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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

January/February 2012 • Vol. 2012 No. 1

10 Top Concerns for ASC Physicians

By Rachel Fields

As the trend of physician employment and physician practice acquisition continues at a rapid pace, surgery center physicians are struggling to determine where they will fit in the future of healthcare. They know that surgery centers provide a high-quality service at a cost that hospitals and their outpatient departments cannot match — but reimbursement reductions and increased regulatory burdens seem to indicate that the rest of the world hasn't caught on. Here, five surgery center physician leaders discuss their top concerns for surgery center ownership and participation in 2012.

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12 Ways to Improve Physicians' ASC Experience in 2012

By Rob Kurtz

Here are 12 ways ambulatory surgery center leaders plan to improve the experience of their ASC physicians in 2012.

1. Plan free monthly, educational seminars for patients. John D. Brock, administrator for NorthStar Surgical Center in Lubbock, Texas, says his ASC will provide free monthly, educational seminars to give physicians "the venue to educate potential patients on new and existing procedures and treatment methods for various health issues such as incontinence, migraines and joint replacement," he says.

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40 of the Most Powerful People in Healthcare

By Rachel Fields

As some states challenge the Affordable Care Act in court, others are pushing implementation of regulations under the federal reform law. The healthcare industry in 2011 is a fragmented and fascinating place. Here are 40 people who have been instrumental in shaping healthcare policy, trends and debate over the last year.

Mark T. Bertolini. Mark Bertolini is chairman, CEO and president of Aetna, a health insurance company with more than $34 billion in 2010 revenue, a workforce of more than 34,000 and operations in North America, Asia, Europe and the Middle East. A member of the company's board of directors, Mr. Bertolini assumed the role of CEO in Nov. 2010 and the role of chairman in April 2011. Mr. Bertolini recently described his company as "an evolving technology services company with a big insurance vehicle" in an interview with *Healthcare IT News*. Aetna has been investing in research and development in

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Answering Questions Regarding the FDA Announcement on the STERIS System 1® Transition Deadline

By Barbara Trattler, RN, MPA, CNOR, CNA

On December 22, 2011 the U.S. Food and Drug Administration (FDA) announced that STERIS can continue to provide support on the STERIS System 1® (SS1) through August 2, 2012.

However, this only applies to customers who have completed the following:

- **Placed an order for a legally-marketed alternative technology to replace all SS1s**
- **Completed a "Certificate of Transition"**
- **Returned the completed certificate to STERIS corporation**

This is important for healthcare facilities that rely on the SS1 to process critical devices and must purchase a replacement option. At Advanced Sterilization Products (ASP), we have received many questions from customers regarding the December 22 FDA announcement on the SS1 transition deadline.

Q. Do I have another six months to purchase an alternative to my SS1?

A. No. The deadline to purchase a legally-marketed alternative remains February 2, 2012. However, healthcare facilities that have open orders to replace their SS1(s) and have completed the STERIS "Certificate of Transition" by February 2, 2012, may continue receiving support for their SS1(s) through August 2, 2012.

Q. What do I need to do by the February 2, 2012 deadline?

A. If you have not already, place your order for an alternative technology and fill out the "Certificate of Transition." If you have ordered a replacement system that will not be installed prior to February 2, 2012, you should also complete the"Certificate of Transition" so that there is no disruption to device processing at your facility.

Q. What alternatives to the SS1 does ASP offer?

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For more answers to your pressing questions, please visit www.aspjj.com for the ongoing ASP Video Webisode series that will address issues that your facility faces every day. You may also Like Us on Facebook.com/aspjj or Follow Us on Twitter.com/aspjj.com

* 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.

† Recommended practices for sterilization in the perioperative practice setting. In: Perioperative Standards and Recommended Practices. Denver, CO: AORN, Inc; 2012:561-566

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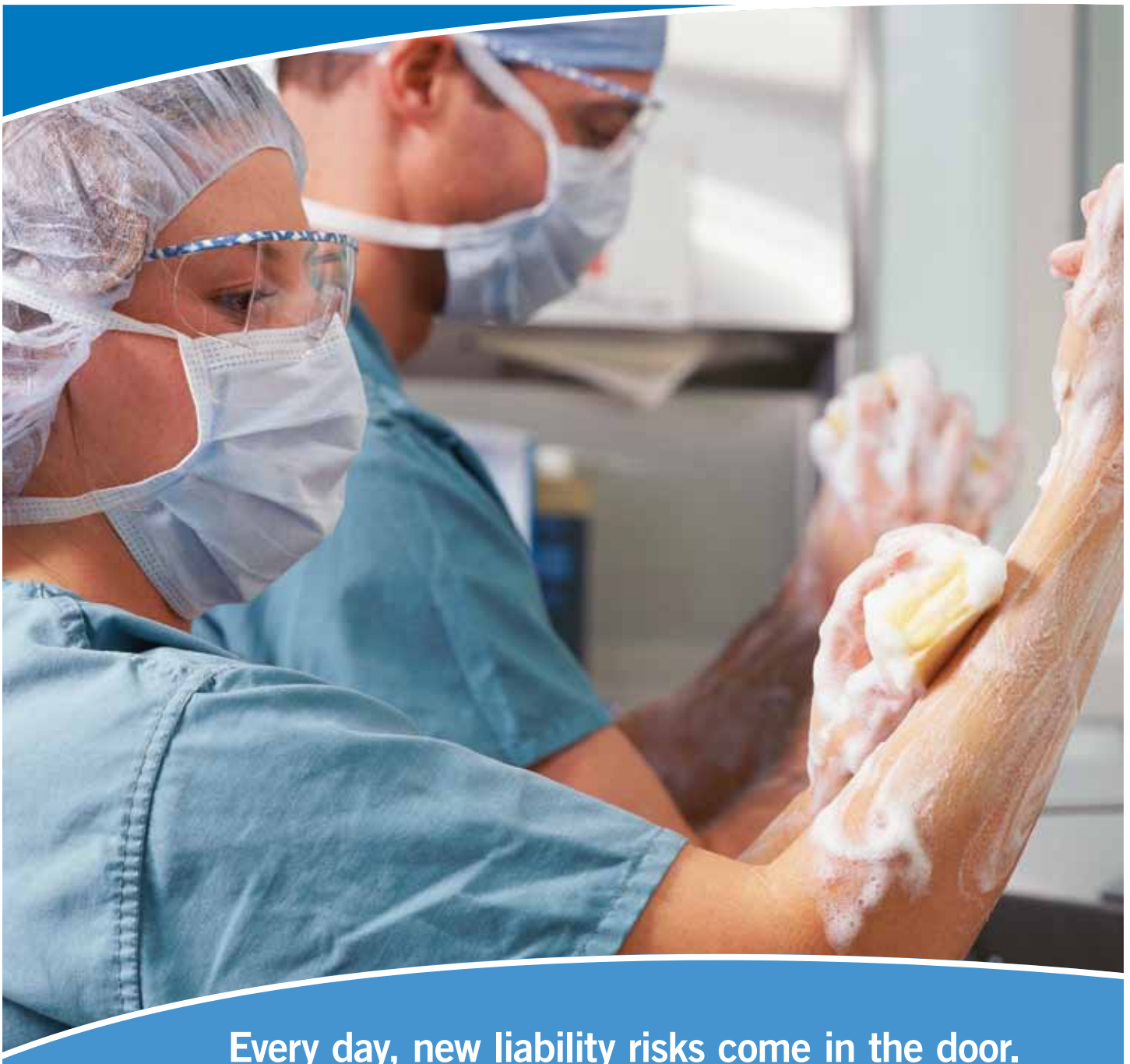

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ASCREVIEW
Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

January/February 2012 Vol. 2012 No. 1

FEATURES

Publisher's Letter

5 Core Concepts for Healthcare Providers This Year; 2012 Becker's Hospital Review Annual Meeting — May 17-18, Chicago; Save the Dates: ASC Conferences 2012

Here are five core concepts for healthcare providers this year, as well as observations on key healthcare delivery trends during 2011.

1. Substantial shifting of healthcare providers. 2011 was an absolutely fascinating year in terms of pieces moving around the healthcare map. We saw an uptick in the amount of acquisitions by hospitals of hospitals and practices. Irving Levin and Associates reported that the top 10 hospitals mergers were valued at $5.6 billion in 2011, up from $3.8 billion in 2010. A recent Price Waterhouse Health Research Institute survey reported 46 percent of physicians are interested in hospital employment. This type of interest is consistent with the number of practice transactions we are seeing.

2. Assessing acquisitions, independence. We expect that in 2012 parties will be spending a good deal of time digesting the acquisitions they made last year and making sure that they have met their expectations. We expect independent hospitals and independent practices to take a deep breath and really assess their situation before aggressively moving forward to give up their independence.

3. ASC transactions, out-of-network, going public and more. The surgery center industry also saw a number of transactions involving national companies and hospitals buying surgery centers. We also saw (1) big chains pursue wholly the model whereby they partner with hospitals to acquire centers, (2) a return of big chains buying centers without hospital partners and (3) a couple large chains showing continued interest in acquiring physician-owned hospitals. In this sector, we also continue to see more and more aggressive action by payors as to out-of-network patients and increased effort to scramble for independent physicians to fill slots in surgery centers. We expect a few large ASC chains to test the public markets in 2012.

4. Increased governmental investigations. In 2011, we also witnessed significant increases in governmental investigation on a whole variety of fronts, including physician hospital relationships, false claims and billing and coding claims. With more integration of both providers and of payors, we expect more antitrust claims as well. Further, with more healthcare fraud investigators on the street, there will most likely be increases in anti-kickback and Stark Act investigations. RACs will also have an increasing material impact on hospital net income.

5. 2012 developments. We expect 2012 to be a very interesting year. There will be (1) a Supreme Court decision on the Patient Protection and Affordable Care Act's constitutionality, (2) a presidential election and (3) a great deal of overall uncertainty in the markets as to the direction of the country, and as to the direction of the healthcare sector.

6. Becker's Hospital Review Annual Meeting — Great Topics and Speakers Focused on ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties. The Becker's Hospital Review Annual Meeting will be held May 17-18 at Hotel Allegro in Chicago. The two-day event will be co-chaired by Chuck Lauer, former pub-

lisher of *Modern Healthcare,* and Scott Becker, publisher of *Becker's Hospital Review*, and will feature keynote speakers Bob Woodward, Coach Mike Ditka and Suzy Welsh. More than 40 hospital and health system CEOs, CFOs and COOs will be featured among the event's 124 speakers and 74 sessions. Register today by visiting www.regonline.com/beckershospitalreviewannualmeeting_1041813. Registrations received before April 1 will receive a discount.

7. Save the Dates — ASC Conferences 2012. We have two outstanding surgery center conferences planned for this year. First, we have our 10th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference. This will be held June 14-15 in Chicago. We will, once again, combine great and interesting keynote speakers including Lou Holtz and Tucker Carlson with a terrific amount of practical and focused guidance. The 19th Annual ASCs Improving Profitability and Business and Legal Issues will be held Oct. 25-27 in Chicago.

Should you have any questions or if we can be of help in any manner, please do not hesitate to contact me at sbecker@beckershealthcare.com or call me at (800) 417-2035.

Very truly yours,

Scott Becker

P.S. If you are interested in exhibiting at or sponsoring the Becker's Hospital Review Annual Meeting, the June ASC conference or advertising in our publications, please contact Jessica Cole at (312) 929-2625 or jessica@beckershealthcare.com for more information.

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10 Top Concerns for ASC Physicians
(continued from page 1)

1. Decreasing reimbursements. Surgery center reimbursement continues to lag behind hospital reimbursement for the same procedure, adversely affecting distributions to ASC physician-investors. Larry Patterson, MD, medical director of Eye Centers of Tennessee and the Cataract and Laser Center in Crossville, Tenn., says declining reimbursement is always a concern for surgery center physicians, who are forced to produce ever-increasing volume to make up for loss of revenue. "We're being asked to get less and less money, and yet the government is giving us more and more burdens and regulations," he says. "You can only go so far in cutting costs and increasing volume."

T.K. Miller, MD, medical director of Roanoke Orthopedic Center and Roanoke Ambulatory Surgery Center in Virginia, says ASC physicians have little choice when it comes to dealing with governmental rate reductions. "Whether we feel [CMS fee schedules] are appropriate, they are what they are, and we have to work with them," he says.

He adds that fee schedules also trickle down to private insurance, adversely affecting specialties like GI and pain management that have recently suffered from cuts to Medicare rates.

2. Regulatory changes. Updates to the Medicare Conditions for Coverage have left some surgery centers with mountains of paperwork and significant changes to make in preparation for CMS surveys. Dr. Patterson says he has seen the Conditions for Coverage interpreted in different ways by different surveyors, making it difficult for his surgery center to know exactly how to meet the standards.

He says one of the requirements impacts sterilization in ophthalmic facilities by requiring that providers not compound drugs in the surgery center. He says some surveyors have interpreted the mixture of dilating drops and antibiotics immediately prior to surgery as a form of compounding. "Some surveyors claim that's compounding, but it's not," he says. "Instead of putting two or three drops in someone's eye, you're mixing them together in a separate container. Anyone with any amount of sense would realize that what we're doing causes no harm." He says while documentation is a major stressor for administrators struggling to meet CMS requirements, the actual changes to surgical practice are more time-consuming and frustrating.

He says while documentation is a major stressor for administrators struggling to meet CMS requirements, the actual changes to surgical practice are more time-consuming and frustrating.

3. Hospital employment of physicians. Physician recruitment continues to present a challenge for surgery center physicians, who need colleagues to bring case volume to keep their centers financially healthy. Physicians are increasingly seeking hospital employment as a shelter from reimbursement reductions and regulatory burdens, and even those physicians that would choose ASC investment do not have the available capital to invest. "Physician recruitment has been challenging and will, in my opinion, continue to be competitive," says Urfan Dar, MD, manager and medical director of Theda Oaks Surgery Center in San Antonio. "New graduating physicians do not have the resources available to invest in an ASC and tend to see employee positions with salary guarantees."

Richard Kube, MD, CEO, founder and owner of Prairie Spine Institute in Peoria, Ill., says gone are the days of creating volume by adding a groundbreaking service line that no one else in the community offers. "Five years ago, spine was one of the frontiers in ASCs, but at this point, ASCs have evolved to the point where a lot of physicians in your community are doing those cases in surgery centers," he says. "Those physicians have been gobbled up, too."

He says rather than recruit more physicians, ASCs must focus on driving more patients to the ASC to make their existing physicians busier. He says his practice has focused on building relationships with primary care physicians in the community in order to drive referrals — rather than new surgeons — to the ASC.

4. Hospital acquisitions of surgery centers. Hospitals are increasingly purchasing surgery centers to improve relationships with local physicians, provide a convenient surgical option for their providers and increase market share. Dr. Patterson says this trend means many surgery center physicians are facing a choice: sell all or part of their ASC to a hospital, or try to survive on significantly less reimbursement than a hospital outpatient department receives for the same cases.

"Hospitals are buying up surgery centers because hospitals are reimbursed handsomely for outpatient cases in comparison to [freestanding ASCs]," he says. "The government doesn't realize the problem they've created. The disparity in payments between hospitals and surgery centers is huge, and now that hospitals are buying surgery centers left and right across the country, the cost of medical care is only going to get higher."

He says freestanding surgery centers may struggle to compete with hospital-owned surgery centers in the same community, as the hospital-owned ASCs will often have the benefit of hospital-influenced contracts, electronic medical record software and other advantages.

5. Medicare quality reporting program. Dr. Patterson says the Medicare quality reporting program, which is expected to start in the fourth quarter of 2012, is a cause for concern for smaller surgery centers without the software to track quality data. "Small, single-specialty facilities like ophthalmic centers generally don't have a lot of experience with quality reporting," he says. "We don't have EMR in our surgery centers, we're strapped for resources and if we have to report on every claim by the end of 2012, that's going to be tough."

Unfortunately for ASCs without the capacity to collect data, surgery centers that do not report data to the Medicare program in 2012 will pay for their neglect down the road. An ASC that does not successfully report data to the Medicare program in 2012 will receive a 2 percent reduction in Medicare payments in 2014, and failure to report in subsequent years will affect future years' payments in the same way. In 2012, surgery centers

only have to worry about reporting the required data, but surgery centers may be penalized for poor quality outcomes in the years to come.

6. Cost of implants. Dr. Miller says orthopedic-driven surgery centers may no longer enjoy insurance contracts that accept the costs of implants as dictated by suppliers. In the past, he says insurance companies would accept increases passed along over the course of the year and negotiate carve-outs to accommodate the cost of implants in the contract. He says as insurance companies become less willing to accept additional costs, surgery centers may have to try a new strategy. Dr. Miller says there is sufficient overlap in the orthopedic implant market that it is possible to select a primary implant vendor and negotiate reduced costs based on that relationship. Of course, this requires consensus from ASC physicians and careful ongoing assessment of case costs on the part of the ASC administrator.

"For orthopedic- and spine-based centers, this will be an area of significant change from the status quo," he says. Dr. Miller says surgery centers must assess every new implant for a "traditional" procedure for cost feasibility. New implants and old implants may be similar, but that does not necessarily mean they cost the same amount.

7. Electronic medical records. Jason Lockette, MD, an otolaryngologist at Shoals Outpatient Surgery in Florence, Ala., says integration of EMR systems will become more of an issue as more physician practices incorporate them. "It will be difficult for the standalone center to offer the same amenities — ease of access to lab, path and operative notes — that a hospital with an integrated network of employed physicians can," he says.

He adds that most surgery centers would benefit from an affordable computer software system to monitor and track supplies and case costs because a manual process makes it difficult and costly to follow such metrics.

Dr. Miller believes one of the top challenges of 2012 will be integrating the ASC EMR with the physician practice EMR. "Integration of an ASC's EMR and physician users' EMR systems has combined, exponential benefits," he says. "The ability to access records, templated notes and computer-based scheduling — with templated scheduling sheets — can provide huge dividends in reduced costs associated with perioperative assessment, reduction in case cancellations, OR equipment picks, implants needs and par levels and transcription costs."

8. Availability and cost of staff. Dr. Lockette cites "increasing supply and labor costs" as one of the most pressing concerns for next year, and salary surveys seem to support this fear. Registered nurse salaries increased 1.1 percent from 2009-2010, according to data from the ASC Association salary survey — and small surgery centers may be hit the hardest. According to data from VMG Health, nurses in ASCs with 1-2 ORs earn more than their counterparts in ASCs with three or more ORs. Surgery centers may be forced to cut into physician distributions to offer staff competitive salaries.

Steven Shin, MD, a physician with Kerlan-Jobe Orthopaedic Clinic in Los Angeles, says the availability of properly trained nurses and surgical technicians is also a concern. As competition increases for practitioners in short supply, surgery centers will have to get creative with their benefit packages and environment perks to attract the best talent. Most ASC physicians agree that competent, consistent staff members are one of the most attractive parts of working at a surgery center.

9. Accountable care organizations and healthcare reform. Accountable care organizations remain an unknown for most surgery center physicians, as the integrated care models are designed for larger health systems and the outcome of federal healthcare reform has yet to be decided. While some physicians are preparing for a world with the Affordable Care Act as law, others are hoping it will be overturned by the Supreme Court or effectively eliminated by the electing of a Republican president in 2012.

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- 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 at The Brooklyn Hospital Center, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP
- Key Strategies to Align Independent and Employed Physicians - Paul Summerside, 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
- Hospital Strategies for Surviving and Thriving in the Changing Healthcare Environment - Russ Richmond, MD, McKinsey Hospital Institute

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Dr. Miller says whatever happens to healthcare reform, ACOs are still a cause for concern for surgery centers. "How will ASCs position themselves for an appropriate 'piece of the pie'?" he says. "Simply being the low-cost and most efficient provider may not be enough."

Surgery center physicians who hope to take advantage of Medicare ACOs and commercial look-a-likes should start conversations with their local hospitals now to determine how ACOs will affect their community and whether surgery centers will have a chance to participate in the model.

10. Investments in specialty-specific technology. ASC physicians agree that investments in clinical technology will be a major concern for the next year, as surgery centers struggle to compete with local hospitals and ASC physicians desire the latest equipment. Dr. Miller and Dr. Dar agree that more pain centers will expand their repertoire to include ultrasound-guided multi-side regional blocks and selective injections, which can reduce x-ray exposure in pain management. For these purchases, calculating return on investment is critical to determining whether the ASC has sufficient revenue and case volume to offset the cost of the equipment over time.

Dr. Patterson believes ophthalmic ASCs will grapple with whether to invest in a femtosecond laser over the next few years — a significant issue, considering the lasers can cost around $400,000 up front, with an additional "click" fee per case. He personally believes that femtosecond lasers are not financially feasible for most surgery centers at the moment. He discussed a return on investment model that showed a surgery center would have to perform 493 cases a year to break even on the laser purchase, even if the surgery center charged each patient $950 per case. He says while the technology may improve the physician experience of the cataract procedure, it does not necessarily improve clinical quality to any significant degree — at least not yet. "We all want to be the first one to say, 'We do laser cataract surgery,' but I don't think you'll get a competitive advantage by having the laser," he says. ■

Contact Rachel Fields at rachel@beckershealthcare.com.

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12 Ways to Improve Physicians' ASC Experience in 2012
(continued from page 1)

2. Offer latest and best equipment. Mr. Brock says he plans to offer physicians the most current and technologically advanced equipment and instrumentation. "This is to ensure that they are able to provide the highest level of care to our patients," Mr. Brock says.

3. Provide educational materials. Chuck Brown, administrator of Bidwell Surgery Center, a Health Inventures ASC in Middletown, Ohio, says his ASC is working to keep physicians "abreast of the constant updates and possible regulatory changes and their impact on the healthcare environment via newsletters, email updates and locker room discussions."

4. Ensure convenience. Mr. Brown says he and the Bidwell Surgery Center staff members will continue to work to make the surgery center as convenient as possible for them. "The intent is [to] be an extension of their office practice," he says. "We keep in constant contact with their schedulers, managers, etc., to foster a relationship and help in any way we legally can."

5. Streamline the credentialing process. Christopher Collins, RN, BSHCA, administrator/director of nursing for NJSR Surgical Center in Pompton Lakes, N.J., says NJSR is considering a new program to streamline the credentialing process to improve new physician throughput by "creating PDF forms that can be completed online, e-fax and email submissions of documents and an improved verification process," he says.

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6. Add a specialty. Mr. Collins says NJSR Surgical Center will be expanding its breadth of operations to include orthopedic cases, starting in Dec. 2011. "The associated equipment required, the staff training and the additional surgical day will not only improve our physician cadre, but our bottom line," he says.

7. Update and enhance ASC's website. Todd Currier, CMPE, CPA, administrator for Northern Wyoming Surgical Center in Cody, says his ASC recently updated and enhanced its website. "It includes all the physicians that utilize our facility with pictures, bios and links to their own websites," he says. "As we have seen a downturn in the economy, it has become more apparent that the patient population needs to choose a physician that utilizes our facility, and any way we can enhance our physician's exposure within the community can only assist our facility.

"In that light, we will continue to modify our website to provide useful information on all of our physicians and push our press/radio advertisements to use our website for more information," Mr. Currier says. "In addition we will be proving details, videos and information for common procedures performed within our facility."

8. Develop monthly newsletter for medical staff. In 2011, Mr. Currier says Northern Wyoming Surgical Center instituted a quarterly newsletter to its medical staff. In 2012, the center will start sending the newsletter every month. "[The newsletter] illustrates the positive areas within our ASC, patient satisfaction quotes and areas that are in need for improvement — both at the facility level and physician level," he says. "I feel we need to keep our providers abreast of the changes that affect our ASC on a timely basis, not waiting too long to make changes. Areas such as on-time starts, staffing changes that may affect them, instrumentation changes/standardization issues, equipment needs/concerns will all be addressed on a monthly basis. These issues will be presented as more in a briefing format to minimize reading time. Monthly visits with individual physician can address any of the issues in more detail."

9. Accommodate all cases. Regina Robinson, RN, MBA, CMPE, CASC, director of Peninsula Surgery Center in Newport News, Va., says her ASC will continue to try hard to meet the expectations of its surgeons by working any of their cases into the schedule, whether the cases are the same day or not. "We fit the patients in, and the surgeons have become flexible knowing this is occurring, especially when they are the ones looking to add a last minute case," she says.

10. Maintain flexible start times. Ms. Robinson says her ASC is working to allow physicians to customize their start times while keeping the OR schedule in line and efficient. "The surgeon owners are flexible to allow non-owners to book their cases before them, which makes everyone happy," she says.

11. Keep schedulers informed of open block time. Amy McKiernan, RN, nursing administrator for Louisville (Ky.) Surgery Center, an ASD Management facility, says her ASC is working to make sure all available open time at the ASC is announced to physicians' schedulers. "So that [way], if they want to add a case here or there, we can accommodate them.

12. Inquire about interest in new instruments. Ms. McKiernan says her ASC will be asking if there are any new instruments the physicians would like the surgery center to consider acquiring. "Our ENT docs are always coming up with something they would like to have that does not always show to be cost effective, but giving them one special 'toy,' if it is not too expensive, will make them happy," she says. "Showing them ways we save on monthly or quarterly basis gets them excited, too." ■

Contact Rob Kurtz at rob@beckershealthcare.com.

Achieving Record Profits Every Year During the Recession: 8 Steps From Gateway Surgery Center Administrator Craig Bryan

By Rachel Fields

Since the recession started affecting patient finances and ASC budgets in 2008, healthcare facilities have struggled to cut costs, increase case volume and negotiate payor contracts that won't sap their profitability.

But despite the doom and gloom in the newspapers over the past few years, not all ASCs have suffered record losses. Craig Bryan, administrator of Gateway Surgery Center in Concord, N.C., says his ASC has seen double-digit growth in volume and revenue every year since 2008. The center has also experienced record profits every successive year.

"When I speak to my peers, a lot of them say, 'How do you do it? How do you make it happen?'" he says. Here he explains 8 steps Gateway Surgery Center took to not only survive, but flourish during a time of widespread economic decline.

1. Isolate your most profitable service lines and concentrate on those. Mr. Bryan says the key to surviving a recession is to focus on the service lines your surgery center can excel with. He says succeeding with a service line means investing in technology to attract physicians, maintaining strong relationships with the physicians in those specialties, hiring and training for those specific specialties and providing better care and outcomes than anyone else in the market. In an ideal world, an ASC would be able to do this with every service line and procedure that was appropriate for the outpatient setting. However, with realistic resources, surgery centers should focus on 2-4 service lines for which they can become "centers of excellence."

He says his surgery center focuses on GI, ENT, orthopedics and general surgery. He says to decide on those specialties, he looked at the market and identified areas that were not being met or maximized. He says when the ASC makes budgeting decisions, it prioritizes the four key service lines and makes sure the physicians are provided with excellent staff, technology and equipment. "Those key service lines — that's where our capital priorities go," he says. "We do a lot of other things — basically anything you can do on an outpatient surgery basis — but our core model is those key specialties."

2. Soften your collections policy. When the economy took a turn for the worse, many ASC administrators responded by implementing strict collections policies. The logic seemed to make sense: If revenue is all-the-more critical to profitability, you have to make sure patients are paying their bills to make money. However, Mr. Bryan says that when the recession hit, his ASC responded in an unusual way — by softening the collections policy and eliminating the mandate that patients pay up-front.

"You don't want the unintentional consequence of losing revenue stream and business because you try to strong-arm patients into paying you," he says. "You don't want to forfeit a dollar to pick up the time. Even if the patient defaults, you will still collect $1,000 or $2,000 from the insurance company." He also says in this economy, you don't want to spread the idea that your surgery center is "all about the money."

Mr. Bryan says surgery centers can help patients pay their bills by asking for a certain percentage of the bill prior to surgery, a certain percentage on the day of surgery and a certain percentage in the weeks or months that follow. "If you can help the patient set up a payment plan, that alleviates the financial burden," he says. "They're still going to owe that money for the surgery, but you can help them manage the financial burden much more effectively." Setting up a payment plan also makes it more likely that you will actually collect from patients, rather than having to send them to bad debt when they start ignoring your calls.

3. Incentivize staff members to collect from patients. If you soften your collections policy, you need a way to make sure you're collecting money from patients, Mr. Bryan says. His center has started a program that incentivizes staff members to collect from patients without being rude or overly persistent. "It's a competitive program, and whoever is the top collector gets a monthly bonus check," Mr. Bryan says. "Everybody has a chance, from our patient financial counselors to our registration staff to our billing office."

The catch: If a staff member receives even one patient complaint during the month, they are disqualified from the program for that month. "You have to be seen as a patient advocate," Mr. Bryan says. "You can't be forceful in your nature."

4. Move collections in-house. Mr. Bryan says his center has moved collections in-house rather than using a third-party company. He says patients find comfort in talking directly with surgery center staff and are more likely to pay their bills or respond to calls because they don't feel that they're "in trouble" with an outside collector.

"We focus on the patient first and we make sure that the patient feels like we're working for them," he says. "We're not just trying to call and collect money." He says the collections team is very upfront about explaining out-of-pocket responsibilities prior to surgery and going through benefits and coverage with patients.

5. Rework block guidelines to grow volume. Mr. Bryan's surgery center has also reworked block guidelines to grow volume. When he arrived at the center, the entire schedule was completely full, and physicians were only required to maintain a 30 percent utilization rate to keep their block. That meant the surgery center was scheduling block time physicians did not consistently fill with cases. He said the center clearly had a lot of time open in the schedule that could be used to make money.

"If you're only scheduling 50 percent of your cases and leaving the other spots open, you end up scheduling many more cases in that open time," he says. Currently, the center blocks about 60 percent of its time and leaves the other 40 percent open. The center physicians must also maintain a 75 percent utilization rate to keep their block time.

6. Add a new service line if possible. While some surgery centers may not have the option to add a new service line, Mr. Bryan says the addition of ophthalmology to his center helped grow volume and improve profitability. He used an interesting strategy to add the service line: Instead of using a large specialty group in a nearby market that competed with the center's existing partners, he sought out a specialty group in nearby Charlotte.

"We tapped into a market that we hadn't previously been in, and we built the ophthalmology up to 500 cases in year one," he says. "It's a mutually beneficial strategy because the physicians tapped into a new [patient] market and we tapped into a new market, too." He says the

specialty group was committed to joining the ASC community and helped the transition by building an office in Concord and making an investment in the surgery center.

7. Focus on employee satisfaction. Employee satisfaction is essential if you don't want to continuously re-hire and re-train staff members — which cost more money than retaining a staff member you already employ. Mr. Bryan says his surgery center focuses on leadership rounding, meaning all managers are out on the floor with staff and listening to conversations to make sure they proactively address issues before these issues become problems. He says the center also conducts annual satisfaction surveys and then puts together departmental focus groups to look at the results.

In these focus groups, staff members come up with their own ways to handle the issues at the center. For example, employee recognition recently recorded lower than on previous year's surveys. To solve the problem, staff decided to form a social committee that plans employee recognition events every month. The center now also has boards throughout the facility where staff members can recognize each other with informal notes. The management sends out gift cards and thank you cards to employees who go "above and beyond," and staff members can approach Mr. Bryan and ask him to personally thank an employee who has been working hard. "This stuff has to come from the staff members because each person enjoys being recognized differently," he says.

8. Focus on high volume specialties when negotiating managed care contracts. When negotiating managed care contracts, Mr. Bryan says "you have to decide who you want to be as a business and where you want your focus to be." You probably won't be able to achieve across-the-board increases for your specialties, so focus again on your "centers of excellence" specialties and try to achieve maximum reimbursement in those. "Focus on those high-volume procedures that will ultimately drive the highest top-line revenue," he says. "Get carve-outs wherever possible and provide your insurers with data so they understand what your costs are." ■

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How Does Your Surgery Center Measure Up: Same Center Performance Trends

By Kevin McDonough, CFA, Senior Manager, and Colin Park, Manager, VMG Health

There was a collective hope by ambulatory surgery center market participants that performance declines experienced during 2008 and 2009 were only temporary and largely driven by extraordinary market dynamics brought on by the economic downturn that plagued the United States and world economies during this period. Growth would return to the ASC market as the economic environment as a whole gradually improved. It has been our observation, however, that performance trends in 2010 and early 2011 have not entirely supported such a theory. Although it's clear that the downturn accelerated and amplified declining performance trends, there continues to be numerous headwinds the industry is presently facing that are outside of the recent recession and subsequent sluggish recovery. These headwinds include the following:

- Oversaturation of ASCs in many markets.
- Increasing employment of specialists by health systems.
- Declining ability to bill and collect using an out-of-network strategy.
- Increasing consolidation within the managed care payor industry — large, poor reimbursing payors have an increased market share.
- Inability to recruit young physicians to replace high volume utilizers that are nearing retirement.

In an effort to further explore recent ASC performance, VMG conducted a study of same center volume and reimbursement trends and will highlight our observations in a two-part piece that focuses specifically on volume and reimbursement trends. Part I, will focus exclusively on same center volume trends, broken out by specialty and region. In part II, net revenue per case trends will be analyzed.

Within this study, 118 ASCs located throughout the United States were analyzed to compare 2009 to 2010 case volume and net revenue per case growth. Data was gathered using VMG Health's published *Multi-Specialty ASC Intellimarker*. Intellimarker is a compilation of information that provides detailed financial benchmarking information and analysis on ASCs around the United States.

Part I: Same center volume trends

Same center growth trends: aggregate and by specialty

As illustrated in the chart below, overall case volume for the 118 ASCs analyzed decreased from an aggregate 525,445 cases in 2009 to 523,928 cases in 2010. This represents a minimal decrease of 1,517 cases, or a 0.3 percent decrease.

SAME CENTER 2009 TO 2010 ASC CASE VOLUME GROWTH BY SPECIALTY*

	Case Volume			
	Cases Performed		2009 to 2010 Growth	
	2009	2010	# of Cases	% of Cases
Otolaryngology	45,513	47,305	1,792	3.9%
Gastroenterology	125,641	125,523	(118)	-0.1%
General Surgery	36,550	33,410	(3,140)	-8.6%
Obstetrics/Gynecology	21,046	20,105	(941)	-4.5%
Ophthalmology	67,937	65,259	(2,678)	-3.9%
Oral Surgery	4,473	4,674	201	4.5%
Orthopedics	76,206	74,938	(1,268)	-1.7%
Pain Management	81,499	82,734	1,235	1.5%
Plastic Surgery	15,951	17,447	1,496	9.4%
Podiatry	16,436	16,274	(162)	-1.0%
Urology	25,782	27,541	1,759	6.8%
Neurology	2,706	2,709	3	0.1%
Other	5,705	6,009	304	5.3%
Total:	525,445	523,928	(1,517)	-0.3%

*Data is representative of a sample size of 118 same center, ambulatory surgery centers located throughout the United States.

Plastic surgery and urology cases, representing 3.3 percent and 5.3 percent of the 2010 total volume, respectively, show the largest percent growth in volume at 9.4 percent for plastic surgery and 6.8 percent for urology. As many of the plastic cases are definitively elective, the growth in volume suggests that those individuals electing to have such procedures performed have been relatively un-phased by the economic downturn. Urology also had the second largest increase in total cases with an additional 1,759 cases performed in 2010. Otolaryngology had the largest increase in total number of cases performed at 1,792 cases. An interesting trend to note related to plastics, urology and ENT is that physicians in these specialties have generally not been targeted by health systems for employment. This is a potential explanation for why we're observing growth in these specialties over others.

Representing 6.4 percent of the total 2010 volume, general surgery experienced the largest percentage and total case decline, declining from 36,550 cases performed in 2009 to 33,410 cases in 2010. Ophthalmology also had a large decline from 2009 to 2010, decreasing by 2,678 cases.

Gastroenterology, representing the largest percentage of the total case volume at 24.0 percent, experienced a very moderate case volume decrease of 0.1 percent, or 118 total cases. Pain management, with the next largest number of cases performed in 2010 at 15.8 percent of total volume, experienced a moderate increase in volume with 1,235 more cases performed in 2010 than 2009.

Same center growth trends: by region

The surgery centers used for this analysis were further analyzed by categorizing each center into the appropriate region of the United States as shown below:

Accounting for 24.2 percent of the 2010 case volume, the Midwest region experienced the largest increase in case volume, growing by 2.9 percent, as shown below. The most notable aspect of the Midwest region was the explosion in pain management (by specialty not shown) growth where there was a 16.8 percent increase from 2009 to 2010.

SAME CENTER 2009 TO 2010 ASC CASE VOLUME GROWTH BY REGION

	Cases Performed		2009 to 2010 Growth	
Region	2009	2010	# of Cases	% of Cases
West	45,897	45,873	(24)	-0.1%
Midwest	123,039	126,551	3,512	2.9%
Southwest	193,533	190,467	(3,066)	-1.6%
Southeast	102,593	99,540	(3,053)	-3.0%
Northeast	60,383	61,497	1,114	1.8%
Total:	525,445	523,928	(1,517)	-0.3%

Representing 19 percent of the 2010 case volume, the Southeast region showed the largest decline in volume with a 3.0 percent decrease. The Southeast region experienced a decrease in case volume for every specialty

with the exception of plastic surgery and general surgery. The largest decreases in case volume for the Southeast region was a 5.9 percent decrease in gastroenterology cases and a 6.7 percent decrease in ophthalmology cases. The most significant shift in case volume for the Southeast region was a 35.6 percent increase in plastic surgery cases.

The West region experienced the smallest percent change in case volume with a 0.1 percent decrease. The Southwest region had a 1.6 percent overall decrease in volume. The most notable decreases for the Southwest region included general surgery volume decreasing 12.5 percent and pain management decreasing 11.8 percent. The largest increase for the year was a 35.5 percent increase in urology volume.

The Northeast region experienced a 1.8 percent growth in overall case volume. Gastroenterology increased 17.9 percent with approximately 2,200 additional cases performed.

As illustrated in part I of this analysis, we are observing flat to slightly declining volume trends throughout most of the country.

Part II: Same center net revenue/case trends

Part II focuses on net revenue per case trends for the same centers analyzed in part I. Before the results of the analysis are detailed, the findings must be caveated with a broader understanding of trends in Medicare reimbursement to ASCs. Beginning in 2008 and concluding in 2011, Medicare phased in a new ASC payment methodology with a goal to transition ASC reimbursement from grouper based to APC (hospital) based. In 2008, the first phase of the new payment system began with a 75/25 blend of the 2007 ASC payment rate. In 2009, a 50/50 blend applied; in 2010, a 25/75 blend applied; and in 2011, the new payment system is being fully implemented.

With the final phases of the new payment system being implemented, specialties historically providing the highest volume of Medicare services (i.e., ophthalmology and gastroenterology) are expected to experience a decline in net revenue per case. Conversely, specialties historically providing lower levels of volume to Medicare patients (i.e., orthopedics and obstetrics/gynecology) are expected to experience an increase in net revenue per case.

Same center growth trends: aggregate and by specialty

As illustrated in the chart below, overall net revenue per case (NRPC) for the 118 ASCs analyzed increased from an aggregate $1,663 per case in 2009 to $1,702 per case in 2010. This represents a minimal increase of $39 per case, or 2.3 percent growth.

SAME CENTER 2009 TO 2010 ASC NET REVENUE/CASE GROWTH BY SPECIALTY*

	NET REVENUE/CASE**			
	Net Revenue/Case		2009 to 2010 Growth	
	2009	2010	$/Case	%/Case
Otolaryngology	$1,805	$1,816	$11	0.6%
Gastroenterology	$855	$847	($8)	-0.9%
General Surgery	$2,014	$2,107	$94	4.7%
Obstetrics/Gynecology	$2,537	$2,674	$138	5.4%
Ophthalmology	$1,391	$1,390	($1)	0.0%
Oral Surgery	$1,121	$977	($144)	-12.9%
Orthopedics	$2,826	$2,922	$96	3.4%
Pain Management	$1,254	$1,323	$69	5.5%
Plastic Surgery	$1,794	$1,817	$23	1.3%
Podiatry	$2,218	$2,286	$68	3.1%
Urology	$1,879	$1,942	$63	3.4%
Neurology	$5,216	$5,979	$763	14.6%
Total:	$1,663	$1,702	$39	2.3%

*Data is representative of a sample size of 118 same center, ambulatory surgery centers located throughout the United States.
**Net revenue per case is weighted by number of cases performed at each surgery center as a percent of total number of cases performed for all centers by modality.

Nine of the 12 specialties shown above displayed an increase in net revenue per case from 2009 to 2010. Neurology had the largest growth in dollars and percent with a $763 increase per case, or 14.6 percent growth. Obstetrics/gynecology experienced the second largest growth in net revenue per case, exhibiting an increase of $138. Orthopedics and general surgery were closely behind, increasing $96 (3.4 percent) and $94 (4.7 percent) per case, respectively. Podiatry increased $68 (3.1 percent) and urology increased $63 (3.4 percent) per case. A significant driver for the overall increase in net revenue per case can be largely attributed to the growth in orthopedic and pain management reimbursement given the prevalence of the procedures in the ASC setting.

Of the 12 specialties shown above, only 3 specialties had lower net revenue per case in 2010 versus 2009. Oral surgery experienced the largest decline at $144 per case, representing a 12.9 percent change. Gastroenterology decreased 0.9 percent, or $8 per case. Ophthalmology reimbursement remained relatively flat.

Same center growth trends: by region

The surgery centers used for this analysis were further analyzed by categorizing each center into the appropriate region of the United States as displayed in the map shown in Part I.

Accounting for approximately 9.0 percent of the total 2010 cases examined in this analysis, the West region experienced the largest increase in net revenue per case, increasing by $214 per case, as shown below. The most notable aspect of the West region was the large increase in net revenue per case for orthopedics (by specialty not shown) increasing $441 per case. The West experienced a decline in net revenue per case for only three specialties: gastroenterology (-$17), plastic surgery (-$29) and podiatry (-$51).

Representing 24 percent of the 2010 case volume, the Midwest region also showed an increase in overall net revenue per case of 2.8 percent or $55 per case. The most notable increase in net revenue per case by specialty is a 12.5 percent ($258) increase in general surgery. The Midwest region experienced growth in all specialties with the exception of pain management (decrease of 5.5 percent).

SAME CENTER 2009 TO 2010 ASC NET REVENUE PER CASE GROWTH BY REGION

	Net Revenue/Case		2009 to 2010 Growth	
Region	2009	2010	$ Growth	% Growth
West	$1,640	$1,853	$214	13.0%
Midwest	$1,970	$2,026	$55	2.8%
Southwest	$1,666	$1,654	($12)	-0.7%
Southeast	$1,316	$1,346	$30	2.3%
Northeast	$1,636	$1,647	$12	0.7%

Following closely to the Midwest region, the Southeast region (representing 19 percent of the 2010 case volume) experienced a $30 increase in overall net revenue per case, or a 2.3 percent increase. The Southeast region experienced large reimbursement growth in oral surgery (26.1 percent), urology (8.0 percent), obstetrics/gynecology (7.7 percent) and plastic surgery (7.5 percent). The Midwest region experienced a decline in only otolaryngology (-1.2 percent).

The Northeast region experienced the lowest increase in net revenue per case with only a moderate 0.7 percent increase, or $12 per case. The Northeast had large growth in both general surgery (12.4 percent) and gastroenterology (10.9 percent), but also had large declines in oral surgery (-22.2 percent).

The only region to experience a decline in overall net revenue per case was the Southwest region, comprising 36.4 percent of the 2010 case volume tested. The Southwest region had a decline in all specialties with the exception of orthopedics (11.9 percent increase), obstetrics/gynecology (2.0 percent increase) and otolaryngology (0.5 percent increase). The most notable declines in net revenue per case were neurology, decreasing 31.5 percent, and oral surgery, decreasing 15.0 percent.

As illustrated in part II of this analysis, we are observing trends of a moderate increase in net revenue per case for almost all specialties throughout most of the country. The specialties that did exhibit declines in reimbursement were likely the result of the phase-in of the new ASC payment methodology.

Although the ASCs in this study do not represent all ASCs across the nation, the sample size certainly represents a population large enough to draw meaningful conclusions. It should be further noted that the ASCs in this study have come to our firm to provide transaction and valuation services. As such, these centers have active management that have consistently pursued physician recruitment and share movement within their ASC. This is a vital endeavor in positioning their respective ASC to be in the best possible position given the myriad headwinds facing the industry. ■

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40 of the Most Powerful People in Healthcare (continued from page 1)

the last decade, and its recent $6 billion health IT acquisitions and development of new applications are part of a strategy simplify system use. Aetna has made headlines lately because of disputes between the insurer and hospital chain HCA, which has pushed for rates that Aetna says are "significantly higher than other area hospitals," according to a *Palm Beach Post* report. About 36,000 Aetna clients hang in the balance between HCA's East Florida affiliate and Aetna in the negotiation.

Donald Berwick, MD. Don Berwick, administrator of the Centers for Medicare & Medicaid Services, oversees Medicare, Medicaid and Children's Health Insurance Programs — three programs that collectively provide care to nearly one-third of Americans. Before assuming leadership of CMS, Dr. Berwick was president and CEO of the Institute for Healthcare Improvement, a non-profit organization that aims to reduce readmissions, infections and other patient safety issues around the world. Dr. Berwick strongly believes in the need to redistribute healthcare resources from the rich to the poor and has been criticized for his favorable statements about the British healthcare system. Dr. Berwick has been quoted as saying that "sick people tend to be poorer and … poor people tend to be sicker and … any healthcare funding program that is just, equitable, civilized and humane must, must redistribute wealth from the richer among us to the poorer and less fortunate." Dr. Berwick celebrated his 65th birthday in Sept. 2011, making him eligible for the Medicare program he oversees.

John Bluford III. John Bluford was named chair-elect of the board of trustees of the American Hospital Association in July 2010 and assumed the chairmanship in 2011. As chair of the board of the AHA, Mr. Bluford is the top elected official of the national organization that represents the country's hospitals and health systems. Mr. Bluford has served as CEO and executive director of Truman Medical Centers, a non-profit hospital system comprised of two hospitals, a health department and a behavioral health network, since 1999. He has said that a "special area of focus" during his chairmanship for the AHA will be to create a culture of wellness among healthcare employees that will hopefully extend into the communities they serve.

Richard M. Bracken. Richard Bracken, chairman and CEO of Hospital Corporation of America, began his career with the company in 1981 and has since held various executive positions within HCA. He was appointed president of HCA's Pacific Division in 1997, COO in July 2001 and president and COO in Jan. 2002. He was then elected to the HCA Board of Directors in Nov. 2002 and became CEO in Jan. 2009. HCA recently announced the company will pay Bank of America $1.5 billion to buy back more than one-sixth of the hospital operator's outstanding shares, which have reportedly been battered by a slowdown at operating rooms and worries about Medicare cuts. Mr. Bracken said he views the repurchasing of the common stuck as an accretive investment in the company and an opportunity to enhance stockholder value.

Angela F. Braly. Angela Braly is the chair of the board of directors, president and CEO of WellPoint, the nation's largest health benefits company in terms of membership, with approximately 34 million Americans covered through its affiliated health plans. In 2010, WellPoint generated operating revenue in excess of $57.8 billion and employed around 37,500 associates. Ms. Braly was named president and CEO in June 2007 and assumed the role of the chair of the board in March 2010. Under her leadership, the company's commitment to its mission has been strengthened by diversifying its business portfolio to offer more comprehensive health solutions. Ms. Braly has led the company in the divestiture of WellPoint's prescription benefits management business to Express Scripts, increased transparency through the Anthem Care Comparison tool to provide cost information to consumers and the measurement of progress made in improving quality of care through a proprietary Member Health Index.

William F. Carpenter. William Carpenter serves as the chairman of the board, president and CEO for LifePoint Hospitals, headquartered in Brentwood, Tenn. He has served as CEO since June 2006, prior to which he served as executive vice president and chief development officer. Having led the company's acquisition activities as chief development officer, Mr. Carpenter understands the importance of ensuring a smooth transition between acquiring and owning a hospital. Under Mr. Carpenter's leadership, the company started a transitional services division that is present at the creation of a deal to work side-by-side with the development team from the moment a deal is struck. LifePoint formed a joint venture with Duke University Health System in Jan. 2011, creating an entity designed to improve healthcare delivery by creating flexible affiliation options for community hospitals. Duke/LifePoint is one of the first joint ventures between an academic health system and a hospital operations company.

Carolyn M. Clancy, MD. Carolyn Clancy was appointed Director of the Agency for Healthcare Research and Quality in Feb. 2003, just after the entity was established, and was reappointed in Oct. 2009. As director of AHRQ, her primary focus has been on reducing medical mistakes, improving consistency of healthcare across disciplines and calculating the financial toll of healthcare decisions. AHRQ has recently funded several successful research projects that promote patient safety, including an initiative to reduce hospital-acquired infections in Michigan. Ms. Clancy told *The Hill* in Sept. 2011 that researchers saw "dramatic" results by using a basic checklist combined with a different approach from hospital leadership and a system that asked employees to "check and balance" one another. AHRQ is now working with other stakeholders to expand the experiment to other conditions and regions.

Richard L. Clarke, DHA, FHFMA. Richard Clarke, president and CEO of the Healthcare Financial Management Association, has led his organization to significant growth in membership, scope and influence since assuming the post in 1986. He announced his retirement, effective July 31, 2012, early this year. During Mr. Clarke's tenure, HFMA has grown 40 percent, and operating revenue has grown 408 percent. Mr. Clarke has long supported the viewpoint that the U.S. healthcare system is economically unsustainable, and this conviction led HFMA to launch an examination into the principles and components of a new healthcare system. This examination has taken shape in public and private demonstration projects, as well as in the 2010 healthcare reform law. Mr. Clarke spearheaded HFMA's Value Project, which gathered the support of 17 leading hospitals and health systems to identify how hospitals can "bend the cost curve" while improving quality. The first Value Project report was released in June 2011.

David Cordani. David Cordani, CEO of Cigna, recently led the Bloomfield, Conn..-based company in rebranding itself for the first time in a generation. The company recently adjusted its brand to market to individuals as well as employers, spending $25 million on a rebranding effort that includes television and print advertising, a new social media presence and a softer, less corporate logo. The company has also dropped the all-capital CIGNA spelling of its name. Mr. Cordani said personalization is important to contemporary consumers, and Cigna wanted to connect better with its customers. Mr. Cordani became president and CEO of the company in Dec. 2009, after serving as president and COO since June 2008. He has held numerous other executive Cigna positions and, prior to Cigna, worked with Coopers & Lybrand in Washington, D.C.

Delos "Toby" Cosgrove, MD. As president and CEO of Cleveland Clinic in Ohio, Dr. Delos "Toby" Cosgrove presides over a $5 billion healthcare system that includes the Cleveland Clinic, nine community hospitals, 15 family health and ambulatory surgery centers and locations in Florida, Toronto and Abu Dhabi. His leadership at Cleveland Clinic has emphasized patient care and patient experience, including the re-organization of clinical services into patient-entered, organ and disease-based institutes. Dr. Cosgrove and his health system have made headlines in recent months after the CEO criticized proposed rules for accountable care organizations, saying they create "significant

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barriers" that would discourage hospitals from adopting the new model. Cleveland Clinic is one of several prominent national health systems that has declined participation in the "pioneer" ACO program, a blow to the Obama administration considering that the program was designed for systems exactly like Cleveland Clinic.

Nancy-Ann DeParle. Nancy-Ann DeParle is the deputy chief of staff for policy in the administration of President Obama, a position she came to after serving as the director of the White House Office of Health Reform. Ms. DeParle was named as one of the new White House chief of staff's deputies during a major shakeup in White House staffing in early 2011. Ms. DeParle came to the Obama administration with first-hand knowledge of the push for health reform, having served as the director of the Health Care Financing Administration from 1997-2000. She is an expert on Medicare and Medicaid and has helped the Obama administration expand those programs in the push for universal coverage.

Thomas C. Dolan, PhD, FACHE, CAE. Thomas Dolan is president and CEO of the American College of Healthcare Executives, an international professional society of more than 35,000 healthcare executives. The organization has comprehensive programs in credentialing, education, career counseling, publications and research and serves as one of the healthcare industry's top professional associations, influencing executive opinion on matters such as acquisitions and mergers, quality and patient safety, CEO performance expectations and board certification. As of Jan. 2011, the organization had 24,184 members. Prior to his appointment as president and CEO of ACHE, Dr. Dolan served as the organization's executive vice president. Before joining the College, he held a variety of teaching, research and administrative positions at St. Louis University, the University of Missouri-Columbia, the University of Washington and the University of Iowa.

Trevor Fetter. Trevor Fetter is president and CEO of Tenet Healthcare, a position he assumed in Sept. 2003. He originally joined Tenet in 1995, serving as executive vice president, CFO and a member of the office of the president. Tenet made headlines in 2011 over its relationship with Community Health Systems, first for suing the hospital operator for wrongfully billing insurers and second for rebuking CHS' offer to buy Tenet for $7.25 a share. Mr. Fetter said at the time that Tenet's business strategy would "deliver greater value than Community Health's inadequate proposal," an interesting position considering the pressure on hospital systems to be acquired by larger competitors. In April 2011,Tenet sued CHS for billing insurers for unnecessary patient stays, alleging the hospital operator made between $280 million and $377 million through improperly admitting Medicare patients between 2006 and 2007.

Teri G. Fontenot, FACHE. Teri Fontenot is the president and CEO of Woman's Hospital, a 356-bed Level III regional referral hospital that serves as the largest birthing and neonatal intensive care facility in Louisiana. The hospital is also the largest freestanding, non-profit woman's hospital in the country. Ms. Fontenot has led the hospital in the development of a $400 replacement campus, which will open in summer 2012 with increased capacity for current services and new growth opportunities. In addition to her work as head of Woman's Hospital, Ms. Fontenot will serve as chairman of the American Hospital Association starting in 2012, becoming the top elected official of the organization that represents America's hospitals and health systems. Ms. Fontenot serves on the American Hospital Association Long Range Policy Committee and chairs the AHA Health Forum board. She also chairs the CEO Committee of the American College of Healthcare Executives and has served as a member of the Advisory Committee on Research on Women's Health for the National Institutes of Health and chair of the board of the Louisiana Hospital Association.

George C. Halvorson. George Halvorson is chairman and CEO of Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, headquartered in Oakland, Calif. Kaiser Permanente is the nation's largest non-profit health plan and hospital system, serving approximately 8.8 million members and generating $42 billion in annual revenue. Mr. Halvorson serves on committees and boards of several industry-leading associations, including the board of America's Health Insurance Plans, the American Hospital Association's advisory committee on health reform and the Institute of Medicine roundtable on value and science-driven healthcare. Kaiser has made $5.7 billion since 2009, and Mr. Halvorson was paid $8 million in total compensation in 2009 alone — a fact that has recently brought the health system under fire as 21,000 employees held a strike against the hospital chain for higher wages. Kaiser officials responded by saying they were "disappointed" by the strike by National Union of Healthcare Workers at such an early stage in contract negotiations.

Stephen J. Hemsley. Stephen Hemsley has been CEO of Minneapolis-based UnitedHealth Group, the parent company of UnitedHealthcare, since 2006. Before joining UnitedHealth Group, he worked for Arthur Andersen as a managing partner and chief financial officer. Mr. Tersigni is also the immediate past chair of the Catholic Health Association of the United States. UnitedHealth Group is the nation's largest insurance company based on revenue, pulling in $87.4 billion in revenues in 2010 and benefitting around 70 million Americans. In Sept. 2011, UnitedHealthcare of Florida signed a contract with the state of Florida, agreeing to provide HMO services in 18 counties. The announcement came after the 1st District Court of Appeal rejected parts of a legal challenge filed by United and declined to issue a stay. The other 49 Florida counties were divided among five HMOs that reached agreements with the state separately.

Charles "Chip" Kahn III. Chip Kahn served as the driving force behind the ad campaign that dismantled Bill Clinton's 1993 healthcare reform plan, and he has played a significant role in the debate over President Obama's reform efforts as well. The head of the Federation of American Hospitals, Mr. Kahn acts as an influential lobbyist within the healthcare industry and served on the late Senate Health, Education and Labor Committee to hash out healthcare reform before drafting legislation. The Federation of American Hospitals has pushed for universal coverage, including the mandate that individuals carry health insurance. In early Sept. 2011, the FAH issued a news release that commended President Obama for focusing on job growth but expressed concerns about the impact of future federal policies on America's hospitals. Mr. Kahn said in the release that the 2 percent Medicare cuts embedded in the Budget Control Act would lead by nearly 50,000 hospital job losses and $30 billion in lost wages by 2021. He said deeper Medicare and Medicaid cuts would dramatically escalate these losses.

Sister Carol Keehan, DC. Sister Carol Keehan is the ninth president and CEO of the Catholic Health Association of the United States, having assumed her duties in Oct. 2005. She is responsible for all association operations and leads CHA's staff at offices in Washington, D.C., and St. Louis. She has worked in administrative and governance positions in healthcare for more than 35

years, most recently as board chair of Ascension Health's Sacred Heart Health System in Pensacola, Fla., and prior to that as president and CEO of Providence Hospital in Washington, D.C. Sister Keehan publicly supported the Affordable Care Act but has criticized Secretary Kathleen Sebelius' narrow religious exemptions for the provision of contraception. On Aug. 1, 2011, HHS announced that only certain religious institutions could opt out of providing contraception, a move that Sister Keehan said would not "protect our Catholic health providers."

Jeremy Lazarus, MD. Dr. Jeremy Lazarus, a board-certified psychiatrist in private practice in Denver, was elected president-elect of the American Medical Association in June 2011. Prior to his election, Dr. Lazarus served as speaker of the AMA House of Delegates from 2007-2011 and vice speaker from 2003-2007. He is also a past president of the Colorado Medical Society. He has chaired several AMA task forces on a wide variety of topics, including health system reform. Representing the AMA on the Health Coverage Coalition for the Uninsured, Dr. Lazarus has been one of the organization's chief spokespersons on issues involving the uninsured. He is only the second psychiatrist to be president of the AMA.

H. Stephen Lieber, CAE. Since 2000, Stephen Lieber has served as the president and CEO of the Healthcare Information and Management Systems Society, the largest U.S. cause-based, non-profit healthcare association focused on the optimal use of IT in healthcare. He serves not only on the board of directors of HIMSS and its related corporations, but also on the board of the Certification Commission for HIT and the Health Information Technology Standards Panel, which he co-founded. In his role as leader of HIMSS, Mr. Lieber has established the Society as a global leader on technology standards, IT adoption, IT certification, electronic health records and interoperability. In a Feb. 2011 interview with Mobi Health News, Mr. Lieber said healthcare is on the cusp of a "mobile era," and the presence of mobile content at the HIMSS conference demonstrates that transition.

Steven H. Lipstein. As president and CEO of BJC Healthcare in St. Louis, Steven Lipstein oversees one of the nation's largest healthcare organizations, with annual net revenues of $3.5 billion and more than 26,000 employees. During his tenure with BJC, Mr. Lipstein has positioned the healthcare system for the future through the creation of the Center for Advanced Medicine and Alvin J. Siteman Cancer Center. The Center for Advanced Medicine, a cooperative effort between Barnes-Jewish Hospital and Washington University School of Medicine, houses a wide range of outpatient services and consolidates more than 30 locations where services were offered previously. Mr. Lipstein is also one of 21 board members to lead the Patient-Centered Outcomes Research Institute, a federal non-profit organization established by the healthcare reform law in 2010. PCORI conducts comparative effectiveness research to provide quality, evidence-based findings on how diseases and health conditions can be effectively prevented, diagnosed, treated and managed appropriately.

Kevin E. Lofton. Kevin Lofton is the president and CEO of Denver-based Catholic Health Initiatives, the third-largest Catholic healthcare system in the nation with $9 billion in annual revenue and 73 hospitals. According to Mr. Lofton, CHI is developing accountable care organization pilots in four markets and will invest $1.5 billion in EHRs and other IT systems from 2010-2015 to enhance quality of care. The hospital system is in the midst of a potential merger that would put Jewish Hospital & St. Mary's Healthcare and University Hospital in Louisville under the control of Catholic Health Initiatives by merging the hospitals with St. Joseph Health System of Lexington.

The merger has met with controversy because the hospitals have agreed to follow Catholic healthcare directives, including not providing sterilization and birth control. The company also recently acquired therapy services from Applied Medical, a large independent physical and occupational practice in North Dakota.

Farzad Mostashari, MD, ScM. Farzad Mostashari serves as National Coordinator for Health Information Technology within the Office of the National Coordinator for Health Information Technology at HHS. Dr. Mostashari joined ONC in July 2009 and was appointed National Coordinator on April 8, 2011, succeeding David Blumenthal, MD. Dr. Mostashari recently said he supports a delay of stage 2 of meaningful use, per the suggestions of the Health IT Policy Committee. He said delaying stage 2 of meaningful use to 2014 may encourage providers to attest to meaningful use this year, but those who have already attested should still be rewarded. The Office of the National Coordinator plans to release proposed rules for meaningful use of EHRs by the end of 2011 or early 2012 and will complete the rules in the summer of 2012.

Gary D. Newsome. Gary Newsome became president and CEO of Health Management Associates, a hospital operator based in Naples, Fla., in Sept. 2008. From early 1998 until Sept. 2008, Mr. Newsome was employed by Community Health Systems, which he joined as a group vice president and left as division president. Health Management Associates is a for-profit company that mainly operates hospitals and other healthcare facilities in the southern United States. Despite inclusion of several HMA hospitals on a recent Joint Commission list of the 405 "best" hospitals in the country, shares of the hospital operator fell 34 percent between late July and mid-September. Analysts believe stock prices may have fallen over concerns about the weak economy and possibly cuts to Medicare payments, which could come as a result of a deficit-reduction plan.

John H. Noseworthy, MD. Dr. Noseworthy, a neurologist, became president and CEO of Mayo Clinic in Nov. 2009. Dr. Noseworthy joined Mayo in 1990 and has served in various leadership positions, among them chairman of Mayo's Department of Neurology and vice chairman of its Rochester executive board. He also served as editor-in-chief of *Neurology*, the official journal of the American Academy of Neurology. Among other projects, the Mayo Clinic has recently made progress toward the launch of a Center for the Science of Health Care Delivery, which will identify the most efficient best practices in the diagnosis, treatment and care of patients by analyzing data and conducting research into new care delivery systems. Mayo Clinic believes this kind of research is essential as state and federal policymakers continue to struggle with the nuances of healthcare reform. Dr. Noseworthy also recently announced Mayo Clinic's involvement in an initiative to create global smoke-free workplaces.

Pres. Barack Obama. President Obama is the 44th and current President of the United States and the first African American to hold the office. President Obama graduated from Columbia University and Harvard Law School and worked as a civil rights attorney and constitutional law professor for the University of Chicago Law School before serving as a United States Senator from Illinois from 2005-2008. President Obama's 2010 passage of healthcare reform continues to make waves in the healthcare community, with some lawmakers pushing implementation of regulations such as health insurance exchanges, and others fighting the Affordable Care Act in court. According to surveys released by Gallup and the National Center for Health Statistics in Sept. 2011, President Obama's healthcare overhaul has proven effec-

tive in reducing the number of young adults without health insurance. One survey estimated that the number of uninsured people ages 19-25 dropped from 10 million in 2010 to 9.1 million in the first three months of 2011.

Thomas M. Priselac. Thomas Priselac serves as president and CEO of Cedars-Sinai Health System in Los Angeles, a position he has held since Jan. 1994. Mr. Priselac has been associated with Cedars-Sinai since 1979, and prior to being named president and CEO, was executive vice president from 1988-1993. The Cedars-Sinai Health system is one of the nation's leading providers of healthcare services, providing physician services through the Cedars-Sinai Medical Care Foundation, a full-time academic faculty and an active private attending staff. With annual revenues over $1.7 billion, Cedars-Sinai Medical Center is the largest private hospital in the western United States. In addition to his work with Cedars-Sinai, Mr. Priselac serves as chairman of the American Hospital Association Board of Trustees and is past chair of the Association of American Medical Colleges.

Kenneth E. Raske. Kenneth Raske has been president of the Greater New York Hospital Association since 1984. An expert on healthcare policy and finance, he has played a key role in shaping the New York and national healthcare delivery system and has been instrumental in growing GNYHA to the nearly 250 hospitals that it represents. Over the past several years, GNYHA has played a critical role at the state level, opposing healthcare funding cutbacks and advocating for the passage of legislation that would help protect funding for teaching hospitals and charity care programs. On the federal front, the association has been an advocate in the pushback against deep Medicare and Medicaid cuts, particularly to teaching hospitals. Under Mr. Raske's leadership, GNYHA has developed a portfolio of business subsidiaries called GNYHA Ventures, which includes Nexera, Innovatix and New Business Initiatives. GNYHA's advocacy efforts receive substantial financial support from these businesses, creating a valuable symbiotic relationship.

Ian Read. Ian Read is CEO of Pfizer, the world's largest research-based biopharmaceutical company, which discovers, develops and manufacturers a portfolio that spans the spectrum of human and animal health products. Mr. Read began his career with Pfizer in 1978 as an operational auditor and worked in Latin America through 1995, holding positions in a number of the company's fastest-growing operations, such as Pfizer Mexico and Pfizer Brazil. Pfizer named Mr. Read CEO in Dec. 2010, following the retirement of former CEO Jeffrey B. Kindler. Mr. Read was appointed the company's leader as Pfizer prepared to face generic competition from its top-selling cholesterol treatment Lipitor. Despite deep cuts to the company's $8 billion global research and development operations in Feb. 2011, Pfizer has been expanding operations lately with acquisitions and property development. In Sept. 2011, the company announced it would purchase biotech real estate in Cambridge, Mass., to make room for 400 employees. The company has also considered a sale of its nutrition business, a spin-off of its animal health business and the establishment of a business that sells generic drugs for increased profit.

Mitt Romney. Mitt Romney, the governor of Massachusetts from 2003-2007, is a candidate for the 2102 Republican Party presidential nomination. In April 2006, Mr. Romney signed the Massachusetts health reform law, which requires nearly all Massachusetts residents to purchase health insurance coverage and has been heralded as the predecessor to federal healthcare reform. The bill also established means-tested state subsidies for those who do not have adequate employer insurance and make below an income threshold. Mr. Romney's involvement in the landmark Massachusetts legislation, which he agreed to after months of negotiations with a Democratic legislature, has been seen by Republicans as a "black mark" on his record, one that could make him unpopular with conservative voters who oppose the federal healthcare reform law. Like every other Republican candidate, Mr. Romney has said he would seek to repeal the Affordable Care Act and has said he would issue an executive order on the first day of his presidency that would grant every state a waiver from its enforcement of "Obamacare."

Paul Ryan. Paul Ryan is the U.S. Representative for Wisconsin's first congressional district, a position he has held since 1999. He is a member of the Republican Party and serves as the chairman of the House Budget Committee, where he has significant impact on the Republican Party's long-term budget proposal. In April 2011, he introduced a plan titled The Path to Prosperity as a counter to President Barack Obama's budget proposal. The House passed this plan by a vote of 235-193, but the bill died in the Senate later in the month. Among its key features, the plan would have reformed Medicare and Medicaid by ending the current Medicare program starting in 2022 and converting Medicaid payments to block grants starting in 2013. The current Medicare plan would be replaced with a new program — still called Medicare — involving voucher-like "premium support payments" and increasing the age of eligibility. The plan would also make several changes to the healthcare reform law, repealing the requirement that most residents obtain health insurance and repealing tax credits for small employers that offer health insurance.

Kathleen Sebelius. Kathleen Sebelius was sworn in as the 21st secretary of the Department of Health and Human Services in April 2009. Since then, she has led efforts to implement reforms through the Patient Protection and Affordable Care Act, including policies that focus on wellness and prevention, adoption of electronic medical records, recruitment of more primary health providers and expansion of insurance coverage. In Sept. 2011, Secretary Sebelius reported that the Affordable Care Act has succeeded in expanding healthcare coverage to hundreds of thousands of young adults. One survey, conducted by the CDC's National Center of Health Statistics, found that the number of uninsured Americans ages 19-25 dropped from 10 million in 2010 to 9.1 million in the first three months of 2011. Upon the announcement, Secretary Sebelius also criticized politicians who support the repeal of the Affordable Care Act. "It's very disappointing to hear some people in Congress talk about repealing the law and taking away this security, "she said in a statement.

Peter Shumlin (D-Vermont). Peter Shumlin is the 81st and current governor of Vermont, elected during the 2010 election. On May 26, 2011, Gov. Shumlin signed a bill that put Vermont on a path to become the first state in the country to adopt a single-payor health system. The federal healthcare reform law would not allow Vermont to enact a single-payor system until 2017, but the state is asking the administration to grant a waiver so that it can establish a system by 2014. Gov. Shuman has previously criticized the current health insurance system, saying his experience as the owner of a successful travel business lets him "know firsthand that the biggest obstacle to job growth is the 10, 20, 30 percent increases in insurance premiums." Prior to being elected governor, Gov. Shumlin represented the held a Vermont Senate seat for eight terms, from 1992-2002 and from 2006-2011.

Wayne Smith. Mr. Smith has been president and CEO of Community Health Systems since 1997 and has helped the company grow from $742 million to more than $12.1 billion in net revenue. He graduated from Trinity University in San Antonio, Texas, with a master's degree in hospital administration. Mr. Smith spent 23 years working for Humana, where he progressed from hospital administration to president and COO. While at Humana, he was tasked with turning around a financial crisis brought about by a flaw in the company's Humana Health Plans, which he successfully accomplished in two years. In 1997, Mr. Smith became president and CEO of CHS, where he focused his attention on purchasing non-urban, non-profit hospitals. CHS merged with Triad Hospitals in 2007 and is currently the second largest acute-care hospital chain in the United States.

Glenn D. Steele Jr., MD, PhD. Glenn Steele is president and CEO of Danville, Pa.-based Geisinger Health System, a role he accepted in 2001 after leaving the Department of Surgery at the University of Chicago. Dr. Steele is widely recognized for his investigations into the treatment of primary and metastatic cancer and colorectal survey and serves on the editorial

boards of numerous medical journals. Geisinger Health System recently signed a definitive agreement to join with Bloomsburg Health System, two months after the system received final regulatory approval to merge with Shamokin Area Community Hospital. The system is also planning a takeover of Community Medical Center in Scranton, Pa., demonstrating a nationwide trend of increased mergers and acquisitions among large health systems. Geisinger has been praised as a model of low-cost, quality healthcare by President Obama, who in June 2009 encouraged providers nationwide to look to the system and learn from its success.

Anthony Tersigni, EdD, FACHE. Anthony Tersigni was appointed president and CEO of St. Louis-based Ascension Health in June 2004, prior to which he served as executive vice president and COO from Jan. 2001-Dec. 2003. He has also held leadership positions at other health systems, including St. John Health in Detroit, Sisters of St. Joseph Health System in Ann Arbor, Mich., and Sisters of Charity Health Care systems in Cincinnati. As president and CEO of Ascension, Mr. Tersigni heads the largest Catholic healthcare system in the nation — even more so after the acquisition of Alexian Brothers Health System in suburban Chicago. ABHS and Ascension announced the signing of a letter of intent in April and said the goal was to complete a definitive agreement and receive necessary state and federal agency approvals by the end of 2011.

Richard Umbdenstock, FACHE. Richard Umbdenstock became president and CEO of the American Hospital Association in Jan. 2007, following a term as the elected AHA board chair in 2006. His career includes experience in hospital administration, health system leadership, association governance and management and HMO governance. Mr. Umbdenstock recently criticized President Obama's recommended Medicare and Medicaid cuts, which could reduce beneficiaries' access to care and eliminate around 200,000 jobs over the next 10 years. He said the president's plan to reduce federal healthcare spending by $320 billion over the next decade "would mean decreased access to care for our nation's seniors and could overload emergency rooms, shut down trauma units and reduce patient access to the latest treatments," according to an AHA statement. Mr. Umbdenstock has also argued in favor of payment extensions for physicians; he testified before a Congressional panel about section 508 wage reclassifications; outpatient hold-harmless payments for rural and sole community hospitals; and reasonable cost-based payment for outpatient clinical lab tests in smaller rural hospitals.

Chris Van Gorder. As president and CEO of San Diego-based Scripps Health since 2000, Chris Van Gorder has led the non-profit health system through a series of financial and culture changes, positioning the system as one of the nation's leading health providers. When Mr. Van Gorder was appointed CEO in 1999, Scripps Health was losing $15 million a year, and the management had recently received a "no-confidence" vote from its medical staff. Mr. Van Gorder responded to the crisis by implementing a physician leadership cabinet, building strategic alliances and pushing a more transparent management style. Through a joint venture with North American Medical Management California, Scripps Health recently formed an integrated delivery network with seven physician groups in San Diego County that is organized to respond to alternative care management agreements. Mr. Van Gorder also serves as chairman of the American College of Healthcare Executives, a professional society of more than 30,000 healthcare executives.

Robert M. Wah, MD. Robert Wah, MD, a reproductive endocrinologist and obstetrician/gynecologist, began serving as chair of the American Medical Association Board in June 2011. He practices and teaches at the National Naval Medical Center in Bethesda, Md., Walter Reed Army Medical Center and the National Institutes of Health. A nationally recognized expert in health information technology, Dr. Wah is chief medical officer for Computer Sciences Corporation and works with public agencies using technology to deliver better information for better decision-making. When he assumed his board position in June, Dr. Wah wrote in American Medical News that the AMA is working hard to champion medical ethics, oversee medical education, set standards and improve quality for physicians and medical practice. "One of the central questions to be addressed is: What will the medical profession of the future be?" he wrote. "As we answer this question, we will develop the tools, technology and services that physicians will need in the future."

William C. Weldon. William Weldon is the chairman and CEO of Johnson & Johnson, the sixth chairman in the company's over 100-year history. Mr. Weldon has spent his entire working life at J&J, joining as a sales representative in 1971. As CEO, Mr. Weldon has engineered some of the company's largest acquisitions, including the purchases of Alza and Pfizer's consumer health product line. Mr. Weldon has instigated significant financial successes during his tenure at Johnson & Johnson, including an 80 percent revenue growth since he took over the company in 2002. Under his leadership, Johnson & Johnson has popularized the concept of a "decentralized" corporate environment, meaning responsibility is given to relatively autonomous leaders in local markets. In a 2008 interview with the Wharton School of the University of Pennsylvania, Mr. Weldon said, "... the problem with centralization is if one person makes one mistake, it can cripple the whole organization. This way, you've got wonderful people running businesses." ■

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10 Steps to Maintain Control of an ASC's Central Supply Area

By Regina Robinson, RN, MBA, CMPE, CASC, Director, Peninsula Surgery Center in Newport News, Va.

An ambulatory surgery center is always looking for ways to control and reduce its costs and central supply is one area that should be monitored carefully. Each ASC has its own procedure for controlling and measuring the items in central supply and it is important to have solid steps to ensure this is ongoing. Here are 10 suggested steps to help maintain control of this very important site of an ASC.

1. One person in charge. Most ASCs have a materials management person that is responsible to keep up with all the supplies that are ordered and delivered and used daily. While there are many items stocked in the central supply area, this person should know exactly which items can be depleted quickly and watch these more often than others.

2. Keep a close inventory of the items that are used the most. These may be low-cost items or could be high-cost items but they are used more frequently than other items. As such, it may be harder to control the inventory because of the rapid turnover. The materials management personnel should be very mindful of these items, since inaccurate tracking might lead to count discrepancies and not having the item for surgery.

3. Establish PAR levels. This is a big undertaking but is very important to ensure proper levels are maintained on items so there is no shortage and overstocking is minimized. Items that sit on a shelf unused are equal to money and should be avoided if possible.

4. Stocking should be done by employees. Usually the employee in charge of ordering supplies for this area is the one that stocks the shelves. However, there are times when an item is ordered directly from a company and local reps will make the delivery and offer to stock the item themselves. While this may make the job easy for the employee, it also allows a non-employee in a restricted area. All non-employees should be escorted to the area and supervised when restocking the shelves. Some ASCs elect not to let reps in this area at all.

5. Check if the order is complete and accurate. The actual order sheet should be compared side by side with the packing slips, while unpacking the boxes. It is easy for an item to be missed and not sent by the company, or the items may be on back order. The materials management person must be alert to these potential variations that could cost the center money. The variations must be fixed immediately by calling the company or keeping track of items that are back ordered. A system should be in place to monitor the paper trail to ensure that all ordered items were delivered. If there is an item missing, this paperwork should be kept separate until the item has been received.

6. Review contracts. Ongoing review of contracts, especially implants, is very important. The prices of all items could change without notice and there could be an annual 3 percent increase built into the original contract.

7. Weekly or monthly inventory counts. This would depend on the center and the method of keeping track of the items. Some centers will do weekly inventory counts on the top 20-40 most used items and then monthly inventory on other items. The rapid turnover items can be easily overlooked and require more frequent ordering. This helps to maintain the PAR levels and keep costs under control.

8. Annual inventory. Each ASC should do an annual inventory to ensure the items on the shelf match the orders placed for that year. This type of inventory is for every item, and is measured to the individual items and not by boxes. This will let you know the amount of money you have on the shelf and the discrepancy amount from the orders placed. If the amounts differ greatly, it could signal a problem.

9. Review and compare new items. This should be an ongoing task. There are many items on the market that are comparable to each other. While some ASCs will only order a certain manufacturer's item, it is important to consider alternatives. This can be time consuming but it can be done for certain items every six months and add up to large cost savings. A comparison of these selected items should include the quality, quantity and price. A determination should be made about the quality of the item and if there is flexibility. If an item has that flexibility, then a review of different manufacturers can begin and how it relates to your current item and the effect of this change.

10. Ensure specific items meet the need. While it is a goal to minimize the selection of the same items, it is very important to make sure the items meet the needs of the patients and surgeons. Physician-owners are understanding of controlling costs and might be willing to look at alternatives that may assist in controlling or cutting costs. The owners learn to appreciate limiting the variables on products. ■

Learn more about Peninsula Surgery Center at www.peninsulasurgerycenter.com.

Average Revenue Per Case for Common ASC Specialties: 20 Benchmarking Statistics

By Rob Kurtz

Here are 20 benchmarking statistics about revenue per case — broken down by average (statistical mean) gross charges and net revenue — for common specialties in ambulatory surgery centers, based on data from VMG Health's *Multi-Specialty ASC Intellimarker 2011*. *Note:* Specialties are listed in alphabetical order.

ENT

1. Gross charges (average) — $7,433

2. Net revenue (average) — $1,761

GI/Endoscopy

3. Gross charges (average) — $3,517

4. Net revenue (average) — $778

General Surgery

5. Gross charges (average) — $6,058

6. Net revenue (average) — $1,689

OB/GYN

7. Gross charges (average) — $6,788

8. Net revenue (average) — $1,953

Ophthalmology

9. Gross charges (average) — $5,708

10. Net revenue (average) — $1,267

Oral Surgery

11. Gross charges (average) — $3,464

12. Net revenue (average) — $1,078

Orthopedics

13. Gross charges (average) — $9,398

14. Net revenue (average) — $2,585

Pain Management

15. Gross charges (average) — $4,103

16. Net revenue (average) — $955

Podiatry

17. Gross charges (average) — $7,574

18. Net revenue (average) — $1,871

Urology

19. Gross charges (average) — $6,484

20. Net revenue (average) — $1,639 ■

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.

10 Trends in ASC Payor Reimbursement & Contracting for 2012

By Rachel Fields

Reimbursement trends can impact surgery centers significantly, depending on their specialty mix and their dependence on particular payors. Eric Woollen, vice president of managed care for Practice Partners in Healthcare, discusses 10 trends that may impact payor reimbursement and contracting for surgery centers in 2012.

1. GI and pain may suffer under Medicare in 2012. Mr. Woollen says gastroenterology and pain management overall continue to take minor decreases on Medicare reimbursement this year, a trend that could signal trouble ahead for GI- and pain-driven surgery centers. When Medicare reduces reimbursement, commercial payors are likely to take notice and follow suit, meaning surgery centers that perform a high volume of low-reimbursed cases will have to be careful with costs and volume to stay profitable.

Luckily, Mr. Woollen says these two specialties may be safe because of the high volume they bring in. "GI and pain are typically still volume-driven from an operations standpoint," he says. "The more efficient you are and the quicker you can turn a room over, the more likelihood for overall positive revenues."

2. Medicare quality reporting will start in 4Q 2012. Mr. Woollen says Medicare quality reporting will begin for surgery centers in the fourth quarter of 2012. While the program does not come with financial incentives for proven quality, Mr. Woollen says the program gives ASCs "a chance to provide to Medicare that we have high-quality, cost-effective services." Building this repository of data will give surgery centers leverage in the future in lobbying for increased reimbursement from the federal government. While surgery centers are nationally recognized as a provider of high-quality care, the industry desire is to submit the data to back up these claims.

For now, data reporting is the only requirement for surgery centers, and ASCs will not be penalized for what the data indicate. For example, in 2013, CMS will ask ASCs to report whether they used a safe surgical checklist during the 2012 calendar year. As long as your ASC informs CMS that you used a safe surgery checklist, you have fulfilled the obligation. Failure to report the required data to the Medicare program in 2012 will result in reductions of Medicare payments to that facility in 2014, and failures to report in subsequent years will affect future years' payment to the same extent.

3. More commercial payors are giving the option of using an implant management service. Orthopedic-driven centers may see a trend of commercial payors offering the option of an implant management service, Mr. Woollen says. "It's something I'm seeing in proposals as we move forward with contracting," he says. "In the past, if we were able to get the implants paid, the reimbursements would come directly to the facility. Now we have these implant management services that take the risk somewhat off the facility." He says this can be beneficial for orthopedic centers trying to get implants covered or paid in the facility contract.

4. Percentage of Medicare may not be the smartest option. Mr. Woollen says while many ASC administrators pursue "percent of Medicare" as a model for their payor contracts, he does not recommend the strategy. He says the model works well when Medicare reimbursement remains relatively predictable year over year, but in the current climate of "negative pricing reimbursement changes," percent of Medicare can prove less profitable than other models. For example, if Medicare slashes reimbursement levels significantly, a contract that pays 150 percent of Medicare will suddenly become much less profitable.

5. Payors are increasingly using "homegrown" payment methodologies. Mr. Woollen says most commercial payors use their own payment methodologies that combine crosswalks from the old Medicare grouper-based methodology with more up-to-date payment determinations. He says the "homegrown" methodologies have become popular due to the number of procedures moving into the outpatient setting in recent years.

For example, procedures like spine surgery are not currently reimbursed in an outpatient ASC setting under Medicare but are reimbursed by many commercial payors. Because spine cases are unable to be performed in the ASC under Medicare, the old grouper methodology would not be helpful in setting reimbursement terms. Instead, the payors may use guidance from a myriad of different sources to determine how new procedures should be classified and reimbursed.

6. Out-of-network is shrinking, but probably won't disappear completely. While other experts have predicted an end to out-of-network reimbursement, Mr. Woollen believes out-of-network will still work for some centers. "The ability to perform OON is shrinking, whether that's the result of the types of products on the market or the ability of some commercial plans to use internal policies to not pay OON claims," he says. "I'm of the professional opinion that OON will not completely go away."

He says markets that still depend heavily on self-insured patients may be able to survive on OON reimbursement in the next few years. "When you have a fully-insured scenario, you have much more market control from the payor," he says. "When more patients are self-insured, the payor isn't taking on the risk. They're simply providing a network and performing administrative functions."

7. Dependence on a single payor is dangerous. Most ASCs should look for their case mix to come from a variety of payors, Mr. Woollen says. In certain states, a particular commercial payor may represent 90 percent of the commercial market, and surgery centers have little choice as to where their volume comes from. In general, however, surgery centers should look for a variety of payor sources, whether that means government payors or commercial insurers.

Depending heavily on Medicare or a single commercial payor can be treacherous because a unilateral rate decrease can drastically affect surgery center profitability. Medicare, which usually pays at a lower rate than commercial payors, should not make up the majority of a surgery center's payor mix unless the ASC can provide significant volume to offset the low profit margin.

8. Data is still king in negotiations. Having formerly worked for United Healthcare, Mr. Woollen says the most common error he sees ASC leaders make in payor contract negotiations is failing to review and understand relevant data. He says ASC leaders should understand their case costs down to the procedure. "Every time you do an ACL repair, every time you do a meniscus repair, you need to understand what it costs," he says. Make a spreadsheet that lists the average cost of every procedure your surgery center performs by physician, then cross-reference those costs with the terms of your payor contracts.

"At a minimum, you need to understand every time an ACL comes in, what does it mean from a particular payor?" he says. "If you can't [cover the costs on a procedure], itmay be time to open up the contract and talk to that particular payor." He says presenting this data to the payor at your contract negotiation can validate cost concerns in asking for higher reimbursement levels. Bring along data on quality, cost savings and patient satisfaction in your surgery center to tip the scale in your favor.

9. Physician re-syndication means a second look at payor contracts. If your surgery center is going through a growth phase, you

might want to take another look at your payor contracts, Mr. Woollen says. "If you're going to add a new specialty or a new physician group, you need to know what kind of cases that group is going to bring, what kind of capital equipment is necessary and what kind of supplies are necessary," he says.

Take a look at the cases coming into your center, and make a note of the short- and long-term expenses your ASC will incur by adding a new group or specialty. Once you know how much you will have to spend on your new cases, you can negotiate with the payors and propose reimbursements that make sense for each case.

10. Neck, spine and bariatrics are increasingly accepted by payors. Mr. Woollen says he sees three specialties — neck, spine and bariatrics —moving into the outpatient setting at an increasing rate due to payor acceptance. He says initially, ASC leaders could not always contract with commercial payors for neck and spine procedures because of concerns about risk. "If there's an adverse event, it's a high-acuity case, and you're talking about potential transfers to the hospital," he says. "That made payors kind of nervous. As time has evolved, we've been able to demonstrate that we screen these patients and we can provide the same high quality level of care at the ASC at a cost savings to both the plan and patient."

He says bariatrics has followed a similar path. In the past, payors preferred physicians to direct patients toward other methods of weight loss — diet and exercise, namely — before recommending weight-loss surgery. While weight-loss surgery is still hit-or-miss with commercial payors, the development of quality standards and the designation of "Bariatric Centers of Excellence" have made insurance companies more comfortable. "Payors are starting to feel more comfortable with the quality, and they're covering these procedures more often," he says. ■

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7 Goals for ICD-10 Preparation for the Next Six Months

By Rachel Fields

The official start date for ICD-10 isn't until Oct. 1, 2013, but that doesn't mean surgery centers should delay the implementation process. Rhonda Buckholtz, CPC, CPMA, CPC-I, of AAPC, discusses seven steps surgery center leaders should take over the next six months to prepare for the transition.

1. Start anatomy and physiology training for coders. Code set training should not start until 6-9 months before ICD-10 implementation, Ms. Buckholtz says. If training starts earlier than that, coders are likely to forget the information and need additional training, which would cost the center more money. Instead, coders should be focusing on anatomy and physiology training to make sure they can code to the level of specificity required by ICD-10.

Coders can take external courses in anatomy and physiology or bone up on the subject using an up-to-date textbook. Whichever method you choose, make sure to pay for training to retain coders: Once the ICD-10 implementation date rolls around, coders will be in short supply and you want to build loyalty before then.

2. Start training physicians on documentation. Physicians need to start working on ICD-10 documentation immediately, Ms. Buckholtz says. "ICD-10 has a much higher level of specificity, and some of the concepts found in ICD-10 weren't found in ICD-9."

She has conducted thousands of documentation readiness audits through AAPC and has found that about 35 percent of the time, the coder is unable to assign an ICD-10 code based on physician documentation. "Either you can't assign a code, or you can't assign one to the level of specificity that is going to be required," she says.

If physicians are hesitant to start documentation training, emphasize that if their claims do not get paid, they will be living on 65 percent of their previous revenue, she says. If you can afford to hire a consultant to perform an external audit, Ms. Buckholtz recommends this strategy. Otherwise, you can test physician documentation progress on a regular basis by asking coders to try assigning ICD-10 codes based on the information given.

3. Talk to your vendors about their transition plans. Call up your software vendors as soon as possible to talk about their ICD-10 transition plans, Ms. Buckholtz says. You should also take a look at your vendor contracts and determine whether government-mandated upgrades are considered free through your contract. Ms. Buckholtz says the price of upgrades simply depends on the company — some will offer the service for free, and some will charge a hefty fee.

Some vendors may even choose not to make the transition to ICD-10 — an issue you need to know about as soon as possible. "You don't want to be left hostage at the last minute, finding out your vendor is not going to make the transition," she says. You may also find the vendor offers the software upgrades for free, but you don't have the hardware to accommodate it. Find out your areas of need now so you can budget for any necessary purchases over the next few years.

4. Talk to commercial payors about their transition plans. Check with your commercial payors immediately to find out how they're making the transition to ICD-10. You need to know whether they are going to make changes to policies and payments so you can adjust your processes and reimbursement expectations to match. Ms. Buckholtz says you may also discover your payor offers free education on ICD-10. Call up your representative today to find out if you can take advantage of complimentary training or, at the very least, talk through the transition process.

5. Make a contingency plan for workers' comp — especially if you are orthopedic-driven. Workers' comp and auto insurance are not required to make the switch to ICD-10, which could pose problems for your surgery center if you rely heavily on them for orthopedic procedures. In most cases, the payors will probably make the switch, but you should contact your workers' comp and auto insurers anyway to find out. "Especially in orthopedic practices and centers, you need to find out whether your panels are making the decision and then make a decision on whether or not to stick with the payor," Ms. Buckholtz says.

6. Follow the "day in the life" of a diagnosis code. There are many ASC policies, procedures and software products that will be affected by the transition to ICD-10 — in fact, every piece of paper or program that contains diagnosis codes. To make sure you don't miss any areas that will be affected, go through the "day in the life" of a diagnosis code at your facility, from the first time the surgery center calls the patient to the last check-in after discharge.

"Go through and do the physical inventory to find out where the diagnosis code is tied into your center," Ms. Buckholtz says. Ask your staff members to help you in this process; chances are, your business office manager and receptionists will know where diagnosis codes live in your center and how they affect your operations.

7. Determine which policies and procedures will be affected by ICD-10. Some policies and procedures will be affected by the transition to ICD-10, especially those that require diagnosis codes on forms, Ms. Buckholtz says. For example, every time a surgery center provides a service for a Medicare beneficiary, the staff has to provide an advanced beneficiary notification. If your surgery center has made customized ABN forms for this process, you will need to adjust the code fields to fit with ICD-10. ■

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350 People in the ASC Industry to Know

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

David J. Abraham, MD. Dr. Abraham is a physician at the Reading Neck and Spine Center in Wyomissing, Pa. He is a board-certified in orthopedic surgery and a member of the American Academy of Orthopaedic Surgeons, North American Spine Society and the Pennsylvania Orthopedic Society.

Margaret Acker, RN, MSN, CASC. Ms. Acker is administrator at Southwest Surgical Center in Byron Center, Mich., and former CEO of the Blake Woods Medical Park Surgical Center in Jackson, Mich. Previously, she served as nursing supervisor/house manager at Foote Hospital and clinical nurse manager for Foote Health System (now Allegiance Health) in Jackson.

Clifford G. Adlerz. Mr. Adlerz is president, COO and director of Symbion. Before co-founding Symbion, he served as COO of Uni-Phy, as division vice president of HCA (formerly Columbia/HCA Healthcare Corporation) and as a regional vice president for HealthTrust.

Ross Alexander. Mr. Alexander is administrator at The Surgery Center of Fort Collins (Colo.), a multi-specialty ASC owned and managed by a group of surgeons, Poudre Valley Health System and SCA. Mr. Alexander began at SCFC as its business manager but was promoted to administrator a year later.

Amy Allard, BSN, MPH, RN. Ms. Allard is administrator of Ramapo Valley Surgery Center in Ramsey, N.J. The multi-specialty ASC focuses on orthopedics, general surgery, ENT, podiatry, pain management, ophthalmology, gynecology and dentistry, and performs around 4,500 cases annually.

Amir Arbisser, MD. Dr. Arbisser is an ophthalmologist and co-founder of Eye Surgeons Associates in Bettendorf, Iowa, where he also serves as board chairman. Dr. Arbisser received his MD from Baylor College of Medicine in Houston and completed his ophthalmology residency at University of Texas Health Science Center in Houston.

Richard G. Areen, MD. Dr. Areen is a highly experienced otolaryngologist who is in practice with Sacramento Ear, Nose & Throat, where he is president. Dr. Areen has directed various outpatient surgery centers and is currently president of the governing body of Sutter River City Surgery Center in Sacramento. He has been an active participant in state and federal advocacy for the ASC industry.

Dale A. Armstrong, MD. Dr. Armstrong is chairman of the board of Mason City (Iowa) Surgery Center and the president of the Mason City Clinic. He is board certified in adult and child and adolescent psychiatry. Dr. Armstrong completed his fellowship in child and adolescent psychiatry at the University of Oklahoma Health Sciences Center.

Brent Ashby. Mr. Ashby is the administrator of Audubon Surgery Center and Audubon ASC at St. Francis and Women's Surgical Center, all located in Colorado Springs. Previously, he was the administrator of the Provo (Utah) Surgical Center for seven years, and he practiced law at a large firm in Phoenix.

John Atwater, MD. Dr. Atwater is a spine surgeon at Downstate Illinois Spine Center and McClean County Orthopedics, both in Bloomington, Ill. He treats a wide range of spinal conditions and performs many types of spinal surgery. He received his medical degree from the University of Virginia in Charlottesville.

Kenneth Austin, MD. Dr. Austin is an orthopedic surgeon at Rockland Orthopedics & Sports Medicine in Airmont, N.Y. He received his medical degree from New York University School of Medicine. His expertise includes treating traumatic and sports-related injuries of the upper and lower extremities, and hip and knee replacements.

Lisa A. Austin, RN, CASC. Ms. Austin serves as vice president of ASC operations for Pinnacle III. She currently is president of the Colorado Ambulatory Surgery Center Association and serves on the surgery center advisory board of MedAssets.

David Ayers. Mr. Ayers is the CEO of Nueterra Healthcare. He has 20 years of experience developing, building and managing ambulatory facilities including surgery, imaging, physical therapy and urgent care centers. Mr. Ayres previously was vice president of a Fortune 500 company that specialized in ambulatory care product lines.

David F. Bacon. Mr. Bacon is the CEO of Meridian Surgical Partners. He has more than 22 years of experience in healthcare, previously serving as the CEO and CFO of Medifax-EDI. He also has experience in public accounting with Lattimore, Black, Morgan & Cain.

Norman Douglas Baker, MD, FACS. Dr. Baker is a surgeon at the Ophthalmic Surgeons and Consultants of Ohio in Columbus. Dr. Baker earned his medical degree from Ohio State University College of Medicine in Columbus and completed his fellowship at Emory University School of Medicine in Atlanta.

Joseph Banno, MD. Dr. Banno is the founder and co-owner of Peoria (Ill.) Day Surgery Center and is past chairman of the ASC Association and a current executive committee member. He is a board-certified urologist with the Midwest Urologist Group. He received medical degree from the University of Chicago and completed its comprehensive urology program.

Robert O. Baratta, MD. Dr. Baratta is partner and CEO of Ascent Surgical Partners in Nashville, Tenn. He is an ophthalmologist who has more than 25 years of experience managing surgery centers. He previously served as chairman and CEO of Ascent, as well as president, CEO and vice chairman of the board of directors of Ecosphere Technologies.

Gregary W. Beasley. Mr. Beasley is the president of the ambulatory surgery division of HCA and previously served as COO and senior development office, Western region, for the division. Prior to coming to HCA, he served as controller and COO at HealthSouth Medical Center (formerly Dallas Specialty Hospital).

Timothy Beluscak II. Mr. Beluscak is the administrator of Jacksonville Beach (Fla.) Surgery Center, a four-OR, multi-specialty surgery center that is part of the Symbion Healthcare family of surgery centers. He previously served as director of outpatient surgery and endoscopy at Shands Jacksonville (Fla.) Medical Center.

Scott Benglen. Mr. Benglen is CEO of Via Novus Medical, a healthcare consulting group based in Dillon, Colo. He started his career in aviation as a commercial airline pilot for United Airlines. He has also served as a financial negotiator for United Pilots' Contract 2000.

Sean Benson. Mr. Benson is the co-founder of ProVation Medical and has been involved in the company's operations since its inception in 1994. He has experience in research and development, product management, sales, marketing, business development and client services.

Fernando Bermudez, MD. Dr. Bermudez is the medical director of Eastside Endoscopy Center and the medical director of G.I. Medicine Associates in St. Claire Shores, Mich. He has served as division head of the department of gastroenterology at St. John Hospital and medical director of the endoscopy unit at St. John Hospital.

Sandy Berreth, RN, MS, CASC. Ms. Berreth is the administrator of Brainerd Lakes Surgery Center in Baxter, Minn., a multi-specialty ASC that performs general surgery,

gynecology, orthopedics, ophthalmology, facial plastics, ENT, urology, podiatry and pain management. She has been with the center since it opened in 2005.

Todd Beyer, DO. Dr. Beyer is president of Novus Clinic in Tallmadge, Ohio. He is also on the board of directors for the Ohio Association of Ambulatory Surgery Centers. Dr. Beyer specializes in LASIK and refractive surgery, oculofacial-plastic surgery and advanced cataract/lens implant surgery.

Gerald Biala, RN, MS,CNOR. Mr. Biala is a senior executive of Assay Healthcare Solutions. He has experience in management and operations of surgical and anesthesia services in both hospitals and ASCs. He has worked in a consulting role for momore than 15 years and previously served as national director for surgical services consulting for Ernst and Young.

Chris Bishop. Mr. Bishop is senior vice president of acquisitions and business development for Blue Chip Surgical Center Partners. He previously served as vice president of business development for Ambulatory Surgical Centers of America. He has 15 years of experience in leadership roles in the medical device and surgery center industries.

Jeff Blankinship. Mr. Blankinship is the CEO and president of Surgical Notes, which provides transcription services to more than 450 surgery centers and 6,500 physicians in 42 states. Under his leadership, Surgical Notes has partnered with several large ASC development and management companies and leading surgeons across the country.

Steven Blom, RN, MAHSM, CASC. Mr. Blom is the regional director for National Surgical Care, which was acquired by AmSurg corp., and executive director of Specialty Surgery Center in San Antonio. Mr. Blom began his an ICU nurse and spent most of his career in critical care and cardiac catheterization labs.

Henry H. Bloom. Mr. Bloom is the founder of The Bloom Organization, a healthcare-consulting firm devoted to providing project-related services to healthcare providers. He has structured and negotiated numerous healthcare transactions including physician practice acquisitions and divestitures and joint venture arrangements.

Robert Boeglin, MD. Dr. Boeglin, an ophthalmologist, is the board president for Midwest Eye Institute in Indianapolis and co-founder of Health Venture Management, a company that develops surgery center partnerships between physicians and Clarian Health. Dr. Boeglin attended Indiana University for medical school and completed a glaucoma fellowship at Yale University.

Tim Bogardus. Tim Bogardus is the director of ASCs for Community Health Systems. He previously served as group vice president for Nueterra Healthcare where he was responsible for the operations of seven ASCs and surgical hospitals. He was also vice president of operations for a start-up ASC company and administrator for two de novo ASCs.

Dotty Bollinger. Ms. Bollinger serves as the chief operating officer at Laser Spine Institute. In three years with Laser Spine Institute, Ms. Bollinger has established processes and procedures that have approved efficiency of care at all facilities. She was instrumental in implementing the company's electronic medical records program and has led accreditation efforts as well.

Tom Bombardier, MD. Dr. Bombardier is a board-certified ophthalmologist, Ambulatory Surgical Centers of America's COO and one of its three founding principals of the company. Before founding ASCOA, he established the largest ophthalmic practice in western Massachusetts, two ASCs and a regional referral cen-

ter. Over the past 15 years, he has been a real estate developer on Cape Cod, Mass.

Regina Boore, RN, BSN, MS. Ms. Boore is the principal and CEO of Progressive Surgical Solutions and administrator at Newport Bay Surgery Center in Newport Beach, Calif. She has more than 25 years of clinical, administrative, teaching and consulting experience in ambulatory surgery. Prior to coming to Progressive Surgical Solutions, Ms. Boore worked as a perioperative nurse, OR supervisor and ASC director.

Todd Borst. Mr. Borst is the CEO of Smithfield Surgical Partners. The company collaborates with physician partners to create and manage medical office buildings, surgical facilities and medical malls. Smithfield maintains minority ownership of its surgical facilities when construction is complete.

Bonnie Brady, RN. Ms. Brady is the administrator of Specialty Surgical Center, a multi-specialty, two-OR ASC in Sparta, N.J. Ms. Brady has served as administrator of SSC since May 2008. She previously served as a regional director of nursing for three ASCs.

Brett Brodnax. Mr. Brodnax is executive vice president and chief development officer at United Surgical Partners International. Due to his leadership, efforts and integrity, he has made USPI one of the fastest-growing ambulatory surgical chains with a portfolio of nearly 100 surgical centers and several surgical hospitals located across the country.

Michael Bukstein, MD, FACS. Dr. Bukstein is a general surgeon who serves as the board president of the Northeast Missouri Ambulatory Surgery Center in Hannibal and practices general surgery at Hannibal Clinic. He received his medical degree from University of Missouri Medical School in Columbia and completed his residency at the University of Wisconsin in Madison.

T. Taylor Burnett. Ms. Burnett is CEO and administrator of The Plastic Surgical Center of Mississippi, a physician-owned surgery center in Flowood. She started her career as a marketing major and worked as a production assistant for film and ran the office of her family's business. She later pursued a career in nursing and worked PRN in at her local hospital.

John Byers, MD. Dr. Byers is an otolaryngologist with the Surgery Center of Greensboro (N.C.) and Greensboro Ear, Nose and Throat Associates, where he has practiced since 1994. He has served on the surgical peer review and operating room committee for Greensboro-based Moses Cone Health System for 10 years and currently serves as medical director of the Surgery Center of Greensboro.

Jason B. Cagle. Mr. Cagle is general counsel for United Surgical Partners International, a healthcare facilities management and development company. Before joining USPI, he was in the corporate and securities section at Vinson & Elkins in Dallas.

Joe Cappiello. Mr. Cappiello is the chief operating officer for Healthcare Facilities Accreditation Program. He previously served as vice president of the field of operations for The Joint Commission and led his own consultancy to help healthcare facilities improve and maintain compliance with accreditation standards.

Robert J. Carrera. Mr. Carrera is the president of Pinnacle III. With more than 20 years of healthcare experience, he has spent the last 15 years developing and managing ASCs, physical/occupational rehabilitation centers, diagnostic imaging facilities and occupational medicine clinics nationally. He has been active in ASC-related legislation in Colorado, Minnesota and Utah.

John Caruso, MD. Dr. Caruso has more than 16 years of neurological surgery experience. Since completing residencies at the Eastern Virginia Graduate School of Medicine and the University of New Mexico, he has been in private practice with Neurosurgical Specialists in Hagerstown, Md.

Frank J. Chapman, MBA. Mr. Chapman is the COO of Asheville (N.C.) Gastroenterology Associates and is past president of the Medical Group Management Association Gastroenterology Administrators Assembly. He is the first non-physician to hold a seat on the practice management committee of the American Society for Gastrointestinal Endoscopy and is a member of the AAAHC board of directors.

John Cherf, MD. Dr. Cherf is an orthopedic surgeon, president of the Chicago Institute of Orthopedics, president of OrthoIndex and clinical advisor to Sg2, a healthcare intelligence and information services company. He has more than 20 years of clinical experience in orthopedics and sports medicine. He co-founded the orthopedic department at the Neurological & Orthopedic Institute of Chicago

Thomas Chirillo. Mr. Chirillo is senior vice president of corporate development at Surgery Partners. Mr. Chirillo has spent over 17 years in the healthcare industry, many of which were spent in eye care with Becton Dickinson, CIL-CO, Ioptex Research and Guidant.

Rajiv Chopra. Mr. Chopra is a principal with The C/N Group. He has prior work experience in the banking and management consulting industries. Before joining The C/N Group, Mr. Chorpa was a principal consultant in the strategic change practice of PricewaterhouseCoopers Consulting.

Raman Chopra. Mr. Chopra is principal for The C/N Group. He oversees the firm's diagnostic imaging and hospitality operations and all marketing and technology related activities. Prior to joining The C/N Group he spent seven years in strategic consulting, with his last position as director of consulting services for Equifax.

Ravi Chopra. Mr. Chopra is the president and CEO of The C/N Group, which develops, owns and operates healthcare facilities. He holds a variety of operational responsibilities, including ASC and real estate operations, and he oversees the finance and accounting for the company and its affiliates. He previously served as a principal consultant in the strategic change practice of PricewaterhouseCoopers Consulting.

Richard N. Christie, MD. Dr. Christie is a physician development manager at ASCOA and a board-certified OB/GYN with a private practice in Newport Beach, Calif. As an investor and physician at The Newport Beach Surgery Center, he has extensive personal knowledge of the ASC industry. He has been involved in real estate development in Newport Beach and Palm Springs, Calif.

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

Joe Clark. Mr. Clark serves as executive vice president and CDO for SCA. Previously, Joe served as the president and CEO of HealthMark Partners and as CEO of Response Oncology, a publicly traded cancer management company.

James H. Cobb. Mr. Cobb is the founder, president and CEO of Orion Medical Services. He previously served as CEO for the Pacific Cataract Laser Institute and Pacific Eye Center. He has been a member of the Medical Group Management Association for 20 years as well as a member of the American Society of Ophthalmic Administrators.

James R. Colgan, MD. Dr. Colgan is a member of board of managers of Sierra Surgery Hospital, a hospital/physician joint-venture surgical specialty hospital in Carson City, Nev. He has been chairman of the board for Carson Ambulatory Surgery Center, founder of Physicians Managed Care and medical director and board member of Physicians Select Management.

Daniel Connolly. Mr. Connolly is the vice president of payor relations for Pinnacle III. He performs all aspects of managed care contracting including contract negotiations, renegotiations, analysis, market analysis, implementation and compliance monitoring for ASCs in multiple markets.

Mary Ann Cooney, RN. Ms. Cooney is the administrator of Riverside Outpatient Surgery Center in Columbus, Ohio, that is managed by Health Inventures. She began her career in nursing and gained valuable experience in the hospital setting prior to joining the surgery center in 1981 as the administrator.

Christine Corbin, MD. Dr. Corbin is a GYN surgeon and medical director of the Surgery Center at Tanasbourne in Hillsboro, Ore., a Blue Chip Surgical Partners facility. She is the founder and president of Northwest Gynecology Associates. Dr. Corbin graduated from Northeastern Ohio Universities College of Medicine in Rootstown, Ohio, and completed her residency at Rush Presbyterian St. Luke's Medical Center in Chicago.

Rebecca Craig, RN, CASC. Ms. Craig is CEO of Harmony Surgery Center in Fort Collins, Colo. She began her career as a registered nurse, working at a rural hospital in the OR, PACU, gastroenterology and pain management areas. She held several management roles in perioperative services before moving into outpatient and ambulatory surgery.

Bill Cramer. Mr. Cramer co-founded Access MediQuip in 1997 and developed the business model which serves as the foundation for the company's current portfolio of strategic medical device solutions and continues his involvement in planning for the company's strategic growth. He serves as vice chairman of the board, focusing his time and energy on strategic relationships and government affairs.

Deborah Lee Crook. Ms. Crook is the administrator of Valley Ambulatory Surgery Center in St. Charles, Ill. Previously, she was director of nursing at Valley's post-surgical recovery care center before becoming administrator there and with the ASC. She began her career as a staff nurse with experience in cardiac and ICU nursing.

William Crowder Jr., MD, FACOG. Dr. Crowder helped to start the Conroe (Texas) Surgery Center in 1983 with 16 other physicians. The ASC was re-syndicated and a new larger facility was built in 2003. He has been chair of the board of managers at the new facility.

R. Blake Curd, MD. Dr. Curd is chairman of the board of directors of Sioux Falls, S.D.-based Surgical Management Professionals. He is an active proponent of physician ownership in healthcare and has served as a director for Physician Hospitals of America. He has also been a manager for Medical Facilities Corp.

David Daniel. Mr. Daniel is the vice president of operations at Baptist Health System and former CEO of Lakeland (Fla.) Surgical and Diagnostic Center. He previously served in the Navy Medical Service Corps where he managed naval hospitals and clinics. He was also administrator and COO of a large medical clinic and a physician group practice.

Urfan Dar, MD. Dr. Dar is been principal, manager and medical director of Theda Oaks Surgery Center in San Antonio, which performs

close to 10,000 cases annually. He is board certified by the American Board of Pain Medicine and the American Board of Anesthesiology.

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

Joey Daugherty, RN. Mr. Daugherty is the administrator of Total Pain Care, a single-specialty ASC that focuses on pain management procedures in Meridian, Miss. He started his career as a registered nurse in the emergency room at Rush Foundation Hospital in Meridian before transferring to the Pain Treatment Center at Rush.

D. Paul Davis, CPA, CMA. Mr. Davis serves as the president and CEO of Broomfield, Colo.-based Amblitel, a full-service back office, business intelligence and ASC consulting company that he founded in 2009. Mr. Davis has more than 25 years of healthcare industry experience and has held diverse senior leadership roles with ASC management companies.

Tom Deas Jr., MD, MMM. Dr. Deas has served as medical director of two Fort Worth, Texas-based ambulatory endoscopy centers since their development in 1995 and 2002. He is board certified in internal medicine and gastroenterology and holds a master's in medical management from UT Dallas School of Business.

Gregory P. DeConciliis PA-C, CASC. Mr. DeConciliis is the administrator of Boston Out-Patient Surgical Suites and has served as administrator of Boston Out-Patient since its inception. Mr. DeConciliis is a licensed physician assistant and previously worked at New England Baptist Hospital. He continues to remain on staff at the hospital and assists with surgical procedures at the center.

Richard DeHart. Mr. DeHart is the co-founder and CEO of Pinnacle III and has more than 18 years of experience in the outpatient healthcare industry. He provides Pinnacle III's clients with expertise in strategic planning, development and management of ASCs, diagnostic imaging and physical rehabilitation services.

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

Ann S. Deters, MBA, CPA. Ms. Deters is CEO and co-founder of Vantage Outsourcing (formerly Vantage Technology), which provides cataract outsourcing to hospitals and ASCs throughout the Midwest, South and Southeast. She also started 7D, a consulting and management service company for ASCs.

Michael Doyle. Mr. Doyle is CEO of Surgery Partners, based in Tampa and Chicago. In this role, he is responsible for overseeing the firm's day-to-day operation and expansion through partnerships. He has experience developing and managing hospitals, surgical centers and imaging centers.

Ken Drazan, MD. Dr. Drazan is a partner at Bertram Capital Management based in San Mateo, Calif., which includes GENASCIS among its portfolio companies. He has been a leader and investor in different businesses that serve the ASC market. Previously, he was the CEO and founder of Arginox Pharmaceuticals and was a leading academic liver transplant surgeon and basic scientist at Stanford University and UCLA.

Tom Ealey, CPA. Mr. Ealey is a professor and consultant at Alma (Mich.) College. He has been in healthcare for more than 30 years, working as an accountant with physician offices and long-term care organizations and then as a healthcare consultant with interests that include improving administration and regulatory compliance. He went on to serve as a practice administrator, working for two orthopedic groups and a family medicine group.

Vicki Edelman, RN. Ms. Edelman is the administrator of Blue Bell (Pa.) Surgery Center, a four-room, multi-specialty ASC that opened in Sept. 2008. She has been a nurse for 32 years and began her career in medical surgical nursing and high-risk obstetrics.

Jack Egnatinsky, MD. Dr. Egnatinsky is the president of the AAAHC Board of Officers for 2011/12. He is a board certified anesthesiologist who has held a number of academic and clinical leadership positions within his specialty. He is an instructor for the AAAHC Surveyor Training Program, has served as a medical director for AAAHC and is on the board of directors for the AAAHC Institute for Quality Improvement.

Rose Eickelberger. Ms. Eickelberger is the director of surgical services at Beacon Orthopaedic Surgery Center in Sharonville, Ohio. Ms. Eickelberger began at Beacon in May 2006. Previously, she was the director of nursing and assistant director at the Cincinnati Eye Institute.

Stephanie Ellis, RN, CPC. Ms. Ellis is the owner and president of Brentwood, Tenn.-based Ellis Medical Consulting and has provided healthcare consulting services to ASCs in that capacity since 1992. She has written many articles and spoken at numerous seminars on a wide variety of healthcare topics, including coding, billing and reimbursement issues.

Christian Ellison. Mr. Ellison is senior vice president at Health Inventures. He has formed numerous physician/hospital joint-venture partnerships and been instrumental in building Health Inventures' business domestically and internationally. Mr. Ellison was previously a senior consultant to the healthcare industry with Arthur Andersen.

Pamela J. Ertel, RN, BSN, RNFA, CNOR, FABC, CASC. Ms. Ertel oversees daily operations at The Reading Hospital SurgiCenter at Spring Ridge and serves as president of the Pennsylvania Ambulatory Surgery Association. Under Ms. Ertel's leadership, patient volume at the center increased by three percent in 2010 with no increase in supply costs due to supply standardization.

Fawn Esser-Lipp, RN. Ms. Esser-Lipp has been an RN for 14 years, serves as a certified operating room nurse, infection preventionist and OR manager at The Surgery Center in Franklin, Wis. She is also responsible for overseeing the pain management and GI endoscopy clinic, among other departments. She is an active member of AORN and APIC.

James "Jay" Etheridge Jr. Mr. Etheridge is the CEO of Implantable Provider Group. His medical industry career began in pharmaceuticals before moving to medical devices, where he has a proven track record as a results-oriented senior level operating executive with a keen understanding of the implantable medical device industry.

Carolyn Evec, RN, CNOR. Ms. Evec is the administrator at The Surgery Center at Beaufort (S.C.). Previously, she opened a surgery center in Missouri and served as the nurse manager at that location. She has 30 years of nursing experience and primarily worked in the OR.

Paul G. Faraclas. Mr. Faraclas is president and CEO of CTQ solutions. Prior to CTQ, he was vice president of ISH in Fairfield, N.J., for four years, where he helped grow the practice into the nation's largest acute care consulting firm. He also has experience as national director of sales for professional services for USInternetworking and also spent time in managed care.

Azadeh Farahmand. Ms. Farahmand is the founder and CEO of GHN-Online and principle business architect for its products. He has more than 20 years of experience in the healthcare industry, with a special focus on revenue and reimbursement.

Mark Farrow. Mr. Farrow is founder, president and CEO of Tulsa, Okla.-based Orthopedic Resources, a licensed, accredited and Medicare-approved durable medical equipment provider. He has more than 20 years of experience in the surgical device and post-operative equipment business. He is also the founder of Compression Solutions, a company of Orthopedic Resources, also based in Tulsa.

Allan Fine. Mr. Fine is the senior vice president and chief strategy and operations officer at The New York Eye & Ear Infirmary. He has previously served as the managing director at Healthios, a healthcare advisory firm in Northbrook, Ill., and as the director of Navigant Consulting.

Alisa Fischer, CASC. Ms. Fischer is the administrator of St. Augustine (Fla.) Surgery Center. Prior to St. Augustine, she served as an administrator at HCA and BayCare Health System. She also ran the OR schedule at a 16-suite OR in Lexington, Ky.

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

Robin Fowler, MD. Dr. Fowler is a pain management physician and executive director and owner of Atlanta-based Interventional Management Services. He has served as pain management advisor for several private insurance carriers and has participated in speaking engagements around the country. He is a member of the American Academy of Pain Medicine, National Pain Foundation and American Pain Society.

James L. Fox Jr., MD. Dr. Fox is the founding leader of the Ravine Way Surgery Center in Glenview, Ill., and practices at the Illinois Bone & Joint Institute. He is a board certified orthopedic surgeon who has been practicing for more than 20 years. His clinical interests include general orthopedic surgery, fracture care and arthroscopy, as well as orthopedic oncology.

Richard Francis Jr. Mr. Francis has served the chairman of Nashville, Tenn.-based Symbion Healthcare since March 2002 and as CEO of the company since its inception in 1999. Prior to his work with Symbion, Mr. Francis worked as the president and CEO of UniPhy, which operates multi-specialty clinics, independent practice associations and other outpatient services.

Brandon Frazier. Mr. Frazier is the vice president of development and acquisitions at Ambulatory Surgical Centers of America, with a focus on development of de novo ambulatory surgery centers and the acquisition of existing centers. Before joining ASCOA, Mr. Frazier worked at Smith & Nephew with an exclusive focus on ASCs.

Jim Freund. Mr. Freund is the senior vice president of business development of GENASCIS. He is a 20-plus year ASC industry veteran who has worked with more than 600 ASCs. He has experience directing sales, strategic planning and marketing.

Tom Fry, MD. Dr. Fry, a board-certified orthopedic surgeon, currently sits on the board of Lutheran Campus ASC in Wheat Ridge, Colo., a Pinnacle III facility. His practice is Colorado Hand & Arm, also based in Wheat Ridge. Dr. Fry earned his MD from Ohio State in Columbus and completed his residency at Fitzsimons Army Medical Center in Aurora, Colo.

Ed Gallo. Mr. Gallo is CEO of GENASCIS. He has more than 25 years of financial, technical and general management experience in healthcare. He is responsible for GENASCIS' rollout of its single-source revenue cycle solution for ASCs, as well as all other strategic initiatives of the company.

Tom N. Galouzis, MD, FACS. Dr. Galouzis is president and CEO of the Nikitis Resource Group. He is also a practicing general surgeon in northwest Indiana and previously served as associate staff in the department of surgery as a clinical instructor of surgery at the University of Chicago Pritzker School of Medicine.

Robert Gannan, MD, PhD. Dr. Gannan is the founder and clinical strategies advisor for Doylestown, Pa.-based Physicians Endoscopy. Dr. Gannan established Eastside Endoscopy Center as one of the first outpatient endoscopy centers in Washington. Although he retired from clinical practice in Dec. 2006, he is a regular speaker at national meetings of gastrointestinal physicians.

Nap Gary. Mr. Gary is the COO of Regent Surgical Health, where he is responsible for all operations and physician relations at the company's centers. During his more than 20 years of experience in the healthcare industry, he has served as senior vice president and assistant corporate counsel for HealthSouth. Prior to his entry into healthcare, he spent time at the Haskell Slaughter Young and Rediker law firm.

Ann Geier, RN. Ms. Geier is the senior vice president of operations at Ambulatory Surgery Centers of America and an ASCOA representative on the ASC Quality Collaboration Expert Group, which sets standards for national quality of care benchmarking. She has filled leadership positions at AAASC and Ambulatory Surgery Foundation.

David S. George, MD. Dr. George is a board-certified ophthalmologist at the Eye MDs (of George, Strickler and Lazer) and specializes in topical cataract surgery, glaucoma and diabetic eye care. He has served as a member of the board of directors for the ASC Association and the Outpatient Ophthalmic Surgery Society.

Gregory George, MD, PhD. Dr. George is founding principal of SurgCenter Development, which has developed more than 60 physician-owned ASCs under his leadership. He is also a practicing ophthalmologist. He graduated from M.I.T., received his medical degree and a PhD in ocular physiology from Duke University in Durham, N.C.

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

Bill Gilbert. Mr. Gilbert is the vice president of marketing at AdvantEdge Healthcare Solutions. In that role, he oversees product management and marketing. AHS applies technology to maximize client revenue and decrease client costs.

Scott E. Glaser, MD, FIPP. Dr. Glaser is a well-respected pain specialist and founder of the Pain Specialists of Greater Chicago in Burr Ridge, Ill. He serves as director on the national board of the American Society of Interventional Pain Physicians and was heavily involved in the lobbying efforts required to ensure passage of the NASPER bill. He still works closely with the Illinois Department of Health.

Eric Gleichman. Mr. Gleichman is an executive vice president and the chief development officer of Foundation Surgery *Affiliates*. Prior to this role, he served as FSA's vice president of legal services. He has 17 years of progressively responsible healthcare experience on both the payor and provider sides, most notably in strategic development, contract negotiations, and mergers and acquisitions.

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

John J. Goehle, CASC, MBA, CPA. Mr. Goehle founded Ambulatory Healthcare Strategies alongside Vito Quatela, MD, where he is COO. During his career, he has written several books and frequently speaks on topics related to the surgery center industry.

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

president-elect of the Physician Hospitals of America. Mr. Gosney has a diverse background in healthcare spanning more than 25 years.

Michael Gossman, BSBA, CASC. Mr. Gossman is the administrator at the Cedar Lake Surgery Center in Biloxi, Miss., a multi-specialty center. Previously, he served as administrator at Methodist Ambulatory Surgery Center in New Orleans, where he oversaw the start-up of the center. He was president of the Mississippi Ambulatory Surgery Association for four years.

Judy Graham. Ms. Graham was administrator of Cypress Surgery Center, a free-standing, multi-specialty ASC that opened in Dec. 2000. She stepped down in late November. She has a strong clinical background in the OR and ambulatory surgery and previously served as an OR manager and a clinical director in ASCs before becoming an administrator.

Michael Guarino. Mr. Guarino has been in the surgery center business for more than a decade and currently works at the Orthopedic Surgery Center of Clearwater (Fla.). An accountant by trade (and former IRS employee), he has been successful in working the day-to-day operations of ASCs, along with long-term planning.

Steven A. Gunderson, DO. Dr. Gunderson is CEO/medical director of Rockford (Ill.) Ambulatory Surgery Center. He has been affiliated with Rockford Anesthesiologists Associated, where he was a member of its board of directors and on the executive committee. He has been active in healthcare for more 30 years.

Amanda Gunthel. Ms. Gunthel is the administrator of Wilton (Conn.) Surgery Center, a two-OR, two-procedure room ASC that specializes in ophthalmology and pain management. Ms. Gunthel has been with Wilton since its inception, and before taking on the role of administrator, she worked for four years as director of practice management and development with the healthcare management firm that first opened the center.

John Hajjar, MD, FACS, MBA. Dr. Hajjar, a urologist, is the chief medical officer and chairman of Surgem. He developed one of the first ASCs in New Jersey at Fair Lawn and has been managing facilities profitably since 1992. Dr. Hajjar also operates one of the largest private urology practices in the United States.

Mark Hall. Mr. Hall is managing partner of Wasatch Healthcare Management, a Salt Lake City-based healthcare management and development company. Mr. Hall has 23 years of experience creating physician empowerment opportunities and ancillary income strategies.

David Hamilton. Mr. Hamilton is the president and CEO of Mnet Financial, based in Aliso Viejo, Calif., and has become a trusted name within healthcare collections for ASCs, imaging centers and outpatient hospitals. Since 1999, he has assisted more than 300 facilities with collections.

John Hammergren. Mr. Hammergren is chairman, president and CEO of McKesson Medical-Surgical. He also serves on the Hewlett Packard board of directors and is a member of the Business Council and Business Roundtable. He has previous experience in supply chain management.

Marilyn Hanchett, RN. Ms. Hanchett is the senior director of clinical innovation at the Association for Professionals in Infection Control and Epidemiology. She is dual-certified in infection control and healthcare quality and has spoken and written on the topic of infection control on numerous occasions. Before joining APIC, Ms. Hanchett served at CMS as infection control technical lead for the ASC program.

Kenneth N. Hancock. Mr. Hancock is the president and chief development officer of Meridian Surgical Partners. He has more than 20 years of experience in the healthcare industry developing ASCs and surgical hospitals, as well as recruiting and building relationships with physicians. He is the former executive vice president, chief development officer and co-founder of Surgical Alliance Corp.

Anne Hargrave-Thomas. Ms. Hargrave-Thomas is CE O of Lakes Surgery Center in West Bloomfield, Mich. The ASC has continued to grow despite a local struggling economy. She is a member of the Michigan Ambulatory Surgical Association and has more than 30 years of experience in healthcare and nursing.

Andrew Hayek. Mr. Hayek is the president and CEO of SCA, where he also serves on the board of directors. Prior to SCA, Mr. Hayek served as a division president at DaVita and president and COO of Alliance Healthcare Services.

Bill Hazen, RN. Mr. Hazen is the administrator of the Surgery Center at Pelham, a four-OR, two-procedure-room, multispecialty center that is a joint venture between a hospital and local physicians in Greer, S.C. He previously was director of special projects at Spartanburg (S.C.) Regional Medical Center. He also opened and developed the Hyperbaric Medicine and Wound Center at the hospital.

Tom Hearn, MBA. Mr. Hearn is senior vice president of ambulatory care at Novant Health. He previously served as chief development officer and then CEO at MedCath. He has also worked for VHA and Carolinas HealthCare System during his career.

Edward P. Hetrick. Mr. Hetrick is president of Facility Development & Management and has more than 20 years of experience in the healthcare industry. Before founding FDM, he was vice president in Healthcare Facilities Management, a firm that specializes in reimbursement consulting for physicians and outpatient hospital accounts, a position which he still holds today.

Bo Hjorth. Mr. Hjorth is the vice president of business development at Regent Surgical Health. More than half of his 20-plus years in healthcare have been dedicated to the outpatient industry. Previously, he was the vice president of operations at Community Care, where he oversaw three surgery centers in Indiana and Maryland.

Stephen Hochschuler, MD. Dr. Hochschuler, founder of Texas Back Institute in Plano, has served as president of the Spine Arthroplasty Society and founding member of the American Board of Spinal Surgery. He has served in leadership positions of several spine technology companies, including SpineMark and Innovative Spinal Technologies.

Tracy Hoeft-Hoffman, RN, MSN, MBA. Ms. Hoeft-Hoffman is the administrator at Hastings Surgery Center, a Nueterra Health facility. She has more than 20 years of experience in nursing management and administration. She is involved with the Nebraska Association of Independent Ambulatory Centers and Nebraska Medical Group Management Association.

Jeremy Hogue, JD, MBA. Mr. Hogue is the president, CEO and co-founder of Sovereign Healthcare, a privately-held company based in Orange County, Calif., that partners with physicians for the ownership and management of ASCs. He previously served as vice president of Audax Group and was an associate with Lehman Brothers.

Christopher Holden. Mr. Holden is the president, CEO and director of AmSurg. He has more than 21 years of experience in the healthcare industry, most of which he has spent in multi-facility and multi-market healthcare management. Before joining AmSurg, he served as senior vice president and a division president of Triad Hospitals.

Scott Holley, MD. Dr. Holley is the president and founder of Great Lakes Plastic & Hand Surgery in Portage and Battle Creek, Mich. He is board certified in general surgery and plastic surgery, and holds the certificate of added qualification as a specialist in hand surgery. Dr. Holley has been president of the Michigan Association of Hand Surgery.

Tracey Hood. Ms. Hood is the administrator of Ohio Valley Ambulatory Surgery Center, which is managed by ASCOA. She has been with Ohio Valley since Nov. 2007. Ms. Hood has a wide range of nursing experience, as she previously worked as an ASC charge nurse, OR circulating registered nurse, PACU nurse and certified emergency RN, among others.

Gregory Horner, MD. Dr. Horner is the managing partner of Smithfield Surgical Partners, a national ASC management and development firm, and a board member of the California Ambulatory Surgery Association. He is a fellowship-trained hand surgeon. Prior to forming Smithfield, he founded multiple ASCs.

Georganna Howell, RNFA, CNOR, CEN, LNC. Ms. Howell is nurse administrator of Greenspring Surgery Center in Baltimore, part of OrthoMaryland, which opened in 2006. Ms. Howell joined Greenspring in June 2009. She has experience as a nurse for adult and pediatric trauma.

Joseph W. (Woody) Hubbard. Mr. Hubbard is vice president of ambulatory care for Novant Health, a North Carolina Health System that includes 12 hospitals and 12 ASCs. Previously, he was chief development officer for Bariatric Partners, a single-specialty surgical services provider. Mr. Hubbard has more than 25 years in healthcare operational management and business development.

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

Thomas Jacobs. Mr. Jacobs is CEO and co-founder of MedHQ, a business office solutions provider for outpatient healthcare businesses. As CEO, he has led MedHQ from start-up to a profitable company that operates in 10 states.

Richard K. Jacques. Mr. Jacques is president and CEO of Covenant Surgical Partners and has more than 15 years in the ASC industry, including holding senior management positions with both public and private healthcare companies. He previously served as president and director of Surgical Health Group, a developer and manager of single- and limited-specialty surgery centers.

Leslie R. Jebson, CMPE. Mr. Jebson is the executive director of the Orthopaedics and Sports Medicine Institute at the University of Florida in Gainesville. After assuming the role four years ago at the new 130,000 square-foot facility, he has been a driving force in the Institute's momentous volume and market growth. The Institute now has more than 100,000 patient visits and 6,000 surgical procedures performed.

Marion Jenkins, PhD. Dr. Jenkins is founder and CEO of QSE Technologies, an IT systems integrator in Denver. He has authored more than 50 articles and presentations on the role of

technology in business, and serves on the Colorado Regional Health Information Organization Technology Advisory Committee.

Jack E. Jensen, MD, FACSM. Dr. Jensen is a board-certified orthopedic surgeon and medical director of Athletic Orthopedics and Knee Center, an integrated healthcare plaza specializing in the care of knees, and the founder of a surgery center in Houston. He has a very active role in the Texas Ambulatory Surgical Center Association and remains an extremely solid contributor to the ASC industry.

Beth Ann Johnson, RN. Ms. Johnson is vice president of clinical systems for Blue Chip Surgical Center Partners. She joined Blue Chip from LCA Vision where she was vice president of operations responsible for the growth of the ophthalmic surgery center business. Previously, she was with Aetna as a director of provider relations, recruitment and contracting.

Douglas V. Johnson, MBA. MR. Johnson is COO of RMC Medstone Capital and has served on the board of directors of Physician Hospitals of America. He is a seasoned professional and administrator with more than 35 years in the healthcare industry. He has worked in many capacities in the industry and at all levels in both freestanding and system institutions.

Jen Johnson, CFA. Ms. Johnson is a partner in professional service agreements with VMG Health. She previously served in the Forensic and Litigation Services department of KPMG, was a finance professor at the University of North Texas and did consulting work in business valuation, financial projections and operational systematizations for various companies.

Sandra J. Jones, MBA, MS, CASC, FHMA. Ms. Jones is the executive vice president and COO of ASD Management and president of Ambulatory Strategies. She previously served as regional managed care coordinator, risk manager and facility administrator for Premier Ambulatory Systems. She was also CEO and COO at for-profit hospitals and case management director for several hospitals and clinics.

Kelly Kapp, RN. Ms. Kapp is the administrator of Specialty Surgery Center of Westlake Village (Calif.). Ms. Kapp began her nursing career as an OR nurse at L.A. County Hospital. She then was an assistant at Southern California Orthopedic Institute and served as orthopedic coordinator at St. John's Regional Medical Center in Oxnard, Calif.

Mike Karnes. Mr. Karnes is the CFO and co-founder of Regent Surgical Health. He recently served as chief administrative officer of GTCR-Golder Rauner, one of the nation's largest and oldest venture capital firms. He also has been CFO for Prime Group Realty Trust and Balcor, a subsidiary of American Express.

Richard A. Kaul, MD. Dr. Kaul is president of New Jersey Spine & Rehabilitation. He is a board-certified minimally invasive spine specialist, with an expertise in the diagnosis and treatment of spinal conditions using minimally invasive techniques. He has performed more than 400 minimally invasive spinal procedures.

I. Naya Kehayes, MPH. Ms. Kehayes is managing principle and CEO of Eveia Health Consulting & Management, based in Issaquah, Wash. She previously served as regional director of operations and managed care of National Surgery Centers. She also coordinated orthopedic development in the Northwest region of the country and was a surgical hospital administrator for Columbia/HCA Healthcare Corporation.

David Kelly, MBA, CASC. Mr. Kelly is the administrator of Samaritan North Surgery Center, a multi-specialty center with four ORs and two procedure rooms in Dayton, Ohio. He joined the facility in late 2006 and has a background in finance, IT and operations.

R. Matthew Kilton, MBA, MHA. Mr. Kilton is principal and COO of Eveia Health Consulting & Management, based in Issaquah, Wash. Before joining Eveia, Mr. Kilton was CEO of Renton, Wash.-based Valley Orthopedic Associates, a division of Proliance Surgeons. He earned master's degrees in Business Administration and Health Services Administration from Xavier University in Cincinnati.

Beverly Kirchner, RN, BSN, CNOR, CASC. Ms. Kirchner is the owner and CEO of Genesee Associates. She served on the Association of periOperative Registered Nurses board of directors, has authored many AORN manuals and leads research in collaboration with the organization on violence in the nursing workplace.

Susan Kizirian, RN, MBA. Ms. Kizirian is COO of Ambulatory Surgical Centers of America and has more than 17 years of experience in ASC operations, serving as executive director and consultant for ASC management and development. She serves as lifetime past president emeritus on the board of directors of the Florida Society of Ambulatory Surgery Centers and past president of the Ambulatory Surgery Management Society.

Douglas D. Koch, MD. Dr. Koch is medical director of Baylor Vision, the refractive surgery clinical and research group at Baylor College of Medicine in Houston. He is also professor of ophthalmology at the Cullen Eye Institute at Baylor College of Medicine. He is editor of the *Journal of Cataract and Refractive Surgery* and past president of the International Intra-Ocular Implant Club and the American Society of Cataract and Refractive Surgery.

Marc E. Koch, MD, MBA. Dr. Koch is the president and CEO of Somnia Anesthesia Services, where he focuses on furthering the company's mission of offering high-quality and cost-efficient anesthesia solutions to hospitals, ASCs and office-based facilities nationwide. He co-founded the medical practice Resource Anesthesiology Associates in 1996.

Satish Kodali, MD. Dr. Kodali is an ENT physician and one of the physician owners of The Surgery Center in Franklin, Wis., a joint venture between Associated Surgical & Medical Specialists and Aurora HealthCare Ventures. He currently serves as president of The Surgery Center's board of managers and was a key player in negotiations during the joint-venture process.

Greg Koonsman, CFA. Mr. Koonsman is the founder and senior partner at VMG Health, where he specializes in valuation, transaction advisory, and feasibility. He has acted as an advisor in transactions for more than 250 hospitals, 1,000 surgery centers and 1,500 physician organizations. He founded Practice Performance, a physician management organization providing outsourced business management services.

Matthew Kossman. Mr. Kossman is a senior director at SCA. He has previous experience as a senior healthcare consulting manager at Pershing Yoakley & Associates and as senior director of finance and director of operations at DaVita. He was also director of operations and finance at Johns Hopkins Hospital.

Catherine W. Kowalski, RN. Ms. Kowalski is the executive vice president and COO for Meridian Surgical Partners. She has more than 20 years of experience in the healthcare industry and is the former executive vice president of operations and co-founder of Surgical Alliance Corp., a specialty surgical hospital company. Ms. Kowalski is also a registered nurse.

Donald Kramer, MD. With a medical practice spanning more than 25 years, Dr. Kramer has developed several successful ASCs in the Houston market. He founded Northstar Healthcare, which develops and, in conjunction with physician partners, owns and operates ASCs in concentrated markets.

Timothy Kremchek, MD. Dr. Kremchek is one of the leading shoulder surgeons in the country and is a physician with Beacon Orthopaedics & Sports Medicine in Sharonville, Ohio. He has developed plans and thoughts around operating surgery centers and building and marketing brands for orthopedic surgeons. His professional interests include advanced arthroscopic repair of shoulder and knee injuries.

Richard Kube, MD. Dr. Kube is the CEO, founder and owner of Prairie Spine & Pain Institute in Peoria, Ill. He is a fellowship-trained

spine surgeon who performs minimally invasive, motion-preserving surgical techniques, including sacroiliac joint surgery. He earned his medical degree from Saint Louis University School of Medicine and currently serves as a faculty member at the University of Illinois School of Medicine in Peoria.

Michael Kulczycki. Mr. Kulczycki is the Joint Commission's executive director for its Ambulatory Care Accreditation Program. He leads a team of dedicated staff throughout the Joint Commission who serve ambulatory customers.

Peter R. Kurzweil, MD. Dr. Kurzweil is the founder of the Surgery Center of Long Beach (Calif.) and is an internationally recognized orthopedic surgeon with expertise in arthroscopic and reconstructive surgery of the knee and shoulder and the treatment of athletic injuries. He is the fellowship director for the Southern California Center for Sports Medicine in Long Beach.

Brent W. Lambert, MD, FACS. Dr. Lambert is the principal and founder of Ambulatory Surgical Centers of America. He is a board-certified ophthalmologist and previously developed and owned three ambulatory surgical centers, including the first eye ASC in New England. Dr. Lambert is currently responsible for business development at ASCOA.

Luke M. Lambert, MBA, CFA, CASC. Mr. Lambert is the CEO of Ambulatory Surgical Centers of America, a position he has held since 2002 after having served as CFO for five years. He previously worked for Smith Barney in international sell-side equity research and at Booz, Allen & Hamilton and Ernst & Young in venture exploration and reengineering business processes.

Linda M. Lansing. Ms. Lansing is the senior vice president of operations and clinical services at SCA. She is a nurse with 38 years of healthcare experience in hospital and outpatient services, physician practice management, intensive care, pediatrics, dialysis and ambulatory surgery centers. She also serves as part of the Expert Group for the ASC Quality Collaboration.

Matt Lau, CPA. Mr. Lau is the corporate controller at Regent Surgical Health, where he brings 14 years of finance and accounting experience. Previously he held positions with Paincare America and Option Care. He earned his MBA from DePaul University Kellstadt Graduate School of Business in Chicago.

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

John W. Lawrence Jr. Mr. Lawrence is the senior vice president and general counsel for Surgery Partners, formerly NovaMed. He is responsible for all legal matters relating to the company and its operations, including structuring and negotiating all development transactions. His background is in general corporate practice with a focus in mergers and acquisitions.

Scott Leggett. Mr. Leggett is CEO of Surgery One, which manages four multi-specialty ASCs in the San Diego area. He has more than 17 years of experience in orthopedics and holds a master's degree in exercise and sports science from the University of Florida in Gainesville.

Jeffrey Leider, MD. Dr. Leider is a co-owner of Great Lakes Surgical Center in Southfield, Mich., as well as a physician and surgeon at the American Ear, Nose and Throat Institute in Farmington, Mich. He is a fellow of the American Academy of Otolaryngology and Head and Neck Surgery and has published numerous research articles during his career.

Jeff Leland. Mr. Leland is the CEO of Blue Chip Surgical Partners, a surgery center management and development company focused on bringing outpatient spine surgery to the ASC. He previously served as executive director of Lutheran General Medical Group and as a senior-level executive with Advocate Health Care in Chicago, where he was responsible for business development and Advocate's 225,000-member health plan.

Brad D. Lerner, MD, FACS. Dr. Lerner is the clinical director at Baltimore-based Summit Ambulatory Surgery Centers. He has practiced urology for more than 20 years and has served as the clinical director of ASCs. He was one of the first fertility specialists in Maryland and is highly experienced in urologic microsurgery.

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

Bruce Levy, MD, JD. Dr. Levy is CEO of Austin (Texas) Gastroenterology and serves on the Texas Ambulatory Surgery Center Society Board of Directors. He is a board-certified anesthesiologist who previously practiced at The Methodist Hospital and served on the Baylor College of Medicine faculty, both in Houston.

Michael J. Lipomi. Mr. Lipomi is president and CEO of Surgical Management Professionals. Mr. Lipomi has more than 30 years of experience in hospital and ambulatory surgery facility management. Prior to his current role, he was president of Dallas-based RMC MedStone, where he owned and managed several surgery centers and a surgical hospital.

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

Rodney H. Lunn. Mr. Lunn is the principal of the Surgical Health Group. Over the past 17 years, he has developed more than 150 ASCs throughout the United States. He is often considered the original pioneer in taking the concept of ASCs and transforming it into a practical, successful business model in dozens of states.

James J. Lynch, MD, FACS. Dr. Lynch is the president, founder and CEO of SpineNevada based in Reno, and he also serves as the director of spine service for Regent Surgical Health. Dr. Lynch is a board-certified neurological surgeon who specializes in complex spine surgery, cervical disorders, degenerative spine, spinal deformities, trauma, tumor infection and minimally invasive spine surgery.

Scott T. Macomber. Mr. Macomber is the executive vice president and CFO for surgery Partners, formerly NovaMed. He is responsible for the company's financial management, treasury and reporting functions. He has previous experience in the healthcare information technology business as CFO of Extended Care Information Network.

Neal Maerki, RN, CASC. Mr. Maerki is the administrator of Bend (Ore.) Surgery Center. He started his career with BSC in 1997 as a nurse, then nurse manager and finally as administrator. He previously worked as a telemetry floor manager and an ICU staff nurse before moving into ambulatory surgery.

Anthony Mai. Mr. Mai is the senior vice president of healthcare finance at Sun National Bank. He has more than 13 years of experience with originating transactions and has originated more than $300 million in new deals for outpatient facilities, physician groups and hospitals.

Tom Mallon. Mr. Mallon is the CEO of Regent Surgical Health, which he co-founded in 2001. He was previously a partner with Gryffindor Capital Partners and Same Day Surgery. Prior to joining Same Day Surgery, he was vice president of leasing and marketing for JMB Realty and later for Miglin-Beitler Developments, both in Chicago.

Laximaiah Manchikanti, MD. Dr. Manchikanti is the CEO of Pain Management Center of Paducah (Ky.) as well as chairman of the board and CEO of the American Society of Interventional Pain Physicians and Society of Interventional Pain Management Surgery Centers. He has been in private practice in Paducah since 1980, and has been instrumental in the preservation of interventional pain management.

Becky Mann. Ms. Mann is the director of Houston Orthopedic Surgery Center in Warner Robins, Ga. She came to Houston Orthopedic in May 2007 and was involved in the development of the center. She has been working in the medical industry for 37 years and in surgery or in post-surgical care for her entire career.

Lee James Marek, DMP. Dr. Marek is a podiatrist at North Point Surgery Center in Fresno, Calif., and associate professor at California College of Podiatric Medicine. He completed his surgical residency at Fountain Valley (Calif.) Regional Hospital.

Tyler Marsh. Mr. Marsh is executive vice president of business development at Wakefield & Associates. He was formerly the co-owner of Affiliated Credit Services and has specialized in healthcare debt collections for the past nine years. He leads the business development unit at ACS and has been responsible for expansion into several states.

John Martin. Mr. Martin is the CEO of OrthoIndy, an Indianapolis-based orthopedic practice with 14 locations around the city. The practice includes 70 orthopedic specialists who focus on joint replacement, spine care, trauma, orthopedic oncology and extremities care. The physicians of OrthoIndy also own a specialty hospital, Indiana Orthopaedic Hospital.

Lori Martin. Ms. Martin, administrator and director of nursing at SUMMIT Surgery Center, is responsible for the day-to-day operations of one of the newest surgery centers in Reno. She was an integral part of opening the center and is now focused on recruiting physicians, hiring quality staff and achieving financial success.

Reed Martin. Mr. Martin, COO of Sioux Falls, S.D.-based Surgical Management Professionals, has more than 28 years of healthcare management experience. He most recently held the position of COO in the physician services division for Nueterra Healthcare. He has also been vice president of operations for Nueterra.

Sarah Martin, RN, CASC. Ms. Martin is a vice president of operations for Meridian Surgical Partners. She has close to 30 years of healthcare experience, focusing in the ambulatory surgery area for the past decade. Prior to joining Meridian, Ms. Martin was the regional director of ASCs for Universal Health Services where she managed both ASCs and specialty hospitals. She presently serves on the board of the ASC Association.

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

Brian Mathis. Mr. Mathis is vice president of surgery at SCA, where he has served for nearly three years. In the past, Mr. Mathis served as associate and then manager at management consulting firm McLean, Va.-based Blue Ridge Partners.

Sara McCallum. Ms. McCallum is administrative director of Sheboygan (Wis.) Surgery Center, a multi-specialty surgery, endoscopy and pain management center. She has many years of experience in ASCs and has opened six surgery centers throughout her career. She worked at most of the centers in a variety of roles including executive director, director, risk manager and staff nurse.

Rob McCarville, MPA. Mr. McCarville is a principal with Medical Consulting Group. He has an extensive portfolio in the field of healthcare facility management, administration and strategy. He previously built a strong reputation by developing innovative strategies to increase profitability during his time overseeing 16 separate physician practices.

Bernard McDonnell, DO. Dr. McDonnell is a physician surveyor and team captain for Hospital Facilities Accreditation Program. Dr. McDonnell has experience surveying acute care hospitals, critical access hospitals, ASCs and stroke centers. He is a retired physician, having spent a large part of his career as an otolaryngologist in Philadelphia.

Kevin McDonough. Mr. McDonough is a senior manager at VMG Health, where he has provided valuation, transaction advisory and operational consulting services for clients. He has served as a consultant in the formation and development of several physician-hospital joint venture initiatives.

Dawn McLane, RN, MSA, CASC, CNOR. Ms. McLane is the regional vice president of Health Inventures in Broomfield, Colo. During her career, she has served with Aspen Healthcare and as CDO for Nikitis Resource Group. During that time, she participated in the management and development of more than 20 surgery centers.

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

Todd Mello. Mr. Mello is partner and co-founder of HealthCare Appraisers in Castle Rock, Colo. He has more than 20 years in healthcare finance and valuation experience. He previously served as vice president of business development for a neuro-musculoskeletal physician management company.

Cathy Meredith, RN, BS, CASC. Ms. Meredith serves as vice president of finance for ASCOA. Her ambulatory systems expertise extends to physician offices, where she has set up office-based operation rooms, endoscopy suites and pulmonary function and cardiac testing labs.

Tyler Merrill. Mr. Merrill is a physician development manager for ASCOA. Prior to joining ASCOA he worked as a sales representative for Pfizer Pharmaceuticals. In addition to traditional sales training, he has experience developing business strategy for online start-ups as well as storefront ventures.

Keith Metz, MD. Dr. Metz is the medical director of Great Lakes Surgical Center in Southfield, Mich., which includes four ORs and one procedure room. He is a clinical anesthesiologist and he has served on the board of directors for the ASC Association. Dr. Metz earned his medical degree at Wayne State University in Detroit.

Thomas A. Michaud, CPA. Mr. Michaud is the CEO of Foundation Hospital *Affiliates*. Prior to founding FHA's parent company, Foundation HealthCare *Affiliates*, in Jan. 1996, he held the positions of COO and CFO of a regional surgery center management company. During his career, has also developed bariatric centers.

Evelyn S. Miller, CPA. Ms. Miller is the vice president of development for United Surgical Partners International. Before joining USPI, she was executive vice president of Medway Health Systems, overseeing the financial operations of its medical clinics.

Steve Miller. Mr. Miller is the director of government and public affairs with the Ambulatory Surgery Center Association. Before joining ASCA, he was the director of OPHTHPAC and political affairs for the American Academy of Ophthalmology. He also was the senior director of legislative affairs for the American Health Care Association.

T.K. Miller, MD. Dr. Miller is the medical director at Roanoke (Va.) Ambulatory Surgery Center and physician with the Roanoke Orthopedic Center, which merged with the Carilion Clinic in Nov. 2009. He has subspecialty experience in sports medicine, arthroscopy and knee and shoulder reconstruction.

Krystal Mims. Krystal Mims is president of Texas Health Partners. She is responsible for the overall management of five managed facilities. She has been with Texas Health Partners since its inception.

Kristian M. Mineau II. Mr. Mineau is the president and CEO of Constitution Surgery Centers, based in Newington, Conn., which operates 12 ASCs in the surrounding area. He co-founded CSC in 1997 and has led the company's growth for more than 10 years. He was also the founding president of the Connecticut Association of Ambulatory Surgery Centers.

Theresa Mizzitti, MHA, MBA, CASC. Ms. Mizzitti is the administrator of Eastside Surgery Center, a multi-specialty surgery center in Columbus, Ohio. The center is a joint venture between physicians and OhioHealth and is managed by Health Inventures. She has served as administrative director for Consolidated Health Services and was practice administrator for University Orthopaedic Physicians.

Steve Mohebi. Mr. Mohebi is the chief development officer of Smithfield Surgical Partners in Rocklin, Calif. Along with his colleagues, Mr. Mohebi manages the company in developing medical office buildings, surgical facilities and medical malls. Smithfield maintains ownership of the surgical facilities after helping during the construction phase..

Melodee Moncrief, RN, BSN, CASC. Ms. Moncrief is the administrator for the Big Creek Surgery Center in Middleburg Heights, Ohio. She has been with the center since Oct. 2005 and helped with the development, initial staff hiring and start-up of the center. She has more than 15 years of experience in the ASC industry and previously served as an administrator of another center.

Yvonda Moore, MBA, CHFP. Ms. Moore is the director of implementation at GENASCIS, a Los Angeles-based company that provides billing, coding and transcription services to ambulatory surgery centers. She has more than 20 years of experience in healthcare accounting/finance and business office operations.

Amy Mowles. Ms. Mowles is president and CEO of Mowles Medical Management. She has successfully guided numerous new ventures and established ASCs and physician practices through the complicated maze of regulations, licensing, certification and accreditation processes.

Cindy Moyer. Ms. Moyer is the administrator of the Surgery Center of Pottsville (Pa.), a multi-specialty, two-OR center. Ms. Moyer has been with the center since it opened in 2006. She previously ran an ENT and allergy practice for 21 years and prior to that worked with an internal medicine group.

Tom Mulhern, MBA. Mr. Mulhern is the executive director of Limestone Medical Center, a large medical office building complex and ASC in Wilmington, Del. He has been a leader in the development of ambulatory surgical services and as an advocate for the industry.

Rob Murphy. Mr. Murphy is founder, president and CEO of Murphy Healthcare Group in Montvale, N.J., and New York City. He has played a key role in the turnaround of more than 30 ambulatory surgery centers. His ASC turnaround group specializes in revitalizing, restructuring and acquiring underperforming ASCs in the United States.

James E. Mutrie. Mr. Mutrie serves as vice president, assistant general counsel and compliance officer for United Surgical Partners International, an owner and operator of more than 165 surgery centers and surgical hospitals. In his position, Mr. Mutrie is responsible for legal, governance and corporate compliance matters at USPI's facilities.

Robert Nucci, MD. Dr. Nucci is a fellowship-trained spine surgeon and founder of Nucci Spine & Orthopedics Institute in Tampa, Fla. He helped develop and implement minimally invasive surgical techniques and serves as an international speaker on spine surgery. He is a member of the American Academy of Orthopaedic Surgeons and the North American Spine Society.

David W. Odell, CPA. Mr. Odell is the founder and president of MedBridge Surgery Center Billing, which has been providing comprehensive billing services exclusively to ASCs for more than 10 years. As a CPA by trade, Mr. Odell has over 12 years' experience in the ASC industry, with a focus on maximizing net revenue through enhanced billing and collection processes.

Joan F. O'Shea, MD. Dr. O'Shea is a dually trained neurosurgeon and spine surgeon and

founder of The Spine Institute of Southern New Jersey in Marlton. She has published several papers on treatments for patients suffering from spinal cancers and complex spinal disorders. She has been an invited lecturer for the American Association of Neurological Surgeons and is a member of the North American Spine Society and Women in Neurosurgery.

Jon O'Sullivan. Mr. O'Sullivan is a senior principal and founding member of VMG Health. He has experience in transactional advisory services in the healthcare market, financial valuation and joint ventures. He previously founded PracticeTech, a provider of network technology solutions and support within the healthcare industry.

Mike Orseno. Mr. Orseno is the revenue cycle director at Regent Surgical Health, based in Westchester, Ill. He focuses on monitoring and testing components of the revenue cycle process to ensure compliance and accuracy. He previously served as the revenue cycle administrator for the Chicago Institute of Neurosurgery and Neuroresearch.

Scott Palmer. Mr. Palmer is the president and COO of the ambulatory surgery center division of SourceMedical Solutions, based in Wallingford, Conn. He has more than 25 years of experience working with outpatient healthcare facilities, having been the founder and president of Temple Information Systems. He also founded Prescient Healthcare Systems and helped launch CTQ Solutions.

Michael Pankey, RN, MBA. Mr. Pankey is the administrator of the Ambulatory Surgery Center of Spartanburg (S.C.). He previously served as administrator and clinical resources manager in multiple locations. Mr. Pankey also served as the president of the South Carolina Ambulatory Surgery Center Association.

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

Charles Peck, MD, FACP. Dr. Peck is the president and CEO of Health Inventures, based in Broomfield, Colo., where he actively oversees the company's growth in outpatient surgery partnerships as well as physician practice management and inpatient perioperative management with hospitals and physicians. He has more than 30 years of healthcare experience as a clinician, internist, rheumatologist, scientist and other roles within the healthcare environment.

Ron Pelletier. Mr. Pelletier is vice president of market strategy for SourceMedical Solutions. He has experience in the operational and design aspects of technology systems for outpatient surgery. He has helped several facility operators select and implement systems and has designed procedures and protocols for better returns on system investments.

Jeff Péo. Mr. Péo is the vice president of acquisitions and development for the Ambulatory Surgical Centers of America. He graduated from Brigham Young University in Provo, Utah, with a degree in manufacturing engineering. Prior to joining ASCOA, Mr. Péo ran a knowledge management and IT consulting division for a Fortune 100 company.

Linda Peterson. Ms. Peterson is the CEO of Executive Solutions for Healthcare, based in Chandler, Ariz. She has more than 30 years of experience in development and operational management of healthcare organizations. Her main areas of expertise include design and development of new business and product lines as

well as merger and acquisition experience in the ambulatory service sector.

Kenneth Pettine, MD. Dr. Pettine is the co-founder of Rocky Mountain Associates in Orthopedic Medicine in Loveland, Colo., and the founder of the Society for Ambulatory Spine Surgery. He has an extensive background in spinal surgery, research and rehabilitation and is board certified. Dr. Pettine co-invented, designed and patented the Maverick Artificial Disc.

Stanford R. Plavin, MD. Dr. Plavin has served as a member of Ambulatory Anesthesia of Atlanta since its inception and has been the managing partner for the last several years. He is an active member of local and state anesthesia societies and is the immediate past president of the Greater Atlanta Society of Anesthesiologists.

Thomas J. Pliura, MD, JD, PC. Dr. Pliura is a physician and attorney at law with the company he founded, zChart, an electronic medical records-related company based in LeRoy, Ill. He has also served as founder and manager of four ASCs. In 1998, he sought and received the first favorable Medicare Advisory Opinion in the country, certifying that a proposed ASC was exempt from Stark Laws under a rural provider exemption.

John Poisson. Mr. Poisson is the executive vice president of Physicians Endoscopy, based in Doyleston, Pa. During his more than 17 years of healthcare experience, he has served in senior management positions within both corporate development and operations roles. Prior to Physicians Endoscopy, Mr. Poisson was vice president of client services at Transcend Services and vice president of new business development at Coastal Physician Group.

William A. Portuese, MD. Dr. Portuese is the current president of the Washington ASC Association and Washington State Chapter of Facial Plastic Surgeons. He specializes in plastic, cosmetic and reconstructive surgery of the face and neck and has studied recent advancements in facial cosmetic surgery, including tissue adhesive techniques and lower eyelid surgery without external incisions.

William Prentice, JD. Mr. Prentice is the executive director of the ASC Association and Ambulatory Surgery Foundation. He previously served as senior vice president of government and public affairs at the American Dental Association and vice president of a New Jersey public affairs firm. He has more than 17 years of experience working with healthcare organizations.

Vito Quatela, MD. Dr. Quatela co-founded Ambulatory Healthcare Strategies and serves as CEO. He developed and owns two ASCs in Rochester, N.Y., and founded HUGS, a non-profit organization that does medical mission trips to third-world countries. He is a board-certified facial plastic and reconstructive surgeon and is the immediate past president of the American Academy of Facial Plastic and Reconstructive Surgeons.

David J. Raab, MD. Dr. Raab is on the board of managers at the Illinois Sports Medicine & Orthopedic Surgery Center and is a fellowship-trained sports medicine physician with Illinois Bone & Joint Institute, both in Morton Grove. His professional interests include total joint replacement, arthroscopy and pediatric orthopedics. He also serves as an assistant professor at Northwestern University Medical School in Chicago.

Lori Ramirez. Ms. Ramirez is the founder, president and CEO of Elite Surgical Affiliates and previously served as a senior vice president with United Surgical Partners International where she was directly responsible for developing the second-largest network of surgical facilities for the company. In this role, Ms. Ramirez oversaw 20-plus surgical facilities.

Michael R. Redler, MD. Dr. Redler is a founding partner of The Orthopaedic and Sports Medicine Center in Fairfield, Conn. He is a fellowship-trained orthopedic sports medicine and hand surgeon. He serves as an orthopedic consultant to Major League Lacrosse and associate clinical professor for the department of physical therapy and athletic trainers at Sacred Heart University in Fairfield, Conn.

J. Michael Ribaudo, MD. Dr. Ribaudo is the founder, chairman and CEO of Surgical Synergies and has more than 27 years of experience as a surgeon, healthcare executive and real estate developer. He has served as executive vice president of Surgical Health and HealthSouth Surgery Centers. He has served on the board of directors for Flow International and chaired its compensation committee.

Gary A. Richberg, RN, ALNC, CRN-A/C, CASC, CAPPM. Mr. Richberg is the administrator at Pacific Rim Outpatient Surgery Center in Bellingham, Wash. He previously served as an administrator of the Institute of Orthopedic Surgery in Las Vegas and has spent time in the United States Navy as a hospital corpsman.

Rosalind Richmond. Ms. Richmond is the chief coding compliance officer for GENASCIS, a company that provides billing, coding and transcription services to ambulatory surgery centers. She has more than 30 years of experience as a coding and HIM consultant. During her career, Ms. Richmond also served as the data quality committee chair for Colorado Health Information Association.

Patrick Richter. Mr. Richter is the vice president of business development for United Surgical Partners International. Prior to joining USPI, he spent 13 years serving in various capacities at Baylor Health Care System in Dallas, most recently as the vice president of business development. Mr. Richter received a master's degree in taxation from Texas A&M University.

Herbert W. Riemenschneider, MD. Dr. Riemenschneider is the principal physician and urologic surgeon at Riverside Urology in Columbus, Ohio. He is also a clinical assistant professor of urology at The Ohio State University's College of Medicine and is the director of urologic education at Riverside Methodist Hospitals, both in Columbus. Dr. Riemenschneider performed the first prostate cryoablation in Ohio in 1993 and continues to perform the procedure today.

Anne Roberts, RN. Ms. Roberts is the administrator at the Surgery Center at Reno. She began her career as a nurse in the emergency department, spending 16 years as a staff nurse and 10 years as the manager of a busy ED seeing 55,000 patients annually.

Regina Robinson. Ms. Robinson is the director and administrator at Peninsula Surgery Center in Newport News, Va. Services at the surgery center includes general surgery, gynecology, orthopedics, otolaryngology, pain management and plastic surgery. The ASC includes electronic medical records and electronic patient monitoring throughout the facility.

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

Lisa Rock. Ms. Rock is the president of National Medical Billing Services, which specializes in freestanding outpatient surgery center coding and billing. She has been in the healthcare field for 23 years.

Paul L. Rohlf, MD. Dr. Rohlf began practicing at Urological Associates in 1969. After a long and successful career serving thousands of patients, he retired from the practice in 2007. During his career, he served as president of the American Association of Ambulatory Surgery Centers. He was the initial urologist who obtained the first surgery center certificate of need for a center in Iowa and remains a strong leader in the ASC industry following his retirement.

Jay Rom, MBA, CPA. Mr. Rom is the president of Blue Chip Surgical Partners. Before joining Blue Chip, he served as CEO of a cardiology group in Cincinnati with 15 physicians and was vice president for physician services of the Franciscan Health System, where he was responsible for a 60-physician multi-specialty group.

Michael Romansky, JD. Mr. Romansky is the

Washington Counsel and vice president of corporate development for the Outpatient Ophthalmologic Surgery Society. He has practiced exclusively in health law, representing healthcare providers, companies and organizations. He also has served as the Washington counsel to many other medical specialty and health trade associations.

Stephen Rosenbaum. Mr. Rosenbaum is CEO for Interventional Management Services. He has more than 15 years of healthcare experience working with physicians and physician-owned facilities. Prior to joining IMS, he created SourceRevenue, an independent healthcare consulting company.

Kenneth L. Rosenquest. Mr. Rosenquest is the senior vice president of operations at Constitution Surgery Centers, based in Newington, Conn., and oversees the company's hospital joint ventures. He served as administrator of one of the top performing orthopedic surgery centers in the country and has experience in all aspects of ASC management from operations to billing to equipment acquisition.

Michael Rucker. Mr. Rucker is the executive vice president and COO of SCA. He has previous experience as a divisional vice president of operations at DaVita, where he was responsible for physician practice management and dialysis services. He has also worked in public accounting as a CPA.

Cathy Rudisill. Ms. Rudisill is a partner at Nelson Mullis Riley & Scarborough, with more than 20 years of experience in commercial real estate and financial transactions. Her practice includes working with joint ventures and development agreements and she has published several law-related articles in professional publications.

Blayne Rush. Mr. Rush is president of Ambulatory Alliances, a boutique investment banking, business brokerage and strategic advisory firm for surgery and radiation oncology centers. With more than 15 years experience in healthcare, he has completed acquisition searches for more than 200 healthcare clients, ranging from physician-owned cancer centers to large corporations focusing on the oncology market.

Michael E. Russell II, MD. Dr. Russell is a spine surgeon at Azalea Orthopaedics in Tyler, Texas. He serves on the board of directors and as president of Physician Hospitals of America and Texas Spine and Joint Hospital in Tyler. He earned his medical degree at the University of Southwestern Medical School in Dallas a completed a spine surgery fellowship at The Carolinas Medical Center at Charlotte (N.C.).

Mary Ryan, RN. Ms. Ryan is the administrator of Tri State Surgery Center, a multi-specialty facility in Dubuque, Iowa. Currently managed by Health Inventures, the center was launched in 1998 by Medical Associates Clinics and Health Plans and Mercy Hospital. Ms. Ryan has also served as regional director during her tenure with Health Inventures.

Dan Saale. Mr. Saale is the executive vice president and CFO of Nueterra Holdings. He oversees all the financial activities of the company and directs the financial services within each of Nueterra's physician partnership ventures. He was previously vice president of finance for Health Midwest.

Karen Sablyak, CPA. Ms. Sablyak is CFO and executive vice president of management services at Physicians Endoscopy, which develops and manages endoscopic ASCs. She has directed a transition to a paperless A/R billing system and strives to enhance performance through the company's payor contracting services, group purchasing discounts and performance benchmarking.

Nader J. Samii. Mr Samii is CEO of National Medical Billing Services, a leading revenue cycle outsourcing company focused strictly on ASCs. He was the co-founder and president of revenue cycle company, Ajuba International and has also worked as a corporate finance attorney and an investment banker at both Merrill Lynch and UBS.

Kuldip S. Sandhu, MD, FACP, FACG. Dr. Sandhu is a gastroenterologist at the Sutter Roseville (Calif.) Endoscopy Center in and is president of Capitol Gastroenterology Consultants Medical Group. He completed his internship and his residency in internal medicine at MLK-Drew Medical Center in Los Angeles.

Tona Savoie, RN. Ms. Savoie is administrative director of Bayou Region Surgical Center in Thibodaux, La. The ASC operates as a 50-50 partnership between physician investors and a subsidiary of the local community hospital, Thibodaux Regional Medical Center. It is managed by ASD Management.

John Schario, MBA. Mr. Schario is CEO of Nueterra Healthcare and brings together the extensive resources that let Nueterra develop, operate and nurture ambulatory care facilities including ASCs and surgical hospitals. Her managerial background includes the development and operation of surgery centers, imaging facilities and occupational medicine clinics.

Bob Scheller Jr., CPA, CASC. Mr. Scheller is the COO of the Nikitis Resource Group. In the past 15 years, he has been involved in the development and management of more than 50 surgery centers. He is currently responsible for nationwide development, management and consulting services for NRG.

Donald Schellpfeffer, MD. Dr. Schellpfeffer is CEO of Medical Facilities Corp., and has more than 18 years of experience in ambulatory surgical environments. He is currently medical director of Sioux Falls Surgical Center, which he co-founded, and president of Anesthesia Associates, the largest anesthesia services provider in South Dakota.

Robert M. Schwartz, JD. Mr. Schwartz is managing director of strategic resources with Proliance Surgeons. He is a former senior administrator at Yale New Haven (Conn.) Hospital and former senior vice president of American Medical Response.

Bruce A. Scott, MD. Dr. Scott is the medical director of SurgeCenter of Louisville (Ky.) and serves on the physician leadership team for SCA. Dr. Scott is a board-certified otolaryngologist and founder and president of Operative Ventures.

Matt Searles. Mr. Searles is the managing director of Merritt Healthcare, a company he has served with for more than 10 years. He has managed and advised dozens of healthcare facilities. His background includes experience in corporate finance and venture capital-backed companies.

Phenelle Segal, RN, CIC. Ms. Segal is the president of Infection Control Consulting Services. She has more than 28 years of experience in infection prevention and control, and has led the State of Pennsylvania's mandatory Healthcare-Associated Infections Advisory panel. She also provides consulting services to ASCs, an acute care hospital and nursing home facilities.

John Seitz. Mr. Seitz is the co-founder, chairman and CEO of Ambulatory Surgical Group. He has more than 25 years of experience in healthcare, having previously co-founded and served as president of Surgem, based in Oradell, N.J. He previously founded and served as CEO of Cornerstone Physicians.

Caryl Serbin, RN, BSN, LHRM. Ms. Serbin is executive vice president and chief strategy officer for SourceMedical, which provides clinical and business software solutions for ambulatory surgery centers. She was founder and CEO of Serbin Surgery Center Billing, which was recently acquired by SourceMedical as the core of their new billing division, Revenue Cycle Solutions.

David Shapiro, MD. Dr. Shapiro is a partner with Ambulatory Surgery Company, an ASC consulting company. In addition to his time as a practicing anesthesiologist, he has served on the board of directors for the Ambulatory Surgery Center Association and chaired the Florida Society of Ambulatory Surgery Centers.

Jeffrey Shanton. Mr. Shanton is the director of billing at Journal Square Surgical Center in Jersey City, N.J. He is an ASC industry activist and has met with New Jersey lawmakers on ASC-related legislation. Previously, Mr. Shanton served as director of billing for American Surgical Centers.

Joshua A. Siegel, MD. Dr. Siegel is the sports medicine director at Access Sports Medicine & Orthopaedics in Exeter, N.H., and the founding partner and managing member of Northeast Surgical Care. He has treated professional, national and Division I collegiate athletes and has mastered the latest techniques in arthroscopic surgical treatments of the knee, shoulder and elbow.

Jeffrey Simmons. As chief development officer for Westchester, Ill.-based Regent Surgical Health, Mr. Simmons is responsible for overseeing the company's acquisition and development of surgery centers. He began his healthcare career more than 25 years ago as vice president of marketing at American Medical International, overseeing business development for 18 hospitals.

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

Bill Simon. Mr. Simon is co-founder and vice president of Innovative Healthcare, which he founded in 1995. He also developed the Pain & Rehabilitation Medical Group, a 7,000-square-foot outpatient facility located in the South Bay of Los Angeles. He holds a bachelor's degree in finance, as well as a juris doctorate, and is currently a member of the State Bar of California.

Thomas A. Simpson, MD, FACS. Dr. Simpson is chairman of the board of directors for the Iowa City Ambulatory Surgery Center and led the board of this multi-specialty ASC as it came together to plan and develop the ASC with Mercy Hospital. He also serves as president of the board of directors for Mercy of Iowa City Regional PHO and is a former president of the Iowa Academy of Otolaryngology.

Carol Slagle, CASC. Ms. Slagle is the administrator of Specialty Surgery Center of Central New York, managed by ASCOA. She was in the first group to take the CASC credential test and previously worked in the medical sales field. She recently oversaw the ASC as it made major expansion and renovation.

John Smalley. Mr. Smalley is a current special consultant and former principal with Healthcare Venture Professionals. He has more than 30 years of experience with both public and private healthcare organizations. Prior to co-founding HVP with partner Chuck Owen, Mr. Smalley served as senior vice president for Quorum Health Resources and its predecessor companies.

Brooke Smith. Ms. Smith is administrator of the Maryland Surgery Center for Women in Rockville, an ASCOA center. She successfully took a struggling ASC and turned it into a safe, profitable and professional facility, increasing collections from $70,000 a month to $240,000 and decreasing days in A/R to 25 days.

Sheldon S. Sones, RPh, FASCP. Mr. Sones is president of Sheldon S. Sones and Associates, a pharmacy and accreditation consulting firm based in Newington, Conn. Established in 1985, the group, serving more than 100 sites in five states, specializes in safe medication management and pharmacy consulting to freestanding and hospital-based ambulatory surgical, endoscopy and renal dialysis centers.

Kenny Spitler. Mr. Spitler is chief development officer for Interventional Management Services. In his role as CDO for IMS, he oversees all development activities for the company, including syndications and acquisitions. Mr. Spitler previously served as senior vice president – development for HealthMark Partners.

Donna St. Louis. Ms. St. Louis currently serves as a vice president for ambulatory services at BayCare Health System. Before joining BayCare, she was a group president for Symbion and responsible for more than 45 ASCs.

Jimmy St. Louis III, MBA. Mr. St. Louis is the chief corporate operations officer at Laser Spine Institute in Tampa, Fla. Laser Spine Institute includes four surgery center locations in Tampa, Philadelphia, Scottsdale, Ariz., and Oklahoma City. Surgeons at Laser Spine Institute perform a proprietary minimally invasive endoscopic spine surgery.

Donald E. Steen. Mr. Steen founded United Surgical Partners International in Feb. 1998 and served as its CEO until April 2004. He continues to serve as chairman of the board of directors and the executive committee. He is also a general partner at Walsh, Carson, Anderson & Stowe.

Marc Steen. Mr. Steen is market president in Atlanta for United Surgical Partners International, where he oversees six USPI ambulatory surgery centers in the Atlanta market, along with management responsibilities for Resurgens Orthopaedics. He previously served as vice president of development and operations in Arizona and Nevada markets.

John C. Steinmann, DO. Dr. Steinmann treats traumatic spinal injuries as well as degenerative problems of the neck and low back. He is the director of Spine Trauma at Arrowhead Regional Medical Center in Calton, Calif., as well as an assistant clinical professor at Western University.

Steven H. Stern, MD, MBA. Dr. Stern is vice president for Cardiac & Orthopedics and Neurosciences at UnitedHealthcare. He is a board-certified orthopedic surgeon subspecializing in adult reconstruction. At UnitedHealthcare, he is

responsible for issues relating to musculoskeletal care including joint arthroplasty surgery.

Jim Stilley. Mr. Stilley is the CEO of Northwest Michigan Surgery Center, a multi-specialty surgery center in Traverse City, Mich. He has been with NMSC for 4.5 years. Prior to coming to the surgery center, he was an executive director with National Surgical Care and served as a lieutenant commander in the U.S. Navy.

Debra Saxton Stinchcomb, RN, BSN, CASC. Ms. Stinchcomb is a consultant at Progressive Surgical Solutions. She previously served as director of operations preparation and transition management for Health Inventures. She has also held positions as an ASC administrator, assistant regional vice president and regional vice president.

Stephanie L. Stinson, RN, BSN, CASC. Ms. Stinson is administrative director for Strictly Pediatrics, a pediatrics-only ASC in Austin, Texas, managed by ASD Management. Working as a nurse for 17 years, she served as a staff nurse in the neurosurgical intensive care unit, surgery and recovery rooms.

C. Scott Stone. Mr. Stone is the executive vice president and chief financial and administrative officer for Source Medical Solutions. He has experience as COO of Nelson Brantley Glass Contractors and as group vice president of eBusiness and internet operations at HealthSouth.

Lewis Strong, MD. Dr. Strong is the president of the Skyline Endoscopy Center in Loveland, Colo., a Pinnacle III facility. He earned his MD and completed his internship, residency and fellowship at Case Western Reserve University in Cleveland. Dr. Strong was a founding member of the local physician's health organization and served as its president for four years.

Shaun Sweeney. Mr. Sweeney is the vice president of sales at Cygnus Medical, a company that specializes in products and services for the endoscopy suite, operating room and sterile processing department.

Alsie Sydness-Fitzgerald, RN, CASC. Ms. Sydness-Fitzgerald is on the board of directors for the ASC Association and participated in the development of the Certified Administrator Surgery Center credential. She has built up outstanding experience in the clinical, business and management aspects of the ASC industry as the director of clinical operations for HCA's ambulatory surgery division.

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

Kevin Tadych, MD. Dr. Tadych is medical director Northwoods Surgery Center in Woodruff, Wis., a Pinnacle III facility. His practice is Northern Wisconsin Bone & Joint in Minocqua, and consists of general orthopedics with a focus on sports medicine, carpal tunnel syndrome, spine disorders and joint replacements.

Barry Tanner. Mr. Tanner has been president and CEO of Physicians Endoscopy, based in Doylestown, Pa., since 1999. The company currently manages 17 endoscopy centers. He previously co-founded Navix Radiology Systems, helping the company grow to more than $75 million in revenues, and was COO of HealthInfusion.

Vivek Taparia. Mr. Taparia is director of business development for Regent Surgical Health, which develops, manages and invests in surgery centers. He performs due diligence on new business opportunities and leads strategic initiatives for the company's centers. He previously developed marketing strategies for a surgical product line at Johnson & Johnson.

Larry Taylor. Mr. Taylor is president and CEO of Practice Partners in Healthcare, based in Birmingham, Ala. He previously served as president and COO for a large provider of ASCs and has worked with physicians on projects ranging from acute care to diagnostics, physical rehabilitation and outpatient surgery centers. Mr. Taylor entered healthcare as a certified athletic trainer and focused on delivery of sports medicine and orthopedic care.

Larry Teuber, MD. Dr. Teuber is the founder and physician executive of Black Hills Surgery Center, one of the country's most successful small surgical hospitals, and is a board-certified neurological surgeon. He is president of Medical Facilities Corp., and the founder and managing partner of The Spine Center in Rapid Falls, S.D.

David Thoene. Mr. Thoene is a founder of Medical Surgical Partners. Prior to that, he was the vice president of business development for Titan Health. He has 24 years of experience consulting for and developing ASCs along the West Coast, including the turnkey development of ASCs, hospitals and medical office buildings. He has developed surgery center investments for physicians, academic medical centers and health systems.

Dan Thomas. Mr. Thomas is the president of Provista, a group purchasing company. He is the former CEO of VIant, a large independent PPO network. Before that, he was chairman of the board of directors at Concentra and served as the company's president and CEO.

Joyce (Deno) Thomas. Ms. Thomas is senior vice president of operations for Regent Surgical Health. Before joining Regent, she served as the executive director of Loveland (Colo.) Surgery Center and worked for HealthSouth as a regional director of quality improvement and as an administrator.

George Tinawi, MD. Dr. Tinawi is a co-founder of Surgery Center Partners and its management subsidiary, Endoscopy Management Services Organization. He was a practicing physician in Mountain View, Calif., from 1986-2004, developing a clear understanding of the business issues faced by physicians in today's challenging environment.

William Tobler, MD. Dr. Tobler is a neurological surgeon and president and director of neurosurgery at The Christ Hospital Spine Surgery Center in Cincinnati. He earned his medical degree from University of Cincinnati College of Medicine and is a member of numerous professional organizations, including North American Spine Society and Congress of Neurological Surgeons.

Daniel J. Tomes, MD. Dr. Tomes is a neurological and spine surgeon, and president of Southwest Lincoln (Neb.) Surgery Center, a Blue Chip Surgical Partners facility. He serves on the board of directors for Madonna Rehabilitation Hospital in Lincoln and is the medical director for Gogela Neuroscience Institute, BryanLGH Medical Center in Lincoln.

Kimberly L. Tude Thuot, MAOM, CMPE. Ms. Tude Thuot is the administrator and executive of Yakima (Wash.) Ambulatory Surgical Center, a three-OR, physician-owned, multispecialty ASC. She began as a nursing and dental assistant before moving into administration at dental practices.

Arnaldo Valedon, MD. Dr. Valedon is the chief ambulatory division and managing partner of First Colonies Anesthesia Associates in Baltimore. He is a diplomate of the American Board of Anesthesiology and currently serves on the ASC Association's Program Committee for ASCs for 2011.

LoAnn Vande Leest, RN. Ms. Vande Leest is clinical director and acting CEO of The Surgery Center in Franklin, Wis., a joint venture between Associated Surgical & Medical Specialists and Aurora Health Care Ventures. The Surgery Center has five operating suites, four procedure rooms, two endoscopy GI suites, areas for pre- and post- surgery observation, and a recovery area.

Pedro Vergne-Marini, MD. Dr. Vergne-Marini is founder and managing member of Physicians' Capital Investments, which is based in Plano, Texas. It has developed and constructed 14 medical office and clinical facilities in just its first three years. More than 500 physicians have invested in PCI projects. The company currently has 11 projects in development or construction.

Jonathan Vick. Mr. Vick is founder and president of ASCs Inc., which is based in Valley Center, Calif., and has assisted in development, merger and acquisition transactions for more than 200 physician-owned ASCs, endoscopy centers and surgical hospitals. He previously founded and was a principle shareholder of Surgery Center Development Corp., as well as a corporate partner for a national network of surgery and endoscopy centers.

George A. Violin, MD. Dr. Violin is a board-certified ophthalmologist and one of the three founding principals of Ambulatory Surgical Centers of America. He owned and developed two ASCs and a large, multiple-office ophthalmic practice in eastern Massachusetts.

Jeffrey L. Visotsky, MD, FACS. Dr. Visotsky is a member of Illinois Bone and Joint Institute and founder of the Morton Grove (Ill.) Surgery Center. He is a board-certified orthopedic surgeon and specializes in conditions of the hand, elbow and shoulder, arthroscopy shoulder/elbow, shoulder reconstruction and replacement, among other areas.

Kara Vittetoe. Ms. Vittetoe is an administrator, Thomas Johnson Surgery Center in Frederick, Md., an ASCOA center. Surgeons at the ASC focus on general surgery, gynecology, neurospine, podiatry and urology. She has served with the center since it opened in 2008.

Brice Voithofer. Mr. Voithofer leads the anesthesia, pain management and surgery center division of AdvantEdge Healthcare Solutions. He is responsible for operations, client support and growth. He has experience in managing radiology, anesthesia and pathology practices and previously served at medical billing and payor firms in several capacities.

Jack Wagner. Mr. Wagner is president and CEO of Micro-Scientific Industries, a company focused on producing products to prevent microbial transmission in the healthcare industry. The company produces products for hand care, medical and surgical equipment and instrumental disinfection, ultrasonic care and delicate blade cleaners.

Dianne Wallace, RN, BSM, MBA. Ms. Wallace is the executive director of the Menomonee Falls (Wis.) Ambulatory Surgery Center. She has administrative experience in hospitals, home health, medical groups and ambulatory surgery. She has been president of the Wisconsin Surgery Center Association and the MGMA ASCA executive committee.

Randy Ware. Mr. Ware is the president and founder of West Coast Medical Resources, a medical supplies surplus company. He is co-founder and previously served as vice president of Custom Orthotic Laboratory and has experience in the payroll processing industry.

Michelle Warren, RN, BBA. Ms. Warren is the executive director of Powder River Surgery Center in Gillette, Wyo. She began her career in healthcare as a surgical tech and has spent many years as an operating room traveling nurse, working mostly in trauma, orthopedic, spine and open heart specialties.

Michael Weaver. Mr. Weaver is a vice present of acquisitions and development at Symbion. He is a nationally recognized speaker on surgery center and physician-owned hospital acquisitions and development, and is a contributor to several national trade publications.

Drigan Weider, MD. Dr. Weider is a board member of Boulder (Colo.) Surgery Center, a Pinnacle III facility. His practice is Mapleton Hill Orthopaedics in Boulder. Dr. Wieder has developed a specialty in sports medicine and a strong interest in arthroscopic shoulder and knee reconstructions.

Robert Welti, MD. Dr. Welti is senior vice president of operations for Regent Surgical Health. He previously served as the medical director and administrator of the Santa Barbara Surgery Center and also was affiliated with Santa Barbara Cottage Hospital for 20 years.

Robert Westergard, CPA. Dr. Westergard is the CFO of Ambulatory Surgical Centers of America. He previously served as the controller for Truman Capital Advisors and has experience in finance and accounting in the software, chemical and healthcare industries

Thomas Wherry, MD. Dr. Wherry is co-founder of Total Anesthesia Solutions. In addition to his roles as medical director for the Surgery Center of Maryland in Towson and consulting medical director for Health Inventures, he has collaborated with professionals in the United Kingdom, Japan and Kuwait to improve the delivery of ambulatory surgery.

Kathleen Whitlow, RN, BS, CASC. Ms. Whitlow serves as COO for Blue Chip Surgical

Center Partners. She joined the company as a partner and vice president of operations. She has more than 25 years of experience in the medical/healthcare industry, working in a variety of capacities and positions.

William H. Wilcox. Mr. Wilcox serves as the president and CEO of United Surgical Partners International. He previously served as CEO of United Dental Care, president of the Surgery Group of HCA and president and CEO of the ambulatory surgery division of HCA.

Donald Wilson. Mr. Wilson founded a predecessor to Cirrus Health in 1996 and now serves as Cirrus' CEO. Over the last 10 years, his focus has been exclusively devoted to the development of medical operations platforms and medically oriented real estate projects.

Kimberly L. Wood, MD. Dr. Wood is co-chair of the ASC Quality Collaboration and founder of kmdWOOD, which provides consulting services to the ASC industry. She has participated in several collaborative and cooperative initiatives, including the ASC Advocacy Committee and the ASC Coalition.

Terry Woodbeck. Mr. Woodbeck is the CEO of Tulsa (Okla.) Spine & Specialty Hospital. He has more than 30 years of healthcare experience, including physician practice management, clinic administration and research in the field of capitation rates and managed care contracting. He previously served as CEO of Oklahoma Spine and Brain Institute in Tulsa.

Kim Woodruff. Ms. Woodruff is the vice president of corporate finance and compliance at Pinnacle III, based in Fort Collins, Colo., and is a member of the Healthcare Billing Management Association. She previously served as practice manager for a group of psychologists and business office manager and controller for an outpatient physical and occupational therapy practice.

Tom Yerden. Mr. Yerden is CEO and founder of TRY HealthCare Solutions in Salmon, Idaho. He has experience developing more than 70 surgery centers and founding Aspen Healthcare. He has also served in executive positions with several healthcare systems and large physician group practices.

Cindy Young, RN, CASC. Ms. Young is the administrative director of the Surgery Center of Farmington (Mo.), where she started as a staff nurse and moved into the administrator position. She previously was a nurse at a rural hospital.

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

Joseph Zasa, JD. Mr. Zasa is a managing and founding partner ASD Management, based in Dallas and Los Angeles, where he works with existing ASCs that require turnaround expertise as well as developing new outpatient surgery centers. He previously served as the president of the Texas Ambulatory Surgery Center Association and continues to serve on the board.

Robert Zasa, MAHHA, FACMPE. Mr. Zasa is a managing and founding partner of ASD Management, which has bases in Dallas and Los Angeles. His career spans more than four decades of managing and developing ASCs. He is a fellow in the American College of Medical Practice Executives.

Becky Zigler-Otis. Ms. Zigler-Otis is the administrator of the Ambulatory Surgical Center of Stevens Point (Wis.), a position she has held since Jan. 2008. Before coming to the center, she worked at Bay Area Medical Center in Marinette, Wis., where she held many positions over a 10-year period.

J.A. Ziskind, JD, MBA, PhD. Mr. Ziskind is the founder, president and CEO of Global Surgical Partners, which focuses on developing and managing hospital/physician and physician-owned joint-ventured ASCs. He has been actively involved in Florida's healthcare industry over the past 35 years, having served as CEO of Cedars Medical Center and as a healthcare lawyer.

Greg Zoch. Mr. Zoch is managing director and a partner with Kaye/Bassman, where he has marketed healthcare organizations and been involved in recruitment. His primary focus is on the strategic growth and staffing initiatives of client companies that develop, manage, consult with or own and operate ASCs and specialty hospitals.

Chris Zorn. Mr. Zorn is vice president at Spine Surgical Innovation, global distributor of the Swivel Port MIS System. He is also executive director of Minimal Incision-Maximum Sight (MIMS) Institute, which aims to increase the awareness about the Swivel Port and help physicians and administrators network with other specialists with common challenges, among other services.

Bryan Zowin. Mr. Zowin is president of Physicians Advantage, based in Jacksonville, Fla. The company provides the Comprehensive Asset Protection Solutions program to help physicians with planning and implementing advanced wealth preservation and accumulation strategies.

Faris Zureikat. Mr. Zureikat is an administrator at North Texas Surgery Center in Dallas. The ASC is accredited by the Joint Commission and includes specialists in dental and oral surgery, orthopedic surgery, ophthalmology, podiatry, urology and pain management, among others. ■

Lessons From 35 Years in the ASC Industry: Q&A With Cypress Surgery Center Cofounder and Administrator Judy Graham

By Rachel Fields

Judy Graham, the administrator and cofounder of Cypress Surgery Center in Wichita, Kan., stepped down in late November after 35 years in the ambulatory surgery center industry. Ms. Graham began her surgery center career in 1976, as a registered nurse at the second surgery center in the nation. She started there as a PRN and moved quickly into the role of clinical director. While at Surgicare, Ms. Graham was named by HCA — the ASC's majority owner — as the company's "operating room director of the year."

In 2000, Ms. Graham left Surgicare to help a group of physicians start Cypress Surgery Center. She helped build the center from the ground up, filling the ORs with cases and eventually expanding to a multi-specialty ASC with six ORs and two endoscopy suites. In 2010, the center performed 10,900 procedures; Ms. Graham expects more than 11,400 in 2011. Here she discusses her career as an ASC administrator, the lessons she's learned and the importance of physician and employee satisfaction to a well-run center.

Q: How have you seen healthcare change in the last 35 years? What has been the most challenging time in healthcare during your tenure?

Judy Graham: I think I'd have to agree with other ASC leaders that this is one of the most challenging times in healthcare. I think the last four years in our industry have been the toughest due to the economy. Folks don't have insurance, and elective surgeries go to the back burner until they have more money or insurance coverage comes back into the field. That's probably the time I've seen it be the most challenging.

Before the last four years, I think the industry as a whole and locally was quite productive. We were successful here in Wichita. The surgery center I worked at in the beginning [of my career] — Surgicare — was the second ASC in the nation. The biggest thing to happen since then has been the transition of cases that you can do in an outpatient setting. The complexity of the cases has increased, and we've seen advances of anesthesia drugs that have made it easier for patients to wake up and get out of the center after an hour or two.

The acceptance of the ASC industry has also increased. In the beginning, ASCs were seen as a place to do wisdom teeth and other small surgeries. They were seen as a "flash in the pan" that wouldn't last. I think it's phenomenal how far we've come in this many years, especially considering the kinds of cases we do now. In some states, being able to keep patients for 23 hours has also changed our complexity of cases tremendously. [In Kansas], we can now do hysterectomies and other surgeries that require a 23-hour stay. That has been a good change for us.

Q: What has been your most significant success in terms of cutting costs?

JG: The one thing I can think of off the top of my head is trying to educate physicians as to what things cost. In most centers, the surgeons are investors, and I think if they know and can see what things cost, they tend to realize that it's going to cost them in the long run. This doesn't mean cutting costs in terms of jeopardizing patient quality of care, but instead doing things that are more cost-effective. Physicians don't always need the extra fluff that they think they need.

I think you can educate surgeons by being visible in the center and just by talking to them. If you see one surgeon's case costs going up, pull him aside and say, "Hey, we don't want to limit you on what you use, but we want you to realize what these things cost. If you do understand, we're more than happy to use them. We want to accommodate your needs." Just have a personal conversation with them without being confrontational. Most of the time, if they understand how much supplies cost, they're willing to make a change.

Of course, with new advances in surgery, there are devices nowadays that you just can't cut costs on. If you're using [Gynecare Thermachoice] or MyoSure, those devices are expensive and there's no way to cut the costs. You just have to grin and bear it.

Q: How has your case mix/specialty mix changed over the years? Have you found some specialties are more successful or profitable for your ASC than others?

JG: This doesn't apply to every state, but in our state, one new specialty we added that we found fit really well — and had good reimbursements — was dental rehab. I had never looked at it before because I thought it tied up your operating rooms for a long period of time. But with our reimbursements here in Kansas, it's been a really good fit for us, and we do a pretty high volume of those cases.

Other cases that have always worked well are orthopedics, ENT and GYN. Those are the three basics we've found to work best. Our case mix has shifted a bit, and we do a lot more pain management now that we didn't used to do. That's a good fit for us. But for the most part, the basic cases have remained ortho, ENT, GYN and general surgery.

Q: What was the process like for adding dental rehab to your ASC?

JG: It's pediatric dental rehab, so we just looked for a pediatric dentist that was performing those cases and would be interested in doing it at the center versus the hospital. A lot of dentists do the cases in their offices, but we just went out and recruited our dentist and explained how good it would be for patients to do cases at the center. I've always thought that if you get a surgeon into our center and show him how things go here, we'll be able to keep him. The pediatric dentist has been very happy.

There are some costs involved in implementing dental rehab, but we were very fortunate in that he brought all his own equipment. We had no upfront capital expense. If you don't have someone who will bring in their own equipment, there will be an upfront capital expense — but your payback would be very quick if reimbursements were like they are in Kansas.

Q: What have been your biggest challenges as an ASC administrator? How did you handle them?

JG: I always think the biggest challenge is to keep your surgeons happy. You need to make them feel special, and you need to make them want to come to the surgery center. They have a lot of choices, and you need to respond to their needs and not waste their time because there's always someone looking for them elsewhere. Our biggest challenge has been to keep volume up and be responsive to physicians. You also need

to be responsive to employees, so that they stay at your center after you train them. It's costly to train new employees. And of course, we always concentrate on giving great patient care.

Q: What do you find physicians want to know about, and what would they rather you took care of by yourself?

JG: They want to hear what's going on in the center. If they're investors, they want to hear how the center is doing and whether there are any problems. But most of all, they want to come to a place where they know the staff knows their routine, where patients get quality care and where their time isn't wasted. They should feel special when they walk in the door. They should feel that we want them there and we love them and we'll do everything we can to make sure their time there is enjoyable. If you don't have the surgeons, you don't have the cases.

Q: What have you learned about leading people as an ASC administrator?

JG: I think building relationships over the years has been really important with the staff. Staff members are the strength of any organization, and they really are the heart of the organization. If they're not happy, your center will never be successful. I think one thing I've found is not to sit in an office — to instead put scrubs on, know what's going on in your center and get your hands dirty. There's nothing worse to me than an administrator with "princess syndrome" who doesn't know what's going on in the center.

We do what it takes to get the cases done. When the staff sees that I'm [willing to pitch in on a case], they realize that anything I ask them to do, I'm willing to do also. I think that's wonderful — I know administrators have a whole other side of the job, where they have to crunch numbers and do the financials and sit in the office a certain amount of time. But being in the OR and the clinical areas where staff can see you makes a huge difference. And of course, they all want to be treated with respect.

Q: What advice would you give to new ASC administrators coming into the industry?

JG: Know your business. Study your business and know what goes on in your center. Know the ASC industry. Know your physicians, take good care of them and learn what they want and what they like. As far as taking care of your employees, understand them, know them well and make sure they know that you'll do whatever it takes to get the job done in the center. Pay attention to detail. You need to know all your key cost indicators to keep your costs where they need to be. Understand what drives a center's success. Keep supply costs under control as well as salaries and benefits, because those are your two biggest costs.

Achieve a vision for the future of the center. Know where you want to go and what your goals are. This means understanding your caseload volume, what your costs are going to be, how you're going to recruit new physicians and what you can do to keep salary costs down. Flexible staffing has been very important for us in this economy. Nobody wants to let people go, so you need to help your staff understand that on slower days, you have to flex staffing a bit. It's huge to keep those costs under control. And finally, just make sure you keep getting physicians and cases in the door. ■

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10 Steps to Add a Gastric Lap-Banding Service Line to a Surgery Center

By Rachel Fields

In 2008, North Star Surgical Center in Lubbock, Texas, added a gastric lap-banding service line to its cadre of procedures. Though the service line has been put on hold temporarily, due to the untimely death of an ASC physician in May 2011, Mr. Brock says the first few years of the program enjoyed significant success.

"In the articles I read about the best procedures for an ASC, neuro is always up there and orthopedics is always up there, but this should be there too," he says. "It's a great procedure for an ASC. It's safe, we've had outstanding outcomes and it's not overly expensive." Here he shares 10 steps involved in adding a gastric lap-banding service line to a multi-specialty surgery center.

1. Determine a need. The first step in adding a gastric lap-banding line is to determine whether your community needs the service, Mr. Brock says. The Lubbock, Texas, medical community is comprised of about a million people because the city draws patients from west Texas and eastern New Mexico. As the largest medical market between Albuquerque, New Mexico, and Dallas/Fort Worth, Lubbock has a large number of patients who might potentially seek lap-band surgery.

Mr. Brock says the community also has a surprising dearth of physicians who perform the procedure. These reasons indicate that the community has a significant "need" for a lap-band service. If your community is smaller in size and already has several well-known physicians offering lap-band services, the procedure may not be as profitable for your surgery center.

2. Achieve buy-in from your physicians and medical director. To add any service line, you need to talk to your physician-partners and gain their approval, Mr. Brock says. He said in order to achieve buy-in, the most important thing is to be completely transparent about the service line you plan to add. "You want to be totally transparent — in other words, what is the procedure going to cost you, and what do you stand to realize from a revenue perspective? What are the risks involved?"

He says in addition to your physicians, it's also important to gain buy-in from your medical director and director of nursing, as they will be heavily involved in implementing the service line.

3. Outline the costs. Before you seriously consider adding a service line, you must know whether it will be profitable, Mr. Brock says. Go over the costs of the procedure as well as your expected reimbursement from your payors. "The greatest costs in doing this procedure are the medical supplies — the band and other medical supplies on top of that," he says. "You should know how long the procedure takes so you can calculate how much your staffing costs will be." Mr. Brock estimates that the gastric lap-banding procedure takes about 1.5-2 hours, depending on the surgeon.

4. Assign a bariatric coordinator and a practice liaison. Mr. Brock says the addition of gastric lap-banding requires two extra roles at the ASC: a practice-ASC liaison and a bariatric coordinator. He says these positions are critical if your ASC wants to earn a Bariatric Center of Excellence designation, a mark of high quality that some payors require to cover the procedure. Mr. Brock hired a liaison and assigned the bariatric coordinator duties to an OR charge nurse who already worked at his surgery center.

The liaison functions as a communicator between the physician practices and the ASC and serves as the contact person for the patient, Mr. Brock says. When patients come in through the website, the liaison pulls those names, contacts them, works with them on their insurance and coordinates informational sessions about the procedure. The bariatric coordinator oversees the clinical aspects of the procedure and makes sure everything is performed to the correct standard of care.

5. Expand your online presence and marketing. Mr. Brock says gastric lap-banding is unique in that patients often use the internet to find physicians, rather than talking to their friends or going through a referring primary care physician. "These patients go and seek out lap-banding on the internet by looking at reviews of doctors," he says. "You have to allocate expense dollars to the promotion of the procedure." He says his surgery center hired a web expert to redesign the website, develop an SEO strategy and reach out to the weight-loss community.

Mr. Brock says his center also markets the procedure by holding seminars to inform patients of their options. "We do two seminars a month locally, and [our physician] also did them in Amarillo, Texas, and Albuquerque," he says. "People come to the seminars, and it's the first step toward changing their life."

6. Develop strict patient admission criteria. Because gastric lap-banding treats patients who often have significant co-morbidities, the patient admission criteria needs to be thorough, Mr. Brock says. Ask your anesthesia provider and surgeon to collaborate and draw up patient criteria

based on industry standards and experience. For example, patients may need to undergo sleeping tests to detect the presence of sleep apnea before coming to the ASC for surgery.

Patients with other significant co-morbidities, such as heart problems, may also not be appropriate for surgery at a freestanding ASC. The FDA standard for lap-band surgery is a minimum BMI of 30 with at least one weight-related health condition, though most private insurance companies won't cover gastric surgery in otherwise healthy people with a BMI under 40.

7. Plan to handle patients paying cash. Understand that many gastric lap-banding patients will want to pay for their procedure in cash, Mr. Brock says. "Some insurance companies don't cover it, which is frankly mind-boggling," he says. "It's not an overly expensive procedure, and all it does is improve enrollees' health going forward." Until insurance companies start to cover the procedure more frequently, he says, ASCs must prepare for patients to cover the bill themselves. He says his surgery center has brought in Care Credit, which offers a healthcare financing plan to the patient to assist them in paying for the procedure.

8. Determine what payors will ask from you. Payors are becoming more comfortable with bariatric surgery, but you still may have to jump through hoops to negotiate a profitable contract, Mr. Brock says. "A lot of payors require that patients show they've done a year's worth of work to lose the weight on their own before covering the procedure," he says. This means you may need to work with the patient to prove prior weight-loss attempts before the payor will cover the procedure.

Mr. Brock recommends gaining an understanding of how each of your payors reimburses for gastric lap-banding. If a patient comes to the surgery center with payor X, for example, you want to know whether the payor covers the procedure, what you will have to do to get the procedure covered and whether you will be able to negotiate carve-outs. Mr. Brock says carve-outs are important for gastric lap-banding to cover the cost of the actual lap-band.

9. Make sure anesthesia providers are comfortable treating obese patients. Most anesthesia providers should have experience treating patients with co-morbidities, but it's worth your time to sit down with your anesthesiologists and discuss their comfort level with obese patients. "These patients have breathing issues and occasional sleep problems, and that's the obvious difference in how these patients are treated," Mr. Brock says. "An anesthesiologist who is knowledgeable of the factors that come into play in taking care of obese patients would be able to perform this case." The anesthesiologist should also be involved in the development of surgical criteria to make sure patients with excessive co-morbidities are sent to the hospital instead of the surgery center.

10. Develop a good relationship with your device manufacturer. Mr. Brock says his surgery center has benefitted from a good relationship with Allergan, the company that manufactures and sells the lap-band they use. He says the device company has been helpful in sharing best practices with the facility and helping the ASC grow the service line. In order to create a good relationship with a device company representative, he says it's important to establish trust and help both parties realize that a mutual beneficial outcome is possible. ■

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15 New Benchmarks on ASC Administrator Compensation

By Rachel Fields

Here are 15 new statistics on ASC administrator salary, based on data from VMG Health's *Multi-Specialty ASC Intellimarker 2011*.

1. Mean salary: $109,184

Based on location

2. West United States: $114,109

3. Southwest United States: $100,779

4. Midwest United States: $104,372

5. Southeast United States: $110,311

6. Northeast United States: $109,268

Based on size

7. 1-2 operating rooms: $95,750

8. 3-4 operating rooms: $106,271

9. More than four operating rooms: $109,286

Based on case volume

10. Less than 3,000 annual cases: $101,850

11. 3,000-5,999 annual cases: $104,998

12. More than 5,999 annual cases: $109,448

Based on net revenue

13. Less than $4.5m annually: $100,942

14. $4.5m-$6.99m annually: $105,942

15. More than $6.99m annually: $113,100 ■

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10 Ways to Improve Profitability for Pain Management

By Abby Callard

Pain management is a specialty in flux. Not only are more chronic pain sufferers seeking out treatment, but the release of a recent Center for Disease Control report, which found more people die from prescription drug overdoses than heroin and cocaine combined, has created a backlash over opioid prescriptions and a call for alternative treatments.

"We're in an era where pain management is high profile," Robert Saenz, CEO of Tulsa Pain Consultants and president of VIP Medical Consulting, says. "There are many more patients walking through the door. I believe that out of chaos, there is opportunity."

Richard Kube, MD, CEO, founder and owner of Prairie Spine and Pain Institute, says part of that opportunity is creating an integrated pain practice.

"There's a vast opportunity to capture a market which is a very, very good performance margin for your practice," he says.

By changing the way Tulsa Pain Consultants operated, Mr. Saenz increased the center's revenue by about $10 million annually. Here are 10 steps for a pain management center to increase profitability. Some of these are easy fixes, such as automating telephone calls, and others involve a fundamental shift in the way a practice operates.

1. Increase patient volume. The first step to increasing profitability in a pain management practice is to generate more patients, says Scott Anderson, COO, Prairie Spine and Pain Institute. Most patients come to a pain management practice on referrals from primary care physicians, so one way to increase patient volume is by generating more referrals from primary care physicians.

"When you're considering generating new patients, the clinical model is as important or more important than any other component of the practice," he says. "What clinical services are you going to provide that create a unique story that makes the referring physicians want to send you 100 percent of their patients with a pain condition? When you have built a strong relationship with multiple providers, your interventional business will be dramatically enhanced."

2. Hire a physician liaison. Once a practice establishes what primary care physicians want and works toward providing that, someone has to tell the primary care physicians that the services are available. Hiring a physician liaison is an effective way to do this, says Mr. Anderson.

"This person should be out in the field five days a week, buying lunches for and interacting with the primary care physician community," Mr. Anderson says.

A well trained and highly motivated physician liaison should be able to add 50-75 referrals to your practice (or ASC) every month. The ideal person for the job holds a four-year degree in an allied health field such as functional or behavioral health. They should have an outgoing personality and be very comfortable meeting and speaking with people. Mr. Anderson says to stay away from people with nursing degrees or experience as a pharmaceutical representative.

3. Communicate with primary care physicians. Communication with primary care physicians who refer patients is key and will ensure that physicians continue to refer to your facility, says John Bookmyer, CEO of Pain Management Group, a management company in Findlay, Ohio.

"Providing timely reports and updates to referring physicians and primary caregivers and specialists is critical and included in every step of our pain management care plan," he says. "We see our relationships with referring physicians as partnerships. They know their patients' history and needs, and we bring insight, support and treatment to an area that many primary care physicians do not have training and a comfort level with."

4. Provide the referring primary care physicians with the clinical services they want. This is where many pain practices have fallen short, Mr. Anderson says.

"The number one thing a primary care physician is looking for is to meet the needs of their chronic pain patient population by taking over the management of that patient's condition," Mr. Anderson says. "When you take over the management of that patient's condition, you will see a significantly higher number of referrals." Of course you will need to build a team to manage this new influx of patients and their unique needs, as your specialists cannot afford to coordinate care for this patient population.

Dr. Kube estimates that 95 percent of pain management practices operating today are moving toward a procedure-based model instead of an integrated care model.

"A lot of the pain practices are trying to become very much in tune with and involved with doing procedures all the time," he says. "As such, the very reason for primary care physicians to refer the patient to you in the first place is being diminished by most pain practices. Chronic pain management is a part of pain management. If you're going to be a pain center, you really have to do all of it."

Providing comprehensive pain management services also ensures that practices aren't losing pieces of revenue such as physical therapy, behavioral therapy, durable medical equipment and other clinical services. With this model, Mr. Anderson estimates the revenue per patient life will grow from $2,500 to $10,000-15,000 using a fully integrated facility based care model

5. Maximize physician case load. Once the practice establishes a pipeline for referrals, all the physicians need to be working at their capacity in order to maximize procedures and make sure the practice can handle the increased case load. One way to do this is by ensuring every staff member is working at his or her pay grade, says Mr. Saenz. For example, physician assistants should not be taking patients from the waiting room to the procedure room. A less-qualified staff member can handle that so the physician assistant can concentrate on higher-level tasks. This will trickle up to the surgeons themselves, and they will have more time to be doing procedures, Mr. Saenz says.

Although he has found resistance among physicians, Mr. Saenz says increasing case load is not about rushing procedures but rather speeding up the other aspects of a visit such as registration, insurance verification, setting a patient up in a room and discharge.

"If you reduce the wait time, you're able to accommodate more flow," he says. "Pain management is a volume-driven practice. Let's say an epidural steroid injection could take 10-15 minutes depending on the doctor, if you add on another 15 minutes of unnecessary processing time, you just cost yourself one more patient that you could have seen. If you can add one patient per hour, that's 15 more procedures a week. If you do the math, it starts accumulating over a year."

6. Offer cutting-edge treatments. Part of creating a unique story for referring physicians is being able to perform all pain management procedures such as spinal cord stimulator implants and radiofrequency ablation.

Mr. Saenz says the returns for physicians are favorable for both of these procedures.

Francis Riegler, MD, co-founder of Universal Pain Management, says that because there are only three medical device manufacturers of spinal cord stimulator devices, the market is highly competitive. He recommends practices check with other vendors in their area to make sure they are getting the best price. There are also rebate programs for these devices.

7. Incorporate anesthesia. Mr. Saenz has also seen some practices incorporating anesthesia into some of their procedures when it's medical necessary. Anesthesia can add increased revenue when compared to no sedation or conscious sedation.

"The important thing to remember here is that this has to be based on a patient-by-patient case and strict protocols should be adhered to in order to abide by regulatory requirements and standard of care," says Mr. Saenz.

8. Maximize the center's use of space. At Tulsa Pain Consultants, Mr. Saenz evaluated every inch of space within the center including the large conference room that was not bringing in any revenue, he says. After converting the room into two additional procedure rooms, the practice cut its wait time from eight weeks to five days.

"That just enhanced our volume intensely," he says.

9. Automate reminder phones calls. When Mr. Saenz arrived at Tulsa Pain Consultants, reminder phone calls were made by operators. He set up an automated system that reduced the cost of the hundreds of daily calls to pennies, he says. Patients would press a button to indicate that they weren't coming, and a scheduler would call them back. The practice was able to reduce no-shows this way.

"By plugging that flaw, we were able to keep the schedule full," he says. "We got rid of last-minute holes. The schedule is the most important part of flow."

10. Double-check all reimbursements. Receiving proper reimbursements is essential to profitability, and making sure staff is well-trained can ensure reimbursement is done correctly.

"We encourage well-trained preauthorization and registration personnel to ensure compliance with payor agreements when scheduling patients," says Mr. Bookmyer. "In addition, we have equally well-trained physicians help manage denials when received after service."

Mr. Saenz recommends that the contracts with payors are double-checked to make sure the practice received the agreed-upon reimbursement for every procedure. He also warns physicians to make sure they are coding their procedures correctly.

"In many cases, we find that they're undercoding," Mr. Saenz says. "Sometimes doctors become so intimidated that they tend to undercode, and they're hurting themselves and their profitability. All these changes and tweaks may sound like small dollars, but when you're treating thousands of patients, these dollars add up to significant revenue." ■

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5 Points on Physician Involvement in the ASC Supply Chain

By Abby Callard

Supplies are often a large element of a surgery center's budget and one of the easiest areas to save money without sacrificing quality. A center's physicians can have an impact on the cost of supplies, though they might need some convincing to get involved.

"By virtue of their leading role in healthcare delivery, physicians are in a great position to influence the supply chain," says Richard Peters, senior director of ASC services at Provista, a supply chain improvement company. "Their selection and utilization of the products used in the surgical suite are often major driving factors of supply costs."

But physicians are not such an easy sell when it comes to getting involved in the supply chain, says Alan B. Kravitz, MD, a general surgeon and investor at Montgomery Surgery Center in Rockville, Md., and an advisor for Surgical Care Affiliates' supply chain team. Dr. Kravitz and Mr. Peters discuss five points on physician involvement in supply chain management.

1. Surgeons are trained not to care about cost. Dr. Kravitz says that surgeons are not sensitive to cost simply because they were never trained to think about the cost of their supplies.

"Surgeons are not very intuitive to cost, because we don't care," says Dr. Kravitz. "We've all gone through residencies in hospitals where we get what we want when we want it. Very often, hospitals are able to pass the cost on to someone else. Surgeons are fairly apathetic as to how much things cost."

2. Educate surgeons and appeal to their competitive nature. Dr. Kravitz says even though surgeons were not trained to think about costs, if they are educated on the cost of their supplies and procedures, they can be persuaded to start thinking more about the cost of what they do. Mr. Peters says giving physicians insight into the financial impact of their supplies can push them to get involved.

"Even if they don't have a financial stake in the organization, most physicians like to be considered in important decisions, and savings from the supply chain can lead to enhancements that surgeons value," says Mr. Peters.

When looking at physician involvement, there is no substitute for a conversation, he says.

"Administrators should plan to meet with active surgeons in the center at least quarterly to review overall performance, to ensure that the surgeon's needs are being met, to identify and resolve any concerns about scheduling or staffing and to discuss issues such as supply utilization that might not come up in routine work conversations," says Mr. Peters. "In addition, periodic review of preference cards, case costing and waste should be a natural time to discuss supply utilization."

Analyzing cost per procedure for each surgeon is one way to start the conversation about cost. If one surgeon's costs are higher than his or her peers, that can be the starting point for a conversation and eventual change.

"Physicians are highly competitive by nature, and very responsive to data," says Mr. Peters. "For example, if you have a surgeon whose case costs are out of line relative to peers or to reimbursement for a certain procedure, providing them blinded data comparing their costs to their peers or data on reimbursement relative to costs can be a strong motivator to change their behavior."

3. Encourage surgeon agreement on low-cost products. It's not just the high-cost items that increase supply costs, Mr. Peters says.

"While high-cost items like implants might come most immediately to mind on this topic, the notion of physician preference can even extend to things most people regard as a commodity, like gloves," he says. "If you have two surgeons that each prefer a different brand of surgical glove, you'll have to have twice as many total gloves in stock than if they can both agree. While that additional cost might be nominal in this example, extension of the idea across the supply chain can add up to significant expense."

Dr. Kravitz has seen a similar disagreement over brands of suture, which is "just string," he says. The Montgomery Surgery Center began switching from Ethicon sutures to B. Braun because B. Braun, a large company in the European market, was trying to gain a larger market share in the U.S., and the lower price would save the center thousands of dollars.

"At our center, we've been successful at making the change, although there's a plastic surgeon who thinks he can tell the difference, so he gets to use what he wants," Dr. Kravitz says. "We don't want to alienate him. We may shop at Costco for our home and get Kirkland brand. But in surgical equipment, we like name brands."

4. Treat non-investor surgeons as customers. Dr. Kravitz says non-investor surgeons often think of themselves as customers in an ASC because they are bringing in cases for which the center gets reimbursed. In this situation, they don't have much incentive to worry about cost because it doesn't affect them. He says they also expect to have everything ready for them and often only get involved in supply chain and inventory when there's a problem.

"Surgeons are trained with the expectation that what you need will be there," he says. "I think that in general, we rely on our administrator to take care of the inventory. I've gotten involved only when it doesn't work, and that's frustrating."

Like in the case of the plastic surgeon who preferred Ethicon sutures, Dr. Kravitz says many center administrators are worried about alienating surgeons over supply costs.

"In many surgery centers, the administrators are very afraid of alienating the surgeons who are customers and even the surgeons who are partners," he says. "The bigger the surgery center, the less the administration feels it should interfere."

Administrators can strike a balance, but if a surgeon absolutely prefers a certain name-brand product, administrators should concede.

5. Physicians don't like change, and that includes changing supplies. Surgeons are a tough nut to crack when it comes to changing their ways, Dr. Kravitz says.

"Surgeons are very superstitious," he says. "We like what we like, and that's the way it is. Doctors are a conservative bunch, and surgeons are the most? conservative of the conservative."

However, Dr. Kravitz does see more physicians becoming aware of supply costs because of healthcare cuts and the fact that everyone is operating on such a tight margin.

"I think there's a growing awareness of surgeons that they need to get involved in supply chain," he says. "As the margins get really narrow, it benefits you to be a smart shopper. Even thought you're not buying, you're influencing what gets purchased."

Dr. Kravitz says that physicians, by virtue of their training and practice, drive a lot of healthcare costs in the U.S.

"We've generally very cost insensitive. In many situations, the patient doesn't care because they have insurance; the doctor doesn't care because he doesn't pay. Who ends up paying is everybody," he says. "We are trained not to care. That's a factor in the high cost of healthcare." ■

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10 Things to Expect From an ASC Anesthesia Provider

By Rachel Fields

Meena Desai, MD, managing partner of Nova Anesthesia Professionals, discusses what to expect from an anesthesia provider in an ambulatory surgery center — and how to evaluate performance on an ongoing basis.

1. ASC experience. First and foremost, ASC anesthesia providers should come to the center with ASC experience, Dr. Desai says. The culture of an ASC is very different from a hospital, and behavior that would be acceptable at a hospital can derail the relationships, finances and clinical quality of a surgery center. "We work in the ASC environment really hard and fast, and we do it with no extra staff or new toys," Dr. Desai says. "Hospital anesthesia people are not used to helping themselves because they've got extra staff to help them." She says anesthesiologists with ASC training are forced to be more resourceful, flexible and confident with their skills because they often work alone.

2. Positive impact on the bottom line. Anesthesiologists can positively impact the bottom line at a center by improving efficiency, Dr. Desai says. "Are they constantly waiting to complete a task before they start another task?" she says. "Are you always waiting for them to do a block during OR time?" She says ASC leaders should talk to staff members and anesthesia providers about where the most time is wasted during the surgical encounter. For example, a staff member might have to stand around while an anesthesiologist performs a pre-op evaluation and looks at charts for the first time — tasks that should be performed prior to the surgical encounter. If a one-room center is doing an orthopedic day and needs a block for a shoulder case, that case should be scheduled first so the block is placed before OR time starts. Anesthesiologists can participate in this discussion and determine how to streamline these activities so no one is left standing idly.

3. Relatively quick room turnovers. Benchmark your room turnover times and expect anesthesiologists to help stay relatively close to that benchmark, depending on the type of case they are working. Dr. Desai says in a GI suite, turnover times should average about 7-8 minutes; in a multi-specialty ASC, turnover might be as high as 12 minutes. "If you're way over that — and it could be due to many, many factors — anesthesia should help play a role in fixing that," she says. The ASC leaders can also look from practitioner to practitioner to determine whether one anesthesia provider contributes to higher turnover times than the others.

4. Attention to drug and disposable lists. Anesthesiologists should help you streamline the drugs and disposables you use, Dr. Desai says. "We

don't usually keep five sizes of endotracheal tubes, and anesthesiologists should help you [narrow that number down]," she says. "You can go with one brand of drug and try generic if you can, unless there's a new proven reason to try the latest thing."

She recommends asking anesthesiologists to sit down with a list of drugs and disposables and determine which providers spend the most money on supplies. In this discussion, anesthesia providers may discover their rationale for using a particular supply is faulty. For example, an anesthesiologist may want to use a more expensive drug that saves a few minutes in the operating room. But unless the ASC is able to schedule another case because of the extra time, the drug may not be worth the additional cost.

5. Playing on the "ASC team." Your anesthesiologists should be on the "ASC team" — not the practice team or the hospital team, Dr. Desai says. "There are many ways their participation can be helpful in the surgery center," she says. "For instance, there are a lot of drug shortages, and you need to know how to accommodate them on short notice. Do the anesthesia providers care about any of the issues that actually affect you, and do they accommodate those issues if possible?"

Anesthesiologists should demonstrate a vested interest in the success of the ASC — an interest that goes beyond working hours, Dr. Desai says. For instance, some surgery centers must now buy end-tidal CO2 monitors to comply with new regulations. "Perhaps the surgery center doesn't need the $5,000-$6,000 monitor and can use the handheld monitor instead," Dr. Desai says. "This lets you comply with regulations while saving money." In this case, your anesthesia providers should be able to tell you whether the more expensive monitors are necessary.

6. Designated group leader. Your surgery center anesthesia group should designate a leader to act as a liaison between the anesthesiologists and the surgery center. This leader should be a "people person," because anesthesiologists interact very differently with surgeons, ASC administrators and staff members. The leader should understand the nuances of each relationship and act as an informational source when someone has a question.

Once the anesthesia leader has been chosen, that leader can assign anesthesiologists within the group to head other projects. For example, one anesthesiologist might have a particular expertise on brand name versus generic drugs, meaning he or she should head a committee to decide drug purchases.

7. Consistency among anesthesiologists. Anesthesiologists should work to reduce variability from one provider to another, Dr. Desai says. This kind of consistency promotes better clinical quality and reduces cost. For example, using the same selection criteria for all patients will ensure the ASC does not treat patients who must be admitted to the hospital. If anesthesia providers agree to use the same equipment and items, the ASC can save money on more expensive supplies and achieve better contracts by buying in bulk. Anesthesiologists should sit down as a group and hash out these issues, and benchmarking data on clinical quality and supply costs should demonstrate this consistency.

8. Proactive attitude toward regulatory and technological changes. Every year, regulatory changes and technological advancements alter the way physicians treat patients. If your ASC anesthesiologists sat down and created a patient criteria list last year, the list may be outdated by now. "Many things have changed between last year and this year, and you need to make sure someone is looking at that and determining that what you're doing is relevant and appropriate today," she says. Anesthesiologists should review ASC anesthesia policies on a yearly basis at minimum and advise ASC leaders on policies, equipment purchases and selection criteria.

9. Commitment to thorough patient selection. Dr. Desai strongly believes that pre-operative patient selection and screening is the only way to avoid undue cancellations at a surgery center. She says this process should start with the surgeon's office, so schedulers do not book the wrong patients in the first place. "We in-service the surgeon's office every six months and go over anything that's changed or anything they're missing," she says. "For instance, who has come through in the last six months who shouldn't have come through?"

She says it's much easier to catch these patients at the scheduling point than to cancel a case because a patient's neck is too thick or their body weight is too high. She says anesthesiologists should go over patient selection criteria and determine which patients are appropriate for surgery at the ASC.

10. Low rate of unplanned hospital admissions. Dr. Desai says surgery center anesthesia providers should be expected to keep the rate of unplanned hospital admissions low. "You want to fall less than the national rate, and that rate is very small for ASCs," she says. "Unplanned admissions can result from any post-operative complication that would require monitoring overnight or hospitalization." She says unplanned admissions can be caused by a variety of factors, including surgical factors — bleeding, perforation or a surgical complication — and anesthesia factors — aspiration, chest pain, shortness of breath or low oxygen saturation.

She says most unplanned admissions can be avoided through thorough patient selection. If your surgery center is seeing more unplanned admissions than usual, dig down and determine the cause. "It might not be because of the anesthesia, but you need to know," she says. ■

Learn more about Nova Anesthesia Professionals at www.nap123.com.

10 Questions to Ask When Setting ASC Administrator Compensation

By Rachel Fields

Surgery center staffing costs are a significant part of an ASC budget, and ASC administrators are generally the highest-paid staff member in a center. In order to attract highly qualified candidates while maintaining a tight budget, surgery centers must be careful about how much they pay their leaders. Greg Zoch, partner and managing director with Kaye/Bassman International, discusses 10 concepts that affect compensation for ASC administrators.

1. Why did the previous administrator leave? If you suspect that your compensation is driving away administrator candidates, you should first understand why the previous administrator left his or her position, Mr. Zoch says. Conduct an exit interview with every employee to determine why they are leaving. Make it clear that total honesty is encouraged, and ask if there are any problems within the center that make it an unpleasant place to work. If the administrator is leaving for a higher-paying job, they will often be honest and share that another surgery center in the area pays $10,000 more a year or has a more robust benefits package. Information gathered during exit interviews can be valuable in many ways.

2. What do surgery center administrators make on a national basis? According to data from the ASC Association's 2010 ASC Employee Salary & Benefits Survey, the median salary of an administrator in 2010 was $93,870. Administrators with the CASC credential earned higher salaries, and administrators with the CASC credential and no clinical background earned a median salary of $110,000. Of course, national data is only useful up to a certain point: First of all, Mr. Zoch points out that no one conducting an administrator search is looking for an "average" candidate. If you want an exceptional leader in your ASC, you will probably have to pay more to attract them to your center.

Second of all, national data only gives a broad overview of the amount paid to surgery center administrators across the country. If you live in New York, your average cost of living will be higher, and therefore your salaries will need to increase accordingly. If you live in rural Montana, you can probably get away with paying less than your counterparts in big cities. Start with national benchmarking data to get a feel of the range — most surveys and healthcare experts agree that the average surgery center administrator makes anywhere from $95,000-$120,000.

3. What do surgery center administrators make in your region? Once you have an idea of national benchmarks on ASC administrator salaries, you should hone in on your region and determine what candidates would make at competing ASCs in the area. You can start by eliminating hospitals from the equation, Mr. Zoch says. In all likelihood, hospital outpatient department managers will make more than ASC administrators and do not have experience in the business, regulatory, and operational metrics needed to effectively run an ASC. ASC owners should look for candidates who bring several years of surgery center experience to the interview.

Instead of looking solely at salary surveys, Mr. Zoch recommends using a third-party service to determine the salaries being paid at local ASCs. If you're lucky, people may be very upfront with you about the salaries offered at other facilities in the area — but in all likelihood, few will offer you such proprietary information. A third party can help by using their industry contacts to determine how your compensation matches up to surgery centers in the area.

4. What kind of administrator does your surgery center need? If you're searching for a new ASC administrator, you will pay more for the qualities that really boost a resume to the top of the pile. For example, an administrator with an RN background, an MBA or a CASC credential will demand higher compensation than an administrator with no advanced degrees or certifications. Similarly, an administrator with 15 years of turnaround experience will probably want more money than a clinical coordinator rising into the position of administrator for the first time.

Make sure you're hiring an administrator that fits your surgery center's needs not just your budget! Your physicians may not care if your administrator has a clinical background, as long as he or she has a good head for business and can take care of the financial side of the operation. Conversely, you may want a surgery center administrator who has spent time as a registered nurse in the operating room and can roll up his or her sleeves when needed. Don't automatically assume that your candidate has to have every qualification you can imagine — you'll pay much more for a highly pedigreed resume. Sit down with your physicians and determine which traits you're willing to pay for, and which you can really live without. Then interview only those who fit the bill.

5. How much is the administrator asking for? While national and local benchmarking data is useful to provide a range of administrator salaries, Mr. Zoch says the market will ultimately dictate how much you have to pay your administrator. "Our opinion doesn't count about what somebody should be making or what we've paid in the past," he says. "Ultimately the market tells us what we have to pay." He says once you find a candidate that you like, you may find that you want to pay them $120,000, but they are currently earning $125,000 and want to start at $130,000 at your center. If the candidate is not willing to budge on his or her price, you will end up with a choice: lose your best candidate or agree to pay the requested salary. But be careful not to low-ball offers with the expectation of a negotiation. Offering someone a position that pays them less than they are currently making can turn a good candidate off or kill your chances outright. Remember you are setting the tone of a new relationship; one that should be based upon fairness among other things.

Mr. Zoch says because of the way the market dictates salary, it's important to find an ASC administrator who will truly benefit your center. He says that he looks for administrators with ASC experience — ideally in an administrator position. He spends time speaking with ASC owners to outline the center's goals, challenges, strengths and budget and then jointly determines what kind of administrator the center needs and how much the center can afford to pay. In some cases, you may be able to offset a candidate request for higher than normal base salary by offering a robust bonus structure or benefits package; in other cases, they may simply choose to look elsewhere while you find a candidate who fits your budget.

6. What "level" of benefits will you offer? Mr. Zoch says benefits can be divided into three areas: basic health benefits, paid time off and retirement/education benefits. He says surgery centers should not underestimate the power of a strong benefits package to improve an average salary offer. "You have to understand the people who are likely candidates for leadership positions," he says. "What age group do many of them come from? A great percentage is in their 40s and 50s, and at that age, they may be concerned about health insurance benefits and retirement." He says administrators have certain expectations from ben-

efit packages that competitive surgery centers should try to fulfill to attract strong candidates. For example, most administrators will expect a health benefits package that includes health, dental, vision and either short- or long-term disability. For those centers that want to go "above and beyond" and attract the best candidates, they may consider paying 100 percent of the employee's portion of the health insurance premium— or even 100 percent of the employee's family's portion as well.

The second area centers around paid time off (PTO), which Mr. Zoch says should include a minimum of seven national holidays, two personal days and three weeks of vacation for a minimum of 24 days total PTO. He says surgery centers should hesitate to skimp on vacation to save money. For example, if the administrator asks for four weeks of vacation, that extra week will only cost the surgery center about $2,000. That amount is negligible in the grand scheme of things and may make the difference between landing a great candidate or an average candidate. If the ASC's vacation policy is limited by an third party, like a hospital or management company, the ASC may be able to offer extra compensation in lieu of vacation.

The third benefits area includes retirement benefits, continuing education and professional development. Mr. Zoch says providing a 401(k) should be a given, and ASCs should try to match the employee's contribution to some extent. The ASC should also offer to pay for continuing education and professional development to make sure the administrator can continue to hone his or her skills.

7. How much do you plan to offer as an annual bonus? ASCA data shows that in 2010, 75 percent of surgery center administrators were eligible for bonuses. Mr. Zoch says while surgery centers should offer raises to keep up with changes in the market, bonuses can be given to incent and reward good business behavior. He says the average bonus for an ASC administrator is around 15-25 percent of base salary per year. He says bonuses should be based on clear criteria that are set out at the beginning of the year.

The criteria should be limited to a few categories for improvement, and Mr. Zoch says at least one category should be somewhat subjective. This will help boost morale if the administrator works very hard but is unable to lower staffing costs or improve profits — two objective measures that might be included in the bonus criteria. He says the ASC administrator should go through a yearly review, where ASC physician leaders and the board discuss successes, failures and areas for improvement over the past year. He says the ASC can also offer "stretch" bonuses, in which the administrator receives more money for doing a better job. For example, the administrator might receive $10,000 if they hit the target budget portion of the bonus and $20,000 if they exceed budget expectations by 50 percent.

8. How will market fluctuations impact salary over time? Keep in mind when you make a salary offer to a new administrator that you will probably have to factor in annual raises to keep up with market demands. According to ASCA data, the median salary of an administrator increased 1 percent between 2009 and 2010, and that was during a slow economy. Salaries are likely to keep increasing in future years based upon supply and demand. ASC administrators should receive a yearly salary increase if the market shows that administrators in the region are steadily making more money. Otherwise, you risk losing your leader to a competitor.

9. Are there problems with your surgery center that can't be fixed by a higher salary? If your administrator expresses discontent with his or her job, don't automatically assume that a raise will solve the problem. Mr. Zoch says too many surgery center boards "throw money" at unhappy administrators, assuming that a higher salary will immediately improve satisfaction. "Money cannot fix problems that are not monetary," he says. "It's never only about money."

He says if your administrator seems dissatisfied with the job, sit down and discuss the issues or problems with the physicians, staff members, workload and other factors before you discuss a raise. More than likely, the administrator will bring up a few problems that could be fixed without a salary increase. Mr. Zoch warns surgery center leaders, "However, if you promise to make changes, you've all got to follow through because if you don't, you will only make things worse."

10. Can your administrator "grow" into the ideal candidate over time? You may want to start a less-qualified administrator at a lower salary if you are confident they can grow into the ideal candidate through training, professional development and continuing education. Of course, this doesn't mean hiring someone with no experience just to save money. But you may not need an ASC administrator with 10 years experience turning around failing centers and an MBA, an RN and a CASC certification. That person will likely cost you more than $120,000 — the higher end of the range of administrator salaries.

Instead, you may want to consider promoting a clinical director who wants to learn the administrator position, if you have the time and expertise to train them. Then send them to conferences and put them through additional training to help them understand the financial and operational side of the business. This really depends on the resources you have to invest in training. If your surgery center is successful and the physicians are heavily involved in operations, you can probably hire a less-experienced administrator and give them raises over time. If the center is failing and you need a strong hand to steer you in the right direction, you should plan on paying more money for an expert. ■

Learn more about Kaye/Bassman International at www.kbic.com.

7 Steps to Turn Quality Data Into a Useful, Compliant Improvement Study

By Rob Kurtz

So you have a great idea for a quality study. You identify the problem or opportunity — it is meaningful and measurable. You take the time collect great data. But now what do you do with it?

"You take that information and use it to create a positive change," says Daren Smith, BSN, director of clinical services for Surgical Management Professionals. Follow these seven steps offered by Mr. Smith to convert your data into recommendations, and those recommendations into change.

1. Analyze your data. Ask yourself, "Does it give you the information you need to promote change?" Mr. Smith says. "Does it provide the statistical basis to substantiate the problem or opportunity?"

2. Take the analysis to your quality committee. Here is where you will want to discuss the results and determine whether the results significant enough to institute change, he says. If they are not; skip the next step, and determine how you will gather enough data and results to bring about significant changes. If they are significant enough…

3. Brainstorm and research some possible recommendations for solutions to the problem. "Take some time to investigate your options based on the data you collected," Mr. Smith says. "Look at all your options. You will want to take a team approach to this and send members of your staff out to investigate how others solved the problem or exploited the opportunity. Look at message boards, resource materials, management companies, Internet searches, and questioning your peers can all be effective ways to research.

4. Gather your team together and let the ideas fly. "Nothing works better than some hearty discussion to get the cream to rise," he says.

5. Organize the recommendations and take them to the next level. Depending on your organizational structure, this could be a medical director, a medical advisory board or the board of directors.

6. Tell your story. You're finally ready to put the study together. "Construct an executive summary of your study," Mr. Smith says. He says it should contain the following components:

- An introduction that identifies the problem or opportunity and how it was discovered.
- A couple sentences to explain your data collection method.
- A sentence or two summarizing your findings and conclusions based on those findings. Charts and graphs are a great way to illustrate your findings.
- A statement that illustrates your team members' recommendations and why they think they will be successful.
- Finally include a timeline for the change and the plan for restudy (if there is one).

"The summary does not need to be fancy or really detailed," he says. "Most can be accomplished in a page or less."

7. Present the study. Provide the concise and organized study document to your staff, board and accreditation agency. "Putting this in their hands makes it real and tangible, not just theoretical," Mr. Smith says. "You have involved many people along the way and that should help you create some momentum for the change." ■

Learn more about Surgical Management Professionals at www.surgicalmanprof.com.

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10 Ideas for ASC Quality Improvement Studies

By Rachel Fields

Jan Davidson, RN, MSN, is the AORN perioperative education specialist focusing on ambulatory surgery centers. Here she shares 10 ideas for quality improvement studies in a surgery center.

1. How well are you managing postoperative pain in the recovery room?

2. How many cases were you not able to put on the schedule each week because of staffing issues?

3. What is the patient's or family's perception of the care they receive?

4. How satisfied is your staff?

5. How profitable are your insurance contracts? How much do you make on each case once expenses are accounted for?

6. Do you duplicate paperwork? For example, does the surgeon fax over all the paperwork, ask the patient to bring paperwork to the center and print out paperwork as well?

7. How many cancellations or no-shows do you have every month, and what is the reason?

8. Do you use your block time effectively? Are there physicians who have block time they don't use but won't give up?

9. Do your cases start on time? How many of your cases start 15 minutes late or more?

10. How much could you save on supplies if your physicians standardized their supplies and equipment? How many different brands does your surgery center use? ■

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