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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

February 2012 • Vol. 2012 No. 2

10 Predictions on ASC Merger & Acquisition Activity in 2012

By Rachel Fields

Joe Clark, EVP and CDO for Surgical Care Affiliates, Aaron Murski, senior manager with VMG Health, and Luke Lambert, CEO of ASCOA, discuss their thoughts on ambulatory surgery center merger and acquisition activity over the next year.

1. De novo surgery center development will continue to decrease. Mr. Clark believes development of de novo centers will continue to drop in 2012, as the pool of surgeons interested in ASC investment shrinks. "I think most surgeons who are interested in investing are already

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Looking Ahead: 6 Thoughts From Physicians on the Future of ASCs

By Abby Callard

Last year, average case volume, revenue per case and staff and physician salaries increased, according to VMG Health's *Multi-Specialty ASC Intellimarker 2011* when compared to 2010. However, the number of procedures performed in the ASC setting remained the same. The year 2012 brings an uncertain regulatory environment, decreasing reimbursements and an increase in minimally invasive techniques and technology. ASC physicians share their thoughts for 2012 and beyond.

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10 Top Concerns for Surgery Center Administrators in 2012

By Rachel Fields

Low reimbursement, low volume, increasing physician employment, increasing regulatory requirements, increasing staff shortages, increasing market saturation: These are only a few of the issues affecting ambulatory surgery centers at the moment. While ASCs are still able to provide high-quality care at a lower cost than their hospital competitors, they are doing so under increasing strain from economic pressures, physician shortages and regulatory mandates. Here are 10 of the most pressing concerns for ASC administrators in 2012.

1. High deductibles. Patients are increasingly unable to pay for outpatient surgery because of the high deductibles included in their insurance plans, according to Lynda Simon, RN, administrator of St. John's Clinic: Head and Neck Surgery in Springfield, Mo. "We have young couples with insurance

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By Barbara Trattler, RN, MPA, CNOR, CNA



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* Does not eliminate bedside precleaning. Manual cleaning of medical devices (endoscopes) is not required prior to placement in the EVOTECH® ECR when selecting those cycles that contain a wash stage.

† AORN Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Settings 2011 - Recommendation XVI: Quality XVI.h, p. 477-485

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Publisher's Letter

Transaction Market Robust; Agenda Set for 10th Annual Orthopedic, Spine and Pain Management Drive ASC Conference

This issue focuses on transaction and valuation issues for surgery centers. It is an active time for transactions with (1) hospitals examining joint ventures with physicians, (2) physician-owned ASCs looking at a range of strategic options, and (3) a few of the national companies considering going public or engaging in similar large scale transactions over the next few years. For well performing surgery centers, the market is fairly robust.

We have also included in this issue the brochure for our 10th Annual Orthopedic, Spine and Pain Management Driven ASC Conference. The conference will be held June 14th to 16th. We have an incredible agenda focusing on the most important issues facing surgery centers. The conference has a very keen focus on specific spine, orthopedic and pain management issues. The agenda includes legendary Coach Lou Holtz, and great Washington personalities Sam Donaldson and Tucker Carlson. Early registration discounts for the conference end May 1st. We encourage you to register today and reserve your hotel rooms shortly.

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

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10 Predictions on ASC Merger & Acquisition Activity in 2012 (continued from page 1)

involved in surgery centers, so I think that's going to quell demand for new centers," he says. "My guess is that there will be limited de novo activity next year, and I think any transactions will be either acquisitions or mergers of centers as overbuilt markets tend to consolidate."

2. Hospital interest in acquiring surgery centers will increase. Mr. Lambert predicts hospitals will increasingly look to acquire surgery centers to grow market share and solidify relationships with community physicians. He believes multi-specialty centers will be most commonly targeted. He says the availability of under-performing or high-risk centers in the ASC industry may lead hospitals to consider turnaround opportunities. "Sometimes there are surgery centers that are failing, and hospitals will pick them up cheap and are happy to do so," he says. Mr. Clark adds that hospitals are looking at surgery centers as a way to prepare for payment reform.

3. Relationships between hospitals and management companies will increase. Mr. Clark believes hospitals will look to bring ASC management companies into surgery center acquisitions to create a three-way joint venture. Management companies can provide much-needed guidance about managing and profiting from surgery centers. He says while most hospitals will be looking for majority interest in a surgery center, they may give up some operational control if they can form a joint venture with a trusted management company. "Hospitals bring a certain amount of benefit, and I think a hospital partnered with a management company with a specific focus on managing surgery centers will be the best option," he says.

4. More turnaround opportunities. Mr. Clark says there are plenty of turnaround opportunities available for hospitals and management companies because most markets are overbuilt and many surgery centers are suffering due to economic pressures. "There are a high number of centers that are not functioning very well," he says. "I think most management companies are going to have turnaround capabilities — at least the more substantial management companies with sophisticated processes and tools."

5. Surgery center mergers may occur, but issues stand in the way. Mr. Clark and Mr. Lambert believe 2012 will see more mergers between individual surgery centers, though there are several common obstacles to a successful merger. First, competing physician groups in the same community may not want to merge their centers and contribute to each other's business. Second, centers may have long-standing commitments — such as a long-term lease or outstanding debt — that prevents physicians from leaving an existing center to merge with a competitor. "Some of the fixed costs don't go away even if you merge centers," Mr. Lambert says. Despite these issues, however, Mr. Lambert says discussions of mergers are becoming "more common."

6. ASC prices are moving upward. Mr. Lambert believes pricing is moving upward because of a significant dearth of low-risk surgery centers for sale. "When I say low risk, I mean those that are larger, profitable, multi-specialty, in-network facilities, and there aren't a lot of them out there," he says. "Those that are there, in my experience, have been realizing very attractive valuations."

But he says the pricing climb isn't limited to high-performing centers. Historically, surgery centers dependent on out-of-network reimbursement have not been well valued and, as a result, almost no transactions in this segment have occurred. He said the industry is starting to see this change with more out-of-network center transactions occurring at higher valuations. He says the buyers want these centers and have to pay a price that is acceptable to the current owners. "At the end of the day, people have realized that no one sells for a three multiple," he says. "There are out-of-network transactions occurring at multiples similar to those of the low end of in-network facilities. People realize that even though out-of-network is somewhat threatened, there are situations where it is likely to continue for some time."

7. Management companies will exit management and ownership of some ASCs. Mr. Murski believes that some surgery centers will part ways with their existing management company and look for more suitable options. "This is happening in cases where the ASC is marginally performing or, for strategic reasons, the ASC really does need to affiliate with a hospital partner or a different management company to thrive," he says.

8. Higher-risk centers can still be attractive. Mr. Lambert says riskier centers may still attract buyers — just not the typical "timid" buyer who is owned by institutional investors. Even if these riskier centers can be purchased relatively cheaply, executives find it untenable to have to explain revenue declines to their boards a couple of years after an acquisition, even if they were priced with that expectation. "There are plenty of well-run out-of-network facilities out there, but most have risk," he says. "Just because you have reimbursement risk doesn't mean you're not well-run. Timid buyers just don't have stomach for them." Other center characteristics that contribute to center risk include physician age, one or two payors dominating the market and hospital employment of referral sources and specialists.

He says in 2012, the biggest risk factors for surgery centers will be reimbursement and physician hospital employment. If a surgery center is located in a market where the local hospital is employing physicians and buying up practices, the value of the center will be less to those entities not having a presence in the community, but may increase for those battling for share in the community.

A perennial source of risk for many surgery centers results from not having solid non-compete agreements with their physician owners. It's natural that a center's big producers look for ways to capture a greater share of the profits they generate and that can lead them to consider competitive investment opportunities.

9. Private equity-backed companies may acquire in preparation to go public. Mr. Lambert believes private equity backed ASC companies may have greater urgency to increase their rate of acquisitions so as to improve their growth trends in preparation for going public.

Additionally, there may be an increase in the number of ASC owners looking to sell an interest in their centers towards the end of the year, given the planned expiration of the federal tax cut extensions. "I think that may drive some activity where people say, 'If we're going to do this, let's do it now at the lower tax rates,'" he says.

10. Lack of physician investors will drive ASC merger consideration. Mr. Murski believes that ASCs may consider merging or forming a partnership between two centers as the pool of available physician investors becomes smaller. However, he says while ASC leadership may be supportive of a merger or partnership, convincing physician investors may be more challenging. ■

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Looking Ahead: 6 Thoughts From Physicians on the Future of ASCs
(continued from page 1)

1. An aging population means increased procedures in many ASC specialties.

As the baby-boomer generation ages, the demand for age-related procedures will increase. For example, an Ophthalmic Market Perspectives report estimated the volume of cataracts grew from 2.4 million in 2000 to 3.2 million in 2010, and Larry E. Patterson, MD, medical director of Eye Centers of Tennessee and the Cataract and Laser Center, Crossville, Tenn., and past president of the Outpatient Ophthalmic Surgery Society, has already seen an increase in his cataract surgery volume.

"My cataract surgery volume is significantly up compared to the last few years," he says. "There are just more older people who are getting cataracts. This current generation is a little more aggressive. They are not as tolerant of visual loss. They want their cataracts out earlier."

Physicians predict that other specialties, such as urology and gynecology, will see an increase in demand for procedures as well.

"I think that the practice of urology has benefited because there are relatively few urologists rela-

tive to the population of patients that we treat," says Herb Riemenschneider, MD, staff urologist and founder of the Knightsbridge Surgery Center in Columbus, Ohio. "There are demand issues, and if we can address them appropriately, the patients and we can benefit. Urology is actually in a good position relative to the other specialties because of this supply and demand."

Amy E. Rosenman, MD, urogynecologist, clinical assistant professor at the UCLA School of Medicine and in private practice at Saint Johns Health Center in Santa Monica, Calif., says gynecological problems such as prolapse, a condition where the uterus falls into the vagina, increase with age.

"Since the demographics are going to be more incontinence and prolapse, it would behoove us all to figure out how to package that in an ASC setting," she says.

2. Scope of practice debates threaten certain specialties.

Certain procedures are becoming more feasible for the outpatient setting as physicians adopt minimally invasive techniques. However, for certain specialties — such as ophthalmology and pain management — this change has driven non specialists to perform procedures.

Optometrists have long been fighting for the right to perform certain laser surgical proce-

dures in their offices. Earlier this year, Kentucky passed the "Better Access to Quality Eye Care Act," which expanded the scope of practice for optometrists to include certain surgical procedures. The use of laser technology has in some ways made surgical procedures easier, but the misconception that they are simple or minor surgeries is wrong, Dr. Patterson says.

"It's only minor as long as there are no complications," he says.

He calls the law "an embarrassing mark on Kentucky" and is afraid the trend may spread to other states.

"Because of that success, there are going to be attempts all over the country," he says. "I don't think they'll be quite as successful elsewhere."

A similar battle is going on in the pain management specialty. Demand is increasing at a natural rate, but other factors, such as non-certified pain management physician performing pain management procedures, are leading to an inflated utilization rate.

"As the baby boomers are getting older, there is — based on demographic trends — a natural tendency for the demand to be rising," says Francis Riegler, MD, co-founder of Universal Pain Management in Victorville, Calif. "One of



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the other things you've got going on is that there are a whole lot more of these procedures being done across the board."

These procedures aren't always done by specialized pain management physicians, he says.

"If you're a physician who's not a trained pain management physician, you can go out and do these procedures and get paid the same amount of money as a legitimate, fellowship-trained pain management physician," he says. "One of the things is that the utilization rate [of pain management procedures] has been rising more than the natural rate of increase."

3. Cost will be the deciding factor on whether certain procedures can be done in the ASC. In the current atmosphere of declining reimbursements, some procedures that are feasible in the outpatient setting are not financially viable in an ASC. In addition to shrinking reimbursements, the equipment that allows many procedures to be performed in the ASC is often cost-prohibitive.

"The one thing we always run into has to do with equipment and cost issues," T.K. Miller, MD, of Carilion Clinic Orthopaedics and Medical Director of the Roanoke Ambulatory Surgery Center,

says. "That to me becomes the limiting factor. There are procedures that we could do, but [they are] cost-prohibitive to do."

Orthopedic procedures at-risk for being cost-prohibitive include rotator cuff repair with acromioplasty and ACL repair with allograft. Dr. Miller says acromioplasty, which increases the space for the rotator cuff in the shoulder, is being bundled with the reimbursement code for rotator cuff surgery. So even though the procedure takes more time and equipment, the reimbursement is the same. Allograft materials — donor tendon or ligament implanted during an ACL reconstruction — are not always covered by payors. Because of a lack of reimbursement, this "bread and butter" procedure can become unprofitable and has to be moved back to the hospital setting.

In the pain management specialty, Standiford Helm II, MD, medical director of Pacific Coast Pain Management Center in Laguna Hills, Calif., and president of the American Society of Interventional Pain Physicians, thinks there will be an increased emphasis on "good value" procedures.

"Pain procedures that are going to thrive are those which add value," he says. "A good example is the MILD procedure, which treats ste-

nosis at a cost far below surgery. In a fixed budget world, that difference will be definitive as to what therapy, if any, is provided. While patients will be interested in increased function, the insurers or ACOs will be more likely to respond to decreased utilization of resources."

4. Increased patient demand for same-day surgery will drive volume. As minimally invasive techniques become more prevalent, many younger surgeons — and even knowledgeable patients — are pushing for procedures to move from the inpatient to outpatient setting.

"Almost any surgeon that we hire with fellowship training is going to look at what they can do in an ASC setting," says Dr. Miller. "We've gone from patient comments of 'I can't believe you can do that in an outpatient setting' to 'Why do I have to stay in the hospital?'"

This demand by patients has also increased the traditional ASC patient population. Dr. Miller recently performed a revision rotator cuff repair on a woman over the age of 70. In the past, he might not have considered doing that case in an ASC, but the woman expressed her desire to have surgery in an ASC rather than hospital setting. Dr. Miller reviewed the perioperative ex-

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pectations with the patient and her family, consulted with her primary care physician to make sure she had few co-morbidities, and the surgery was performed successfully in the ASC.

5. Minimally invasive procedures continue to increase. Minimally invasive surgical techniques are increasing and allowing more procedures to move to the outpatient setting. This trend is expected to continue.

Dr. Miller says that minimally invasive hip procedures such as arthroscopic hip reconstructive procedures are transitioning to the ASC environment. This transition will continue over the next few years.

"Hips are where shoulders were 10 years ago," he says. "We start with diagnostic capabilities, evolve to debridement and clean up and, as instrumentation evolves, are moving to consistently reliable reconstructive techniques."

As with most sports-based surgeons, Dr. Miller now does almost all of his shoulder reconstructions with arthroscopic techniques and says this trend will be seen with other joints. He says hip is next on the list.

Another procedure increasingly done in the

ASC setting is hysterectomy — specifically laparoscopic and vaginal hysterectomies. Dr. Rosenman thinks there will be an increase in laparoscopic and vaginal hysterectomies performed on an outpatient basis. She sees the change depending on a good post-operative care program.

"We've gotten there with midurethral slings," she says. "We can get there with hysterectomies."

The Advisory Board, a research, consulting and technology firm, predicted laparoscopic hysterectomy procedures would increase starting in 2010 and that by the end of 2010, 44 percent of all hysterectomies performed in the United States will be done laparoscopically. By 2017, this figure is expected to jump to 55 percent.

6. Reimbursement continues to be up in the air. With the population aging, more patients will fall under Medicare reimbursement, and private payors are increasingly looking a Medicare rates to set their own. An uncertain healthcare reform environment means many physicians are unaware of what exactly reimbursement will look like in the future.

"One of the insidious ways that the Medicare program pulls down the payment for physicians is by changes in the codes," Dr. Riegler says.

Medicare can reduce the cost of reimbursements by bundling codes. Next year, Dr. Riegler says the code for fluoroscopic guidance will be bundled into the procedure codes. This has been done in other specialties, such as orthopedic and spine, as well.

However, Dr. Rosenman says Medicare has begun to reimburse more gynecological procedures done as an outpatient.

"Over the years, Medicare has gotten smarter," she says. "They sometimes miss the forest for the trees, but when they get it, they get it."

Dr. Rosenman says certain private payors are now telling her that a hysterectomy procedure is going to be done as an outpatient. They better understand the cost-benefit to doing appropriate procedures in an ASC setting.

"Outpatient reimbursement for private insurance companies is usually ahead of Medicare," she says. "They have pretty good reimbursement for outpatient surgery. Clearly it's cheaper in an outpatient setting. Good surgery centers have very clear criteria as to who is safely done there and who isn't. This helps to avoid disasters and keep your cost predictable." ■

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10 Top Concerns for Surgery Center Administrators in 2012 (continued from page 1)

through their employer, and their deductible is \$5,000," she says. "They have an annual income of \$15,000-\$20,000, and they're living on faith that medical bills or surgery will not be necessary."

High deductibles can be crippling for a surgery center because patients will either forego surgery due to the expense or undergo surgery and then allow the bill to be sent to bad debt. In order to keep days in A/R at an industry benchmark of 35-40, surgery centers must work with patients to set up payment plans that allow the patient to pay a small amount over a period of time.

Otherwise, the business office will spend too much time chasing down patients who owe money, often with very little result at the end. But Ms. Simon says even payment plans can be problematic for patients with limited finances. "We are seeing increased bad debt because of more patients with a self-pay status," she says. "They sign up for payment plans with no intention of ever paying the bill."

2. Aging nursing population. According to a 2011 survey of registered nurses by AMN Healthcare, the average age of registered nurses increased from 2010 to 2011, jumping from 48.5 to 49.2 years old. In 2011, 44 percent of nurses were 40-54 years old, and 36 percent of nurses were 55 or older. This means 80 percent of nurses were 40 or older, which poses a problem for ASCs recruiting nurses in the future.

In addition to the age issue, 71 percent of nurses said they were not confident that healthcare reform would increase the supply of nurses. "The workforce is aging out, and the nursing schools are not offering surgery rotations," Ms. Simon says. "I met a new grad and asked her how much time she spent in surgery during her training. The sobering answer: one day."

Margaret Acker, administrator of Southwest Surgical Center in Byron Center, Mich., agrees that nurse recruitment poses a problem for her surgery center in the coming years. "As most RNs aren't young, how are we supposed to recruit and retain qualified providers?" she says.

3. Increase of Medicare/Medicaid as a payor source. Two facts are certain: The baby boomer generation is hitting Medicare age, and expansion of healthcare coverage will add millions of Medicaid beneficiaries to state and federal payrolls. This means the number of patients with commercial coverage, who usually represent the most lucrative cases for surgery centers, is remaining relatively stagnant, while the number of federally covered patients is increasing.

"Medicare and Medicaid pay poorly," Ms. Simon says. "Additionally, insurance companies are looking to Medicaid and Medicare to base their calculations of reimbursement." Many surgery centers are moving away from payor contracts that base payment on a "percentage of Medicare," considering specialties such as GI and pain management have suffered hits from Medicare in recent years. Most surgery centers do not accept much Medicaid — VMG puts the percentage of payor mix at an average of 3 percent for 2011 — but the increase in covered lives may mean more Medicaid cases scheduled at ASCs.

4. Cutting staff costs while retaining staff. Staffing is one of the two biggest costs for surgery centers, meaning that cash-strapped ASCs must keep staffing costs in line in order to maintain profitability. Unfortunately, cutting staff hours can result in losing staff permanently to the local hospital or another surgery center. "How do we maintain our excellent standard of care if we lose staff because of flexing hours?" says Michelle Dickison, RN, CASC, administrator of Baptist Plaza Surgicare in Nashville. The most common remedies for high staffing costs include flexing staff hours, sending staff home on light days and cross-training staff members so they can perform

more than one job (which, of course, costs money). While these tactics may be effective for saving money, they are often damaging to staff morale and retention.

Ms. Dickison also expressed concern over surgery center staff members who are struggling with house and car payments and other personal financial issues. "They are struggling with these things, and we are sending them home early," she says. "How do we continually motivate staff and create a positive work environment when we are asking for more in less amount of time?"

5. Maintaining high volumes. High volumes are essential for profitability at a surgery center. Ms. Dickison says it can be challenging to know how much the economy is affecting volumes, and how much the surgery center could be improving volumes with more effort. "Are we capturing all the volume that's expected?" she says. Mike Pankey, RN, administrator of Ambulatory Surgery Center of Spartanburg (S.C.), says he has seen a lack of self-employed physicians coming out of school. "Our independent physician population is aging rapidly here, and high unemployment rates have started to affect our volumes after two years," he says.



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In many centers, volume depends on a few physicians who bring a majority of their cases to the surgery center. While this strategy can be profitable in the short term, dependence on a few physicians can cause major volume problems if one physician retires, dies or stops bringing cases to the center.

6. Patients waiting longer to undergo surgery. In a May *New York Times* report, several insurers discussed the “low level” of medical use in 2011, filling insurance company coffers while patients postpone care due to strained budgets. In 2010, about 10 percent of people covered by their employer had a deductible of at least \$2,000, according to non-profit research group Kaiser Family Foundation, compared to just 5 percent of covered workers in 2008. When patients are more careful with their money, they are less likely to schedule elective surgery, creating volume problems for surgery centers.

Ms. Simon adds that when patients put off surgery for too long, the risk of complications becomes higher. “Patients are waiting longer to have necessary surgery,” she says. “Sicker patients equal more co-morbidities, poorer outcomes, litigation and increased infections.”

7. Regulatory issues. Accreditation and regulatory requirements are a constant battle for surgery center administrators as they attempt to update processes, policies and paperwork from year to year to meet standards. Brent Ashby, administrator of Audubon Surgery Center in Colorado Springs, says regulatory requirements are the biggest challenge for his surgery center this year. “From my perspective, one of the greatest challenges facing ASC administrators is keeping up with the ever-changing state and federal regulations,” Mr. Ashby says. “In the past few years, we have seen numerous regulation changes by CMS and the Colorado Department of Public Health and Environment. Achieving and maintaining Medicare accreditation has become more difficult of late, [and] staying on top of this consumes more of my time than it has in the past.”

In 2012, ASCs will be tasked with a new regulatory requirement: CMS’ new quality reporting program for ASCs. Under the program, ASCs that fail to report required information will face a reduction in their Medicare payments. For example, beginning on Oct. 1, 2012, surgery centers will be required to report data on patient burns, patient falls, wrong side/site/patient/procedure/implant, hospital admissions and transfers and prophylactic IV antibiotic timing. 2013 will introduce two more measures: safe surgery checklist use in 2012 and 2012 volume of certain procedures. While these two measures will not be reported until 2013, ASCs must ensure they are using a safe surgery checklist and have a system in place to capture surgical volume data on Jan. 1, 2012.

8. Hospital employment poaching physicians. Ms. Acker says she continues to see hospitals employing physicians and thereby preventing them from bringing cases to the ASC. Many hospital employment con-

tracts include a non-compete clause that prevents physicians from owning shares in a facility. This means that surgery centers, which depend on physician investment and case volume from those investors, may be dependent on their existing investors rather than being able to recruit new ones.

Greg Horner, MD, managing partner of Smithfield Surgical Partners, says even in California, where hospital employment of physicians is illegal, “medical foundations” allow physicians to integrate with large health systems without direct employment. He said while primary care physicians are the first targeted by hospitals seeking physician employees, specialists — particularly orthopedic surgeons, ophthalmologists, pain management and spine — are next on the list.

The significance of the issue differs from city to city: According to a June study from the Center for Studying Health System Change, Cleveland, Indianapolis and Greenville, S.C., are close to saturation in hospital employment of primary care physicians and specialists. In contrast, northern New Jersey and Miami face low physician interest in employment. The authors also found that while there are still strained relations between physicians and hospitals, more physicians are actively seeking employment and more hospitals are employing physicians than in the past.

9. Implementation of EMR. The federal requirements for surgery center EMR are still unclear, and studies of physician practices indicate that smaller centers are probably behind in EMR implementation as well. According to a national Health Affairs study of small and midsize physician practices, only a quarter of practices used an EMR for progress notes, and fewer practices than that used an EMR to its “full potential.”

Ms. Acker says she and her colleagues are unsure whether to implement an expensive EMR when they do not know yet what the requirements will be for surgery centers. Surgery centers are also tasked with investing in systems that are compatible with the systems installed at their physician practices.

10. Investment in new technology. There are plenty of options for ASCs looking to invest in new technology in 2012 — the problem is whether they can afford it. Anesthesiologists performing orthopedic cases can benefit greatly from ultrasound-guided regional anesthesia, if the ASC can afford the ultrasound equipment necessary for the technique.

Ophthalmic surgery centers across the country are starting to invest in Alcon’s LenSx femtosecond laser — an attractive option, if the surgery center can foot the \$500,000 bill. Surgery center administrators must look carefully at return on investment to determine whether case volume will make up for the cost of the equipment. ■

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28 Pain Management-Driven ASCs to Know

By Abby Callard

Pain Management-Driven ASCs to Know

This is a list of pain management-driven surgery centers researched and compiled by the Becker's ASC Review editorial staff. Surgery centers do not pay and cannot pay to be selected for inclusion on this list. Centers are listed in alphabetical order. This list is not an endorsement of any individual's or organization's clinical abilities.

Advanced Surgical Concepts – Pain ASC (Baton Rouge, La.). Advanced Surgical Concepts is an outpatient surgery center located in the same facility as Comprehensive Pain, the state's only accredited center for pain treatment specializing in spinal cord stimulation, selective nerve root blocks, gastrointestinal pain, fibromyalgia, cancer pain, diabetic neuropathy and chronic pain. The surgery center has four accredited pain management physicians: Sandra Weitz, MD, Alpesh Patel, MD, Tulsi Bice, MD, and Koshy Mathia, MD. In addition to pain management, the center also performs procedures in urology, plastic surgery and chiropractic specialties in its two operating rooms. The ASC is state-licensed and accredited. www.advancedsururgicalbatonrouge.com

Boston PainCare Surgery Center (Waltham, Mass.). This AAAHC-accredited clinic opened in May 2007 and currently has 10 board-certified physicians. The center uses technology to quantitatively measure patients' pain levels and functionality improvements. The center averages 3,700 procedures a year, 3,400 of which are pain management. Treatment includes radiofrequency ablation and spinal cord stimulator implants.

"We are an integrated practice, which sets us apart from other pain centers," says Kathleen Leitao, MM, RN, CNOR, the center's director of surgery. "We have several specialists treating one singular disease: pain. We believe in looking at the patient as a whole and not finding just one single solution." www.bostonpaincare.com

Centers for Pain Solutions (Nashua, N.H.). The Centers for Pain Solutions was started in 1999 and has five board-certified physicians and one nurse practitioner who practice in three locations throughout New Hampshire.

"I think what sets us apart is that our physicians are highly qualified and educated," says Linda Childs, the center's officer manager. "I think we're very compassionate to the pain issues of our patients."

The staff rotates between the three centers and performs 15-30 procedures on a daily basis. Pain Solutions offers discography, spinal cord stimulation, spinal catheters, radiofrequency nerve lesioning and disc nucleoplasty, among other treatments. All the centers are accredited by AAAHC. www.painsolutionsusa.com

Center for Pain Control (Wyomissing, Pa.). James H. Hsu, MD, and Jason T. Bundy, MD, have treated low back and leg pain, neck and arm pain, whiplash, headaches, musculoskeletal pain, reflex sympathetic dystrophy, diabetic and vascular neuropathies, cancer pain and facial pain at this ASC for more than

12 years. Dr. Hsu has expertise in regional anesthesia techniques, especially ultrasound-guided regional blocks. The center also employs a licensed acupuncturist. Staff constantly measure treatment outcomes and both patient and referring physician satisfaction. www.centerforpaincontrol.net

Christiana Spine Center (Newark, Del.). The Christiana Spine Center has been in operation on the Christiana Care Hospital campus since June 2000 and operates an ASC that was created 2.5 years ago near the hospital campus. The center's facility manager, Valerie Manges, says the ASC specializes in spinal epidurals, discography and nerve ablations. The 9 physicians also have experience in electromyography, fluoroscopic spine procedure, physical medicine, rehabilitation and spinal reconstructive surgery, and perform more than 5,000 procedures annually. The ASC is located in a medical office building that offers massage therapy, physical therapy and chiropractic care. This center is AAAHC accredited. www.christianspinespinecenter.com/surgerycenter.html

Hallandale Outpatient Surgical Center (Hallandale Beach, Fla.). This multi-specialty center was founded in 2006. Of the 24 physicians who practice at the center, seven of them are pain management physicians. About 80 percent of the center's cases are in pain management — around 1,400 cases a year. Treatment options include peripheral nerve stimulation, spinal cord stimulation, percutaneous disc decompression, interscalene catheters for frozen shoulder manipulation, cervical and lumbar discography, trigeminal nerve blocks and radiofrequency denervation and lumbar sympathetic nerve blocks and radiofrequency denervation. The center is state- and Medicare-licensed and accredited by AAAHC. www.hbosc.com

Harrisburg Interventional Pain Management Center (Mechanicsburg, Pa.). Harrisburg Interventional Pain Management Center is a Medicare-certified and AAAHC-accredited facility licensed by Pennsylvania to provide ambulatory and outpatient surgery. The center is exclusively focused on interventional pain management and is located in the same building as Susquehanna Valley Pain Management, where the three ASC physician-partners — Malik Momin, MD, Norman Haueisen, MD, and Maximilian Braun, MD — practice. Procedures include radiofrequency lesioning, lumbar discograms, trochanteric bursa injection and facet joint injections. www.susquehannapaincenter.com

High Pointe Surgery Center (Lake Elmo, Minn.). High Pointe Surgery Center is a multi-specialty, four OR center that offers orthopedics, hand surgery, plastic surgery, podiatry, ophthalmology, adult and pediatric urology, gynecology and pain management. Pain management contributes 20 percent of the annual gross revenue and one-third of the center's case volume — the center is on track to perform 1,500 pain procedures in 2011. The interventional pain management program at High Pointe Surgery Center was initiated in 1999, and treatment includes trigger point injections, facet blocks, nerve stimulators and radiofrequency pro-

cedures. Two physicians perform pain management procedures. The center's outcome data and patient satisfaction scores are regularly above the national average, says Keri Talcott, the director of corporate communication at Surgical Management Professionals, the company that manages the center. www.hpsurgery.com

Hyde Park Pain Management (Hyde Park, Mass.). Hyde Park Pain Management received its state license in June 2010, and its two board-certified physicians now perform more than 75 pain management procedures each month. Administrator Kathy Kelleher says the center's state-of-the-art facility sets it apart; it includes technology and equipment to do trials for neurostimulation, nerve stimulation and radiofrequency procedures. The center also has Spanish-speaking staff to cater to the towns and cities around Boston. The center is accredited by AAAHC.

Idaho Physical Medicine and Rehab (Meridian, Idaho). The surgery center opened in 2007, but the center's five physician-owners have been practicing in the area for more than 15 years. The center performs 2,000-2,300 procedures annually, and all are focused on pain management, says Marlene Stowe, the center's administrator. Services include fluoroscopic spine injections, radiofrequency ablation, spinal cord stimulation and acupuncture.

While the center doesn't perform spine stimulation implants, it performs trials where the leads are implanted for a few days to determine if the implant would help with pain management. If the implant helps, the center refers the patient to surgeon who can insert the permanent implant. This center is accredited by AAAHC. www.idahopmr.com

Interventional Spine and Pain Management ASC (Conyers, Ga.). Robin Fowler, MD, founded Interventional Spine and Pain Management ASC in 2005 and was listed on the Becker's ASC Review list of "70 of the Best Pain Management Physicians in America." The flagship Conyers location opened in 2007 and has two operating rooms, is licensed exclusively for single-specialty pain management and performs more than 7,000 annually. The ASC is accredited by the Joint Commission.

Treatment provided at the ASC includes peripheral nerve stimulators, spinal cord stimulators, transforaminal epidurals and radiofrequency ablation. The center's website includes videos, learning materials and a patient satisfaction survey. Interventional Spine and Pain Management also operates five locations around Georgia (Atlanta, Conyers, Covington, Monroe and Sandy Springs), as well as three additional centers in Punta Gorda, Fla., and Alamogordo and Roswell, NM. www.spinepains.com

Matrix Surgery Center (Saginaw, Mich.). The Matrix Surgery Center is a \$3 million, 3,500-square-foot expansion of the Matrix

Medical facility, which has been treating pain in the Saginaw area since 1999, when it was associated with Covenant HealthCare. Richard Lingenfelter, MD, founded the private practice in February 2003 and practiced there until his death in 2009. The current physicians are Michael Papenfuss, DO, and Diane Czuk-Smith, MD. The center has three operating rooms and five treatment rooms. In addition to Medicare certification, the Matrix Surgery Center earned the Joint Commission's Gold Seal of Approval in 2007. www.matrixpain.com/surgery_center.html

New England Pain Care, Pain and Wellness Center (Peabody, Mass.). New England Pain Care, founded in 2003 by Julien Vaisman, MD, is located in the same building as the Pain and Wellness Center, which Dr. Vaisman founded in 1996. The ambulatory surgery center has three board-certified physicians — Dr. Vaisman, Joe Ordia, MD, and Benjamin Kripke, MD — as well as specialists in areas such as psychology, physical therapy and acupuncture. At the center of the patient-focused treatment is the Providers' Roundtable, a bi-weekly meeting where the entire provider team reviews individual cases.

The center's website includes videos of physicians explaining different procedures such as spinal cord stimulation and radiofrequency ablation that they call PWctv. The center is accredited by AAAHC. www.newenglandpaincare.com

Overlake Surgery Center (Bellevue, Wash.). This AAAHC-accredited center was founded in 2000 as a joint venture between Overlake Hospital Medical Center and several physicians who still perform cases at the center. Although the center is multispecialty, about 50 percent of its cases are in pain management, says Executive Director Wendy Taylor. The center's eight pain management physicians perform 3,500 interventional pain management procedures annually including vertebroplasty, spinal cord stimulators and hypogastric plexus blocks. Paul Dreyfuss, MD, is a recent past president of the International Spine Intervention Society, and Ray Baker, MD, is a recent past president of the North American Spine Society and vice president of the National Association of Spine Specialists. www.overlakesurgery.com

Pain Care Center of Georgia (Stockbridge, Ga.). This AAAHC-accredited center was opened in 2009 by Vincent Galan, MD, as part of Pain Care of Georgia, a group of four clinics and one ASC. Dr. Galan is board certified in anesthesia and double-board certified in pain medicine by both the American Academy of Pain Medicine and the American Board of Anesthesiology's subspecialty certification in pain management. He specializes in minimally invasive spine surgery, cervical, thoracic and lumbar radiofrequency, spinal cord stimulators, discography, facet joint disease, complex regional pain syndrome and neuropathies. Amit Patel,

MD, also practices at the center and specializes in facet neurotomy for spinal arthritis pain, minimally invasive herniated disc decompression, radiofrequency ablation for neuropathic pain, and spinal cord stimulation for failed back surgery syndrome. The center is involved in clinical trials. www.georgiapaincare.com

Pain Management Center of Paducah (Paducah, Ky.). The Pain Management Center of Paducah is the home of Laxmaiah Manchikanti, MD, who serves as medical director of the center as well as chairman of the board and CEO of the American Society of Interventional Pain Physicians and the Society of Interventional Pain Management Surgery. Dr. Manchikanti is one of the most renowned pain management physicians in the country. The center began operation in 1992, and now performs more than 9,000 procedures annually. Although the center also offers orthopedic surgical services and ophthalmology services, more than 80 percent of its practice is in pain management. The center is accredited by AAAHC.

"In essence, our center was the first in the nation approved for pain management procedures," says Dr. Manchikanti. "Now there are close to 300 [pain management] centers across the country." www.thepainmd.com

Pain Management Center of Virginia (Reston, Va.). This surgery center is affiliated with the Virginia Spine Institute, which has been in practice since 1992. The Pain Management Center of Virginia was started in 2006, and the center's two pain management physicians now perform more than 3,500 procedures a year — about 75 percent of the center's total case volume. Treatment includes acupuncture, discography, fluoroscopic guided injections, caudal steroid injections, radiofrequency ablation and spinal cord stimulators.

Erin C. Orr, marketing director of Virginia Spine Institute, says the "all-under-one-roof" model, which includes surgeons, non-operative doctors and physical therapists, sets the center apart. www.spinemd.com

Peninsula Procedure Center (Redwood City, Calif.). The five board-certified physicians at this AAAHC-accredited center perform more than 3,000 pain management procedures annually including epidural injection, nerve blocks, spinal joint block and injections and rhizotomy. The center opened in Sept. 2007 and is managed by MedBridge

"[The center] has retained 95 percent of its original staff since the doors opened, which brings an incredible amount of experience and knowledge to each individual patient and case," says Alex Sumner, sales and marketing, MedBridge. "The center and physicians have an exemplary track record of safety and of exceeding high standards of patient care." www.peninsulapc.com

Premier Pain Center (Covington, La.). The center's founding physician, Allan T. Parr, MD, served as the president of the American Society of Interventional Pain Physicians and has been practicing pain management in the Covington area since 1994. The center offers specialty procedures such as spinal cord stimulation, drug infusion systems, neurosurgical and permanent anesthetic procedures and vertebroplasty. Physicians are Dr. Parr and Ann Conn, MD. Both Dr. Parr and Dr. Conn were included on the Becker's ASC Review list of "70 of the Best Pain Management Physicians in America." This center is accredited by the AAAHC. www.alparr.com

Riverdale Surgery Center – Pain ASC (Riverdale, N.J.). The center offers treatments for chronic back pain, neck pain, neuropathic pain, sciatica, cancer pain and postoperative pain. The center's physician, Amr Hosny, MD, performs procedures such as lysis of adhesions, radiofrequency ablation and spinal cord stimulation, in addition to all types of steroid injections. Dr. Hosny is board certified in interventional pain medicine, anesthesiology and hospice and palliative medicine. He has lectured on spinal cord stimulation for neuropathic pain and complex regional pain syndrome to pharmacological approaches for chronic pain.

Sioux Falls Surgical Hospital Pain Clinic (Sioux Falls, S.D.). This ASC is located within the Sioux Falls Surgical Center, which was founded in October 1985. The center's medical director, Timothy Metz, MD, is board certified in anesthesiology and perioperative ultrasound and has advanced certification in kyphoplasty and spinal cord stimulation techniques. He was also included on the Becker's ASC Review list of "70 of the Best Pain Management Physicians in America." [<http://www.beckersasc.com/orthopedic-spine-driven-asc/70-of-the-best-pain-management-physicians-in-america.html>] The center is accredited by AAAHC. www.sfsurgical.com/pain-management

The Spine Center (Maryland). The Spine Center operates nine locations throughout Maryland. The first of its centers opened in Rockville in 1998, and a 10th center is scheduled for Greenbelt in 2012. Each ASC coexists with a medical practice and is Medicare certified and AAAASF accredited. In 2010, The Spine Center's 15 physicians performed almost 45,000 procedures and have treated more than 70,000 since the center opened in 1998. Treat includes discotomies, neurostimulation trials and implants and intra-discal electro-thermal ablations. www.myspinedoctors.com

Springfield Surgical Specialists (Springfield, Mo.). Pain management specialists Jim Daily, MD, and Thomas Brooks, MD, work in the same facility with 12 orthopedic surgeons and one general surgeon. Dr. Daily says he helped start the ASC because, "I was in the hospital environment for 22 years and I was

tired of not being able to give the type of care and attention that I wanted to give."

He says the center's greatest strengths are fewer time constraints, lower infection rate, less threatening environment, a higher degree of patient respect and customer service. www.springfield-surgicalasc.com

Stonegate Surgery Center-Pain Management (Austin, Texas). Of the nearly 7,000 procedures this AAAHC-accredited surgery center performs annually, 5,700 of those are in pain management. The physician-owners formed the center five years ago. The center has eight pain physicians and nine surgeons who focus on pain management procedures, orthopedics, podiatry, spine and general surgery. Administrator Lauri Rose, MBA, CASC, says the center's success is attributable to the teamwork approach taken by every staff member.

"The medical and nursing staff work together to provide the best services for the patients entrusted to our care," says Ms. Rose. "This team approach is maintained throughout the continuum of patient care." www.stonegatesurgerycenter.com

Theda Oaks Surgery Center (San Antonio, Texas). The Theda Oaks center opened in 2004 and performs 9,500-10,000 procedures per year — about 40 percent of those in pain management, and the rest in gastroenterology. Urfan Dar, MD, the center's medical director, is board certified by the American Board of Pain Medicine and the American Board of Anesthesiology. Dr. Dar has been in practice in San Antonio since 1994.

He has been listed as one of the top 100 physicians in San Antonio and appeared on the Becker's ASC Review list of "70 of the Best Pain Management Physicians in America." The center offers cervical, thoracic and lumbar procedures such as radiofrequency rhizotomy and percutaneous disk decompressions as well as spinal cord stimulator trials and implantations. The center is accredited by AAAHC. www.thedaoaks.com

Total Pain Care (Meridian, Miss.). This AAAHC-accredited center's 18,400-square-foot space has three single-specialty procedure rooms, eight pre-op beds and a nine-bed recovery room.

The center and its two board-certified physicians have treated patients for 15 years. Kenneth E. Staggs Jr., MD, was a founding member and past president of the Mississippi Pain Society, and Eric J. Pearson, MD, also served as president of the Mississippi Pain Society and is currently the president-elect of the Southern Pain Society.

Treatments performed at the center includes spinal implants, radiofrequency and fluoroscopically guided pain injections. Total Pain Care also produces a 60-second weekly video series on pain and pain management that airs on the local ABC affiliate and is available on the center's website. www.totalpaincare.org

West Central Surgical Center (Toledo, Ohio). This AAAHC-certified center was created in 2005 and serves Northwest Ohio and Southeast Michigan. The center's four physicians perform more than 9,000 pain management procedures annually including radiofrequency ablations, transforaminals, pump trials, spinal cord stimulator trials and SI joint injections. The ASC operates at the same location as one of the Centers for Comprehensive Pain Management, a practice started by William G. James, Jr., MD, medical director, in 2003. Dr. James is the president of DECA Health and a diplomat of the American Boards of Anesthesiology and Pain Medicine. www.cc4pm.com

Wilton Surgery Center (Wilton, Conn.). This AAAHC-accredited ASC specializes in pain management and ophthalmology and opened in September 2005. The center has 24 physicians — three of whom are board-certified in interventional pain management. The center performs 5,000 procedures annually — about 1,700 in pain management — in its two operating rooms and two-procedure rooms.

Amanda Gunthel, administrator of Wilton Surgery Center, says the center's procedures include everything related to pain management from "epidurals all the way through spinal cord stimulator implants." The center is currently in a partnership with AmSurg and Stamford Hospital, and Ms. Gunthel says that relationship has increased the quality of care. The center is accredited by AAAHC. www.wiltonsurgerycenter.com ■

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Valuing an Out-of-Network Center in 2012: Thoughts From VMG Health's Kevin McDonough

By Abby Callard

When looking to buy a surgery center, the percentage of out-of-network cases an ASC does is one of the most important factors a buyer considers. In a recent VMG Health survey, 93 percent of buyers said heavy reliance on out-of-network payors had a "very high" impact on the ASC's value. Seven percent said it had a "high" impact.

A high percentage of out-of-network cases results in a lowering of the multiple a surgery center sells for, says Kevin McDonough, CFA, senior manager of VMG Health. The reduction can often be as high as 50 percent. The general trend in surgery center valuation is a widening margin in the multiples, Mr. McDonough says.

"Our observation of the ASC transaction market over the last five-10 years is that the valuation ranges we're seeing and the relative multiples have widened significantly," he says. "With respect to valuation, you simply cannot paint the entire industry with a single brushstroke. We've observed almost as many acquisitions occurring at discounted multiples as we have observed at the very top end."

Five to seven years ago, control-interest acquisition multiples fell consistently right around a 7 times EBITDA range. Now, Mr. McDonough says, acquisition multiples are significantly more varied.

"For those ASCs that are deemed high-risk, buyers will either discount the multiple offered or utilize higher multiples however adjust or "normalize" underlying EBITDA to account for significant risk factors."

Of the myriad of headwinds facing the industry, an out-of-network reimbursement strategy can be considered one of, if not the most significant, risk factors for a surgery center.

"Our observation has been that it is significantly more difficult to consummate a transaction with an out-of-network center," Mr. McDonough says. "The primary reason stems from the fact that there's an inherent disconnect between what a buyer believes an out-of-network earning stream is worth and what the seller believes it to be. In general, the seller believes the strategy does not pose an immediate threat to earnings and is unwilling to accept what they perceive to be a below-market offer. Buyer's in today's market are risk adverse and are unwilling to pursue an acquisition without discounting that out-of-network earnings stream.. As you can see, sometimes these two divergent opinions create an impasse that cannot be bridged."

There isn't a magic number for how much an out-of-network surgery center's valuation will be discounted; it depends on a lot of factors, he says. Some of these factors include the difference in reimbursement rates between out-of-network and in-network in a certain market and how difficult the payors are making it to collect on that out-of-network reimbursement and what types of strategies the payors are pursuing to eliminate or obstruct the pursuit of this strategy.

Although widely varied, the standard difference between the out-of-network and in-network rates are about 4-5 times comparable in-market rates, Mr. McDonough says. If the reimbursement rate for out-of-network is significant higher than this, all else being equal, additional risk is present.

Jon Vick, president of ASCs Inc. in Valley Center, Calif., has developed a scale of multiple reductions based on the percentage of out-of-network cases. He says if 75-100 percent of a center's volume is out-of-network, the

multiple could be expected to be reduced by 40-50 percent. If 50-75 percent of a center's volume is out-of-network, the multiple could be expected to decrease by 20-30 percent. If 25-50 percent is out-of-network, Mr. Vicks says the multiple would decrease by about 15-20 percent. He recalls an orthopedic and pain management center that did close to 100 percent of its cases out-of-network. The center's multiple fell from 6 times EBITDA to just over 3 — a drop of almost 50 percent.

However, having a high percentage of out-of-network cases is not a deal breaker, Mr. McDonough says. The most important part is to demonstrate to the buyer why it's a sustainable strategy — and in certain cases, it may be.

"The perception in the industry five to seven years ago was that this was a short term strategy that meet its demise in short order," he says. "Each year it's becoming more and more difficult to pursue the strategy, however it's had greater legs as an overall strategy than anyone had thought."

When pitching the strategy to potential buyers or to a third-party valuator, Mr. McDonough says to highlight the reasons they believe the strategy is sustainable. Examples include demonstrating that the center historically has had no problem collecting out-of-network reimbursements and that the difference between in-network and out-of-network reimbursements is not so significant that it creates extreme risk. He also recommends minimizing a center's other risks — of which there are many, he says.

Emphasizing the positive attributes of a surgery center is vital. Physician activity serves as the life-blood of any surgery center. As such, portraying a young, energetic, financially committed and highly active physician base is crucial. Emphasizing the positives is an important step in ensuring that buyers see beyond the out-of-network risk, he says. ■

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Surviving on a High Percentage of Medicare: 8 Thoughts From Mirage Endoscopy Center's Dana Folstrom

By Rachel Fields

Mirage Endoscopy Center, a joint venture between physicians and Eisenhower Medical Center managed by Health Inventures, sits in the Coachella Valley in Rancho Mirage, Calif., a warm, sunny area flooded with retirees. The large population of elderly people means that Mirage Endoscopy Center depends on a high percentage of Medicare reimbursement — around 50-60 percent, according to administrator Dana Folstrom. Medicare reimbursement is a dangerous game for any surgery center, but because the center is GI-focused, a high percentage of Medicare reimbursement poses a significant challenge to profitability. Since 2007, CMS has instituted around 20 percent in cuts to GI rates, with more expected in the future.

When CMS first announced cuts to GI reimbursement several years ago, Mr. Folstrom realized that significant measures would be necessary to maintain or increase profitability. Here he discusses what the center has done to stabilize revenue and keep physicians happy despite reliance on an unstable reimbursement platform.

1. Take an aggressive approach with commercial payors. Surgery center administrators can't do anything to change Medicare reim-

bursement, so centers with a high percentage of Medicare volume must concentrate on using their managed care contracts to offset decreased governmental reimbursement rates. Mr. Folstrom talked to his major insurers — Blue Cross Blue Shield, Aetna and United Healthcare — and negotiated contracts with “escalators” every year to make up for the continuing decline in Medicare rates.

He says the payor contracting department through Health Inventures helped the center take a “fairly aggressive approach” with payors. The center sent soft termination letters to each payor in order to move negotiations along and provided data to payors that showed the benefit of using the surgery center for patient cases. “It's cheaper and more efficient for payors to do procedures in the ASC,” he says. “We're just honest with the payors. Medicare is cutting our reimbursement, we want to stay open and we provide a high-quality cost-saving service to our community”

2. Move away from percent of Medicare contracts. When Medicare starting cutting GI reimbursement, Mr. Folstrom decided to move the center away from “percent of Medicare” contracts, which reimburse based a percentage of ever-changing Medicare reimbursement rates. Instead, the center started negotiating contracts based on “case rates,” payment to the provider based on a pre-agreed fee that includes all aspects of care regardless of additional costs incurred during the procedure. Mr. Folstrom says case rate contracts have been more profitable for the surgery center, though some smaller payors reimburse based on percent of charges.

3. Concentrate on reducing average days in A/R. Administrators agree: The longer you wait to collect your money, the less likely you are to get paid in full. Mr. Folstrom said from a cash flow standpoint, it became very important for the ASC not to allow A/R to age beyond a certain point. “That was a real focus for us — keeping our A/R around 28, 29 or 30 days and keeping our aged A/R down to 5 percent,” he says. “We have to make sure we get the billing out and that we're following up.”

He says the biggest issue that contributed to high days in A/R was problems with initial billing. “Your initial billing has to be clean,” he says. The surgery center changed its original clearinghouse and has managed to sign most of its payors up for electronic billing. Mr. Folstrom says electronic billing allows the office staff to track a claim while the payor is reviewing it. “When you do a hard bill, you call the payor and they say they didn't receive the claim,” he says. “With electronic billing, I can say, ‘I know you received it, because it's right here in the system.’”

4. Bill directly to Medicare. Mr. Folstrom's ASC has also started billing directly to Medicare to increase the speed at which claims are paid. “Because we do such a high percentage of Medicare, we went to direct bill to Medicare,” he says. “They have a software product you can use, and the turnaround on those claims becomes much quicker.” He says with the Medicare software, his staff finds it easier to identify errors with the billing, correct them and re-submit in a timely fashion. He says the software also makes it easier to communicate with Medicare about when payments are due back to the surgery center.

5. Increase efficiency. Low reimbursement increases the necessity for high volume, meaning a Medicare-dependent surgery center must be ef-



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ficient to schedule as many cases as possible. Mr. Folstrom says efficiency depends on several things: providing the staff support to move patients through the center quickly, remodeling problem areas to improve patient flow and cross-training employees.

"From a staffing standpoint, we make sure we have adequate staff to move the patients through the center with no wait time," he says. "That way, we're not waiting for staff to get from one area to another or finish something and then get to the next patient." He says cross-training employees also helps with efficiency because the ASC can assign a PACU task to a pre-op nurse if the pre-op is empty and all the other nurses are swamped.

6. Negotiate lower prices for high-volume supplies. To save money in a GI ASC, Mr. Folstrom recommends looking at the supplies you use most often and talking to your vendors about better pricing. He says his center has been successful in negotiating lower prices for forceps and snares — two of the highest-volume items — by encouraging competition among vendors.

"We don't like to jump around among vendors — that's not the point," he says. "We just made it pretty clear that based on the reimbursement rates we were receiving, we weren't going to be able to pay [our vendor's current rates] long-term." He says he emphasized to vendors that the surgery center performs a high volume of GI in the area, making the ASC a "desirable account" for suppliers.

7. Talk to physicians about high-cost GI supplies. Mr. Folstrom says there are several supplies in his ASC that are too expensive for Medi-

care-reimbursed cases. For example, when the surgery center performs esophageal dilation, the physicians have the option to use a multi-inflation balloon that opens to different sizes. Unfortunately, the multi-inflation balloon is expensive enough that the surgery center will not make money on the procedure if it is used.

He says the same holds true for gold probes or banding and clipping supplies. "Typically patients that require these interventions will present with higher acuity, and we will screen them to assure they are seen in the appropriate clinical setting to ensure a quality outcome," he says. "It allows us to proactively plan with our physicians to provide alternate supply solutions that will provide the same quality outcome for our patients." While Mr. Folstrom says the surgery center has not stopped taking certain Medicare procedures, he does talk to physicians about lower-cost options that will improve their distributions without jeopardizing quality.

8. Set physician expectations for time per procedure. ASC efficiency does not only depend on how quickly staff can turn over a room, Mr. Folstrom says. "The center has worked with physician to create a process that allows us to do the amount of volume needed to remain profitable," he says. "We have an extraordinary buy-in from all our physicians on the patient flow and block time structure, and this helps ensure on-time starts and efficient use of center resources." He says this buy-in allows the center to maintain high volume, quality outcomes and high patient satisfaction scores. ■

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What Percentage of Your Surgery Center Should You Sell?

By Abby Callard

Once physician-owners decide to sell a surgery center, they must decide on what percentage of the center to sell. Jon Vick, founder and president of ASCs Inc., which has assisted in development, merger and acquisition transactions for more than 200 physician-owned ASCs, endoscopy centers and surgical hospitals, says the decision should be based on the goals of the physician-partners.

He says there are three basic models for selling a surgery center: selling a minority share, selling a majority share and forming a three-way joint venture between an ASC, a management company and a hospital.

"Usually, we don't see both majority and minority purchase proposals for any one center," he says. "Once we know what the physicians' goals are, it becomes pretty clear which model is best."

Mr. Vick discusses the advantages and disadvantages of each model, as well as his recommendations for which centers should choose which model.

Selling a minority share

Mr. Vick says the minority interest option is best for centers that need more surgical volume and could benefit from a turnaround. These centers are generally between 40-50 percent utilized. By bringing in a management company, the center can take advantage of the company's recruiting and management expertise while maintaining control and the option to sell the center for a higher value later on.

"Let's say there's a center owned by five doctors, and it's 50 percent utilized," Mr. Vick says. "Rather than selling 51 percent, the owners would do better to sell 30 percent to a company that would increase the utilization by recruiting doctors, renegotiating the contracts and increasing revenue. Then they can take it and sell it for a much higher value."

Mr. Vick says approximately half of ASC management companies are interested and willing to purchase a minority stake in a center, and they generally purchase between 20-30 percent. These are usually smaller management companies who are interested in turnarounds.

"One of the main advantages of selling a minority interest is that a lot of the companies will work to make the center more profitable and thus more valuable," he says.

The management company will generally come in for one to three years, recruit more physicians, increase profitability and distributions to all of the partners and then sell a majority interest of the center to a larger company or joint venture with a hospital.

"A big advantage of a selling a minority interest is that some of the most successful minority-owner companies are willing to sell again," he says. "You can get a much higher multiple and a much higher value for all of the sellers."

The main disadvantage in a minority share sale is the valuation multiple is substantially less than for a majority interest — usually around 3-5 times EBITDA, or earnings before interest, taxes, depreciation and amortization. However, when the center becomes more profitable the owners can sell a majority interest at a much higher multiple, typically between 6-7.5 times EBITDA.

Selling a majority share

Mr. Vick says a center that is operating more or near at capacity — in the range of 80 percent or so — should consider selling a majority interest to a company that is looking for high cash flow, and that has the resources to expand the center.

"A center that is fully utilized and doing very well would be better off selling a majority interest to one of the larger companies that has the capital to

buy very successful centers," he says. "This allows the physicians to diversify their investments."

Selling a majority share is also a good option as an exit strategy for surgeons who are near retirement as this way they will receive full value for the shares they sell, rather than a discounted value. The management company would then recruit younger surgeons to replace the older ones. It is important that the selling surgeons develop a list of prospective buyers who could become partners.

The average valuation multiple for a majority interest sale is 6.5 times EBITDA, Mr. Vick says. This is substantially higher than the average multiple for a minority interest sale. Very rarely will a company buy more than 51 percent interest, he says. In certain cases, such as interest owned by retiring or unproductive physicians, the company will buy those shares to resell to younger, busier surgeons.

One of the presumed disadvantages of selling a majority interest of a center is the management company can assume total control, though Mr. Vick says that is easily mitigated.

"A lot of people think that by selling 51 percent, you're giving up control," he says. "Theoretically, that's true, but practically, physicians can add terms to the operating agreement so that the doctors can retain control over all the medical issues plus certain operational issues that the doctors want to have a say in. Losing control need not be a concern if the partnership is constructed properly."

Another advantage of selling a majority interest is that some companies that buy majority interest offer a combination of cash and stocks, which can result in a much higher total return when the value of appreciated value of the stock is realized.

"The stock component can be worth more down the road, so that the total return could be significantly more than a company that's just buying 51 percent for cash alone," he says. "It can boost the multiple up to 8 or 9 times EBITDA."

Even though the multiple is higher for majority interest sales, one disadvantage is that the physician owners lose the ability to resell the center down the line when it might be more profitable, Mr. Vick says.

"The disadvantage of selling 51 percent is that that's the only transaction the doctors will do," he says. "The opportunity for resale disappears."

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Forming a three-way joint venture

Mr. Vick says forming a joint venture with both a hospital and a management company is a good option for a multi-specialty center that has a lot of surgeons and needs help with recruiting and contracting.

"In a three-way deal, the doctors want to maximize their ASC's sales value, so they would sell 51 percent to a joint venture between a hospital and a management company," he says. "In that scenario, the hospital might buy 26 percent and the management company might buy 25 percent."

This deal usually results in a higher valuation multiple than a sale to a hospital alone, and the ASC management company ensures that the center will continue to be operated efficiently and economically. This sale results in a "best of both worlds" scenario, Mr. Vick says. The hospital has hospital contracts but not the ASC expertise, and the management company has the ASC expertise.

"This way, the seller would end up with a hospital partner and have access to hospital contracts and a surgery center management company that knows how to run surgery centers," he says.

A joint venture generally starts with the formation of a separate company that is 51 percent owned by the hospital and 49 percent owned by the management company, or a 50/50 split, Mr. Vick says. The surgery center would be operated by that joint venture, which is governed by its own laws and operating agreement.

Because the joint venture owns 51 percent, they have ultimate control, he says. In this situation, physicians can maintain control of certain aspects by requiring a super majority vote for specific actions or adding terms to the operating agreement. ■

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Selling Your Surgery Center? Physicians Alliance Surgery Center's Journey to a "Very Attractive" Offer

By Lindsey Dunn

Earlier this year, the 16 physician owners of Physicians Alliance Surgery Center in Cape Girardeau, Mo., embarked on a journey to find a partner for their four-operating room ambulatory surgery center. The surgery center, which opened in 2000, had grown to feature several specialties, including ear, nose and throat, general surgery, gynecology, ophthalmology and orthopedics, and the partners hoped to continue to grow the center.

However, according to Brian Schafer, MD, an orthopedic surgeon and partner in the center, the physicians, who operated the center independently along with an administrator, had "grown the center as far as we could given our management abilities and needed some real management expertise to expand it further." Additionally, the partners realized that healthcare reform was guiding healthcare delivery toward more coordinated, consolidated services and they desired to align with a partner who could help them fit into this future model of healthcare delivery.

Attractive center seeking partner

Bringing in an outside partner also allowed the physicians to "take some chips off the table," in regards to their financial stake to the center, says Daniel A. Brown, founder and managing director for Creative Health Capital, the firm PASC hired to help them through the transaction process. Creative Health Capital began working with PASC in January, and helped to develop the center's request for proposal, which received more than 25 responses from potential ASC management company and hospital partners. Based on the RFP responses, PASC brought in a handful of potential partners for interviews and eventually decided to move forward with Cape Girardeau-based Saint Francis Healthcare System, which offered to acquire 51 percent of the center at a "very attractive" multiple, according to Mr. Brown. "Saint Francis was very accommodating and really sold their ability to enhance the profitability of the center by adding more service lines," he said.

The physicians' decision to bring in a local health system as a majority partner was driven by a variety of factors. First, the health system would provide additional management and recruiting resources. Second, making the health system a majority owner could provide access to more favorable managed care and vendor contracts and help the center better manage its costs. Partnering with a hospital also meant the center would not be required to pay a management fee to a surgery center operator, which would

have been necessary if they had selected an ASC chain, says Dr. Schafer.

Additionally, the physicians sought a partner that would not erode the physician-oriented culture of the center. "The doctors still have a lot of say in how the center will run. A key consideration for the doctors was ensuring the center wouldn't be run like a hospital," says Mr. Brown. "The hospital provides synergies on both the revenue and cost side and supports the physicians, but [the physicians] still manage the center." According to Dr. Schafer, the day-to-day operations of the center haven't changed much since the deal closed Sept. 15. However, the health system has begun to work with them to develop a strategic plan and perform a "very methodical evaluation" into how to best grow the center, says Dr. Schafer.

The transaction also involved separating the physician-owners' real estate and corporate assets. That is, a separate group of investors, which includes some of the ASC's physician owners, acquired the ASC's real estate and now leases the facility back to the corporate entity. The deal allowed physicians who wanted to continue to own the real estate to buy out the other partners, who wanted to focus their investment on the center's operations.

Key learnings

According to Mr. Brown, the center received such an attractive offer because it committed to analyzing each offer comprehensively. The projected profits distributed to the physician owners for several years down the line were modeled under each proposed offer. Encouraging competition among potential partners is also critical to getting the highest price possible. The value of the offers received by the surgery center increases after it expanded its RFP process, says Aaron Kneas, a managing director for Creative Health Capital who was involved in the deal.

For Dr. Schafer and his partners, a key learning was that despite their deep clinical knowledge, their business acumen, especially around an issue as complex as a transaction was limited. "There's a lot more than meet the eye," he says. "There were a lot of issues that you may not really think twice about unless they're pointed out to you but could really be major sticking points after a deal closes." ■

Contact Lindsey Dunn at lindsey@beckershealthcare.com.

How Hospital Employment Will Affect ASC Physicians in 2012

By Rachel Fields

When asked about their primary concern for the ASC industry in 2012, Greg Horner, MD, managing partner of Smithfield Surgical Partners doesn't miss a beat: "The hospital integration process," he says. "You are probably aware that free-standing medical groups are vanishing over time, and as they integrate, they're either integrating as hospital employees or large multi-specialty medical groups." In California, where Smithfield is based, the integration process does not take the form of employment because the law prohibits the corporate practice of medicine. Instead, physicians have started to form "medical foundations" that integrate with large health systems — a method of partnership that allows hospital-physician integration without direct employment.

Dr. Horner says the increasing trend of hospital employment and integration puts specialists in an awkward position. If they choose to become employed by or integrated with a hospital, they may be precluded from participating in an ASC through hospital non-competes. If they opt to stay with the surgery center over choosing hospital partnership, they may lose a significant percentage of their referral base, as referring physicians are often the first ones to become employed. "The second step after employing primary care doctors is to ask those specialists — particularly orthopedic surgeons, ophthalmologists, pain management and spine — to follow that

grave train," Dr. Horner says. "They end up joining up as well to protect their referral sources."

While physician employment and integration may seem like a death knell for the surgery center industry, Dr. Horner says Smithfield has discovered "it isn't such a bad thing." Here he explains how physician employment may affect the ASC industry in the coming year.

1. Management companies and ASC physicians may actually benefit from employment. While individual surgery centers may be feeling the recruitment pinch as hospitals employ more and more physicians, surgery center management companies are in a good position to take advantage of the trend, Dr. Horner says. Hospitals that integrate heavily with physicians often own surgery centers to give their providers options. Management companies are well-suited to managing hospital-owned surgery centers because hospital control does not always improve the efficiency and profitability of the surgery center. "We have three current deals with hospitals where the hospitals have significant control over the physicians in the market, but they're not finding they're getting a great deal of efficiency out of their surgery centers," Dr. Horner says.

When the hospitals hire Smithfield to take over management of the surgery center, their first recommendation is that the hospitals syndicate to the physicians and give up a certain amount of management responsibility. "A couple of the centers were almost defunct and about to close until the hospitals systems started to get it and syndicated to the physicians and outsourced the management," he says. "That improves their relationship with the specialists." Management companies can profit from running the operational side of the surgery center, and physicians can reap the benefits of hospital integration while still exercising control over decisions that affect the ASC.

2. Hospitals will seek efficiency once they own physicians. Hospitals employ and integrate with physicians to gain a level of control over their own networks and the surrounding catchment area, Dr. Horner says. At the same time, he says hospitals are quickly realizing that when they gain control of specialists, they must employ some sort of gain-sharing relationship in order to achieve maximum efficiency. If physicians are dependent on the same yearly salary without ownership, they are less likely to work on cutting costs, decreasing wait times and preventing delays.

"I don't think it's that hospitals are inefficient at running surgery centers — I just don't think it's possible to achieve the same profitability that can be achieved when the surgeons have an ownership interest and skin in the game," Dr. Horner says. He says hospitals are more likely to incentivize physicians to improve surgery center efficiency once they realize that significant cost savings can be achieved when physicians care about the financial health of the facility. He says in many cases, the "control" hospitals seek over their surgery centers is somewhat of a formality. "The hospital wants to be able to have a first refusal on the sale of the center, or they want some level of control over governance," he says. "Even if the control is not exercised, they like to know that they have it."

3. Large multi-specialty groups can gain market share in the same manner as hospitals. If physicians choose not to integrate with or become employed by hospitals, they can still maintain profitability and control over the market through a large multi-specialty group. "Specialists — particularly large, orthopedic groups — are uniquely positioned to form multispecialty groups and achieve more control over the market," Dr. Horner says. "Once an orthopedic surgery group gains a significant

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scale, they routinely branch into other entrepreneurial directions such as imaging, physical therapy and surgery centers." This is the template for a multispecialty group.

He says this helps the physicians build an "economy of their own" that does not depend on referrals from hospital-employed or primary care physicians. "Orthopedic surgeons are a little more independent than other specialists," he says. "People come in off the street with lumps and bumps, and we are often the first touch point for patients in the healthcare system." He says orthopedic surgeons in several markets have begun leveraging their "econo-

mies" to launch powerful multispecialty or single specialty groups. "We are involved with similar projects in the market areas near our centers," he says.

Dr. Horner believes that ultimately, small, independent medical groups are going to consolidate. "Whatever structure replaces them is not as important as the efficiency they can achieve," he says. "Cost effectiveness and quality are the drivers of this change. For this reason, ambulatory surgery centers will play an important role in the consolidation movement for the foreseeable future." ■

Learn more about Smithfield Surgical Partners at www.smithfieldmd.com.

The Surgery Center Market: 5 Observations for 2012

By Scott Becker, Melissa Szabad, Amber Walsh, Bart Walker and Rachel Fields

We have several different observations as we look at the market for surgery centers this year. These are as follows:

1. Strong interest from buyers. There remains very strong interest from a handful of national company buyers that are looking to invest in robust high earning centers as well as turn around centers. "ASC merger and acquisition activity in 2011 was strong, with transactions happening across the size spectrum," says Aaron Murski, senior manager with VMG Health. "This should definitely continue into 2012, as appetite for growth remains strong among the management companies, considering the continued maturation of the ASC industry." There still remains substantial private equity investment in the surgery center market and great interest in company growing earnings. Thus, we have not seen a tapering off of interest in solid earning centers. Multiples for serious, very strong centers remain in the 6.5 to 7.5 times EBITDA range. Multiples for out of network centers are much lower and transactions are difficult to complete. According to VMG Health's *Value Driver 2011* survey, 93 percent of management and development companies consider high reliance on out-of-network payors a "very high" risk, rating higher than dominance of a single payor, significant number of aging physicians and local hospital employment.

The ability to acquire centers at significant multiples is also assisted by an improved lending and finance environment as compared to the last few years.

2. Pace to close deals is slower. The pace to close deals is now measured in multiple months versus one to two months. We find more and more often the transaction takes three to six months to close versus the typical 30 to 90 days. This is often the case both on the hard core large scale acquisitions as well as the turn around centers. We used to say that when you involved a hospital it expanded the time line by three to six months. The same extension of timeline is true

of many turn around centers today. In the turn around centers, time length may have slowed due to less optimism as to the ease of turning around the center. However, we do note that some of the best acquiring parties are still great at expediting transactions and are willing to do so.

According to data from HealthCare Appraisers, interest in turnaround opportunities decreased in the last several years, with 29 percent of management companies seeking turnaround centers in 2010 compared to 82 percent seeking de novo opportunities. Joe Clark, EVP and COO for Surgical Care Affiliates, believes there may be more interest in turnaround opportunities in 2012 due to overbuilt markets damaging surgery center profitability. "There are a high number of centers that are not functioning very well," he says. "I think most management companies are going to have turnaround capabilities — at least the more substantial management companies with sophisticated processes and tools."

3. Hospitals remain interested as buyers. Hospitals, where they have a heavily employed presence, are often looking to buy 100% of a center and convert it to a hospital outpatient department. In contrast, where hospitals have not fully engaged in an employment strategy, they are still very anxious to align more closely with physicians and look at surgery centers as potential profit lines and alignment opportunities. 2011 saw a great deal of joint venture activity between hospitals and physicians. In a market by market basis, we saw increased effort by hospitals to invest in or buy ASCs outright. Further, hospital pricing on acquisitions is generally very competitive with national company pricing.

4. Activity in CON states is brisk. Because of the amount of available physicians in certificate of need states where surgery center development has not been over developed and particularly in CON states where there is not the heavy presence of an employed model, there is tremendous interest in physician alignment through joint venture surgery centers. We see

a tremendous amount of activity in some of the Southeastern United States as well as in the greater New York area and New Jersey area. In 2011, we reported on 13 new surgery center developments in New York, 11 in Florida, 10 in New Jersey and 9 in North Carolina, in addition to three North Carolina joint ventures and three Florida joint ventures.

5. Spine, orthopedics, pain management, gastroenterology and ophthalmology. The key specialties for surgery centers tend to remain the three to five key specialties that have been the key specialties for a substantial period of time. Orthopedics, gastroenterology and ophthalmology are the top three specialties. Spine and pain management are also very important. According to data from HealthCare Appraisers, 94 percent of management companies view general orthopedics as desirable, compared to 88 percent for orthopedic spine, 82 percent for ophthalmology, 76 percent for ENT and pain management and 70 percent for GI. There remains tension with spine between performing procedures in the hospital or the surgery center. In contrast with pain management, the tension lies between the surgery center and the office of the physician. ■

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28 ASC Joint Ventures Planned or Developed in 2011

By Rachel Fields

Here are 28 joint ventures between physicians, surgery center management companies and/or hospitals during 2011, organized alphabetically by state. *Note:* If you were involved with an ambulatory surgery center joint venture partnership in 2011 and it is not listed here, email rachel@beckersasc.com.

Alabama

1. An ASC in Tusculumbia was planned to operate as a hospital/physician joint venture. An ASC in Tusculumbia, Ala., owned by and in operation on the campus of Helen Keller Hospital, was planned to become a hospital/physician joint-venture ASC. Keller Outpatient Surgery Pavilion, which opened in 2009, will be majority owned by the hospital. Physicians will have the opportunity to buy up to 49 percent of the ownership shares in the outpatient surgery center.

Arizona

2. Three Arizona surgery centers were added to a USPI/Catholic Healthcare West agreement. A joint-venture partnership between United Surgical Partners International and San Francisco-based Catholic Healthcare West added three Arizona ASCs to its portfolio in July. The ASCs — Metro Surgery Center in Phoenix, Surgery Center of Peoria and Surgery Center of Scottsdale — were previously managed by USPI but not affiliated with the health system.

California

3. Health Inventures announced a partnership with California's Sansum Clinic. In September, Health Inventures announced it had entered into a partnership with Sansum Clinic to develop and operate a new ASC in Santa Barbara, Calif. The ASC is planned to be open to patients in 2014, and is part of a larger development intended to improve access to specialty care in Santa Barbara County.

4. Regent Surgical Health partnered with a California hospital and 17 physician partners on two joint venture ASCs. Regent Surgical Health announced in November that it would partner with Lodi (Calif.) Memorial Hospital and 17 physician partners on two surgery centers. The joint-venture ASCs were Lodi Outpatient Surgical Center and the Endoscopy Center of Lodi. The facilities provide specialties including ENT, endoscopy, general surgery, orthopedics, podiatry, ophthalmology and urology.

5. French Hospital Medical Center in California became the majority owner of Templeton Surgery Center. French Hospital Medical Center, based in San Luis Obispo, Calif., has announced it became the majority owner of Templeton (Calif.) Surgery Center in March. Under the new partnership, services provided by the ASC will not change, according to a news release from French Hospital. The ASC will continue to be managed by the physician members, along with administrators from French Hospital.

Connecticut

6. Health Inventures announced the opening of a new joint-venture ASC in Connecticut. Health Inventures announced it opened a new joint-venture surgery center in Norwalk, Conn., in partnership with Norwalk Hospital and 15 local physicians. Norwalk Surgery Center is a multispecialty ASC focusing on chronic pain management, ENT, ophthalmology, orthopedics and general surgery.

7. Greenwich (Conn.) Hospital and Orthopaedic & Neurosurgery Specialists announced a joint-venture ASC agree-

ment. Greenwich (Conn.) Hospital and Orthopaedic & Neurosurgery Specialists, based in Greenwich, announced a joint-venture ASC agreement in May. Under the agreement, surgeons from ONS will perform procedures at Greenwich Hospital's Leona M. and Harry B. Helmsley Ambulatory Surgical Center one day a week.

Florida

8. C/N Group partnered with Gulf Comprehensive Surgery Center in Florida. The C/N Group entered into a joint-venture agreement with Gulf Comprehensive Surgery Center in Englewood, Fla. Under the venture agreement, C/N Group will take an ownership position in the surgery center, as well as provide certain administrative services to the facility.

9. New joint-venture Red Hills Surgical Center opened in Tallahassee. The Red Hills Surgical Center, a joint-venture ASC between Tallahassee Memorial Hospital and 35 local physicians, opened in April. The ASC is a 17,000-square-foot multi-specialty facility which features five operating rooms. It will be used by physicians from local practices representing specialties including ENT, orthopedic surgery, general surgery and obstetrics/gynecology, according to the release.

10. Surgery Partners acquired its 50th ASC. Surgery Partners announced the acquisition of its 50th ASC in Orange City, Fla., in September. The new facility is one of the state's newest outpatient multispecialty surgical facilities, according to the report.

Illinois

11. Regent Surgical Health partnered with Chicago's Swedish Covenant Hospital and 23 physicians on a new surgery center. Regent Surgical Health announced it was partnering with Chicago's Swedish Covenant Hospital and 23 physician partners on a new ASC included in a \$55 million expansion of the hospital's medical campus. The surgery center is scheduled to open in July 2012.

Iowa

12. Surgical Management Professionals started managing Iowa's Gateway Surgery Center. In September, Surgical Management Professionals announced it had signed an agreement with Gateway Surgery Center in Clinton, Iowa. Gateway, owned by Medical Associates, a 50-provider multispecialty group in Clinton, is a multispecialty surgery center featuring two operating rooms and two procedure rooms. The ASC provides services in general surgery, ophthalmology, orthopedics, gynecology, ENT, podiatry, urology, gastroenterology and pain management.

Kentucky

13. Ownership of Kentucky Surgery Center was transferred between competing health systems. The ownership interest in Louisville Orthopaedic Surgery Center in St. Matthews, Ky., held by Louisville, Ky.-based Jewish Hospital & St. Mary's HealthCare, was transferred to Louisville-based Baptist Healthcare System at the end of the year. The ownership transfer comes after Baptist agreed in late August to provide a site for University of Louisville physicians to perform tubal ligations. After the transfer, Baptist will partner with Louisville Orthopaedic in owning the surgery center.

14. Jewish & St. Mary's Healthcare partnered with Premier Surgery Center to boost competition. Jewish & St. Mary's HealthCare signed a deal in May to bring Premier Surgery Center of Louisville to the health system's Old Henry campus. Under the partnership deal, Jew-

ish & St. Mary's became part-owner of both Premier and SurgeCenter of Louisville, the latter of which performed 4,261 surgeries last year. The centers were previously co-owned by Surgical Care Affiliates and community physicians.

Maryland

15. Blue Chip Surgical Center Partners announced a partnership with Baltimore's Greenspring Surgery Center. Blue Chip announced a new partnership with Greenspring Surgery Center in Baltimore, introducing three new spine surgeons to the orthopedic and pain surgeon ownership group. The 6,300-square-foot surgery center opened in January 2007 and has one operating room and two procedure rooms. It handles a range of orthopedic surgical treatment.

16. SCA entered into a management agreement with Maryland's Suburban Outpatient Surgery Center. Surgical Care Affiliates entered into an agreement to manage the surgical services Bethesda, Md.-based Suburban Outpatient Surgery Center, a subsidiary of Suburban Hospital Healthcare System, a member of Johns Hopkins Medicine. SCA's management objectives included strengthening current ASC service lines and launching new service lines and specialties.

Michigan

17. Michigan surgeons and hospitals formed a joint venture to co-manage surgical services. Forty-three Michigan surgeons entered into a 50-50 joint venture with Southfield, Mich.-based Providence Hospital and Novi, Mich.-based Providence Park Hospital, both part of St. John Providence Health System, to co-manage the hospitals' inpatient and outpatient surgery services in May. Surgeon investors will receive hourly compensation for management and committee services as well as incentive payments for meeting certain quality and efficiency benchmarks, according to the report.

Missouri

18. Missouri Health System acquired a majority stake in a local surgery center. Saint Francis Healthcare System, based in Cape Girardeau, Mo., acquired a majority interest in Physicians Alliance Surgery Center in Cape Girardeau in September. The health system owns a 51 percent interest in the ASC, while the remaining 49 percent interest is shared by physicians.

Montana

19. Symbion partnered with Montana's Great Falls Clinic. Symbion entered into a new partnership with Great Falls (Mont.) Clinic in August. Symbion agreed to provide additional capital and management services to the Great Falls Clinic's outpatient multispecialty medical group practice (Main Clinic, Specialty Center, Immediate Care Center and Northwest Clinic), the Great Falls Clinic's surgery center (Great Falls Clinic Ambulatory Surgery Center), and the Great Falls Clinic's hospital (Great Falls Clinic Medical Center).

New York

20. ASCOA partnered with a New York City hospital and local surgeons for a new joint-venture surgery center. Ambulatory Surgical Centers of America announced a partnership with Roosevelt Hospital in New York and 26 local surgeons to develop a new, multispecialty outpatient surgery center on Manhattan's West Side. The ASC will be called the Roosevelt Surgical Center and is expected to open in the first half of 2013.

North Carolina

21. New North Carolina joint-venture surgery center was planned by Southeastern Regional Medical Center. Southeastern Regional Medical Center, based in Lumberton, N.C., is planning a new joint-venture surgery center. SRMC management sees the joint-venture opportunity as a way to increase physician alignment. The ASC is expected to cost \$27 million.

22. Rex Healthcare sold a minority share of Rex Surgery Center of Cary (N.C.) to a physician group. Rex Healthcare, based in Raleigh, N.C., sold a 22 percent controlling stake in Rex Surgery Center of Cary (N.C.) to a physician group in March. The 25-physician group paid \$3 million for the shares of the ASC, with the option to buy additional shares and grow its stake up to 45 percent over the next year. Rex Healthcare retained its majority stake the facility but involved the physicians in operational decisions.

23. SCA entered an agreement with Moses Cone Health System for a North Carolina surgery center. In January 2011, Surgical Care Affiliates announced it had entered into a formal agreement with Moses Cone Health System, Carolina Neurosurgery and Vanguard Brain and Spine, which purchased an interest in the general partnership that operates the Greensboro (N.C.) Specialty Surgery Center. The ASC will be jointly owned by the three organizations, the center's physician partners and SCA. It will continue to be managed by SCA.

Ohio

24. Surgical Management Professionals purchased an interest in Ashtabula Surgery Center in Ohio. Surgical Management Professionals purchased interest in Ashtabula (Ohio) Surgery Center in September. The center is a 5,200-square-foot facility with two operating rooms, one procedure room, 14 credentialed physicians, five credentialed CRNAs and 15 employees. It offers orthopedics, ophthalmology, pain management, podiatry and chiropractic services.

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25. Meridian Surgical Partners acquired Ohio's Eastwind Surgical. Meridian Surgical Partners acquired a majority interest of Eastwind Surgical in Westerville, Ohio, in July. The ASC, which was established in 2007 by the members of Central Ohio Neurological Surgeons, specializes in outpatient neurosurgery and pain management procedures.

26. New Ohio joint-venture surgery center was planned for Columbus. A new hospital/physician joint venture ASC was planned for Columbus, Ohio, as a partnership between OhioHealth Corp. and independent practice Hand and Microsurgery Associates. Health Inventures will manage the facility, which occupies the first floor of a 47,000-square-foot medical building. The project is expected to open in April 2012.

Rhode Island

27. SCA sold Wayland Square Surgicare in Rhode Island to a local hospital. In March, Surgical Care Affiliates sold Wayland Square

Surgicare in Providence, R.I., to Rhode Island Hospital. The company will continue management of the ASC. Rhode Island Hospital received approval for a change in effective control from the Rhode Island Department of Health and took ownership of the facility from SCA in 2010.

Texas

28. Texas' University General Health System acquired an interest in Mainland Surgery Center. University General Health System in Houston completed the acquisition of a minority interest in ASP of Dickinson LLP, d/b/a Mainland Surgery Center, in Dickinson, Texas, in May 2011. UGHS has an exclusive right to acquire the balance of the equity under certain terms and conditions. The transaction includes a management services agreement with UGHS Management Services, a wholly owned subsidiary of University General Health System. ■

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5 Questions to Ask When Resyndicating Your Surgery Center

By Rob Kurtz

Robert Carrera, president of Pinnacle III, identifies five questions ambulatory surgery centers need to ask themselves when preparing to resyndicate to new investors.

1. Do we have a process in place to properly vet prospective investors? Mr. Carrera suggests using the same process with these investors as that which was utilized with your initial group of investors. "If you're not properly conducting due diligence on the front end, it's inevitable that you're going to end up with someone who is not the partner you wanted," he says.

2. Do these investors share our philosophies? The physicians you're considering bringing in to your ASC should have philosophies that align with the philosophies embodied by your current physicians and any outside investors, such as a hospital or management company, says Mr. Carrera.

3. Are they physicians we want to be associated with from a quality standpoint? Mr. Carrera recommends ASCs learn as much as they can about prospective investors, including any information available about them from a quality standpoint. "Are they considered slow and/or expensive?" he asks. "From a quality perspective, would you feel comfortable with your family member going to them? All of those things go into determining whether someone should or would be considered a good partner or investor in the center."

4. Do we know their other commitments in the community? This is an important question to ask because you need to know what

might prevent these physicians from bringing cases to your center or distract them from their commitment to your ASC. You also want to learn this information because if they are invested in other ASCs, these partnerships could make it difficult for them to meet safe harbor regulations.

"Is it a situation where they have so many other investments that in a year from now, they're going to have a hard time filling out an affidavit stating they meet the compliance guidelines?" Mr. Carrera says.

5. Are we focused too much on bringing in new investors and cases and not enough on whether they're the right fit? This question ties back into the first question of following a process that will help ensure new investors are good, long-term partners. Mr. Carrera has observed some ASCs overlook a prospective physician's poor reputation and focus more on the cases he or she could bring to the facility. "They'll go for quantity as opposed to quality," he says. "[Some facilities] are jumping at any opportunity to hook an additional investor."

While the number of available physicians for recruitment has declined, it is critical for ASCs to not rush a decision on bringing in a new partner. "It's not inexpensive to bring people into the partnership," Mr. Carrera says. "Significant levels of both financial and human resources are put out there to get them into the partnership. If you didn't do your due diligence, you may find yourself actively working on removing or trying to remove a newly recruited physician, which is going to create additional expenses." ■

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How to Use Technology to Improve ASC Efficiency: Q&A With Scott McDade of McKesson Medical-Surgical

By Rob Kurtz

Everyone wants to get more out of their increasingly limited resources we all face today. Using technologies throughout ambulatory surgery centers can help deploy personnel on more productive activities. Many technology solutions are offered by your distributors to help you gain efficiencies throughout your organization. These solutions extend far beyond just ordering supplies. We spoke with Scott McDade, vice president of surgery centers at McKesson Medical-Surgical, to address several questions relating to how ASCs can best use technology to improve their efficiency.

Q: Materials management is the most obvious place to start where medical supply distributors can help increase efficiencies. Where should an administrator begin looking across their organization to identify where they need help?

Scott McDade: Ordering online offers a number of benefits that are just not available through any other means. Your distributors' websites will likely provide real-time product availability, so you know right away what products you order are going to be filled right away. More advanced websites offer features and tools to help you quickly identify cost-savings alternatives, such as private label items or other national brands that can help you reduce expenses. Make sure you look for a distributor that can provide med-surg items and pharmaceutical items from the same website and on the same order so your finance department is only processing one transaction. This is an important step to consider if saving time is an important initiative for you and your ASC.

Q: What other technologies can help save time and effort in the ordering process?

SM: Look for rapid order guides and purchasing lists within the ordering site. Those provide a simple step in that direction. If you really want to gain efficiency, you should use barcode scanning technology. The scanners allow you to move directly into the storage room to assess inventory levels, scan items and enter quantities — no more notepads are needed to write down item numbers and this approach is more accurate than reentering the numbers into an order form. Just return the scanner to the docking station and automatically upload the items directly into the distributor's ordering site. Really good scanners will display the item description and unit of measure to help you eliminate errors and get the products you need.

You'd be amazed how much time this could save. For example, in a recent case study of a multi-specialty surgery center performing 2,000-plus cases per year, the materials manager spent 16 hours per week, nearly half of the time, manually creating supply orders. After implementing barcode scanning technology, the ASC realized an estimated 60 percent reduction in hours spent processing orders, which included assessing inventory levels, resulting in an annual savings of over \$19,000.

Q: What do you suggest centers look for to help them manage the forms and red tape involved in ordering pharmaceuticals?

SM: Consolidating as much as possible would be my recommendation. Does your vendor allow you to do as much as you can with one technology? Bouncing from one site to the next is not the best use of staff time

And regulatory forms — no one likes filling out DEA 222 forms to order schedule II controlled substances. Talk about time consuming and frustrating! The DEA has established an automated process for approving elec-

tronic orders of schedule II pharmaceuticals called CSOS, which stands for controlled substance ordering system. Your vendor should offer a CSOS ordering system that is seamlessly integrated with their med-surg supply ordering system. The benefits of this paperless option are huge! These include fewer errors, unlimited items in each order, faster processing and decreased transaction costs — this one technology alone could help save hours in staff time and duplication of effort.

Q: How do all these systems talk to each other? It sounds like a lot of logging in and out and back in again. Where is the efficiency there?

SM: Short answer: connectivity. Having accurate case cost and preference card information is critical to your surgery center and helps lead to better business decisions. Your vendor should offer you the ability to connect directly with your practice management systems. This solution alone increases the accuracy of information and delivers time-saving efficiencies by eliminating manual processes. Imagine entering your order into your practice management system and you are done! No more printing of hard copies and re-keying the order into another site. Materials managers can enter the order one time. Connectivity also feeds order confirmation and pricing updates directly back into your system to help improve the accuracy of your case costing information and streamline your accounting functions. This is another simple way to improve business performance.

Q: Those are some good solutions to help with efficiency within the facility. What are some technologies that can help with patient interactions and satisfaction?

SM: Three areas come to mind where technology can help improve patient interactions. Insurance verification is perhaps most important — knowing that you are going to get paid. It's also important for patients to know what their obligation is prior to performing the procedure. Patient eligibility solutions can help maximize reimbursement and reduce claim denials by verifying insurance coverage and patient co-pays in real-time. This can not only save time for your staff, but also help identify patients who may be unable to pay. Another simple and seamless way to increase business performance!

Q: So what's another option?

SM: ePrescribing. Making things easy for the patient is key to patient satisfaction. Not to mention it will also save staff time and provide a more secure process for managing prescriptions. With ePrescribing you can transmit patient's prescriptions directly to their preferred pharmacy so the prescription is ready when they arrive — this means no paper scripts, no phone calls and less chance of prescription errors.

Q: With the increased focus on HIPAA compliance and electronic health records, what's available to help doctors and facilities communicate with patients?

SM: Secure communications with patients and between facilities is imperative and can be tricky. Patient portals are available and offer a secure environment for doctors to post patient results, answer questions and even request payments — all with complete documentation. These portals can also be a solution for facilities to interact with each other regarding patient status, referral information and follow-up. Efficiency and security is a great combination. ■

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

By Rachel Fields

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

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

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

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

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

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

Long-term, the number one technological development is cloud computing. The simplest way to explain cloud computing is to say that you're taking your server out of your facility and putting it

in a professionally-managed data center. You're doing that to achieve some well-defined benefits today: anywhere, anytime access, reduced risks, access to improved web-enabled applications, improved interoperability and significantly lower total cost of ownership over time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First, track your quality metrics and consider posting them to your web site periodically. For example, [you could post], “Over 98 percent of our patients report that they would recommend our facility to their friends and family” and con-

sider adding some patient quotes to your facility — de-identified, of course. Your website is the first contact that most patients will have with your facility, and you will want to make a favorable and lasting impression.

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

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

Q: What else can we expect for future trends?

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

Learn more about SourceMedical at www.sourcemed.net.

5 Tips for Updating a GI Center’s Technology

By Abby Callard

While implementing the latest technology can be a challenging and expensive procedure for ASCs, it’s usually worth the investment because it can attract both patients and physicians to a center. New York GI Center, a single-specialty GI ASC in Bronx, N.Y., has taken this advice to heart: The center’s records are completely electronic, its endoscopy equipment is state-of-the-art and it uses only 100 percent disposable endoscopic accessories.

James DiLorenzo, MD, president of NYGI, says that technology is more of an investment than an immediate money maker. He offers five tips to help ASC leaders keep their GI technology up-to-date.

1. IT is the backbone of your center. Dr. DiLorenzo recommends ASC leaders prioritize information technology when deciding where to invest. He says the key to using technology is a solid IT infrastructure

“A key to operating a high-quality, high-volume ASC is IT infrastructure,” he says. “The building blocks of your practice management, electronic nursing/anesthesia data and procedure reporting software make a seamless workflow possible. Without it, your documentation will never be complete, nor will you be able to track quality metrics and physician practice patterns.”

The center has also invested in internet security to protect confidential patient information as well as a new inventory management software that will allow the center to use barcodes to track inventory use.

2. Connect with the outside world. The financial incentives for meaningful use of electronic health records, while not currently applicable to surgery centers, encourage providers to connect with each other using electronic health records and IT systems. Dr. DiLorenzo recommends surgery centers pursue interoperability as EHRs become more advanced.

NYGI belongs to a healthcare information exchange. Patients sign a consent form and their information procedure results become available to participating healthcare facilities. “Invest some money in the connectivity and the interface,” Dr. DiLorenzo says. “It is really good in terms of continuity of care and access to important information by a wide range of facilities.”

3. Budget. How much money a center can realistically spend on updating technology varies, but centers have to be willing to reinvest some of its profits into the facility.

“You have to budget for it,” he says. “Figure out if there are things that you aren’t doing that you should be. If there’s something new coming down the line equipment-wise, you have to budget for [it].”

Once the budget is set, the center director or administrator can look at the technology available and decide what to invest in and what to skip. Dr. DiLorenzo says administrators should go through each piece of technology and discuss the potential return on investment. If the technology will attract more physicians or patients to the center, the ASC may be able to make back the invested capital by increasing case volume. He says ASC leaders should not expect an immediate payback with most technological investments, but the center should be able to pay for the equipment over time. "You have to look at the economics," he says. "Based on reimbursement, will you be able to handle it?"

4. Think of technology as an investment. Dr. DiLorenzo stresses that not all technology investments will pay off right away. For example, his ASC added an argon plasma coagulation unit, which is used for treatment of gastrointestinal bleeding.

"You don't really look at that as a piece of equipment that is going to be a money maker for the center. It distinguishes us from every other office space facility," he says. "I have to be able to do what people can't in an office setting."

Being able to attract patients and physicians to an ASC is essential to re-

maining profitable. He says although patients won't generally come in requesting specific equipment, physicians do come in with an idea of the equipment they need to complete their procedures.

"I think for the doctors doing cases, you need the latest generation endoscopes so that they feel comfortable doing their cases," he says. "You want to have that instrumentation, the high-definition monitors, the standard things. If you don't invest in the best quality equipment, you won't be able to recruit high quality physicians."

5. Train your staff. Last but not least, make sure the staff is trained on the equipment. "You could have every possible piece of equipment with all the bells and whistles, but if the staff isn't caring and well-trained, the equipment doesn't matter," Dr. DiLorenzo says.

For each new piece of equipment brought into the NYGI center, the staff goes through an in-service training with the manufacturer. Initially, he says, they'll have a core group of technicians go through training and demonstrate competency. Only then will staff and technicians be able to use the technology with patients. ■

Contact Abby Callard at abby@beckershealthcare.com.

Automating Processes & Services in a Surgery Center: Q&A With Troy Clifton of Encircle Healthcare

By Rob Kurtz

Troy Clifton is vice president of sales and marketing for Encircle Healthcare, a provider of web-based automation and integration services for healthcare organizations.

Q: For ambulatory surgery centers to remain competitive and profitable, they need to regularly find ways to improve efficiency while, hopefully, reducing costs. One such way often suggested is automating processes and services. Why is automation a truly viable solution? What benefits does it offer?

Troy Clifton: If we look across the ASC industry, and really the healthcare industry as a whole, unlike most other industries there still remain numerous manual and redundant processes. At the simplest level, these manual processes contribute to substantial inefficiency, which translates to dollars wasted. What's more, they are often highly prone to error, which can have a negative impact on overall quality and performance. In today's challenging environment, more than ever facilities need to seek out ways to manage expenses, ensure full reimbursement and remain competitive by offering unsurpassed service to patients and

stakeholders. Eliminating inefficient processes through automation is a key step facilities must make towards achieving these goals.

Q: What problems can arise from automation? How can ASCs overcome these challenges?

TC: Like almost any technology deployment, change management remains the number one obstacle that we encounter in our work. Often, when you take a process that was previously highly dependent on manual intervention and change it to a highly automated process utilizing technology, you must embrace it, and ensure your entire team is on board with the project and the end goal. This almost always means that workflow must be adapted in order to maximize the benefits of the new processes.

The other critical stage of making automation work requires that you carefully plan and configure all aspects of the tools you are utilizing. For example, any technology you employ must follow a set of rules that govern how it performs a certain task. In a sense, you have to teach the tool how to react to a certain event or trigger. If you

get this wrong, the tool may not be as effective, or even worse, it may not output the desired result.

Q: If an ASC is considering moving a manual process to using a technology to automate the process, what steps does a facility need to take to ensure a smooth transition?

TC: Proper planning and thorough change management are keys to successfully applying any technology to your workflow. Define and set a clear goal, and establish reasonable expectations. For example, perhaps it is unreasonable to expect that a technology can replace a manual process 100 percent of the time. However, if you can eliminate 80 percent of the work associated with a task, and then craft a modified workflow around how you complete the remaining 20 percent, there is no reason you won't be successful in gaining efficiency, saving time and money and achieving a meaningful return on investment for your technology acquisitions. ■

Learn more about Encircle Healthcare at www.mysurgicenter.com.

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- Allan Fine, Senior Vice President, Chief Strategy & Operations Officer, The New York Eye & Ear Infirmary
- Leslie R. Jebson, Executive Director, University of Florida Orthopaedics and Sports Medicine Institute, Program Director, University of Florida Graduate Program in Physician Practice Integration



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PROGRAM SCHEDULE

Conference – Thursday, May 17, 2012

7:00am – 9:00am	Registration
9:00am – 5:00pm	Conference
5:00pm – 7:00pm	Reception, Cash Raffles, Exhibits

Conference – Friday, May 18, 2012

7:00am – 8:00am	Registration and Continental Breakfast
8:00am – 5:10pm	Conference, Including Lunch and Exhibit Hall Breaks
5:10pm – 6:30pm	Reception, Cash Raffles, Exhibits

Thursday, May 17, 2012

7:00 – 9:00 am
Registration

9:00 – 9:45 AM

A. Developing a Strategy for Your Hospital and Health System

Stephen Mansfield, PhD, President and CEO, Methodist Health System, Charles "Chuck" D. Stokes, MHA, Chief Operating Officer, Memorial Hermann, M. Michael Shabot, MD, Chief Medical Officer, Memorial Hermann, moderated by Bill Woodson, Senior Vice President, Sg2

B. Physician Compensation – A Review of Compensation Metrics for 5 Key Areas; Primary Care, Cardiology, Oncology, Orthopedics and Neurosurgery

Timothy Reed, Physician Practice Valuations Practice Leader, Sullivan Cotter and Associates, Inc.

C. Exploring the Facts and Fantasies of Physician Hospital Integration: Real World Examples of What Works, What Doesn't and Why

Peggy Naas, MD, MBA, Vice President, Physician Strategies, VHA Inc., Lani Berman, MBA, Vice President, Performance Services, VHA Inc.

D. Key Concepts for Successful Clinical Integration

Eric T. Nielsen, MD, Vice President, The Camden Group, and Teresa Koenig, MD, The Camden Group

9:50 – 10:30 AM

A. Key Strategies to Align Independent and Employed Physicians

Paul Summerside, CMO, BayCare Clinic, Chris Karam, President & CEO, CHRISTUS St. Michael Health System, Allan Fine, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, moderated by Kristian A. Werling, Partner, McGuireWoods LLP

B. Key Thoughts on Budgeting in Times of Uncertainty

John R. Zell, VP of Finance and CFO, OSF St. Joseph, Henry Brown, CFO, Westchester Hospital, Joseph Guarracino, Senior Vice President & CFO, The Brooklyn Hospital Center, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Hospital Physician Alignment: Implications on Profits and Performance

Alex Hunter, Managing Director, Navigant, Michele M. Molden, Executive Vice President and Chief Transformation Officer, Piedmont Healthcare

D. What's New, Next and Best in Healthcare Strategy, Marketing and Communications

Rhoda Weiss, PhD, National Healthcare Consultant, Speaker, Author & Editor, Marketing Health Services Magazine

10:35 – 11:10 AM

A. Payor Provider Integration - A Case Study

Bob Edmondson, Vice President of Strategic Planning and Business Development, West Penn Allegheny Health System

B. Managed Care Negotiation Strategies 2012

Gregg P. Leff, Executive Vice President, Med Metrix

C. Developing a High Reliability Organization - Learning from Other Industries

Charles "Chuck" D. Stokes, MHA, Chief Operating Officer, and Michael Shabot, MD, Chief Medical Officer, Memorial Hermann

D. The Evolution of Service Line Co Management Relationships, Best Practices

Gerry Biala, SVP of Perioperative Services, Surgical Care Affiliates, and Matthew Kossman, Senior Director, Surgical Care Affiliates

11:15 – 12:00 PM

A. Key Thoughts from Center of Medicare and Medicaid Innovation

Valinda Rutledge, Director of Patient Care Models Group, Center for Medicare/Medicaid Innovation

B. Sustainable Physician Compensation Model Design: Critical Success Factors for Building Productivity-Based Compensation Models

Marc D. Halley, President & CEO, and William Reiser, VP, Product Development, Halley Consulting

C. Core Strategies to Succeed as an Independent Hospital

Kerry Shannon, Senior Managing Director, FTI Consulting, Alan H. Channing, President & CEO, Sinai Health System, Joseph Guarracino, Senior Vice President & CFO, The Brooklyn Hospital Center, moderated by Kate Carow, Principal, Carow Consulting

D. Valuing Practices for Acquisitions - Assessing Acquisition Price and Compensation

Jon O'Sullivan, Senior Partner, Jonathan Helm, AVA, Manager, VMG Health

12:00 – 12:45 PM

Networking Lunch & Exhibits

12:50 – 1:30 PM

A. Developing an Outstanding Group Practice, Financial Sustainability, Culture and Other Issues

Jeff Mason, CEO, BayCare Clinic, Marc D. Halley, President & CEO, Halley Consulting, Joseph Golbus, MD, President, NorthShore University HealthSystem, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Consolidation - Strategic Thoughts for Consolidations and Independent Hospitals

Carsten Beith, Co-Head of Tax-Exempt M&A, Cain Brothers, Anu Singh, Senior Vice President, Kaufman Hall, Victoria Poindexter, Principal, H2C, LLC, moderated by Adam Lynch, Vice President, Principle Valuation

C. Building a Leading Neurosurgery and Spine Program

Casey Nolan, Managing Director, Navigant

D. Using Co-Management Effectively to Improve Results

Jen Johnson, CFA, VMG Health, Michael Piver, Director Orthopedic & Spine Services, Tanner Health System

1:35 – 2:20 PM

A. The 5 Best Ideas for ACOs, PHOs and Shared Savings Agreements

Charles "Chuck" Peck, President & CEO, Health Inventures, LLC, H. Scott Sarraan, MD, MM, Chief Medical Officer, Blue Cross Blue Shield of IL, Mike Kasper, CEO, DuPage Medical Group, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Strategy, Quality and Efficiency

Imran Andrabi, President & CEO, Mercy St. Vincent Medical Center, Samantha Platzke, Sr. Vice President Operations & Systems Effectiveness, and Ben Sawyer, Executive Vice President, Care Logistics

C. Bundling Orthopedics and Other Key Concepts to Improve Orthopedic Volumes

John D. Martin, President & CEO, OrthoIndy, Julie Fleck, COO, Parkview Ortho Hospital, Doug Garland, MD, Medical Director of Orthopedics, Long Beach Medical Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP

D. Replacing Revenue for a Hospital When Developing Ambulatory Businesses

Robert Zasa, MSHHA, FACMPE, Founder, ASD Management

2:25 – 3:05 PM

A. Key Concepts to Be a Great Hospital CEO - How to Succeed and Develop Raving Fans

Paul R. Summerside, MD, Chief Medical Officer, BayCare Clinic, Peggy Naleppa President & CEO, Peninsula Regional Medical Center, Angela Marchi, Division Vice President, Health Management Associates, moderated by Kristian A. Werling, Partner, McGuireWoods LLP

B. Key Strategies for CFOs

Gary E. Weiss, CFO, NorthShore University HealthSystem, William T. Cusick, Executive Vice President/CFO, St. Mary's Hospital, Henry Brown, CFO, Westchester Hospital, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Muskoskeletal Programs and Physician Alignment For Hospitals

Jeff Leland, CEO, Blue Chip Surgical Center Partners and Megan Perry, CEO, Sentara Health System

D. Keys to Successful Implementation of Physician Alignment Initiatives

Charles "Chuck" Peck, President & CEO, and Christian D. Ellison, Vice President, Health Inventures, LLC

3:05 – 3:20 PM

Networking Break & Exhibits

3:20 – 4:10 PM

A. Keynote Panel - The Unintended Consequences of the Affordable Care Act

Ken Hanover, CEO, Northeast Health System, Andrea Price, CEO, Mercy Northern Region, Stephen Mansfield, PhD, President & CEO, Methodist Health System, moderated by Charles S. Lauer, Author, Consultant, Speaker and Former Publisher of Modern Healthcare Magazine

B. Panel Discussion - Key Thoughts on Hospital Restructuring and Turning Around Hospitals

Paul Rundell, Managing Director, Alvarez & Marsal Healthcare Industry Group, Michael R. Williams, MD, CEO, Hill County Memorial, moderated by Barton C. Walker, Partner, McGuireWoods LLP

C. The Radiology Department of the Future -Maintaining Profits From Imaging as the World Evolves

Phillip Heckendorn, CEO, and David Walker, COO, RadCare

D. Valuing and Assessing Co Management Relationships

Scott Safriet, MBA, AVA, Partner, Health-Care Appraisers, and Amber McGraw Walsh, Partner, McGuireWoods LLP

4:15 – 5:00 PM

KEYNOTE – Leadership and Management in 2012

Mike Ditka, Legendary NFL Player and Football Coach

5:00 – 7:00 PM

Networking Reception, Cash Raffles & Exhibits

Friday, May 18, 2012

7:00 – 8:10 AM –

Registration and Continental Breakfast

8:10 – 9:00 AM

KEYNOTE – From Nixon to Obama

Bob Woodward, Legendary Political Journalist & Associate Editor, The Washington Post

9:00 – 9:45 AM

A. Keynote Panel - The Best Ideas for Health Systems and Hospitals Now

R. Timothy Stack, President & CEO, Piedmont Health System, Stephen Mansfield, PhD, President & CEO, Methodist Health System, Michael O. Ugwueke, CEO, Methodist Healthcare North and South Hospitals, Charlie Martin, CEO, Vanguard Health System, moderated by Charles S. Lauer, Author, Consultant, Speaker and Former Publisher of Modern Healthcare Magazine

B. The Current State of the Healthcare Credit Markets

Shane Passarelli, Senior Vice President, Healthcare Finance Group, Kevin Vermeer, CFO, Iowa Health System, Don Ensing, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Healthcare Reform - Future Thoughts on Success

Alan Sager, PhD, Professor of Health and Policy Management, Boston University School of Public Health

D. Patients Come Second, Employees Come First

Paul Spiegelman, CEO, The Beryl Companies, and Britt Berrett, CEO of Texas Health Presbyterian Hospital in Dallas

9:50 – 10:30 AM

A. Developing an ACO and Alignment Strategy for Your Health System

Marty Manning, President, Advocate Physicians Partners

B. What Should a Hospital CEO and CFO be Paid?

Paul Esselman, Executive Vice President and Managing Principal, Rebecca Kapphahn, Engagement Manager, Cejka Executive Search

C. A Perspective on the Medical Staff of the Future

Ron Greeno, MD, CMO, Cogent HMA

D. Fixing Physician Hospital Joint Ventures That are Struggling

Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America

10:30 – 10:45 AM

Networking Break & Exhibits

10:45 – 11:30 AM

A. Keynote Panel - Great Leadership

Moderated by Suzy Welch, Author, Television Commentator, Business Journalist, Panelists: Kristine Murtos, President, Skokie Hospital, Melissa Szabad, Partner, McGuireWoods LLP, Teri Fontenot, CEO, Woman's Hospital, Pamela Stoyanoff, EVP & COO, Methodist Health System, Laurie Eberst, President & CEO, CHW Ventura County and St. John's Regional Medical Center

B. 5 Key Financial Ratios That Providers Should be Tracking

Kate Guelich, Senior Vice President, Kaufman, Hall & Associates

C. The Financial Return on Different Physician Alignment Strategies - How to Assess the Financial Implications of Different Alignment Strategies

Luke C. Peterson, Partner, Strategy, and Kate Lovrien, Partner, Strategy, Health System Advisors

D. The Most Common Medical Staff Problems and Issues and How to Handle Them

Tom Stallings, Partner, McGuireWoods LLP

11:35 – 12:20 PM

A. Keynote Panel - Evolving Strategy - Thinking 10 Months and 10 Years Into the Future

Moderated by Suzy Welch, Author, Television Commentator, Business Journalist, Panelists: Cathy Jacobson, President, Froedtert Health, Donna Katen-Bahensky, President & CEO, University of Wisconsin Hospitals and Clinics, Tammie Brailsford, RN, COO, Memorial Care Health System, Amber McGraw Walsh, Partner, McGuireWoods LLP

B. The Importance of Data and Analytics in a Bundled Payment Approach

Bob Kelley, Senior Vice President, Center for Healthcare Analytics, Thomson Reuters

C. Ideas and Concepts to Improve Cardiovascular Program Profitability

Andrew Ziskind, MD, Partner, Senior Executive, Accenture, moderated by James Palazzo, Managing Director, Navigant

D. Key Concepts to Police, Improve and Measure Quality

Kathleen Crawford, MSN, MBA, FACHE, Chief Operating Officer, Ashtabula County Medical Center, HFAP Nurse Surveyor, Linda Lansing, SVP of Clinical Services, Surgical Care Affiliates, Marion Martin, RN, MSN, MBA, COO, The Center for Quality, Innovation and Patient Safety, Roper St Francis Healthcare

12:20 - 1:05 pm

Networking Lunch and Exhibits

1:05 - 1:45 PM

A. ACOs in Action

Andrew Ziskind, MD, Partner, Senior Executive, Accenture

B. Hospital Transaction Preparation and Process Design

Barry Sagraves, Juniper Advisory, Rex Burgdorfer, Juniper Advisory, Martin Machowsky, SVP, Strategic Communications, McGuireWoods Consulting, Kristian A. Werling, Partner, McGuireWoods LLP

C. Generation Y - An Examination of the Mindsets in Employing the Next Generation of Orthopedic Surgeons

Les Jebson, Executive Director, University of Florida Ortho and Sports Medicine

D. Avoiding a Hurricane: How to Evaluate Your Anesthesia Provider and Ensure Your OR's Success

Marc E. Koch, MD, President & CEO, Somnia, Inc.

1:50 - 2:30 PM

A. Aetna's ACO Initiatives - Our Work With Health Systems to Pilot ACO Initiatives on Hospital Employee Populations

Debbie Lantzy-Talpos, Market Head, Aetna

B. Key Developments in Medicare Reimbursement and Implications for the Delivery of Care

Ken Perez, Senior Vice President of Marketing, MedeAnalytics, Inc.

C. An Analysis of What Works What Doesn't - Key Thoughts for Physician Hospital ASC JVs

Tom Mallon, CEO, Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

D. 10 Keys to Assessing the Short- and Long-Term Sustainability of Your

Hospital and Running a Successful Acquisition or Joint Venture Program

Scott Becker, JD, CPA, Partner, and Barton C. Walker, Partner, McGuireWoods LLP

2:35 - 3:10 PM

A. The Best Ideas on Physician/Hospital Integration - What Works, What Doesn't

Bob Wilson, Executive Director, Health Care Advisory Services, Grant Thornton, I. Naya Kehayes, MPH, Managing Principal & CEO, Eveia Health Consulting & Management, Mickey Bilbrey, Vice President of Eastern Operations, Quorum Health Resources, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Optimizing Resources - Guaranteed New Savings and Revenues

Richard Kunnes, MD, Managing Principal, CEO, Sevenex

C. Acquiring Cardiology Practices - Key Concepts on Price and Compensation

James M. Palazzo, MBA, Managing Director, Navigant

D. Physician Relations: Best Practices in Leveraging QA Programs to Manage and Affect Positive Change

John DiCapua, MD, Vice President Anesthesiology Services, North Shore-Long Island Jewish Health System, Deputy CEO, CMO, North American Partners in Anesthesia

3:15 - 3:50 PM

A. New Types of Transactions to Deal With the Changing Environment - Payors Acquiring Providers, For-Profit and Not-For-Profit Hospital JVs and Joint Operating Agreements

Carsten Beith, Co-Head of Tax-Exempt M&A, Cain Brothers, Casey Nolan, Managing Director, Navigant, and Kristian A. Werling, Partner, McGuireWoods LLP, moderated by David Jarrard, President & CEO, Jarrard, Phillips, Cate & Hancock

B. Building a World Class Oncology Program - A Case Study

Gerard Nussbaum, Director of Technology, Kurt Salmon

C. Hospital Strategies for Surviving and Thriving in the Changing Healthcare Environment

Russ Richmond, MD, CEO, Objective Health

D. Clinical Variation, Quality and the Role of the CMO

Bill Mohlenbrock, MD, FACS, Chairman and CMO, Verras

3:55 - 4:30 PM

A. False Claims, Anti Kickback Investigations and Other Common Issues of Litigation

Jeffrey C. Clark, Partner and David J. Pivnik, Associate, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Acquisitions of ASCs, Imaging Facilities and Other Ancillary Businesses - How to Examine Opportunities and How to Assess Pricing and ROI

Matt Searles, Managing Director, Merritt Healthcare

C. 5 Core Concepts on How to Reduce Readmissions

Jasen Gundersen, MD, MBA, CPE, SFHM, Chief Medical Officer, Hospital Medicine, and Eric Heckerson, RN, MA, FACHE, Vice President of Operational Performance, TeamHealth

D. Turning Today's PHO into Tomorrow's ACO

Elizabeth Simpkin, Vice President of Consulting Services, and Carole Black, MD, Chief Medical Officer, Valence Health

4:35 - 5:10 PM

A. Performance Improvement Initiatives for Hospital Affiliated Practices

John McDaniel, MHA, President & CEO, Peak Performance Physicians

B. An EMR for the Revenue Cycle: Documenting the Business Side of Care at Saint Joseph's Medical Center

Rebecca T. Black, Vice President, Revenue Cycle, Saint Joseph's Hospital of Atlanta

C. Personalizing the Management of Atrial Fibrillation - How Cardiac MRI can Improve Your Outcomes and Bottom Line

Jeremy Foterhringham, RN, MHSA, JD, Director, CARMA Center, University of Utah Healthcare

D. 5 Basic PR Tactics That Every Health System Should Remember

Marion Crawford, President, Crawford Strategy

5:10 - 6:30 PM

Networking Reception, Cash Raffles & Exhibits

Great Topics and Speakers Focused on ACOs, Physician Hospital Integration, Improving Profitability, and Key Specialties - 74 Sessions - 124 Speakers



Bob Woodward, Author, Associate Editor, The Washington Post – Mr. Woodward is regarded as one of America's preeminent investigative reporters and non-fiction authors. He has worked for The Washington Post since 1971 as a reporter, and is currently associate editor of the Post.

While a young reporter for The Washington Post in 1972, Woodward was teamed up with Carl Bernstein; the two did much, but not all, of the original news reporting on the Watergate scandal that led to numerous government investigations and the eventual resignation of President Richard Nixon. Gene Roberts, former managing editor of The New York Times has called the work of Woodward and Bernstein "maybe the single greatest reporting effort of all time. Woodward has authored or coauthored 16 non-fiction books in the last 36 years. All 16 have been national bestsellers and 12 of them have been #1 national non-fiction bestsellers – more #1 national non-fiction bestsellers than any contemporary author.



Suzy Welch, Author, Popular Television Commentator, and noted Business Journalist – Ms. Welch's New York Times bestselling book, *10-10-10: A Life Transforming Idea*, presents a powerful decision-making strategy for success at work and in parenting, love and friendship. *10-10-10*

became an instant success and is now published in 29 countries worldwide, and an updated version has been released in paperback. In addition, she is a contributor for ABC's Good Morning America, and has been widely featured in major media outlets including The Today Show and Time Magazine. Together with her husband Jack Welch, Suzy is also co-author of the #1 international bestseller *Winning*, its companion volume, *Winning: The Answers*, and "The Welch Way," a weekly column on business and career challenges which appeared in *BusinessWeek* magazine from 2005-2009 and was published in 45 major newspapers across the globe by The New York Times Syndicate. In 2010, the Welch's launched an online MBA program through Chancellor University



Mike Ditka, Legendary Hall of Fame NFL Football Player and Coach - Pro Football Hall of Fame player and Super Bowl-winning coach Ditka joined ESPN as an NFL analyst in 2004. With a combined 26 years of playing (12) and head

coaching (14) experience, Ditka is an analyst on Sunday NFL Countdown and Monday Night Countdown and makes regular appearances on ESPN Radio and SportsCenter. Ditka also served as a game analyst during ESPN's Monday Night Football doubleheader games in 2007 and 2008, alongside Mike Greenberg and Mike Golic. Ditka boasts a career few can match. He is only the second person to win the Super Bowl as a player (Dallas, 1972), assistant coach (Dallas, 1977) and head coach (Chicago, 1986). He was elected to the Pro Football Hall of Fame in 1988, the first tight end to receive this honor



Valinda Rutledge, Director of Patient Care Models Group, Center for Medicare/Medicaid Innovation – In June 2011, Ms. Rutledge was hired in a senior leadership position as Director of the Patient Care Models Group at the CMS's new Center of Medicare and Medicaid Innovation. Previously, she was the CEO of CaroMont Health in Gastonia, North Carolina. At CaroMont Health, she led the development of the 210 day bundled knee payment arrangement between CaroMont Health and North Carolina's largest health insurer, Blue Cross

and Blue Shield of North Carolina. This initiative was designed to provide value based care leading to enhanced care coordination. Prior to CaroMont Health, Ms. Rutledge was CEO of Bon Secours Saint Francis Health System in Greenville, South Carolina. She was also Senior Vice President of the Bon Secours Health System with responsibility for system-wide physician alignment strategies, as well as market leader for both Kentucky and South Carolina. Rutledge holds two advanced degrees: a Master of Business Administration from Butler University in Indianapolis and a Master of Science in Nursing from Wayne State University in Detroit.



Charles S. Lauer – Mr. Lauer was the publisher of Modern Healthcare for more than 30 years, taking it from a monthly money-losing proposition when Crain Communications purchased the magazine in 1976 to the nation's leading healthcare news weekly. Known throughout the healthcare industry and beyond as a leader, Chuck Lauer is now a healthcare consultant, an author, public speaker and award-winning businessman who is in demand for his motivational messages to top companies nationwide.

Mr. Lauer's career includes early success as a retail representative for Life Magazine at Time, Inc., and later as a drug merchandising manager of Look. The consummate salesman, he served as Midwest Sales Manager for two McGraw-Hill trade publications and was general sales manager for the publications of the American Medical Association where he became the AMA's director of communications. He also held various positions with Family Media, Inc. and Petersen Publishing. He is a graduate of Middlebury College in Vermont. Mr. Lauer served in the United States Army as a corporal during the Korean War and continued his postgraduate education at the Northwestern University Medill School of Journalism in Evanston, Illinois.

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When Does Surgery Center Case Volume Peak and Valley? A Statistical Analysis of 9 Common Specialties

By Rob Kurtz

In what month can ambulatory surgery centers expect to perform the most and least procedures? GENASCIS, a provider of outsourced revenue cycle management services, performed an analysis of the case volume for 393 client ASCs over a 12-month basis (October 2010-September 2011) using its MEDIBIS technology platform. It identified the month with the highest and lowest case volume for nine common ASC specialties.

They are as follows (specialties are listed in alphabetical order):

ENT — Highest month: March (12,229 procedures); Lowest month: September (7,220 procedures)

Gastroenterology — Highest month: March (31,925 procedures); Lowest month: January (26,643 procedures)

General surgery — Highest month: March (12,399 procedures); Lowest month: February (10,507 procedures)

OB/GYN — Highest month: March (5,324 procedures); Lowest month: February (4,312 procedures)

Ophthalmology — Highest month: March (24,018 procedures); Lowest month: January (19,486 procedures)

Orthopedics — Highest month: December (30,369 procedures); Lowest month: July (23,307 procedures)

Pain management — Highest month: March (27,943 procedures); Lowest month: February (22,716 procedures)

Podiatry — Highest month: December (3,881 procedures); Lowest month: September (2,603 procedures)

Urology — Highest month: March (6,410 procedures); Lowest month: October (5,315 procedures) ■

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11 Evolving Issues in Healthcare and Business

By Scott Becker, Drew McCormick, Allison Harms and Samuel Bernstein, McGuireWoods

This article briefly discusses 11 different healthcare and business issues. We have divided the article the letter into three key sections. The first focuses on hospital and physician issues. Second, a brief observation on urgent care and sleep labs. Third, a brief discussion of key business issues, focusing largely on a new book by Jim Collins.

I. ACOs, Hospitals, Physicians and Physician-Hospital Relationships

1. Pioneer ACOs. The Pioneer ACO Model is a CMS Innovation Center initiative designed to support organizations with experience operating as accountable care organizations or in similar arrangements. The Pioneer ACO model will test the impact of different payment arrangements in helping these organizations achieve quality and cost goals. After a weak start, 32 provider organizations ultimately enlisted in the Pioneer ACO Project. Many of the ACO participants are very prestigious systems, such as Allina Hospitals and Clinics, Beth Israel Deaconess Physician Organization, and the University of Michigan Health System.

The U.S. Department of Health and Human Services made a wise decision by making the process of testing the ACO model more manageable for health systems. An article entitled “Pioneer ACOs: Promise and Po-

tential Pitfalls,” posted by Steven Lieberman on Dec. 29, 2011 in *Health Affairs Blog* states:

“The 32 Pioneer ACOs selected by CMS will operate in 18 states for up to 5-year periods. Hospitals are key players in 22 (69 percent) of the Pioneer ACOs, with 16 integrated delivery (or healthcare) systems, 4 hospitals-physician partnerships, and 2 individual practice associations (IPAs) named for hospitals where the physicians have affiliations (or employment). The remaining 10 Pioneer ACOs (31 percent) are predominately IPAs, with one identified as an alliance of 5 multi-specialty medical groups. (The Leavitt Partners survey reported hospitals sponsored 99 (60 percent) of ACOs, with 38 (24 percent) sponsored by IPAs, and 27 (16 percent) sponsored by insurers, a category not relevant for Medicare ACOs.) In addition to urban entities, the selected Pioneer sites include ACOs that serve rural areas.”

Time will tell whether the ACO will endure as a significant part of the healthcare landscape.

2. Exclusive relationships between hospitals and payors. Recently, hospitals and health systems with great market positions are looking again at exclusive relationships with payors. This again threatens to become a substantial issue for independent surgery centers, physician practices and competing

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hospitals. One of the earliest exclusive agreements was struck between Boston-based PartnersHealthcare and Blue Cross Blue Shield of Massachusetts in 2000. BCBS gave Partners increased reimbursements in exchange for Partners' promise to seek similar pay increases from Blue Cross competitors. Since 2000, Partners has received a 75 percent increase in payments from Blue Cross, but health insurance premiums have also risen by 78 percent since that agreement. There is some evidence that the government is monitoring the anticompetitive effects of such behavior. For instance, in Feb. 2011, the Department of Justice took an aggressive stance against a health system under Section 2 of the Sherman Antitrust Act in *United States v. United Regional Health Care System* (No. 7:11-cv-00030-O (N.D. Tex., Feb. 25, 2011)). In *United Regional Health Care System*, the DOJ alleged that United Regional Health Care System possessed monopoly power in the sale of both inpatient hospital services and outpatient surgical services to commercial health insurers.

3. Community hospital sales and consolidation. Given the changing healthcare environment, we are seeing frightened looks on the faces of the Boards of community hospitals. This has led to an unprecedented willingness to engage in potential sales of hospitals to national chains or larger systems. On the flip side, buyers may often obtain substantial market benefits from consolidation (see, e.g., "Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About," *Forbes*, by Avik Roy, August 22, 2011; "Hospital Merger Mania on the Rise Across the U.S.," *Next Hospital*, by Katherine Rourke, April 30, 2011). The occurrence of hospital mergers and acquisitions increased by 33 percent in 2010 compared with 2009. The dollar volume of transactions also increased substantially in 2011.

4. Physician independence. Notwithstanding the talk of physician practice acquisitions and physician integration with hospitals, we are hearing from several large independent physician practice groups that they have remained very busy despite the fact that systems they once worked with are acquiring competing practices. In orthopedics, for example, it is commonly discussed that almost 12.5 percent of the healthcare budget is spent on orthopedics in total. This means that many systems must have a large orthopedic presence and compete aggressively to employ orthopedic surgeons. Despite the hospital pressure to accept employment, the independent orthopedists seem to be weathering the changes fairly well.

A 2011 survey conducted by PricewaterhouseCoopers found 56 percent of physicians want to more closely align with a hospital in order to increase their income, yet 20 percent of physicians surveyed said they don't trust hospitals and another 57 percent "sometimes" trust hospitals.

5. Professional services agreement. Once again, a number of systems have been considering professional services agreements with physicians and physician groups. Such arrangements are a middle ground between the acquisition of a physician practice and subsequent employment

of its physicians, and other kinds of relationships between health systems and physicians. As such, professional services agreements are growing in popularity as an option for increasing integration with a number of specialties, while enabling the physicians to maintain private practice. In the article, "When PSAs Are the Right Choice," *Health Leader Media*, July 13, 2010, author Karen Minich-Pourshadi writes:

"Physician compensation expert Max Reiboldt, president and CEO for The Coker Group, an Alpharetta, GA-based healthcare management consulting firm, refers to these PSA arrangements as "employment lite"—and he says they can offer a good opportunity for both hospitals and physicians. Unlike traditional service agreements, in which a person is hired for a specific function or for limited service, PSAs allow the facility to work with the doctors, allowing them to keep their independence while the hospital can build in quality measures to help create greater alignment for the physician with the hospital's goal.

"A PSA takes the shape and look of employment, but the physician or practice retains its independence, and if the deal doesn't go well, then the doctor can go back to private practice," he says.

In a professional services agreement model, a health system will typically purchase a substantial amount overall of a physician's time but will not acquire the physician's practice. We will see whether or not this becomes a sizable part of the physician-hospital universe or, whether instead the popularity of the professional services agreement model is merely a stop gap measure for certain systems. The challenge with the physician services agreement model is that it is much more difficult to fit payments to physicians within various anti-kickback safe harbors and antitrust safety zones than in the practice acquisition and subsequent employment model.

6. Opting out of Medicare. Notwithstanding the difficult economy, we are hearing from more and more physicians that they have decided to opt out of Medicare. This is occurring more frequently in certain specialties in which physicians are not overly reliant on Medicare business or hospital referrals. For instance, the *New York Times* reports that of the 93 internists affiliated with New York-Presbyterian Hospital, only 37 accept Medicare, according to the hospital's website. Further, we typically see the decision to opt out of Medicare with physicians who have built tremendous brands and franchises and that can afford to not take Medicare patients. Interestingly, despite opting out of Medicare, many of these physicians nevertheless continue to see Medicare patients on either a pro bono basis or through other means (see, for example, "Doctors are Opting Out of Medicare," by Julie Connally, *New York Times*, April 1, 2009.)

7. Privileges and disputes. We have observed an increase in the number of privilege and peer review disputes involving physicians and hospitals.




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We are not exactly sure what is driving increased clinical reviews. However, a great article was published in 2011 on the concept that the Health Care Quality Improvement Act has resulted in abuses of the peer review system through the courts. The article, entitled "How Courts are Protecting Unjustified Peer Review Actions Against Physicians by Hospitals," *The Journal of American Physicians and Surgeons*, by Nicholas Kadar, Volume 16, Number 1, Spring 2011 states:

"Nevertheless, the courts have disregarded the legislative history of HCQIA in the HCJ, and have interpreted and applied HCQIA in a way that protects unjustified peer review actions against physicians by hospitals against Congress's expressly stated contrary intent."

As a result, according to Kadar, the courts improperly review motions for summary judgment based on HCQIA immunity and improperly dismiss cases on summary judgment before a physician has an opportunity to present the merits of his or her case.

II. Urgent Care and Sleep Labs.

1. Urgent care. The number of urgent care sites is growing tremendously. For instance, the number of facilities has now grown to 9,200, including approximately 600 new facilities this year. The development in the urgent care arena includes traditional urgent care clinics as well as clinics inside of retailers such as Wal-Mart, Walgreens, and CVS. The growth in urgent care sites has occurred in response to a direct consumer desire to be able to see physicians at the consumer's convenience (see, e.g., "Health Law May Accelerate Growth in Urgent Care Centers," *Kaiser Health News*, Phil Galewitz, Dec. 7, 2011). Interestingly enough, in response to the increase in urgent care,

many large practices and systems have substantially improved their own customer care and their speed at which they are able to see patients.

2. Sleep labs. We continue to see the evolution of sleep labs and sleep lab relationships. Various structures for sleep labs include independent diagnostic testing facilities, extensions of a physician's practice, hospital-based sleep labs, hospital-owned freestanding sleep labs, and joint ventures, to name a few. We often query the method by which sleep labs are structured. As of late 2010, there were about 2,100 accredited sleep labs with an approximate growth of 10 percent per year.

III. Great Business Issues.

1. Great leaders. We continue to be cognizant of the import of great (and poor) leadership on organizations. In health systems as well as in great companies and charitable foundations, there seems to be nothing more important than strong leadership that is truly concerned about the organization (see, e.g., "4 Great CEOs and 1 Who Missed the Boat," *Motley-Fool*, by Molly McCluskey, Nov. 11, 2011).

In her article, "The Best Performing CEOs in the World," *Harvard Business Review*, January 2010, authors by Morten T. Hansen, Herminia Ibarra and Urs Peyer write: "Our data highlights the great extent to which CEOs account for variations in company performance beyond those due to industry, country and economic swings"

As we read articles about the overpayment or compensation to leadership we come away with the conclusion that it is not so much that great leaders are overpaid, it is rather all the other people inhabiting leadership spots that are CEOs that are not worth what they are paid. In es-

sence, it is hard to place a value on a great CEO but many organizations that do not have great CEOs have been paying as though they do.

2. Great Business Book – "Great by Choice". In reading the most recent book by Jim Collins, "Great by Choice," we continue to believe that he has more clarity on what it takes to be a great organization than almost anybody else. His core philosophy is the concept that putting great people in place (i.e., the "who" issue) remains the most important issue in creating successful organizations. We agree strongly with this sentiment. Collins also has several other great concepts in the book. For example, he speaks of testing concepts (bullets vs. cannonballs), consistent discipline, and a core set of business concepts or a blueprint to guide the organization.

On testing Collins states:

"Amgen's early days illustrate a key pattern we observed in this study: fire bullets, then fire cannonballs. First, you fire bullets to figure out what'll work. Then once you have empirical confidence based on the bullets, you concentrate your resources and fire a cannonball. After the cannonball hits, you keep 20 Mile Marching to make the most of your big success."

On people he notes:

"Microsoft used extreme standards to select the right people for Microsoft, with Gate's summing up in 1992," "Take away our 20 best people and I tell you that Microsoft would become an unimportant company." Biomet paid fastidious attention to getting the right people in every seat, using stock options at all levels to attract and retain the best talent. All the 10X companies cultivate cult-like cultures wherein the right people would flourish and equally, where the wrong people would quickly self-eject. The 10X study is predicated on the premise of unending uncertainty, which increases the importance of First Who; if you cannot predict what's going to happen, you need people on the bus who can respond and adapt successfully to whatever unforeseen events might hit."

Finally, on the concept of constant performance he spoke of the consistent achievement of goals rather than sporadic phenomenal growth:

"John Brown understood that if you want to achieve consistent performance, you need both parts of a 20 Mile March: a lower bound and an upper bound, a hurdle that you jump over and a ceiling that you will not rise above, the ambition to achieve and the self-control to hold back. The 20 Mile March is more than a philosophy. It's about having concrete, clear, intelligence, and rigorously pursued performance mechanisms that keep you on track. The 20 Mile March creates two types of self-imposed discomfort: (1) the discomfort of unwavering commitment to high performance in difficult conditions, and (2) the discomfort of holding back in good conditions. ■

Contact Scott Becker at sbecker@beckershealthcare.com.

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5 Business Lessons for Physicians

By Abby Callard

Some physicians are astute when it comes to the business side of running an ambulatory surgery center, but for others, calculating return on investment and creating a marketing strategy takes them out of their comfort zones.

Kristine Mighion, MD, MBA, managing director and CEO of Healthcare Consultants International and host of Intimety.com's Healthcare Executive show, and Marion Lee, MD, MBA, Centers for Pain Management in Tifton, Ga., and immediate past president of the Georgia Society of Interventional Pain Physicians, offer five business lessons for ASC physicians.

1. Keep thorough records and look for trends. Keeping complete records not only allows a physician to better understand the operations of a center, from expenses to case mix to cost per procedure, but also helps identify trends and opportunities for improvement.

"Understanding the importance of accounting and record keeping for any business is key," Dr. Mighion says. "That tends to be an area where doctors are not as strong. They don't get tend to be exposed to those concepts, and they don't tend to think that way."

She says physicians should have their ASCs track number of patients, type and quantity of procedures, as well as total revenues and revenue per procedure. They should review the records monthly or quarterly, and look for trends from month to month, quarter to quarter, and year to year. An analysis of these metrics can inform a physician whether the center does a lot of small procedures with lower returns or fewer large procedures with bigger returns, and as a result can help a physician plan the best procedure mix for the future. This analysis can also detect rising expenses and pinpoint exactly where, when and why the increase took place.

2. Keep track of return on investment. Dr. Mighion says this is a method for physicians to determine how long it takes to recoup money invested in their center. To calculate ROI for an investment, divide the annual amount of money that investment generates by the total amount invested. For example, if a \$100,000 investment in a specific project generates an additional \$20,000 each year, the ROI is 20 percent. This also means it will take five years for the center to recoup the physician's original investment. A ROI of 20 percent is a good rate and is typical of what venture capitalists and other investors strive to earn on their investments over five years. However, if a center must invest heavily in capital purchases, such as operating room equipment or a new expansion, then it may be reasonable to plan for a lower ROI and a longer time to breakeven on that investment.

3. Realize how hard it is to manage people. Dr. Mighion says the

hardest part of running a business, regardless of whether it's an ASC or an ice cream store, is managing staff, but being aware of and acknowledging that challenge can go a long way.

"If you know that, you can set your expectations and hopefully decrease your frustration level that may arise from managing staff," she says.

A critical component of effective management is adopting a 360-degree management style, which means physicians listen to the complaints and suggestions from staff and staff listens to the complaints and suggestions from the physicians, Dr. Lee says. Allowing staff members to have more say in how the center is run is also a great way to motivate them, he says.

While many centers offer bonuses for motivation, getting employees invested in how the center's success goes further for retaining and recruiting the best employees, he says. Asking staff members to solve a problem, such as how to reduce waiting times to get patients into operating rooms, can motivate employees, and the solution is more likely to be implemented compared to when the order comes from the top down.

4. Develop a strategy. Dr. Mighion says it's important for a center to set goals, develop a strategy for reaching those goals and measure success.

"You can set goals and say this is how we're going to do it, but if you don't know how to measure your success, it's hard to know to what extent you've actually succeeded in achieving your goals," she says.

For example, a center might set the goal of getting 100 new patients for a certain procedure by the end of the year. The strategy might be to create a robust marketing plan that targets the right people who are potential patients for that procedure. Success would be determined by whether or not the 100 new patients were obtained, as well as the ROI on that marketing project. Centers should calculate how much money was spent on the marketing plan and how much new revenue came in to see if the plan was successful.

5. Continually market the center. A marketing plan is a specialized part of a center's strategy, Dr. Mighion says. She has seen success with a variety of marketing strategies — including radio, television and print advertisements — and it really comes down to knowing a center's audience and market. For example, if most of a center's patients are older, an Internet-heavy marketing plan might not be the best option, she says. Figuring out who the center should target as possible patients and how, is part of market research, and this can be done in-house if staff has time, or it can be outsourced, she concludes. ■

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30 New Statistics on Surgery Center Staff Compensation

By Rachel Fields

Here are 30 new statistics on ASC staff compensation, according to VMG Health's *Multi-Specialty ASC Intellimarker 2011*.

Average hourly wages

Nurse staff: \$32.12

Tech staff: \$20.92

Administrative staff: \$23.09

Total hourly: \$27.03

Administrator salary: \$109,184

Based on location

West

Nurse staff: \$36.61

Tech staff: \$23.04

Administrative staff: \$23.98

Total hourly: \$29.25

Administrator salary: \$114,109

Southwest

Nurse staff: \$31.58

Tech staff: \$20.64

Administrative staff: \$21.36

Total hourly: \$26.34

Administrator salary: \$100,779

Midwest

Nurse staff: \$29.79

Tech staff: \$19.43

Administrative staff: \$22.38

Total hourly: \$25.83

Administrator salary: \$104,372

Southeast

Nurse staff: \$30.28

Tech staff: \$18.95

Administrative staff: \$22.78

Total hourly: \$26.12

Administrator salary: \$110,311

Northeast

Nurse staff: \$32.58

Tech staff: \$20.26

Administrative staff: \$24.49

Total hourly: \$27.48

Administrator salary: \$109,268 ■

Source: Information comes from VMG Health's Multi-Specialty ASC Intellimarker 2011 benchmarking study. VMG Health is a leading valuation and transaction advisory firm in healthcare. To receive a complimentary copy of VMG Health's Multi-Specialty ASC Intellimarker 2011, visit www.vmghealth.com/index.html.

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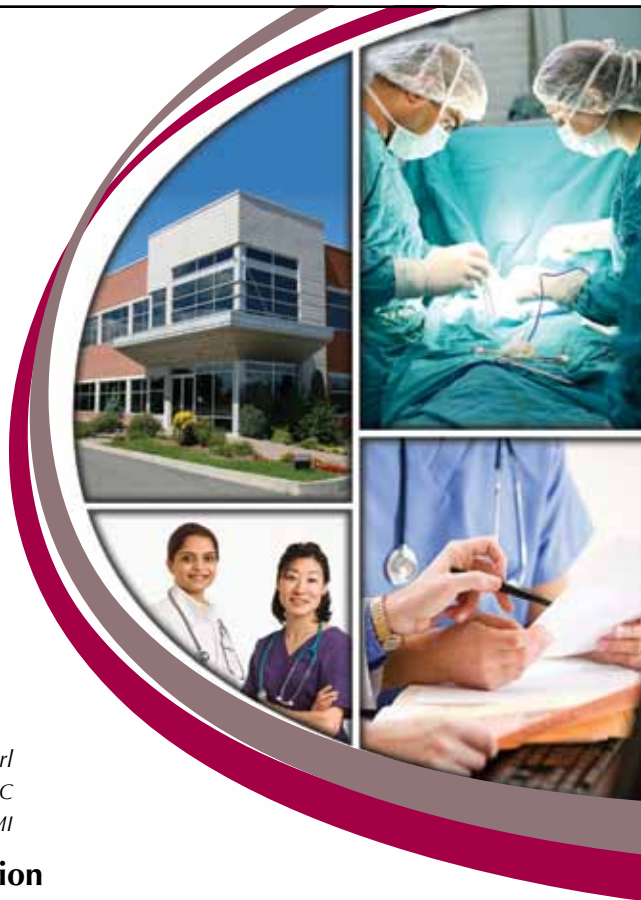
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5 Trends Impacting Outpatient Spine in 2012: Thoughts From Dr. Thomas Schuler

By Rachel Fields

Thomas Schuler, MD, spine surgeon and president and CEO of Virginia Spine Institute, discusses the outlook for outpatient spine surgery in the next few years.

1. Patient demand for — and physician acceptance of — minimally invasive techniques. In the last few years, Dr. Schuler has seen a growing acceptance of minimally invasive techniques on the part of patients and physicians. “Minimally invasive techniques mean different things to different people, but the goal is to minimize surgical trauma to the patient while accomplishing the desired goal,” he says. “For physicians, that means forgetting their old, pre-conceived biases and expanding to the new reality that can happen if we are able to accomplish things with less surgical dissection.” He says physician bias partially originates from medical training programs that do not teach minimally invasive techniques. He says medical training programs must stop clinging to traditional methods of surgery in order to develop more advanced minimally invasive techniques and provide patients with physicians who can perform the procedures.

He says as more physicians adopt minimally invasive techniques, patients are requesting the less-invasive surgeries as well as the option for outpatient surgery. “Patients are demanding for us to continue to evolve minimally invasive techniques,” he says. “As patient demand continues to evolve to less-invasive procedures, it will open up the door for more people to be treated that way.”

2. Medicare’s hesitation to accept outpatient spine. Medicare currently does not reimburse for spine surgery in the outpatient setting, meaning surgery centers must contract with commercial payors if they want to perform spine surgery. Dr. Schuler believes Medicare should start reimbursing for outpatient spine in order to support the progression of more complex surgeries into a low-cost, high-quality setting.

He says the length of stay required by Medicare for spine surgery procedures is not accurate and should be amended to allow same-day surgery. “In this area for cost savings, Medicare is prohibiting patients from benefitting from the modern options that are available,” he says. “They’re increasing costs because they’re requiring the procedure is done as an inpatient procedure.”

3. Gradual ratcheting down of payment for spine centers. As spine surgery becomes more widespread in surgery centers, Dr. Schuler believes commercial reimbursement rates will drop considerably. He says the

increase in spinal procedures has driven up the expenditure of healthcare dollars on spine, and the procedures have come onto the public’s collective radar screen. “Now that it’s on the radar screen, it’s looked at as an area for cost savings by insurance companies,” he says. “They want to cut costs, so they look at areas with a growth in utilization and incorrectly conclude that there’s a growth because surgeons are making money from the procedures.”

He says the next 10 years will see a significant increase in the difficulty of patients being able to receive appropriate services, both non-operatively and operatively. “As time moves forward, it will be harder and harder to get authorization of services and harder for surgery centers and physicians to get paid for it,” he says.

4. Movement of lumbar fusions into surgery centers. Dr. Schuler says lumbar fusions are the most recent procedure to move into outpatient surgery centers. The goal of lumbar fusion surgery is to restore nerve function, prevent abnormal motion and relieve pain by fusing the vertebrae together. Dr. Schuler says lumbar fusions are moving into surgery centers because new approaches decrease patient pain and increase safety.

“The surgical dissection required to perform these procedures often requires inpatient management for patient safety and patient pain control,” he says. “As our technical skills allow us to be much less destructive of the surrounding tissues, patients experience much less pain and the procedure can be done on an outpatient basis.” He says the procedure should be performed in ASCs only for single-level or possibly two-level lumbar fusions.

5. Increased revenue for ASCs that have not started spine yet. The good news: For surgery centers that have not added spine to their list of specialties but plan to do so, the next few years should see a boost in revenue and volume. “The gradual push of inpatient procedures to outpatient procedures may drive an increased surgical volume for surgery centers,” he says. “The ASCs would benefit from getting in this line, since the trend is to push things out of inpatient settings.”

He says surgery centers that already have an established spine program will likely see a decrease in revenue due to falling reimbursement rates from commercial payors. However, surgery centers that have not yet added spine should see increased revenue because spine reimbursement is still quite good compared to other specialties. ■

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5 CON Conflicts Over Proposed Surgery Centers in 2011

By Rachel Fields

Building a surgery center is arguably more difficult than it was 10 years ago. With saturated markets, increased attention from hospital competitors and strict certificate of need laws in many states, surgeon groups often struggle to gain approval for their projects against a wall of concerned competitors. Here are five conflicts over proposed surgery centers that occurred in 2011.

1. Alaska's Kahtnu Ventures is still hoping to build an ASC, despite CON denial and concerns from the local hospital. In November, an Alaska surgeon group submitted an application for a certificate of need with the Alaska Department of Health and Human Services to build an ambulatory surgery center. The group, Kahtnu Ventures, intended to build an 8,365-square-foot ASC. The application was denied because of "untimely submission of information," but the group says it still hopes to build the center.

The original application caught the attention of Central Peninsula Hospital, based in Soldotna, Alaska, which said that if the ASC were approved, it could impact the hospital's outpatient surgery volume and profits. The surgeon group is now in discussions with the hospital about developing a relationship with the eventual goal of opening the ASC.

2. Georgia's WellStar Health gained approval for a surgery center after an appeal from a hospital competitor. Atlanta-based Northside Hospital challenged plans for a new surgery center in Cobb, Ga., after WellStar Health System received a certificate of need for the ASC earlier in 2011. Administrative hearings were held over the summer to determine the result of the appeal, and the Department of Community Health eventually approved the appeal again. WellStar plans to invest \$80 million in a facility that will span 250,000 square feet and contain the surgery center and other services.

3. North Carolina's Wake Forest Baptist Medical Center's CON application was protested by competitor Novant Health. The North Carolina Court of Appeals will determine whether Wake Forest Baptist Medical Center in Winston-Salem, N.C., will be able

to build a \$38.7 million ambulatory surgery center. State regulators have twice approved the proposed 72,300-square-foot ASC, but the approval has been appealed both times by competitor Novant Health. The surgery center would contain seven new operating rooms and one transferred from N.C. Baptist Hospital next to its main campus.

4. North Carolina's Cone Health was denied a CON for a new surgery center after protestations from numerous competitors. North Carolina state regulators denied a certificate of need application by Cone Health to add a new ASC to its MedCenter High Point (N.C.) facility after objections from numerous competitors. The state rejected the application on grounds that the new ASC is not necessary due to declines in surgery demands and enough available operating rooms.

The decision followed objections from competitors Novant Health and High Point Regional Health, which claimed the proposed surgical center would be a duplication of services the two health systems currently provide in the north High Point and Kernersville areas. Cone Health officials planned to talk with staff of the N.C. Division of Health Service Regulation to address their concerns or eventually to appeal the state's findings.

5. North Carolina's Mission Hospital was denied CON approval after Park Ridge Health and local physicians opposed the ASC build. North Carolina state regulators rejected plans by North Carolina's Mission Hospital to relocate an endoscopy unit to a new outpatient surgery center, following opposition from Hendersonville-based Park Ridge Health and some local physicians. The facility would have been located four miles north of rival Park Ridge Hospital, and critics said the facility would have duplicated existing services, including six endoscopy suites in Henderson County.

Mission CEO Ron Paulus, MD, said he found it offensive that anyone would characterize Mission as a "predatory" organization, despite recent physician practice acquisitions. He said patients in Fletcher would be able to receive care closer to home at a facility that charged lower prices than nearby hospitals. ■

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6 Points on Building an ASC Joint Venture With an Academic Medical Center

By Rachel Fields

Regent Surgical Health recently entered into a joint-venture agreement with an academic medical center — a departure from the traditional three-way joint-venture model of an acute-care hospital, management company and physician group. Under its agreement with Robert Wood Johnson University Hospital in New Brunswick, N.J., Regent will help move the hospital outpatient department to a freestanding surgery center, for which ownership will be divided between the management company, the hospital and private practice physicians in the community. Regent and the hospital will collectively own 51 percent of the center and the physicians will own 49 percent.

According to Jeffrey Simmons, Regent's chief development officer, this partnership is the company's first with an academic medical center. "What's unique about it is that the doctors that work there will be a combination of faculty doctors from the medical school and private practice doctors," he says. He outlines six factors he expects will affect the joint venture, as well as offering some advice about operating a successful partnership.

1. The academic medical center will be able to strengthen ties with private practice physicians. According to Mr. Simmons, Robert Wood Johnson is pursuing the joint venture in part to strengthen its relation-

ship with private practice physicians in the community. "A lot of private practice doctors work in the hospital but have not participated much in partnerships with the hospital," he says.

He says while private practice physicians would traditionally have to set up a partnership at another surgery center to benefit from distributions, they can now expand their relationship with the hospital to include participation in a hospital-sponsored surgery center.

2. The hospital will take a reimbursement cut in order to build relationships and provide discounts to payors. Accord-

ing to Mr. Simmons, the surgery center is currently 100 percent owned by the hospital as a hospital outpatient department. Since the center is an HOPD, Medicare payments are almost twice as much as they would be for a freestanding surgery center. Private payors often follow Medicare's lead by paying more for surgeries performed in the HOPD than they would for an independent surgery center. When the HOPD changes to an ASC, the rates will decrease significantly, Mr. Simmons says. "We're going to be lowering rates to both governmental and private payors because this will be a freestanding surgery center," he says. "The cost to everyone will be less."

He says Robert Wood Johnson should be applauded for accepting a reduction in reimbursement rates. Instead of receiving more robust reimbursement from the HOPD, the hospital will receive only a portion of a lower reimbursement rate because part of the revenue will go to the physician-owners. "They're taking a reduction in payment in order to partner with private practice physicians in the community," he says. "That's what makes this a very unusual project."

3. Efficiency at the surgery center should increase under a management company. Mr. Simmons believes the academic medical center's ASC will benefit from the pres-

ence of a management company, which can provide expertise in ASC operations that a hospital might lack. "Our job is to get the doctors in and out of the facility as quickly as possible so they can either go back to their clinic or to whatever other pursuits they have," he says. "Companies like ours are in business to make the experience for the doctors more efficient, the turnover times less and the scheduling easier."

He says other processes, including equipment requests, should be easier when Regent is managing the surgery center. "Previously, the doctors had to go through hospital committees and compete with other hospital needs," he says. "This is a separate business entity that will make its own capital decisions." He says physician satisfaction should increase once these bureaucratic hurdles are removed.

4. Private practice physicians and faculty physicians will work together at the center. One of the greatest challenges for the Robert Wood Johnson surgery center will be the combination of private practice physicians and university faculty physicians in the same facility, Mr. Simmons says. He says the schedules, concerns and priorities of physicians can be very different depending on whether they own their own practice or work directly for the hos-

pital. He says Regent will promote partnership between the two physician groups by treating everyone fairly. "You can't play favorites based on whether someone's an owner or not," he says. For example, equipment requests will be weighed equally regardless of whether the request comes from an owner.

He says the physicians have also agreed to work together at the surgery center and pursue the common goal of quality patient care. "The private practice doctors who are joining us in this facility are unique in that many of them used to be on the faculty," he says. "All the doctors have agreed to live by the same standards and priorities of care that would be expected of any doctor, whether they were private practice or faculty."

5. Management companies must be transparent with hospitals to make a joint venture work. Regent Surgical Health has developed about 15 hospital partnerships, and Mr. Simmons says the company has learned a great deal along the way about how to operate a joint venture. "You now have a partner — a hospital that has many more interests and constituents than just the doctors," he says. "You have to be transparent with them and get their advice and make sure you're not doing things that are harmful to hospital operations."

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In the case of Robert Wood Johnson, he says the hospital is already accepting a slight financial reduction in order to foster private practice partnerships. This means the management company has to be cognizant of how equipment purchases and staffing affect the profitability of the center. "Most surgery centers operate in a vacuum, but when you have a hospital partner, you have to consider their needs," he says. He says the management company and physicians must also keep in mind that the surgery center is on the hospital campus, so it's important to keep staffing benefits and parking fees consistent.

6. This transaction may open the door for more partnerships with academic medical centers. Mr. Simmons says Regent is hoping this partnership will open the door for other, similar academic medical center transactions. "We'd like to see more transactions that combine the needs of faculty medicine with private practice doctors on a major hospital campus," he says. He says partnerships with academic medical centers are still relatively uncommon for physician groups and management companies, but this could change as research facilities look to gain market share by building relationships with private practice physicians.

He says this type of partnership can also benefit faculty physicians because of the efficiency and predictability of a surgery center schedule. "Hopefully it's more efficient for the faculty doctors than waiting for a case that could be bumped for a trauma case," he says. "Decisions can also be made very quickly because it's a small group of doctors making the decision versus a large medical institution." ■

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5 Ways to Save Money at GI Driven Surgery Centers

By Rachel Fields

GI-driven surgery centers must run as well-oiled machines in order to turn a profit; due to reimbursement cuts for the specialty, efficiency is critical, and tactics that can decrease turnover times, speed up cases and decrease supply costs are essential to profitability. Brent McLean, administrator of Memorial Mission Surgery Center in Chattanooga, Tenn., discusses five ways his GI-driven ASC cut costs over the last year.

1. Streamline GI supplies. Mr. McLean says his center cut supply costs in 2011 by moving GI supplies to a centralized location, rather than stocking them in each separate procedure room. Previously, each room stocked its own supplies, and staff members tended to hoard supplies because they were worried they would run out. With the new system, the GI supplies are all stored in a central location in the GI lab, approximately 15 feet away from the procedure rooms. Each procedure room has a par level to stop supplies from being hoarded and to keep everyone aware of how supplies are distributed.

“Previously, each procedure room was considered its own room,” Mr. McLean says. “We could have plenty of supplies in the GI lab to handle the entirety of the cases, but because someone didn’t have the supplies in their room, they would contact materials. Instead of materials storing any GI

supplies, they just take it right off the truck and over to a central spot in the GI lab.”

2. Stock supplies for the next day. To keep staff members from hoarding supplies, Mr. McLean has instituted a policy where staff stock supplies for the next day only. “They stock at the end of the day from that central GI area only for the next day’s cases,” he says. “Historically, they would just grab a whole bunch and have enough for three days.” This keeps everyone on the same page, because every room has roughly the same amount of supplies, he says.

3. Post a communication board to track supply shortages. Mr. McLean says his center also posted a communication board in the central supply area so staff members could mark down any items in short supply. He says the center receives shipments every other day for GI because the center is located next to a hospital, so supplies can easily be re-ordered if they run low. “We have the ability to put that burden on the supplier as opposed to having to keep our inventory high,” he says. “That was a big win in the second half of 2011, operationally and financially.”

4. Use walkie-talkies to increase efficiency. GI centers thrive on efficiency because procedures can be performed quickly. The faster

you can move, the more volume you’ll be able to accommodate, and the more money you will make. Mr. McLean says his staff members use walkie-talkies to communicate between rooms instead of having to page providers.

“They use the walkie-talkies to say, ‘We’re done here, you can roll,’” he says. “We only have three procedure rooms, and towards the end of the year, it gets pretty busy.” Walkie-talkies are relatively inexpensive and can do help to significantly increase efficiency and decrease turnover times in your facility, he says.

5. Fill out charts as you go. Mr. McLean says his surgery center staff members also help to save money by filling out as much of each day’s chart as possible as the day progresses. This saves time for staff members because it eliminates a backlog of paperwork and allows staff to complete charts during little moments of “down time” throughout the day. “We fill out little areas because it makes it easier and makes the day run smoother,” he says. He says the ASC also uses an automated dictation system that standardizes physician notes and saves time on paperwork. ■

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Gastroenterology in 2012: Q&A With Dr. Glenn Littenberg of ASGE

By Abby Callard

Glenn Littenberg, MD, chair, ASGE Practice Management Committee, future recipient of ASGE’s Distinguished Service Award at Digestive Disease Week 2012 and gastroenterologist at Huntington Hospital in Pasadena, Calif., shares his thoughts on the future of gastroenterology.

Q: Do you see yourself or your group participating in an ACO-like arrangement now or in the future?

Dr. Glenn Littenberg: In California, these arrangements are not new concepts. Regional medical groups like the one I participate in, HealthCare Partners, has a very substantial and effective experience in the type of managed care envisioned for ACOs, and will be participating in a CMS Pioneer ACO as well as an ACO with a private payer.

The challenge is to see if patients in non-restricted — Medicare fee for service — or wide-network PPO systems will find enough value in the ACO to participate. In markets like California, patient satisfaction and care access are both quite good and clinical outcomes seem no worse than for patients in traditional fee for service.

Q: How does your practice ensure patient satisfaction?

GL: Trying hard to give patients access when they want and need it, including being accessible by phone and through online methods when efficient and appropriate; giving them sufficient time and particularly attention to what they feel their needs are — not just what we think is medically most appropriate — and understandable advice that they’re likely to remember and treatment plans that are practical and affordable, so that they work. And most importantly, performing their procedures safely, effectively and communicating the results and implications of their diagnosis clearly and quickly.

Q: What procedure has been most helpful to the patients in your practice?

GL: The greatest benefit to the patient lies in the face-to-face assessment of the individual and the advice we can render in consultations and office follow up visits. However, patients probably value the skillfully done colonoscopy most, since it is the most broadly performed procedure with the greatest potential impact on future lives saved, extended and suffering avoided. With colonoscopy, there is also the satisfaction patients get from knowing that they’re okay. ■

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Is Your Center Ready for Bariatric Patients? A Checklist From Drs. Scott Cunneen and Peter LePort

By Abby Callard

Bariatric procedures are more often being done in the ambulatory surgery setting. The most common procedure in ASCs is gastric banding, which experts estimate makes up 90 percent of bariatric procedures performed in ASCs. Bariatric surgery represents a business opportunity for ASCs because payors, including Medicare, are increasingly reimbursing surgery centers for appropriate patients.

But treating bariatric patients, who are often extremely overweight, presents unique challenges for a surgery center, from ensuring the furniture is appropriate to making sure the staff handles sensitive issues with aplomb.

Dr. Scott Cunneen, director of bariatric surgery at Cedars-Sinai Medical Center in Los Angeles and author of *Weighty Issues: Getting the Skinny on Weight Loss Surgery*, and Dr. Peter LePort, medical director of the MemorialCare Center for Obesity at Orange Coast Memorial Medical Center in Fountain Valley, Calif., provide a seven-item checklist for accommodating bariatric patients in a surgery center.

1. Equipment is rated for extra weight and larger size. Dr. LePort says that one of the most important pieces of equipment a surgery center needs to accommodate overweight patients is a wheelchair specifically for bariatric patients. Standard wheelchairs are often only rated up to 350-400 pounds, but bariatric wheelchairs can be rated up to 850 pounds. The chairs are often wider as well to accommodate larger patients. Dr. Cunneen reminds centers to make sure that the doors are big enough for the larger wheelchairs. Another essential piece of equipment is the operating table itself.

"The operating table needs to have the capacity to support heavier patients since many times, you're tilting it," Dr. Cunneen says. "You need to make sure it doesn't get stuck."

Other equipment needs include gurneys, preoperative and postoperative beds, extra large gowns, extra large abdominal binders, longer tubing, larger retractors and other surgical equipment. Special surgical equipment is easy to order as long as a center administrator knows what to ask for, Dr. LePort says.

2. Waiting area is furnished with larger furniture. The waiting area is the patient's first impression of a surgery center, and not being able to fit comfortably in the furniture will not leave a great impression.

"If they can only fit one cheek in the chair, that's not going to be met with a lot of welcoming remarks when the patient leaves," Dr. Cunneen says.

Dr. LePort says although buying bigger furniture might seem like a small thing, it's important to patients not have to worry whether or not they can fit in the chair.

3. Bathrooms fixtures are floor mounted. Another safety issue that arises is whether or not the bathrooms are appropriately constructed for handling heavier patients, Dr. LePort says. Usually, toilets and sinks are bolted to the wall, but when a 400-pound patient puts his or her weight on that sink, it might pull right out of the wall. Both toilets and sinks need to be floor mounted to support the extra weight.

4. Staff has done sensitivity training. Dr. LePort says it's important for everyone at the center — even the staff who clean the rooms — to go through sensitivity training.

"A lot of these people have some interaction with the patient or the patient's families," he says. "Even peripherally, just by sweeping the floor, they have contact."

Oftentimes, the training involves making staff aware that their actions and words can be interpreted by a patient as inappropriate or hurtful. One example is laughter, Dr. LePort says.

"If something is funny that has nothing to do with the patient, patients assume they're being laughed at," he says. "We try to make sure that people are aware that that could happen. We don't want people in the surgery center to be stone-faced; they need to be able to react. If they know the patients might interpret it that way, they can walk a little closer to them while they're doing it so the patients can hear what's funny."

Dr. Cunneen says sensitivity training extends to the use of terms such as fat, obese and morbidly obese. His staff is generally told to use words such

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as large or other euphemisms because patients don't like to be reminded of their weight. On that same point, he makes sure staff gives patients the correct size gowns because handing a size 30 patient a size 10 gown is embarrassing for both parties, he says.

"That shows that [staff members] aren't sensitive to their size," he says. "How's that going to make that patient feel? Most patients don't like to go to the doctor. They don't want to have something thrown back in their face that reminds them that they're large."

Like Dr. LePort, Dr. Cunneen says his sensitivity training program focuses on helping staff better understand overweight patients.

"The training is really just to reinforce the fact that for these people, it's very serious," Dr. Cunneen says. "We have a tendency to put too much comedy on someone's disease of being overweight. Even though the stereotype is the jolly fat person, that's generally not true. They don't want to hear jokes about them being fat. Most people don't get that."

5. Staff members who deal directly with patients have received professional training. In addition to sensitivity training, staff members who interact directly with the patients need specialized training, Dr. LePort says. This includes the best way to get a patient in and out of bed, roll a patient over in bed, get them in and out of a wheelchair and walk them down the hall.

"They need to be trained, otherwise the patient is going to fall and hurt themselves or the staff member might get injured if they use their own body as they normally would," he says.

For example, if a patient needs to get out of bed, the best way is for the patient to be rolled and then to sit up because it's difficult for them to just sit up outright, Dr. LePort says.

6. Anesthesiologists are comfortable with overweight patients. Having an anesthesiologist comfortable working on overweight patients — who tend to have more breathing problems and more difficult airways to intubate — is essential, Dr. Cunneen says.


"One of the more dangerous things about these procedures is the anesthesia," he says.

Anesthesiologists should have special tools such as advanced anesthesia intubating tools to help them intubate a difficult patient, he says.

7. The center has an agreement with an inpatient facility experienced in handling bariatric patients. Both physicians agree that having an agreement with an in-patient facility is important — and having an agreement with a facility familiar with treating obese patients is even better. Dr. LePort says even the smallest complications during surgery can necessitate a transfer to a hospital. Dr. Cunneen says it's essential that this arrangement be made ahead of time.

"If it's clear that this patient needs to go to a hospital, have that arranged beforehand so you're not calling 911 or having a fire drill to figure out where to go," he says. ■


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Improving ASC Billing and Collections: 5 Critical Steps to Take Now

By Rob Kurtz

Michael Orseno, revenue cycle director for Regent Surgical Health, discusses five steps ambulatory surgery centers should take to improve their billing and collections efforts in the new year.

1. Make sure all of your payor contracts are loaded into your billing and collection software. If your billing and collections software allows it, make sure all of your contracts are uploaded, Mr. Orseno says. This will feed into other areas such as electronic remittance advice ERA — an electronic version of a payment explanation — and contractual variance reports. Some payors change their rates at the beginning of the year, so ensure all of your existing contracts are up to date.

2. Review your managed care contracts to make sure you're being paid properly. “If you have your contracts loaded into the system, it makes management's job exponentially easier because you will be able to run reports to determine how much you were paid versus how much you were supposed to be paid for different procedure codes,” Mr. Orseno says. “Then you can identify where you're being underpaid or if you're not charging enough for a particular procedure.”

3. Enable ERA and electronic funds transfer EFT with all payors. Once you have ERA coming from your payors, your ASC can now start auto-posting. “Auto-posting will cut down tremendously on your staff costs,” says Mr. Orseno. “Once you have the contracts loaded in the software, your poster will see how much you were supposed to be paid, how much [the payor] paid and whether or not they should post it or not. This is all done electronically and at half the time it used to take manually”

Enabling EFT will get funds to you facility faster and also help prevent the likelihood of fraud or lost checks.

“Both ERA and EFT will help decrease your A/R days,” Mr. Orseno says.

4. Use your clearinghouse to send attachments to payors electronically. Mr. Orseno says many delays he has seen in the A/R process are attributable to the requirement set by most payors of requiring documentation to support submitted claims. This documentation includes operative reports and implant invoices.

“Now our clearinghouse allows us to scan [these documents] and send

them electronically,” he says. “Some payors will accept the attachments electronically, some won't, but our clearinghouse will handle that. For those that [accept attachments electronically], we now have date-stamped material, so if the payor comes back and says we haven't sent this, we have documentation with both the date and time it was sent.”

If your clearinghouse doesn't offer this as an option, Mr. Orseno advises you to push for it because “this is the way of the future,” he says.

5. Arrange for payment on all unmet deductibles and coinsurance upfront. Mr. Orseno says this step is especially important this time of year as most patients have unmet deductibles and higher co-insurance and/or co-pays. Arranging for payment on all unmet deductibles and coinsurance upfront will help decrease collections costs and days in A/R, he says.

“And it's important here that we're saying *arrange* for payment of unmet deductibles and coinsurance,” Mr. Orseno says. “We want our centers to arrange for payment, not necessarily collect on them. Collecting on them leads to myriad issues, including increased staff costs and legal issues. On the one hand, it's a positive that the center is bringing money in the door, but some contracts, such as Medicare and others, won't allow that.”

It is very challenging — often close to impossible — to determine how much of the deductible will hit the ASC, he says. If full payment is collected on the front end and the physician's office gets hit with the deductible, the ASC must spend staff time processing refunds.

Mr. Orseno recommends ASCs use a credit card authorization form, take a patient's credit card information and authorize the charge of a certain amount. When the claim is adjudicated, call the patient and inform him or her of how much you're going to charge the credit card at that time.

“Physician offices are collecting money now, so a lot of times the ASC will be left ‘holding the bag’ when patients say they already paid the physician and are not going to pay [the ASC],” Mr. Orseno says. “So if you just arrange for payment, you're not really collecting a payment until the claim is adjudicated.” ■

Learn more about Regent Surgical Health at www.regentsurgicalhealth.com.

10 FAQs About ICD-10

By Rachel Fields

Here are 10 frequently asked questions about ICD-10, based on information from the Centers for Medicare and Medicaid Services.

Q: What is the ICD-10 compliance date?

A: Oct. 1, 2013.

Q: Will the transition to ICD-10 be postponed?

A: No. The Oct. 1, 2013, compliance date is firm. There are no plans to extend the deadline.

Q: What does ICD-10 compliance mean?

A: ICD-10 compliance means that all HIPAA covered entities are able to successfully conduct healthcare transactions on or after Oct. 1, 2013, using the ICD-10 diagnosis and procedure codes. ICD-9 diagnosis and procedure codes can no longer be used for healthcare services provided on or after this date.

Q: Will ICD-10 replace Current Procedural Terminology (CPT) procedure coding?

A: No. This change does not affect CPT coding for outpatient procedures. ICD-10 procedure codes are for hospital inpatient procedures only.

Q: Who is affected by the transition to ICD-10? If I don't deal with Medicare claims, will I have to transition?

A: Everyone covered by the HIPAA must transition to ICD-10 on October 1, 2013, including providers and payers who do not deal with Medicare claims.

Q: Do state Medicaid programs need to transition to ICD-10?

A: Yes. Like all other HIPAA covered entities, state Medicaid programs must comply with ICD-10 by October 1, 2013. CMS is continuing to work with Medicaid programs to help ensure they meet the deadline.

Q: What happens if I don't switch to ICD-10?

A: Claims for all services and hospital inpatient procedures provided on or after October 1, 2013, must use ICD-10 diagnosis and inpatient procedure codes. (This does not apply to CPT coding for outpatient procedures.) Claims that do not use ICD-10 diagnosis and inpatient procedure codes cannot be processed. It is important to note, however, that claims for service and inpatient procedures provided before October 1, 2013, must use ICD-9 codes even if they are submitted after the compliance date.

Q: If I transition early to ICD-10, will CMS be able to process my claims?

A: No. CMS and other payers will not be able to process claims using ICD-10 until the October 1, 2013, compliance date. However, you should plan to start ICD-10 testing with payers beginning in 2012.

Q: Codes change every year, so why is the transition to ICD-10 any different from the annual code changes?

A: ICD-10 codes are different from ICD-9 codes. ICD-10 has a completely different structure from ICD-9. Currently, ICD-9 codes are mostly numeric and have 3-5 digits. ICD-10 codes will be alphanumeric and contain 3-7 characters. ICD-10 is more robust and descriptive with "one to many" matches in some instances.

Like ICD-9 codes, ICD-10 codes will be updated every year.

Q: Why is the transition to ICD-10 happening?

A: The transition is occurring because ICD-9 codes have limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated and obsolete terms and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full. A successful transition to ICD-10 will be vital to transforming our nation's healthcare system. ■

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9 Supplies That Endanger Profitability for ASC Cases — and How to Reduce the Damage

By Abby Callard

Effectively managing a surgery center's supplies can cut costs and raise profits. But what about must-have supplies that are so expensive they single-handedly threaten the profitability of a case? Surgery center administrators and physicians share some high-cost supplies and how they have successfully managed to mitigate those costs.

1. Allografts. Tona C. Savoie, RN, administrative director, Bayou Region Surgical Center in Thibodaux, La., says the center has trouble with the pricing on allografts — specifically for ACL and PCL procedures. The average cost of an allograft for ACL reconstruction was about \$1,800, while the total cost of the procedure is more than \$5,000. According to the ASC Association's 2011 Medicare payment calculator, the national average payment of an ACL knee repair is \$3,371.

2. Balloons for ablation procedures. Brooke E. Smith, administrator, Maryland Surgery Center for Women in Rockville, Md., says the balloons used for ablation procedures can cost up to \$1,000 a piece. The balloon is inserted, expanded and burns the lining of the uterus. She says some physicians at the center have returned to doing the procedure the "old school way" with a roller bar. As long as the physicians keep their skills up, the outcomes are the same. She says using a roller does take about five minutes longer per procedure, but the bars cost \$12 each — saving the center more than \$900 per case.

3. Balloon sinuplasty items. Another expensive item that the staff at the Bayou Region Surgical Center has trouble with are the supplies used for sinus procedures. The procedure uses a small, flexible balloon catheter to enlarge sinus passageways and relieve sinusitis. The balloon is not reusable and costs \$1,200-\$1,500 per procedure. Adding another headache, if the surgeon combines the traditional endoscopic method with the balloon, a center can only use the CPT code for the endoscopic procedure and not the balloon procedure.

4. Hip arthroscopy equipment. In order to perform this procedure, a surgeon needs a special operating table, dedicated c-arm capability and hip specific arthroscopic equipment. This represents a large capital investment, says T.K. Miller, MD, an orthopedic surgeon with Carilion Clinic Orthopaedics and medical direc-

tor of the Roanoke Ambulatory Surgery Center. However, with the right surgeon and the right center, the procedure can be done profitably, he says.

5. Multi-inflation balloon for esophageal dilation. Dana Folstrom, administrator of Mirage Endoscopy Center in Rancho Mirage, Calif., says the multi-inflation balloon used for esophageal dilation is so expensive that the center will not make any money on the procedure if it's done on a Medicare case.

6. Orthopedic implants. John Brock, administrator at NorthStar Surgical Center in Lubbock, Texas, says any type of orthopedic implant is going to mean high costs for a surgery center.

"With orthopedic implants, you're getting into high dollars and the issue that comes into play are the payors," he says.

Oftentimes, the payor will reimburse based on the procedure regardless of which implant was used.

These implants include supplies used for open reduction internal fixation, or inserting implants to aid bone healing, and Achilles tendon repairs, says Ms. Savoie.

7. Pump tubing for hysteroscopy procedures. Ms. Smith says pumps for hysteroscopy procedures cost \$106 per procedure, but there is a less expensive alternative.

"If it's going to be a quick diagnostic procedure, you can truly just use cystoscopy tubing and a pressure bag," she says.

This brings the cost per procedure down to a mere \$4. The Maryland Surgery Center for Women saved more than \$50,000 a year by making this switch. If the surgeon starts the procedure and realizes the procedure is going to be more involved, the tubing can be switched in less than two minutes, Ms. Smith says.

8. Spinal cord stimulators. Implanting a spinal cord stimulator for the treatment of back pain is usually a two part process: a trial phase, where the patient essentially takes the stimulator for a test drive, and then a final implantation of the device if the trial was successful. Mr. Brock says it's this two-step process that makes the device itself and the procedure a potentially cost-prohibitive endeavor.

"You have to make sure the procedures that are scheduled are appropriate," he says. "This is done by working with the doctors — so much of this is about physician education anyway. Our way is to provide them with the cost information. We don't tell them what product to use or how to use it, but we make them aware of the cost. That is a critical part of all of this."

9. Tape for urological sling procedures. While sling procedures are generally well reimbursed — \$5,000-\$8,000 according to Regent Surgical Health — the tape used for the procedure can cost up to \$4,000. Mesh implants are also needed for the procedure, so it's essential that the cost of supplies is negotiated to keep the procedure profitable, says Goran Dragolovic, senior vice president of operations for Surgical Care Affiliates.

Tips to bring down the costs

Jessey Arrambide, RN, BSN, CNOR, executive director at Oregon Outpatient Surgery Center and vice president and program chair of the Oregon Ambulatory Surgery Center Association, recommends surgery centers consign expensive items such as implants.

"We have told them, 'We'll use your product, but you have to consign to us,'" she says. "Implants can be so expensive that you don't want to purchase them and then let them sit on the shelf."

Another way to mitigate the high cost of these items is by working with insurers to carve out, or reimburse the price of the implant separate from the procedure itself, the cost of the implant from the reimbursement itself, Ms. Savoie says.

"Many insurances do not cover implants or high dollar items separately," she says. "At times, we are able to negotiate carve outs, but that is getting increasingly more difficult. The southern region seems to have more difficulty getting implant reimbursement than the Northeast. Ultimately the best scenario is getting insurance contracts with carve outs. When that is not an option, we search for different vendors or attempt to negotiate pricing in order to perform the cases at the center." ■

Contact Abby Callard at abby@beckershealthcare.com.

5 Changes for Outpatient Anesthesia in 2012: Thoughts From Dr. Gilbert Drozdow

By Rachel Fields

Gilbert Drozdow, MD, MBA, is president of the anesthesiology division of Sheridan Healthcare, one of the nation's largest providers of hospital-based physician services, including over 1,200 anesthesiology providers and more than 800 providers in emergency medicine, radiology, neonatology and hospitalist services in 142 hospitals and outpatient facilities in 21 states. He discusses five ways outpatient anesthesia will change over the next year.

1. Movement of procedures into outpatient settings. According to Dr. Drozdow, one of the most significant trends occurring within outpatient anesthesiology is the movement of procedures traditionally performed in hospital facilities into ambulatory surgery centers and physician offices. "This is related to the improved efficiency that ASCs can provide," he says. "There are fewer delays in the outpatient settings because hospitals have to deal with emergency procedures, which can disrupt the daily flow in the surgical theater."

He says the specialization of the ASC environment also gives anesthesiologists the chance to perform procedures more efficiently. The ASC environment is absent the complex processes and equipment that are necessary in a hospital environment because of higher-acuity cases. "The advantages of the ambulatory environment appear to have an impact on both patients and surgeons," he says. "Smoother scheduling allows for faster turnover of cases, which is linked to improving patient and surgeon satisfaction."

2. Increased use of regional anesthesia under ultrasound guidance. Dr. Drozdow says outpatient anesthesiologists increasingly use regional anesthesia under ultrasound guidance, a procedure which provides for greater post-operative pain control and permits complex cases to be performed in an outpatient environment. The use of regional anesthesia is especially important as more complex orthopedic cases move into the ASC setting. Peripheral nerve blocks especially are popular for orthopedic cases because they allow the provider to isolate and anesthetize a specific area in the arm or leg without putting the patient to sleep.

Dr. Drozdow says regional anesthesia is also useful for patients with a higher risk of complications who might historically have been deemed too risky for the outpatient setting. "For example, sleep apnea patients who run the risk of post-operative respiratory complications can have their procedures done in an outpatient environment, and avoid general anesthesia," he says. "Orthopedic procedures that were traditionally only done in hospitals, such as bone fractures, can now be performed safely."

3. Use of multi-modal pre-emptive anesthesia. In addition to the use of complex regional anesthesia, outpatient anesthesiologists are also using multi-modal preemptive anesthesia, or the use of intravenous and oral medications to reduce the need for post-operative narcotic pain relief and alleviate post-operative nausea and vomiting. PONV can be a major determination of patient satisfaction in a surgery center, as the patient will likely remember the post-operative recovery period better than the actual surgery. By using multi-modal preemptive anesthesia, anesthesiologists can help reduce recovery room time, decrease the risk of readmissions and reduce the patient's risk of developing chronic pain conditions, Dr. Drozdow says.

The benefits are not only clinical: ASCs on a budget should consider multi-modal preemptive anesthesia to prevent delays and clogged PACUs. "There are [also] economic benefits in utilizing these modalities, including greater operating room throughput and faster discharge of patients," he says.

4. Development of outpatient anesthesia as a subspecialty. Dr. Drozdow says outpatient anesthesia has gradually become a subspecialty within the profession, meaning more attention paid to research, clinical best practices and networking for anesthesiologists that work in ASCs.

"The outpatient anesthesiologist ... is represented by dedicated professionals committed to strong leadership and clinical expertise in the outpatient setting," Dr. Drozdow says. "For example, there is SAMBA — Society for Ambulatory Anesthesia — that is working assiduously to define best practices, enhance patient safety and establish independent thinking apart from a traditional, hospital-based focus."

Many ambulatory anesthesiologists agree that this focus is necessary because of the inherent differences between the hospital and outpatient setting. For example, outpatient anesthesiologists work in a smaller space with a smaller, more consistent group of staff, generally dealing with high volumes of the same procedures and developing criteria to make sure only appropriate patients are treated in the ASC.

5. Increased emphasis on regulatory environment. Dr. Drozdow says patients will and should be more critical of accreditation achievements when choosing centers in the future. Anesthesiologists should aim to work at accredited centers that follow "the same standards as hospitals, in both credentialing and governance," he says.

Dr. Drozdow adds that anesthesiology practices are under greater pressure from accrediting bodies this year: New requirements from The Joint Commission in demonstrating ongoing professional provider evaluation are forcing anesthesiology practices to identify solutions to meeting these obligations and challenges. "These solutions require leveraging informatics as well as human resources with specific content knowledge," he says. "This forces anesthesiologists to either invest themselves in building this infrastructure support or seek to affiliate with national physician-driven organizations that have the business scale to deliver these critical services." ■

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5 Essential Skills for Surgery Center Anesthesiologists From Dr. Thomas Wherry

By Rachel Fields

Providing anesthesia in a surgery center is different from practicing in the hospital setting, due to a different patient mix, environment and average case acuity. Thomas Wherry, MD, principal for Total Anesthesia Solutions and consulting medical director for Health Inventures, discusses five essential skills for ASC anesthesia providers.

1. Experience with pediatrics. Dr. Wherry says if a surgery center is planning to perform surgery on pediatric patients, the contracted anesthesia group should include providers with pediatric anesthesia experience. This doesn't mean the anesthesiologist has to be fellowship-trained in pediatric anesthesiology — according to Dr. Wherry, fellowship training is more applicable for anesthesiologists assisting with complex in-patient cases.

He says anesthesiologists with pediatric experience are essential for cases that involve children because they understand the differences in dosage, airway management and medication needs between a child and an adult. "They're not just little adults," he says. "There is a physiologic difference and a medication requirement difference and a dosing difference. Airway management is probably the biggest one. You need to have that skill set, or it's not going to go well and the surgeons are not going to be happy."

He says when adding a new anesthesia provider or group, the ASC administrator should inquire as to how many pediatric cases the group has performed in the past. "You also might want to call other locations where they've practiced and make sure they are competent in dealing with pediatric patients," he says.

2. Knowledge of regional anesthesia and peripheral nerve blocks. Anesthesia providers who work in an orthopedic-driven

surgery center should have a strong knowledge of how to perform peripheral nerve blocks, Dr. Wherry says. Peripheral nerve blocks are popular for orthopedic cases because they allow the provider to isolate a nerve in the arm or leg and anesthetize the area without putting the patient to sleep. "Peripheral nerve blocks take a higher skill level than other [regional anesthesia techniques] because you're really isolating a particular nerve, so you have to have knowledge of anatomy and be able to do that on patients of all shapes and sizes."

He says peripheral nerve blocks are also useful because the anesthesia provider can insert the block prior to surgery, give the patient a lighter general anesthetic and then wake them up more quickly after the procedure. The patient usually suffers less pain after surgery with a peripheral nerve block than with general anesthesia, he says. These techniques are especially useful as surgery centers treat more and more obese patients, who have a higher risk of complications under general anesthesia.

Dr. Wherry says the "ultimate" skill for a regional anesthesia provider is the ability to perform ultrasound-guided peripheral nerve blocks. "If I were going to open an orthopedic center, I would want providers that are very skilled at doing blocks and doing them efficiently," he says. If the provider is unskilled, blocks may take up to 20-30 minutes to insert one, so a high skill level is necessary.

3. Strong airway management technique. As surgery centers increasingly treat more obese patients, Dr. Wherry says surgery center anesthesia groups must have significant expertise in airway management. He says the all providers should feel comfortable using a Glide-Scope or other fiber optic device — tools that every surgery center should provide.

He says airway management problems generally apply to obese patients, patients with obstructive sleep apnea and — in rarer cases — patients with anatomical abnormalities or congenital diseases. He says if your surgery center doesn't staff an anesthesiologist with airway management expertise, you may end up cancelling more cases or having bad outcomes.

4. Ability to manage patients with co-morbidities. The acuity of surgery center cases is only increasing, Dr. Wherry says. Twenty years ago, surgery centers were able to staff with providers who were at the end of their careers and had not undergone training in years. Nowadays, he says you need anesthesiologists and CRNAs who are comfortable dealing with patients with an American Society of Anesthesiologists Class 3 status, meaning the patient has severe systemic disease. Without an anesthesiologist or CRNA who is comfortable with these patients, you will end up sending cases to the hospital or transferring more cases than necessary.

He says anesthesia providers in an ASC setting should understand how to treat patients with multi-system diseases and co-morbid conditions such as diabetes and asthma. "It's a higher-skilled anesthesiologist or CRNA who is comfortable in the screening and management of these patients, as well as post-op management and making sure they go home to a safe environment," he says.

5. Cooperative attitude. Dr. Wherry says one of the most "underappreciated skills" of ASC anesthesia providers is the ability to cooperate with surgeons and other caregivers and act as a "perioperative physician" in the outpatient setting. He says anesthesiologists who are used to a hospital setting may not be accustomed to pitching in with surgery center initiatives and engaging in the whole running of the center.

"Especially if you're looking for a medical director, who is often an anesthesiologist, that person needs to be respected by the surgeons, work well with the nursing staff and be a good teacher and leader and mentor," he says. The anesthesiologist should want to work in a small, intimate environment and should care about seeing the patient through the pre-operative, operative and post-operative stages of care. ■

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8 Steps to Increase Orthopedic Case Volume at an ASC

By Rachel Fields

O orthopedic case volume is a high priority for surgery centers, as orthopedic cases can deliver a sizable profit and competition is high among ASCs and hospitals for surgeons. Thomas Holecek, administrator of Palos Surgicenter in Palos Heights, Ill., discusses eight ways ASCs can increase their orthopedic case volume.

1. Determine if orthopedics will work at your facility. Having a strong orthopedics program can be very beneficial for a multi-specialty surgery center because the specialty has not been so adversely affected by reimbursement changes, like other specialties have, Mr. Holecek says. This can cause volume problems for your center because orthopedics is an increasingly competitive specialty for surgery centers; leaders recognize the profit to be made from orthopedic cases, so they want to gain the loyalty of surgeons as soon as they enter the community. "Everybody would like a strong ortho presence," he says. "However, it is a challenge to develop and maintain."

2. Work with potential surgeons to get them comfortable with the center. If you're planning to recruit a surgeon to your center, especially one who is just out of training, take the time to build the relationship and trust. Get him or her acquainted with your ASC, the staff, and your processes. Investing the time upfront to cultivate a relationship with physicians will be rewarded by their bringing strong volumes to your center.

Most physicians new to your ASC will have concerns about patient safety, efficiency, and the quality of your care. Mr. Holecek recommends meeting several times with each potential physician and discussing the following:

- Which procedures they wish to perform at the surgery center
- The insurance contracts they desire for their patients-discuss the pros and cons.
- Preferences for instrumentation and supplies
- Equipment the surgery center would need to purchase if you are adding new procedures
- Data on the surgery center's quality and safety
- The center's experience with orthopedic cases and the details of staffing and turnaround.

Once the physician has been approved by your center, encourage the surgeon to start bringing cases to the surgery center and then follow-up closely. Develop a good working relationship with the surgeon's scheduler. Make sure your scheduler is facilitating, and not impeding, the scheduling of cases. Once the surgeon has performed some cases, you can evaluate their preferences. "This is how we have developed a relationship with



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one newer surgeon who is bringing us increasing volumes as his practice grows," Mr. Holecsek says. "As we work together, we get better and he gets more comfortable with us."

3. Build a relationship with a large orthopedic group in your community. Mr. Holecsek's center benefits from a strong relationship with a large orthopedic group in its community. When a new physician joined the group, Mr. Holecsek was able to build a relationship with the new physician based on the existing relationship with that practice. He says building that relationship comes down to consistent communication.

This may seem obvious, but he says many ASC administrators aren't often able to devote the time to visit the practice and talk to the key staff members, such as their administrator and scheduler. "The trust must be earned. You have to be a resource to them through the good days or the struggles to find out what's working and what isn't working," he says. "If a patient has a complaint or an issue, take the lead to follow-up completely until that patient is satisfied with the care given."

At some point, all ASCs experiences a change — such as a new scheduling system, staffing changes, EMR implementation, renovation or introduction of new procedure. Let the practices know about the changes in advance whenever possible. Also make sure to follow up with the physician's office staff regularly about preference cards and physician satisfaction to make sure you're maintaining loyalty among providers.

4. Consider expanding your specialty list — with the proper research. If you're introducing a new surgeon to your ASC, you may find that he or she wants to perform procedures that you have never done before. This is a great opportunity to increase your case volume, providing the new procedure can be done safely, efficiently and cost-effectively at your center. Patient safety, of course, should be your primary concern. Realistically, some procedures may be better suited for the hospital setting.

Next, you will need to ensure your staff has the requisite training and knowledge to perform quality work. A good example would be spine procedures: After extensive staff training on equipment and patient positioning by Regent Surgical Health nursing advisors, Mr. Holecsek's ASC was ready to successfully perform microdiscectomy procedures. If you have staff members with experience in the procedure, they can mentor the others. If you are unable to provide the equipment, expertise, and available time to perform the new procedure, it is likely not a good match for your center or for an ASC setting. Also note that not all procedures are Medicare-approved for the ASC setting.

Profitability will be a critical concern for any new procedure. Mr. Holecsek recommends calculating return on investment for the equipment required for the procedure. Look at your expected reimbursement and determine how long it will take you to get a return on your investment. Once you have those numbers, make sure they are presented to the board for approval. Mr. Holecsek prefers to get ROI within a 6-12 month period, depending on the volume, reimbursements, and costs involved.

5. Improve efficiency. If your surgery center is able to perform cases safely and efficiently, physicians will prefer bringing cases to your center. Mr. Holecsek feels efficiency depends on many component parts working in harmony. For example, efficiency begins with scheduling. Physician schedulers should have no problems getting a case on the ASC books. You should also communicate well with patients during the pre-op call to make sure that patients arrive at the facility on-time, and that they are following all of their instructions, thus preventing unnecessary case delays.

In pre-op and the operating room, surgery center staff should work as a team to get the patient ready in a timely manner and turn over rooms quickly. Orthopedic cases are especially difficult in terms of room turn-over because of the additional equipment, supplies, and instruments.

"More time is required to turnover most orthopedic cases," Mr. Holecsek says, especially compared to the other specialties at his center. Quick turn-around results in the physician staying close by, and being ready for the next case when you are.

6. Don't let case volume drop off during renovation. Mr. Holecsek's ASC recently underwent a significant renovation to improve the facility and attract new physicians and patients. A facility renovation is a great way to boost case volume, since physicians and community members will notice your project and want to experience the newly-remodeled facility. On the other hand, a renovation can span several months and involve significant noise and physical change, creating an obstacle to maintaining robust case volume. Mr. Holecsek says his ASC did not experience a decline in case volume during its renovation due to the ability of the staff to keep the ASC safe, clean, and functional.

"Physicians want to know whether the patient has a safe pathway throughout the continuum, if there are efficiency barriers, and if infection control is maintained" he says. "If they see you've maintained a good, clean work environment, they'll feel comfortable bringing their patients to you." He says he benefited from the expertise of the general contractor's adherence to healthcare regulations during construction, along with routine meetings with senior Regent Surgical Health advisors. Mr. Holecsek performed required walk-throughs several times a day to make sure the corridors were clear and there were no fire or safety issues during construction.

7. Give tours to new physicians. If you become aware of new physicians in the area who might want to bring procedures to your surgery center, ask your current physicians to reach out to them and introduce themselves. "Your physicians can encourage their colleagues to come over and take a look at your surgery center," Mr. Holecsek says. "For us, it helps that we have a newly renovated surgery center. It's very attractive, neat and like new. That's what they want." Market your center's most attractive features, such as its efficiency, its proximity to physician offices or its comfortable physician locker room and lounge areas.

8. Monitor volume trends to watch for issues. Monitor each physician's case volume and watch for unexpected drops, Mr. Holecsek says. "If a physician's volume is trailing off, you need to investigate the reasons right away," he says. The physician may be dissatisfied, or he may be performing more cases that aren't appropriate for the surgery center. He also may be taking cases to the hospital without realizing they could be taken to the ASC.

Whatever the reason, follow up as quickly as possible by determining from the physician's schedulers or the physician why volume is down. Once you understand the issue, work to remedy it and let the physician know you're trying to accommodate their needs. ■

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