG Health. Her expertise is related to the in-depth knowledge required to understand fair market value challenges, market data and regulatory guidelines associated with valuing professional service arrangements for healthcare systems and life sciences companies.

Milla Jones. Ms. Jones serves as vice president of government relations for United Surgical Partners International. She has 40 years of healthcare experience and is also active on the board of the Texas ASC Society and with many other state ASC associations.

Sandra Jones, MBA, MS, CASC, FHFMA. Ms. Jones, executive vice president and chief operating officer for ASD Management, has vast expertise in surgery centers, physician practices and hospitals. She was president of Ambulatory Strategies, and a regional managed care coordinator, risk manager and facility administrator for Premier Ambulatory Systems.

Amanda Kane. Ms. Kane is manager of business development for Blue Chip Surgery Center Partners. Bringing 10 years of experience in serving physicians to her current role, Ms. Kane joined Blue Chip from Safe Sedation, an anesthesia services provider. There, she helped attain more than $5 million in annual revenue while managing key relationships with surgeons and office staff.

I. Naya Kehayes, MPH. Ms. Kehayes is the founder, managing member and CEO of Eveia Health Consulting & Management. She is a nationally recognized for her expertise in reimbursement systems, managed care and insurance contract negotiations. She is a former president of the Washington Ambulatory Surgery Center Association.

Mary Ann Kelly. Ms. Kelly began at Madison (Ala.) Surgery Center as the clinical director prior to completion of construction. In his role, she was involved in staffing the facility, purchasing supplies and completing capital purchases as the staff prepared the physical facility for opening.

Cindy King. As Health Inventures' assistant vice president of clinical quality and compliance, Ms. King works closely with and provides consultation and education to corporate and client members. Her professional career includes involvement with ambulatory surgery centers and the development, launch and governance of several ASCs.

Susan Kizirian, BSN, RN, MBA. Ms. Kizirian is the COO of ASCOA and has more than 27 years of experience in all aspects of ASC operations. She is one of the founders and lifetime president emeritus of the Florida Society of Ambulatory Surgical Centers and past president of the Ambulatory Surgery Management Society.

Catherine W. Kowalski, RN. Ms. Kowalski brings more than 20 years of healthcare experience to her position as executive vice president and COO for Meridian Surgical Partners. She previously served as the executive vice president of operations and co-founder of Surgical Alliance Corp.

Heidi Kruger. Ms. Kruger is the executive director for Laser Spine Institute in Scottsdale, Ariz. She joined Laser Spine Institute in 2008 as a seminar patient coordinator and transitioned leadership roles. Under Ms. Kruger's leadership, the center maintains a patient satisfaction rate of more than 95 percent and cares for more than 125 surgical patients each month.

Beth LaBouyer, RN, BSN, CNOR. Ms. LaBouyer has served as the executive director of the California Ambulatory Surgery Association since 2004. Prior to her role as executive director, she served on the CASA Board of Directors. CASA has over 340 members and is an extremely active association, advocating on behalf of ASCs.

Angela Laux. Ms. Laux started as the administrator of Bellin Orthopedic Surgery Center in Green Bay, Wis., in June 2010. In 2011, the center surpassed all its budget goals for case volume and revenue. In 2011, the center also launched a website that includes patient education information forms and videos.

Beverly LeMaster. Ms. LeMaster serves as clinical director and administrator of Physicians' Surgical Center in Belleville, Ill., a position she has held since 2010, when the two positions were combined. She is currently facilitating the expansion of pain management services within the center.

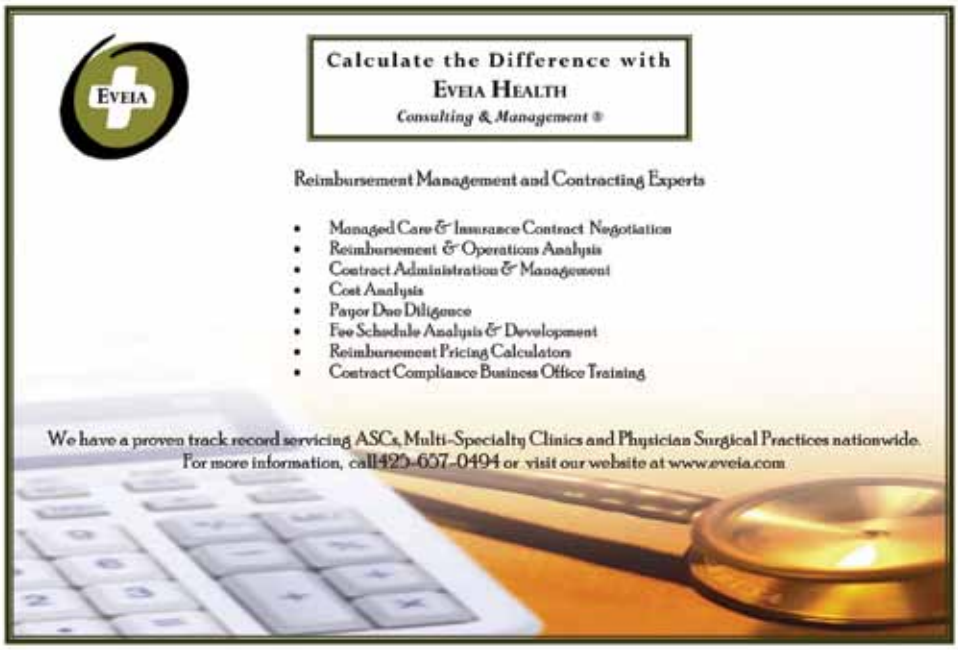
Kathy Lindstrom, RHIT. Ms. Lindstrom works as a coding specialist for ProVation Medical, which she joined in January 2007. Her expertise lies in ICD-9, ICD-10, CPT and terminology coding, which involves analyzing data from SNOMED, RxNorm, LOINC and MEDCIN. Additionally, she specializes in clinical documentation with the surgical specialties of general surgery, gynecology, plastics, ophthalmology and otolaryngology.

Becky Mann. Ms. Mann is the director of Houston Orthopedic Surgery Center. Ms. Mann came to Houston Orthopedic in May 2007 and was involved in the development of the center. Ms. Mann has been working in the medical industry for 38 years in surgery or in post-surgical care.

Lori Martin. Ms. Martin, administrator and director of nursing at SUMMIT Surgery Center in Reno, Nev., since 2009, is responsible for the ASC's day-to-day operations. Ms. Martin continues to serve as secretary for the Nevada Ambulatory Surgery Center Association, and the center recently underwent a state survey with zero deficiencies.

Sarah Martin, MBA, RN, CASC. Ms. Martin serves as vice president of operations for Meridian Surgical Partners. She has over 30 years of healthcare experience. She is a board member of the Ambulatory Surgery Foundation and restarted the Tennessee Ambulatory Surgery Center Association, serving as president and executive director.

Christy A. May, MS, RHIA. Ms. May is a coding and medical content specialist for ProVation



Medical, a Wolters Kluwer company, where she primarily focuses on physician clinical coding, ICD-9, ICD-10 and CPT coding. She also focuses on terminology coding, which involves analyzing data from SNOMED CT, RxNorm, LOINC and MEDCIN.

Amy McKiernan, RN. Ms. McKiernan joined Louisville (Ky.) Surgery Center in January 2005, three months after the center opened. The center currently performs plastics, orthopedics, ENT and pain management in two ORs and seven pre-op/recovery bays.

Dawn McLane, RN, MSA, CASC, CNOR. Ms. McLane has worked in the ASC industry since 1995 and currently serves as regional vice president of operations. She joined Health Inventures in 2010 and is responsible for pre-operations and operational accountability for joint venture ASCs at multiple surgery center sites.

Cathy Meredith, RN, BS, CASC. Ms. Meredith is a vice president of finance for ASCOA. She has been managing surgery departments since 1979 and has extensive experience in all phases and aspects of inpatient and outpatient surgery management and development. Prior to joining ASCOA, Ms. Meredith worked primarily in the development of ambulatory surgery centers with Woodrum/ASD.

Evelyn S. Miller, CPA. As vice president at United Surgical Partners International, Ms. Miller is responsible for the operations of two Pennsylvania markets. Prior to joining USPI, she was executive vice president of Medway Health Systems.

Krystal Mims. Ms. Mims is president of Texas Health Partners. She is responsible for the overall management of five managed facilities. She was CFO of Texas Back Institute in Plano and also administrator of Steadman Hawkins Denver Clinic.

Dee Moncrief. Ms. Moncrief has been with her center, Big Creek Surgery Center in Middleburg Heights, Ohio, since October 2005 and was involved with the development, initial staff hiring and start-up of the center. She brings 15 years of experience in the ASC industry to her current role.

Jennifer Morris. Ms. Morris serves as administrator of Stateline Surgery Center in Galena, Kan., which opened March 28, 2010. The center has two ORs and performs primarily orthopedic cases. In 2011, after the Joplin, Mo., tornado, volume doubled overnight, requiring the addition of a third operating room.

Amy Mowles. Ms. Mowles is president and CEO of Mowles Medical Management, a consulting and management company in business for 15 years. She has successfully guided hundreds of single and multi-specialty centers in 22 states and fully developed 35 ASCs, most concentrating on interventional pain management.

Susan Nance, RN, CASC. Gateway Surgery Center in a Phoenix, Ariz., is a primarily orthopedic-driven, free-standing surgery center owned partly by physicians and partly by AmSurg. She leads the center by example and has implemented many positive changes to enhance patient care.

Jessica Nantz. Ms. Nantz is the president and founder of Outpatient Healthcare Strategies. She has worked in the healthcare field for 25 years, with the past 15 years focused in the outpatient healthcare setting. She held a senior level executive position operating and managing more than 80 facilities. In 2003, she founded mdStrategies, which she later sold and went on to be founder and principal of ASC Strategies.

Amber Patterson. Ms. Patterson is practice administrator of Ear Nose & Throat Clinic and Westside Surgery Center in Douglas, Ga. In her first three years with the center, she has researched the best deals on ASC equipment, worked with a consultant to ensure the facility was built according to state guidelines and hired and trained new staff.

Linda Kelley Peterson, MBA. Ms. Peterson is founder and CEO of Executive Solutions for Healthcare. She has more than 35 years of experience in ambulatory healthcare. She was in a leadership position at HealthSouth and executive director for ambulatory care at The Joint Commission.

Linda Phillips, RN. Ms. Phillips has served as administrator of Southgate Surgery Center in Michigan since 1999. During her tenure as administrator, she expanded the ASC from a one-room, single-specialty center to a four-room, multispecialty ASC and increased the number of surgeons on staff from one to 20.

Terry Rajendran, MHA. Ms. Rajendran is co-founder and CEO of Johnstown, Colo.-based LaClaro, a revenue cycle software company that specializes in the ASC market. She serves as revenue cycle director at Surgical Center at Premier in Colorado Springs.

Toni Rambeau. Ms. Rambeau started at Surg-Center of Glen Burnie (Ind.) in August 2008 as materials manager and was promoted to administrator in May 2009. During her time at the center, she has helped increase patient revenue, case volume and the amount of providers credentialed at the center.

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Lori Ramirez. Ms. Ramirez founded Elite Surgical Affiliates in 2008 and now leads the company as its president and CEO. She previously served as senior vice president at United Surgical Partners International, where she was directly responsible for developing the second-largest network of surgical facilities for USPI in Houston.

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

Anne Roberts, RN. Ms. Roberts is the administrator at the Surgery Center at Reno (Nev.), a multispecialty ASC that is owned by physician partners, Saint Mary's Hospital, and Regent Surgical Health. Ms. Roberts came to the Surgery Center at Reno in February 2006 when it opened and became administrator in October 2006.

Beverly Robins. Ms. Robins serves as director of accreditation services for Chicago-based Healthcare Facilities Accreditation Program, the nation's oldest hospital accreditation organization, established by CMS in 1965. At HFAP, Ms. Robins is responsible for establishing and implementing HFAP policy, as well as overseeing surveyor placement.

Kate Rock. Ms. Rock has over 15 years of healthcare leadership experience. She currently serves as executive director of Doylestown Surgery Center in Warrington, Pa., a community 30 minutes north of Philadelphia. The multi-specialty center, which opened in May 2001, sees an annual case volume of 4,500.

Lisa Rock. Ms. Rock is the founder and president of National Medical Billing Services. Ms. Rock is a trusted business advisor to ASC clients in more than 35 states and a respected healthcare management leader with over 30 years of experience. Her wide-ranging background consists of vice president of business office operations for an ASC development and management company and director of training and education for a large regional payor.

Lauri Rose. Ms. Rose, administrator of Stonegate Surgery Center in Austin, Texas, has been involved in the development and management of ASCs since 1997. In her career, she has successfully developed, managed, and improved the financial stability in over 15 ASCs.

Mary Ryan, RN, CASC. Ms. Ryan is the administrator of Tri State Surgery Center in Dubuque, Iowa, which performs over 5,000 cases annually and is managed by Health Inventures. She is a past AORN chapter president and a founding member of the Iowa ASC Association.

Kris Sabo, RN. Ms. Sabo has been involved with Pend Oreille Surgery Center in Ponderay, Idaho, since 2007. She currently holds the position of executive director of the center, in which she oversees 17 employees and 11 providers of various specialties.

Glenda Satterly, RN. Ms. Satterly is the administrative director of the Kentucky Surgery Center, a multi-specialty surgery center opened

in 1986. She started at the center as an OR circulator and was promoted to clinical director before becoming administrative director.

Tona Savoie. Ms. Savoie is the administrative director of Bayou Region Surgical Center in Thibodaux, La., a multi-specialty surgery center that opened in July 2007. The ASC operates as a 50-50 partnership between physician-investors and Thibodaux Regional Medical Center. It is managed by ASD Management.

Misty Scales. Ms. Scales is the business manager of Southern Indiana Surgery Center in Bloomington, an ASD Management-affiliated facility.

Lisa Schriver, RN, CNOR. Ms. Schriver is the administrator of Turk's Head Surgery Center in West Chester, Pa. Turk's Head is a physician-hospital joint venture that opened in May 2005. Ms. Schriver started with Turk's Head in 2005 as the clinical director and moved up to become administrator.

Donna Scroggins, RN. Ms. Scroggins serves as the COO for Surgical Development Systems. Her responsibilities include development and management of physician-owned outpatient surgery centers. Previously, Ms. Scroggins was regional director for National Surgery Centers.

Caryl Serbin, RN, BSN, LHRM. Ms. Serbin is executive vice president and chief strategy officer for SourceMedical, which provides clinical and business software solutions for ASCs. She was founder and CEO of Serbin Surgery Center Billing, which was acquired by SourceMedical.

Laurie Simon. Ms. Simon, administrator of Western Reserve Surgery Center in Kent, Ohio, started her career on the physician side of practice management and ancillary services management. February 2005, Ms. Simon completed the AORN ASC Administrator Certificate Program.

Carol S. Slagle, CASC. Ms. Slagle has been the administrator of ASCOA-managed Specialty Surgery Center of CNY in Liverpool, N.Y., since 1999. While the ASC started as a single specialty ASC with five surgeons, it has grown to a multi-specialty center with 31 surgeons.

Donna Slosburg, RN, BSN, LHRM, CASC. As executive director of the ASC Quality Collaboration, Ms. Slosburg helps ASCs improve healthcare quality and safety by developing standardized quality measures, publically reporting quality data and assembling tools for infection prevention. She joined the ASC industry in 1987.

Gloria Smith. Ms. Smith is the business manager of MD Aesthetic Surgery Center in Houston.

Laura Smith. Ms. Smith has been employed with Tampa Bay Specialty Surgery Center since 2004, when she joined the center as a pre-op registered nurse and is now administrator. She is fully involved in the financial, management and clinical aspects of running the ASC.

Debra Saxton Stinchcomb, RN, BSN, CASC. Ms. Stinchcomb is a consultant at Progressive Surgical Solutions and has more than 30 years of experience in the healthcare industry. She has served on the FASA Board, ASCA Board, and AASA Association.

Mary Sturm. Ms. Sturm is senior vice president of clinical operations for Surgical Management Professionals. She has over 25 years of experience in management of clinical operations and is responsible for start-up, operational and clinical activities for SMP ASC/GI centers and specialty hospitals. She has since been engaged in the development or management of several centers in South Dakota, Minnesota, Iowa, Illinois, Iowa and Vancouver, B.C.

Maggie Summerfelt. Ms. Summerfelt serves as administrator of Advanced Surgery Center in Omaha, Neb., a physician-owned facility. She was hired in October 2005 to manage construction of the ASC, hire staff and obtain initial state licensure and Medicare certification.

Sue Sumpter. Ms. Sumpter has been with Creekside Surgery Center in Anchorage, Alaska. She has implemented a total joint program there and is currently working on developing a spine program. She worked at Loveland (Colo.) Surgery Center from 2003 to 2011.

Keri Talcott. Ms. Talcott serves as director of corporate communications for Surgical Management Professionals, where she brings over 10 years of healthcare management experience to her role. Ms. Talcott is in charge of corporate marketing, communications and advancing the strategic marketing initiatives of the organization and its clients. Most recently, she held the position of interim executive director for Physician Hospitals of America.

Elaine Thomas, RN. Ms. Thomas began her position as administrator manager in the St. Francis Mooresville (Ind.) Surgery Center in June 2006, and was promoted to director in 2007. She is a member of AORN and the Indiana Federation of Ambulatory Surgery Centers.

Meg Tomlinson. Ms. Tomlinson has served as administrator of Metrocrest Surgery Center in Carrollton, Texas, since September 2002. The center merged with USPI effective July 1, 2010, and has seen various changes to the business office staff since that time.

Kimberly L. Tude Thuot. Ms. Tude Thuot joined the physician-owned Yakima (Wash.) Ambulatory Surgical Center in August 2009. Since then, the center has been through a re-accreditation, moved billing in-house and is adding neurosurgery and spine to the facility.

Lori Vernon. Ms. Vernon, regional vice president for operations, joined Health Inventures in late 2003 and currently has oversight of six ambula-

tory surgery centers. She participates in clinical operations support and oversees the planning of administrator education.

Susan Vitort, BSN, CNOR. Ms. Vitort is the Administrator of Physicians Surgery Center of Tempe (Ariz.), a two-OR, one-procedure room, multi-specialty surgery center that opened in September 1999. Previously, she was director of perioperative services, endoscopy at the Cardiovascular Center at Banner Desert Samaritan Medical Center in Mesa, Ariz.

Kara Vittetoe, CASC. Ms. Vittetoe is the administrator of Thomas Johnson Surgery Center in Frederick, Md., which is managed by ASCOA. She has been with the center since it opened in 2008 and previously spent the majority of her career in the private sector of healthcare management.

Suzanne Webb. Ms. Webb is the CEO of ASC Billing Specialist, a billing company that serves surgery centers and physician practices. With 26 years of experience, Ms. Webb currently takes responsibility for operating a medical billing company that specializes in out-of-network services, consulting and training new clients, teaching clients about profitable practice management, coaching and implementing controls.

Suzanne Wienbarg, RN, CASC. Ms. Wienbarg is a senior vice president of operations at ASCOA, with more than 30 years of experience in healthcare management and operations. Previously, she was a vice president of operations for the ambulatory surgery division of HealthSouth.

Kathleen Whitlow, CASC. Ms. Whitlow is the COO for Blue Chip Surgical Center Partners. She has over 28 years of experience in healthcare. She leads an experienced Operations Team at Blue Chip, working with the finance and development teams.

Kim Woodruff. During Ms. Woodruff's tenure with Pinnacle III, her role has evolved from vice president of business office operations to her current role as vice president of corporate finance and compliance. She assumed her current position in 2008.

Lexa L. Woodyard. During her five years as administrator of Cabell Huntington (W.Va.) Surgery Center, Ms. Woodyard has racked up several accomplishments. She helped decreased supply expenses per case, increased net revenue per case and negotiated better paying contracts with selected insurance carriers.

Cindy Young, RN, CASC. Ms. Young has been with the Surgery Center of Farmington (Mo.) for the past 13 years, during which time the center has shown consistent quarter-over-quarter profit increases, high patient, staff and physician satisfaction scores and quick turnover times. She is now administrator of the ASC.

Monica M. Ziegler, MSN, CASC. Ms. Ziegler has been the administrator for Physicians Surgical Center in Bethlehem, Pa., for seven years, growing case volume to 5,300 cases a year. Ms. Ziegler was given the responsibility of a second center, the Center for Specialized Surgery, one year ago.

Becky Ziegler-Otis. Ms. Ziegler-Otis has served in her current role as administrator of the Ambulatory Surgical Center of Stevens Point (Wis.) since January 2008. In this position, Ms. Ziegler-Otis has worked diligently to keep days in A/R at benchmark levels. ■

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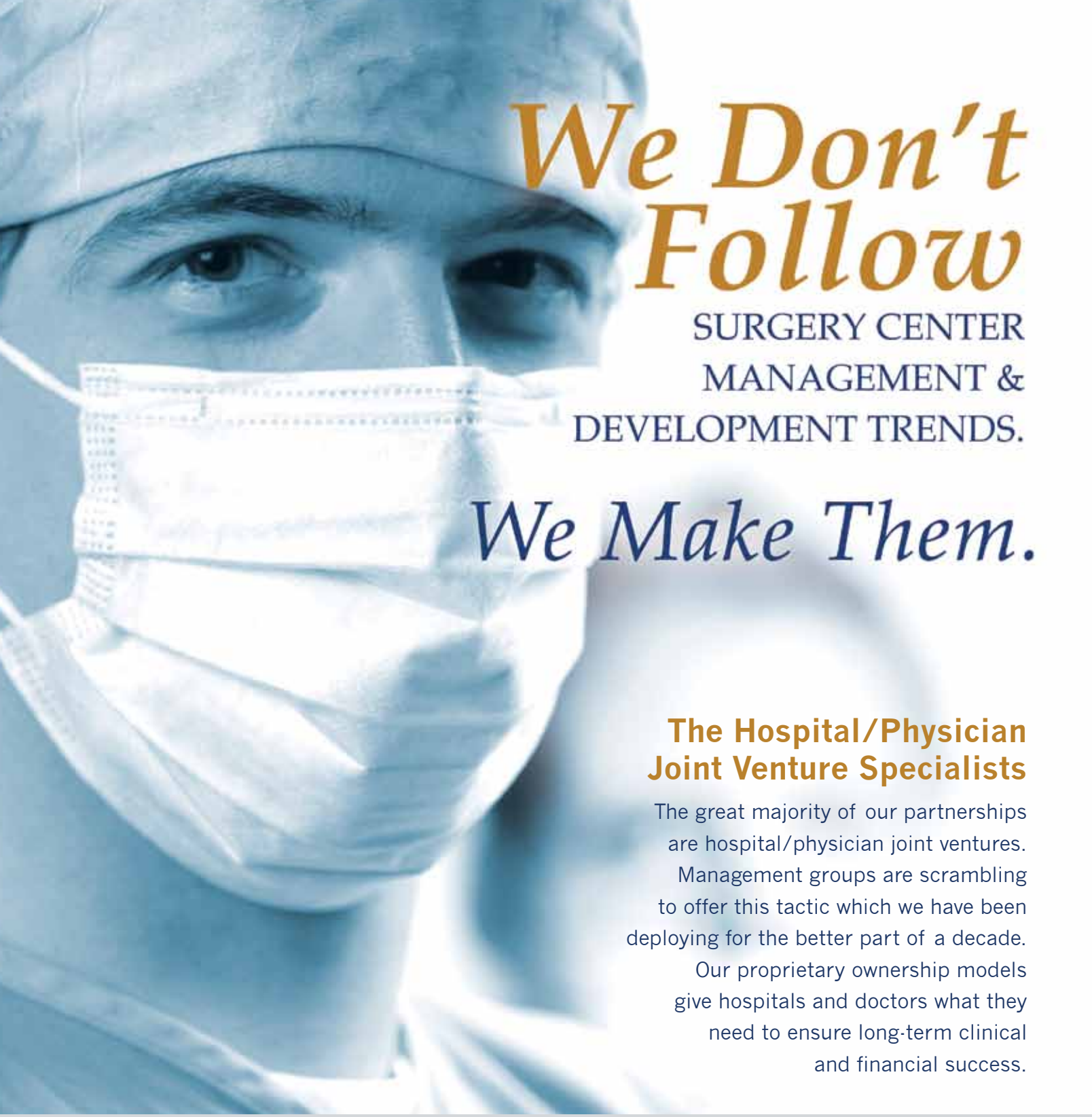

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7 Steps to Kick-Start a Positive Surgery Center Culture

By Laura Miller

Mary Sturm, RN, MBA, senior vice president of clinical operations at Surgical Management Professionals, discusses seven steps to kick-start a positive culture in ambulatory surgery centers.

1. Start the positive culture at the top. Surgery center leaders must be invested in a positive culture and set the tone for every other employee in the center. This means owners, board members and other appointed leaders must strive for excellence in their behavior as well as clinical practice.

"The owners and board of governors at the surgery center set the expectation for managers, leaders and staff members," says Ms. Sturm. "They want to own and work at a center of excellence and the only way to provide that is with a positive culture. It does really start with the leaders of the organization and their commitment to doing whatever it takes to create a surgery center that everyone is passionate about."

One way to impact the surgery center's culture is by greeting individual staff members by name and really listening when they have suggestions. You should also be an advocate for quality at the center.

"Are you as focused on quality and patient care as you expect the worker bees to be?" says Ms. Sturm. "You need to 'walk-the-walk' and really treat people well. Focus on safety and quality because that's what you expect from employees to create a positive culture."

2. Spend time in the break room. As surgery centers become larger and more staff members are brought on, it becomes increasingly difficult for upper leadership and physician partners to form a relationship with other staff members at the ASC. However, knowing each employee's name, successes and concerns are still important. One way to become more familiar with the employees and what goes on at the ground-level of the surgery center is by interacting with them in the employee break room.

"Physicians and administrators can sit in the employee lunch room and have their breaks with the employees," says Ms. Sturm. "They can rub shoulders and get to know a little bit about the non-clinical aspects of what goes on at the surgery center. The break room is where you really get your finger on the pulse of what is going on in the center."

3. Be selective in the hiring process. As you hire new employees, be selective about who you bring onto the team. Make sure they will fit into the positive culture you are trying to create at the center and add to the team as a whole.

"For the most part, surgery centers have a schedule that is very attractive to individuals and I think ASCs can be very selective about the employees they hire," says Ms. Sturm. "There is a tendency, especially among surgeons, to equate a good employee to having a great deal of experience and competence in what they do. You definitely want a good clinician, but the mandate needs to go a step further to be very passionate about the employees they hire."

Surgery centers must promote an expectation of excellence among their employees; employees must be competent and have good behavior. "It falls on the leaders of the organization to screen and hire employees who are good citizens and bring that professionalism and citizenship to the surgery center beyond just the clinical concepts," says Ms. Sturm.

4. Work on performance improvement for employees who don't fit. If you notice an employee who doesn't fit this culture of excellence — or someone who has been lagging more recently — introduce a strategy for performance improvement to help them get on track. Calling the program "Performance Improvement" suggests that you are giving them a chance to become better at what they do, not just saying they are unsalvageable.

"Identify where they need to be better, share the expectations with them very clearly and definitively and give them every opportunity to succeed, and help them succeed," says Ms. Sturm. "There can be great success stories when employees take their behavior to heart, reflect on that and really improve. Sometimes they do not improve and when they show you they are not able to change their behavior and act in a manner that isn't appropriate, they aren't a good fit for the center."

5. Let bad apples go. When employees refuse to change their behavior even after going through a performance improvement program, you must be willing to let them go. "Sometimes you will get a bad apple in the bunch and when you dwell on the expectations for someone and they still aren't a good fit, I am very passionate about letting them go," says Ms. Sturm. "The saying 'one bad apple can spoil the bunch' sounds trite, but it really can affect the well being of your department and surgery center."

Bad behavior can come from any employee, but is particularly prevalent among employees who were previously working in a hospital setting. "When they work in a hospital setting for a long time where there isn't the same expectation for good behavior, they can come into the surgery center and think it's business as usual," says Ms. Sturm. "They will have passive aggressive behavior that is really toxic in the ASC."

If you allow employees to continue their bad behavior without consequences, you risk other employees following suit. "When you let bad behaviors continue, you are sending a message to the other employees that it's okay," says Ms. Sturm. "The leaders aren't acting on the bad behavior and therefore they find it acceptable and it can become more of a norm than it should be."

6. Align leader and employee goals with reward. Aligning leadership and employee interest goes a long way to promoting a positive environment in the surgery center, and when the goals of both are met you can reward employees. The incentives can be minimal — such as a pizza party if patient satisfaction goals are met — but it really does make a difference.

"We are very fortunate that our SMP centers have boards of directors that are very much in line with the fact that when the centers are successful, employees are providing great patient care," says Ms. Sturm. "Our physician owners know that low infection rates and high patient satisfaction have a lot to do with employees doing the right thing. Providing rewards for reaching these goals demonstrates that the employees' hard work is recognized and valued."

7. Make sure there is a sense of "fun." Providing good healthcare to patients is serious and must be treated that way. However, the surgery center doesn't always have to be a serious place; inject a sense of "fun" into the center by making sure employees enjoy coming to work and take pride in what they do.

"While the business of surgery is very serious, the really successful surgery centers also create an environment where there is a sense of fun," says Ms. Sturm. "By that I mean an atmosphere where everyone enjoys themselves in the workplace."

One of the reasons why surgery centers are attractive to healthcare professionals, and often have high employee retention, is because employees are given the resources they need to do their jobs well. "They are given the appropriate equipment, supplies and nurse-to-staff and patient ratio that allows them to take pride in the care they provide," says Ms. Sturm. "They become very good at their craft." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

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9 Points on Recruiting New Physicians in Tough Markets

By Taryn Tawoda

Tony Stajduhar, president of the permanent physician recruitment division at Jackson & Coker, discusses four major market barriers surgery centers may face when recruiting new physicians.

Major market problems

1. Gastroenterologists and urologists are in high demand. The demand for particular specialists and subspecialists changes with the needs of patients and the availability of treatments. As the population continues to age, for example, there will be a heightened need for specialists like gastroenterologists and urologists, says Mr. Stajduhar. Demand for cardiovascular surgeons is decreasing, however, due to the availability of less invasive cardiology treatments.

A lack of new residency or fellowship programs for sorely-needed specialties will intensify future shortages, he says. "There are no major increases in medical school enrollment, and nothing comes close to settling the needs or demands for doctors going forward."

2. Rural markets lack appeal to physicians and their families. It is often difficult to attract physicians, spouses and children to towns with populations of 40,000 people or fewer, says Mr. Stajduhar. "I'd estimate that less than 10 percent of the physician population wants to practice in rural America, and with the current shortage of physicians, this will continue to get worse," he says.

Healthcare providers in smaller towns often have to compromise by partnering with a larger physician practice group in a major city that can send a physician to the rural community, he says.

3. Markets are oversaturated with ambulatory surgery centers. An overabundance of new and existing ambulatory surgery centers is a concern for Mr. Stajduhar. "There are so many people who have wanted to get into the ambulatory surgery center business," he says. "Five to 10 years ago, you would see one here and one there, but now, many groups are opening up ASCs." As competition among ambulatory surgery centers intensifies, it becomes more difficult to distinguish one center among others when recruiting in-demand specialists, he says.

4. Hospitals and ambulatory surgery centers are competing directly for specialists. It is not uncommon for an ambulatory surgery center to be located across the street from a hospital, which can leave both groups competing to recruit the same type of specialists, says Mr. Stajduhar. "When there's no joint venture, that definitely gets conflict going," he says.

Competitive recruitment strategies

Surgery centers in the above markets may need to employ creative and competitive recruitment strategies to distinguish their centers. The recruitment process should focus on building a relationship with the physician and portraying the surrounding community as a compatible fit — not just for the physicians, but for spouses and family members, too, says Gary Seaberg, director of strategic accounts at HEALTHeCAREERS.

"It's about the whole package – we tend to isolate, but physicians don't just want to come here to practice medicine," he says. "They want to be part of the community." Surgery centers that emphasize this sense of community will have an edge in recruiting physicians to more challenging areas.

Mr. Seaberg discusses five steps in relationship-focused recruitment.

1. Gauge the physician's interests ahead of time. An effective recruitment strategy goes beyond the act of practicing medicine and encompasses lifestyle factors that make a surgery center unique, says Mr. Seaberg. In order to paint an appealing lifestyle picture for the physician, it is important to first arrange a phone call to discuss personal interests. "I always recommend doing your due diligence ahead of time," he says.

The initial communication process typically begins with at least one phone conversation followed by an in-person meeting prior to touring the surgery center. "The purpose of the phone interview is to capture information and develop a relationship," he says, adding that phone conversations are always preferable to having the physician fill out an interest questionnaire. Voice and in-person interactions will create a more meaningful and memorable impression. "It's important to meet them ahead of time, as much in advance as you possibly can," he says.

2. Ensure that the physician speaks with members of the community who share mutual interests. Emphasizing mutual interests will allow the physician to envision a life in the surgery center's town. If a prospective physician is interested in golfing, for example, schedule a dinner with other members of the community who are active golfers, Mr. Seaberg says. "Create an interview process that lasts for several days — include dinners, tours of the community and discussions with others with similar interests," he says. "Make them feel welcome before they even move there."

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3. Accommodate the needs and interests of the physician's family. A recruiter should ask to speak with the physician's spouse in an initial phone conversation to gauge his or her interests, Mr. Seaberg says. The physician's spouse may oppose relocation altogether. "Some physicians meet their spouse in a major metro area, usually at medical school, and they may not want to move to a different location," he says. "You need to understand that factor when recruiting doctors to smaller towns, for instance."

If a physician has children, arrange a meeting with the local school superintendent during a visit, says Mr. Seaberg. Discuss the children's interests and which activities within the school district are compatible. "In small communities, it's not difficult to do this," he says. The same practice can be applied to religion — finding and highlighting the closest church can help convince the family that the community would be a good fit. "In one case, there wasn't a synagogue in a particular community, but there was one that we identified 75 miles away that the family could be a part of," he says.

4. Recruit physician assistants. Surgery centers staffed with at least one physician assistant will have a competitive advantage over those that do not have the extra help, says Mr. Seaberg. "Recruiting physician assistants is a huge selling point to a prospective physician" because they often allow physicians to see more patients, he says. "Patients can see a physician assistant who is under the supervision of a physician while that physician is in surgery. The patient can also do a lot of the pre- and post-surgical follow-ups with the physician assistant."

Though physician assistants are particularly advantageous in smaller communities, they appeal to physicians in both rural and metro areas, says Mr. Seaberg. As physician shortages continue, physician assistants will become increasingly valuable recruitment incentives. "There is a big need for physician assistants, and whoever has that competitive advantage will win," he says.

5. Never stop the recruiting process — even after the physician signs on. Recruitment should last indefinitely, particularly in smaller communities, says Mr. Seaberg. "You can't assume, 'Oh, we got this physician here. Now he will be happy and stay forever.' But you don't actually stop the process."

It is important to continue to schedule evaluations, social events and meetings with members of the community to keep the physician engaged. "An analogy would be the case of a politician who is always campaigning, always winning votes," Mr. Seaberg says. "When the vote actually does come up for that politician, you want to make sure that the voters know the right candidate."

As with politicians and voters, a surgery center that builds a community connection will increase the odds of physicians staying on board long-term. "You can recruit someone who is specifically there to practice medicine, but they won't stay long," he says. "They'll get discouraged and will leave as soon as something better comes along. But [building a relationship] creates a much better opportunity of maintaining longevity with that physician." ■

15 Statistics on Physician Compensation for Key Surgery Center Specialties

By Laura Miller

Here are 15 statistics on surgeon compensation for key ambulatory surgery center specialties based on data from Medscape's Physician Compensation Report 2012. The report is based on data collected in February 2012 and includes 24,216 physician respondents.

Orthopedists

1. 19 percent received $100,000 or less

2. 19 percent received $500,000 or more

3. Mean income was $315,000

Urologists

4. 19 percent received $100,000 or less

5. 14 percent received $500,000 or more

6. Mean income was $309,000

Gastroenterologists

7. 13 percent received $100,000 or less

8. 15 percent received $500,000 or more

9. Mean income was $303,000

Ophthalmologists

10. 21 percent received $100,000 or less

11. 4 percent received $500,000 or more

12. Mean income was $270,000

General surgery

13. 19 percent received $100,000 or less

14. 8 percent received $500,000 or more

15. Mean income was $265,000 ■

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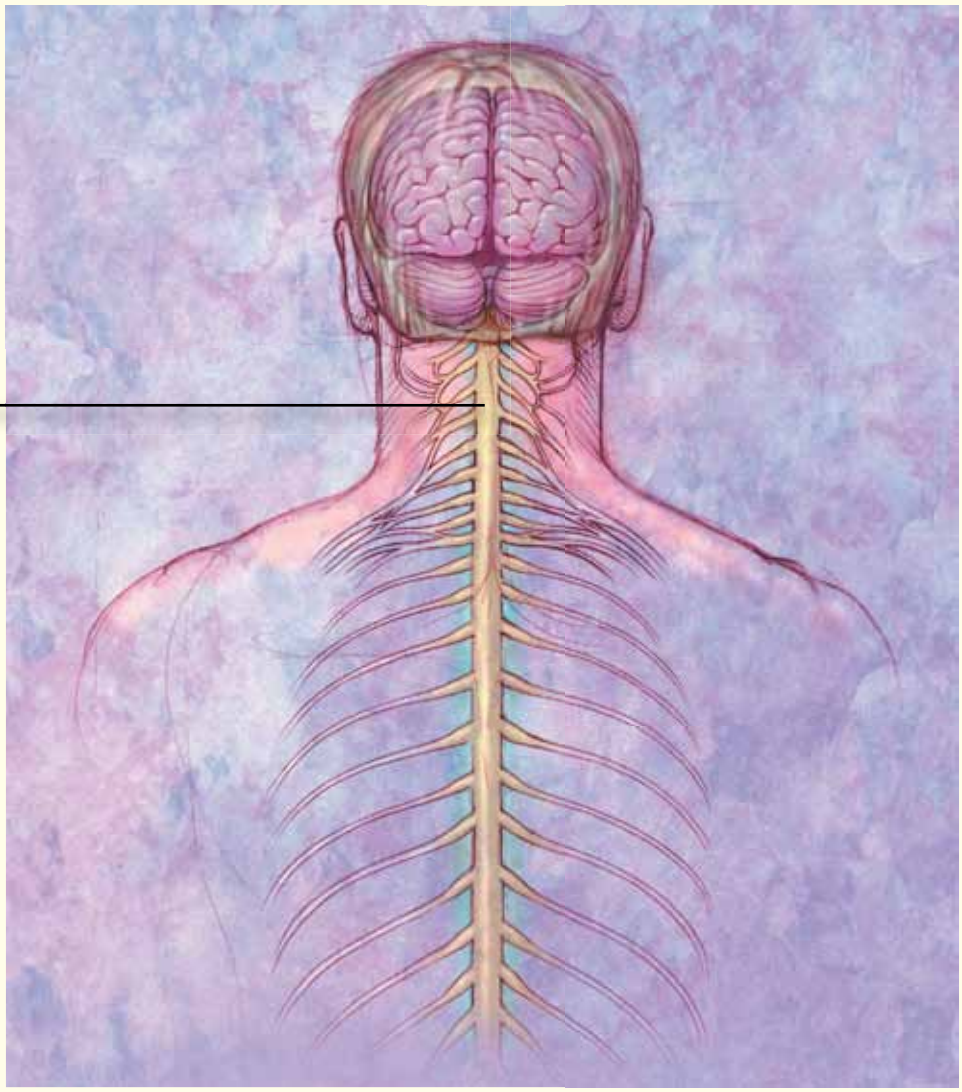

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