

INSIDE

**56 ASC
Management &
Development
Company CEOs
to Know** p. 26

**10 Proven Ways to
Improve Surgery
Center Efficiency** p. 21

**What Percentage
of Orthopedic
Surgeons Will
be Employed in
5 Years?
10 Responses** p. 31

**Staff Salaries in
Surgery Centers:
50 Statistics to
Know** p. 46

**7 Points on How
Surgery Centers
Should Handle
ACOs** p. 40

INDEX

**Turnarounds: Ideas to
Improve Performance** p. 20

**Transaction and
Valuations Issues** p. 23

**Gastroenterology &
Endoscopy** p. 34

**Coding, Billing &
Collections** p. 38

**ASC Supply Chain
& Materials
Management** p. 42

**Anesthesia and Anesthe-
sia-Related Issues** p. 43

BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

July/August 2011 • Vol. 2011 No. 6

6 Best Specialties for Surgery Centers

By Rachel Fields

Specialty choice can make or break an ASC, depending on reimbursement rates, supply costs, case volume and availability of market share. Here is a list of the six “best” specialties for ASCs, based on several advisors’ assessments, ranked in order of preference based on the results from the 2010 ASC Valuation Survey by HealthCare Appraisers, which was completed by 17 ASC companies representing more than 500 surgery centers throughout the country.

Each listing includes advisors’ thoughts on how to reap the benefits of a desirable specialty. Do you agree with these rankings? Please send your thoughts and feedback to rachel@beckersasc.com.

continued on page 9

12 Major Issues Facing the Surgery Center Industry

By Rob Kurtz

The ambulatory surgery center industry is facing tremendous uncertainty, perhaps of historical proportions, says Brent Lambert, MD, founding principal of ASCOA.

“This is probably — since I started in this industry 27 years ago — the most concerned, anxious or even depressed I’ve ever seen this industry,” says Dr. Lambert. “We see this in questions from our partners, from our would-be partners and we encounter it wherever I go, even among seasoned people and people who own companies like ours.”

continued on page 13

10 Top Priorities of Surgery Center Physicians

By Rachel Fields

Two surgery center administrators, one physician and a management company CEO discuss 10 common priorities of surgery center physicians — and what ASCs can do to keep their physicians happy.

1. On-time case starts. Surgery centers are by nature more efficient than hospitals, and surgeons expect to take advantage of that efficiency when they invest or bring their cases to the center. Lynn Dugan, RN, BSN, administrator of Paramount Surgery Center of Mesa (Ariz.), says when a surgeon first arrives at her surgery center, she sets clear expectations about timeliness and explains that when one surgeon is late, it affects the other scheduled cases. She then monitors physician start times and brings the data to the governing board to review.

“If it’s just random and minor and we know that, that’s fine, but if it’s chronic,

continued on page 14

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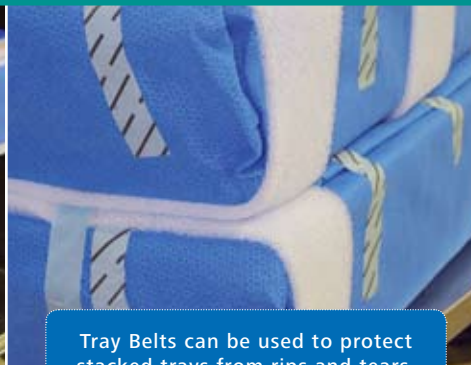
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FEATURES

- 1 6 Best Specialties for Surgery Centers
- 1 12 Major Issues Facing the Surgery Center Industry
- 1 10 Top Priorities of Surgery Center Physicians
- 7 Publisher's Letter
- 16 Future of Physician-Owned Facilities: Q&A With Dr. Jeff Hessing of Treasure Valley Hospital and SCA
- 18 5 Trends Affecting the Future of Ophthalmology in Surgery Centers

Turnarounds: Ideas to Improve Performance

- 20 6 Ways an ASC Can Lose Physicians — and What to Do About it
- 21 10 Proven Ways to Improve Surgery Center Efficiency

Transactions & Valuation Issues

- 23 5 Factors That Heavily Influence ASC Value
- 24 7 Questions on Surgery Center Transactions and Valuation Issues: Q&A With Stephan Peron of VMG Health
- 26 56 ASC Management & Development Company CEOs to Know
- 31 What Percentage of Orthopedic Surgeons Will be Employed in 5 Years? 10 Responses

Gastroenterology & Endoscopy

- 34 10 Strategies to Improve Endoscopy Center Operations
- 36 10 Critical Social Media Guidelines for Surgery Center Physicians and Staff

Coding, Billing & Collections

- 38 Assembling a Robust Revenue Cycle Team: How to Hire and Retain Great Billers, Coders and Collectors
- 40 Staff Salaries in Surgery Centers: 50 Statistics to Know
- 41 Motivating Employees Through Effective Incentives: Q&A With Brian Brown of Meridian Surgical Partners

ASC Supply Chain & Materials Management

- 42 5 Strategies to Make Successful Capital Acquisitions

Anesthesia and Anesthesia-Related Issues

- 43 4 Tactics to Weather the Drug Shortage From Dr. John Dombrowski
- 45 5 Reasons Why Surgeons Still Join Surgery Centers
- 46 7 Points on How Surgery Centers Should Handle ACOs
- 47 Advertising Index

Publisher's Letter

18th Annual ASC Conference – Improving Profitability and Business and Legal Issues; Keynote Speakers Include Sam Donaldson; Bill Walton and Adrian Gostick; 90 Sessions; – Oct. 27- 29, 2011; Westin Hotel, Michigan Avenue; Chicago

On p. 31 is the brochure for the 18th Annual Ambulatory Surgery Centers Improving Profitability and Business and Legal Issues Conference. We have an outstanding agenda this year. We have included three keynote speakers — Sam Donaldson, Bill Walton and Adrian Gostick. We also have 90 sessions in total. We encourage you to register early. We have kept the price of the main conference the same. We have reduced the price for people attending the main and pre-conference to encourage people to join the entire conference.

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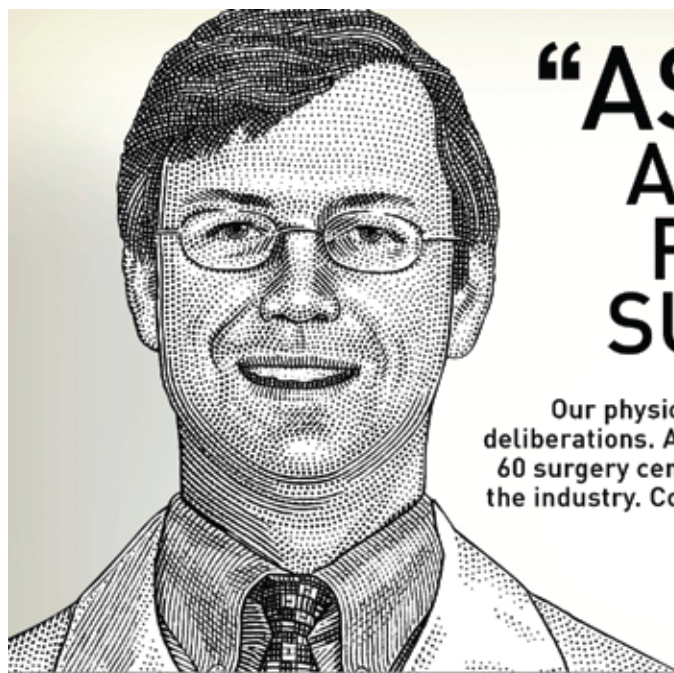
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3. **Assessing the Future Demand for ASCs, A Panel Discussion** — Barry Tanner, President & CEO, Physicians Endoscopy, Brian Mathis, Vice President Strategy, Surgical Care Affiliates, and Vivek Taparia, Director of Business Development, Regent Surgical Health
4. **What is Great and What is Not Great Physician Leadership for Your ASC** — Brad Lerner, MD, Summit ASC
5. **Should You Sell Your Practice to a Hospital? What Will the Agreement Look Like? What are the Key Issues?** — Kristin A. Werling, Partner, Geoffrey C. Cockrell, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods LLP
6. **The Best and Worst Procedures for ASCs and What an ASC Should Get Paid** — Matt Lau, Director of Financial Analysis, Mike Orseno, Revenue Cycle Director, and Vivek Taparia, Director of Business Development, Regent Surgical Health
7. **Determining the Exact Cost of a Procedure** — Terry Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital
8. **The 5 Best and Worst Specialties for ASCs - An Outlook for the Next Five Years** — Larry Taylor, CEO, Practice Partners in HealthCare
9. **Extreme Makeover: Surgery Center Edition - Lessons Learned From a Dozen Turnaround Projects** — Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgical Center Partners
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6 Best Specialties for Surgery Centers (continued from page 1)**1. General orthopedics**

What makes it good: General orthopedics is ranked the best specialty for ASCs, with 94 percent of HealthCare Appraisers respondents calling general orthopedics “desirable.” Chris Bishop, senior vice president of acquisitions and development for Blue Chip Surgical Partners, says it comes as no surprise that general orthopedics leads the pack because of its historic popularity. The challenge of performing orthopedics now, he says, is the saturation of the orthopedic surgeon market in many areas of the country.

“Most of the busy orthopedists are already invested in surgery centers, so it’s hard to find a group that’s not invested or eager to leave a bad surgery center,” he says. He says because most orthopedists can perform cases in a timely fashion, the biggest consideration for surgery centers should be contract negotiation. Since orthopedics has high case costs, administrators must take supply and implant costs into account when negotiating rates with payors.

Mr. Bishop says orthopedists are particularly suited to the ASC environment because of their tendency toward “alpha male or alpha female” personalities. “One of the biggest risks in the ASC industry is the hospital employing surgeons, and one of the things we find about orthopedists is that these surgeons tend to be more independent-minded and less likely to accept hospital employment agreements,” he says. “When you’re thinking about the risks of the surgery center industry going forward, orthopedists are a little less likely to trust the hospital to manage their practice effectively.”

Mr. Bishop says orthopedics is also attractive to ASCs because it presents a wide variety of available subspecialties. He says surgery centers should look first to hand surgeons, who can provide high case volume, short case time and good reimbursement. Sports medicine physicians who perform ACLs and arthroscopies can also be a good fit for surgery centers.

How to do it right: Good contract negotiation is essential to profiting from orthopedics, Mr. Bishop says. He claims that most developers typically begin out-of-network and then determine whether the center can feasibly move in-network. “We explain to the payor, ‘We’d prefer to move in-network with you, but here’s the cost to provide these orthopedic procedures at the facilities, including implants,’” he says. “We ask them to help us negotiate a fair market value agreement that takes into account the high cost of the supplies or implants.”

He says it also helps to case-cost every single case to help physicians understand pricing decisions. “One physician may use three shaver blades, while the other physician uses a single shaver blade,” he says. “Part of it is the technique, but a lot of it is just unfamiliarity with the cost of supplies.” He says showing physicians the difference between their preference cards can motivate surgeons to shave hundreds of dollars off a single case.

While adding orthopedics to a surgery center is a substantial investment — Mr. Bishop estimates an average cost of \$300-\$400,000 — the investment should pay off if case volume is high. “If you’re talking about a three-person practice and they’ll bring 1,000 cases to your center, you can certainly justify the investment in the equipment,” he says. “You’ll most likely pay it off over four or five years.” He says surgery centers should look for a minimum threshold of 700 orthopedic cases per year before they start buying equipment.

2. Orthopedic spine

What makes it good: Orthopedic spine comes in second on HealthCare Appraisers’ list of most desirable specialties, with 88 percent of respondents calling it desirable. Mr. Bishop says spine is attractive to surgery centers at the moment because it presents “fresh blood” to the industry.

“There are 6,000 surgery centers now in the United States, and most of the specialties have been pretty well picked over in the last 30 years,” he says. “Spine has only become a viable option in the last five years or so.” As technological advances allow physicians to perform smaller incisions and

provide better post-operative pain control, spine surgeons and payors are increasingly comfortable with moving cases into the ASC setting.

He claims that spine is relatively easy to add for a surgery center that already performs orthopedics. “If you already have a C-arm, you can add spine for \$100-\$150,000,” he says. “If you’re already doing musculoskeletal procedures in your surgery center, spine is complimentary to what you’re already doing.” While Medicare has not yet approved spine for Medicare beneficiaries, Mr. Bishop says this delay is actually a positive for centers. “Commercial payors have not seen this kind of case volume shifting en masse from the hospital setting to the surgery center setting, so when we approach commercial payors, they’re talking about a savings of 30-50 percent compared to what they’re paying the hospital for the same procedure,” he says.

He says spine surgeons, who are typically well-known and reputable providers in their communities, are the ideal addition to a surgery center that wants to focus on recruitment. The addition of spine to an ASC might also open avenues for recruitment of physicians in other specialties. “Pain is a logical recruit when you’re doing spine because there are a lot of complimentary benefits between those two specialties,” he says. “We also find that if spine surgeons make a call to ENT or other specialties, they tend to have a little more influence over what the other physicians are thinking.”

How to do it right: Since spine is still predominantly an inpatient specialty, Mr. Bishop says the average spine surgeon will be able to bring around 75 cases to the surgery center annually. This means an ASC considering spine should ensure case volume from several surgeons before investing in the specialty, he says. “If you have to spend \$300,000 to perform spine, it doesn’t make sense if you have a single spine surgeon,” he says. “You have to do the math and figure out the return on investment.”

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He says negotiating managed care contracts is a critical component to ensuring a strong return. If your surgery center does not know how to negotiate managed care contracts, outsource to a professional with negotiation experience. It may take time to convince payors that spine cases can be brought safely into the ASC, but persistence should pay off eventually.

3. ENT

What makes it good: ENT is listed as the third most desirable specialty on the HealthCare Appraisers list, earning the approval of 76 percent of management and development companies. According to Lynda Dowman Simon, RN, manager of St. John's Clinic: Head & Neck Surgery in Springfield, Mo., ENT cases are appropriate for ASCs for three basic reasons: They're short in length, they use minimal supplies and they have a quick recovery period. Reimbursement for ENT cases is also relatively robust; while reimbursement for some cases dropped in the last year, rates for many ENT cases remained stable and some increased. Ms. Simon says the majority of her center's cases can be performed at a significant profit because supply costs are limited — the exceptions are cases receiving Medicaid reimbursement and the few cases that require expensive implants.

She adds that ENT complications are generally less severe than complications for other specialties, and postoperative patient education is easier because the surgeries are well-known. "There's a certain way you expect to feel after you have sinus surgery or a tonsillectomy, and people can talk about it over the kitchen table," she says. "They have an idea of what's going to happen."

How to do it right: Ms. Simon says case selection and efficiency are the two biggest factors impacting the success of ENT in a surgery center.

"With ENT, you have to be careful about what you bring to a surgery center because of cost and reimbursement," she says.

As with all specialties, facilities should keep track of historic case costs and send cases to the hospital if they expect reimbursement not to cover costs. "If you want to put in a sinus stent that injects steroids to control polyp regrowth, and your cost for supplies is \$10,000 or more, you have to send that case to the hospital," she says. You also have to be aware of the procedures that will not be reimbursed in an ASC setting. For instance, in Missouri, for a Medicaid patient, a frenulectomy is reimbursed at the hospital but not in the surgery center.

Luke Lambert, CEO of ASCOA, says good contract negotiation is also an important consideration for ENT: While sinus procedures can be profitable because they involve multiple procedures, contracts that do not pay the ASC for multiple procedures do not take advantage of the increased reimbursement. "If you're only getting paid for one procedure per case, you're not going to do well with sinus surgery, but if [payors are] paying for multiple procedures, it can work out well," he says.

In order to profit from ENT, Mr. Lambert also cautions surgery centers to watch out for physician practices that accept a majority of Medicaid cases. "A lot of the work in ENT is focused on pediatric patients, and families with children are disproportionately on Medicaid," he says. "If you're in a low-income area, you might see 70 percent of your practice being Medicaid, which, from a reimbursement perspective, makes it challenging for a surgery center to make money."

Because short case length is one of the biggest advantages of the specialty, ENT-driven surgery centers should get their cases "down to a science,"

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 Becker's Annual ASC Conference, June 9-11

Ms. Simon says. She says a bilateral myringotomy tubes procedure should have an average turnover time of around five minutes, while tonsil cases should turn over in approximately eight minutes. Mr. Lambert adds that surgery centers with ENT should involve ENT physicians in choosing an anesthesia group, as pediatric ENT cases will require particularly skilled anesthesiologists.

4. Ophthalmology

What makes it good: According to the HealthCare Appraisers survey, 76 percent of management and development companies approve of ophthalmology as a surgery center specialty. Mr. Lambert says ophthalmology is "terrific" for surgery centers because skilled surgeons can perform cases in 15 minutes or less. "Because they're fast cases, even though each individual case doesn't pay very much, you can do well with it," he says. Cataract surgeries represent the majority of money-making ophthalmology cases in surgery centers, and the patient population for cataracts tends to include a large number of Medicare beneficiaries. While Medicare reimbursement is not particularly high for these cases, surgery centers can profit if case and turnover times are short.

Mr. Lambert says ophthalmologists are often extremely loyal to surgery centers because of the increased efficiency compared to the hospital setting. "Typically a surgery center will provide the surgeon with two rooms to bounce between," he says. "He'll do one case, finish that case and go over to the next room. Surgeons can spend their whole day doing surgery and just walking back and forth between the two rooms, whereas in the hospital, they may not get two rooms and turnover times can be half an hour between cases."

How to do it right: Surgery centers with large pre- and post-operative areas are best-equipped to handle ophthalmology, as the rapid pace of the cases means pre-op and recovery areas must be able to accommodate the number of patients. Mr. Lambert says the key to profiting from ophthalmology is efficiency: "You have to have all your processes functioning very well because it's a volume situation," he says. "If you do 10 cases in a room in orthopedics, you can make money, but you might be shooting to do twice as many in ophthalmology." He says the busiest ophthalmologists will perform around 1,000 cases per year.

While retina procedures are slowly moving into the surgery center setting, Mr. Lambert says the biggest profit driver is still cataract surgery. He says surgery center physicians can profit by providing the required "additional services" to cataract patients that choose to pay more money out-of-pocket for a presbyopia-correcting lens. "These lenses don't typically help center profitability because most centers are not marking

them up to any significant degree," he says. "But because the surgeons have to provide extra services, they make more."

5. Pain management

What makes it good: Pain management is listed as the fifth most desirable specialty by ASC management and development companies, with 76 percent of respondents calling the specialty desirable for surgery centers. Amy Mowles, president of Mowles Medical Practice Management, says pain management is appropriate for surgery centers because it is relatively inexpensive to equip and cases can be turned over very quickly. "If you look at the actual cost of providing the vast majority of pain management procedures, even if you're only getting a facility fee of \$294 for Medicare for the top of our most commonly-performed procedures, that should be a huge margin of revenue," he says. "If it's not, you're doing something vastly wrong."

She says the "vast majority" of procedures can be performed for a direct cost of \$25, and ASCs that cannot perform procedures at this cost are either negotiating poor supply costs or scheduling staff inappropriately. She adds that the movement of pain management procedures from surgery centers to office-based settings

has slowed down following the addition of pain management procedures to the ASC payment list. "It's clear that Medicare wants these done in an ASC," she says. "They realize the acuity of their beneficiaries, and they realize that pain management is a very provocative procedure. They want their enrollees to have the assurance of appropriate staffing, equipment and emergency protocol."

How to do it right: Ms. Mowles says pain physicians should perform approximately 20 procedures a day in an ASC to ensure robust



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profits. "You'll have to be doing 2,700-3,200 billable procedures per year to support one class B operating room," she says. "If the physicians can't do that, you don't want them." She says multi-specialty ASCs can also save money by pulling supplies on the shelf rather than ordering a custom tray. Single-specialty ASCs, on the other hand, may want to order a custom tray but evaluate their options to see if prices can be lowered by eliminating certain supplies.

6. GI/endoscopy

What makes it good: GI is the sixth most popular specialty on the HealthCare Appraisers survey, with 70 percent of management and development companies calling it desirable. According to Frank Principati, COO of Physicians Endoscopy in Doylestown, Pa., gastroenterology procedures work well for surgery centers because they can be performed efficiently with few complications and low risk of infection for patients. With short turnover times and relatively quick procedures, GI-driven centers should expect to perform around 3000-3,500 cases per year in each procedure/operating room, with each GI physician bringing around 500-1,000 cases to the center annually.

Mr. Principati believes GI-driven centers enjoy high patient satisfaction scores because of the specialty's natural efficiency. Open-access colonoscopy programs contribute to patient satisfaction by providing screening examinations without a pre-procedure visit, and shorter wait times and ease of scheduling give ASCs a leg up over hospitals. He also feels that the age of GI patients may be dropping as people pursue upper endoscopy for conditions such as heartburn and GERD, opening up a new segment of the market for surgery centers. "You may start seeing patients in their 30s and 40s who then become your patients for screening colonoscopies when they turn 50," he says.

How to do it right: "A successful GI center depends on the efficiency of your cases," Mr. Principati says. Medicare cuts have impacted GI reimbursement over the last four years, so GI-driven centers need to be mindful of utilization and turnover times and keep track of variable costs to stay profitable. "There's a lot of great benchmarking available that allows you to see how you're performing [compared to other centers]," Mr. Principati says. "It comes down to monitoring metrics on staff, drugs, supplies and other variable costs."

He reports that while the bulk of GI volume and revenue comes from colonoscopies and upper endoscopies, some physicians may be interested in bringing other procedures, such as hemorrhoid banding, into the surgery center. "There are a number of centers that have realized the benefit of adding these procedures, and it's a great way to fill block time and expand services that we're providing to our patients," he reports.

While the number of GI physicians is declining — a problem plaguing many specialties — Mr. Principati says surgery centers can improve recruitment by offering ownership to physicians. "Having ASC ownership capabilities makes it more attractive, but it's still a very competitive process as far as recruiting," he says. Physician Endoscopy's partnered physicians have been successful in marketing their centers and actively participating in recruitment efforts. ■

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12 Major Issues Facing the Surgery Center Industry (continued from page 1)

Dr. Lambert and Luke Lambert, CEO of ASCOA, identify 12 of the top issues currently facing ASCs which are contributing to this industry-wide feeling.

1. Disappearance of out-of-network. The opportunity for surgery centers to bill OON is disappearing, Dr. Lambert says. "Whether people like to admit it or not, we've been dependent on OON or at least a hybrid model," he says. "In many ASCs this was the difference between profitability and negative EBITDA performance. That's gradually going away. It is disappearing to the extent that it's affecting everyone's bottomline."

2. Huge squeeze on profits. ASCs nationwide are finding it increasingly more difficult to maintain profit margins as government and third-party payors hold or even reduce their payment rates.

"With CMS, there's effectively no escalator, it's virtually nothing," Dr. Lambert says. "CMS doesn't give us any bump up, so that affects all payors. They see what CMS is doing and they're not disposed to giving us escalators. The payments are ratcheting down on a per case basis and the costs are escalating on a per case basis."

Over the last decade, ASCs have faced increasing costs in areas such as labor and supplies, says Mr. Luke Lambert. With no or trivial reimbursement increases for many years and increasing costs surgery centers have been in a progressive margin squeeze over the past decade.

"People are giving up and accepting no profit and losing money," Dr. Lambert says. "This is a real concern as an industry as a whole."

3. Ranks of surgeons are depleting due to hospital employment. "The private practice of medicine and its waning nature is such that there's no one to recruit for ASCs when people retire or leave for other employment," Dr. Lambert says. "There are no replacements."

4. Future of healthcare reform. "There's so much uncertainty here that no one can go to sleep at night feeling they know what's going to happen," says Dr. Lambert. "There's zero certainty. We don't know what form it's going to be in. There are legal challenges through the courts based upon the interpretation of the Commerce Clause. And with the fragile state of our economy, can we even afford it as a country? There's growing evidence that we can't. Then there's the political uncertainty — if Obama isn't re-elected, then healthcare reform is dead."

5. Evidence of recession. With the report that the country's unemployment rate increased a tenth of a percent in May, there is evidence the country might be heading into another recession. "A tenth of a percent might seem like nothing but there were only 50,000 jobs created last month," Dr. Lambert says. "It seems like we're heading into another recession."

6. Feasibility of accountable care organizations. "Most of the changes that were intended [by the federal government] to save money have been kicked down the road but the initial glimpses we get of what the government thinks are going to be the source of savings have been, frankly, a tremendous disappointment," says Mr. Luke Lambert. "Look at the ACO rules. If this is what we're counting on saving healthcare in this country, it's not going to work."

Dr. Lambert views ACOs as a "bureaucratic morass that shows no evidence it's going to save one cent and probably, in total, is going to be extremely expensive to the people who choose to participate, whoever that is going to be."

7. Mandates handed down to insurance companies. Another component of healthcare reform — mandates handed down to insurance companies on coverage — has only served to drive up costs even further, says Mr. Luke Lambert.

"Yes, the private sector has been able to implement them but it's propelling healthcare costs, so instead of healthcare reform looking like it's going to reduce costs, instead it's been doing exactly the opposite of what it was intended to do," he says.

8. Power of the new Independent Payment Advisory Board.

A controversial provision of healthcare reform was the establishment of the Independent Payment Advisory Board, a 15-member group to be appointed by the president and tasked with developing recommendations regarding procedures, medications and spending priorities for Medicare and Medicaid. IPAB is mandated to implement its first proposal in 2015.

"This is 15 people who don't answer to anybody who are going to decide how ASCs are going to be paid in the future," says Dr. Lambert. "What kind of randomness are we going to be subjected to? It's of great concern."

9. Potential benefit of value-based purchasing. One of the few current positive issues for ASCs is new legislation under consideration which would establish a value-based purchasing system that rewards ASCs for high-quality outcomes, says Dr. Lambert. "But when I look over the landscape, that's one of the only things I can hang my hat on in terms of good news," he says.

10. Increase in transactions and consolidations. There has been a noticeable increase in ASC transactions for the past 6-12 months which see one management and development company acquiring another, and Mr. Luke Lambert expects there are more to come. "Those transactions are evidence of a substantially more challenging environment than existed when these companies got started," he says.

"I think there's going to be so much consolidation going forward," adds Dr. Lambert. "What we're seeing is the high profile [transactions], but there's consolidation going on between little guys, people stepping away from [the business]. They're down to one center whereas maybe they were managing four or five before."

11. Hospitals as willing partners. More ASCs are turning to their local hospitals for partnerships, selling the hospital majority control, and this is saving many surgery centers, Dr. Lambert says. "You've seen ASCs fall into the waiting arms of the hospitals a) to get bailed out and b) to get improved reimbursement," he says. "The hospitals can go to the payor, say they have a majority control of a surgery center and tell the payor they can't operate at the level they're paying the independent ASC, so they need a 30 percent bump in payment."

More good news for ASCs is many hospitals are now viewing surgery centers as part of their strategic plan, says Mr. Luke Lambert. "Hospitals are taking a more constructive posture toward ASCs," he says. "They're considering whether to buy a surgery center as a means to get into new markets or maybe open an ASC in a competing market."

12. Effective management an ongoing challenge. Dr. Lambert says that while he regularly encounters ASCs which are passed the turnaround stage because they are encumbered with debt, there are still many surgery centers which, despite poor management, are still ripe for saving.

"There are still huge opportunities with or without hospitals for huge turnarounds," he says. "We like them done in conjunction with a hospital joint venture to get the [payment] bump but they can still be done without the joint venture. We still see terribly managed ASCs, but with a little effort, these could still be made to be very profitable." ■

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10 Top Priorities of Surgery Center Physicians (continued from page 1)

the governing board might make the decision to have a financial penalty toward the physician causing delays," she says. Ms. Dugan says she has also given her director of nursing and charge nurse authority to bump the chronically late surgeon if necessary.

Jared Leger, CEO and managing partner of Arise Healthcare, says surgery centers can provide designated physician parking to make it easier for physicians to get to the surgery center. "We try to do things to make them more efficient," he says. "We have designated parking so the doctor can park there and then walk into the ASC through the back entrance." He says this provides an advantage over the hospital, which will probably ask physicians to park further away in a parking garage.

2. Flexible scheduling. Chris Metz, MD, an orthopedic surgeon with Brainerd Lakes Surgery Center in Baxter, Minn., says while the normal start time at his surgery center is 7:15 a.m., the staff will start cases at 6:30 a.m. if needed. He says he appreciates being able to perform bigger procedures after less-complex procedures, rather than having to perform big cases back-to-back and causing delays.

"Try to accommodate physicians when they want to add cases at the last minute, David Kelly, MBA, CASC, administrator of Samaritan North Surgery Center in Dayton, Ohio, and employee of Health Inventures, says. At his surgery center, the scheduler tries to keep available time on the schedule every day so patients can be scheduled at short notice. "You have to have free time in your schedule so it's not all blocked," he says. "Try to have one room per day in the morning or afternoon where you can put those extra cases."

Ms. Dugan says her ASC tries to make scheduling easier by building a relationship with the physician office. Her staff has developed a binder for the physician office scheduler that includes information on the key contacts in the surgery center, a template for the H&P, order form and patient information form and a list of the items the patient should receive prior to surgery. "We set up a one-on-one meeting between the office scheduler and the surgery center scheduler, and the surgery center scheduler goes to the office and brings the binder and talks to them about how we do it here," she says. She says establishing a face-to-face relationship is the best thing you can do to make sure your physician's cases are brought to the ASC.

3. Appropriate equipment and supplies. Nothing is more frustrating for a physician than arriving at the operating room to find that the center has laid out inappropriate equipment, Mr. Kelly says. He says his specialty resource nurse tries to keep physician preference cards up-to-

date by paying attention to physician requests. "It'll send a physician over the edge if they think, 'I've told you five times that I don't use this or I want something else,'" Mr. Kelly says.

Ms. Dugan adds that physicians get frustrated when they notice staff members opening an expensive supply that is not appropriate for the case. "Physicians know that if you open the wrong stent or the wrong supply, that can [offset] the profit of the case," she says. "You need to educate the staff to make sure they understand the surgeons see the center as a business."

Her ASC staff has created a high-cost item spreadsheet that staff references to make sure they understand supply costs. "We have a policy in place that says no high-cost item will be opened until it's been verified with the surgeon and surgical tech prior to the case," she says.

4. Knowledgeable staff. Happy physicians love their team and enjoy working with them, Ms. Dugan says. Ideally, you should try to keep effective ASC staff members working at your center for as long as possible. They will become experts in your physicians' procedures, and your physicians will get used to working with the same, competent people. Ms. Dugan says she tries to boost employee longevity by letting staff members know they are appreciated on a regular basis. "I'm a big believer in team-building, so we celebrate everyone's birthday, Nurses Day and Tech Day," she says. "It's the small things that make people want to come to work."

While you would ideally like to keep your top workers for as long as possible, sometimes staff members have to leave and you are forced to hire new people. Ms. Dugan recommends using a temp agency to hire new staff members for the front office. "You pay more up front, but if they're not a good fit, you don't have to go through all the termination paperwork," she says. For clinical staff, she hires PRN initially and then moves people to full-time status once she knows they fit well with the center. She also recommends looking for team members with ASC experience.

Mr. Leger says surgery centers can please physicians by involving them in the hiring process as well. When an Arise surgery center needs a new team member, the administrator asks the physicians for their input. For example, he says if an ASC needs a new surgical tech, the physicians can usually recommend a few people to come in for interviews.

5. Notification of staffing changes prior to surgery. You may have to add an unfamiliar face to the OR if one of your staff members calls in sick or goes on vacation, Ms. Dugan says. But if you are replacing a familiar staff member with someone the physician has never met before, make sure to notify the physician beforehand to prepare him or her for the change. Let them know you have screened and hired a temporary staff mem-

ber and invite the physician to give feedback on how the new person performs. "If the surgeon walks in and doesn't recognize the people, they automatically assume the [new staff members] don't know what they're doing," she says.

6. Efficient case turnover. Dr. Metz says many physicians open or join surgery centers for the added efficiency, so short waiting times and prompt case turnover is essential. "We came from a hospital that wasn't necessarily as efficient as we wanted, and the ability to balance cases has been a nice change from that situation," he says.

Surgery centers are challenged to keep room turnovers efficient without overstaffing and losing money, Ms. Dugan says. If possible, the ASC should use a "floating team" to keep an eye on each room while physicians are working. "Especially if you're running multiple ORs, you need a charge person and a surgical tech or assistant to keep an eye on what's happening with each room and who's going to be done quicker," she says. New infection control guidelines require more in-depth cleaning, so you may need to allow for 10 minutes to prepare a room for the next case.

She says surgery centers can also improve room turnovers by making a note when a room will transition from a complicated, equipment-heavy case to a simpler case. "If you're doing a very large sinus case that has tons of equipment and then you're doing another one that's somewhat simple, you need more turnover time to get that equipment out," she says. "If you put that in the schedule, the surgeon sees that it's not affecting their time."

7. No case cancellations due to inadequate screening. Mr. Kelly says physicians will become easily frustrated if the ASC has to cancel cases due to inadequate patient screening. Case cancellation hurts patient satisfaction and revenue and disrupts the physician's schedule, so it should be avoided whenever possible. At his surgery center, the anesthesiologists provide the guidelines for preoperative phone calls, and staff members follow those guidelines to catch any patients that are at increased risk of complications. This could mean patients who are overweight, suffer from sleep apnea or respiratory problems or have a history of adverse reactions to anesthesia. "If they're over a certain age or have a history of heart disease, they may need an EKG ahead of time," he says. Preoperative phone call staff should ask clear, direct questions that get to the root of the patient's history and current medication use. Additionally, leveraging technology, like an online pre-op assessment tool where the patient enters his own health history at his leisure and his own pace, is a great way to get complete information.

Dr. Metz says patients should also be fully prepared for their surgery by the time they arrive at the surgery center. "I think the physician clinics that refer patients here are all about education and making sure patients are comfortable with what's

going to happen to them," he says. Surgery centers should make sure to distribute information on the surgical procedure and process to avoid panicked or confused patients on the day of surgery.

8. Satisfied patients. Patient satisfaction can be impacted by a variety of factors, including wait times, staff attitude and postoperative recovery. Physicians want their patients to report a satisfying experience in the surgery center, so your relationship with your surgeons will suffer if your staff is rude or your cases are significantly delayed. Make sure that staff are coached on friendly, professional behavior, and ensure that when case delays occur, you apologize to the waiting patient and keep them up-to-date on the situation. Mr. Leger says surgery centers can also go the extra mile by providing tracking tools in the waiting room to inform family members of the surgery's progress. "We have an LDC monitor that shows the patient's initials and where they're at in the process," he says.

Mr. Kelly says patient satisfaction can also be impacted by the instructions they receive for post-operative care. "One of the challenges we all have is that patients and family members do not always remember what you tell them, so our goal

is to provide comprehensive discharge instructions," he says. "It minimizes headaches for the doctors by increasing compliance with post-op care. The doctors don't want a patient coming into the office and saying they didn't know what they were supposed to do after surgery."

9. Decisions supported with data and benchmarking. Surgery centers with limited budgets can't please every physician by using 10 different vendors for the same supply within a specialty, Mr. Kelly says. In these cases, you may have to explain to your physicians that you can't afford the "latest and greatest" technology they would like, and you would prefer them to standardize some supplies to save money. To effectively communicate this to your physicians, use data and benchmarking tools to back up your decision, he says. "They want information in terms of trending, showing benchmarks and highlighting actual expense compared to budget," he says. "Physicians are very competitive, so they don't want to see their name in last place [when it comes to cost]."

Mr. Leger says partner physicians are "trained to analyze data," meaning surgery centers should present financials rather than trying to convince them with anecdotes. He says his surgery centers

give physicians a 15-page financial report as well as a front-page summary sheet that addresses financial progress. "If the physician is busy, it takes five minutes to read the study and understand how we're doing," he says.

10. Someone to act as a "go-between" to facilitate positive hospital and physician partnerships. If your surgery center has investor partners, the administrator should act as a "middle man" to create a mutually favorable relationship between the parties, Mr. Kelly says. "The doctor wants to focus on providing quality clinical care, which the hospital desires as well, while also being fiscally responsible," he says. "As the administrator, you've got to act as the go-between and help build those relationships by bridging the gap in each partner's vision of success and deliver results." These partnerships need this "middle man" to bring the hospital and physicians together to implement successful business plans from what is sometimes perceived as competing or unaligned priorities. This is especially important to soothe tensions in cases where they were previously competitors. ■

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Future of Physician-Owned Facilities: Q&A With Dr. Jeff Hessing of Treasure Valley Hospital and SCA

By Rob Kurtz

Jeff Hessing, MD, is an orthopedist and physician-owner of Treasure Valley Hospital in Boise, Idaho, as well as a member of the physician leadership team for Surgical Care Affiliates. He has been in practice for more than 25 years in Boise and is part of an orthopedic group that has remained independent in its practice, unlike the estimated 60 percent of orthopedists in the Boise area who are employed by one of the two large hospitals in town.

Dr. Hessing is also a former physician-owner of an orthopedic-driven ambulatory surgery center, which was sold to a hospital in Dec. 2009, and is part of a group exploring new ASC ownership opportunities in Boise.

Dr. Hessing discusses his outlook on the future of physician-owned facilities and why Boise can serve as a model for physician ownership.

Q: Physician employment by hospitals is a growing trend, as is evident in Boise, and yet you have not only maintained independence as a practice and ownership in a hospital but are in discussions about becoming an owner of an ASC for a

second time. Why are you seemingly going against the hospital-employment trend?

Dr. Jeff Hessing: I believe that physicians need to stay at the reign of healthcare and that's the opinion of our group. When our ASC was sold to one of the large hospitals two years ago, I was not one voting in favor of it. Overnight our prices were doubled when the hospital took control of our facility and converted it to their own facility. We had several patients complain about that transition, wanting to know why two years ago they had their knee scoped at the ASC for \$7,000 and now it was costing \$18,000.

On the other hand, for the specialty hospital which I have 4 percent ownership in (Treasure Valley Hospital is 60 percent owned by physicians, 40 percent owned by SCA), we have just completed an interesting review of our EOB information and we have very good information on pricing in this town. We can show that our pricing at Treasure Valley Hospital is indeed approximately 50 percent below market of the big hospitals in town for outpatient surgical charges. I'm very aware of what physician-owned facilities in this town cost, charge and are reimbursed and can compare those to the other two major hospital systems in town.

If you look at the [Medicare Hospital Compare website at www.hospital-compare.hhs.gov] which has Medicare data taken from millions of Medicare claims and rates hospitals by area, go to our zip code in Boise and you'll find we are the highest rated facility when it comes to patient satisfaction, safety measures and quality. I know that the physician-owned facilities I have been a part of are the highest-quality, most-efficient and least-costly facilities in the region. I believe that happens because physicians are in charge of healthcare. We can balance the patients' needs with the bottom line. We can make the right decisions that bring down the costs of what we do.

At our facility, we treat almost the exact same percentage of Medicare and Medicaid that the other facilities in town treat. We do no-pays and we write-off, on a percentage basis, more of our care than they do. At the same time we pay taxes and we work for-profit. I've been in this practice now for 15 years with my own facilities, and I absolutely believe we are the low-cost, high-efficiency, high-quality providers. I believe that is why I am so bullish about physician-owned facilities.

Q: How do you see your business growing with increasing competition from the large hospitals?

JH: I believe that the downward pressure on pricing and reimbursements in our system in the future will drive cases out of the big facilities like our two local hospitals into facilities like Treasure Valley Hospital or physician-owned ASCs, and they'll be driven there because of the cost savings and high quality. Rather than threatening our survival, I believe it will fuel our growth in the future. I personally see that as a must if healthcare in this country is going to survive. You have to get these cases into facilities that can do them much cheaper and at a higher quality.

Q: What efforts are you undertaking to bring in more cases?

JH: We are evaluating all of the options. We are in the process right now of talking with a local physician-run network to work out a cost structure with companies signed-on [to the network] to put us on a first tier for their surgical care for the cases we do. They'll get a lower expense to the employee for that decision.

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Another of our efforts is focused on two large family practice groups in town, which are 50-60 member groups. We are talking with both of them to reassure them there are independents in this market. We're organizing the independent doctors in this town around a common theme of maintaining our independence, supporting one another.

You have to be creative. You have to have a compelling story that shows there are other alternatives [to hospital employment]. We're showing Treasure Valley that this is what's happening. I believe we have stayed the initial rush and now I think we're going to see growing support.

I believe the future is driving patients to us, not away from us, because the hospitals can't compete with us for what we do. That's why I think we're standing exactly squarely where I want to be. I think that's where the patients are coming. I know that's also the opinion of SCA and the private equity group that's behind us. We do have some hurdles to overcome. Most of that is the public doesn't really know about us but I believe we're getting our story out.

Q: How are you able to maintain such optimism and confidence in physician-ownership when so many of your peers in Boise have moved to physician employment?

JH: I think [Boise has] probably one of the highest percentages for hospital-employed orthopedists you're going to see in the country as I look at the data. And I think if we can [have successful physician-owned facilities] here in Boise with the kind of employment, it can be done anywhere. It's really paranoia that's driving physicians to the hospitals today. They're afraid of all of the pending legislation, accountable care organizations and how they are going to remain competitive.

I can tell you we're going to compete just fine as physician-managed facilities. I think Boise is a good test case. Give it another 2-3 years in Boise and I think you'll see the pendulum swing the other way. For some physicians who are employed by hospitals now, like many urologists in the area, their contracts with the hospitals are just ending and most of them have decided not to up again and not let the hospital employ them again. It's already starting to crack in Boise. I think you'll see those who want to ride it out will do just fine.

If you can offer physicians an alternative that makes sense to them and lets them maintain their independence, that's what a physician will choose. That's why we all went into medicine. I don't believe we went into medicine hoping we would be employed by a hospital. ■

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5 Trends Affecting the Future of Ophthalmology in Surgery Centers

By Rachel Fields

Mark Packer, MD, FACS, CPI, ophthalmologist at Oregon Eye Surgery Center in Eugene, Ore., discusses five issues impacting the future of ophthalmology in the ASC setting.

1. Technological developments in cataract surgery. According to Dr. Packer, one of the most significant changes in surgery center ophthalmology comes with the introduction of the femtosecond laser. "The laser essentially automates the principle steps of cataract surgery that are traditionally done by hand," he says. "It's going to change the way we do cataract surgery because the technique is so different. There's no question that we're moving in this direction." He says the biggest issues for ophthalmology-driven surgery centers, now that the femtosecond laser has been approved, are cost and adaptation. The laser is expensive (around \$400,000) and large, an issue for surgery centers with limited capital and space. According to Dr. Packer, these obstacles to implementation might account for the limited use of the laser in surgery centers across

the country. He says the movement toward femtosecond adoption will likely take place in the next five years. "In five years, it'll seem like it happened overnight," he says.

For Oregon Eye Surgery Center, adoption depends on adjusting workflows and financing the purchase. "We've got two rooms for cataract surgery, and we'll put the laser in one of those rooms," he says. "I know [other surgery centers] are thinking about having the laser outside the operating room, since they perform all the steps of the procedure without violating the surface of the eye. You don't need to be in a sterile environment to do that, so some have talked about having patients circulate past the laser." He says the surgery center is planning to purchase the laser toward the end of 2011, though the biggest obstacle is still the \$400,000 price tag and cost of maintenance.

2. Rise of premium services. In 2005, Dr. Packer says CMS ruled that Medicare beneficiaries would be allowed to pay for extra services associated with lens implants that reduced or elimi-

nated the need for eyeglasses or contact lenses after surgery. "Initially, in 2005, it was presbyopia-correcting lenses, and then it became toric lenses, which correct astigmatism," he says. He says the ruling means that providers can charge patients more out-of-pocket for "premium services" that enhance the services covered by Medicare. "This creates a kind of avenue to incorporate [equipment like] the femtosecond laser, because the thinking is that the outcomes with the laser are going to be better, and since the laser is expensive, we don't have any way to pay for it out of standard Medicare reimbursement," he says. "But if we incorporate the use of the laser for patients undergoing surgery for presbyopia and astigmatism, we can build the cost of the laser into the cost of performing those services."

He says he expects the provision of "premium services" to increase as physicians struggle to survive on current reimbursement rates. "We can offer these premium services that are paid out-of-pocket, and that creates a whole separate revenue stream that provides great value to pa-

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tients and high levels of satisfaction," he says. "It's kind of akin to a plastic surgeon who may do reconstructive work that is covered, but also does all these cosmetic, non-covered, out-of-pocket procedures." He says these services may help physicians survive as Medicare reimbursement rates continue to drop.

3. Age and volume of cataract surgery patients. Dr. Packer says he has seen an increase in younger cataract surgery patients, or patients who choose to undergo cataract surgery before age 65. "People elect to have surgery earlier because it's perceived as safer," he says. "They think, 'Why should I put up with difficulty driving at night? My neighbor had it done and had a great outcome.' I think we'll see a bit of a downward drift in mean age for cataract surgery."

He says despite the increase in younger patients, however, the majority of cataract patients are still over 65, the age at which Americans become eligible for Medicare. As the baby boomer population approaches retirement age and the number of insured Americans increases following health reform, he says he expects to see an increase in patient volume — though it may not be the drastic leap that some expect. "Here in Oregon, it's more of a gradual rise," he says. "It's not like we're going to double our volume this year. I think we will start to see a more gradual

increase as the population ages and a positive flow of retiring people comes to the area."

4. Increasing use of EMR. A 2006 study by the American Academy of Ophthalmology showed that 12 percent of surveyed practices had EMR systems in place, with 7 percent in the implementation process and 10 percent with plans to implement EMR within the next 12 months. Dr. Packer says while those numbers have undoubtedly increased in the last five years, he still believes the percentage of EMR adoption among ophthalmologists to be relatively low. "The vast majority still have that hill to climb," he says.

He says ophthalmologists implementing electronic medical records should prioritize integration with the surgery center or hospital system. "It really was important for us to have our clinical system fully integrated with our ASC system," he says. "I was visiting a major academic medical center recently, and I was horrified to find out that the EMR used in their clinics was different from the one used across the street at the surgery center." Dr. Packer says when he wants to schedule a cataract surgery, it takes "two clicks" to create an H&P and an order set, and the surgery is communicated immediately. He says if ophthalmology-driven ASCs expect to see an increasing volume of patients, they need to prioritize EMR implementation to im-

prove patient flow.

5. Stricter Medicare regulations. Regulations introduced by Medicare in May 2009 will almost certainly impact surgery centers; Dr. Packer's ASC has already undergone an inspection that the center passed with flying colors. The regulation changes and impending inspection meant that the ASC had to tweak several processes to show compliance, Dr. Packer says. "We instituted additional documentation for infection control, and we had to start having more frequent meetings of our QA committee with more minutes produced," he says. "We also had to buy new autoclave trays with the covers locked down. We had been carrying instruments in an open tray."

He says while the center had to change very little in terms of patient care, there were some necessary fixes. "The way we had been doing our YAG laser procedures, we hadn't been admitting the patients and checking their vitals. We have to do that now," he says. "We had to hire another half-time equivalent nurse to make everything work out." In order to prepare for the survey, the center hired a consultant to perform a mock audit and outline the ASC's deficiencies. Dr. Packer says the investment paid off when the surgery center passed the inspection with zero deficiencies. ■

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6 Ways an ASC Can Lose Physicians — and What to Do About it

By Leigh Page

Losing a key physician is a scary prospect for an ambulatory surgery center because it can mean taking a big hit in surgical case volume, says Mike Lipomi, president and CEO of Surgical Management Professionals in Sioux Falls, S.D. Here he lists six different ways physicians can exit ASCs and how to deal with each one.

1. Retiring physician. Physicians often plan their retirement three to five years in advance, but it is important to act early so that surgical volume will continue coming in. When you hear something, approach the surgeon directly. “If you have good rapport with the physician, it will be easy to be direct,” Mr. Lipomi says. “You can say, ‘I hear you are looking at retiring. What are your plans?’” “Typically, the physician will want to bring in a younger partner to take over the practice. The ASC’s concern is whether the younger physician will keep up ties with the center.

The new physician may, in fact, want to do things entirely differently, such as using an inpatient setting or another surgery center where he has a friend. It is important to have a discussion before any commitments are made. “The ASC should immediately be starting to work with the new doctor,” Mr. Lipomi says. The center can offer him shares in the center, preferably from the retiring physician, and services like highly sought-after block times, access to preferred supplies and the surgeon’s choice of staff. Unfortunately, however, “an ASC will often focus on the needs of the older, stable physicians who’ve been there and overlook the younger guys,” Mr. Lipomi says. But if the younger physician commits to the ASC, “your volume may never slow down and, in fact, may pick up a little, because he will be more active,” he says.

2. Retirement in a split practices. When physicians in one practice are split between two or more ASCs, the retirement of one of the physicians affiliated with your ASC can be tricky. The danger is that your physician’s patients could be transferred to one of the physicians using another ASC. To preclude this, “you have to be doing some very focused recruiting of the other doctors,” Mr. Lipomi says. The retiring physician could be enlisted for support.

3. Physician leaves town. Sometimes a physician decides to move to a whole new location, putting his ASC’s volume up for grabs. He can’t take those patients with him. “We had a doctor who, with very short notice, de-

cided to join the Navy,” Mr. Lipomi says. “We asked him what would happen to his practice, and he said ‘I don’t know and I really don’t care.’ That’s when we knew we had to do something.” The ASC stepped in and facilitated an acquisition of the practice by another local physician. In a phased-in acquisition, the acquiring physician may pay all of the practice’s overhead, allowing the exiting physician to wind down without incurring debts.

4. Sudden death. Aside from the personal loss, the death of a key physician can be very troublesome for an ASC, particularly if the deceased physician was a solo practitioner who had no one lined up to give the practice to. In this case, someone from the ASC should call the physician’s widow and ask if she needs any help dealing with the practice. Arrange for physicians affiliated with your ASC to acquire it. This process should move quickly, in perhaps three to four days, Mr. Lipomi says. If it is drawn out, the patients start finding new physicians on their own. “Patients and referring physicians have needs,” he says. “As soon as patient patterns change, they won’t come back.” The physician who takes over the practice also needs to make sure he is contracted with the deceased physician’s major payors. If not, he can usually get temporary permission to use the physician’s insurance ID.

5. Physician loses his license. If a physician is charged with fraud or loses his license, the surgery center is not only embarrassed but can lose a great deal of volume. In this case, however, the ASC should move slowly and cautiously, Mr. Lipomi says. “These can be horrible situations,” he says. “The feds may come in and close down his office and everything is a mess. Things will be in flux for a while, so it’s important to lay back until the matter plays its course and then step in.” It may not be possible to sell the practice until certain regulatory matters are settled.

6. Physician goes into rehab. When the physician steps down from his practice for several months to deal with a drug or alcohol problem, other physicians need fill the breach to make sure his patients are retained. This can also apply to disciplinary actions where licenses are suspended for a limited period of time, such as six months to a year. If would be overwhelming for one physician to take over the volume of another practice even temporarily, but five different physicians could do it, Mr. Lipomi says. “Each physician would get one in every five patients, which is workable,” he says. Again, the ASC acts as a catalyst, bringing these physicians together to meet the problem. ■

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10 Proven Ways to Improve Surgery Center Efficiency

By Rachel Fields

Sandy Berreth, RN, MS, CASC, administrator of Brainerd Lakes Surgery Center in Baxter, Minn., and Vicki Edelman, administrator of Blue Bell (Pa.) Surgery Center, discuss 10 ways their surgery centers improve efficiency.

1. Send out start times the day before surgery. Ms. Berreth recommends administrators send out surgeon start times the day before surgery via email. Most surgeons have regular access to email, and a reminder can help improve timeliness and eliminate the excuse of, “I didn’t know.”

2. Ask surgeons to do paperwork in advance. Ms. Edelman says her surgery center asks surgeons to prepare the necessary paperwork before arriving at the ASC. “You don’t want the doctor to come in on the day of service and do an H&P,” she says. The chart should be ready to go as soon as the physician walks into the center, and consent forms should be signed beforehand. She says her center has been successful in training physicians to complete paperwork ahead of time by introducing the policy as soon as a physician starts at the center and then staying firm on the expectations.

3. Use a “reservation sheet” to check supply needs. Ms. Berreth says her ASC asks physicians to fax over a reservation sheet that lists every supply the surgeon needs for the case. Surgery centers can improve efficiency if the right supplies are waiting for the surgeon when he or she arrives. That way, staff members don’t have to scramble to stock the OR at the last minute, and the physician is ready to start the case as soon as the patient is ready. “It works really well to keep everybody on the same page,” Ms. Berreth says.

4. Find an efficient anesthesia group. An efficient anesthesia group can speed up case transitions tremendously, Ms. Edelman says. Make sure to ask questions about efficiency and the group’s philosophy during the interview, and check references to determine whether other facilities have had problems with the group’s timeliness in the past. Ms. Edelman recommends speaking with the anesthesiologists as a group, as the opinions of the group’s medical director or leader may not match the attitudes of each individual provider.

5. Penalize late starts. Physician tardiness can have a significant effect on efficiency, as one late start pushes back other cases and slows down the whole day. Ms. Edelman’s surgery center has instituted a policy that penalizes physicians if they show up late three times. “If you are late three times, you will not get an early morning start,” she says. She says the penalty comes down to a board decision, and the ASC has been firm about enforcing the policy with chronically late providers.

6. Don’t keep the patient waiting. Ms. Berreth says her surgery center tries to let the patient sit in the waiting room for no more than five minutes. “It’s important that they don’t think, ‘My appointment was for 8:30, so why am I still sitting here at 8:45?’” she says. If a staff member doesn’t come to collect the patient within five minutes, the surgery center makes a second call to the pre-op area. Ms. Berreth’s ASC also pre-assigns rooms to make sure staff members know where to take the patient.

7. Do the same thing every time. Ms. Edelman says surgery centers can improve efficiency by establishing policies and following those policies for every appropriate case. For example, ASCs should try to get room turnover down to a science; every staff member should know what he or she is responsible for and should not need to consult anyone to complete those tasks. For example, Ms. Berreth says during room turnover, ASC

staff members should know exactly how to clean instrumentation and who is responsible for getting it done.

8. Improve hand-offs with consistent communication. Ms. Berreth’s ASC has improved hand-offs from pre-op to OR and from OR to phase one recovery by developing a one-page worksheet for nurses to follow. The sheet lists the patient’s vital statistics, the presence of the H&P, any patient allergies and the surgical site. “It’s a one-page document, which helps because the OR nurse isn’t having to look through the whole chart to find the necessary information,” Ms. Berreth says.

9. Use a float nurse to handle turnover. Ms. Berreth says her surgery center uses a float nurse to handle tasks between cases. She says float nurses can be very helpful when other providers are busy with cases. “I have a two-minute average turnover time for ophthalmology and a five-minute turnover for orthopedic cases, and one reason is because I have a float nurse who does all that stuff in between cases,” she says. While a float nurse costs the surgery center more money, Ms. Berreth considers the investment worthwhile.

10. Don’t assume EMR will solve your problems. If you want to improve your surgery center’s efficiency, don’t assume that implementing an electronic medical record system will immediately speed up wait times and case length, Ms. Berreth says. “It doesn’t necessarily work,” she says. “EMRs are more difficult to handle because you’re constantly clicking and saving.” While EMRs can effectively improve patient safety and organization in an ASC — and are worth considering — don’t depend on them to fix efficiency problems. ■

Contact Rachel Fields at rachel@beckersasc.com.

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5 Factors That Heavily Influence ASC Value

By Rachel Fields

VMG Health's 2011 *ValueDriver ASC Survey* queried leaders from the country's 20 largest and most well-respected ASC management and operating companies and found that five factors impacted surgery center value more than others.

1. Reliance on out-of-network volume.

Ninety-three percent of respondents said that a high reliance on out-of-network volume posed a "very high" risk for a surgery center. Buyers may shy away from OON centers because the future of reimbursement is uncertain: Payors may force the center to go in-network, decreasing earnings significantly. Buyers may alternately choose to value OON centers as if they were in-network, foregoing the OON "premium."

2. Few physicians generating the majority of the profits.

A well-valued ASC will have the "Goldilocks" number of physician owners — not too few, not too many. According to the HealthCare Appraisers survey, manage-

ment companies generally prefer 6-10 physician owners for a single-specialty surgery center and 11-15 owners for a multi-specialty surgery center. Too many physician owners can dilute ownership shares and decrease physician investment in the center's success. If physicians are making very little in distributions, they may be less likely to bring profitable cases to the center.

3. High physician ownership in competing facilities.

Physicians with ownership in competing facilities may feel conflicted about where to send their cases, potentially decreasing center profitability and contributing to the success of a competitor. According to the VMG Health survey, 93 percent of respondents believed a high level of physician ownership in competing centers had a "high" or "very high" effect on ASC value.

4. High reliance on non-owner physicians.

Non-owner physicians may be less invested in surgery center success than physicians

with a stake in the center's financial health. Non-owner physicians may also drop out of contact with the center more easily. According to the VMG Health survey, high reliance upon non-owner physicians to derive significant volume and revenue has a high impact on EBITDA multiples.

5. High concentration of revenue from a single payor.

High reliance on a single payor can be deadly for an ASC if the payor decides to cut reimbursement rates significantly. ASC valuation firms want to see a diverse payor mix for surgery centers, meaning no one payor can have a significant effect on profitability. Seventy-three percent of VMG Health survey respondents felt that a high concentration of patient volume/revenue from a single payor posed a "high" or "very high" risk, and over half of respondents felt similarly threatened by the dominance of a single payor in the center's market. ■

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7 Questions on Surgery Center Transactions and Valuation Issues: Q&A With Stephan Peron of VMG Health

By Rob Kurtz

Stephan P. Peron, AVA, is a partner with VMG Health.

1. Q: How are ambulatory surgery centers being priced today?

Stephan Peron: In today's economic environment there has been a greater segregation in pricing based on quality due diligence in the eyes of a buyer to qualify an investment as a high-quality investment versus a low-quality investment. The same holds true for the surgery center market. ASCs considered high quality from a general market perspective must possess certain attributes that surgery center investment companies find to be attractive in regard to the ability to generate a strong return on investment. The prices on the high-quality surgery centers are still strong as compared to the market before the financial crisis in 2008 and 2009. The prices on the lower-quality surgery centers came down a few years back and have remained depressed as compared to times when the debt was readily available.

2. Q: Does pricing depend on type of specialty? If so, which are better, which are worse?

SP: The value of an ASC could depend on the specialty mix as well as the case mix within a certain specialty. What drives prices of ASCs, in a simplistic view, is the ability to generate a return on the investment for long period of time. Therefore, certain specialties such as plastics, in which the price paid to the ASC is heavily negotiated by the referring physician, typically drive a lower return to the ASC. Other specialties that can easily move to a physician in-office suite, such as pain management and diagnostic endoscopy cases could carry a higher risk and lower the value of the ASC if the referring physicians are not owners in the subject center and subject to a non-compete.

3. Q: What are other key factors assessed for pricing?

SP: Upon conducting a fair market value analysis of an ASC there are numerous aspects that one must consider to determine the value relative to the risk of the ASC investment. A few general key factors that need to be considered for pricing an ASC are: a) Understanding the rights being exchanged between the two parties. Control rights of an ASC typically drive

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a premium in the market versus minority rights. b) Risks surrounding the ability to maintain and grow the revenue of the ASC. As an example, understanding physician ownership in relation to the cases being performed drives different risk profiles. Another example would be determining if the ASC is in-network versus out-of-network. c) Determining if the ASC has the right expense profile in place today and allows the ASC the ability to grow. For example, if the ASC is fully utilized and there is not an ability for the ASC to grow due to physical constraints, that would need to be considered. e) Competition to the ASC. One must consider if the ASC owns a Certificate of Need in a strong CON state. As another example, the subject ASC has strong historical earnings but a new ASC is being built in the same service area of which many current referring physicians have purchased an interest in the new ASC.

4. Q: Is the amount or frequency of transactions up or down over the last 6-12 months?

SP: Our firm works with numerous ASC management/development companies, health systems and physician groups, and it is our opinion that the number of transactions has remained steady to a slight increase. We have seen an increase in the number of health systems acquiring or buying an interest in freestanding surgery centers.

5. Q: Is pricing up or down from last year?

SP: If we assume all factors regarding an average ASC investment opportunity remain equal between the two time periods, the prices being paid for ASCs are consistent with last year. Regarding ASCs that would be consid-

ered strong ASC investments, we have seen higher prices now as compared to the same time last year.

6. Q: What are buyers most concerned about?

SP: Many of the buyers concerns would be similar whether the investment carries control rights or minority rights but certain concerns would be viewed differently. A few similar concerns would be a) the ability to maintain the historical physician referral relationships and ability to grow new relationships; b) the risks associated with the ASC generating the expected cash flow relating to the ASC; and c) the general age and condition of the ASC, specifically in relation to maintaining the physician referrals and future capital needs.

7. Q: Is there still a buy and sell market for ASCs?

SP: Yes, there is still a liquid market for ASCs. There are no major ASC reimbursement changes on the near horizon. A strong investment market in ASCs still exists and numerous development companies striving for short- and long-term growth. There is an argument that the overall ASC market is becoming saturated when comparing number of operating rooms relative to number of available surgeons. On the other hand, the ASC market is still largely fragmented, with the largest of ASC owners holding only a 2-4 percent market share. ■

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56 ASC Management & Development Company CEOs to Know

By Sabrina Rodak

Here are profiles of 56 notable ambulatory surgery center management and development company CEOs who were selected through research and reviewed by our editorial staff. CEOs are listed alphabetically by last name.

G. Edward Alexander (Surgical Development Partners). Mr. Alexander is president and CEO of SDP. His experience in healthcare management includes serving as CFO of TeamHealth, founder and CFO of OrthoLink Physicians, founding president and CEO of Surgical Alliance and vice president of finance and treasurer of Medaphis. He has also served as vice president of finance and controller of Realty Development and CPA at Deloitte and Touche. He earned his degree from Emory University in Atlanta.

David Ayers (Nueterra Healthcare). Mr. Ayers is CEO of Nueterra Healthcare and has 30 years of experience developing, building and managing hospitals as well as ambulatory surgery, imaging, physical therapy and urgent care centers. He also has experience working with physicians and health systems to develop partnerships. Mr. Ayers is on the board of directors of Physicians Hospitals of America. He earned a degree in physical therapy from the University of Missouri in Columbia.

David "Buddy" F. Bacon, Jr. (Meridian Surgical Partners). Mr. Bacon is a founder and the CEO of Meridian Surgical Partners and has more than 22 years of experience in the healthcare sector. He served as CFO of Medifax-EDI, a Nashville, Tenn.-based healthcare IT company, for five years and as CEO for two. Prior to Medifax-EDI, Mr. Bacon worked in public accounting with Lattimore, Black, Morgan & Cain. He graduated from David Lipscomb College in Nashville with a BS in accounting and is a CPA.

Robert O. Baratta, MD (Ascent Surgical Partners). Dr. Baratta is partner and CEO of Ascent Surgical Partners. He is an ophthalmologist who has 25 years of experience managing surgery centers. He previously served as chairman and CEO of Ascent, LLC as well as president, CEO and vice chairman of the board of directors of Ecosphere Technologies, formerly known as UltraStrip Systems. Since 1996 Dr. Baratta has been on the board of directors of FPIC Insurance Company, where he served as chairman from 1999-2007. He has also served as a director of First Professionals Insurance

Company and president and board chairman of Stuart Eye Institute.

Richard M. Bracken (Hospital Corporation of America). Mr. Bracken serves as chairman and CEO of HCA. In 1981 he joined HCA, where he has held many executive positions, including COO and president. He has also served as CEO of the Green Hospital of Scripps Clinic and Research Foundation in San Diego and CEO of Centennial Medical Center in Nashville, Tenn. He has served on the boards of the California Hospital Association, Federation of American Hospitals and United Way of Metropolitan Nashville. He is also a member of several professional organizations and is a fellow in the American College of Healthcare Executives.

Jesse Chamberlain (Artisan Medical). Mr. Chamberlain is managing partner of Artisan Medical and has over 15 years of experience in healthcare, including healthcare sales, international sales and product development for Johnson & Johnson, Chiron Vision and Bausch & Lomb. He previously managed Procter & Gamble's Co-op Merchandising Agreements compliance program in Cleveland. He earned an MBA in organizational development.

Ravi Chopra (The C/N Group). Mr. Chopra serves as president and CEO of The C/N Group. In his current position, the company has completed healthcare-related projects totaling more than \$75 million in capital expenditures. The company and its affiliated entities comprise an annual revenue base in excess of \$20 million. Prior to founding The C/N Group in 1980, he served in various executive management positions in the steel industry, including chief industrial engineer for Youngstown Steel (now International Steel Group) and director of engineering services for Wisconsin Steel (now Envirodyne Industries). He holds a BS in mechanical engineering from Punjab Engineering College in Chandigarh, India, an MS in electrical engineering from Oklahoma State University in Stillwater and an MBA from Xavier University in Cincinnati.

James H. Cobb (Orion Medical Services). Mr. Cobb is founder, president and CEO of Orion Medical Services. He has more than 38 years of experience in management and has focused the past 25 years in the medical field. He has developed, constructed and managed seven high-volume ASCs in the last 12 years. He previously served as CEO for the Pacific Cataract Laser Institute and Pacific Eye Center and is a

member of the Medical Group Management Association and the American Society of Ophthalmic Administrators.

Richard L. DeHart (Pinnacle III). Mr. DeHart is co-founder and CEO of Pinnacle III. He has more than 18 years of experience in outpatient healthcare. In the past he oversaw the management of 14 surgery centers and provided operational services for several outpatient rehabilitation facilities. He graduated from California State University at Chico.

Michael Doyle (Surgery Partners). Mr. Doyle is CEO of Surgery Partners. 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. Throughout his career, Mr. Doyle has been a hands-on manager and he applies his practical experience of managing and developing healthcare services to his current position. He spent 10 years in a large corporate healthcare organization, where he became senior vice president of operations. Mr. Doyle earned a Bachelor's in physiotherapy from Dalhousie University in Nova Scotia, Canada, and an MBA from Troy (Ala.) State University.

Richard E. Francis, Jr. (Symbion Healthcare). Mr. Francis serves as chairman and CEO of Symbion, positions he has held since 2002 and 1999, respectively. Under his leadership, Symbion became a publicly held company and an ASC chain with nearly 100 successful surgery centers. He previously served as president and CEO of UniPhy, which formed Symbion with Ambulatory Resource Centres in 1999. He has also served as senior vice president of development and regional vice president of HealthTrust. During his time with HealthTrust, he was responsible for operations of 11 hospitals in five states.

Gregory George, MD, PhD, Sean O'Neil (SurgCenter Development). Dr. George and Mr. O'Neil are founding principals and CEOs of SurgCenter Development. Dr. George, a practicing ophthalmologist, received his medical degree and PhD in ocular physiology from Duke University in Durham, N.C. Mr. O'Neil, who has over 25 years of experience in healthcare management, completed postgraduate studies in health services administration at California State University, Northridge. Under Dr. George and Mr. O'Neil's leadership, SurgCenter Development has developed over 60 physician-owned ASCs.

John H. Hajjar, MD, FACS, MBA (Surgem). Dr. Hajjar, CEO of Surgem, is a urologist who developed one of the first ASCs in New Jersey at Fair Lawn and has been managing facilities since 1992. Dr. Hajjar also operates one of the largest private urology practices in the United States, with 17 physicians in 11 locations. He also participates in and performs surgery at two of Surgem's locations.

Andrew Hayek (Surgical Care Affiliates). Mr. Hayek serves as president, CEO and a member of the board of directors of SCA. Since the beginning of 2011, the company has been part of three different partnerships between healthcare providers. The company is affiliated with 18 healthcare providers from across the country. Prior to SCA, he served as president of a division of DaVita, a renal dialysis company, and as president and CEO of Alliance Healthcare Services. Mr. Hayek previously worked for Kohlberg Kravis Roberts & Co., a global private equity firm, and the Boston Consulting Group. He serves on the board of directors of Senior Home Care. Mr. Hayek earned a BA from Yale University in New Haven, Conn.

Edward P. Hetrick (Facility Development & Management). Mr. Hetrick is the

founder and president of Facility Development & Management, and has over 30 years of experience in the healthcare industry. His previous positions include vice president at Healthcare Facilities Management, director of operations management at a major teaching institution, operating room administrator and consultant within the healthcare division of an accounting firm. He also has experience with planning and implementing manual and automated systems. Mr. Hetrick earned a BS from the United States Military Academy at West Point (N.Y.) and an MBA and MPH from Columbia University in New York City.

Jeremy Hogue (Sovereign Healthcare). Mr. Hogue is co-founder, president and CEO of Sovereign Healthcare. He previously served as vice president of Audax Group, a private equity investment firm where he launched and ran the firm's West Coast office. He was also an associate in the investment banking group of Lehman Brothers. Mr. Hogue received his JD from Harvard Law School in Boston and his MBA from the University of Southern California in Los Angeles.

Christopher A. Holden (AmSurg). Mr. Holden has been AmSurg's president, CEO and director since Oct. 2007. The company special-

izes in managing and developing 3,000-4,000-square-foot single-specialty centers. During his time with AmSurg, the company's growth has accelerated through acquisitions. He has more than 21 years of experience, primarily with multi-facility and multi-market healthcare management. He previously served as senior vice president and a division president of Triad Hospitals, where he was a founding team member and officer. Mr. Holden also held several officer positions with Nashville, Tenn.-based Columbia/HCA Healthcare.

Richard K. Jacques (Covenant Surgical Partners). Mr. Jacques, president and CEO of Covenant Surgical Partners, has over 15 years of experience in the ASC industry, including senior management positions with both public and private healthcare companies. He was previously president and director of Surgical Health Group and vice president of business development for AmSurg, where he helped develop a system and methodology the company used to acquire or develop almost 100 ASCs during his time there.

Marc Jang (Titan Health). Mr. Jang, founder, president and CEO of Titan, has held executive positions in healthcare for almost 20 years. He has focused specifically on ASCs for the past 10 years. He has experience in finance; mergers and



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acquisitions; and development and operations. Mr. Jang previously served as vice president of finance for Sacramento, Calif.-based Sutter Surgery Centers and regional vice president for ASC Network.

Luke Lambert, MBA, CFA, CASC (Ambulatory Surgical Centers of America).

Mr. Lambert has served as CEO of Ambulatory Surgical Centers of America since 2002, after having served as CFO for five years. His background includes experience in financing, strategy and operations. 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. Mr. Lambert earned his MBA from New York City's Columbia Graduate School of Business and was among the first to earn the CASC designation in 2002. ASCOA currently operates 34 facilities across the country and continues to look for new partnership opportunities.

Jared Leger (Arise Healthcare). Mr. Leger is managing partner and CEO of Arise. He began his career as an RN in the operating room, but has spent most of his time in healthcare business. He previously served as a partner in a privately held healthcare management company, and has experience in the medical-device industry, ASC development and ASC transactions. He has also syndicated and operated several physician-owned surgery centers. In addition to leading Arise, Mr. Leger currently owns a real estate investment company. He is CASC certified.

Scott Leggett (Surgery One). Mr. Leggett is CEO of Surgery One and has more than 17 years of experience in orthopedics. He has served in a development and regional management role for U.S. Orthopedics, which was acquired by National

Surgical Hospitals in 2001. Mr. Leggett previously developed and managed the OrthoMed Spine & Joint Conditioning and WellStrong Centers for the orthopedic department of the University of California, San Diego. He was president of the California Ambulatory Surgery Association from 2006-2007 and now serves on the board. He earned an MS in exercise science from the University of Florida in Gainesville.

Jeff Leland (Blue Chip Surgical Center Partners).

Mr. Leland is CEO of Blue Chip. The company currently works with 12 surgery centers, many of them focused on spine surgery. He previously served as executive director of Lutheran General Medical Group, a 260-physician, multi-specialty medical group in Chicago. In the past he served as a senior-level executive with Advocate Health Care in Chicago, responsible for both business development and Advocate's 225,000-member health plan. He was also president of HealthSpring Medical Group and CEO of Western Ohio Health Care, an HMO with more than 200,000 members that was acquired by United HealthCare. Mr. Leland is an alumnus of the Harvard Business School in Boston.

Michael Lipomi (Surgical Management Professionals).

Mr. Lipomi serves as president and CEO of SMP and has over 30 years of experience in hospital and ambulatory surgery facility management. Surgical Management Professionals offers both ownership and non-ownership management services for providers. The company currently works with 11 healthcare providers across the country and in Canada. His first position was with American Medical International at El Cajon Valley Hospital in San Diego. Later in his career he served as CEO of Stanislaus Surgical Hospital in Modesto, Calif.

Prior to his current role he was president of RMC MedStone, where he owned and managed several surgery centers and a surgical hospital.

Rodney H. Lunn (Surgical Health Group).

Mr. Lunn is principal of Surgical Health Group and has extensive background in ASC development. Practice Development Associates, which he founded in 1987, was one of the first companies to focus on surgery center development. Over the past 17 years, Mr. Lunn has developed more than 150 ASCs throughout the United States. He was a founder, director and the senior vice president of AmSurg, controller for MEDINC, vice president of finance and CFO of American Medical Centers and owner and manager of acute care hospitals. He also has experience in the HMO industry, in which he served as CFO of INA (now Cigna) Healthplan of Texas and vice president of HealthAmerica of Florida.

Thomas Mallon (Regent Surgical Health).

Mr. Mallon co-founded Regent Surgical Health in 2001 and serves as CEO. Over the past 10 years, the company has grown to include 18 facilities nationwide, serving 45,000 patients per year and attracting 400 physician partners. The leadership team is committed to helping groups develop a new surgery center or assist in immediate improvements of an existing facility. He was previously a partner with Gryffindor Capital Partners, a Chicago-based venture-capital fund, and at Same Day Surgery, which acquired five distressed and underutilized ASCs and a physician management company. Prior to joining Same Day Surgery he was vice president of leasing and marketing for JMB Realty and later for Miglin-Beitler Developments. Mr. Mallon holds an MBA from Harvard Business School in Boston.

Thomas A. Michaud (Foundation Surgery Affiliates).

Mr. Michaud is founder and CEO of Foundation Surgery Affiliates. Prior to founding FSA in 1996, he served as COO and CFO of a regional surgery center management company. He has also been a partner in a local CPA firm, the COO of a regional wholesale company and manager of management information systems and materials at an aerospace company. Mr. Michaud earned a BS in accounting from Boston College and a CPA while serving as a staff accountant with the firm Ernst & Young.

Krystal Mims (Texas Health Partners).

Ms. Mims, a CPA, is president and CEO of Texas Health Partners. She previously served as CFO for Physician's Medical Center, a specialty hospital in Plano, Texas, Southlake (Texas) Specialty Hospital and Presbyterian Hospital of Rockwall (Texas). Her background in healthcare began in physician practice management. She was CFO for Texas Back Institute in Plano, CFO of Practice Performance and administrator of Steadman Hawkins Clinic Denver in Greenwood Village, Colo., and Lone Tree, Colo.

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Kris Mineau (Constitution Surgery Centers). Mr. Mineau co-founded CSC in 1997 and serves as its president and CEO. Prior to founding CSC, Mr. Mineau was a pilot in the U.S. Air Force and received a Bachelor's in management from the U.S. Air Force Academy in Colorado Springs. He is involved in many professional organizations, including the Connecticut Association of Ambulatory Surgery Centers, where he served as its founding president.

Steve Mohebi (Smithfield Surgical Partners). Mr. Mohebi is chief development officer of Smithfield Surgical Partners in Northern California, and manages the company along with Chief Operating Officer Gregory Horner, MD, and President Todd Borst. Smithfield develops medical office buildings, surgical facilities and medical malls. Smithfield maintains minority ownership in its surgical facilities.

Robert Murphy (Murphy Healthcare). Mr. Murphy is founder and CEO of Murphy Healthcare and has been involved in the turnaround of more than 30 ASCs with a total market capitalization of more than \$650 million. The turnarounds were overseen by Murphy Healthcare's ASC Turnaround Group. In his role as CEO, he focuses on strategic planning for each center as well as mergers and acquisitions. He is on the board of trustees of Mount Saint Mary College in Newburgh, N.Y. He received a Master's in health administration from Iona College in New Rochelle, N.Y.

Fred W. Ortmann, III (Ortmann Healthcare Consultants). Mr. Ortmann is founder, president and CEO of Ortmann Healthcare Consultants. He has more than 30 years of experience in healthcare, including developing ASCs in 26 states. He founded Ortmann Healthcare Consultants in Sept. 2001 after helping to found AmSurg, where he served as vice president for center development. He has also served as a consultant to Olympus America. He received his MHA from Baylor University in Texas. *Note:* Shortly after publication of this list, Ortmann Healthcare Consultants **announced the retirement** of Mr. Ortmann. Chris McMenemy, former VP, will take over company operations and the company will now provide consulting services under the new name Ortmann Healthcare Consulting Services.

Chuck Peck, MD, FACP (Health Ventures). Dr. Peck, an internist and rheumatologist, serves as president and CEO of Health Ventures. The company currently manages approximately 30 ASCs and surgical hospitals around the country. He has over 30 years of healthcare experience as a clinician, educator and leader. He began his career at University Hospitals of Cleveland and Case Western Reserve Medical School. Since then, he has held many positions in the healthcare industry, including CEO of a physician group multispecialty practice, partner with a glob-

al healthcare consulting firm, president of several regions of a national health insurance company, CMO of a retail health clinic operator and CMO/COO of a disease management company, which he helped turn around. Dr. Peck is also a featured author and regularly speaks in front of national audiences.

Vito Quatela, MD (Ambulatory Healthcare Strategies). Dr. Quatela co-founded AHS 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 into 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.

William B. Rabourn, Jr. (Medical Consulting Group). Mr. Rabourn is CEO and a managing principal of MCG, a consulting firm that provides ASCs with financial, IT and marketing services, among others. Mr. Rabourn, founder of MCG, was previously a business instructor at Missouri State University in Springfield and CMO and vice president of a major financial institution. He also co-founded Vein and Laser Centers. Mr. Rabourn is a member of the American Society of Cataract and Refractive Surgery and the American Society of Ophthalmic Administrators.

Lori Ramirez (Elite Surgical Affiliates). Ms. Ramirez is founder, president and CEO of Elite Surgical Affiliates. She has more than 12 years of experience in surgical development, operations and management. Prior to founding the company in Jan. 2008, she was a senior vice president of United Surgical Partners International, where she developed the second-largest network of surgical facilities in Houston. Ms. Ramirez was also involved in strategic planning, operations management, physician partnerships and financing in surgery centers. She has experience joint venturing with health systems such as Memorial Hermann in Houston and Irving, Texas-based CHRISTUS Health System.

J. Michael Ribaldo, MD (Surgical Synergies). Dr. Ribaldo is chairman and CEO of Surgical Synergies. He has more than 27 years of experience as a surgeon, healthcare executive and real estate developer. He previously served as executive vice president of Surgical Health and HealthSouth Surgery Centers. He currently serves on the board of directors of Flow International and chairs its compensation committee. He is also co-founder of Surgical Anesthesia Services. Dr. Ribaldo had graduate medical school training at Emory University in Atlanta, Washington University in St. Louis and New York University in New York City.

Stephen Rosenbaum (Interventional Management Services). Mr. Rosenbaum is co-founder and CEO of IMS. His background

includes work with physicians and physician-owned facilities. In his more than 15 years of healthcare experience he has served as vice president of finance for development at MedCath and helped develop Carolinas Surgery Center. Mr. Rosenbaum also created an independent healthcare consulting company, SourceRevenue, where he was involved in the development of a neurosurgical hospital and physician-owned hospital. He also worked with The Bloom Organization to provide investment banking services to physician-owned ASCs, during which time he was involved in more than \$100 million of ASC transactions.

Kenneth R. Ross (Solara Surgical Partners). Mr. Ross is CEO of Solara Surgical Partners and has over 30 years of management experience in healthcare, energy and finance, including 17 years in operations management, finance, strategy and business development in several healthcare industries. He previously founded and developed Solara Healthcare, where he helped develop seven long-term acute care hospitals. Mr. Ross is a fellow of the American College of Healthcare Executives, a member of the University of Oklahoma Health Sciences Center Adjunct Faculty and a CPA.

Jeff Sapp, Nancy Kastner (Innovative Surgical Solutions Management). Mr. Sapp and Ms. Kastner are principals of Innovative Surgical Solutions Management. With 21 years of healthcare management experience, Mr. Sapp has served as president of Physicians' Strategic Alliance; co-founder and senior vice president of development for Surgical Synergies; founder and CEO of Innovative Surgical Solutions, which later became Surgis; co-founder and executive vice president of ASC Operations for Surgis; and vice president of development for USPI. Ms. Kastner has experience with ASCs gaining AHCA approval, increasing commercial contract reimbursement, achieving turn arounds and establishing correct billing practices.

Bob Scheller, CPA, CASC (Nikitis Resource Group). Mr. Scheller is CEO and COO of NRG. He previously served as senior vice president of Aspen Healthcare. Before becoming involved in the ASC industry, he worked in public accounting and later hospital administration and physician practice consulting. He earned his Master's in business from the University of Wisconsin in Madison.

Donald Schellpfeffer, MD (Medical Facilities Corp.). Dr. Schellpfeffer is CEO of MFC and has over 18 years of experience in ambulatory surgical environments and 22 years in general, cardiovascular and trauma practices. He has served as medical director and a member of the management committee of Sioux Falls (S.D.) Surgical Center since he founded it in 1985. He also serves as president of Anesthesia Associates, the largest anesthesia services provider

in South Dakota. Dr. Schellpfeffer received a PhD in animal physiology from the University of Minnesota in St. Paul and an MD from University of South Dakota School of Medicine in Vermillion.

Matt Searles (Merritt Healthcare). Mr. Searles has been a Partner with Merritt Healthcare for more than 10 years. During that time, he has managed and advised for dozens of healthcare facilities across the country. His background includes experience in corporate finance and venture capital-backed companies. He previously served as the senior vice president of finance for a Greenwich, Conn.-based service company where he oversaw an expansion from \$10 million in revenue to more than \$100 million in revenue. He earned his MBA from Duke University in Durham, N.C.

John R. Seitz (Ambulatory Surgical Group). Mr. Seitz is co-founder, chairman and CEO of ASG. He has over 25 years of experience in healthcare, including founding and leading start-up companies. Prior to joining ASG, Mr. Seitz co-founded and served as president of Surgem, where he directed the development and operation of eight ASC projects. He has also served as founder and CEO of Cornerstone Physicians, a medical practice management company. Mr. Seitz is a graduate of Boston's Harvard Business School Owners and Presidents Management program.

Bill Simon (Innovative Healthcare Management). Mr. Simon is president and founder of Innovative Healthcare. Before founding the company in 1995, he developed the Pain & Rehabilitation Medical Group, a 7,000-square-foot outpatient facility in Los Angeles. He holds a bachelor's in finance and a JD, and is currently a member of the State Bar of California.

Barry Tanner, CPA (Physicians Endoscopy). Mr. Tanner has been president and CEO of Physicians Endoscopy since 1999 and co-authored the company's business plan with CFO Karen Sablyak. The company currently manages 17 endoscopy centers. Before joining PE, Mr. Tanner was co-founder, CFO and COO of Miami-based Navix Radiology Systems. During that time, he helped the company grow from zero to more than \$75 million in revenues. He has also served as COO of HealthInfusion, a Miami-based provider of home intravenous therapy services. Before joining the healthcare industry Mr. Tanner worked in financial services managing financial and operational turnarounds of publicly-traded companies. He co-founded the financial services company Scientific Leasing, which he operated for more than 10 years.

Larry D. Taylor (Practice Partners in Healthcare). Mr. Taylor is founder, president and CEO of PPH. The company currently has

management contracts and ownership arrangement with seven surgery centers in operations and six additional centers in the development and construction phase. He has 25 years of experience in healthcare delivery, management and physician relations. Throughout his career, Mr. Taylor has worked with physicians in an office setting and experienced the processes, challenges and expectations healthcare providers face. He previously served as president and COO of a large provider of ASC services. As a certified athletic trainer, his initial entry into healthcare was focused in the delivery of sports medicine and non-surgical orthopedic care. He has had responsibilities for multiple healthcare sites across the United States and United Kingdom over the course of his career. He also serves as an adjunct professor in healthcare at the University of Alabama at Birmingham.

David M. Thoene (Medical Surgical Partners). CEO David M. Thoene founded Medical Surgical Partners and has 27 years of experience in ASC consulting and development. He has served as vice president of development for FSC Health and Titan Health, and founded the development arm of Randlett Associates. Mr. Thoene helped develop the two models for locally-owned and managed ASCs.

George Tinawi, MD (Surgery Center Partners). CEO Dr. Tinawi co-founded Surgery Center Partners and its management subsidiary SCP Management with Samuel Marcus, MD, five years after they created a free-standing surgery center for their own practice. Dr. Tinawi was a practicing physician in Mountain View, Calif. He is board certified in both internal medicine and gastroenterology. He graduated from the Medical School of University of Aleppo in Syria.

William Wilcox (United Surgical Partners International). Mr. Wilcox has served as CEO of USPI since April 2004. The company currently owns and operates outpatient surgical facilities across the United States and United Kingdom. Over half of the facilities in the United States are jointly owned facilities with non-profit healthcare systems and hospitals. He has also served as the company's president and a director. Prior to joining USPI Mr. Wilcox served as CEO of United Dental Care. Previous positions also include president of the Surgery Group of HCA, president and CEO of the ambulatory surgery division of HCA and president, COO and a director of Medical Care International.

Donald C. Wilson (Cirrus Health). Mr. Wilson is CEO of Cirrus Health. Prior to this position he founded one of Cirrus' predecessors and developed an extensive commercial real estate portfolio in various locations across Texas and surrounding states. Over the last 10 years, Mr. Wilson has focused on the development

of medical operations platforms and medically oriented real estate projects, including ASCs, specialty surgical hospitals, acute care hospitals, medical office buildings, primary care clinics, radiation oncology units and other complex medical facilities. Mr. Wilson earned a degree in business administration from the University of Texas in Austin.

Tom Yerden (TRY Health Care Solutions). Mr. Yerden serves as CEO of TRY Health Care Solutions. During his more than 28 years of experience in the ASC industry, Mr. Yerden has worked with group practices and healthcare systems. He previously founded Aspen Healthcare and helped plan, develop, open and manage over 75 surgery centers. Prior to forming Aspen Healthcare, Mr. Yerden held COO and other executive positions in several healthcare systems and large physician group practices where he developed outpatient surgery centers and new outpatient surgical delivery systems. Mr. Yerden has authored several publications on ASC issues and is a national speaker on those topics.

Joseph Zasa, JD, Robert Zasa, MSH-HA, FACMPE (ASD Management). Mr. Joseph and Mr. Robert Zasa are co-founders and managing partners of ASD Management (formerly Woodrum/ASD). The company has developed and managed more than 125 surgery centers. Mr. Joseph Zasa is former president of the Texas Ambulatory Surgery Center Association and currently serves on its board as well as the board of the ASC Advocacy Committee. He previously served as regional director of surgery center operations for ProSurg and corporate counsel for Premier Ambulatory Systems, which Mr. Robert Zasa founded and led to acquire 15 ASCs. Mr. Robert Zasa previously served as vice president of American Medical International and COO of AMI Ambulatory Centers. He is a fellow in the American College of Medical Practice Executives. He also established Premier Ambulatory Systems.

J.A. Ziskind (Global Surgical Partners). Mr. Ziskind, founder, president and CEO of Global Surgical Partners, has been involved in Florida's healthcare industry since the 1970s, including serving as CEO of Miami's Cedars Medical Center. He has also served as a healthcare attorney and helped develop and manage several physician-hospital joint venture ASCs. Mr. Ziskind co-founded and was general counsel to the Florida Society of Ambulatory Surgical Centers, was on the Pan American hospital board of directors and has served as general counsel to the Dade County Medical Association for more than two decades. He currently serves as chairman of the board of directors for Mercy Foundation. ■

Contact Sabrina Rodak at sabrina@beckersasc.com.

What Percentage of Orthopedic Surgeons Will be Employed in 5 Years?

10 Responses

By Laura Miller

According to the American Academy of Orthopaedic Surgeons most recent census data for 2008, 44.3 percent of orthopedic surgeons were practicing in a private practice setting and 20.9 percent were in a solo practice. Only 6.7 percent of orthopedic surgeons were employed by a hospital or medical center and 8.5 percent at academic institutions. Economic and healthcare changes over the next few years are predicted to alter these statistics as more orthopedic surgeons are making the tough decision about where they will practice. "The AAOS study in 2008 shows that as of that time between direct hospital employment and academic medical centers, the number of employed orthopedic surgeons was approximately 15 to 16 percent in 2008," says Scott Becker, JD, CPA a partner at McGuire-Woods. "As of 2011, given the uptick in the last few years, we would estimate that it's closer to 20 percent+ today."

Here, orthopedic surgeons and industry professionals discuss how the trend toward hospital employment is affecting orthopedic and spine surgeons, and what factors play a part in making the employment decision.

Matt Ramsey, MD, orthopedic surgeon and vice chair of operations, Rothman Institute, Philadelphia: I spent 11 years as a full time faculty member of the University of Pennsylvania and left the employed model to go into private practice, which is contrary to the current trend. I don't know what percentage you're going to see in full time hospital employment in five years, but I do think that number will rise. There are a couple of things driving this percentage up right now. A culmination of financial pressures in the market over the past two years has driven reimbursement down and we're at a tipping point. Orthopedic surgeons in a small practice (under four to six surgeons) are finding it extremely difficult to financially support a practice.

I think another factor is the uncertainty about what the future is going to bring with healthcare reform. Electronic medical records and other requirements under healthcare legislation are going to be impossible for small groups to handle when they are already under such pressure right now. These physicians go to an employed model instead of a large group practice because they've been in a small group for a while and they don't

see advantages to larger groups. They think they won't be able to improve their position.

I see the value of becoming employed by a hospital if you're financially strapped and worried about making a living. You give up your autonomy and the way you practice medicine to some degree when you become employed. It's hard to leave a full time employment model, and the challenge becomes what will happen if it doesn't meet your requirements. The foundation of orthopedics is in the solo practitioners and small group models. There are more small-group surgeons than large group surgeons and more solo than employed, but these numbers are changing very rapidly.

David Ott, MD, orthopedic surgeon, Arizona Orthopaedic Associates in Phoenix: My crystal ball isn't better than anybody else's. I have no idea about what the percentage of orthopedic and spine surgeons employed at hospitals will be, but if I had to give a percentage, I'd say about 30-40 percent of orthopedic surgeons will be employed by a hospital five years from now. Private practice and solo practice for orthopedic surgeons isn't a recommended entity. They need to become part of established organizations, whether it be a large group practice, hospital, health maintenance organization or specialty group. The concept of employed physicians is front and center, and it's been going on for a long time in many states. For example, Kaiser Permanente has been employing physicians for a long time and it has worked well for many of those orthopedic surgeons.

There are always going to be guys that will be bought up by the hospital. There are three groups of people in this category: those who are new and want stability and are looking for a paycheck; older guys who are looking for a more hassle-free environment as far as business and a little less stress; and the final group that will be employed by hospitals are those surgeons who cannot be successful in the private practice for whatever reason.

The concept of an accountable care organization has pushed orthopedists into looking into employment models. My crystal ball says that in large metropolitan areas, there will be a large number of orthopedic surgeons who will remain in a practice and fee-for-service model. The surgeons will contract with ACOs, hospitals and insurance companies to provide services.

It could be a traditional fee-for-service model, bundled model or another type of creative payment model.

R.C. Shah, MD, FACS, general surgeon, Medical/Surgical Director at ARH Summers County Hospital and Medical Director, Beckley (W. Va.) ARH: There will be more surgeons employed by hospitals in the future. Most of those in solo practice will leave because coverage is a problem. Solo practice surgeons must tend to office personnel, provide benefits for their staff, deal with practice billing, purchase supplies and buy their own malpractice insurance, all of which is expensive. The trend right now shows less reimbursement and unless a group is very busy and innovative, it won't match the hospital's salary with the fringe benefits.

The benefits of being employed by the hospital include having a fixed number of hours to work per week. Most surgeons in private practice work several more hours and must be available almost constantly. These surgeons cannot always plan their week and often spend more time away from their families. At the same time, there is a need for orthopedic surgeons in every community, whether urban or rural, and that need is only going to increase.

Robert Snyder, MD, orthopedic surgeon, Orthopaedic & Spine Center in Newport News, Va.: In the past it's been about 80 percent of orthopedic surgeons were in private practice and 20 percent were employed by hospitals. The way things are going, it will probably be reversed and more like 80 percent of orthopedic surgeons will be employed and 20 percent will be in private practice. This percentage will vary regionally. Some of these areas that have very large hospital groups will probably have a higher percentage of orthopedic surgeons in the community employed because it will be harder for independent practitioners to survive, and they will be cut out of referral patterns.

I think down the road you will see a lot more orthopedic surgeons becoming employed, for several reasons. Number one, when you are working for the hospital group, they don't have to invest money upfront and they don't have to worry about the economics of a practice. They won't have to keep up with the business side of the practice, which can include building a new facility, hiring and firing a staff member, employee pension plans and ordering supplies.

Secondly, a lot of people coming out of medical schools and residencies want to have well-defined jobs and be able to know that when they do have time off, it will truly be time off. If they aren't on call, someone else in the group will see patients in an emergency situation. Employed surgeons know they aren't going to make the same salaries as surgeons in private practice, but they are willing to forgo the extra compensation to have clarity and defined working hours. They know they will be making a certain salary and they won't have to pay malpractice premiums because their employer pays that. Surgeons employed at hospitals also have retirement plans. These types of things make it look like hospital employment is advantageous to them.

Stuart Katz, FACHE, CASC, executive director, Tucson (Ariz.) Orthopaedic Surgery Center:

I would estimate that 10-15 percent of orthopedic surgeons would be employed by a hospital or health system by 2017, especially if the current payment methodologies of Medicare and Medicaid do not change. I think the younger surgeons — those just finishing residency — are more likely to consider employment than are physicians who are on the “downside” of their careers who have maybe two to four more years of practice and want to “retire in place.” I think one of the employment incentives that a hospital or health system could use is loan repayment, which for the younger surgeons could be a crucial factor in their decision-making process. Physicians working for the Public Health Service and in manpower shortage areas have “loan forgiveness” as part of their employment agreements and I think this will be expanded in the future.

Matt Kilton, principal and COO of Eveia Health & Consulting Management:

My general perspective is that the orthopedic surgery

community will have less interest in being employed than specialists with a greater inpatient focused practice, such as neurosurgeons or trauma specialists. The hospital's true mission of performing inpatient tertiary work doesn't always align with the orthopedic surgeon's practice patterns as an increasing number of surgeries move into the outpatient setting. Exceptions to this would include joint replacements and spine surgery services where many patients still require an inpatient stay. Hand surgeons, sports medicine, arthroscopic surgeons and others who perform the majority of their cases in outpatient settings seem more inclined to remain independent.

Other factors I think will influence the decision include the orthopedic surgeon's access to ancillary revenue, such as an ASC, physical therapy or imaging services. The more diversified in terms of their revenue stream, the less likely it would seem they are to become employed. If surgeons aren't partnered with an ancillary service line, the benefits of becoming employed increase as their professional reimbursements continue to experience downward pressure.

A third influence in this decision is where a surgeon is in the life-span of their career. Are they in the early stages of their career, has their practice achieved a level of maturity or are they in the final phase of their practice? There is an attraction to employment for surgeons entering the sunset of their career, as it mitigates many of the risks associated with private practice. A fairly secure level of income, more predictable call coverage and limited worries and responsibilities with respect to practice operations and management are all benefits of the employment model offered by hospitals. Surgeons that are looking for an exit strategy or a gradual reduction in responsibilities may opt for hospital employment.

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This isn't necessarily the most lucrative option, but there is more certainty involved and less general oversight required as compared to working independently.

Mike Lipomi, president and CEO, Surgical Management Professionals: I think that the split in the next five years will be in the range of 30-35 percent of orthopedic surgeons will be employed, while the rest will be solo practitioners or in group practices. I think the younger physicians have a bias toward employment rather than starting a solo practice or joining a group. While saying this, there are certainly a lot of new graduates who have completed a combined MD/MBA program and have entrepreneurial interests leading them away from an employment career. While the dynamic of reimbursement reductions, practice restrictions and investment limitations will all move more into the employment area, there will still be a majority of surgeons desiring to control their own destiny and practice parameters. I do think the ability to invest in an ambulatory surgery center and/or have some in-office services will be critical to this decision.

Chuck Peck, MD, CEO, Health Inventures: If we assume that there's not going to be any other option for physicians other than employment by the hospital, then the number might be 60 percent. But I think there are other options for physicians, especially by partnering with management companies where the physicians don't have to sell their practice. Many orthopedic surgeons are so panic stricken by healthcare reform that they think hospital employment is the only option. A lot of high-end physicians are doing that. I think it's clearly reimbursement issues that are driving the decision for hospital employment. Orthopedic surgeons are also afraid of the unknown, because we don't know how healthcare reform is going to play out. Some don't understand the implications of bundling payments,

and surgeons and hospitals are going to have to be more aligned so they can figure out how the payment will work. Additionally, don't always have the tools for measuring outcomes for pay-for-performance, which will be important in the future.

The other option for orthopedic surgeons will be to join with other groups and become a larger group practice. If they made themselves larger and contracted or secured professional management, they'll have a greater ability to negotiate reimbursements and have control over their destiny. Right now, many are so panic stricken that they aren't considering other opportunities besides hospital employment.

Ted Schwab, Partner at Oliver Wyman, former CIO at Alegent Health in Omaha. Orthopedists will be the last bastion of independent physicians. Many health and non-academic health systems around the country have tried to employ orthopedic surgeons and failed miserably. They are one of the few specialists that have figured out how to stay independent, increase their income and reduce the cost of care all at the same time.

You may see 10 percent of orthopedic surgeons employed by hospitals in five years, but you'll find 50 percent in hospital joint management programs that are figuring out ways to take 30 percent out of the cost of orthopedic surgery.

Name Witheld, Executive of an ASC Management Company: I'm going to suggest maybe around 15 percent of orthopedic surgeons will be employed by health systems over the next five years, if the current trends hold true. There are exceptions to every rule, but when surgeons are choosing specialties during training, it's the alpha leaders that often self-select into the orthopedic specialty. I, for one (and I may be in the minority), am less pessimistic about rapid employment adoption by orthopedists. They relish their independence in many cases, and they don't feel that the hospital meets their needs or understands their concerns in the current independent arrangement. Why would the hospital better meet their needs, once they are employed? Keep in mind that most orthopedic physician groups including three or more physicians are often still led by an orthopedic surgeon who is 45 years old or older, not by surgeons who finished training in the past five to 10 years, which is where we are seeing a different personality.

I attended a meeting with a larger orthopedic practice where the hospital made an outright plea for employment, for which the orthopedic group respectfully declined during the meeting and disrespectfully mocked after the meeting. There is a healthy distrust between these two parties and the orthopedists do not need the hospital to achieve success, at least not to the same extent as other specialties, such as a general surgeon. ■

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10 Strategies to Improve Endoscopy Center Operations

By Leigh Page

Ruth Keogh, RN, nurse manager at Digestive Health Associates Endoscopy Suites in Stoneham, Mass., cites 10 ways to improve quality and efficiency in an endoscopy center.

1. Get input from staff. One of the best ways to improve operations, Ms. Keogh says, is to listen to staff. “I can’t be everywhere and staff members can provide some great ideas,” she says. She adds that what may sound like a complaint is often an opportunity to improve. At DHA Endoscopy, “people are not afraid to speak up when things need to be improved,” she says. Input at the center can be informal, since it has just 19 employees and Ms. Keogh is often working side-by-side with a staff member. There are also monthly staff meetings. “We have a great dialog here,” she says. “The per diem employees contribute as much as anyone else.”

2. Cross-train to give staff big picture. Cross-training is beneficial even when staff never perform the extra duties they have been cross-trained in. Getting a clear idea of what another person does broadens an employee’s understanding of the whole operation. “It makes for better team-building and a more smoothly running facility,” Ms. Keogh says. When recovery room and admitting nurses are trained to do each other’s job, they all know how to put IVs in and they understand the full surgery process from end to end.

3. Improve adherence to bowel prep. Improving patients’ adherence to bowel prep can reduce cancellations. One way to improve adherence is to rewrite the paperwork the patient receives prior to the procedure so that it is clear and unambiguous. Another way is to set up a 24-hour hotline where patients can ask physicians about preparation procedures. Physicians’ hotline duties can easily be piggy-backed onto overnight call duties at the hospital, Ms. Keogh says.

4. Insert breaks to get schedule back on track. “Running late affects patient satisfaction and staff morale,” Ms. Keogh says. The surgical schedule can be disrupted for a variety of reasons that can be out of anyone’s control. One way to address this problem is for the physician to insert two half-hour breaks each day, which cushion the effect of a late schedule. If cases are running behind, the physician can shorten his upcoming break and start the next case at the scheduled time.

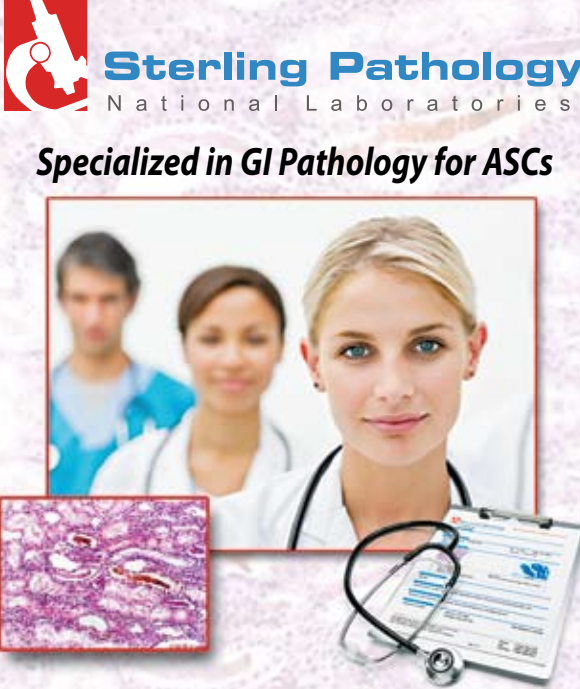
When scheduling a case, it is necessary to be realistic about each physician’s pace, Ms. Keogh says. “Some GI physicians can do 10 colonoscopies in eight hours while others cannot,” she says. Physicians with a slower case should be scheduled for more time so that no one has to run late. Another way to keep the schedule on time is to track physicians who have been running over their allotted time and send them reports monthly.

5. Replace equipment regularly. “Physicians just feel happier using new equipment,” Ms. Keogh says. In addition, updated versions of the equipment can improve quality and efficiency. For example, DHA Endoscopy recently acquired narrow-band imaging, which enhances the fine structure of the mucosal surface, helping to improve detection in a colonoscopy. The center also recently bought high-definition monitor screens, which allow physicians to see a lot more.

6. Physicians can keep staff educated. One way to keep clinical staff members up-to-date in the newest techniques is to ask physicians to pass along what they learned in a CME course. The knowledge transfer does not have to be in a meeting. “It’s informal,” Ms. Keogh says. “They don’t even have to sit down.” It can be done while the physician is working with staff members. Nurses can also receive clinical education geared to them in outside sessions such as at meetings of the Society of Gastroenterology Nurses and Associates.

7. Embrace change. As physicians and staff learn better techniques, clinging to old ways of doing things can get in the way. “The challenge is being able to step outside of yourself, take a clear look and say, ‘Maybe what we have been doing forever doesn’t work,’” Ms. Keogh says. For example, even though it has been shown that IV bags don’t need to be hung for moderate sedation in many cases, “some nurses were initially against this, because it was not what they were taught,” she says. Eventually, however, they understood that the standards have changed.

8. Focus on local best practices. While following national benchmarks and best practices is useful, it’s also important to focus on what is done locally, Ms. Keogh says. For example, “physicians in one area tend to have similar preferences,” she says. Ms. Keogh maintains regular contact with colleagues at other centers to discuss benchmarks and best practices, usually through e-mails and phone calls. She does not limit her discussions to endoscopy centers because all centers share many concerns, such as use of IV bags, she says. Some key metrics, however, are specialty-specific, such as cecal withdrawal times, the time spent examining the colon during withdrawal of the colonoscope. Polyps are more likely to be found if the



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cecal withdrawal time is longer than six minutes, she says.

9. Identify high-acuity patients before procedure. Some cases have to be cancelled at the last minute because when the patient arrives, it turns out he or she has a higher acuity level and should have the procedure done at the center. For example, a patient with home oxygen has an ASA-3 level, ruling out care at DHA Endoscopy. To avoid last-minute cancellations for these reasons, patients going to the center register and fill out paperwork for the procedure at the physician's office.

10. Track and fix patient satisfaction. DHA Endoscopy mails patients a satisfaction survey and logs a respectable 50 percent return rate, with scores on most of the questions in the 97-99 percent range. Questions cover cleanliness, the level of pain and how successful staff was in teaching the patient. Staff members read results carefully, sometimes noting a slip in the score for a certain category. "When we start to see a slip, we talk about how we can fix it," Ms. Keogh says. "Things get fixed very easily because people here care about the results." ■

Learn more about Digestive Health Associates Endoscopy Suites at www.dhaendoscopy.com.

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10 Critical Social Media Guidelines for Surgery Center Physicians and Staff

By Kim Woodruff, VP of Corporate Finance & Compliance, Pinnacle III

Social media is employed in the health-care arena for a variety of beneficial reasons:

- It can be an inexpensive marketing tool.
- It can be utilized to promote wellness and dispel healthcare myths.
- It is increasingly how we stay connected ... to nearly everyone.

When used appropriately, social media in health-care can establish a relationship, create a discussion and build trust in an organization. Suitable and worthwhile reasons for ambulatory surgery centers, and other healthcare facilities, to use social media include:

- promoting physicians when they are providing seminars;
- announcing when the organization/physician wins an award or receives recognition;
- informing the public that an addition or remodel is undertaken/completed;
- publicizing the purchase of a significant new piece of equipment; and
- posting information about a new study when it is released.

On the other hand, inappropriate use of social media can damage a surgery center, its physicians and staff members. Reputations can be damaged, lawsuits might be filed and licenses can be lost. As more people use and connect through social media, the likelihood of these negative ramifications increases.

10 components of an effective social media policy

This makes it critical for ASCs and all health-care facilities to establish an organizational social media policy which ensures the proper level of patient privacy as well as the perceived online professionalism of the physicians, clinicians and employees. Your policy should address the following 10 critical components.

1. Refraining from disclosing confidential and proprietary organizational information.
2. Avoiding exposure of personal identifying information related to a provider or colleague.

3. Assuming personal liability for all communications and information published online.

4. Being aware that company liability can be incurred for communications that are transmitted via an organizational email address.

5. Outlining a physician's or employee's right to participate in social media and networks using their personal email address with the caveat that anything published on personal sites should never be attributed to the organization or appear to be endorsed by, or to have originated from, the organization.

6. Identifying the limitations on material that is allowed to be published online.

7. Retaining control over the creation and management of organizational online content.

8. Responding to an outside party's posts containing inaccurate, accusatory or negative comments about the organization or any of its employees.

9. Refraining from publishing comments about controversial or potentially inflammatory subjects.

10. Avoiding hostile or harassing communications in posts/online communications.

5 guidelines to follow

To help with compliance with your social media policy, follow these five guidelines.

1. Think before you post. Never post anything online that is directly related to a specific patient. Doing so compromises patient confidentiality safeguarded by HIPAA. If specifics about a case are posted — how an injury occurred, the age and gender of a patient, photos containing identifying information (i.e., a birthmark, tattoo, piercing) — anything that leads a patient to believe that his/her case is being alluded to, even in the most generic of forms, may open the posting party up to disciplinary measures, termination, monetary sanctions and/or suspension of a license.

2. Think before you post. Avoid dispensing medical advice or making specific care recommendations via social media.

3. Think before you post. Separate personal and professional content online. Is the information you make available on yourself personally going to affect you (or the organization you work

for/with) in an adverse way professionally? Run the "embarrassment" test. Would you be embarrassed if anyone you knew read something you or one of your colleagues has posted?

4. Think before you post. Maintain appropriate professional boundaries observing the same ethical guidelines in Internet transactions that you would observe in any other context (office visit, phone consult). Refrain from "friending" patients.

5. Did I mention think before you post?!

Recognize that Internet content, even if subsequently removed, is likely available somewhere permanently. Use disclaimers and ensure posts are not in violation of organizational or professional-liability carrier policies or professional societies' ethics codes. ■

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Assembling a Robust Revenue Cycle Team: How to Hire and Retain Great Billers, Coders and Collectors

By Leigh Page

1. Don't hire coders from hospitals or practices.

"A coder with inpatient hospital certification can't handle an ASC, says Eva-Marie Alexander, West Coast regional director for American Academy of Professional Coders Physician Services, based in Redondo Beach, Calif. "They need to be able to handle the outpatient side." Likewise, "don't just bring over a biller or coder from a physician partner's office," advises says Joan G. Dentler, president of ASC Strategies in Austin, Texas. "Handling ASC revenue involves a different skill-set. Hire staff experienced in ASC-specific revenue work."

2. Hire an adequate number of staff.

When visiting ASCs, Caryl Serbin, executive vice president and chief strategy officer for SourceMedical in Wallingford, Conn., said she is often amazed about how few revenue cycle staff there are. "The ASC might have two to three employees to do the same work that we'd have six to eight people working on," she said. Ms. Serbin wouldn't set a particular ratio of billing employees per volume of cases because the number depends on many factors, including the percentage of cases with more

time-consuming payors, such as worker's compensation. Ms. Alexander says staffing levels also depend on case mix. For example, GI and eye cases require fewer billing staff members because they are easier to bill and code, while orthopedic, spine and pain cases tend to be more complex and need more people in the business office.

3. Pay revenue staff well. "Generally, ASCs often find it difficult to hire experienced coders and billers because their business office salary budgets are unrealistic," Ms. Serbin says. "Talented billing personnel tend to migrate to the hospital setting, not necessarily because they pay more, but because they offer better benefits," she says. It is more difficult for a small employer like an ASC to have a good benefits package, but competitive benefits are essential to attracting higher-level employees, she says. Ms. Alexander says the administrator also need to make sure revenue staff are happy. That means frequently reaching out to them, meeting with them and making them part of the larger ASC team. "You need a good paycheck but you also need to be happy to go into work," she says.

4. Make sure they are IT-savvy. Revenue office staff members need to be IT-savvy, Ms. Alexander says. "They can't be afraid to use automated systems. They need to go online and check the status of a case to see if has been paid," she says. "This is much faster than calling up the insurer."

5. Hire a detail-oriented biller. The biller, who sends out the claim and makes sure it reaches the payor, has to be detail-oriented, says Melody Winter-Jabeck, administrator at Ravine Way Surgery Center in Glenview, Ill. The work involves dealing with a claims clearinghouse, so billers have to learn the language of the clearinghouses. "They have to interpret the data and determine trends," she says. "They have to always ask, are we billing something in an inconsistent manner?"

6. Allow coders to specialize. Of all revenue staff positions, the coder has the highest level of expertise and usually the highest pay. Many centers are large enough to have one full-time coder, allowing this person to specialize and do a better job, Ms. Winter-Jabeck says. "This is not a punch-the-clock position," she says. "It requires a lot of concentration and attention to detail." Rather than just looking at the operative report and extracting codes, the coder needs to "review it in an insightful way," picking up potential items for billing that the physician may have overlooked, she says. Ms. Alexander recommends hiring coders with a clinical background. "The best coders in the world are retired nurses or OR techs," she says. "They know exactly what the physician is doing in the OR and can talk peer-to-peer."

7. Certification counts, to an extent.

While it is possible to find a certified coder in urban areas, it can be challenging in less populated areas, Ms. Winter-Jabeck says. Certification is important because "it provides some guarantee of a coder's knowledge level," she says. "It also shows they have some personal initiative and want to reach a more professional level." Ms. Alexander says large ASCs demand certification of coders, "but just having the certificate without experience is not going to help." If presented with the choice of a new coder who has just been certified and an uncertified coder with several years' experience, she would pick the uncertified coder. As part of the hiring agreement, however, that

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person should agree to get certification within six months, she says. While certification is important, “it doesn’t tell you everything,” Ms. Dentler says. “Check out their skills. Many certified coders don’t keep up with continuing education like they should.”

8. Hire a well-organized collector. Even though the collector is often an entry-level job, the work requires a great deal of diligence and organizational skills, Ms. Winter-Jabeck says. “Accounts receivables can quickly get away from you if you don’t have an organized system,” she says. Collectors have to spot trends, such as why a certain type of claim is not being paid. “The sharp collector will say, ‘I’ve noticed in the last month we haven’t gotten paid for x, y and z,’ “ she says. Collectors “touch” every outstanding account every so many days, depending on the ASC’s own predetermined billing schedule, and start working the account when it gets past due.

9. Collectors have to deal with non-paying patients. Being a collector can be a stressful job because it involves asking patients for money, Ms. Winter-Jabeck says. Self-pay patients can become angry or evasive, requiring collectors to combine the skills of a diplomat and a detective. “It takes a little bit of detective work to locate account-holders and verify their explanation as to why they have not paid,” she says. “The work can take multiple phone calls to multiple numbers and perhaps writing letters.” To reduce stress, self-pay accounts are often shared among two or more people in the billing office. “You don’t want to have one person handling all of these difficult bills,” she says.

10. Staff should help each other out. Revenue office personnel need to be cross-trained so that they can handle several roles. “If you are a good collector, you have to be a good biller,” Ms. Alexander says. “The scheduler can do verification of insurance.” Cross-training is more efficient because when one person is done with her work, she can help others out with theirs. She says this mutual approach also helps staff understand the big picture. “They need to understand how every single step of the process affects billing, starting with checking in,” Ms. Alexander says. However, she advises allowing the coder to concentrate on coding, because it is more intensive work. “You can’t interrupt what you are doing and make a phone call on a billing issue,” she says.

11. Groom new coders in-house. “It’s always a good idea to start grooming a new coder,” Ms. Winter-Jabeck says. “The ASC may need a replacement if the current coder is retiring or if it is expanding.” It’s advisable to groom someone from within the revenue office, because that person’s work habits will be familiar and she will already understand the needs of the organization. “You can deal with a known entity,” she

says. “You have to have a lot of trust in this person, because they will be coding your operative reports. If you already have that trust, you only need to increase the skill level.” She says a good candidate for the next coder is the collector, because the work already requires some familiarity with coding.

12. Allow non-coding staff to seek coding certification. Of all the tasks within the revenue office, only coding has a certification process, but it is worthwhile for other revenue office staff to seek coding certification, too, because coding knowledge can help them with their work, Ms. Winter-Jabeck says. Her practice reimburses for the cost of coding courses, provided that the employee gets certified.

13. Encourage continuing education. Continuing education is particularly crucial for coders, because they need to continually keep up with changes in coding rules, Ms. Winter-Jabeck says. Since those rules change annually, the training should be annual. Even brush-up courses can be fairly substantial, lasting half a day or even a full day. Check with community colleges and commercial firms like Karen Zupko & Associates, Ms. Winter-Jabeck says. In less populated areas, coders may have to rely

on internet-based training. “Web-based training can be very helpful, although they will miss the classroom interaction,” she says. “People learn from each others’ questions.” In addition, groups like the American Academy of Professional Coders provide continuing education for coders at their conferences.

14. Consider outsourcing revenue functions. Outsourcing is a good alternative for ASCs that don’t have enough volume to support a full-time position, but it requires a great deal of interaction and strong bonds of trust, Ms. Winter-Jabeck says. Her practice, Ravine Way, outsources coding. “We’re not responsible for keeping that person busy and we don’t need to train them,” she says. The coder has to have open access to the physicians, because she has to continually ask them about their operative notes. “It wouldn’t work if the physicians were not cooperative,” she says. Ms. Winter-Jabeck adds that collections are easier to outsource than coding. The collection contractor can follow the criteria the ASC sets down. “If the center sees A/R go through the roof, it’s obvious the agency is not doing a good job,” she says. ■

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Staff Salaries in Surgery Centers: 50 Statistics to Know

By Rachel Fields

Here are 50 statistics on staff salaries and wages in ambulatory surgery centers, according to data from VMG Health's 2010 Multi-Specialty ASC Intellimarker.

Mean hourly wages for all surgery center staff: \$26.44

Median hourly wages for all surgery center staff: \$25.87

Nurse staff

Mean hourly wage in all surgery centers: \$31.57
Median hourly wage in all surgery centers: \$31.11

Mean hourly wage by location:

- West United States: \$35.33
- Southwest United States: \$31.34
- Midwest United States: \$27.51
- Southeast United States: \$29.36
- Northeast United States: \$31.32

Mean hourly wage by surgery center size:

- 1-2 operating rooms: \$31.57
- 3-4 operating rooms: \$30.88
- More than 4 operating rooms: \$31.14

Mean hourly wage by surgery center case volume:

- Less than 3,000 cases: \$31.70
- 3,000-5,999 cases: \$31.58
- More than 5,999 cases: \$30.80

Mean hourly wage by surgery center revenue:

- Less than \$4.5 million: \$29.82
- \$4.5-\$6.99 million: \$29.69
- More than \$6.99 million: \$31.65

Tech staff

Mean hourly wage in all surgery centers: \$20.33
Median hourly wage in all surgery centers: \$19.76

Mean hourly wage by location:

- West United States: \$22.24
- Southwest United States: \$19.33
- Midwest United States: \$18.38
- Southeast United States: \$18.84
- Northeast United States: \$20.34

Mean hourly wage by surgery center size:

- 1-2 operating rooms: \$18.68
- 3-4 operating rooms: \$20.22
- More than 4 operating rooms: \$19.59

Mean hourly wage by surgery center case volume:

- Less than 3,000 cases: \$20.59
- 3,000-5,999 cases: \$20.16
- More than 5,999 cases: \$19.47

Mean hourly wage by surgery center revenue:

- Less than \$4.5 million: \$19.23
- \$4.5-\$6.99 million: \$18.87
- More than \$6.99 million: \$20.61

Administrative staff

Mean hourly wage in all surgery centers: \$23.00
Median hourly wage in all surgery centers: \$22.69

Mean hourly wage by location:

- West United States: \$24.21
- Southwest United States: \$21.30
- Midwest United States: \$21.62
- Southeast United States: \$22.96
- Northeast United States: \$24.15

Mean hourly wage by surgery center size:

- 1-2 operating rooms: \$22.30
- 3-4 operating rooms: \$22.95
- More than 4 operating rooms: \$22.32

Mean hourly wage by surgery center case volume:

- Less than 3,000 cases: \$23.45
- 3,000-5,999 cases: \$22.76
- More than 5,999 cases: \$22.59

Mean hourly wage by surgery center revenue:

- Less than \$4.5 million: \$24.05
- \$4.5-\$6.99 million: \$21.84
- More than \$6.99 million: \$23.07 ■

VMG information comes from VMG Health's Multi-Specialty ASC Intellimarker 2010 benchmarking study. VMG Health is a leading valuation and transaction advisory firm in healthcare. To receive a complimentary copy of VMG Health's 2010 Multi-Specialty ASC Intellimarker, visit www.vmghealth.com.

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Motivating Employees Through Effective Incentives: Q&A With Brian Brown of Meridian Surgical Partners

By Rob Kurtz

Q: During your presentation at the 9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference in Chicago, you referred to incentivizing employees around collections. What kind of incentives have you seen or employed?

Brian Brown: The main thing I would say is spend time getting to know what motivates the people in your center individually. Some are motivated by money, some are motivated by time off, some are motivated by social gatherings, etc. Make the value of the motivation the same, but it could be different for different team members.

For instance, someone may have enough time off already. If you go to that person and say "Achieve ABC goal and you get another day off," that person may not be very motivated to achieve that goal. But, you find out that person loves the opera. They would be willing to jump through hoops to achieve that goal.

With all that said, here are some specific ideas:

- Movie tickets
- Time off from work
- Happy hour for staff
- American Express gift cards
- Flowers

- Restaurant gift cards
- Tickets to sporting events
- Tickets to concerts
- Electronics — small would be downloadable music, large would be an iPod
- Memorabilia
- Lunch delivered

The key to this is value you set of the goal and your staff. ■

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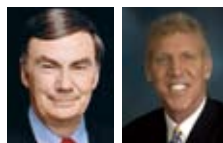
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Here are comments from 10 attendees of previous ASC conferences:

1. **John Fontana, MD, Surgery Center of Beaufort:** "I attended the June conference with our center's administrator. It was a GREAT conference! We found the topics relevant and more importantly they stimulated thoughts about improving our center. I have not previously been to an ASC Communications conference but will be attending another soon."

2. **William Maloney, MD, MPH SportsHealth:** "I was impressed by the wide range of topics for the beginner to the experienced, and the many well-known experts who presented them. I highly recommend the conference to any individual or organization in the ASC space."

3. **Ramon Garcia, MD, Chicago Endoscopy Center:** "I had a very enjoyable time at the conference, met very interesting and important individuals who I am now starting to do business with. I plan to be back."

4. **Lee Carlisle, MD, MARC Day Surgery Center:** "I have to tell you that the ASC Communications conferences are my favorite. I find it the perfect combination of clinical and administrative topics. It has been so beneficial to attend

these conferences to ensure that the direction is which we are going is the correct one. The ASC Communications conferences reinforce my facility's current practices as well as help identify opportunities for improvements. I am already planning on attending the conference in October."

5. **Kenneth Pettine, MD, Loveland Surgery Center:** "I have reviewed the meeting itinerary for October and have concluded if you are going to attend one meeting of the year to learn how to make your ASC function better and anticipate the future, THIS is the meeting. The chance to network will be unsurpassed!"

6. **Basil Besh, MD, Precision SurgiCenter:** "This is the ambulatory surgery center conference to attend! All others pale in comparison. Perfect combination of economics, operations and predictions for the future, not to mention great guest speakers."

7. **Vicki Aten, First SurgiCenter:** "This was one of the best, if not the best conference I have attended. I came back and told our medical director he really needed to go to this next year. I have tons of notes I now need to find time to go through!"

8. **Rose Lopez, Midtown Outpatient Surgery Center:** "I come from a hospital setting and am new to the ASC environment. The conference provided some helpful ideas on how to run the center in a more efficient and profitable way. I'm looking forward to the next conference."

9. **Victoria Caillet, Wooster Ambulatory Surgery Center:** "I attended the conference three years ago prior to our ASC opening; the physician-owners thought it would help me get started. I returned this year and it was great to see what we do here reinforced with how other ASCs run. It makes me feel good that we are doing things right!"

10. **Joy Moore, Oak Surgical Institute:** "The presenters always provide professional and meaningful information. The opportunities for networking are endless at these events!"

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5 Strategies to Make Successful Capital Acquisitions

By Sabrina Rodak

Capital acquisitions play a large role in the success of ambulatory surgery centers. They affect patient safety by ensuring equipment is up-to-date; physician satisfaction by meeting their needs when delivering care; and the center's revenue by creating efficiencies.

"Equipment is really the life blood of surgery centers. Without having up-to-date equipment, surgery centers would be limiting their ability to generate revenue," says Richard Peters, senior director of product management for the supply chain improvement company Provista. He says the two overarching challenges of capital acquisitions are availability of funding and management resources. Mr. Peters suggests five strategies for ASCs to overcome these challenges and optimize capital acquisitions.

1. Include capital acquisitions in the strategic plan. Mr. Peters says successful capital acquisitions depend on preparation and planning. ASCs can prepare by incorporating capital acquisition goals and possible solutions in their strategic plans. The financing plan for the acquisitions should also be included in the strategic plan, according to Mr. Peters.

2. Learn from others. Management resources include knowledge of how to evaluate capital purchases and awareness of different options avail-

able to leaders. ASCs can develop these resources by negotiating with sellers, Mr. Peters says. "Leverage manufacturers to gain the technological expertise required to make decisions [about capital acquisitions]," he says. Questioning sellers can help ASC leaders learn their options in making capital acquisitions. For example, Mr. Peters says facilities that have old equipment they no longer need can dispose of the equipment completely, receive credit (depending on the manufacturer), put the equipment up for auction or sell to other providers.

Another strategy is to speak with ASC leaders who frequently make capital acquisitions. "Start building a network within the community [of] those who might perform capital acquisition on a regular basis. For example, multispecialty clinics acquire capital assets on a regular basis," Mr. Peters says.

Because of the variety of capital acquisitions, gaining knowledge about a specific piece of equipment a center plans to acquire may be most useful. "I would recommend the administrator get to know the CEO or CFO of that clinic and ask a lot of questions about what things they considered when they acquired that piece of equipment," Mr. Peters says.

3. Take advantage of group buy opportunities. Group buy agreements can save ASCs on the initial purchase price and on the total cost of ownership, according to Mr. Peters. Group buys "reduce the initial purchase price based on the level of commitment from the collective group buy participants," he says. The arrangement may also offer pre-negotiating opportunities or special rates, lease options and deferred payment, depending on the company.

4. Consider leasing equipment. Sometimes ASCs can benefit from leasing equipment instead of purchasing it. "It depends on the financial position of the surgery center," Mr. Peters says. Facilities with less funding may benefit from leasing because they can avoid paying a large sum at one time. ASCs should also consider leasing equipment as technology develops.

"Leasing makes more sense if technology becomes available at a rapid pace," Mr. Peters says. Leasing equipment allows for more flexibility. "If your surgery center is replacing equipment on a regular basis before its life span runs to the end, consider leasing because upgrading technology in a lease is easier than acquiring capital before the life cycle is complete," he says.

5. Base decisions on ROA instead of ROI. Mr. Peters says a new, more in-depth approach to evaluating the financial effects of capital acquisitions is calculating return on asset. Compared to the traditional return on investment, ROA accounts for qualitative data as well as quantitative information, such as the purchase price. Important acquisition factors such as physician satisfaction, productivity and price of installation, training and software may also be ignored by ROI.

Mr. Peters says using ROA allows leaders to "evaluate [capital acquisitions] from a holistic perspective. What piece of equipment should be acquired and when? What is the financing mechanism?" While calculating ROI may be easier and faster to develop, ROA provides a more complete assessment of the benefits of capital acquisitions, according to Mr. Peters. ■

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4 Tactics to Weather the Drug Shortage From Dr. John Dombrowski

By Rachel Fields

Hospitals and surgery centers across the country are struggling with shortages of critical anesthetics and other drugs. A recent survey by the American Society of Anesthesiologists found more than 90 percent of anesthesiologist respondents are currently experiencing a shortage of at least one anesthetic. John Dombrowski, MD, a member of the ASA Board of Directors and chair of the ASA Committee on Communications, shares four ways anesthesiologists and facilities can tackle the drug shortages.

1. Collaborate with facility leaders. Dr. Dombrowski says the most important aspect of tackling a drug shortage is promoting collaboration between hospital or surgery center leaders and anesthesia providers. "I think often, the CEO, CFO or pharmacy head doesn't realize the resources they have in an anesthesiologist," he says. "They're not just the people in the OR that put you to sleep. They're involved in perioperative medicine before, during and after surgery."

He says hospitals and surgery centers should work with anesthesiologists to brainstorm ways to weather the shortage. This may include ordering different drugs or understanding that some cases may need to be delayed or cancelled. Anesthesiologists will probably be able to offer numerous suggestions for drug substitutions, knowledge that the hospital or ambulatory surgery center leader might not have if they lack an anesthesia background.

2. Don't panic and hoard drugs. When a drug shortage is announced, Dr. Dombrowski says some facilities may panic and decide to order as many of the affected drug as possible. This may alleviate the shortage for that facility, but he says hoarding drugs exacerbates the shortage for the rest of the industry and damages anesthesia care nationwide. The American Society of Anesthesiologists study found that nearly half of patients who underwent procedures during a drug shortage experienced less than optimal outcomes, such as increased frequency of nausea, longer operating room and recovery times and increased healthcare costs. Providers who stockpile drugs increase the likelihood of these negative effects for patients across the country.

Dr. Dombrowski believes the problem of hoarding could be corrected with better communication between stakeholders. "We need better communication skills to say, 'We've got a production problem, and we're fixing it. Don't hoard drugs because we'll get it resolved,'" he says. He says the FDA and the ASA are working

together to develop 'action alerts' that let providers know the severity of a drug shortage.

3. Look for workarounds when appropriate. Anesthesiologists are highly trained physicians with sufficient medical knowledge and experience to know when certain drugs or treatments in short supply can be substituted, Dr. Dombrowski says. According to the ASA survey, more than 91 percent of respondents have been able to work through the drug shortages by using alternative medications. For example, the nationwide shortage of Propofol has prompted providers to use sodium pentothal as a substitute. While the patient experience may be less comfortable with sodium pentothal, the drug is still safe to use in place of Propofol while the shortage persists. Providers have also turned to regional anesthesia when general anesthesia is not possible, using spinal or epidural anesthetics to numb the patient without putting them to sleep.

"A lot of medicine is not cookbook medicine, and having a medical background, you can decide to do it one way or another way," Dr. Dombrowski says. "There's no algorithm." He says the shortage can push providers to consider creative alternatives. For example, if a facility is experiencing a shortage of a reverse muscle relaxant that acts as the antidote to a muscle relaxant, the anesthesiologist might consider whether

he or she needs to give the patient the muscle relaxant in the first place.

4. Cancel cases when necessary. Dr. Dombrowski says anesthesiologists and surgeons should communicate about whether a drug substitution is appropriate for a particular surgery. If the substitution could endanger patient safety, the providers should not hesitate to cancel or reschedule the case. "Sometimes there's no workaround, and you have to say to the patient, 'After looking at your past medical history and your condition, what we would need to provide you is not really safe,'" he says. According to the ASA survey, approximately 10 percent of respondents have postponed or cancelled procedures as a result of the shortages. ■

Learn more about the American Society of Anesthesiologists at www.asahq.org.

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2. **Developing a Strategy for your ASC** — Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners, Mike Doyle, CEO, Surgery Partners, Richard E. Francis, Chairman & CEO, Symbion
3. **The Best Ideas for Physician/Hospital Alignment** — Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, Charles "Check" Peck, CEO, Health Inventures, R. Blake Curd, MD, Robert Boeglin, MD, President, IU Health Management. Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP
4. **Leadership and Motivation in 2011** — Bill Walton, Former ABC, ESPN, NBC Basketball Announcer, NBA All-Star Basketball Player
5. **What Percentage of Key ASC Specialties Will be Employed by Hospitals Within 5 Years: Orthopedics, GI and Ophthalmology** — Brian Mathis, Vice President, Strategy, Surgical Care Affiliates, Mike Lipomi, CEO, Surgical Management Professionals, Jimmy St. Louis, III, MBA, Vice President Corporate Development, Laser Spine Institute. Moderated by Amber McGraw Walsh, Partner, McGuireWoods LLP
6. **How to Evaluate & Implement New Profitable Services into an ASC** — Robert Zasa, MSHHA FACMPE, Founder, ASD Management, and Kenneth Austin, MD, Orthopedic Surgeon, Rockland Orthopedics and Sports Medicine
7. **The State of the Union for ASCs** — Andrew Hayek, President & CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee
8. **The Best Ideas to Improve Volume and Profits** — Bryan Zowin, President, Physician Advantage, John C. Steinmann, DO, Founder, Alliance Surgical Distributors, Robin Fowler, MD, Executive Director and Owner, Interventional Management Services, and Keith Metz, MD
9. **Should You Sell Your ASC? - A Step by Step Plan for Selling Your ASC: How to Maximize the Price, Terms and Results and How to Handle the Process** — Luke Lambert, CFA, MBA, CASC, CEO, ASCOA, introduced by Scott Downing, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods, LLP
10. **The 5 Best and Worst Specialties for ASCs: An Outlook for the Next Five Years** — Larry Taylor, CEO, Practice Partners in HealthCare

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5 Reasons Why Surgeons Still Join Surgery Centers

By Leigh Page

Robert Zasa, managing partner of ASD Management in Pasadena, Calif., lists five top reasons why surgeons still join ambulatory surgery centers.

1. Control of the OR. “Doctors really desire control of the operating room itself — the people, the supplies and instrumentation they use, right down to the flow of the room,” Mr. Zasa says. “Having the same nurse for your procedures and having a small group of the same anesthesiologists has a big impact on efficiency.”

In contrast, the surgeon in the hospital works with different people all the time. By having the same people, “the surgeon is faster and more efficient,” he says. “Staff members gain a great deal of proficiency doing the same type of procedures on a routine basis.” The nurse who always works with the same physician knows his procedures very well.

2. Control of the schedule. Block scheduling, another rarity in the hospital, provides for optimal efficiency in the ASC. “The ability to do several cases in a row on the same day on a routine basis puts ASC efficiency head and shoulders above the hospital,” Mr. Zasa says. “The surgeon can come in, do all his cases for the day and go back to the office. He doesn’t have to go back and forth.” Blocks make the scheduler more productive, because she almost always works with the same times. Turnover time can be low — about 10 minutes or less, on average, at an ASC — because the cases in one surgeon’s block tend to be similar.

3. Generating extra revenue. In the ASC, the facility fee goes to the physician-partners, not the hospital. Since surgeons have a share in the fees, they are rewarded if they are efficient. “If they do the case at the hospital they get nothing,” Mr. Zasa observes. “An ASC is one of the few things that surgeons can legally own, so they should take advantage of it.”

4. Introducing new procedures. Surgeons can grow their practice by introducing new outpatient services in the ASC. For example, a bariatric surgeon can do lap-band surgery instead of just gastric surgery. Spine surgeons can move quickly to outpatient spine and pain physicians can start using spine stimulators without having to slog through hospital bureaucracy to get approval. “The ASC-based surgeon is able to generate new volume and allow the practice to grow,” Mr. Zasa says.

5. Becoming part of a network. Physicians from different practices who work together in an ASC have formed the basis for other mutually beneficial arrangements. In this era of accountable care organizations, clinics without walls and bundled payments, “doctors can no longer afford to be isolated,” Mr. Zasa says. “They have to be in networks with other doctors.” By working together, physicians can leverage better managed care contracts, reach out to primary care physicians and conduct marketing. ■

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7 Points on How Surgery Centers Should Handle ACOs

By Leigh Page

Jeremy Hogue, CEO of Sovereign Healthcare, an ambulatory surgery center management company based in Mission Viejo, Calif., offers seven points on how ASCs should deal with accountable care organizations.

1. Be proactive. ASCs offer high quality at low cost, both of which directly address two chief needs of an ACO, but don't be sitting by the phone waiting for a call from an ACO. ACOs are distracted by many other issues and once they do get to picking up the phone, they may ignore your ASC. "Go to the ACO and start a conversation," Mr. Hogue says. Sovereign Healthcare, which runs six ASCs, has been reaching out to ACOs in its two markets, Southern California and the Phoenix area. "We're not just enquiring," Mr. Hogue says. "We're actually going in and presenting." Sovereign is telling ACO planners "how we can help them solve their problems," he says.

2. Understand how an ACO ticks. In California, both hospitals and large physician groups are planning ACOs. It's important to remember that while they are not insurers, they have to think like insurers in order to succeed. "You're no longer negotiating with big bad Blue Cross; you're negotiating maybe with a group of physicians down the road," Mr. Hogue says. "But the ACO still has to shift [insurance] risk." It has to think like an

insurer and make sure costs do not exceed premiums. The ACO can take risk in a number of ways, such as Medicare shared savings, private payor capitation or bundled payments.

3. Hospital-run ACOs have an agenda. When a hospital runs an ACO, it wants to widen its network, which involves reaching out to an ASC's specialists but not necessarily to the ASC, because it also does not want to reduce utilization of its own services. "The hospital's aim is to bring more patients in its system so that it can cover its fixed costs, such as running its own surgery center, imaging center or lab," Mr. Hogue says.

4. Ally closely with your surgeon-partners. Since ACOs want badly to sign up independent physicians, it's important for the ASC to ally closely with its surgeon-partners and other surgeons who use the center. Representatives of the ASC should be part of all discussions its surgeons have with ACO officials. Stress to the ACO that the surgeons and the ASC are one package.

5. Avoid exclusive deals. The ACO may offer a generous arrangement to the ASC's physician-partners, but the fine print may read that the surgeon can only use the hospital's facilities, including its ORs. That would leave the ASC out in the cold.

6. Think strategically. "More than anything, navigating these waters requires to think far more strategically than the average ASC management company is used to," Mr. Hogue says. "You can't just sit back and say, 'I want to get the most patients and the highest reimbursement.' You have to think about the long term."

7. Beware of rate creep. ASCs negotiating with ACOs are in danger of "rate creep," a slow slide in reimbursements. Mr. Hogue points to past problems contracting with large physician groups in California that take risk, which basically have the same role that ACOs will have. In this scenario, the ACO offers the ASC extra volume in return for lower rates. The ASC accepts the lower payments for this group of patients because it is getting new volume. Then, however, insurers that cover the ASC's existing patients also sign up with an ACO to take advantage of the discount. Forced to provide discounts for its longstanding groups of patients, the ASC starts losing a lot of money. ■

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