INSIDE: 20th Annual Ambulatory Surgery Centers Conference in Chicago Brochure

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Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

July/August 2013 • Vol. 2013 No. 6

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10 Strategies for ASC Success in Saturated Healthcare Markets

By Laura Miller

Here are 10 strategies for ambulatory surgery center administrators to experience success in healthcare saturated markets.

1. Achieve correct reimbursement. Many ambulatory surgery centers are signing in-network contracts with insurance companies because administrators feel it's necessary to stay viable in the market.

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123 Ambulatory Surgery Center Administrators to Know

By Laura Miller

Margaret Acker, RN, MSN, CASC is the administrator of Southwest Surgical Center in Grand Rapids, Mich., a multispecialty freestanding ASC, and the chair of the Michigan Ambulatory Surgery Association Membership Committee.

Traci Albers is the administrator of North Memorial Ambulatory Surgery Center at Maple Grove (Minn.) and High Pointe Surgery Center in Lake Elmo, Minn. She has more than 15 years of ASC and healthcare management experience.

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Driving Value in Spine Care: Outpatient Spine Surgery

By Richard N.W. Wohns, MD, JD, MBA, is Managing Member and Founder of Neospine

Over the past 20 years, an increasing number of spinal surgeries have transitioned from inpatient to outpatient. This is due to multiple factors including the evolution of minimally invasive spine surgery, improved anesthetic regimens, lower rates of infection and higher patient satisfaction when having surgery in outpatient facilities, and market forces — mainly the rising cost of healthcare.

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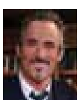
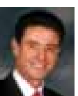
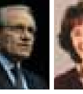
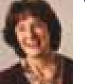

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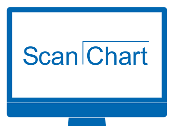

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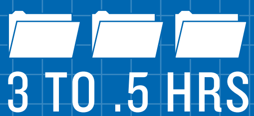

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July/August 2013 Vol. 2013 No. 6

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For information regarding *Becker's ASC Review, Becker's Hospital Review* or *Becker's Orthopedic & Spine Practice Review*, please call (800) 417-2035.

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Publisher's Letter

5 Key Trends for 2013

It has been a fascinating first half of the year in the healthcare industry. This letter briefly outlines what we think are five of the biggest issues facing hospitals and healthcare systems, surgery centers and physician practices this year.

1. High-Deductible Health Plans. The shifting focus to high deductible insurance plans by private employers is likely to seriously impact healthcare provider margins. As implementation of the Accountable Care Act begins, it is becoming clear that many employers will begin to move towards high-deductible health plans to keep their insurance costs down and avoid the so-called Cadillac tax, which imposes fees on employers who offer their employees high-end health plans. In fact, the *New York Times* reported on May 27, 2013 that in the last couple of years there has been a 6 percent jump in employers changing their plans due to the impending Cadillac tax. Moreover, it appears that many employers are considering or switching to high-deductible health plans. High-deductible health plans are likely to impact the healthcare industry by slowing consumer use of healthcare resources. While consumers do not yet have the tools or transparency to begin price shopping for their health services in the immediate future, high-deductible health plans will likely lead to more caution in consumer spending over time.

For a great synopsis of the impact of high-deductible plans on spending, see "*High Deductible Health Plan Study: Five Takeaways,"* California Healthcare Foundation.

2. Healthcare Exchanges. The development of healthcare exchanges is moving more slowly than expected. However, this slower pace in becoming operational may be good news for providers, as the healthcare exchanges will likely pay providers at lower rates for their services. Thus, the predicted migration of business from commercial payers to healthcare exchanges is an issue of great concern to providers.

For additional information on healthcare exchanges, please see "*Health Insurance – Exchanges Clarity Needed to Gauge Impact,*" Fitch Ratings in which Fitch Ratings notes that hospitals are likely to be paid lower amounts under healthcare exchanges than they receive from commercial insurance.

3. Healthcare Consolidation. While a number of independent hospitals remain steadfast in retaining their independence, we continue to see independent hospitals entering into discussions regarding mergers and affiliations with larger partners. Many hospitals remain very concerned about their ability to stay independent long-term in a changing environment where future reimbursement is uncertain. However, independent hospitals that can (1) be dominant in their independent market, (2) be operated in a very lean way, and/or (3) excel in a specific area may be able to stay independent for a long time.

For a different view of healthcare consolidation, please see "*Healthcare Consolidation May Bend to Cost Curve the Wrong Way,*" by Mitchell Brooks, March 16, 2012 at KevinMD.com.

4. Surgery Centers Remain a Good Business. There continues to be erosion of two key factors that comprise and drive revenue for surgery centers. Specifically, there continues to be a decline in physician cases and reimbursement rates. Essentially, there are a limited number of independent physicians available to invest in ASCs and reimbursement for surgery centers is not improving. In contrast, one positive development for surgery centers is that independent doctors are not becoming employed by hospitals as quickly as originally expected, particularly in key specialties. However, there are not as many new specialists today establishing large independent practices as there had been over the last 20

years. Furthermore, in many areas the surgery center market is relatively saturated and there are a limited number of independent physicians available to be owners in third-party ventures or buy into surgery centers because a large number of independent physicians already have ownership interests in other centers or are employed by a health system which prevents them from becoming owners in third-party ventures. Surgery centers are also facing the same reimbursement challenges that hospitals and health systems are facing, including the movement toward high-deductible health plans and healthcare exchanges.

5. Independent Practices and Physician Trends. Many independent physician practices, like independent hospitals, seem intent on remaining independent. However, practices seem to gravitate quickly towards hospital employment when their professional income decreases by even relatively small amounts. That stated, if an independent practice wishes to remain independent, it needs to: (1) be absolutely exceptional in its niche in its geographic area, (2) be very lean and be able to survive with the unknown changes in reimbursement, and/or (3) be so extraordinary in a specific area that it stands out in terms of patient need or payer need. Physician practices are also facing challenges with respect to specialist recruitment, as there remain shortages and surpluses of specialists depending on the market — some markets still have far more specialists than needed. In addition, it will be fascinating to see whether hospital-employed specialists' compensation continues to remain at the lofty levels it is now in the future, or whether hospitals will reduce employed specialists' compensation as reimbursement for hospital services declines over time due to changes in Medicare and the development of healthcare exchanges and high-deductible health plans.

We have two exciting events towards the end of year that will focus on and discuss a lot of these issues. For information on these events, please feel free to contact me by email at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com or Lauren Groeper at Becker's Healthcare lgroeper@beckershealthcare.com. Specifically, the 20th Annual Surgery Center Conference will be taking place October 27th through the 29th. We have great leaders in the surgery center industry scheduled to speak at the conference in addition to keynote speakers such as David Feherty, Rick Pitino, Bonnie Blaire and Bob Woodward. The conference is geared to administrators and physician owners. In addition, in the hospital arena, our 3rd Annual CEO Roundtable will be taking place at the Ritz Carlton on November 14th where we have scheduled an amazing, star studded lineup of hospital senior leadership to speak and discuss the most critical issues facing hospitals and health systems. For brochures on either event, please feel free to email me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com.

Very truly yours,

Scott Becker, Publisher

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10 Strategies for ASC Success in Healthcare Saturated Markets
(continued from page 1)

"It's become difficult for us because insurance companies are denying outpatient surgery, so it's hard to remain competitive," says Hooman Melamed, MD, an orthopedic spine surgeon at DISC Sports & Spine in Marina Del Rey, Calif. "And the rates they are willing to pay aren't conducive to performing cases in the outpatient setting. We have to take patients to the hospital where there is more of a risk for infection, less efficiency, less likely to get the one-on-one nursing, and less likely having the same experienced OR team as the surgery center."

However, contracts — whether in-network or out-of-network — shouldn't undercut surgery center costs. "ASCs must understand the out-of-network benefits to create a game plan to maximize benefits and profits," says Greg Maldonado, President of American National Medical Management. "If the ASC has correct reimbursement, it will attract new physicians and have the capital to purchase state-of-the-art equipment and form a comprehensive marketing strategy to attract patients."

2. Implement a continual improvement mindset. New regulations and healthcare reform updates are constantly coming from state and national governmental bodies, and they impact business for healthcare providers. While regulations seem like a roadblock, they also offer opportunity for innovation.

"I don't think anyone knows what is going to happen with healthcare reform, but you want to have a strategy for success," says Dr. Melamed. "One option is partnering with other big groups in the same specialty to gain bargaining power with insurance companies. If you have a 100-surgeon orthopedic and spine group, that's very powerful. It's happening in Chicago and I think that model will move to other parts of the country."

Develop strategies such as diversifying specialties to stay on the cutting-edge of the marketplace. "If you have the mindset where you are continually trying to improve — thinking about how to attract the patient and where new patients come from — then you'll be able to survive in the changing market," says Mr. Maldonado. "I always tell sales people not to wait for the ship to come in; instead, swim to it. You have to understand where the client base is, both in terms of new physicians and patients."

3. Network with referring physicians and other professionals. Hold a networking event between your specialty physicians and the referring primary care physicians in the community. Show off your facility and surgical skill so primary care physicians are more comfortable referring to your facility.

"You can educate them about the specialists, where the ASC is located and what separates your facility from other ASCs," says Mr. Maldonado. "When they can tell their patients that they have visited the surgery center and can assure them they'll be in good hands, these interactions dampen the fear of the unknown and help with patient retention."

This is also a great marketing tool for the specialist, and referring physicians will be able to visualize their patients at your facility after the open house. "Some primary care physicians have really great relationships with their patients, and the more at ease they can put the patient, the better their surgery will go," says Mr. Maldonado. "Then the patient can report back about the wonderful experience they had."

4. Strengthen the relationships you already have with physicians. In most markets, ASC administrators are battling for physician retention in an increasing trend toward hospital employment. Understand your ASC's niche in the community and constantly strengthen your relationships with current physicians so they keep bringing cases.

"We are working to maintain the relationships we currently have and looking at our facility to see if there is anything we can do to accommodate those physicians," says Maria Scenna, Group Vice President with Nueterra. "Right now we are competing with some of the large hospitals employing physicians, and this new generation of physician workers, and it helps that we are able to specialize and continue to attract surgeons we already have."

When you can show them there is high quality and a slim chance of error because it's more focused and specialized, surgeons are more comfortable as well.

5. Recruit new physicians constantly and tailor your facility toward the surgeons. To compete with hospital employment, many surgery centers are constantly on the hunt for new physicians and recruitment opportunities. Too often, new surgeons in the community or right out of fellowship think hospital employment is their only, or best, option without truly understanding the benefits of the ASC.

"We've been successful in recruiting new physicians to our facility by making it a pleasurable and smooth experience for them to perform cases here," says Ms. Scenna. "We make sure the personnel is consistent and surgeons have the tools and equipment they need to function efficiently. Their pref-

erences are tailored to meet their needs, unlike in a hospital where general operating rooms are large and multi-purpose."

Easier patient flow and higher satisfaction will attract new physicians as well because they want good scores from their patients. "Their satisfaction will be higher because patients enjoy the boutique experience," says Ms. Scenna. "Administrators should constantly round with physicians to make sure they have everything they need."

6. Avoid relationships that don't make sense. Healthcare reform was designed to encourage collaboration between all stakeholders in healthcare, but there are some situations where it doesn't make sense for ASCs to partner or align with other groups.

"Avoid insurance company and hospital relationships where the ASC won't benefit," says Mr. Maldonado. "If the insurance company wants to contract, do your due diligence to ensure it is not one-sided. You should always negotiate from your point of view, never from the buyer's point of view, because ultimately that relationship will be one-sided."

The same principles are important in hospital alignment or joint ventures with ASCs. Make sure those agreements and partnerships are not one-sided and benefit ASCs.

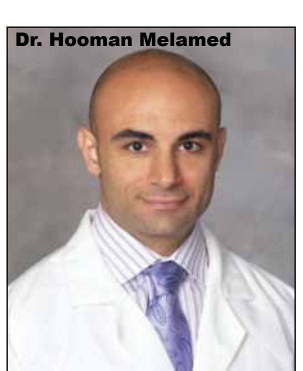
7. Identify new profit centers for ASCs. There are several opportunities for ASCs to add new profit centers and avoid a hospital take-over, including durable medical equipment. Speak with colleagues who have already implemented revenue-adding programs, such as DME, and work with physicians to understand these opportunities.

"It's about seeing the same number of patients but increasing profits by 20 percent or more," says Mr. Maldonado. "There are a lot of potential profit centers most ASCs are missing out on. They should be constantly seeking out new ways to increase profits."

8. Control costs with vendor negotiations. To effectively manage costs at surgery centers, administrators must negotiate supply costs down and make sure physician preference items aren't costing the ASC money. Administrators must always focus on cost-effectiveness so they can purchase new equipment and provide for surgeon needs.

"We work with vendors for pricing and stay focused on the specialties we do well," says Ms. Scenna. "To further drive costs down, we work with physician preferences and educate physicians on the supply differences so they can make the best choice for their patients. With the savings, we are able to spend more money on equipment and keep the rooms updated. We also create a pleasant atmosphere for the patients with the niceties it takes for a personalized experience."

9. Round with patients to improve satisfaction. Whether marketing directly to patients or the physicians who could perform cases at the ASC, high patient satisfaction is crucial. Patients desire a comfortable and welcoming environment where staff members are friendly and wait times are short.


Dr. Hooman Melamed

"We round with patients constantly to see whether they had a good experience," says Ms. Scenna. "We also make sure they have clear instructions for discharge and do everything possible to make it a personal experience."

10. Highlight the benefits of ASCs to the community. Let physicians and patients know how ASCs can benefit their healthcare, from the lower infection rate to faster recoveries from less invasive surgery. Both surgeons and patients are looking for a better healthcare experience than the standard hospital.

Greg Maldonado

"Surgery centers end up costing less because it's an outpatient procedure and patients don't have to return with infections or other complications. You are more likely to end up getting better nursing care and most likely the equipment in the OR is state-of-the-art and of course the overall efficiency is much better," says Dr. Melamed. "We talk about our abilities to perform minimally invasive spine surgery as an outpatient procedure, which a lot of people don't realize is possible."

Maria Scenna

DISC's marketing campaign includes athletes who return to full sports after outpatient surgery, as well as the new equipment and procedures surgeons perform there. ■

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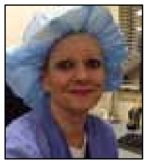
8 ASC Administrators on Efficiency at Their Centers

By Carrie Pallardy

Here eight ambulatory surgery center administrators discuss how their centers achieve high levels of efficiency.

Q: What are the most important factors that you find contribute to the overall efficiency of your ASC?



Leslie Cottrell, Administrator, Baptist Physicians Surgery Center (Lexington, Ky.). Our ASC opened with a clear vision of expectations and goals to promote excellent service and quality patient care. Accountability is reinforced throughout our facility from employees, management team, administrators and board of managers. Patients and providers have a choice of facilities which is reinforced to our employees. Customer service is essential to our success. Daily operational events are assessed to develop alternatives for improvements in providing an efficient and empathetic environment with the highest level of patient care.

Lucinda Hay, Managing Director, Center for Specialty Care (New York). At the Center for Specialty Care, we strive to: coordinate staff hours to maximize productivity and minimize cost; consolidate OR scheduling to maximize efficiency; and to minimize inventory and manage supply costs on a daily basis. Of course, on-time starts and quick OR turnaround times help keep delays to a minimum. We have a flat management model which allows for direct, quick communication between departments and from all staff directly to the CEO. Physicians also feel free to discuss any issues from equipment to staffing with any staff member and that information is communicated to the appropriate individual, department head or CEO. We are unusual because we are a non-hospital, non-physician, family-owned business. This frees the center to focus on the 'big picture'. Decisions can be implemented quickly, in some cases within hours.

Bruce Kupper, CEO of MEDARVA Healthcare, Stony Point Surgery Center (Richmond, Va.). First and foremost, our efficiency is driven by the fact that we hire experienced nurses, operating room techs and anesthesia providers. Our staff members are confident in their clinical and organizational skills. We have also designed our stations and systems around the needs of the staff so they don't have to walk a long way to get things. One of the newest things I'm excited about is a patient tracking software program we recently implemented that works on a touch screen display. The program was developed in-house by our staff and lets us know when patients arrive, if they've been registered, when they are in pre-op, what order they are in for surgery, if they're in the operating room and when they are in post-op. All the information presented on multiple monitors throughout our facility that can be accessed by our staff and the physicians. We are more efficient by establishing a strong relationship between the pre-op and OR teams, eliminating a dividing line that can sometimes exist between the two groups and it all starts with training and communication.

Jeff Wigton, Director of Operations, Central Maine Orthopaedics (Auburn). We have done a lot to improve efficiency within the last year. We have worked to prepare for the unplanned, which can be extremely detrimental to timing in an ASC. It is critical to focus on preoperative patient management, which can be instrumental in avoiding last minute cancellations. Preparing ahead of time is also key from a patient satisfaction stand point. We work to do all intake at the point of service, know anything that will complicate the perioperative work ahead of time and avoid chasing down information after the patient has already undergone a procedure. The better trained your staff is, the less you have to go back and redo work. Our center concentrates on performing the day-to-day tasks correctly the first time.

Keith Smith, MD, Administrator, Surgery Center of Oklahoma (Oklahoma City). An anesthesiologist is in charge of the schedule and our schedule is blocked. We have also overstaffed such that each surgeon generally has two full OR crews and more than one anesthesiologist. This makes for extremely efficient use of the facility.

Ann Cariker, Administrator, Great Basin Surgical Center (Elko, Nev.). We take into consideration the efficiency of our surgery center based on parameters and guidelines that measure quality and safety, physician needs and satisfaction, employee engagement and satisfaction, customer satisfaction, and financial processes. Our quality and safety measures are based on national benchmarking standards and evidence-based medicine. All staff are involved in quality improvement. For example, hand hygiene compliance is a component of all employee evaluations. We ensure cross training of all employees so that staffing issues are not problematic. Each center manager meets with direct reports and/or customers on a one-to-one basis at least once a month to determine individual needs and recognize those employees and medical staff members that demonstrate excellent customer service. Every employee and medical staff member that takes part in a patient's care signs a "Thank You" card, which is mailed to the patient's home. Financial components of the center are reviewed daily, including AR tracking and trending, cash collections, timely billing, complete insurance information and any other details that could impact appropriate payment. The administrator and business office manager meet every day to review all the aspects of the reimbursement process. If you align the employees and medical staff, hold people accountable for their actions and communicate frequently, an organization is on the right path.

Brad Harmon, Administrator, Northern California Surgery Center (Turlock, Calif.). Ambulatory surgery centers have a big advantage over hospitals. Physicians are able to save more time, patients are generally healthier, turnaround time is much quicker and the atmosphere tends to be much more personal. We have cross-trained our team in all areas. Every surgical staff member has the capability to provide support in the pre-operative and post-operative areas. Our center also uses Medical Passport, which allows patients to provide their medical background online prior to coming in for their procedure. Our nurses don't need to spend time chasing down the information after the patient has already arrived. The national average for hours spent on a case is 12 and we currently operate at seven to six hours per case. Physician supplies are standardized. We review supply costs and present the lower cost options to our physicians. We collaborate and switch to lower costs where we can. It is all of the little things that save time and money. We look at saving a few dollars and few minutes where we can and it all adds up.

Sonja Christmas, Administrator, Cy-Fair Surgery Center (Houston). Here at Cy-Fair Surgery Center we work together as a team; each employee fills a specific niche and has cross training to help out in any area that needs it. The center handles its own billing, collecting, insurance claims and medical records. The endoscopy room is the first area of the center to transition to EHR and each new patient file is scanned to be saved in electronic form. The staff meets formally once a month to discuss how the center is running and often meets once a week as needed. Every staff member is self-sufficient. Cy-Fair surgery center averages 60 to 80 procedures a week done by about 20 physicians. ■

6 Key Strategies for Administrators to Bring ASCs Into the New Era of Healthcare

By Laura Miller

Healthcare is constantly changing and surgery center leaders must develop a strategy for success.

"We are seeing a lot of change in this environment, not only within the healthcare arena but also within the small businesses arena," says Charles Dailey, vice president of development for ASD Management. "Operations with 100 employees or less need to take a proactive approach to meeting today's challenges."

Here are six strategies for ambulatory surgery center administrators to bring their ASC into the new era of healthcare reform.

1. Focus on facility operations. Since opening in 1986, ASD Management has attributed much of its success to focusing on facility operations. Whether improving risk management, clinical operations or business office functions, affiliated surgery centers have flourished because of this narrow focus.

"We have established a core set of systems that really provide improvements within all aspects of the surgery center," says Mr. Dailey. "The bottom line in our job is increasing revenue and managing decreasing expenses. Those are the two parts of the game, and by doing them well we are able to achieve financial success."

Fine-tuning the operational systems at ASCs allows each administrator to customize systems that work best for them.

2. Stay flexible for rapid changes. Healthcare providers are facing a slew of new challenges today, and more coming right around the corner. Quality reporting, ICD-10 transitions and meaningful use attestation are a few of the most significant changes for ASC staff and surgeons; administrators must develop a strategy to make big changes and small tweaks to their process accommodating for surgeon and staff needs.

"We have done a good job with this in the past and now we have to do even better based on today's healthcare environment," says Mr. Dailey. "Very rapid changes are coming to us. We are looking at the advent of ICD-10 and we need to properly bill and code. We're looking at changes in regulations which will ultimately impact profitability."

Administrators, physician investors and corporate partners must take a hands-on approach to ensure everyone at the ASC has the right tools to complete their jobs efficiently and effectively.

3. Use financial analytics to optimize accounts receivable. Financial analytics are imperative to identify, evaluate and address strengths and weaknesses at the center. Place special focus on the revenue cycle data to uncover issues that could save your center from future disaster.

"Use a computer dashboard to proactively approach revenue cycle data and take a very deep look into your process," says Mr. Dailey. "We are conducting a forensic approach to really turn over every stone and make sure we are receiving all reimbursement possible. Look at A/R and collection practices with computerized programs. We are using those tools to give us visibility and make decisions about what we find."

4. Maximize expenses. Be proactive about maximizing expenses wherever the ASC can afford additional savings. For example, look at the supply chain and consider going through a group purchasing organization to maximize savings.

"Going through a GPO and reaching out to some of our major spend companies to renegotiate contracts are how we might maximize expenses in supply chain," says Mr. Dailey. "Be aggressive to achieve the best discounts. We are also taking it a step further in the world of orthopedics and embracing the concept of generic implants for products considered commodities. By taking a serious look at costs, we are able to cut down our expenses."

Many surgery centers are experiencing revenue cut backs today, and truly maximizing expenses at every opportunity will offset some of this loss.

5. Approach risk management proactively. It will be important to minimize risk going forward. Make sure everyone at your surgery center is compliant and assign a person, or team, to make sure your center is updated with all regulatory changes coming down the pipe.

"We are taking a really close look at our risk management programs to minimize the potential for issues," says Mr. Dailey. "We want to ensure proper coding and affirm all licensing is accurate, and we also want to take the extra steps to identify key regulatory areas are being updated and adhered to. We've hired extra clinical administrators to go into the centers and conduct audits to make sure we are compliant."

Charles Dailey

6. Address human resources issues like a small business. Most ASCs have less than 100 employees, so they are considered small businesses. Under the Affordable Care Act, any small business with less than 100 employees will likely see insurance policies and human resources expenses skyrocket in the near future.

"From a management point of view, we are proactively doing research on how to deal with these issues and purchase insurance policies that are focused on healthcare and distributed by wholesalers," says Mr. Dailey. "We're looking for vendors selling insurance packages focused on the healthcare industry with valued benefits at a discounted rate. We are working with several organizations to achieve better deals for employees."

Mr. Dailey and his team are looking at small businesses around the country — not just within healthcare — to create and implement benefits plans and model human resources functions. ■

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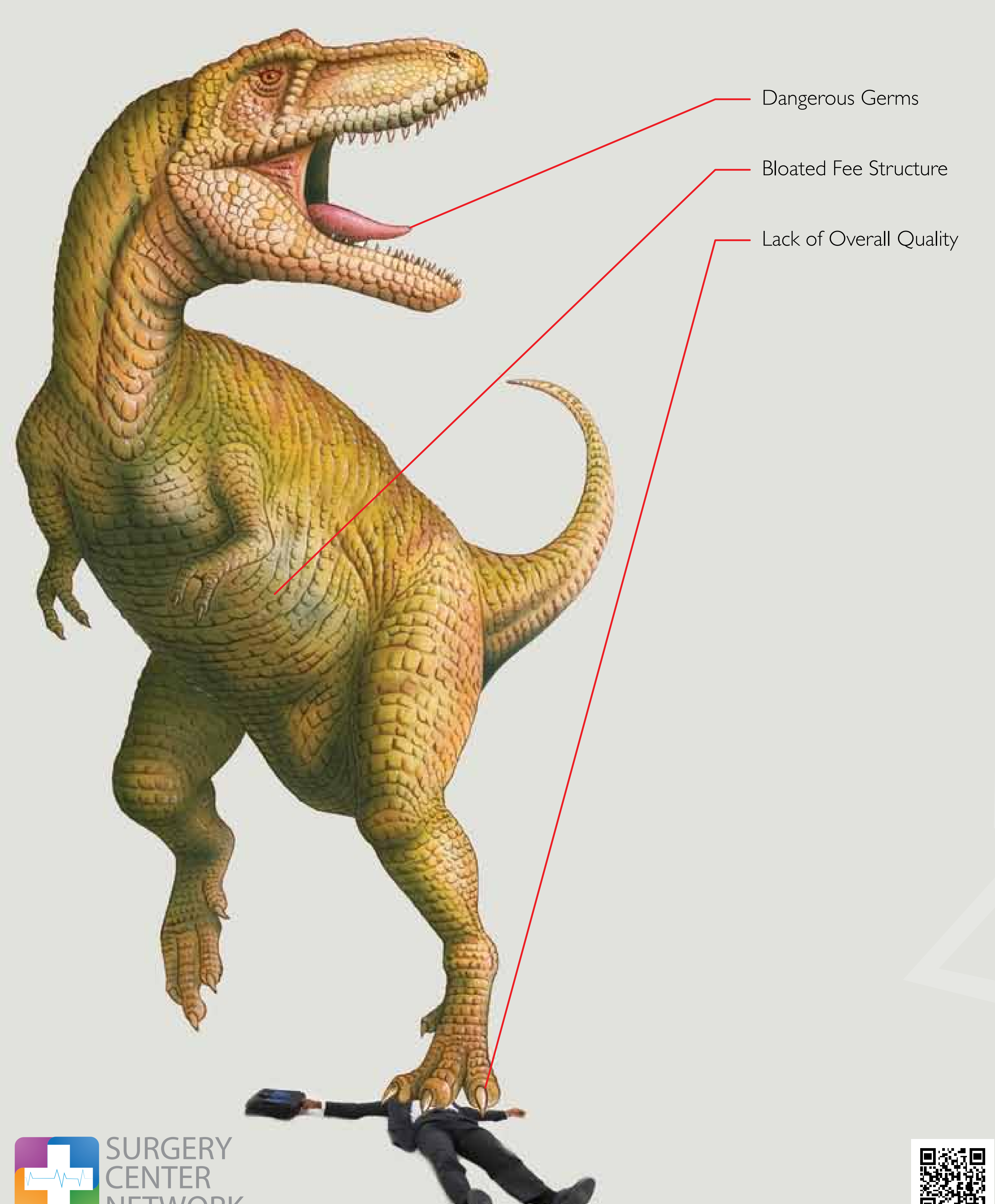

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5 Ideas to Engage Surgeons With Surgery Centers Throughout the Year

By Laura Miller

Kathy Kelly, facility administrator at Viewmont Surgery Center in Hickory, N.C., discusses how she keeps surgeons and staff engaged and excited about her center.

1. Hold an employer open house. Viewmont Surgery Center hosted an employer open house earlier this year for area employers with 100-plus employees to see the facility. The physicians were involved in planning the event.

"Our physicians were very involved in recruiting to make sure the open house was a success," says Ms. Kelly. "We did a short presentation during the open house about the outpatient surgical facilities, cost benefits of coming to an ASC versus the hospital and gave a tour of the facility. The physicians were there to speak with the employers and appreciated staff members who were also at the event to support them."

Many of the employers attending the event had visited the surgeons in the past and were able to connect with them at a different level outside of their offices. "They were able to speak with our surgeons one-on-one in a more relaxed, but still professional, setting about why they liked bringing cases here," says Ms. Kelly.

2. Tap surgeons for marketing ideas. More healthcare providers are finding creative ways to market within their community. Reach out to your surgeons for support in marketing campaigns and ideas about how to best promote the center.

"We had some posters made that were designed and created by our physicians," says Ms Kelly. "They were published for a time and now we have them hanging in the office for each main service we provide. As soon as patients come in, they see huge wall posters about orthopedics, ENT and pain management."

3. Place surgeons on different committees. All surgeons at Viewmont Surgery Center serve on committees focusing on quality, performance improvement and other management areas. Surgeons also serve on the board of directors to give feedback on clinical decisions such as equipment purchases and process updates.

"We have meetings once per quarter and elected committee positions are renewed every year," says Ms. Kelly. "Surgeons are elected by their peers to serve. We also have an open door policy for new ideas, so if there's an issue we can take it to the board for a consensus."

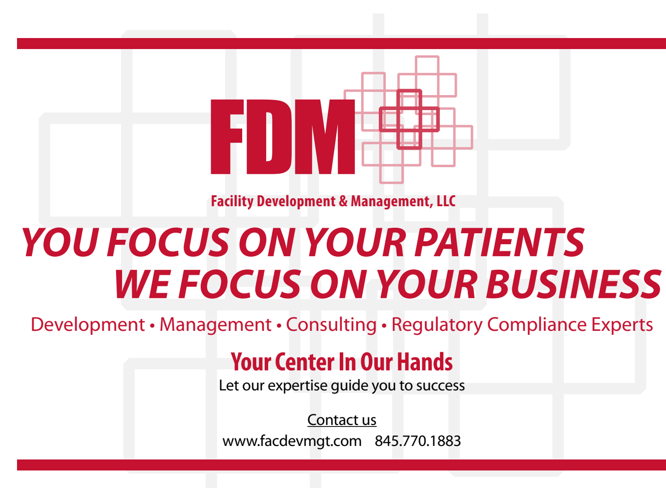
Surgeons have an open invitation to board and committee meetings whether they are board members or not. Annual shareholder meetings also provide an opportunity for all surgeons to gather and share ideas and updates on the center.

4. Become easily accessible to surgeons. Administrators at the surgery center should be easily accessible to their surgeons. Ms. Kelly has an office in the back of the facility near the operating rooms, so surgeons always walk past her office to get patients and once in a while they'll drop in to discuss something that isn't working.

Kathy Kelly

5. Build a team culture at the ASC. It's important for shareholders to be happy, but don't forget to accommodate non-shareholders as well. All surgeons and staff members should feel like they are part of a team providing excellent care and a quality patient experience at the ASC.

"Our surgeons know the staff is competent and that's what keeps them coming back; they know they're part of the team," says Ms. Kelly. "We try to get everyone's input and make everyone happy. Since we are small, patients remember who the surgeons and staff members are." ■



Insurance Plan Options for ASC Staff: 3 Plans to Consider

By Laura Miller

Finding the right employee insurance plan depends on the size of your ambulatory surgery center and demographic of staff members participating. Businesses today are either choosing to self insure or offer low- and high-deductible health plans. However, multiple options should be available.

"Most ASCs offer at least two options for their employees," says John Merski Jr., executive director of human resources at MedHQ. "If a company is offering just a single healthcare option, they are limiting options for their employees. The two options at minimum should be the low- and high-deductible plans. That will help their employees be more informed consumers in the future."

Here are the pros and cons of each option, and what employees should consider when they are deciding on each.

1. Low-deductible PPO plans. The more traditional low deductible PPO plans are ideal for employees who may have large medical expenses and need a high amount of coverage throughout the year.

"Those that have children, families or who are sickly tend to take the PPO offerings because they have a lower deductible," says Mr. Merski. "It costs more in the premium, but the deductible is lower and they can plan accordingly. However, if the employer pays the same amount for both plans and the out-of-pocket payroll deduction is the same, everyone will take the low-deductible plan."

Those with modest to few health issues who are just looking to cover annual check-ups will likely benefit more from high-deductible plans.

2. High-deductible health savings accounts. The more common high deductible plan today is health savings accounts, which allow the employees to set money aside in their own account and withdraw funds when necessary. Usually, these accounts are closer to $1,500 to $5,000 individual deductible level plans.

"If you have young healthy employees, a lot of the groups will choose HSA plans because they don't visit the doctor as much," says Mr. Merski. "They can stockpile money for the time when they do get ill. These plans also keep costs under control to some extent."

HSAs transfer savings from year to year as the funds accumulate. The high deductible plans have lower rates because the employer takes on more risk.

3. Self-insured plans. Most ambulatory surgery centers will not have self-insured plans because they don't have the volume of employees necessary to mitigate risk. A self-insured plan is usually for companies with populations in excess of 75 or more employees.

"If you have a very high risk employee population that has a considerable amount of healthcare issues, going to a self-insured plan generally don't make it," says Mr. Merski. "The expense would be enormous and the resource limitations would place considerable burden on the ASC. They should consider the fully insured plans instead because they are mixing with larger groups and the insurance company is taking some of the risk."

Self-insured plans are usually cheaper than fully-insured plans because the employer doesn't have to share risk with insurance companies; on the other hand, the liability does pose other risks for their employees under the self insured plans and most ASCs choose not to use resources in this way. ■

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5 Strategies for Effective ASC External Benchmarking

By Julie Jung, RN, MSN, VP Clinical Services and Accreditation, Outpatient Strategies & ASC Strategies

There are a number of different stories about the origin of the term "benchmarking," including one that links the first use of the term to shoe cobblers. Cobblers would take a person's foot and place it on a bench. They would then make marks on their benches to designate a certain size. This "bench mark" was used for comparison and helped ensure shoes of a particular size would fit clients.

ASCs also use benchmarks as a means of comparison. External benchmarking, which is a comparison of an ASC's performance against the performance of other ASCs and providers, is a particularly effective method to analyze an ASC's performance, identify areas for improvement and validate processes. Benchmarking is also a regulatory compliance requirement. Medicare, state agencies and accrediting bodies mandate this activity to ensure centers are evaluating ways to provide efficient, effective and safe patient care.

Many ASCs struggle to identify topics for worthwhile benchmarking studies. Follow these five strategies to come up with strong ideas for consideration.

1. Ask the organization's governing board for benchmarking suggestions. It is a Medicare requirement that a surgery center's governing body has complete oversight of the organization, including the receipt of a benchmarking activities report. During governing board meetings, it would be appropriate to ask about ideas for formal benchmarking. Is there something the physicians would like reviewed and compared?

Julie Jung

When board members are involved in suggesting benchmarking activities, they may be more interested in the results, and more likely to participate in development and implementation of improvements if needed.

2. Ask the ASC staff for benchmarking suggestions. As with governing board meetings, when there are staff meetings, ask employees if they have suggestions for benchmarking topics. During the usual business of a staff meeting, as reports are presented, this might trigger ideas based on the topics of discussion. In addition, encourage staff members to bring ideas to future meetings.

Note: If an employee suggests a benchmarking topic because of a specific event or a change seen in quality indicator data, before developing a benchmarking activity around the topic, first determine whether these events are indicative of an ongoing trend and indeed worthy of more attention or if an isolated incident is to blame.

3. Identify topics through surveys and reports. Benchmarking ideas don't necessarily have to be presented verbally. They might also be found in writing.

Look for potential topics when reviewing patient, physician and employee satisfaction surveys; infection/complication surveys from physicians; and any other center-specific reports, including those related to financials. Benchmarking doesn't have to be — and shouldn't just be — related to clinical areas.

4. Participate in large benchmarking projects. There's certainly nothing wrong with benchmarking an organization's performance against a single or few ASCs, but this will only provide a small sample size. By participating in benchmarking activities with hundreds of organizations, there is a much larger population with which to compare the ASC.

For example, the ASC Association has an Outcomes Monitoring Project, which has more than 650 participants and provides benchmarks for more than 40 key indicators. The accreditors often have benchmarking activities, such as those developed by the AAAHC Institute for Quality Improvement. There are also companies that provide benchmarking services to ASCs, such as Voyance (formerly CTQ Solutions), Surgical Outcomes Information Exchange and Press Ganey.

5. Make comparisons with specialty society data. Benchmarking activities do not need to always compare the entire ASC's performance. An excellent external benchmark is using the performance metrics of specialty organizations. One can often find data from societies about specific procedures. For example, when comparing tourniquet time for knee arthroscopies, it would be appropriate and meaningful to review what national orthopedic associations have discovered thru their collection of this data.

Make benchmarking an ongoing effort

Benchmarking — whether it is internal or external — is not an activity to be performed once a year or conducted just to meet regulatory requirements. To achieve and maximize the benefits of benchmarking, ASCs should constantly and consistently work on their benchmarking. This includes data collection and analysis as well as identifying new opportunities for strong benchmarking activities. ASCs that make benchmarking a priority are more likely to identify areas in need of change and achieve significant improvements in all aspects of their operations over time. ■

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How Healthy Is the ASC Transaction Market? Q&A With Colin McDermott of VMG Health

By Heather Linder

Colin McDermott, CFA, CPA, is a senior manager for Dallas-based VMG Health. He specializes in healthcare financial, valuation and transaction issues.

Here Mr. McDermott discusses current trends in the ASC transaction industry, as well as how surgery centers can improve their valuation and market share.

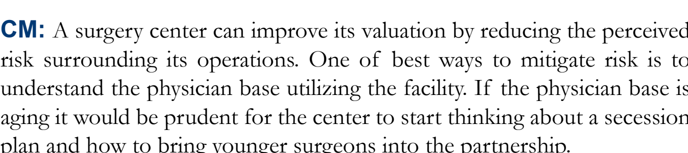
Question: What transaction trends are you currently seeing with surgery centers? Are ASCs still selling to hospitals or has that tapered off?

Colin McDermott: The transaction environment for free-standing ambulatory centers is strong. AmSurg Corporation recently reported that their acquisition pipeline is still robust and indicted that valuations remain in the 6.0 to 7.0x EBITDA range for a controlling interest in a single ambulatory center. This is consistent with what VMG has seen in the marketplace.

Additionally, the transaction environment for ASCs selling to hospitals is still prevalent. With uncertainty due to the consolidation of primary care and specialty physician practices, along with potential reimbursement pressures caused by healthcare reform, it is a proactive strategy for a stand-alone surgery centers to affiliate with a partner, either a hospital or a management company.

Q: What are options for physician owners looking to shift ownership or bring on business help without entirely selling to a hospital or management group?

CM: If physicians are looking to monetize their ownership interest in an ASC but are not interested in selling to a hospital or management company then the only remaining option would be for them to sell their ownership to new physicians. This strategy provides two benefits to the seller. It allows the seller to monetize some of their holdings along with securing future utilization of the facility by new physicians. It is very important to the long term viability of the ASC that young surgeons are provided the opportunity to invest in the facility. If the ASC has a young diversified group of physicians utilizing the facility that typically reflects positively on the future value of the business.


Colin McDermott

Q: What are some tips for surgery centers to improve their valuation? How does physician recruitment play into valuation?

CM: A surgery center can improve its valuation by reducing the perceived risk surrounding its operations. One of best ways to mitigate risk is to understand the physician base utilizing the facility. If the physician base is aging it would be prudent for the center to start thinking about a secession plan and how to bring younger surgeons into the partnership.

Q: How can ASCs become more enticing to physicians?

CM: The key to physician satisfaction in an ambulatory surgery center partnership is having a collaborative decision-making process. Often physicians own less than 50 percent in an ASC, but allowing the physicians to actively participate in important strategic decisions (e.g. new equipment purchases, operating room expansion, involvement in doctor recruitment, etc.) will create an operating environment that is more enticing to the physicians.

Q: Are you still seeing surgery centers seek an affiliation for increased reimbursement rates? Is this an effective strategy? Why or why not?

CM: Although reimbursement is one motivating factor influencing an affiliation, it's not the only benefit. AmSurg recently announced a joint venture with BayCare in Tampa, Fla. While the concept of a hospital establishing a JV with a national chain is not new, this is not a strategy that AmSurg has utilized historically. AmSurg realizes that BayCare has expertise in a particular market while AmSurg brings expertise in the operation of outpatient surgery centers so both parties benefit. Therefore, it can be very effective for a stand-alone ASC to bring in a strategic partner that might assist in managed care contracting, expense management or other areas where operations can be improved. ■

12 Recent Surgery Center Openings & Announcements

By Carrie Pallardy

Fairview in Hibbing and board-certified ophthalmologist Bridget Sundell, MD, have announced they will open the joint venture **Northwoods Surgery Center** in Virginia, Minn.

Farber Plastic Surgery Center, founded by board-certified plastic surgeon Scott Farber, MD, has opened a new cosmetic and reconstructive surgery center in Boca Raton, Fla.

Frontier Endoscopy has announced the opening of **Flushing (N.Y.) Endoscopy Center**, which is the fourth ambulatory surgery center the management and development company has opened since February this year.

Dingmans Medical in Dingmans Ferry, Pa., has proposed a $2.5 million expansion initiative, which would include the addition of an ambulatory surgery center.

The **Veterans Administration** has announced plans to develop an 84,000-square-foot, $14.6 million outpatient surgery center in New York.

Malcom Grow Medical Clinic & Surgery Center at Joint Base Andrews, Md., intends to develop a 345,000-square-foot, $266 million facility that will include an ambulatory care and surgery center.

Carolinas Center for Oral & Facial Surgery has opened a fifth location in Charlotte, N.C.

Hoopes Vision has opened **EyeSurg of Utah**, an ambulatory surgery center in Draper.

Ross Clevens, MD, has opened the **Clevens Center for Facial Cosmetic Surgery and Wellness Center** in Melbourne, Fla.

LASIK Vision Institute has opened **Long Island LASIK Eye Surgery Center** in Garden City, N.Y.

Lexington (Ky.) Clinic has opened the **Endoscopy and Surgical Center of Lexington Clinic.**

The Minnetonka Planning Commission has granted **Minnesota Eye Consultants** approval for a 31,000-square-foot project, which will house the practice's ambulatory surgery center, clinic and offices. ■

123 Ambulatory Surgery Center Administrators to Know

123 Ambulatory Surgery Center Administrators to Know
(continued from page 1)

Kathleen Allman, CASC is the CEO of Millennium Surgery Center in Bakersfield, Calif., a position she's held since 1999. Within two years of her arrival, the center was opening seven cost centers at Mercy Southwest Hospital.

Kim Andry, CASC is the administrator at Great Lakes Surgical Center in Southfield, Mich. She has been a member of the leadership team of the Michigan ASC Association.

Vickie Arjoyan is the administrator and director of Specialty Surgical of Beverly Hills in Los Angeles. The surgery center is affiliated with Symbion Healthcare.

Brent Ashby, CASC is the administrator of two surgery centers — Audubon Surgery Center and Audubon ASC at St. Francis, both located in Colorado Springs, Colo. The two Audubon centers contain 15 ORs and four procedure rooms between them and perform an estimated 19,000 cases annually.

Cathy Atwater serves as the administrator of Banner Health-Union Hills Surgery Center and Banner Thunderbird Surgery Center in Peoria, Ariz., positions she has held since January 2010 and February 2005, respectively.

Beverly Baker has served as the administrator of the Timberlake Surgery Center in Chesterfield, Mo., since 2008. She was instrumental with the new facility's start-up phase and achieving a three-year accreditation with AAAHC.

Rob Bashore is the administrator of Same Day SurgiCenter in Orlando. During his time there, the center has achieved three-year re-accreditation from AAAHC and increased its EBITDA.

Tracey Baughey is administrator at Laser Spine Institute in Wayne, Pa. With more than 27 years of administration and management experience, she brings a great deal of knowledge and insight to the clinical operations of the ASC.

Linda Beaver, RN, MSN, MHA serves as administrator of Gateway Endoscopy Center, a busy endoscopy facility in western St. Louis County managed by United Surgical Partners International. Under her leadership, Gateway Endoscopy Center obtained accreditation by AAAHC.

Christine Behm, BSN, CASC has served as the administrator of San BuenaVentura Surgery Center in Venture, Calif., 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.

Jeffrey Bernhardt is the clinical director at Main Street Specialty Surgery Center in Orange County, Calif., a position he has held since March 2002. He has more than 37 years of experience in healthcare and has been a manager in the operating room for more than 25 years.

Sandy Berreth, RN, MS, CASC serves as the administrator of Brainerd Lakes Surgery Center in Baxter, Minn. She has been in the ambulatory surgery management arena for 13 years and has worked at her current center since 2004.

Josh Billstein spent 10 years as a clinician and practice manager at a busy physician clinic before joining The Polyclinic in Seattle in June 2010. He currently serves as a board member of the Washington Ambulatory Surgery Center Association.

Stephen E. Blake, JD, MBA, CPA serves as the administrator of Central Park Surgery Center in Arlington, Texas, a 100-percent physician-owned facility. He also serves on the Texas ASC Society Board of Directors and completed his term as the society's president.

Chris E. Bockelman, CPA has served as administrator of Foundation Surgery Center in Oklahoma City since April 2010. During his time at the center, he has increased case volume by recruiting three new surgeons previously considered "unattainable."

Rick Bonenfant is the administrator at Brevard Specialty Surgical Center in Melbourne, Fla., a multispecialty ASC with 10 physician owners. The center is affiliated with Ambulatory Surgical Centers of America.

Betty Bozzuto, RN, MBA, CASC is executive director of Naugatuck Valley Surgical Center in Waterbury, Conn., and former president and a founding member of the Connecticut Association of Ambulatory Surgery Centers.

Rick Brochu joined The Surgery Center of Genesee County in Flint, Mich., in 2007. He helped the center move away from a significant volume of pain management, as site-of-service differentials push pain business into physician offices.

John D. Brock, MSHA has been the administrator of NorthStar Surgical Center in Lubbuck, Texas for 7.5 years. He has grown case volume, syndicated multiple new physician partners, added a new service line in gastric lap banding and opened a sixth OR.

Jennifer Butterfield, RN, BSN, CNOR is the administrator of West Bloomfield (Mich.) Surgery Center, a multispecialty ASC. 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 is the administrator of Physicians Day Surgery Center in Naples, Fla. Case volume at Physicians Day Surgery Center rose 50 percent due to the recruitment of several new physicians during her time at the center.

Connie Casey is the administrator of Northpoint Surgery and Laser Center, the first physician-owned

surgery center in the West Palm Beach, Fla., area. She credits her center's success to its dedicated employees, many of whom have been with the center for more than 10 years.

Chris Collins, RN, BSHCA has been with Metropolitan Surgery Center in Hackensack, N.J., since January 2012, when the facility was acquired by UPSI. Prior to his current role, he worked in another New Jersey surgery center and did in-hospital ambulatory work for 20 years.

Cynthia Condron serves as the administrator of South Shore Surgery Center in Bay Shore, N.Y., a facility that opened in collaboration with ASCOA in December 2010. She has more than 15 years of experience in healthcare.

Michael Cox, PhD, FCSM is the CEO of Central Maine Orthopaedics in Auburn, Maine, which includes an ASC. He has held the position since 2008 and has overseen several initiatives to grow the center.

Rebecca Craig, RN, CNOR, CASC, CPC-H is CEO of Harmony Surgery Center in Fort Collins, Colo., a multispecialty, Joint Commission-accredited ASC. Ms. Craig helped to open the joint venture center 12 years ago.

Tracy Cregg CASC is the administrator of Surgery Center of Silverdale (Wash.). She was initially hired as the center's business manager before it opened in May 2007 and was promoted to administrator in February 2009, and has since added specialties and continued AAAHC accreditation.

Dan Cresco, PT is a Group Administrator of the Wauwatosa (Wis.) Surgery Center and Wausau Surgery Center, both partnerships among physician groups and Surgical Care Affiliates (SCA). He attributes his facilities' success to his management company and physician partners.

Deborah Lee Crook, RN, CASC is administrator for Valley Ambulatory Surgery Center & Valley Medical Inn in St. Charles, Ill., a seven-OR, multispecialty surgical facility with an attached post-surgical recovery care center.

Dean Daringer, MBA has more than 20 years of experience in healthcare administration, specializing in joint venture ASC start-ups, as well as problematic centers. She is administrator for Surgery Center of Chester County (Pa.).

Louise Dechesser, RN, MS, CNOR is administrator of MAOS Middlesex Center for Advanced Orthopedic Surgery in Middleton, Conn. She has more than 20 years of experience as a surgery center administrator and 40 years of healthcare leadership experience.

Gregory DeConciliis, PA-C, CASC, is the administrator for Boston Out-Patient Surgical Suites, which opened in July 2004. He has experience as a physician assistant at New England Batiste Hospital. Under his leadership, the ASC has experienced 98 percent "excellent" ratings on patient satisfaction.

Linda Deeming, RN, BSN, MBA/HCM, CNOR, CASC has served as the administrator of Longmont (Colo.) Surgery Center since January 2009. She served as the committee chair for the 2012 CASCA Annual Spring Education Conference.

Roxanne Degnan, RN has been administrator at Riverview Ambulatory Surgical Center in Kingston, Pa., since November 2009. She has made recruiting of physicians, inventory consignment, utilization of staff, employee satisfaction and building a more robust performance improvement program a priority.

Jody Delahunty, RN, CNOR 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. She was instrumental in purchasing instruments, supplies and implants for the center.

Lynda Dowman 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 is the administrator of Blue Bell (Pa.) Surgery Center and currently is employed by ASCOA. The center is a four-room, multispecialty ASC that operates with 22 surgical partners and an additional five affiliated physicians.

Teva Eiler joined Hamot Surgery Center (now UPMC Hamot Surgery Center) in Hamot, Pa., 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.

Pamela J. Ertel oversees daily operations at The Reading (Pa.) Hospital SurgiCenter at Spring Ridge. Under her leadership, the center implemented a new business office software and achieved EMR implementation. She has also been president of PASA.

Carolyn Evec, RN, CNOR has served as the administrator at The Surgery Center of Beaufort (S.C.) for more than 10 years, after opening a surgery center in Missouri where she served as nurse manager. She has 40 years of nursing and administrative experience.

Andrea Fann serves as the administrator of Orthopaedic South Surgical Center in Morrow, Ga., a United Surgical Partners International facility. She has served in the position since 2005.

Judy Fladeboe serves as the administrator of Willmar (Minn.) Surgery Center. During her career, she has accumulated 25 years of experience working in emergency departments and GI/endoscopy units, including 15 years as manager.

Dana Folstrom, RN, CASC is administrator of Mirage Calif. Endoscopy Center, managed by Health Inventures. Prior to joining his current center, he worked in the GI department of Eisenhower Medical Center.

Kerri Gantt has been employed by Gastroenterology Associates of S.W. Florida and Barkley Surgicenter in Ft. Myers for over 19 years. As administrator of the two organizations, she oversees business and clinical operations.

Patricia Graham, BSN, RN, is the executive director of Laser Spine Institute Arizona. She has held this position for the past year and previously served as CEO of MedLogics Consulting for nine years.

Julie Greene is the CEO of Muskegon (Mich.) Surgery Center and Regional Healthcare Management Solutions, a consulting organization. A longtime member of the Michigan Ambulatory Surgery Association Board, she has been involved in several projects including working with BCBS of Michigan to increase reimbursement to a level that allows spine surgeries to be performed in the ASC setting.

Debra Hagendorn is administrator of South Shore Ambulatory Surgical Center in Lynbrook, N.Y. Under her leadership, the AAAHC was passed on the first attempt and the center was given a three-year certificate.

Kimble Hatridge serves as administrator of Texarkana (Texas) Surgery Center, one of Symbion Healthcare's facilities. She has more than 20

years experience in the healthcare industry, and her track record includes successful recruitment and retention of physician partners.

Bill Hazen, RN, CHT, is the administrator of The Surgery Center at Pelham in Greer, S.C., a position he's held since 2004. One of his biggest successes as an administrator has been the introduction of a quarterly employee bonus system.

Tom Holecek became the administrator at Palos Surgicenter in Palos Heights, Ill., managed by Regent Surgical Health, in September 2007. Soon after assuming this position, he was able to gain consensus between the hospital landlord and the board of managers to embark on a $2 million renovation project that would take 12 months to complete.

Carolyn Hollowood, RN, BSN, CNOR, RNFA, CASC is administrator of the four-OR, orthopedic-driven City Place Surgery Center in Creve Coeur, Mo. She has managed to standardize much of the equipment the surgeons use at the center, as well as introduce new procedures and processes into daily operations.

Dale Holmes was hired by USPI in 2009 to turn around Warner Park Surgery Center in Chandler, Ariz. He successfully upgraded the facility, passed CMS and AAAHC surveys and brought the ASC ahead of budget.

Jennifer Holmes, RN, DON was selected by ASC operator Arise Healthcare to open and run its newest outpatient surgery center, Hays Surgery Center in a thriving suburb just south of Austin, Texas. It enjoys a zero percent infection rate, 98 percent patient satisfaction rate.

Debbie Howe, RN, MSN is the administrator and CEO of Northern Rockies Surgery Center in Billings, Mont., a joint venture among Surgical Care Affiliates and 15 physician investors. She has been president of the Montana Association of Ambulatory Surgery Centers.

Karen Howey, CASC is administrator of Macomb (Mich.) Township ASC. During her time there, the center received Joint Commission accreditation, added five more specialties and grown to over 32 full-time employees.

Stuart Katz is executive director of the Tucson Orthopaedic Surgery Center. In his current role, Mr. Katz has helped reduce cost on a per case basis for an ACL from more than $3,000 to under $1,800 by asking surgeons to use more autografts and reduce the ASC's dependence on allografts.

Wendy Kelley is the administrator for Cool Springs Surgery Center in Nashville, Tenn., a Symbion facility. The surgery center was founded in 2000 and includes five operating rooms and one procedure room. During her time there, the surgery center has expanded its pain management program.

David Kelly, MBA, CASC is administrator of Samaritan North Surgery Center in Dayton, Ohio, a position he first took in late 2006. In the past year, despite continued migration from commercial to the government payers, the center's bottom line increased 16 percent over the prior year.

Mary Ann Kelly began at Madison (Ala.) Surgery Center as the clinical director prior to completion of construction. Under her leadership, the ASC has implemented electronic medical records and successfully completed accreditation surveys.

Angela 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.

Liliana Lehmann is the administrator at Hallandale Outpatient Surgical Center in Miami, a position she has held for 10 years. She has more than 20 years of experience in the healthcare market, including time as president of Axis Management & Billing Services.

Beverly LeMaster serves as clinical director and administrator of Physicians' Surgical Center in Belleville, Ill., a position she has held since 2010, when the two positions were combined. Ms. LeMaster is a registered nurse with an ER/OR background who previously worked in a multispecialty center.

Neal Maerki, RN, CASC is the administrator of Bend (Ore.) Surgery Center, a four-OR, three-procedure room, multispecialty surgery center. He has also served on the board of directors for the Oregon Ambulatory Surgery Center Association.

Becky Mann is the director of Houston Orthopedic Surgery Center in Warner Robbins, Ga. She has been working in the medical industry for 38 years in surgery or in post-surgical care, and in her current position added a surgeon to the ASC.

Lori Martin is administrator and director of nursing at SUMMIT Surgery Center in Reno, Nev. She was an integral part of opening the center and is now focused on recruiting physicians, hiring quality staff and achieving financial success.

Stephanie Martin is the administrator of St. Augustine (Fla.) Surgery Center. The surgery center was developed and managed by ASCOA. During her time with the ASC, Ms. Martin implemented a computerized patient assessment system that helped the center identify issues and maintain compliance.

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

Dave Milton is the administrator at Surgicenter in Phoenix, the first ASC in the United States. He says that since being hired by Banner Health, he has been asked many times about his leadership style. He serves on the board of directors for the Arizona Ambulatory Surgery Center Association.

Dee Moncrief has been with 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.

David Moody, RN arrived at Knightsbridge Surgery Center in Columbus, Ohio, three months after Regent Surgical Health took over the facility in 2004. He currently sits on the board of trustees for the Ohio Association for Ambulatory Surgery Centers.

Jennifer Morris serves as administrator of Stateline Surgery Center in Galena, Kan., which opened March 28, 2010. In 2011, the center experienced significant growth; after the Joplin, Mo., tornado, volume doubled overnight, requiring the addition of a third operating room.

Ann Mueller, RN, BSN is the administrator of Pasteur Plaza Surgery Center in San Antonio, a partnership between local physicians and Surgical Care Affiliates. She joined the facility as a staff nurse before graduating to director of nursing.

Thomas Mulhern, MBA, CASC is the executive director of the Limestone Surgery Center in Wilmington, Del., which opened in 1987 as the first ASC in Delaware. He has been with the surgery center since it opened 25 years ago and is a former member of Delaware's certificate of need board.

Susan Nance, RN, CASC is administrator of Gateway Surgery Center in Phoenix, a primarily orthopedic-driven, free-standing surgery center owned partly by physicians and partly by AmSurg.

Teri O'Laughlin, DON runs the Cedar Park (Texas) Surgery Center in a thriving suburb of Austin, Texas. She has more than 20 years of nursing experience. The ASC handles approximately 500 surgeries a month.

Joseph G. Ollayos, MHA, CASC has been employed in the ambulatory surgery industry since 1999 and currently serves as the administrator at Tri-Cities Surgery Center in Geneva, Ill. He was previously business office manager at Elmhurst Outpatient Surgery Center.

Amber Patterson came to Westside Surgery Center in Douglas, Ga., in 2006. In her first three years, she has researched the best deals on ASC equipment, worked with a consultant to ensure the facility was built according to state guidelines, hired and trained new staff, and completed Joint Commission accreditation.

Larry Parrish, MBA is the administrator of Illinois Sports Medicine & Orthopedic Surgery Center in Morton Grove, Ill. He credits some of

his success with the center to his ability to schedule cases efficiently and keep physicians happy.

Mike Pankey helped open his current center, the Ambulatory Surgery Center of Spartanburg (S.C.), in 2002. In 2003, he and his team added two endoscopy suites, and over the next few years, they built volume from 5,000 cases in year one to over 10,000 cases in years six through eight.

Linda Phillips, RN has served as administrator of Southgate (Mich.) Surgery Center since 1999. During her tenure as administrator, she expanded the ASC from a one-room, single-specialty center to a four-room, multispecialty ASC.

Marti Potter is the administrator for Jersey Shore Ambulatory Surgery Center. She has held the position since September 2008 and has experience as risk manager, compliance and privacy officer.

Linda Rahm is the administrator at Pioneer Valley Surgicenter in Springfield, Mass. She has been with the ASC since it opened in 2003 and previously served as COO for a multispecialty group and CEO of a specialty hospital.

Toni Rambeau started at SurgCenter 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 the providers credentialed at the center.

Anne Remm is administrator of Miracle Hills Surgery Center in Omaha. She has more than 28 years nursing experience with 20 years of surgical management experience in the acute-care hospital and ASC settings.

Gary A. Richberg, RN, BSN, CASC has been the administrator of Pacific Rim Outpatient Surgery Center in Bellingham, Wash., since 2006. His responsibilities include oversight of the fiscal and clinical management of the 23,000-square-foot multispecialty surgery center.

Anne Roberts, RN is the administrator at the Surgery Center at Reno (Nev.), a multispecialty ASC that is owned by physician partners, a hospital partner — Saint Mary's Hospital, and a managing partner — Regent Surgical Health.

Kate Rock serves as executive director of Doylestown Surgery Center in Warrington, Pa. She was hired in February 2010, and within 10 months, the center presented a positive bottom line and reduced expenses by over $400,000 from the previous year.

Lauri Rose, MBA, CASC is administrator of Stonegate Surgery Center in Austin, Texas, and has been involved in the development and management of ASCs since 1997. She has successfully developed, managed, and improved the financial stability in more than 15 ASCs.

Mary Ryan, RN, CASC is the administrator of Tri State Surgery Center in Dubuque, Iowa. She is known by her staff for advocating continuous improvement, whereby she relentlessly strives to improve the centers' performance in every area: clinical, financial and operational.

Kris Sabo, RN 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.

Sami Spencer, CMPE, CMM is the CEO for Missoula (Mont.) Bone and Joint Surgery Center, as well as Missoula Bone and Joint. She serves on the board of directors for the American Association of Orthopaedic Executives, where she has been a member for 13 years.

Bill Sammons has been CEO of The Surgery Center of Huntsville (Ala.) for 16 years. He oversaw the growth of the ASC from six operating rooms, four eye suites and a Fisher Mammtome biopsy room to 16 operating rooms, four endoscopy suites and four eye suites.

Glenda Satterly, RN is the administrative director of the Kentucky Surgery Center in Lexington. She started at the center as an OR circulator and was promoted to OR/PACU/pre-operative supervisor and then clinical director before becoming the administrative director.

Tona Savoie is the administrative director of Bayou Region Surgical Center in Thibodaux, La., a multispecialty surgery center that opened in July 2007. The ASC operates as a 50-50 partnership between physician-investors and Thibodaux Regional Medical Center.

David Schlactus is CEO of Willamette Surgery Center and Hope Orthopaedics in Salem, Ore. He has been successful in renegotiating payer contracts to maintain profitability even through the economic downturn.

Lisa Schriver, RN, CNOR is the administrator of Turk's Head Surgery Center in West Chester, Pa., a Blue Chip Surgery Center Partners facility. She started with Turk's Head in 2005 as the clinical director and moved up to become administrator.

Peggy Seidler, RN is CEO of Northbank Surgical Center in Salem, Ore., a freestanding ASC owned by local physicians and managed by Surgical Care Affiliates (SCA). She began her career as an LPN in the Army, where she proudly served our nation for two years.

Reed Simmons holds 16 years of experience in the ASC industry, managing the business office

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functions for several surgical facilities in the Florida area. He currently serves as the acting administrator at Treasure Coast Center for Surgery, a multispecialty ASC located in Stuart, Fla. His background includes handling revenue cycle management, managing a staff of business office personnel, accounts receivable and credentialing, and performing human resources functions.

Laurie Simon is administrator of Western Reserve Surgery Center in Kent, Ohio. She completed the AORN ASC Administrator Certificate Program and has experience with the physician-side of medical practice.

Amy Sinder is the administrator at CBC Surgery Center in Crown Point, Ind. The multispecialty ASC is accredited by the Joint Commission and provides overnight stays in private rooms up to 23 hours.

Carol S. Slagle, CASC has been the administrator of Specialty Surgery Center of CNY in Liverpool, N.Y., which is managed by ASCOA, since its inception in 1999. The ASC underwent a major expansion in 2009.

Jill Sluder, RN, CASC is an administrator and partner of Summit Ambulatory Surgery Center in Houston and has been president of the Texas Ambulatory Surgery Center Society. She has also been an AAAHC surveyor since 2006.

Laura Smith has been employed with Tampa Bay Specialty Surgery Center in Pinellas Park, Fla., since 2004, when she joined the center as a pre-op registered nurse. In 2008, she was promoted to administrator and helped the center earn a three-year accreditation.

Steve Smith, RN, CASC, director of the Surgery Center of Wisconsin Rapids (Wis.), was hired as the circulating nurse when the ASC opened its doors in 2006. In 2011, the center added an ophthalmology service line, along with three ophthalmology physicians.

Natalie Soule, RN, MBA, CNOR, CASC, is the administrator for Premier Orthopaedic Surgery Center in Nashville, Tenn. Surgeons of Premier Orthopaedics offer cases at the surgery center.

Maggie Summerfelt is administrator of Advanced Surgery Center in Omaha, a physician-owned facility with two ORs, two procedure rooms and specialties that include orthopedics, podiatry and pain management. The center opened in 2006.

Sue Sumpter has been with Creekside Surgery Center in Anchorage, Ala., for more than two years.She was recruited in March 2011 to turnaround the finances and case volume of the failing center and has since increased volume significantly and improved profitability.

Jill Thrasher, CASC, is the administrator for Precision Surgery Center of Dallas, an Ambulatory Surgical Centers of America facility. She has held the position since 2008. The multispecialty ASC has AAAHC accreditation and includes physicians focusing on general surgery, pain management, ENT, orthopedic surgery and gastroenterology.

Elaine Thomas, RN 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.

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Meg Tomlinson has served as administrator of Metrocrest Surgery Center in Carrollton, Texas, since Sept. 2002. The center merged with USPI effective July 1, 2010, and has seen various changes to the business office staff since that time.

George D. Trantow, FACHE, CMPE is the executive director of Midvalley Ambulatory Surgery Center, Aspen Orthopaedic Associates and Midvalley Imaging Center in Aspen, Colo. He serves as president-elect of the American Association of Orthopaedic Executives.

Kimberly L. Tude Thuot has been in healthcare administration since 1997 and joined the physician-owned Yakima (Wash.) Ambulatory Surgical Center in August 2009. Since she joined Yakima ASC, the center has moved billing back in-house and is in the process of adding neurosurgery and spine to the multispecialty facility.

LoAnn Vande Leest is the CEO at Northwest Michigan Surgery Center in Traverse City and has been president of the Association of Wisconsin Surgery Centers. At her previous position with The Surgery Center, she facilitated a joint venture with a local hospital system and established a neurological services business line.

Susan Vitort, BSN, CNOR is the administrator of Physicians Surgery Center of Tempe, a two-OR, one-procedure room, multispecialty surgery center that opened in September 1999. She preivously served as director of perioperative services, endoscopy at the Cardiovascular Center at Banner Desert Samaritan Medical Center.

Kara Vittetoe, CASC, is the administrator of Thomas Johnson Surgery Center in Frederick, Md., a one-OR, two-procedure room, multispecialty surgery in a growing rural area. Thomas Johnson Surgery Center in Frederick, Md., which is managed by ASCOA. Ms. Vittetoe has been with the center since it opened in 2008 and previously she spent the majority of her career in the private sector of healthcare management.

Melissa Weik has been administrator of North Pointe Surgery Center in Lancaster, Pa., since January 2008. During her time with the center, she was able to increase revenue through payer contract management and control expenses with product reviews.

Andrew Weiss, CASC has been administrator of The Endo Center at Vorhees (N.J.) since 2003, prior to which he served as an on-site consultant at the center. He Mr. Weiss is responsible for strategic planning, regulatory compliance and managing this high-volume ASC.

John Wipfler, JD, MBA is CEO for OA Centers for Orthopaedics in Portland, Maine, which includes a surgery center. He previously served as CEO of Eyecare Medical Group in Portland and has experience as executive director and general counsel of the Maine Health Care Finance Commission.

Lexa L. Woodyard is administrator of Cabell Huntington (W.Va.) Surgery Center, where she has racked up an impressive list of accomplishments. She has decreased supply expenses per case over the previous calendar year, increased net revenue per case and negotiated better paying contracts with selected insurance carriers.

Cindy Young, RN, CASC has been with the Surgery Center of Farmington (Mich.) for the past 14 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.

Monica M. Ziegler, MSN, CASC has been the administrator for Physicians Surgical Center in Bethlehem, Pa. since its inception. She was given the responsibility of a second center, the Center for Specialized Surgery, two years ago.

Becky 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, she has worked diligently to keep days in A/R at benchmark levels. ■

For the full profiles, visit www.beckersasc.com.

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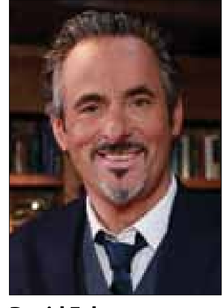
David Feherty

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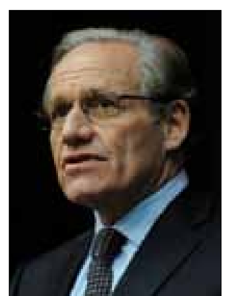
- Keynote - A Nansy Bit of Rough - David Feherty, CBS Golf Commentator and Best-Selling Author
- Keys to Keeping Surgery Centers Profitable Businesses - Robert Zasa, MSHHA, FACMPE, Managing Partner and Founder, ASD Management, Doug Golwas, Senior Vice President Medline Industires, Stephen Blake, Chief Executive Officer, Central Park ENT & Surgery Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP
- ASCs, 10 Months and 10 Years Into the Future; Emerging Business Issues in ASCs - David J. Abraham, MD, The Reading Neck & Spine Center, Linda Ruterbories, RN, ANP, OSC Director, OA Center for Orthopedics, Bill Hazen, RN, CHT, Administrator, The Surgery Center at Pelham
- Success is a Choice - Rick Pitino, Head Men's Basketball Coach University of Louisville
- Anesthesia Issues; Shorten Your Length of Stay in PACU - G-A (Gary) Lawson-Boucher, MD, Lieutenant Commander, Medical Corp., United States Navy, ACSCSWF
- Analyzing the Health System Market - Who Needs to Sell? Why Joint Venture? Greg Koonsman, Senior Partner, VMG Health
- Key Thoughts on Keeping ASC Owners Engaged - Michael Patterson, President & CEO, Mississippi Valley Health, Darlene Johnson, RN, BSN, MSN, CASC, Healthcare Consultants International, Inc., Gary Richberg, RN, BSN, ALNC, CNR-A, CNR-C, CASC, Administrator, Pacific Rim Outpatient Surgery Center, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP
- The State of the ASC Industry - Andrew Hayek, President & CEO, Surgical Care Affiliates
- Which Specialties Are Still Great for ASCs? Which Ones Should ASCs Eliminate Today? Will Hospital Employment Kill ASCs? What ASC Problems are not Fixable? - David J. Abraham, MD, The Reading Neck & Spine Center, Lawrence E. Kosinski, MD, MBA, AGAF, FACG, Elgin Gastroenterology, Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, Fred Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine, ProCare Research, ProCare Systems, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP


Bob Woodward

Bonnie Blair

- ASCs 2013 and 2014 - Where Does the Industry Stand, Where are the Great Opportunities? Nap Gary, Chief Operating Officer, Regent Surgical Health, I. Naya Kehayes, MPH, Managing Principal and Chief Executive Officer, Eveia Health Consulting & Management, Richard N.W. Wohns, MD, JD, MBA, South Sound Neurology, PLLC, Scott Becker, JD, CPA, Partner, McGuireWoods LLP, moderated by Bob Woodward, Legendary Pulitzer Prize-Winning Journalist/Author and Associate Editor, The Washington Post
- Washington D.C., The Budgets, Healthcare, America - Bob Woodward, Legendary Pulitzer Prize-Winning Journalist/ Author and Associate Editor The Washington Post
- Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, Chief Financial Officer, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, Senior Vice President of Operations, Ambulatory Surgical Centers of America
- Achieving Your Personal Best - Bonnie Blair, Speed Skating Champion and Gold Medalist
- ASC Association - Key Priorities for 2014 - Nap Gary, Chief Operating Officer, Regent Surgical Health, and William M. Prentice, JD, Chief Executive Officer, ASCA
- Does Your Infection Prevention Program Meet Survey Requirements? Marcia Patric, RN, MSN, CIC, Infection Prevention Consultant, AAAHC, and Marsha Wallander, RN, Associate Director of Accreditation Services, AAAHC
- Key Thoughts on Medicare Inspections and Survey Readiness - Tracy Harbour, RN, BSN, Administrator, Surgery Center of Pinehurst, Marti Potter, Administrator, Jersey Shore Ambulatory Surgery Center, Marcy Sasso, CASC, Director of Compliance and Development, Facility Development & Management, LLC, moderated by Melissa Szabad, Partner, McGuireWoods LLP
- Opening a State of the Art ASC in Changing Times - Michael Redler, MD, The OSM Center
- Minimally Invasive Hysterectomy in an Outpatient Setting; Successes and Suggestions - Jon Nielsen, MD, North Memorial Ambulatory Surgery Center at Maple Grove

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PROGRAM SCHEDULE

Thursday October 24, 2013

11:30am – 1:00pm	Registration
1:00pm – 5:35pm	Conference Sessions
5:30pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Friday October 25, 2013

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:00pm	Conference Sessions Including Lunch and Exhibit Hall Breaks
5:00pm – 6:00pm	Reception, Cash Raffles, Exhibit Hall

Saturday October 26, 2013

7:00am – 8:10am	Continental Breakfast
8:10am – 12:00pm	Conference Sessions

Thursday, October 24, 2013

1:30 – 4:30 PM
Registration and Exhibitor Set up

Concurrent Sessions
Track A - Improving Profits, Management, Keynote Session

Track B - Improving Profits, Key Trends, Anesthesia, Technology

Track C - Market Strategies, Turnarounds, Compensation Issues

Track D - Out Of Network, Valuation, ICD-10

Track E - Transactions, Valuation and Legal Issues

Track F - Patient Safety, Quality and Accreditation Issues

1:00 – 1:40 PM

A. Keys to Keeping Surgery Centers Profitable Businesses
Robert Zasa, MSHHA, FACMPE, Managing Partner and Founder, ASD Management, Doug Golwas, Senior Vice President, Medline Industries, Inc., Stephen Blake, Chief Executive Officer, Central Park ENT & Surgery Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP

B. How to Grow Your Practice While Working with Emerging Systems of Care
Fred Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine, ProCare Research, ProCare Systems

C. Regional Market Strategies for Pain Management
Robin Fowler, MD, Chairman and Medical Director, Interventional Management Services, Stephen Rosenbaum, Chief Executive Officer, Interventional Management Services

D. 5 Big Out of Network Ideas Debunked
John Bartos, Chief Executive Officer, Collect Rx

E. ASC Roundtable: Outlook for Investment and M&A Activity in the ASC Sector
Michael Stroup, Senior Vice President, Acquisitions, United Surgical Partners International, Inc., Matt Searles, Managing Partner, Merritt Healthcare, Adam Lynch, Vice President, Principle Valuation LLC, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

F. Implementing Safe Surgery Checklists at your Surgery Center
Linda Lansing, Senior Vice President, Clinical Services, and Kelly Bemis, RN, BSN, Director of Clinical Services, Surgical Care Affiliates

1:45 – 2:25 PM

A. The Movement of Higher Acuity Cases to ASCs, Why? How? Who Drives It?
Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgical Center Partners

B. The Single Best Actions to Improve Profits Now
Chris Swing, Vantage Technology, Amy Sinder, Administrator, CBC Surgery Center, Lilliana Lehmann, Administrator, Hallandale Outpatient Surgical Center, Laura Miller, Editor in Chief, Becker's Spine Review/ Becker's ASC Review, Becker's Healthcare

C. Consumerism and Price Transparency
Jeff Blankinship, President & Chief Executive Officer, Surgical Notes

D. ASC Transactions: Analysis and Valuation Trends
Kevin McDonough, CFA, Partner, and Colin Park, Manager, VMG Health

E. Risk Management as Applied to Higher Acuity Procedures
Carol Hiatt, BSN, RN, LHRM, CASC, CNOR, Consultant and Accreditation Surveyor, Healthcare Consultants International

F. Practical HIPAA Compliance Plans for ASCs
Holly Carnell, Associate, Meggan Michelle Bushee, Associate, Melissa Szabad, Partner, McGuireWoods LLP

2:30 – 3:10 PM

A. ASCs 10 Months and 10 Years Into the Future; Emerging Business Issues in ASCs
David J. Abraham, MD, The Reading Neck & Spine Center, Linda Ruterbories, RN, ANP, OSC Director, OA Center for Orthopedics, Moderator TBD

B. Trends in Minimally Invasive Stabilization Surgery
Jeffrey P. Nees, MD, Neurosurgeon, Laser Spine Institute

C. Turnaround - Success Stories From the Field
Joseph Zasa, Co-founder and Managing Partner, ASD Management

D. PPO Out of Network Payments Are Not Dead
Kelly Webb, Vice President and General Manager, ASC Billing Division, MediGain

E. 2013 ASC Valuation Survey
Todd Mello, Partner and Co-Founder of HealthCare Appraisers, and Nicholas Newsad, Analyst, HealthCare Appraisers

F. Three Strategies to Control Labor Cost at Your Surgery Center
Thomas H. Jacobs, President & Chief Executive Officer, MedHQ

3:15 – 3:55 PM

A. Key Thoughts on Keeping ASC Owners Engaged
Michael Patterson, President and CEO, Mississippi Valley Health, Darlene Johnson, RN, BSN, MSN, CASC, Healthcare Consultants International, Inc., Gary Richberg, RN, BSN, ALNC, CNR-A, CNR-C, CASC, Administrator, Pacific Rim Outpatient Surgery Center. Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Anesthesia Issues; Shorten your length of stay in PACU
G-A Lawson-Boucher, MD, Lieutenant Commander, Medical Corp. United States Navy, ACSCSWF

C. How Much Should Administrators, Medical Directors and DONs be Paid?
Joe Ollayos, Adminstrator, Tri-Cities Surgery Center, LLC, Debbie Hall, Administrator, High Plains Surgery Center, moderated by Amber McGraw Walsh, Partner, McGuireWoods LLP

D. ICD - 10 - Are you prepared?
Kevin McDonald, Vice President, Surgery Sales, SourceMedical

E. Co-Management - A Focus on How Payments Work and are Valued
Nicholas Newsad, Analyst, HealthCare Appraisers

F. Using Reprocessing to Reduce Costs
Timothy Merchant, Vice President of Sales, MEDISISS - Medline Industries, Inc.

4:00 – 4:40 PM

A. Can ASCs Still Profit Through Orthopedics - What Works Business Wise and Clinically
Larry Taylor, President & CEO, Practice Partners in Healthcare

B. The Impact on Technology on Physicians Practices in the Future
Mary Hibdon, RN, ASC Strategist, Perioperative, Cerner

C. Analyzing the Health System Market - Who Needs to Sell? Why Joint Venture?
Greg Koonsman, Senior Partner, VMG Health

D. Healthcare Facilities Accreditation Program
TBD

E. Litigation Involving ASCs -- Key Issues, Antitrust, False Claims, Redemptions and Non Competes
Jeffrey C. Clark, Partner, and David Pivnick, Associate, McGuireWoods LLP

F. 8 Steps for Profitable Materials Management
Lori Pilla, Vice President Clinical Advantage and Supply Chain Optimization, Amerinet

4:45 – 5:35 PM

A Nasty Bit of Rough
David Feherty, CBS Golf Commentator and Best-Selling Author

5:35 – 7:00 PM

Networking Reception, Cash Raffles and Exhibits

Friday, October 25, 2013

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

8:00 – 8:05 AM – Introductions

8:00 - 10:10 - General Sessions

10:40 - 5:05 PM - Concurrent Sessions

Track A -Key Specialties, Healthcare Reform, Improving Profits, Joint Ventures

Track B -Cost Reducting and Benchmarking, Ancillaries, Key Procedures, Medical Inspections, EMRs, Reimbursements

Track C - Management, Recruiting Physicians, CMS Guidelines, Employee Engagement

Track D - Documentation, Revenue Cycle, Billing and Coding Issues, Inventory Management

Track E - HR Issues, Selliing Your ASC, 2014 Key Issues, Legal Issues

Track F - Infection Control, Quality, Inspections, Accreditation Issues

8:05 – 8:45 AM

Keynote Panel: ASCs 2013 and 2014 - Where Does the Industry Stand, Where are the Great Opportunities
Nap Gary, Chief Operating Officer, Regent Surgical Health, I. Naya Kehayes, MPH, Managing Principal and Chief Executive Officer, Eveia Health Consulting & Management, Richard N.W. Wohns, MD, JD, MBA, South Sound Neurology, PLLC, Scott Becker, JD, CPA, Partner, McGuireWoods LLP, moderated by Bob Woodward, Legendary Pulitzer Prize-Winning Journalist/Author and Associate Editor, The Washington Post

8:50 – 9:30 AM

B. Washington D.C., The Budgets, Healthcare, America
Bob Woodward, Legendary Pulitzer Prize-Winning Journalist/Author and Associate Editor, The Washington Post

8:50 – 9:30 AM

The State of the ASC Industry
Andrew Hayek, President & CEO, Surgical Care Affiliates

10:10 – 10:40 AM
Networking Break and Exhibits

To Register, Call 800-417-2035 • Fax 866-678-5755 • Email registration@beckershealthcare.com
Register Online at https://www.regonline.com/20thAnnualASC

10:40 – 11:20 AM

A. Which Specialties Are Still Great for ASCs? Which Ones Should ASCs Eliminate Today? Will Hospital Employment Kill ASCs? What ASC Problems are Not Fixable?
David J. Abraham, MD, The Reading Neck and Spine Center, Lawrence E. Kosinski, MD, MBA, AGAF, FACG, Elgin Gastroenterology, Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, Fred Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine, ProCare Research, ProCare Systems, moderated by Scott Becker, JP, CPA, Partner, McGuireWoods LLP

10:40 – 12:00 PM

B. Cost Reduction and Benchmarking, 10 Key Steps to Immediately Improve Profits
Robert Westergard, CPA, Chief Financial Officer, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, Senior Vice President of Operations, Ambulatory Surgical Centers of America

10:40 – 11:20 AM

C. Building Volumes, Practice Growth, Recruiting Physicians and Cases - We Need More Volume
Brandon Frazier, Vice President of Development and Acquisitions, Ambulatory Surgical Centers of America, Jeff Peo, Vice President Development & Acquisitions, Ambulatory Surgical Centers of America, and John D. Martin, Principal, Martin Healthcare Consulting, Moderated by Gretchen Townshend, Associate, McGuireWoods LLP

D. Documentation Improvement and Targeted Analytics to Accelerate Patient Throughput & Increase Patient Volume
Jennifer Brown, RN, Endoscopy Nurse Manager, Gastroenterology Associates of Central Virginia, and Tim Meakem, MD, Medical Director, ProVation Medical

E. HR Issues - Management Techniques for Top Production, Doing More with Less Staff
Stephanie Martin, Administrator, St. Augustine Surgery Center, and Jill Thrasher, CASC, Administrator, Precision Surgery Center of Dallas

F. Secrets to Better Infection Control Compliance
Phenelle Segal, RN, CIC, President, Infection Control Consulting Services, LLC

G. Minimally Invasive Hysterectomy in an Outpatient Setting, Successes and Suggestions
Jon Nielsen, MD, North Memorial Ambulatory Surgery Center at Maple Grove

11:25 – 12:00 PM

A. The Impact of Healthcare Reform on ASCs and Practices
Tom Mallon, Chief Executive Officer, Regent Surgical Health, Barry Tanner, President & CEO, Physicians Endoscopy, LLC, Richard N. W. Wohns, MD, JD, MBA, South Sound Neurology, PLLC, Luke Lambert, CFA, CASC, Chief Executive Officer, Ambulatory Surgical Centers of America, moderated by Anna Timmerman, Associate, McGuireWoods LLP

C. Opening a State of the Art ASC in Changing Times
Michael Redder, MD, The OSM Center

D. Most Common Coding and Billing Errors that Impact Your Bottom Line
Lisa Rock, President, National Medical Billing Services

E. ASC Association - Key Priorities for 2014
Nap Gary, Chief Operating Officer, Regent Surgical Health and William M. Prentice, JD, Chief Executive Officer, ASCA

F. Preparing for Joint Commission Accreditation
Wendy Kelley, Administrator, and P.J. Jarboe, RN, Cool Springs Surgery Center

G. The 5 Most Important Issues Facing ASCs
Mike Pankey, Administrator, ASC of Spartanburg, Bill Hazen, Administrator, RN, CHT, The Surgery Center at Pelham, Erik Flaxman, MHPA, Executive Director, Forest Canyon Endoscopy & Surgery Center, moderated by Amber McGraw Walsh, Partner, McGuireWoods LLP

12:05 – 12:45 PM

A. Implant Costs, How to Manage Shifting Costs
Tom Gallagher, Chief Executive Officer, PDP Holdings, Blaire Rhode, MD, ROG Sports Medicine, Orland Park Orthopedics, Robert Sabra, Jr., MD, Neurological Spine Surgeon, D.I.S.C. Sports & Spine Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP

B. Achieving Your Personal Best
Bonnie Blair, Speed Skating Champion and Gold Medalist

C. Evolving CMS Mandates With Reimbursement and Quality Reporting
Debra Stinchcomb, RN, BSN, CASC, Consultant, Progressive Surgical Solutions, LLC

D. Key Steps to Great Payor Contracting
I. Naya Kehayes, MPH, Managing Principal and Chief Executive Officer, Eveia Health Consulting & Management

E. Should You Sell Your ASC? Valuation, Operating Agreement, Non Competes, Legal and Process Issues
Amber Walsh, Partner, and Scott Becker, JD, CPA, Partner, McGuireWoods LLP

F. OSHA Inspections
Stephanie Martin, Administrator, St. Augustine Surgery Center

12:45 – 1:45 PM
Networking Lunch & Exhibits

12:45 - 1:45 pm

Special Women's Leadership Lunch
Hosted by Bonnie Blair, Speed Skating Champion and Gold Medalist, Amber McGraw Walsh, Partner, McGuireWoods LLP and Melissa Szabad, Partner, McGuireWoods LLP

1:50 – 2:30 PM

A. Keeping Endoscopy Centers Profitable
Barry Tanner, President & Chief Executive Officer, and John Poisson, Executive Vice President & Strategic Partnerships Officer, Physicians Endoscopy, LLC

B. How to Stay Out of Trouble When You Own Ancillaries
Richard N.W. Wohns, MD, JD, MBA, South Sound Neurology, PLLC

C. Strategies to Recruit New Physician Partners
Christine Henry Musa, Vice President of Business Development, and Jamie Crook, Director of Physician Recruiting, Regent Surgical Health

D. Assessing the Movement (and the Impact on Profits) From Out of Network to In Network
I. Naya Kehayes, MPH, Managing Principal and Chief Executive Officer

E. Reorganizing ASCs for Success
Robert Zasa, MSHHA, FACMPE, Managing Partner and Founder, ASD Management and Tom Mallon, Chief Executive Officer, Regent Surgical Health

F. The Patient Acquisition Cycle: Benchmarking and Best Practices for Attracting and Retaining Patients
Scott Christiansen, CCO Partners

2:35 – 3:15 PM

A. Bundled Payments for ASCs - Current Trends and Strategies
I. Naya Kehayes, MPH, Managing Principal and Chief Executive Officer, Eveia Health Consulting & Management, moderated by Bob Herman, Editor, Becker's Hospital Review, Becker's Healthcare

B. Advanced High Acuity Procedures for ASCs
Robert S. Bray, Jr., MD, Neurological Spine Surgeon, and Karen Reiter Chief Operating Officer, D.I.S.C. Sports & Spine Center

C. You Don't Need Another Report, You Need Results
John Seitz, Chief Executive Officer, MMX Holdings (ManageMyASC), Tamar Glaser, Chief Executive Officer, Accreditation Services, Inc. and AccredAbility, Inc.

D. Inventory Management: Importance of Supply Management & Control
Ann Geier, RN, MS, CNOR, CASC, Senior Vice President of Operations, Ambulatory Surgical Centers of America

E. Is HOPD and Co Management Right for Your Center?
Melissa Szabad, Partner, McGuireWoods, and Jen Johnson, CFA, Partner, VMG Health

F. Does Your Infection Prevention Program Meet Survey Requirements?
Marcia Patrick, RN, MSN, CIC, Infection Prevention Consultant, AAAHC, and Marsha Wallander, RN, Associate Director of Accreditation Services, AAAHC

3:15 – 3:40 – Networking Break and Exhibits

3:40 – 4:15 PM

A. Joint Ventures with Hospitals: Models that Work in Today's Healthcare Environment
Nap Gary, Chief Operating Officer, Regent Surgical Health and Jeffrey Simmons, Chief Development Officer, Regent Surgical Health

B. Minimally Invasive Lumbar Decompressions in the ASC
Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration

C. The Ins and Outs of Medical Staff Credentialing
Thomas J. Stallings, Partner, McGuireWoods LLP

D. Income Diversification & Monetization of Assets Through Real Estate Ownership
Pedro J. Vergne, Chief Executive Officer, Physicians' Capital Investments

E. Key Stark and Anti-Kickback Issues ASC Owners Should Be Aware of, PODs, Anesthesia, ACOs, Selling Shares and Other Observations
Scott Becker, JD, CPA, Partner, and Gretchen Townshend, Associate, McGuireWoods LLP

F. Key Tips for Quality Assurance and Infection Prevention
Nicole Gritton, MSN, MBA, Director of Nursing, Laser Spine Institute

4:20 – 5:00 PM

A. The Evolution of Measuring Patient Satisfaction
Paul Faraclas, MBA, President & Chief Executive Officer, Voyance

B. Key Thoughts on Medicare Inspections and Survey Readiness
Tracy Harbour, RN, BSN, Administrator, Surgery Center of Pinehurst, Nueterra Healthcare, Marti Potter, Administrator, Jersey Shore Ambulatory Surgery Center, Marcy Sasso, CASC, Director of Compliance and Development, Facility Development & Management, LLC, moderated by Melissa Szabad, Partner, McGuireWoods LLP

C. Coaching Beyond Sports: How Coaching Improves Employee Engagement, Culture and Patient Outcomes
Karen Howey, Administrator of Beaumont Macomb Township ASC and Nikki Johnson, Vice President Human Resources, Nueterra

D. Pre-Op Screening Prior to Day of Surgery – How to Achieve Patient Compliance
Trish Corey, Sales Associate, Simple Admit

E. Key Steps to Improve Profits in Orthopedic-Driven ASCs
Gregory P. Deconciliis, PA-C, CASC, Administrator, Boston Out-Patient Surgical Suites

F. Trends in Marketing Your ASC to Drive Patient Volume
Dotty Bollinger, RN, JD, CASC, LHRM, Chief Operating Officer, Laser Spine

5:05 – 6:00 PM
Networking Reception, Cash Raffles & Exhibits

Saturday, October 26, 2013

7:15 – 8:15 am – Continental Breakfast

8:10 – 9:00 AM

KEYNOTE – Success is a Choice
Rick Pitino, Head Men's Basketball Coach University of Louisville

9:05 – 9:45 AM

A. Healthcare Outlook 2014 - Key Trends, Opportunities and Threats for ASCs
John Venetos, MD, John Venetos Ltd, R. Blake Curd, MD, Board of Directors Chairman, Surgical Management Professionals, Edward P. Hetrick, President, Facility Development & Management, LLC, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Avoiding Critical Mistakes in New Facility Startups
Joyce Deno Thomas, Senior Vice President, Operations, Regent Surgical Health

C. Key Strategies for Billing and Coding
Paul Cadorette, CPC, CPC-H-ORTHO, CPC-P-ASC, Director of Educational Services, mdStrategies

D. Common Billing Mistakes that Cost Your ASC Money and Correct Modifier and Revenue Code Usage for ASC Claims
Stephanie Ellis, RN, CPC, Ellis Medical Consulting, Inc.

E. ICD 10 and Technology: Tools and Tips to Smooth the Transition
Angela Talton, MBA, RHIA, CCS, CPC, CPC-H, Senior Vice President of Coding, National Medical Billing Services

9:50 – 10:30 AM

A. ASCs and ACOs - Can ASCs Profit With ACOs
Jon Friesen, Chief Financial Officer, U.S. Operations, Nueterra, moderated by Holly Carnell, Associate, McGuireWoods LLP

B. EMRs - How to Improve Productivity and Profits for Physicians and ASCs
Marion K. Jenkins, PhD, FHIMSS, Executive Vice President, 3t Systems

C. From Chaos to Calm: Improving Patient Flow with RTLS Technology
Brett Chambers, Project Manager, IT Consulting, Key Whittman Eye Center, and Jim Stilley, MHA, CASC, FACHE, Director of Clinical WorkFlow Consulting, Versus Technology

D. RAC and CMS Audits: Top Documentation Issues for ASCs and How to Reduce Risk
Stephanie Ellis, RN, CPC, Ellis Medical Consulting, Inc.

E. Utilizing Technology to Improve Revenue Cycle Metrics
Mike Orseno, Revenue Cycle Director, Regent Surgical Health and Tom Hui, HST Pathways

10:35 – 11:15 AM

A. Key Items That Great Administrators and Great DONs Focus On
Marti Potter, Administrator, Jersey Shore Ambulatory Surgery Center, Sandi Berreth, Administrator, Brainerd Lakes Surgery Center, Karen Reiter, RN, CNOR, RNFA, Chief Operating Officer, D.I.S.C. Sports & Spine Center, Moderator TBD

B. Total Joint Reimbursement Strategies in the ASC
Rebecca Overton, Director of Revenue Cycle Management, Surgical Management Professionals

C. Regulatory Processes Between State, Medicare and Accreditation Organizations
Amy Mowles, President and Chief Executive Officer, Mowles Medical Practice Management

D. On-Line Pre-Admission Screening: A Win-Win for Patients, Surgeons, Anesthesiologists, Staff and Administration
Jim Freund, Vice President of Business Development, Medical Web Technologies

11:10 – 12:00 PM

5 Key ASC Legal Issues for 2014, Anesthesia, Safe Harbors, Non Competes, HIPAA and More
Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:00 PM – Meeting Adjourns

CONFERENCE SPEAKERS

Great topics and speakers focused on key business, financial, clinical and legal issues facing ambulatory surgery centers • 87 Sessions, 132 Speakers

David Abraham, MD, The Reading Neck & Spine Center

John Bartos, JD, CEO, Collect RX

Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Kelly Bemis, RN, BSN, Director of Clinical Services, Surgical Care Affiliates

Sandy Berreth, Administrator, Brainerd Lakes Surgery Center

Chris Bishop, SVP, Acquisitions & Business Development, Blue Chip Surgical Center Partners

Bonnie Blair, Speed Skating Champion and Gold Medalist

Stephen Blake, CEO, Central Park ENT & Surgery Center

Jeff Blankinship, President & CEO, Surgical Notes

Dotty Bollinger, RN, JD, CASC, LHRM, COO, Laser Spine Institute

Robert S. Bray, Jr., MD, Neurological Spine Surgeon, D.I.S.C. Sports & Spine Center

Jennifer Brown, RN, Endoscopy Nurse Manager

Meggan Michelle Bushee, Associate, McGuireWoods LLP

Paul Cadorette, CPC, CPC-H-ORTHO, CPC-P-ASC, Director of Educational Services, mdStrategies

Holly Carnell, Associate, McGuireWoods LLP

Brett Chambers, Project Manager, IT Consulting, Key Whittman Eye Center

Scott Christiansen, President, CCO Partners

Jeffrey C. Clark, Partner, McGuireWoods LLP

Trish Corey, Sales Representative, Simple Admit

Jamie Crook, Director of Physician Recruiting, Regent Surgical Health

R. Blake Curd, MD, Board of Directors Chairman, Surgical Management Professionals

Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine, ProCare Research, ProCare Systems

Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration

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Erik Flexman, MHPA, Executive Director, Forest Canyon Endoscopy & Surgery Center

Robin Fowler, MD, Chairman & Medical Director, Interventional Management Services

Brandon Frazier, Vice President of Development & Acquisitions, Ambulatory Surgical Centers of America

Jim Freund, Vice President of Business Development, Medical Web Technologies

Jon H. Friesen, CFO, U.S. Operations, Neuterra

Tom Gallagher, CEO, PDP Holdings

Nap Gary, COO, Regent Surgical Health

Ann Geier, RN, MS, CNOR, CASC, SVP of Operations, Ambulatory Surgical Centers of America

Tamar Glaser, RN, CEO, Accreditation Services, Inc. and AccredAbility, Inc.

Doug Golwas, SVP, Medline Industries

Nicole Gritton, MSN, MBA, Vice President of Nursing and ASC Operations, Laser Spine Institute

Debbie Hall, Administrator, High Plains Surgery Center

Tracey Harbour, BSN, RN, Administrator, Surgery Center of Pinehurst, Nueterra

Andrew Hayek, President & CEO, Surgical Care Affiliates

Bill Hazen, RN, CHT, Administrator, The Surgery Center at Pelham

Bob Herman, Editor, Becker's Hospital Review, Becker's Healthcare

Edward P. Hetrick, President, Facility Development & Management, LLC

Carol Hiatt, BSN, RN, LHRM, CASC, CNOR, Consultant and Accreditation Surveyor, Healthcare Consultants International

Mary Hibdon, RN, ASC Strategist, Perioperative, Cerner

Karen Howey, CASC, Administrator, Beaumont Macomb Township ASC

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Thomas H. Jacobs, President & CEO, MedHQ

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Nikki Johnson, SPHR, VP Human Resources, Neuterra

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Brent Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America

Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America

Linda Lansing, SVP, Clinical Services, Surgical Care Affiliates

G-A (Gary) Lawson-Boucher, MD, Lieutenant Commander, Medical Corp., United States Navy

Liliana Lehmann, Administrator, Hallandale Outpatient Surgical Center

Adam Lynch, Vice President, Principle Valuation, LLC

Tom Mallon, CEO, Regent Surgical Health

Stephanie Martin, Administrator, St. Augustine Surgery Center

John D. Martin, Principal, Martin Healthare Consulting

Kevin McDonald, Vice President Surgery Sales, SourceMedical

Tim Meakem, MD, Medical Director, ProVation Medical

Todd J. Mello, ASA, AVA, MBA, Principal & Founder, HealthCare Appraisers, Inc.

Timothy Merchant, Vice President of Sales, MEDISISS, Medline Industries, Inc.

Laura Miller, Editor In Chief, Becker's Spine Review, Becker's ASC Review, Becker's Healthcare

Amy Mowles, President & CEO, Mowles Medical Practice Management

Christine Henry Musa, Director of Business Development, Regent Surgical Health

Jeffrey P. Nees, MD, Neursurgeon, Laser Spine Institute

Nicholas Newsad, Analyst, HealthCare Appraisers, Inc.

Jon Nielsen, MD, North Memorial Ambulatory Surgery Center at Maple Grove

Joe Ollayos, Administrator, Tri-Cities Surgery Center, LLC

Michael Orseno, Revenue Cycle Director, Regent Surgical Health

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

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Blair Rhode, MD, ROG Sports Medicine, Orland Park Orthopedics

Gary Richberg, RN, BSN, ALMC, CNRA, CNRC, CASC, Administrator, Pacific Rim Outpatient Surgery Center

Lisa Rock, President, National Medical Billing Services

Stephen Rosenbaum, CEO, Interventional Management Services

Linda Ruterbories, RN, ANP, OSC Director, OA Center for Orthopedics

Marcy W. Sasso, CASC, Director of Compliance and Development, Facility Development & Management, LLC

Matt Searles, Managing Partner, Merritt Healthcare

Phenelle Segal, RN, CIC, President, Infection Control Consulting Services, LLC

John Seitz, CEO, MMX Holdings (ManageMyASC)

Jeffrey Simmons, Chief Development Officer, Regent Surgical Health

Amy Sinder, MS, Administrator, CBC Surgery Center

Natalie Soule, RN, CASC, Premier Orthopedic Surgery Center

Thomas J. Stallings, Partner, McGuireWoods LLP

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Michael Stroup, SVP Acquisitions, United Surgical Partners International

Chris Swing, CFO, Vantage Outsourcing

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Larry Taylor, President & CEO, Practice Partners in Healthcare

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Joyce Deno Thomas, SVP of Operations, Regent Surgical Health

Anna Timmerman, Associate, McGuireWoods LLP

Gretchen Heinze Townshend, Associate, McGuireWoods LLP

John Venetos, MD, Gastroenterologist, John Venetos, Ltd.

Pedro J. Vergne, CEO, Physicians' Capital Investment

Barton C. Walker, Partner, McGuireWoods LLP

Marsha Wallander, RN, Associate Director of Accreditation Services, AAAHC

Amber McGraw Walsh, Partner, McGuireWoods LLP

Kelly Webb, Vice President and General Manager, ASC Billing Division, MediGain

Robert Westergard, CPA, CFO, Ambulatory Surgical Centers of America

Richard N.W. Wohns, MD, JD, MBA, South Sound Neurology, PLLC

Bob Woodward, Legendary Pulitzer Prize-Winning Journalist, Author, and Associate Editor, The Washington Post

Joseph Zasa, Co-Founder and Managing Partner, ASD Management

Robert Zasa, MSHHA, FACMPE, Managing Partner and Founder, ASD Management

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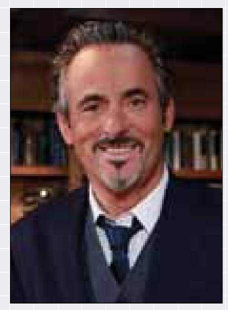
Register Online at https://www.regonline.com/20thAnnualASC



David Feherty

David Feherty was born in the seaside town of Bangor in Northern Ireland. He grew up with aspirations to become an opera singer, until he discovered he had the knack for hitting a golf ball. He jokes about his career change, "I was always interested in music from a very early age. But when I turned pro at age 17, I haven't sung a note since. Now, I only sing to punish my children."

David enjoyed a successful professional career, with 10 victories worldwide and over $3 million in prize money. He was a regular on the European Tour, with victories including the ICL International, the Italian Open, Scottish Open, South Africa PGA, BMW Open, Cannes Open, and Madrid Open. He captained the winning Irish team in the 1990 Alfred Dunhill Cup and played on the European Ryder Cup Team in 1991, an experience that rejuvenated his fervor for golf.

In 1997, David retired from professional golf when offered a position as a golf commentator for CBS Sports. "I always enjoyed talking more than playing, and now CBS and the Golf Channel are paying me for what I like to do most." Thanks to his sharp wit and colorful personality, David has become golf's favorite announcer.

David's success extends beyond broadcasting. He's authored 6 books, several making the *New York Times* bestsellers list: *An Idiot for all Seasons* (Rugged Land LLC 2005), *Somewhere in Ireland, A Village is Missing an Idiot* (Rugged Land LLC 2003) and *A Nasty Bit of Rough* (Rugged Land LLC 2002). Each is "chocked full with belly-busting humor," including his latest bestseller, *The Power of Positive Idiocy* (Doubleday 2010).

Rick Pitino

Rick Pitino, one of the most brilliant minds in coaching, began a new era in University of Louisville men's basketball when he was named the Cardinals' head coach on March 21, 2001.

The first coach in NCAA history to win a national championship at two different schools, Pitino's up-tempo style, pressure defense, strong work ethic and family atmosphere quickly returned Louisville to national prominence where it is firmly seated.

In 28 seasons as a collegiate head coach at five different schools, Pitino has compiled a 664-239 record, a .735 winning percentage that ranks him 12th among active coaches. His current contract ties him with U of L through the 2021-2022 season.

The first coach in NCAA history to take three different teams to the NCAA Final Four, Pitino is a member of the 2013 Induction Class for the Naismith Memorial Basketball Hall of Fame, lofty recognition for a lifetime of basketball achievement.

Pitino served as head coach of the New York Knicks for two seasons. In his initial year there in 1987-88, the Knicks improved by 14 victories and made the NBA Playoffs for the first time in four seasons. The Knicks won 52 games in 1988-89 and swept the Philadelphia 76ers in the first round of the NBA Playoffs.

Aside from his hoops prowess, Pitino has achieved success off the court as well in such realms as broadcasting, publishing, motivational speaking and horse racing. He is an accomplished author, producing such books as the best seller *Success Is A Choice* and *Lead to Succeed.*

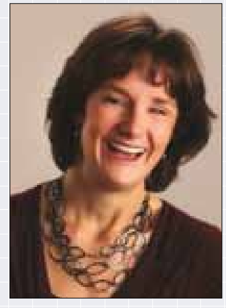
Bob Woodward

Since 1971, Bob Woodward has worked for *The Washington Post* where he is currently an associate editor. He and Carl Bernstein were the main reporters on the Watergate scandal for which the Post won the Pulitzer Prize in 1973. Woodward was the lead reporter for the Post's articles on the aftermath of the September 11 terrorist attacks that won the National Affairs Pulitzer Prize in 2002. In 2004, Bob Schieffer of CBS News said, "Woodward has established himself as the best reporter of our time. He may be the best reporter of all time."

Woodward has authored or coauthored 16 books, all of which have been national nonfiction bestsellers. Twelve have been #1 national bestsellers -- more than any contemporary non-fiction author:

- All the President's Men (1974) and The Final Days (1976), both Watergate books, co-authored with Bernstein
- The Brethren: Inside the Supreme Court (1979), co-authored with Scott Armstrong
- Wired: The Short Life and Fast Times of John Belushi (1984)
- Veil: The Secret Wars of the CIA 1981-1987 (1987)
- The Commanders (1991) on the first Bush administration and the Gulf War
- The Agenda: Inside the Clinton White House (1994)
- Shadow: Five Presidents and the Legacy of Watergate (1999)
- Bush at War (2002)
- Plan of Attack (2004)
- State of Denial: Bush at War Part III (2006)
- Obama's Wars (2010)

Woodward was born March 26, 1943, in Illinois. He graduated from Yale University in 1965 and served five years as a communications officer in the United States Navy before beginning his journalism career at the Montgomery County (Maryland) Sentinel, where he was a reporter for one year before joining the Post.



Bonnie Blair

Success under pressure is the measure of a true champion. There are numerous winners in the world of sports but the celebrated athletes are the few who meet the challenge of pressure time after time. Bonnie Blair is undoubtedly celebrated as the speedskater who produces her best performances when it counts the most.

Bonnie began her race in the 500 meter event of the 1988 Calgary Olympics immediately after her rival Christa Rothenburger of East Germany set a world record. Not to be outdone, Bonnie proceeded to skate the 500 meters faster than any woman had before or has since, capturing the gold medal in a world record time of 39.1. This record stood for 5 years until March 1994, when at the age of 30, Blair met her ultimate goal of shattering the 39 second mark with a time of 38.99.

Career Highlights

- Most decorated female Winter Olympian
- 1994, Gold medalist in 500m and 1000m
- 1992, Gold medalist in 500m and 1000m
- 1988, Gold medalist in 500m
- 1988, Bronze medalist in 1000m
- 1st woman to break 39 second barrier in the 500m
- 1st American to win 3 consecutive gold medals in a Winter Olympic event
- Named one of the Century's Five Best Female Athletes by Sports Magazine
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Improving Profitability and Business and Legal Issues

FROM BECKER'S ASC REVIEW, ASC COMMUNICATIONS

OCTOBER 24-26, 2013

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6 Tactics for ASCs to Survive in a Single Dominant Payer Market

By Laura Miller

Director of Managed Care at Regent Surgical Health Andrea Woodell discusses six tactics for ambulatory surgery center leaders to survive in a marketplace with one dominant payer.

1. Develop a strong relationship with the payer. Surgery center leaders should develop an excellent relationship at multiple levels within the insurance company. If the ASC does not have a designated managed care director, the administrator should be the point of contact for provider relations, while the scheduler can develop a relationship with the payer's preauthorization department. The ASC's medical director should also connect with the payer's medical director to establish and reinforce the surgery center's clinical excellence.

"If they don't like you, they won't help you," says Ms. Woodell. "However, within all those relationships the surgery center should not lose site of the bigger picture, which is getting paid more. In addition ensure claims are adjudicated within payer guidelines to avoid costly recoupments creating ill will within the payer towards the center."

2. Bring quantifiable cost data to the negotiating table. When entering into payer negotiations, provide objective documented cost information from your center. Go beyond the basics of providing invoices for implants. Have discussions regarding costs incurred to upgrade and maintain the physical plant. Include items such as new lights for operating rooms, HVac or a new laser to add additional specialties that are currently seen at the hospital.

"If the dominant payer is not being equitable and covering costs, you can work with your local ASC association while respecting the confidentiality of the agreements," says Ms. Woodell. "You can still have general conversations if they are not allowing procedures to be done in the outpatient setting. Demonstrate how the ASCs are trying to broaden the scope of cases and relocate them to an outpatient setting."

3. Strive to be the best. Become the best clinical provider and show payers you are also achieving the best outcomes, highest patient satisfaction, employer preference and compliant Medicare reporting. If you can work with a large employer to provide better care than others in the marketplace, make sure the insurance company knows this preference.

"A great way to garner the payer's attention is by having strategic employer groups advocate on

"A great way to garner the payer's attention is by having strategic employer groups advocate on your behalf," says Ms. Woodell. "The payer's customer is the company paying their premiums."

your behalf," says Ms. Woodell. "The payer's customer is the company paying their premiums."

The employers want their employees traveling a shorter distance, receiving better outcomes, recovering more quickly and missing fewer days of work. The decreased risk of infection and strong patient satisfaction at the ASC will also bolster employer preference.

"Get employers to advocate on your behalf. Surgeons can develop those relationships," says Ms. Woodell. "It's not just the workers compensation recipient, but all employees needing healthcare."

4. Become the exclusive provider in your market. If your group can lock up a specialty within a certain geographic area, including key physicians, and provide good outcomes, you have more leverage to negotiate better rates with the dominant payer.

"If you have proven outcomes for a unique specialty in the area, you can work with payers for a better rate," says Ms. Woodell. "But your facility must have the ability to objectively document better outcomes, quicker return to work and higher patient satisfaction. Just saying these things doesn't translate into improved reimbursement."

5. Find the right location. If you are developing a new surgery center, the ideal location would be somewhere without significant ASC penetration. If you are locating or acquiring an ASC in a saturated market, don't expect to see significant rate increases.

"If you are able to achieve any type of geographic isolation, that should be used to your benefit in negotiations with the dominant payer," says Ms. Woodell. "I've seen single specialty groups in competitive markets show they reduced subsequent office visits and achieved better outcomes successfully negotiate higher rates with notoriously difficult payers. This comes from having excellent clinicians and documentation."

Andrea Woodell

However, also understand how you are contributing to the single-dominant payer issue in the market. If you are negotiating good rates with the dominant payer, you'll need to negotiate higher rates with other payers in the market, which can negatively influence the non-dominate payers' growth.

6. Choose your partners carefully. It's especially important in markets with one dominant payer to choose physician and administrative leaders who can positively influence your organization. This is also true for hospital and management company partners.

"Their leadership will greatly influence your ability to work with dominant players," says Ms. Woodell. "If you're looking for a hospital partner, chose one that has market penetration or a smaller hospital system leveraging geographic exclusivity."

Physician leaders should be well-respected within the community with a reputation of clinical excellence and high patient satisfaction

"Payers don't want to work with a group that is generating patient complaints," says Ms. Woodell. "You also want to work with physician leaders who can advocate on the surgery center's behalf. They need to calmly and persuasively articulate the ASC's needs at payer meetings." ■

139 Speakers at the 2013 Annual Ambulatory Surgery Centers Conference

The 20th Annual ASC Conference will take place October 24-26 at the Swissotel in Chicago. The conference, which is focused on improving profitability and business and legal issues, brings together surgeons, physician leaders, administrators and ASC business and clinical leaders. The following professionals will be attending and speaking at the conference.

David Abraham, MD. Orthopedic Surgeon at The Reading Neck & Spine Center (Wyomissing, Pa.).

Vickie Arjoyan. Administrator of Specialty Surgical of Beverly Hills (Calif.).

John Bartos, JD. CEO of CollectRx (Rockville, Md.).

Scott Becker, JD, CPA. Partner with McGuireWoods and Publisher of *Becker's ASC Review* (Chicago).

Kelly Bemis, RN. Director of Clinical Services for Surgical Care Affiliates (San Diego).

Sandy Berreth. Administrator of Brainerd Lakes Surgery Center (Baxter, Minn.).

Chris Bishop. Senior Vice President of Acquisitions & Business Development for Blue Chip Surgical Partners (Franklin, Tenn.).

Bonnie Blair. Speed Skating Champion and Three-Time Olympic Gold Medalist.

Stephen Blake. CEO of Central Park ENT & Surgery Center (Arlington, Texas).

Jeff Blankinship. President and CEO of Surgical Notes (Dallas).

Dotty Bollinger, RN, JD. COO of Laser Spine Institute (Tampa, Fla.).

Robert Bray, Jr., MD. Neurological Spine Surgeon with D.I.S.C. Sports & Spine Center (Marina Del Ray, Calif.).

Brian Brown. Regional Vice President of Meridian Surgical Partners (Brentwood, Tenn.).

Jennifer Brown, RN. Endoscopy Nurse Manager for Gastroenterology Associates of Central Virginia (Lynchburg, Va.).

Danny Bundren. Vice President of Acquisitions and Development for Symbion Healthcare (Nashville, Tenn.).

Meggan Bushee, JD. Associate with McGuireWoods (Charlotte, N.C.).

Paul Cadorette. Director of Educational Services for mdStrategies (Cypress, Texas).

Holly Carnell, JD. Associate with McGuireWoods (Chicago).

Brett Chambers. Project Manager of IT Consulting for Key Whittman Eye Center (Dallas).

Scott Christiansen. President of CCO Healthcare Partners (Chicago).

Jeffrey Clark, JD. Partner at McGuireWoods (Chicago).

Trish Corey. Sales Representative for Simple Admit (Baldwinsville, N.Y.).

Jamie Crook. Director of Physician Recruiting for Regent Surgical Health (Westchester, Ill.).

R. Blake Curd, MD. Chairman of Surgical Management Professionals (Sioux Falls, S.D.).

Fred Davis, MD. Clinical Assistant Professor at Michigan State University's College of Human Medicine (Grand Rapids, Mich.).

Timothy Davis, MD. Director of Interventional Pain and Electrodiagnostics at The Spine Institute Center for Spinal Restoration (Santa Monica, Calif.).

Gregory DeConciliis. Administrator of Boston Out-Patient Surgical Suites (Waltham, Mass.).

Joyce Deno Thomas. Senior Vice President of Operations for Regent Surgical Health (Westchester, Ill.).

Stephanie Ellis, RN. Owner and President of Ellis Medical Consulting (Franklin, Tenn.).

Paul G. Faraclas. President and CEO of Voyance (Branford, Conn.).

David Feherty. CBS Golf Commentator and Best-Selling Author.

Erik Flexman. Executive Director of Forest Canyon Endoscopy & Surgery Center (Flagstaff, Ariz.).

Robin Fowler, MD. Chairman and Medical Director of Interventional Management Services (Atlanta).

Brandon Frazier. Vice President of Development and Acquisitions for Ambulatory Surgerical Centers of America (Hanover, Mass.).

Jim Freund. Vice President of Business Development for Medical Web Technologies (Willington, Conn.).

Jon H. Friesen. CFO of Nueterra Healthcare (Leawood, Kan.).

Tom Gallagher. President and CEO of PDP Holdings (Nashville, Tenn.).

Nap Gary. COO of Regent Surgical Health (Westchester, Ill.).

Ann Geier, RN. Senior Vice President of Operations for Ambulatory Surgical Centers of America (Hanover, Mass.).

Tamar Glaser, RN. CEO of Accreditation Services and AccredAbility (Sparta, N.J.).

Scott Glaser, MD. Co-Founder and President of Pain Specialists of Greater Chicago (Burr Ridge, Ill.).

Doug Golwas. Senior Vice President of Medline Industries (Broadview, Ill.).

Nicole Gritton. Vice President of Nursing and ASC Operations for Laser Spine Institute (Tampa, Fla.).

Debbie Hall. Administrator of High Plains Surgery Center (Lubbock, Texas).

Kenny Hancock. President and Chief Development Officer of Meridian Surgical Partners (Brentwood, Tenn.).

Tracey Harbour, RN. Administrator of Surgery Center of Pinehurst (N.C.).

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Bill Hazen, RN. Administrator of The Surgery Center at Pelham (Greer, S.C.).

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Bob Herman. Editor at *Becker's Hospital Review* (Chicago).

Edward P. Hetrick. President of Facility Development and Management (Orangeburg, N.Y.).

Carol Hiatt, RN. Consultant and Accreditation Surveyor for Healthcare Consultants International (Skokie, Ill.).

Mary Hibdon, RN. ASC Strategist, Perioperative for Cerner (Kansas City, Mo.).

Karen Howey. Administrator of Beaumont Macomb (Mich.) Township ASC.

Tom Hui. President and CEO of HST Pathways (Lafayette, Calif.).

Thomas H. Jacobs. President and CEO of MedHQ (Westchester, Ill.).

P.J. Jarboe, RN. Clinical Director of Cool Springs Surgery Center (Franklin, Tenn.).

Marion K. Jenkins, PhD. Executive Vice President of 3t Systems (Greenwood Village, Colo.).

Darlene Johnson, RN. Healthcare Consultants International (Vero Beach, Fla.).

Jen Johnson. Partner with VMG Health (Dallas).

Nikki Johnson. Vice President of Human Resources for Nueterra Healthcare (Leawood, Kan.).

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Luke Lambert. CEO of Ambulatory Surgical Centers of America (Hanover, Mass.).

Brent Lambert, MD. Principal and Founder of Ambulatory Surgical Centers of America (Hanover, Mass.).

Linda Lansing. Senior Vice President of Clinical Services for Surgical Care Affiliates (Deerfield, Ill.).

G-A (Gary) Lawson-Boucher, MD. Lieutenant Commander of the Medical Corp. for the United States Navy.

Liliana Lehmann. Administrator of Hallandale Outpatient Surgical Center (Hallandale Beach, Fla.).

Adam Lynch. Vice President of Principle Valuation (Chicago).

Tom Mallon. CEO of Regent Surgical Health (Westchester, Ill.).

Stephanie Martin. Administrator of St. Augustine (Fla.) Surgery Center.

John D. Martin. Principal of Martin Healthcare Consulting (Mount Laurel, N.J.).

Kevin McDonald. Vice President of Surgery Sales for SourceMedical (Chicago).

Kevin McDonough. Partner with VMG Health (Dallas).

Amber McGraw Walsh, JD. Partner with McGuireWoods (Chicago).

Tim Meakem, MD. Medical Director for ProVation Medical (Minneapolis).

Todd Mello. Principal and Founder of HealthCare Appraisers (Castle Rock, Colo.).

Timothy Merchant. Vice President of Sales for Medline Industries (Mundelein, Ill.).

Laura Miller. Editor in Chief of *Becker's Spine Review* and *Becker's ASC Review* (Chicago).

Amy Mowles. President and CEO of Mowles Medical Practice Management (Edgewater, Md.).

Jeffrey P. Nees, MD. Neurosurgeon with Laser Spine Institute (Oklahoma City).

Nicholas Newsad. Analyst with HealthCare Appraisers (Highlands Ranch, Colo.).

Jon Nielsen, MD. Obstetrician and Gynecologist at North Memorial Ambulatory Surgery Center at Maple Grove (Minn.).

Joe Ollayos. Administrator of Tri-Cities Surgery Center (Geneva, Ill.).

Michael Orseno. Revenue Cycle Director for Regent Surgical Health (Westchester, Ill.).

Jon O'Sullivan. Principal of HealthEconomix (Dallas).

Rebecca Overton. Director of Revenue Cycle Management for Surgical Management Professionals (Sioux Falls, S.D.).

Mike Pankey. Administrator of Ambulatory Surgery Center of Spartanburg (S.C.).

Colin Park. Manager of VMG Health (Dallas).

Marcia Patrick, RN. Infection Prevention Consultant for The Accreditation Association for Ambulatory Health Care (Skokie).

Michael Patterson. President and CEO of Mississippi Valley Surgery Center (Davenport, Iowa).

Jeff Peo. Vice President of Acquisitions and Development for Ambulatory Surgical Centers of America (Hanover, Mass.).

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Marti Potter. Administrator of Jersey Shore Ambulatory Surgery Center (Somers Point, N.J.).

William M. Prentice, JD. CEO of Ambulatory Surgery Center Association (Alexandra, Va.).

Michael Redler, MD. Orthopedic Surgeon at The OSCM Center (Fairfield, Conn.).

Karen Reiter. COO of D.I.S.C. Sports & Spine Center (Marina Del Ray, Calif.).

Blair Rhode, MD. Sports Medicine Physician with Orland Park (Ill.) Orthopedics.

Gary Richberg, RN. Administrator of Pacific Rim Outpatient Surgery Center (Bellingham, Wash.).

Regina Robinson, RN. Director of Peninsula Surgery Center (Newport News, Va.).

Lisa Rock. President of National Medical Billing Services (St. Louis).

Stephen Rosenbaum. CEO of Interventional Management Services (Atlanta).

Linda Ruterbories, RN. OSC Director for OA Center for Orthopedics (Portland, Maine).

Marcy Sasso. Director of Compliance and Development for Facility Development and Management (Orangeburg, N.Y.).

Matt Searles. Managing Partner for Merritt Healthcare (Somers, N.Y.).

Phenelle Segal, RN. President of Infection Control Consulting Services (Blue Bell, Pa.).

John Seitz. CEO of MMX Holdings (Sparta, N.J.).

Amy Sinder. Administrator of CBC Surgery Center (Crown Point, Ind.).

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Pedro Vergne. CEO of Physicians' Capital Investment (Dallas).

Barton Walker, JD. Partner with McGuireWoods (Charlotte, N.C.).

Marsha Wallander, RN. Associate Director of Accreditation Services for The Accreditation Association for Ambulatory Health Care (Skokie).

Kelly Webb. Vice President and General Manager of ASC Billing Division for MediGain (Plano, Texas).

Robert Westergard, CPA. CFO of Ambulatory Surgical Centers of America (Hanover, Mass.).

Richard Wohns, MD, JD. Founder of NeoSpine (Puyallup, Wash.).

Bob Woodward. Pulitzer Prize-Winning Journalist, Author and Associate Editor with *The Washington Post* (Washington, D.C.).

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Joseph Zasa. Managing Partner and Co-Founder of ASD Management (Dallas).

Greg Zoch. Partner and Managing Director of Kaye/Bassman International (Dallas). ■

What do ACOs Really Mean for ASCs? Q&A With Ken Arvin, Esq. of Sheridan Healthcare

By Laura Miller

Ken Arvin, Esq., Vice President Ambulatory Services for Sheridan Healthcare, discusses the impact of accountable care organizations on ambulatory surgery centers and what administrators can do to prepare.

Q: How is ACO development impacting ambulatory surgery centers?

KA: At this point, very little. Few ASCs in the United States are participating in ACOs. ASCs currently participating in ACOs are located in major geographic urban areas with large health systems. ACOs are not yet having a major impact on most ASCs except ASCs associated with these very large healthcare systems. However, it is important to understand what the future holds as ACOs continue to mature and begin to effect ASCs more and more.

Q: What should ASC administrators know about ACOs as they begin to form around the country?

KA: I think at a minimum you have to understand:

- What an ACO is;
- Who will participate;
- How will ACO development impact the ASC's relationships with its physician/hospital partners in the community.

An ASC on its own will normally not be looking at forming its own ACO. An ASC as a standalone entity will usually not be leading an ACO discussion. That discussion will most likely be led by the hospital or health system, or physician members associated with an ASC. I think the administrator has to be very in-touch with the ASC's hospital/physician leadership and understand their needs because those needs will have a direct impact on how the ASC participates in an ACO.

Q: When is it beneficial for ASC leaders to become part of the ACO discussion in their community? How can they ensure a seat at the table?

KA: Many ASCs may not have a seat at the table. If you are an ASC and your physician/hospital partners do not want to participate with the ASC in the ACO, then it will be more difficult to become part of the discussion. We are in the infancy stages of ACO development, so you have to be aware of their development, but you also have to approach their development understanding the potential impact to their own ASC's needs.

Q: What is the potential negative impact ACOs could have on ASCs in different marketplaces? Is there any way to mitigate that risk?

KA: If you are an independent ASC in a very large multi-hospital system community or an ASC in a small town dominated by one or two hospitals, the ACO development could potentially create a situation where an independent ASC is struggling to receive competitive reimbursement rates from third party payor contracts. Another negative impact ASCs may experience as ACOs expand is if a significant amount of an ASC's physician leadership joins an ACO with a hospital system that is a competitor with the ASC.

One way to minimize these situations is by strengthening the relationships between the ASC and its hospital/physician partners. The stronger an ASC's hospital/physician partners are as a group, the better the ASC.

Q: What advice do you have for ASC administrators facing ACOs in their market?

KA: It depends on the situation. If you are a hospital-based ASC or a joint venture ASC, the administrator needs to learn as much as possible about the ACO. Open dialogue and communication with your hospital partners or physicians. You have to be abreast of everything going on with your business. Administrators should understand the laws being implemented and what their physician partners plan for the future.

If you are not involved with a hospital system, determine whether your physician partners are pursuing an ACO strategy and if not, determine which strategy would best serve the ASC. ■

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Driving Value in Spine Care: Outpatient Spine Surgery **(continued from page 1)**

Canada's Shouldice Hospital for hernia surgery in Canada was the original focused factory. The Shouldice model proved that when a limited number of procedures are done in high volume by the same providers and staff, the outcomes are better, costs are lower and patients are more satisfied.

Outpatient spine surgery allows the spine surgeon to maintain tight control of cost and quality, responding to the needs of not only the surgeon and the patient, but also insurance companies. The cost for outpatient spine surgery is 50 percent to 70 percent lower than for the same procedure performed in a hospital. MIS spine procedures are 30 percent to 60 percent less costly than traditional surgery. Besides the lower cost, MIS also offers the significant advantages of shorter recovery times and decreased rates of recurrence. In this era of cost containment, particularly given the demands of all patients, including increasing numbers of babyboomers, for healthy spines, outpatient and MIS spine surgery will continue to increase in frequency. Baby boomers want more immediate results, a quicker return to an active lifestyle and work, and tend to prefer to stay out of the hospital, if possible.

Presently, the spinal procedures frequently performed in an outpatient setting include the following:

- anterior cervical discectomies with fusions (one-, two- and three-level)
- cervical disc arthroplasties (one- and two-level)
- cervical foraminotomies and posterior discectomies
- lumbar microdiscectomies
- lumbar laminoforaminotomies
- lumbar laminectomies
- MIS lumbar fusions including XLIFs, TLIFs, and interspinous process fusions

Cervical arthroplasties or total disc replacements are an excellent example of a fairly new and very successful addition to the world of outpatient spine surgery. Based on the proven safety, cost effectiveness, clinical outcomes and patient satisfaction with anterior cervical discectomy and fusion, it was a natural next step to perform outpatient arthroplasties.

Dr. Richard Wohns

Arthroplasties offer quicker recovery than ACDF, preserve motion of the neck and lessen the chance of developing adjacent disc degeneration that might require further surgery. The five-year disc replacement data compared with

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fusion demonstrated that patients who underwent TDR had a 97.1 percent probability of no secondary procedures, compared with 85.5 percent for ACDF patients who did not experience a reoperation due to implant breakage or device failure. In addition, 2.9 percent of TDR patients had reoperations within five years of the initial surgery, compared with 14.5 percent of ACDF patients.

I have recently reported a consecutive series of 132 outpatient cervical arthroplasties, from 2009 through April 2013, with 92 percent improved symptoms, an average operative time of 60 minutes for one level and 80 minutes for two levels, and an average time to discharge of three hours. There was no significant morbidity and no mortality. There were no transfers to a hospital, no post-operative ER visits, and no late hospitalizations.

The cost for outpatient cervical arthroplasty is lower than the cost for ACDF, and is less than 50 percent of the cost of the same procedure in a hospital.

Outpatient spine surgery will become increasingly more prevalent as new and enabling technologies continue to evolve, insurance companies and the government drive more healthcare to the outpatient setting for economic reasons, and patients become more educated about spine surgery options that meet their lifestyle expectations. ■

For additional information on outpatient spine surgery, contact the author at rwohns@neospine.net.

5 Qualities of Spine ASC Leaders for Today & Tomorrow

By Laura Miller

Spine Center Network was developed by Prizm Development, Inc., two years ago and now acts as a national network of credentialed Spine Centers of Excellence for payers and consumers. Inclusion in the network is based on credentialing criteria that includes having fellowship-trained or highly specialized spine surgeons integrated with spine-specialized physical medicine physicians and spine therapists. Spine Center Network represents those spine centers that meet the credentialing criteria. It currently includes about 18 spine centers across the United States.

"Prizm developed the network because they had just completed a very creative spine care contract with United Healthcare and the medical director asked, 'Where else do you have these kinds of spine centers,'" says James Lynch, MD, FRCSI, FAANS, founder and CEO of SpineNevada, and chairman and director of spine at the Surgical Center of Reno, a member of the Spine Center Network. "Consequently, Prizm developed credentialing criteria for those spine centers that emphasized non-surgical treatment options and invited them to become Spine Center Network."

The credentialing criteria requires: integration of spine surgeons with PMR and spine therapy; production of a Clinical Outcome Report Card; and use of a Home Remedy Book that educates patients on non-surgical treatment options.

"Prizm began developing its non-surgically oriented spine center model more than 18 years ago," says Bob Reznik, President of Prizm Development. "We had done more than 500 one-on-one meetings with health insurance medical directors and large employers. We learned that they really wanted patients to be educated on their non-surgical treatment options. They wanted patients to avoid 'surgical mills' where they too often received surgery without any non-surgical treatment options. They also were frustrated that patients never received any home exercises that strengthen the back, make it more flexible and resistant to future strain. The centers in Spine Center Network emphasize non-surgical options before spine surgery. But when symptoms indicate surgery is needed, they are decisive and try to use a minimally invasive approach."

Mr. Reznik believes that healthcare reform will cause emerging accountable care organizations to seek out these types of spine centers. Consequently Spine Center Network is already developing bundled case rates for spine surgery and non-surgical episodes of care.

"Spine Center Network helps push us along to be sensitive to the needs of employers and payors for predictability and case rates," says Dr. Lynch. "That is the future of spine."

Here are five qualities of spine centers that will be in the best position to lead in the future, and become part of the Spine Center Network.

1. Integrated surgical specialists with non-surgical care. According to Mr. Reznik, around 90 percent of spine issues can be treated non-surgically. Patients and payers are looking for providers who can triage care, fast-tracking patients to the right specialist for their individual needs.

"With healthcare reform, there will be 30 million more potential patients and some of them will have back and neck issues," says Mr. Reznik. "How can we triage these patients so spine surgeons aren't having to assess simple acute back pain cases? Several health insurance plans in Michigan, Minnesota and Nevada have already mandated that physical medicine and rehabilitation physicians act as the gatekeeper. Some states have implemented a surgeon blockade, requiring the patient to see a PM&R physician before seeing a surgeon."

These trends could push spine in a similar direction as cardiac care. Currently, patients with beginning stage heart disease see a cardiologist before the cardiothoracic surgeon.

"In spine, you should have triage protocols so the person with a neurological deficit sees the right specialist," says Mr. Reznik. "I think payers are becoming educated about the high volume of surgery being performed, and healthcare providers need to do a better job of directing the patient to the right provider."

2. Ability to perform minimally invasive procedures. Technology and technique for minimally invasive spine surgery has evolved over the past several years into highly sophisticated instrumentation allowing surgeons to perform traditional procedures with a less disruptive approach. "These benefits are why we opened a new dedicated office facility, Spine-Nevada Minimally Invasive Spine Institute, in July to address patient and insurance carrier needs," says Dr. Lynch.

Proven minimally invasive procedures can have several benefits, including less pain, blood loss, recovery time and cost than open surgery.

"When patients do need surgery, they should be directed to someone who performs a high volume of spine procedures with a minimally invasive approach so patients get the benefit from proficiency as well as a smaller incision," says Mr. Reznik. "These procedures can also reduce the length of stay, and some surgeons can perform them in same-day surgery centers."

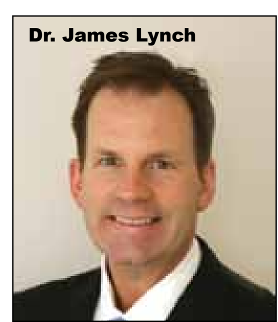
The procedure costs less for the insurance company and patients are able to return to work more quickly, which softens the overall economic impact of spine surgery. Surgeons who perform a high volume of cases will have a more predictable outcome.

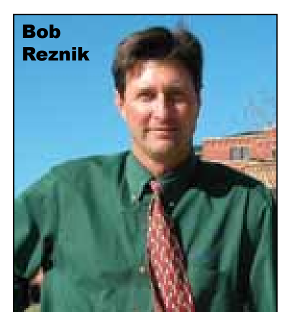
"I think payers are attracted to predictable patient outcomes and rates for surgery," says Mr. Reznik. "I think payers have been burned by unpredictable rates of facilities in the past, and that's one reason why payers are more intrigued by centers with non-surgical treatment options."

However, minimally invasive surgery isn't right for every patient and spine surgeons must understand appropriate patient selection before moving forward with surgical cases.

3. Achieve predictable outcomes. Spine care is expensive and stakeholders want to make sure they have a positive experience. Whether its spine surgery or non-operative treatment, payers may be willing to compensate more for quality in the future.

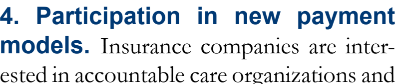
"Case rates can be a win-win for the payer and spine care provider. In return for a predictable total bundled rate, payers can provide reimbursement to the spine surgeon that may actually be better than their current unbundled and heavily discounted CPT code rate," says Mr. Reznik. "From a lot of discussions we've had with payers and medical directors, they aren't trying to abuse spine surgeons with their pricing, but they are frustrated with the unpredictability."


Dr. James Lynch

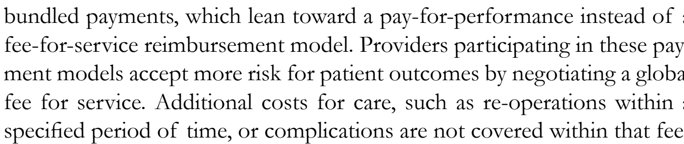

Bob Reznik

A spine center should be transparent with its protocols and philosophy for spine care by publishing online a Clinical Outcome Report Card that is generated not by themselves, which has little credibility, but rather by an outside entity. The report card should reveal not only patient satisfaction, but also what percent of patients are receiving therapy, injections or surgery in the course of their treatment. Also, the report card should reveal what percent received a home exercise program and Home Remedy Book to demonstrate efforts toward prevention of future spine problems.

"Spine Center Network is the only network of truly credentialed spine centers where outcomes are reported online," says Dr. Lynch. "It's truly unique. As such, it is by invitation only, and a very elite group of spine centers."



4. Participation in new payment models. Insurance companies are interested in accountable care organizations and bundled payments, which lean toward a pay-for-performance instead of a fee-for-service reimbursement model. Providers participating in these payment models accept more risk for patient outcomes by negotiating a global fee for service. Additional costs for care, such as re-operations within a specified period of time, or complications are not covered within that fee.



"In 2013 we will be contacting medical directors of regional health insurance plans and ACOs in different locations and presenting them with bundled rates for simple back and neck surgery and ACDF," says Mr. Reznik. "The benefit for member centers is that they would ultimately get access to contracts of ACOs and we would provide a template on which they could bundle pricing for the local ASC and hospital. With that said, every center controls its own rates."

Each location would negotiate individual pricing, at a reasonable rate for the provider. Centers controlling more of the care can better guarantee quality outcomes.

"With healthcare reform, all accountable care organizations will be looking for spine centers that emphasize non-surgical treatment options and minimally invasive spine surgery to reduce costs," says Dr. Lynch. "National payers always have to search to find the best spine centers in the region [and they will be] attracted to the Prizm model that includes PM&R, spine surgeons, spine therapists, clinical outcome report cards, emphasis on home exercise and non-surgical treatment all under one roof."

5. Include patient education beyond medical care. Innovative spine care providers are beginning to focus attention on non-medical treatments for spine care and maintenance, such as fitness and personal health specialists. Spine centers that will be leaders in the future are open to any pathway that would benefit their patients.

"If you look at how heart centers have evolved, you have fitness specialists, cardiac rehab and disease process specialists," says Mr. Reznik. "You are going to see the same thing with spine. Right now spine is more fragmented and patients could see several different specialists and still not receive the right care. The mature spine center of the future will have orthospine surgeons, neurospine surgeons, physical medicine, therapists and exercise physiologists that move patients through to recovery as soon as possible." ■

8 Ideas on Public Relations Programs for ASCs Without Large Marketing Budgets From Central Maine Orthopaedics

By Laura Miller

A few years ago, Auburn-based Central Maine Orthopaedics, which includes a surgery center performing 2,000 procedures per year, devised a plan to stop spending money on advertising and start focusing their attention and resources on relationship building.

"It really paid off," says Jeff Wigton, director of operations at Central Maine Orthopaedics. "We decided to hit the ground running. We e-mailed 4,000 to 5,000 athletes in Central Maine and we were able to pull together a program without any advertising. We see that now when we are out in the community, people know who we are. They know Central Maine Orthopedics and they have heard good things. It's a different approach than sinking all our money into advertising."

Here are eight tactics Central Maine Orthopaedics uses to build a strong public relationship program and market their center without spending advertising dollars.

1. Engage with local businesses. Michael Cox, CEO of Central Maine Orthopaedics, sits on the Chamber of Commerce Board of Directors in his community, and CMO participates in Chamber events. Forming relationships with other businesses in the community grows CMO's professional network and reputation.

"We position CMO as a large community employer and show the level of care we are able to provide is really something to be proud of," says Kelly David, head of public relations and marketing for Central Maine Orthopaedics. "Dr. Cox sends congratulatory notes to businesses that deserve accolades and we stay in contact with them. The more connections we make with our community, the more likely people are to recommend our practice to their family, friends and colleagues."

The Chamber of Commerce in Auburn is very active with several members promoting and interfacing with local businesses. "We want to be on the forefront of peoples' minds, so that when there is a large employer with injured workers or someone who needs surgery, we want them to think of CMO," says Dr. Cox.

2. Form a relationship with referring practices. Central Maine Orthopaedics has a physician-to-physician marketing program to strengthen relationships with referring physicians and their practices.

"Our physicians go to central referring practices and visit those physicians," says Ms. David. "They bring breakfast or lunch for the office staff and talk to administrators about their referral process. We ask how we can make the process easier to them; we are constantly reviewing the process to make sure it's working."

After interviewing the office staff, the group either focuses on what works or fixes what doesn't. Ms. David says the group tracks which physicians have visited referring physicians and how the visits impact referrals to gauge the success of their program.

3. Give community lectures. Surgeons around the country have begun giving community lectures about health and wellness. These lectures can focus on general health or specialty-related topics, such as arthritis or sports injuries for orthopedic surgeons.

"We've done knee and spine seminars, which were really helpful," says Ms. David. "Our data shows this is something that has gained popularity and can bring patients into the practice."

Since CMO keeps track of how patients learn about their services, they have found many people who attend these lectures decide to schedule an appointment. "Our lecture success rates are almost as high as primary care physicians in terms of driving patients into the center," says Dr. Cox.

4. Invite people in for an open house. Organize an "open house" event and invite people onsite to visit with physicians and see your facility. CMO held an "open house" event as part of an "After Hours" series featuring several local businesses, but ASCs can host similar events on their own as well.

"These events really give people a chance to look at the ASC and get to know the practice from the inside out," says Ms. David. "This community is really unique because it's so tight knit; people always want to know what is going on, so getting an inside look at our physicians and facility is really special to them."

Consider how people will move through the building and where they will stand during presentations about the center. Figure out how to introduce your facility to them and highlight the unique qualities of the center during the event.

Jeff Wigton

Michael Cox

Kelly David

5. Hold a fitness or wellness event. Coordinate a healthcare-related event and use local resources, such as the newspaper or hospital newsletter, to promote it. CMO held a free public event last year called "Hit the Ground Running" where physician speakers discussed how to become better runners.

"We sent out email news blasts as a collaborative effort to promote this event," says Ms. David. "We had around 300 to 400 people attend. We are doing a similar event this fall focused on cycling."

In addition to the physician and healthcare experts, CMO plans to bring in well-known industry experts on cycling to present at the event. "We put our best foot forward as a good community citizen when we work on these events," she says.

6. Participate in charity events. Supporting others in the community — especially if you're in a small community — is an effective method of forming new relationships. Participate in charity events, such as United Way projects or food pantries to build a strong reputation in the community.

"We have done a lot to give back to our community, including cleaning up a camp for disabled children and getting it ready for the winter," says Ms. David. "Some of our physicians went to the camp and helped. Those are ongoing relationships we have maintained throughout the year."

CMO has also developed a foundation — Maine Orthopaedic Foundation — for benevolent giving. "We do projects that align with our core values in keeping the community healthy, such as fitness and wellness events," says Dr. Cox. "We also do giving on an annual basis to not-for-profits who are trying to get the community up and going."

7. Engage with patients on social media. One of the quickest ways to build and maintain relationships with current, former and potential patients is through social media. People of all ages are engaging on Facebook, Twitter and other networking sites looking for information and interaction with medical professionals.

"We interact with current patients on social media to get their feedback and we're able to pass that information along to our staff," says Ms. David. "We can either congratulate our staff on a job well done or fix a problem that was brought to our attention."

CMO updates their social media on a daily basis with original and linked content relevant to their followers and patient base.

"We sometimes put CMO-focused content on our social media, and sometimes we put information from other sources as a way to have a back and forth conversation with others," says Ms. David. "We want them to have a warm picture of us. I don't hang my hat on social media — it's not the end-all, be-all — but it's a good way to introduce our surgeons to the community and stay engaged with our patients."

8. Keep websites relevant and updated. Build a quality website and keep it updated with news from the ASC, healthcare industry and blog posts to drive traffic. There are a few simple steps you can take for search engine optimization to ensure your website appears first when people search the ASC online:

- Include key words associated with the center, such as specialty, services and healthcare initiatives;
- Upload photographs onto the website;
- Regularly update content on the website;
- Include links to outside resources on the web.

"We have monitored the numbers on our website and changed our SEO plan to make it more effective," says Ms. David. "We are making our blog more interactive and informative to really tie everything together. Now we pop up more quickly when people search our name or something like 'joint replacement in Maine.'"

Be sure to include information potential patients will appreciate once they click through to your links, such as physician profiles. "Anecdotally, people want to know who their physicians are," says Ms. David. "They are going on the website to check them out. This has created a web of touch points with a real tangible relationship to our community." ■

5 Things to Know About Adding Pain Management to Orthopedics ASCs

By Laura Miller

Orthopedics-driven ambulatory surgery centers looking to continue growth and expansion should consider adding pain management.

"Orthopedics and pain management are a natural fit under the same roof because they compliment each other," says Paul Skowron, senior vice president, operations at Regent Surgical Health. "The specialists refer to each other, so if you are able to bring the specialists under one roof you are increasing their practice volume as well as ASC volume."

Large orthopedic groups may also decide to recruit pain management specialists to provide the continuum of care in their facility. The overall goal is for these physicians to eventually become investors in the ASC when shares are available. Here are five things to know about bringing pain management into an orthopedics-driven ASC.

1. Find the right pain specialist for your center. Screen potential pain physicians and groups in the area for the best chance of building a relationship with these potential future partners. Consider courting individual pain physicians who aren't currently employed within a hospital or practice, or small groups that aren't able to invest in the equipment necessary to perform injections and procedures in-house.

"The pain physicians who would rather use their office space entirely for patient evaluation instead of becoming a mini surgery center are ideal candidates," says Mr. Skowron. "They can participate in surgery center investment where there's proper equipment and staff to perform these procedures in a high volume setting."

If the right type of practitioners aren't available in the community, consider looking internally for surgeons who can perform pain procedures.

"As you think about your strategy, consider whether there are already spine surgeons at the center who can do simple pain injections in addition to complex spine procedures on an outpatient basis," says Mr. Skowron. "You may want to consider asking the spine surgeon to expand procedures to include pain instead of recruiting someone new to save resources there."

Paul Skowron

2. Investigate the physician's reputation and patient satisfaction. Pain patients report notoriously low satisfaction scores because of their pain. As patient satisfaction and quality scores become more important for provider reimbursement and success, consider how lower pain scores might impact the center and take whatever steps necessary to ensure your physicians will have the highest ratings possible.

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"ASC administrators should be concerned about patient satisfaction surveys because managed care companies are now looking at them more closely," says Mr. Skowron. "Pain, as it turns out, is a high contributor to low satisfaction scores at ASCs by nature of patients being in pain. The postoperative staff must be well-trained in addressing the pain patient before discharge."

ASC leaders should also perform due diligence on the pain physician's reputation in the community. High profile issues with patient satisfaction, or lower scores than other pain physicians in the area, are red flags to avoid.

3. Be ready to retrain staff. Pain physicians use much of the same equipment as orthopedic surgeons for their procedures, which means there won't be a big capital investment to bring in pain procedures. However, retraining staff is a necessary step to efficiency with pain patients.

"The length and complexity of orthopedics cases is different from pain cases," says Mr. Skowron. "Pain procedures are usually 15 to 20 minutes long while orthopedics cases are usually more than an hour. As a result, the clinical staff must have the ASC mentality to move quickly and efficiently between cases."

Make sure your transfer staff are familiar with the pace of pain procedures and can perform very quick turnovers to maximize patient volume. At the same time, staff members must also evaluate the patient's pain before they leave.

"Those skills are required and separate from what you would find at the hospital," says Mr. Skowron. "Work with your personnel to make this transition or hire new people who can complement the pain volume."

4. Maximize revenue with high volume and diverse payer mix. Cost per case is low for pain management, and usually payer mix is diverse enough for average net revenue per case to contribute positively to the ASC's margin. However, significant volume is required to cover of the cost of equipment purchase and incremental staff.

"Make sure the schedulers are ready for physicians with high volume pain procedures," says Mr. Skowron. "They should assign the physicians a block where they can come in and do 10 procedures per day. This is often different from what schedulers at orthopedics-driven ASCs are used to."

Schedulers and office staff will likely also increase dealings with insurance companies for pain patients and pay more attention to insurance verification.

"Make sure the margins are good," says Mr. Skowron. "The physicians should have a good payer mix and willing to standardize supplies across practitioners and use GPOs for best pricing."

5. You can work together on an occupational pain program. When courting a pain physician or group, make your ASC more attractive by working with the pain practitioner on building an occupational pain program. If the pain physician has a good reputation and can bring a high volume into the ASC, expanding the occupational pain program is another way to partner with those specialists.

"The program can be part of the surgery center, but there is no particular facility fee for it," says Mr. Skowron. "If you have a hospital partner that has not yet developed its own occupational pain program, that mix of investors can really work well together to develop a diverse occupational pain program."

Depending on your goals, you can either work with interventional pain specialists or physiatrists who do outpatient work. If you are working on a truly comprehensive program, you may want to target both. ■

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10 Key Thoughts for ASC Administrators Before Large Equipment Purchases

By Laura Miller

Michelle Punshon, administrative director for Musculoskeletal Ambulatory Surgery Center at Coastal Orthopedics & Sports Medicine in Bradenton, Fla., discusses 10 key considerations for ambulatory surgery center leaders before making a big equipment purchase. Musculoskeletal Ambulatory Surgery Center at Coastal Orthopedics & Sports Medicine is affiliated with ASD Management.

1. Find out how much you'll be reimbursed. If the equipment purchase is for a specialty or service you don't already provide, check reimbursement rates to make sure payments will cover equipment costs. "Figure out what you will be reimbursed for each procedure using the new machine," says Ms. Punshon. "You'll want to make sure that related procedures will bring in enough revenue to off-set that cost. What case volume will the new equipment bring in?"

2. Take disposables into consideration. Each procedure includes disposables, which bring additional costs to the table. "The cost of the disposables need to be considered when calculating your breakeven point with the purchase of the equipment," says Ms. Punshon. "You also want to make sure you can purchase the different kits your doctors require for the major equipment."

3. Check with GPOs for better contracts. Contact your group purchasing organization to see if they have a contract on the big-ticket items. Sometimes you'll realize a savings from their connections on the big equipment purchases as well as the small. "Make sure the sales rep knows what GPO you are a member of so you get the appropriate pricing," says Ms. Punshon.

4. Factor in preventative maintenance costs. Once the equipment is purchased, you may need preventative maintenance on the machinery to keep it running smoothly and increase its longevity. Keep these costs in mind, too. Down the road, you'll likely run into repair costs as well. Consider global costs over the long-term before deciding to invest. "Ask whether the company will be there to help you support the machine and set it up," says Ms. Punshon. "They should be available for staff in-service days to train on the equipment."

5. Cover all new and refurbished options before deciding on one. Large equipment purchases are a cost-burden, and some ASCs may be able to purchase high quality refurbished equipment for a lower cost. "There are vendors out there specializing in selling refurbished equipment, and that can be a really good deal," says Ms. Punshon. "Sometimes the vendor supplying new equipment has another line of refurbished equipment or a demo unit you can buy at a discounted rate, but it would still come with a warranty."

6. Beware of purchasing the latest fad. You don't want to buy an expensive piece of equipment that will be outdated tomorrow. Instead, focus on equipment that will last for years at the forefront of the field. "I was administrator of a urology center that purchased a laser that was used for several years," says Ms. Punshon. "You are going to invest a lot of money in it, so make sure it will be around long enough to recoup that investment."

7. Limit surgeon wish lists. Every surgeon has a "wish list" of new and expensive equipment they'd like to use at the ASC, but centers don't have the resources to accommodate everyone. "If it's a group of eight surgeons, not everyone can have their special toys," says Ms. Punshon. "Work with all surgeons to build a consensus about which purchases make the most sense."

8. Achieve product line continuity. Purchase the new equipment from a vendor or product line familiar to all ASC surgeons. "You'll want to have some level of continuity between the group and a product line so all surgeons are familiar with using the equipment," says Ms. Punshon. "It's also easier for staff if everyone is using the same products for procedures; you don't want every orthopedic surgeon using a different arthroscope."

9. Conduct staff and surgeon training. Think about workflow with the new equipment and what resources it will take to actually implement in the practice. Time and energy will be spent learning to use the new equipment, and the procedures will likely take longer in the beginning until staff and surgeons learn to become more efficient. "Research what training is needed and available for staff," says Ms. Punshon.

Michelle Pushon

10. Benchmark with other centers that already have this service line. Before purchasing the equipment, talk to administrators and physician leaders at centers already using this equipment and use their benchmarks to project your future success. "Ask these other administrators about their experience with the equipment, maintenance and longevity," says Ms. Punshon. "You don't want to start a service if the equipment goes down a lot; you want it available all the time. Network with your peers in the area to see what they think before moving forward." ■

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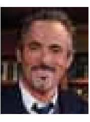

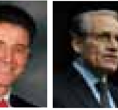
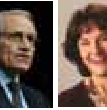

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8 Trends in ASC Payer Rates & Contract Negotiations

By Laura Miller

Here are eight trends in ambulatory surgery center third party payer contract negotiations and reimbursement rates from Dan Connolly, vice president of payer contracting for Pinnacle III.

1. Length of time to complete the process is increasing. Contract negotiations are taking longer today than they have in the past. The credentialing and renegotiation processes are also extended, which means ASC leaders must start the process earlier.

"The amount of time it takes to negotiate with the payer and agree upon a new contract is increasing to several months, and that's not a good thing for ASCs," states Mr. Connolly. "This is an industry where we want to get the contracts up and going as quickly as possible, while maximizing reimbursement." Mr. Connolly recommends the surgery center assemble its negotiation plan and start the negotiation process no later than 120 days prior to when credentialing is expected to be completed, or in the case of renewal, the soonest new rates can take effect.

2. More data is necessary for better rates. Data collection is crucial for ASCs to succeed in negotiating higher rates for procedures. Prepare and present data about clinical quality, cost control and cost comparisons to prove your center needs the rate increase to continue providing high quality treatment in a low cost setting.

"Start the process early and have all your ducks in a row in terms of data collection," says Mr. Connolly. "Everyone is asking for more money and payers are quick to shut that down, but if you show them the evidence and where they are at for market parity, they are more likely to work with you."

In many cases, Mr. Connolly has assembled a formal presentation to demonstrate to the payer that they were significantly below market competitors for commercial rates. Even before the negotiation process officially began, he showed insurance company representatives how payment deficiency impacted the center.

"The data reflected a discrepancy and communicated that a significant increase was necessary," says Mr. Connolly. "The data and discrepancy were our leverage points."

3. Contract terminations may be necessary. If insurance companies can't meet a reasonable rate increase, sometimes the ASC must consider terminating a contract for leverage purposes. Be prepared for long negotiations and set a strict date for completion; if a deal isn't reached within a reasonable amount of time, consider terminating the contract.

"Have that discussion up front to avoid pot holes and agree to move quickly," suggests Mr. Connolly. "If you can't make ends meet, then look at terminating the contract. Put a stop-loss measure into the timeline for negotiations because discussing termination will be taken seriously. However, use caution when playing this card, as it's a real slippery slope."

Some ASCs decide to terminate automatically if the terms aren't met while others may have additional conditions they consider. "Don't take termination lightly," asserts Mr. Connolly. "The goal is to get the job done and maximize your reimbursement within a set period of time. Keep your eye on the ball and remember the payers are negotiating with other groups over the same period of time, so set yourself as a priority."

4. Rate increases are becoming more common. While they aren't the standard, rate increases from third-party payers are becoming more common than they were over the past few years. For combined new and renegotiated contracts, Mr. Connolly has seen anywhere from 5 percent to 88 percent increases over the previous rate this year.

"There is a broad range for reimbursement" notes Mr. Connolly. "If it's gastroenterology in a multispecialty setting, we have seen decent rate increases. I attribute the moderate increase to the leverage of the other specialties. Even in the single specialties, I'm seeing moderate gains that we weren't seeing a few years ago because of fall-out from CMS. "

Mr. Connolly has also seen gains in ophthalmology and orthopedics.

5. Orthopedics and spine contracts are now more favorable. As more high acuity orthopedics and spine cases move from the inpatient hospital to the outpatient surgery center, insurance companies are more willing to negotiate better rates for the ASC — which is still lower than the hospital.

"I'm astonished at what we're seeing for orthopedics because we're seeing some turnaround," says Mr. Connolly. "We have increased reimbursement on many existing contracts and secured carve outs for implants on some contracts where we were not historically able to do that."

Dan Connolly

6. Accounts receivable days are becoming more important. In addition to collecting clinical and operational data on the ASC, track financial data including accounts receivable days and use that knowledge to improve the process. Reducing the number of A/R days can have a big impact on the surgery center's bottom line.

"ASC administrators must get feedback from the business office about the A/R days and which payers are the most difficult from a collections standpoint," says Mr. Connolly. "Look at data from every aspect of the business before going into contract negotiations. You might have a commercial payer that is your highest payer, which is great, but they are only your best payer if their average A/R days are similar to the rest of the market."

If the payer is slow, regardless of their rates, the additional premium of the payment erodes quickly by virtue of the amount of resources it takes to manage that relationship.

7. ASCs must now pay attention to how their numbers stack up. Figure out where your rates fall in the marketplace and, if you are below average, use that knowledge to your advantage.

"Give the payer what they need, but show them the data which reflects how your new rate request fits with market parity," says Mr. Connolly. "Payers are quick to remind us that we are asking for something outside the norm. That might vary across the region, but if you can demonstrate to the payer that they are paying the com-

petition better, show them how much more expensive it is to perform it elsewhere."

If the payer doesn't increase rates to an appropriate amount for the ASC, invite them to take those cases back to the hospital where they will be paying more. "It all goes back to what you can leverage," says Mr. Connolly.

8. More opportunity for risk. There is more opportunity in today's market for ASCs to take on more risk associated with healthcare costs, which is what payers are looking for. Demonstrate to payers you are able to manage costs and take risks along with other providers and patients in the future.

"If we don't demonstrate to the payers that we can manage our costs and take on risk, they will ask someone else to do it," Mr. Connolly says. "If we allow a third party administrator to get involved and the TPA doesn't demonstrate value that comes off the backs of the surgery providers. The system can't afford the costs we've had historically and we must all be part of the solution." ■

13 Statistics on Medicare Patient Volume in ASCs vs. Hospitals

By Carrie Pallardy

Here are 13 statistics on the percentage of Medicare patients that are provided for in ambulatory surgery centers and hospital outpatient departments, according to MedPAC ambulatory surgical center services data. According to data collected in 2010:

In ASCs:
- 86 percent of patients did not have Medicaid
- 14 percent of patients had Medicaid

In HOPDs:
- 76.9 percent of patients did not have Medicaid
- 23.1 percent of patients had Medicaid

In ASCs:
- 78.6 percent of Medicare patients were 65 to 84 years old
- 14 percent of Medicare patients were under 65 years old
- 7.4 percent of Medicare patients were 85 years or older

In HOPDs:
- 67.7 percent of Medicare patients were 65 to 84 years old
- 21.4 percent of Medicare patients were under 65 years old
- 10.9 percent of Medicare patients were 85 years or older

In ASCs:
- 57.9 percent of Medicare patients were female
- 42.1 percent of Medicare patients were male

In HOPDs:
- 56.5 percent of Medicare patients were female
- 43.5 percent of Medicare patients were male

In ASCs:
- 88.1 percent of Medicare patients were white
- 6.8 percent of Medicare patients were African American
- 5.1 percent of Medicare patients were of another race

In HOPDs:
- 84.2 percent of Medicare patients were white
- 10.4 percent of Medicare patients were African American
- 5.4 percent of Medicare patients were of another race ■

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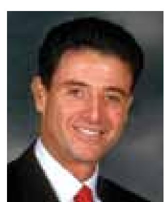
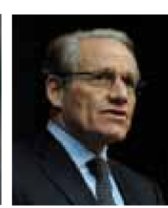

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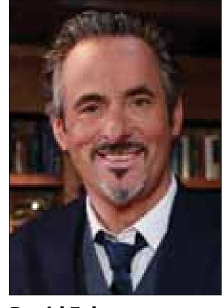
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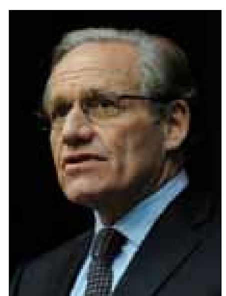
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20 Most Frequently Performed Medicare Surgical Services in ASCs

By Laura Miller

Here are the 20 surgical services most recently performed in ambulatory surgery centers for Medicare patients based on data from the MedPAC analysis of claims filed in 2011.

1. Cataract surgery with IOL insert, 1 stage: 17 percent

2. Upper GI endoscopy, biopsy: 8 percent

3. Colonoscopy and biopsy: 5.7 percent

4. Lesion removal colonoscopy, snare technique: 4.4 percent

5. Injection foramen epidural: lumbar, sacra: 4.1 percent

6. After cataract laser surgery: 3.9 percent

7. Injection spine: lumbar, sacral (caudal): 3.6 percent

8. Diagnostic colonoscopy: 3.6 percent

9. Injection paravertebral: lumbar, sacral: 2.2 percent

10. Injection foramen epidural add on: 2.1 percent

11. Injection paravertebral: lumbar, sacral add on: 1.9 percent

12. Colorectal screen, high risk individual: 1.8 percent

13. Destruction paravertebral nerve, add on: 1.6 percent

14. Colon cancer screen, not high-risk individual: 1.4 percent

15. Cataract surgery, complex: 1.3 percent

16. Upper GI endoscopy, diagnosis: 1.2 percent

17. Cystoscopy: 1.1 percent

18. Lesion removal colonoscopy, biopsy forceps or biopolar cautery: 1 percent

19. Revision of upper eyelid: 0.9 percent

20. Injection spine: cervical or thoracic: 0.9 percent ■

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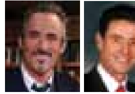
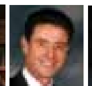
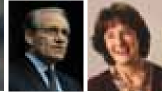

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