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ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

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9 Case Volume & Expense Metrics to Manage in a Profitable Surgery Center

By Rachel Fields

Managing case volume and expense metrics is crucial to the profitability of a surgery center. Here Jessica Nantz, president and CEO of the consulting firm Outpatient HealthCare Strategies, discusses five case volume metrics and four expense metrics that, when measured and improved, bolster ASC profitability and physician satisfaction.

Case volume metrics

1. Block scheduling and utilization. One of the most important case volume metrics to measure is block scheduling and utilization, Ms.

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Reaching Past the "Low-Hanging Fruit": 5 Costs to Cut in Mature ASCs

By Rachel Fields

If you've run a surgery center for a number of years, you have probably exhausted many cost-cutting options: standardizing supplies and cross-training staff, for example. Jim Stilley, CEO of Northwest Michigan Surgery Center in Traverse City, Mich., has worked at his facility for nearly seven and a half years. Here he offers five ideas for cutting costs in a mature surgery center.

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Dr. Raj Rao: 5 Points on How PPACA Will Affect Physicians

By Bob Spoerl

Spine surgeon Raj Rao, MD, is professor of orthopedic surgery at the Medical College of Wisconsin in Milwaukee and is also a major player in U.S. regulatory and health policy. He's a voting member of the Advisory Panel on Orthopaedic and Rehabilitation Devices of the U.S. Food and Drug Administration and also a member of the board of directors of the North American Spine Society.

From 2008 to 2011 — during the drafting and passing of the Patient Protection and Affordable Care Act — Dr. Rao led the national advocacy efforts of the North American Spine Society.

He continues to keep a pulse on what's going on in healthcare policy, especially now, given the Supreme Court will soon issue a decision on the constitutionality of the 2010 healthcare reform law.

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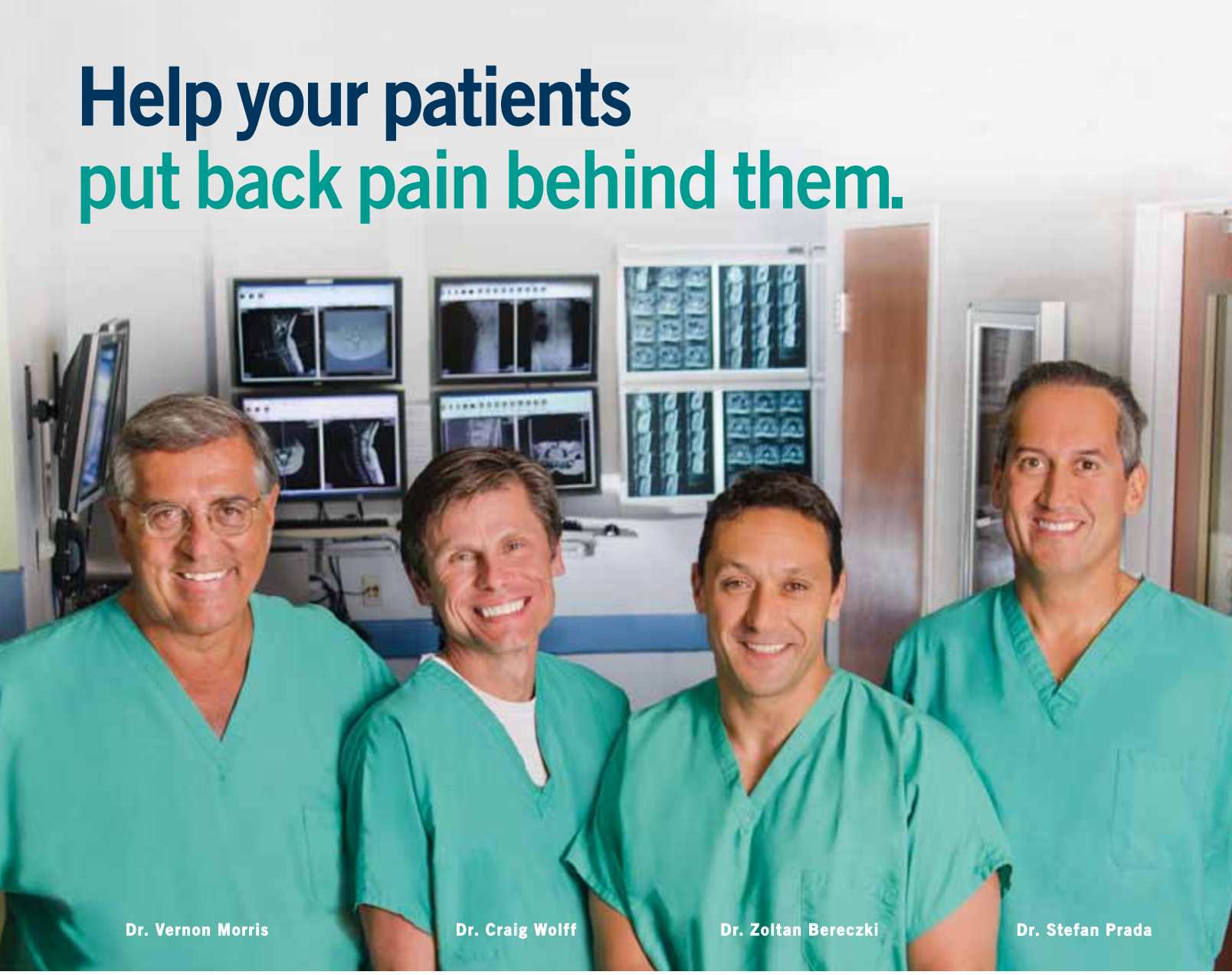

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FEATURES

Publisher's Letter

This issue of *Becker's ASC Review* concentrates on cost-cutting, options for physician/hospital partnership and surgery center valuation — three of the biggest issues facing our industry. The July/August issue also includes two lists: "66 ASC Management & Development Company CEOs to Know," which highlights leaders of influential surgery center companies, and "153 Orthopedic and Spine-Driven ASCs," which showcases surgery centers that perform a majority of orthopedic procedures.

Becker's ASC Review will hold the 19th Annual Ambulatory Surgery Centers — Improving Profitability and Business and Legal Issues Conference from October 25-27, 2012, in Chicago. The conference will feature more than 100 great speakers on ASC profitability and operations, as well as keynote speakers Tony LaRussa, Howard Dean and Ari Fleischer. Mr. Dean and Mr. Fleischer will be debating politics and healthcare two weeks prior to the presidential election.

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

Very truly yours,

Scott Becker

P.S. If you are interested in exhibiting at or sponsoring the conference or advertising in our publications, please contact Jessica Cole at (312) 929- 3675 or jessica@beckershealthcare.com for more information.

9 Case Volume & Expense Metrics to Manage in a Profitable Surgery Center (continued from page 1)

Nantz says. Block scheduling is one of the most effective tools an administrator can use to evaluate which physicians and specialties are supporting their center by tracking their utilization. Ms. Nantz recommends setting a utilization percentage goal — most administrators recommend between 70 and 90 percent — and then measuring how many physicians are meeting that goal.

If your surgery center has a "release block policy," meaning physicians can release their block time to other providers if they don't have cases to schedule, you can also measure how often your physicians release their block time. Ms. Nantz recommends tracking whether the physicians are releasing their block time according to the center's policy, which allows the surgery center to fill the time with other cases.

Once you understand which physicians are filling their block time, you can sit down with the ones that aren't to discuss the cause. Maybe the physician scheduler is taking cases elsewhere, or the physician is dissatisfied in some way with the surgery center. Managing this metric will help determine which physicians are supporting the surgery center and how you can improve physician relations to increase case volume from every provider.

2. Scheduler relations. Your scheduling process must be as simple and painless as possible if you want to increase your case volume, according to Ms. Nantz. She recommends auditing the scheduler in your front office, as well as examining relations with physicians' schedulers. "You need to monitor your scheduler from time to time," Ms. Nantz says. "When I perform an on-site operational assessment, a key component is observing and assessing the responsiveness of the scheduler." She examines the scheduler's reaction to scheduling issues: For example, if a physician's office calls and wants a case during a closed slot, does the scheduler simply say no, or does she look for an alternative? It's essential to know how your scheduler and their back-up staff handle incoming calls, since they directly impact your case volume.

Ms. Nantz says the administrator should also talk to physicians' office schedulers on a regular basis to determine whether they have issues with the ASC scheduling process. "They want to get the schedule on the books with ease," she says. She says regular meetings are also an opportunity to talk about releasing block time. If the physician had three hours of block time that were never used, the administrator should explain that the surgery center could add cases in that time. During these meetings, the administrator will also be able to hear any concerns about the surgery center that the physician shared with his or her staff.

3. Turnaround times. Turnaround times — the amount of time it takes staff to "turn over" a room from one patient to another — have a huge impact on the efficiency of a surgery center. According to Ms. Nantz, surgery center administrators should review turnaround times every month and provide feedback to clinical staff. If staff members know they are being held to a certain benchmark, they will work together to meet the goal.

4. Flexing of operating rooms. You may need more or fewer open operating rooms based on your case volume, and the number should never stay stagnant from week to week regardless of the number of cases. Ms. Nantz strongly urges the administrator to track several metrics — cases per operating room, cases per CPT code and cases per specialty. Once you know how many cases your surgery center is taking in, you can decide how many operating rooms to keep open and how to staff them.

If the surgery center has more cases than usual, you can open an OR and/or call in PRN staff; if the center has fewer cases than usual, you can close or compress your ORs and send some staff home. These metrics should be measured on a daily basis to make sure you are never staffing more people than necessary.

5. Equipment quality. The quality of your equipment will have a significant impact on your case volume, as low-quality equipment or incorrect equipment levels will discourage physicians from scheduling cases. Ms. Nantz recommends that the administrator or clinical manager be in constant communication with the sterile processing department to make sure everyone is aware of any equipment malfunctions or needs.

She also suggests the OR staff report to the clinical manager on a daily basis regarding any issues physicians have with the equipment. "If the doctors say, 'I need this' or 'we didn't have this', that feedback is key, and the problem should be corrected without delay" she says.

Expense metrics

1. Understand your cost per case. Ms. Nantz says the first step to controlling ASC expenses is to understand the costs involved in every case you perform. "You need to know the staff, supply, medication and implant

cost for every case," she says. "If you don't know your cost per case, how do you control your cost? How do you which cases are profitable?" She says cost per case should be divided into four areas excluding overhead:

- Pre-op
- Anesthesia
- Operating room
- PACU

For each area, you should understand the different costs and how they contribute to the overall cost of the case. That way, you can determine which cases your supply costs are highest and which areas have the biggest problems with staffing expense. She also recommends tracking cost per case by physician and specialty, to help you understand which physicians cost more in terms of supplies and which specialty cases are most and least profitable. Case costing by physician also sets a baseline for best practices.

She says preference cards need to be updated regularly to make sure your supply cost per case is accurate. Ms. Nantz recommends asking OR staff members to go through the physician's preference card at the end of the case and mark down which supplies were not needed and which were substituted or added. Then regularly update the preference card in your software system.

2. Review 2-3 standard vendor contracts a month. Ms. Nantz says many ASCs keep binders full of vendor contracts that are to be reviewed on an annual basis. Many administrators leave this review until the end of the year and then skim their contracts, ultimately leaving money on the table because a thorough review in a short period of time is unrealistic. Instead, she recommends reviewing two or three standard vendor contracts every month and looking for areas to cut costs or improve quality or efficiency.

3. Challenge your pricing. Challenging your rates can be intimidating, but it's essential to make sure you're getting the best price from your vendor. Ms. Nantz recommends starting with high-volume and high-price items — those you use the most and those that cost you the most money. "Review your most common items and make sure your vendors are giving you a good deal," she says.

She says this also applies if your center uses a GPO to purchase supplies. Review your GPO contract and determine whether your membership is benefiting the center. "Sometimes in a GPO, you may be required to purchase a certain volume to get a discount," she says. "You need to review those terms to make sure you're really saving money."

4. Audit your materials manager. Ms. Nantz recommends auditing your materials manager regularly to make sure he or she is saving you money. "You really need to monitor how the materials manager is assisting the administrator in expense control," she says.

Make sure the materials manager is reviewing supply costs and shipping fees on a regular basis to look for savings opportunities. Hold a regular meeting to discuss your target for supply costs and any outliers the materials manager has seen while ordering, receiving and stocking supplies. Review your inventory every month; if you see it was $100,000 last month and $125,000 this month, ask your materials manager for an explanation to catch any issues early. ■

Reaching Past the "Low-Hanging Fruit": 5 Costs to Cut in Mature ASCs
(continued from page 1)

1. Install RFID locators to track patient progress. Mr. Stilley says his surgery center has started using RFID locators to track patient progress from the pre-op area to the OR to the PACU. "We use a company called Versus Technologies that puts a badge on the patient, physicians and nursing staff," he says. "It basically tracks everybody in the surgery center." He says the surgery center is equipped with monitors, so the nurses can look up and see how long the patient has been in the operating room. This helps with turnover times, since nurses need to be ready to turn over the room as soon as the patient moves to the PACU.

"If you know the average time a patient stays in the operating room is 20-25 minutes, and you see the patient is at 18 minutes, you know the room will be opening up soon," he says. This helps the pre-op staff prepare the pre-op patient to move into the OR and the PACU staff prepare the recovery area for the incoming surgery patient. He says the surgery center has dropped its average time in recovery by approximately 10 minutes, which has a significant effect on staffing costs. "When you're talking about 18,000 patients times 10 minutes, that's a lot of time," he says.

2. Use nurse-directed teams. Mr. Stilley's surgery center uses "nurse-directed teams," meaning groups of patients are taken care of by an RN, an aide and a medical assistant. He says this saves money by allowing the nurse — who has more clinical qualifications than the aide or medical assistant — to turn over appropriate functions to the other team members and instead focus his or her time on healthcare delivery. "The RNs are basically managing a care team, and it allows them to see more patients per RN because they're delegating other duties," Mr. Stilley says.

For example, the aides are responsible for helping the patient sit up after a procedure, discontinuing the IV with nurse recommendation, transporting the patient out of the facility or getting nourishment for the patient after the procedure. "They're also a trained set of eyes," Mr. Stilley says. "If the nurse is taking care of three or four patients, that's another set of hands and eyes that's there if a patient needs more care." He says this staffing arrangement gives nurses support while reducing staffing costs by cutting the number of RNs in the facility at any given time.

3. Divide up "length of stay" times to determine problem areas. Mr. Stilley says examining length of stay is only useful if you know where holdups exist in your surgery center. He says his surgery center divides up the patient stay into sections to determine where the outliers exist. He says he starts on the front end and looks at:

- How long the patient is in admission
- How long the patient is in pre-op
- Time from when the patient enters the OR until the incision is made
- Time from incision to close
- Time from close to when the patient leaves the OR
- Turnover time (from when the patient leaves the Or to when the next patient enters that OR)
- Recovery time

The surgery center then examines the entire length of stay, from admission to discharge, for the patient. "We like to track and trend those times, because as time pressure builds on the physicians, we like to show to our physicians that we are staying within our norm," he says. "It's helped to minimize the bad days — if they're behind and they feel the surgery center isn't operating in a way it normally does, it allows us to see that the day is an outlier." He says outliers are generally caused by pre-op, when the patient is getting ready to go into the OR. Turnover times are also impacted by the amount of staff present in the ASC on a particular day.

4. Understand the "levers" that make benchmarks move. You won't be able to make changes in your surgery center processes if you don't understand how actions affect your benchmarks, Mr. Stilley says. "I see a lot of data collection and tracking and trending, but we should be making targets and we should know what levers in the organization to pull to move towards those targets," he says.

For example, if supply costs are higher than you would like, make a target and try one action at a time to get to that target. If you try a slew of actions at once, you won't be able to tell which one has the greatest effect — or, even worse, if some have negative effects that are hidden by the positive effects of others. So if supply costs are too high, start by updating physician preference cards; once you've noted the effect, move on to re-negotiating vendor contracts, then standardizing brands, then joining a GPO.

5. Work staff at about 80 percent of possible production. Mr. Stilley says surgery centers should use benchmarking to calculate how much work the staff can do when working at 100 percent productivity. Once you have that number, reduce workload to around 80 percent of total possible productivity. "If we have an unforecasted month, where we're doing 20 percent more than we thought we could do, we know the staff can be stressed for a short period of time," he says.

This tactic will save the surgery center money in two ways. First, the surgery center will be able to work at total efficiency in months when more cases than expected are scheduled. Second, the surgery center staff will work productively but happily the rest of the time, meaning no one is too overworked and turnover rates are likely lower. "If we had to hire more people, that takes away from next year's raises and profit-sharing," says Mr. Stilley. ■

Dr. Raj Rao: 5 Points on How PPACA Will Affect Physicians (continued from page 1)

"While PPACA will certainly have multiple tangible effects on us as the law unfolds, currently it primarily affects physicians and surgeons through a sense of anxiety it provokes about the eventual state of affairs, watching all the preparations by the various stakeholders in healthcare," Dr. Rao says.

Here, Dr. Rao shares insight into what may come in the aftermath of the Supreme Court's decision.

If the Court upholds PPACA:

1. Reimbursement will go down. Dr. Rao notes that a number of regulations are already in play that affect spine surgeons and all physicians because of PPACA — EMRs, patient quality reporting initiatives, e-prescribing and meaningful use criteria to name a few. "We've moved from the bonus phase of many of these regulations where we were given additional money for meeting thresholds on these requirements, to the penalty phase for not meeting the requirements." Should the Supreme Court uphold PPACA, he foresees changes in the amount physicians are reimbursed, with specialists receiving less pay and primary care physicians receiving more.

"Reimbursements for specialty care have been steadily ratcheted down through various avenues over the last 10 years or so," Dr. Rao says. "Reimbursement for primary care has been steadily ratcheted up."

2. Primary care will continue to be incentivized to play a bigger role. State and federal government programs that provide incentives for primary care physicians, and for medical students to choose primary care practice because of shortages in that area are laudable in theory, Dr. Rao says.

In many instances, primary care physicians tend to act as a triage and refer to a specialist for appropriate care. "They simply don't have time to keep up with a rapidly expanding field of medicine, and generally tend to recommend patients receive complex care from physicians who specialize in it," Dr. Rao says.

He gives an example in his field of orthopedic and spine care. Patients with strains in their lower back are okay to receive primary care. But the minute the strain worsens to the point where the pain is unbearable, the patient more often than not will demand to see an orthopedic spine surgeon or other spine specialist who understands back pain on a much more sophisticated level than the primary care.


Dr. Raj Rao

3. Specialty shortages will create access to care issues. Additionally, specialty care is in jeopardy of hitting a shortage as worrisome as primary care in the next 10 to 15 years as physicians retire and baby boomers need more specialized care, according to Dr. Rao.

"What most people don't talk about is the shortage in specialty care," he says. "What has kept

American healthcare glorious is specialty care." He fears that a de-emphasis on specialty care could fade that reputation.

4. Spine surgeons will limit their practices to private payors. Another potential outcome if PPACA is upheld is a lowering of Medicaid and Medicare reimbursements, to the point where some physicians may no longer be financially able to provide care for patients with government payors.

And if PPACA is upheld and some 30 to 40 million more Americans receive federally-subsidized insurance, Dr. Rao foresees some physicians being unable to continue to maintain an independent practice at all.

"The cost of providing quality of care will far exceed the reimbursement of government-sponsored insurance," Dr. Rao says.

If the Court strikes down the individual mandate or all of PPACA:

"If it isn't upheld, all bets are off," Dr. Rao says.

5. A new cost-reducing plan will arise. Politicians and healthcare leaders will need to ask each other what the next version of reform should look like if PPACA is stricken down.

"I don't believe anyone knows what will happen," says Dr. Rao. "There will probably be some reflection on various options, and renewed efforts will develop to somehow reduce costs associated with healthcare." ■

Contact Bob Spoerl at bspoerl@beckershealthcare.com.

5 Management Problems Plaguing Unprofitable Surgery Centers

By Rachel Fields

Ellen M. Johnson, chief operating officer for Facility Development & Management, LLC discusses the problems that most commonly necessitate a surgery center turnaround.

1. Lack of compliance with state/federal regulations and accreditation. Ms. Johnson says Facility Development & Management is often brought in to centers that have issues with federal/state regulation compliance or accreditation requirements. "We find centers are out of compliance," she said. "This in turn affects profitability because when you are out of compliance, it demonstrates inefficiency in operations." Some ASCs hire managers with little or no experience in ASC operations, who have to learn "on the job" rather than reviewing the regulations and accreditation aspects.

Managers can increase their compliance knowledge through the Ambulatory Surgery Center Association and their state associations, Ms. Johnson says. She gives the example of a neophyte manager in charge of compliance and accreditation who may incorrectly identify and prioritize compliance tasks. "They're not sure what it is that has to be done, so they don't ensure that recredentialing gets done or they don't create minutes after holding committee and governing board meetings — things like that," she says.

Ms. Johnson says in turning around a non-compliant center, her company generally tries to work with the existing leadership and educate these people so that they can assume responsibility for meeting regulations. "Our first step is to perform an audit to determine areas of non-compliance," she says. "Then we evaluate each area of non-compliance, prioritize these areas and correct them until we are sure every issue is addressed." She recommends retaining an ASC consultant who can address questions and concerns. Depending upon the profile of your center, you may not need a full-time management company, but you should have a consultant who keeps you abreast of changing regulations and who can conduct periodical audits.

2. Decreased reimbursement due to a shift to managed care contracts. More surgery centers are moving toward in-network contracts as payors pressure physicians and patients not to utilize out-of-network facilities. Ms. Johnson says the move from out-of-network to in-network can negatively affect profitability, as out-of-network reimbursement is generally more lucrative than reimbursement from a negotiated contract.

She says when centers consider moving to managed care contracts, they should look first at the volume of potential in-network cases that are being taken elsewhere. "Sometimes you'll have a physician who does his out-of-network at one center and his in-network at either a hospital or another center," she says. "The first thing to do is find out how many cases are not coming to the center. Based upon the analysis, it may not be to the center's advantage to contract with certain payors."

She says if the surgery center is missing out on a significant number of cases from the larger insurance carriers, it's best to analyze current case profitability to determine how many additional cases the physicians would need to bring in order to compensate for the change in reimbursement. For example, a surgery center moving in-network may be required to perform three more cases to make up for a reimbursement loss from one out-of-network case.

3. Out-of-control costs. Even surgery centers with strong managed care contracts may see decreased profits if their costs are not kept in check, Ms. Johnson says. She says in many cases, surgery centers have no idea where they're losing money because they don't accurately track their overhead or case costs. She recommends investing in an ASC computer system that enables the center's management team to track and compare costs by specialty and physician. Since staffing and supplies are an ASC's two biggest costs, close monitoring of these two areas is paramount. For example, the surgery center may be inefficient in its staffing profiles, leading to extended patient recovery time and possible overtime for staff.

The surgery center may also be spending too much money on supplies. Ms. Johnson recommends joining a group purchasing organization to ensure best pricing on medical supplies. She says it's also important to talk to physicians about what they spend on supplies by showing them usage statistics on various high volume cases. "Physicians are naturally competitive people," she says. "If you point out that one physician spends $800 on mesh and another spends $400, they'll want to investigate the other option." She also recommends ensuring that surgeon preference cards are constantly evaluated for accuracy to make sure the surgery center isn't ordering obsolete supplies.

4. Billing problems leading to poor collections. If your billing department sends out claims late or receives consistent denials due to poor processes in pre-certification, your profitability will suffer, Ms. Johnson says. She says operative notes are an area where physicians can ensure optimal reporting. Having comprehensive operative reports enables the coders to fully utilize codes for billing. "Billing may not be accomplished as efficiently as possible because the operative notes aren't comprehensive." she says. "You will leave money on the table if documentation on all aspects of the case has not been done."

She recommends comparing the center's accounts receivable days to national benchmarks to determine whether your claims are staying with the payor — or on your staff member's desk — too long. In addition to challenging denials, she says denials should also be tracked to determine the cause. Once staff members understand why claims are being denied, they can take steps to alleviate the problem.

5. Aging workforce. Ms. Johnson says staffing can be an issue for surgery centers. She says centers may have trouble recruiting and retaining staff if they can't develop a strong wage and salary program due to financial restraints.

A second challenge for centers is the average age of nurses — OR nurses, specifically. "The average age of this group of professionals is approximately 55 years of age," she says. "How do you maintain a quality level of nursing as your staff look toward a future of fewer hours or perhaps even retirement?" She recommends looking for opportunities for cross-training now, even if you aren't suffering from a staff shortage. "You may have a PACU nurse that has interest in learning to be an OR nurse," she says. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

Learn more about Facility Development & Management at www.facdevmgt.com.

66 ASC Management & Development Company CEOs to Know

Here are 66 CEOs of ambulatory surgery center management and development companies. The CEOs on this list work tirelessly to improve surgery center efficiencies, build strong physician relationships and boost profitability for their partnered centers. CEOs do not and cannot pay to be on this list; there is no fee associated with any *Becker's* list. Please contact Rachel Fields at rfields@beckershealthcare.com with any questions.

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.

Luke Lambert (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 Columbia University in New York City and was among the first to earn the CASC designation in 2002. ASCOA currently operates 37 facilities across the country and continues to look for new partnership opportunities.

Christopher A. Holden (AmSurg). Mr. Holden has been AmSurg's president, CEO and director since October 2007. The company specializes in managing and developing 3,000 to 4,000-square-feet 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.

Jared Leger (Arise Healthcare). Mr. Leger is a co-founder and managing partner of Arise Healthcare. The company currently owns and operates various healthcare-related businesses with a focus on ASCs. His background as a registered nurse, coupled with his healthcare business background, has allowed him to grow Arise Healthcare at an accelerated pace. His past experience includes healthcare finance, mergers and acquisitions, development and operations. He has also syndicated and operated several physician-owned surgery centers. In addition to leading Arise, Mr. Leger owns a real estate investment company based out of Austin, Texas.

Jesse Chamberlain (Artisan Medical). Mr. Chamberlain is managing partner of Artisan Medical and has more than 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.

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 Health Care Advisors, 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 to 2007. He has also served as a director of First Professionals Insurance Company and president and board chairman of the Surgery Center of Stuart.

Joseph Zasa, JD (ASD Management). Mr. Zasa is the co-founder and managing partner of ASD Management (formerly Woodrum/ASD). Founded in 1986, the company is one of the oldest continually operating surgery center companies, with more than 125 surgery centers developed and managed over the last twenty-six years. ASD currently operates 29 ASCs throughout the United States. It is an operations-focused company and has had great success with ASC turnarounds and hospital/physician joint ventures, according to Mr. Zasa. In addition to his work with ASD Management, Mr. Zasa is the former president of the Texas Ambulatory Surgery Center Association and currently serves on its board.

Robert Zasa (ASD Management). Mr. Zasa is a founder and managing partner of ASD Management, a national healthcare services firm that consults with physicians, physician groups, and hospitals to develop and manage ambulatory surgery businesses. Mr. Zasa is experienced in all phases of business development, marketing, expansion, structuring, and management of multi-service ambulatory care facilities, ambulatory surgery centers, and hospitals. In the early 1990s, Mr. Zasa founded and served as president and CEO of Premier Ambulatory Systems, a firm that acquired, developed, owned and operated ambulatory surgery centers across the U.S. Previously, Mr. Zasa was managing general partner of a national ambulatory care consulting firm and was involved in the founding and public offering of the AlternaCare Corporation.

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

Gregary W. Beasley (Ambulatory Surgery Division, Hospital Corporation of America). Mr. Beasley serves as President of HCA's Ambulatory Surgery Division. He was previously COO of the ambulatory surgery division, in charge of daily operations. Prior to joining HCA, Mr. Beasley spent nearly four years at HealthSouth Medical Center as controller and chief operating officer. He has also worked for the VHA for three years and Ernst and Young for two years. Mr. Beasley attended Texas Tech University where he earned a bachelor's degree in business administration in accounting in 1986 and became a certified public accountant in 1989.

Jeff Leland (Blue Chip Surgical Center Partners). Mr. Leland is CEO of Blue Chip Surgical Center Partners. The company has developed and manages 16 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. He was also president of HealthSpring Medical Group and CEO of Western Ohio Health Care, an HMO with more than 250,000 members that was acquired by United HealthCare. Mr. Leland is an alumnus of the Harvard Business School in Boston.

Barry D. Smith (Cirrus Health). As CEO, Mr. Smith is responsible for overseeing the management and overall success of the Cirrus Health organization. Prior to joining Cirrus, Mr. Smith served for more than 20 years with the Baylor Health Care System in Dallas, Texas, where he was senior vice president of finance for HealthTexas Provider Network, a 501(a) corporation wholly owned by Baylor Health Care System. As CFO for HealthTexas, Mr. Smith was responsible for financial and management reporting, accounting, billing and collection and budgeting and long range financial planning. As vice president of finance, Mr. Smith was primarily responsible for the planning, establishment and financial development of the initial investment of approximately $25 million to establish HealthTexas, which included the acquisition of physician practices. Mr. Smith received both his master's degree in accountancy and his bachelor's degree in biology and chemistry from the University of Texas at Arlington. Mr. Smith is a certified public accountant and a member of the Texas Society of CPAs. He is also a part of the VHA 501(a) group as well as an instructor in advancing best care at Baylor.

Daniel S. D'Amico (Clarity Development). Mr. D'Amico serves as CEO of the Clarity Development and Clarity Realty. His healthcare experience includes being vice president of development and operations for multiple hospital companies and developing, syndicating, financing, building, staffing, equipping, opening and serving as the CEO of numerous health care facilities. Mr. D'Amico is a graduate of the United States Military Academy, West Point, N.Y., and has an MBA from Golden Gate University, Monterey, Calif.

Ronald A. Duperroir (Clarity Development). Mr. Duperroir serves as CEO of Clarity Health and Clarity Government Services. He brings 24 years of operations experience with an extensive background in resource loading, resource leveling, scope preparation, client relationships, cost avoidance, continuous design improvement and conducting executive status meetings and client reviews. His education includes a bachelor's degree in public policy from the University of Oregon and a master's degree in healthcare administration from Baylor University.

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 bachelor's degree in mechanical engineering from Punjab Engineering College in Chandigarh, India, a master's degree in electrical engineering from Oklahoma State University in Stillwater and an MBA from Xavier University in Cincinnati.

Kris Mineau (Constitution Surgery Centers). Mr. Mineau co-founded CSC in 1997 and serves as its president and CEO. He has led the company's growth for the past 15 years, partnering with over 200 physicians to build surgery centers in Connecticut, Massachusetts and Rhode Island. Prior to founding CSC, Mr. Mineau was a pilot in the U.S. Air Force and received a Bachelor's degree 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, for which he served as founding president.

Richard K. Jacques (Covenant Surgical Partners). Mr. Jacques, president and CEO of Covenant Surgical Partners, has more than 18 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.

Terry Weisman (Denovo Development). Mr. Weisman serves as president of Denovo Development, which focuses on ground-up development of surgical centers including physicians LLC formation, real estate investment and development, operations and management. He began his career in the workers' compensation industry, developing urgent care, physical therapy and industrial medicine facilities in partnership with physicians. After 11 years in that business, he was hired by Andrew Brooks of California-based company Specialty Surgical Center in order to grow the business. After the company was sold to Symbion, he started De Novo Development, where he currently develops new surgery centers, locates surgery centers for physicians seeking a facility and consults with existing facilities to improve efficiencies and profits. He received his bachelor's degree in psychology from Drury University.

Lori Ramirez (Elite Surgical Affiliates). Ms. Ramirez founded Elite Surgical Affiliates in 2008 and now leads as its president and CEO. Elite provides management and development for surgical facilities, with a special emphasis on orthopedics, spine and pain. With many surgical facilities operational in Texas and many others in the development phase, Elite is off to a "remarkable start," she says. Before founding Elite Surgical Affiliates, Ms. Ramirez was a senior vice president at United Surgical Partners International. In this role, she gained extensive experience in creating joint ventures, including one between Memorial Hermann in Houston and CHRISTUS Health System in South Texas. She also was directly responsible for developing the second-largest network of surgical facilities for USPI in Houston and supervised more than 600 employees. Ms. Ramirez oversaw more than 20 surgical facilities, including two surgical hospitals (one of which included an imaging center and three breast imaging centers).

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, served 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.

Edward P. Hetrick (Facility Development & Management). Mr. Hetrick, the founder and president of Facility Development & Management, has more than 30 years of experience in the healthcare industry, with over 20 years of ASC experience. He has held key administrative positions in major teaching hospitals, national consulting firms and practice management companies. Mr. Hetrick and FDM have developed over 50 surgery centers nationally and managed numerous centers on an ongoing basis. Mr. Hetrick earned a bachelor's degree from the United States Military Academy at West Point (N.Y.) and dual Masters' degrees Business and Public Health from Columbia University in New York City.

Thomas A. Michaud (Foundation Surgery Affiliates). After graduating from Boston College with a bachelor's degree in Accounting, Mr. Michaud earned his CPA certificate while serving as a staff accountant with the international accounting firm, Ernst & Young. Prior to founding Foundation Surgery Affiliates in January 1996, Mr. Michaud held the positions of chief operating officer and chief financial officer of a regional surgery center management company. Mr. Michaud's responsibilities include marketing the Foundation program to potential surgeon partners, developing new geographic and product markets for the company, along with medium and long term corporate planning and strategy.

Cecilia Kronawitter (HDA Enterprises). Ms. Kronawitter serves as president of HDA Enterprises. She began her career as a facility planner and rose to department head of a well-known architectural firm, specializing in healthcare. From there, Ms. Kronawitter decided to open her own firm, where she has personally directed the development of more than 200 facilities worldwide. In 2007, Ms. Kronawitter opened a sister company to HDA Enterprises, where she collaborated with innovative management professionals and formed HDA International Management, a corporation offering a full range of healthcare management consulting services.

Chuck Peck, MD (Health Inventures). Dr. Peck, an internist and rheumatologist, serves as president and CEO of Health Inventures. The company currently manages approximately 30 ASCs and surgical hospitals and 11 sleep centers around the country. He has more than 30 years of healthcare experience as a clinician, educator and leader. Dr. Peck 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 multi-specialty practice, partner with a global 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. He is a fellow of the American College of Physicians and a board member of the Ambulatory Surgery Center Association.

Bill Simon (Innovative Healthcare Management). Mr. Simon is president and founder of Innovative Healthcare, a company that provides development and management services for outpatient surgery and endoscopy centers throughout southern California. IHM has developed five centers and consults with and manages an additional two centers. Mr. Simon's responsibilities include facility development and design, physician recruitment, equipment planning and negotiation and facility leadership and management. Before founding IHM in 1995, Mr. Simon 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.

Jeff Sapp (Innovative Surgical Solutions Management). Mr. Sapp serves as principal of Innovative Surgical Solutions Management along with Nancy Kastner. He has 21 years of healthcare management experience. Prior to joining ISSM, he served as vice president of development for USPI, the largest owner and operator of surgery centers nationwide. He was also the co-founder and executive vice president of ASC operations for Surgis, which was formed in 2001 with the industry's largest contribution ($100 million) from a private equity firm. The company was sold to UPSI for $200 million in 2005. Prior to founding Surgis, Mr. Sapp co-founded and served as senior vice president of development for Surgical Synergies, an ASC company. He has also served as the administrator of Same Day Surgicenter of Orlando.

Nancy Kastner (Innovative Surgical Solutions Management). Along with Jeff Sapp, Nancy Kastner serves as principal for Innovative Surgical Solutions Management, a company that raises funding for new surgery centers and guides them through the development process. Ms. Kastner has expertise in increasing profitability for surgery centers, medical practices and hospitals and conducting a compressive analysis of internal operations. She has conducted a physician buy-out of a financially challenged ASC, taking the surgery center from unprofitable to profitable and 90 percent physician owned within six months. She has also performed conversions of accredited surgery centers to accredited hospital outpatient departments and has successfully appealed numerous Medicare decisions. Ms. Kastner holds a Master's degree in commercial lending from the University of Virginia.

Stephen Rosenbaum (Interventional Management Services). Mr. Rosenbaum is co-founder and CEO of IMS. During more than 20 years of healthcare-related experience, Mr. Rosenbaum has served as vice president of finance for development at MedCath and helped develop Carolinas Surgery Center. In addition, Mr. Rosenbaum created an independent healthcare consulting company, SourceRevenue, where he was involved in the development of a neurosurgical hospital and a 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. In 2008, Rosenbaum joined The Interventional Spine and Pain Management Center and created IMS with Dr. Robin Fowler. As CEO of IMS, Rosenbaum is responsible for the day-to-day operations of ten healthcare companies and over $35 million in annual revenues.

Bill Horne (Laser Spine Institute). Mr. Horne is CEO of Laser Spine Institute. LSI's flagship facility is in Tampa, Fla., and LSI has grown to include four surgical facilities. Mr. Horne underwent a minimally invasive spine procedure performed by Dr. St. Louis, which triggered his interest in minimally invasive spine care. Before joining LSI, Mr. Horne founded Club Operations and Property Management, a leading management company for country, city and yacht clubs.

John R. Seitz (ManageMyASC). Mr. Seitz is President and CEO of ManageMyASC (www.managemyasc.com), a real-time, interactive management tool that provides an unprecedented view into the financial and operational performance of a surgical center with tracking, benchmarking, analysis and recommendations. He has over 25 years of experience in healthcare, including founding and leading start-up companies. Prior to joining ASG, Mr. Seitz 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.

David F. "Buddy" 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.

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.

Donald Schellpfeffer, MD (Medical Facilities Corp.). Dr. Schellpfeffer is the CEO of Medical Facilities Corporation and Sioux Falls (S.D.) Specialty Hospital. As an original founder of Sioux Falls Specialty Hospital, Dr. Schellpfeffer has been its CEO and a member of the management committee since the facility's inception in 1985. He has more than 30 years of experience in ambulatory surgical environments and in general, cardiovascular and trauma practices and has also authored numerous medical publications. Dr. Schellpfeffer received a bachelor's degree from the University of Wisconsin; a master's degree and a bachelor of science degree from the College of Veterinary and Medicine; a Ph.D. in animal physiology from the University of Minnesota; and an M.D. from the University of South Dakota School of Medicine. He completed his residency in anesthesiology in Wisconsin.

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.

Matt Searles (Merritt Healthcare). Mr. Searles has been a partner with Merritt Healthcare for more than 10 years. During that time, he has managed, developed and advised for dozens of healthcare facilities across the country. Mr. Searles is also a registered investment banking agent holding Series 79 and Series 63 licenses. In 2011, Merritt completed $50 million in ASC transactions and expects to complete $85 million in transactions in 2012 as a buy or sell side advisor to hospitals and ASC clients. His background includes experience in corporate finance and venture capital-backed companies. He earned his MBA from Duke University in Durham, N.C.

Amy Mowles (Mowles Medical Management). Ms. Mowles is president and CEO of Mowles Medical Management. She has guided numerous new ventures and established ASCs and physician practices through regulations, licensing, certification and accreditation processes. In 1996, Ms. Mowles became involved with pain management specialists. Recognizing the need for public awareness and education of interventional pain management procedures, she assisted physicians in establishing the Mid-Atlantic Pain Society. Ms. Mowles' experience with CMS policy analysts and ASC and pain management societies cemented her reputation as a leading expert in pain management practices and ASC development.

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 degree in health administration from Iona College in New Rochelle, N.Y.

Bob Scheller (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 MBA from the University of Wisconsin in Madison.

David Ayers (Nueterra Healthcare). Mr. Ayers, CEO of Nueterra Healthcare, offers 30 years of experience developing, building and manag-ing hospitals in addition to leading the development of a number of ambu-

latory surgery, imaging, physical therapy and urgent care centers. Mr. Ayers continues to expand his considerable experience working with physicians and health systems to develop domestic and international partnerships through Nueterra Healthcare's global growth strategy. He also serves on the board of directors of Physicians Hospitals of America and the government affairs committee for ASCA.

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.

Chris McMenemy (Ortmann Healthcare Consulting Services). Ms. McMenemy is president and CEO of Ortmann Healthcare Consulting Services. She recently took on this role after the retirement in June of 2011 of longtime ASC consultant, Fred W. Ortmann, III, a founding member of AmSurg and founder of Ortmann Healthcare Consultants. Ms. McMenemy has worked with the company since its opening in 2001, specializing in financial feasibility studies, regulatory issues and implementation of IT systems. Ortmann Healthcare Consulting Services is continuing the vision of Mr. Ortmann by continuing to develop denovo projects as well as the management of existing ASCs, accreditation assistance, plan of correction assistance, managed care consulting and ASC billing. Ms. McMenemy received her MS from the University of Kansas and is currently on the Medical Advisory Board for Orbis International, whose mission is saving sight worldwide.

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 together with CFO Karen Sablyak. The company currently owns and manages 23 endoscopy centers in partnership with physicians and hospitals. Before joining PE, Mr. Tanner held various senior executive positions in healthcare for over 20 years, working both on the provider side and in financial services.

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. Mr. DeHart provides Pinnacle III's clients with expertise in strategic planning, development and management of surgery centers, diagnostic imaging and physical rehabilitation services. Prior to Pinnacle III's creation, he oversaw the management of 14 surgery centers in five states for one of the nation's largest publicly traded surgery center companies. He also provided operational services for several outpatient rehabilitation facilities. He graduated from California State University at Chico.

Larry D. Taylor (Practice Partners in Healthcare). Mr. Taylor has more than 30 years of experience in healthcare delivery, management and physician relations. Prior to founding Practice Partners in HealthCare, he served as president and COO of the largest provider of ambulatory surgery centers in the U.S. His initial entry into healthcare was focused in the delivery of sports medicine and orthopedic care. As a clinician, he experienced the processes, challenges and expectations healthcare workers face, and his commitments to clinical outcomes and patient care and to those who deliver them remain a focus throughout his career. Since founding Practice Partners, the team has developed and opened multiple surgery centers and has a pipeline of centers under development and con-

struction. The founder also has a background in education and currently serves as an adjunct professor in healthcare at the University of Alabama at Birmingham and participates as a board member for the Ambulatory Surgery Center Association and the Ambulatory Surgery Center Foundation. He is a graduate of West Virginia University and a nationally certified athletic trainer.

Thomas Mallon (Regent Surgical Health). Mr. Mallon co-founded Regent Surgical Health in 2001 and serves as CEO. Over the past 11 years, the surgery center management and development company has grown to include 24 facilities in the US and Europe. Seventeen of those partnerships are hospital/physician joint ventures. The leadership team is committed to structuring sustainable partnerships that align the interests of all parties, and positioning its centers to meet the constantly changing market conditions. With significant experience in venture capital funds, turnarounds and physician recruitment, Mr. Mallon offers each facility his expertise on all aspects of clinical and financial operations. He earned a bachelor's from Denison University and his MBA from the Harvard Business School.

Todd Borst (Smithfield Surgical Partners). Mr. Borst is CEO of Smithfield Surgical Partners and manages the company along with principals Gregory Horner, MD, and Steve Mohebi. Smithfield collaborates with physician partners to create and manage medical office buildings, surgical facilities and medical malls. The company maintains minority ownership of its surgical facilities when construction is complete.

Kenneth R. Ross (Solara Surgical Partners). Mr. Ross is CEO of Solara Surgical Partners and has more than 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.

Jeremy Hogue (Sovereign Healthcare). Mr. Hogue is co-founder, president and CEO of Sovereign Healthcare, which operates surgery centers in California and Arizona, as well as provides management services for physician group practices.. 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.

Brian Massoud, MD (Spine Centers of America). Dr. Massoud is founder and head surgeon at Spine Centers of America in Fair Lawn, N.J. He received training at Texas Back Institute in Plano, and has performed more than 1,000 endoscopic spine surgeries, including endoscopic cervical spine surgery. He also trains spine surgeons in endoscopic procedures, and articles he has authored on the subject are published in professional journals. Along with his clinical practice, Dr. Massoud is an assistant clinical professor of orthopedic surgery at Seton Hall University's School of Health and Medical Sciences in South Orange, N.J. He earned his medical degree from Robert Wood Johnson Medical School in New Brunswick, N.J., completed his orthopedic surgery residency at St. Joseph's Hospital and Medical Center in Paterson, N.J.

Gregory George, MD and Sean O'Neal (SurgCenter Development). Dr. George and Mr. O'Neal are founding principals and CEOs of SurgCenter Development. Dr. George, an ophthalmologist, received his medical degree and PhD in ocular physiology from Duke University in Durham, N.C. Mr. O'Neal, who has more than 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'Neal's leadership, SurgCenter Development has developed over 100 physician-owned ASCs.

John H. Hajjar, MD (Surgem). Dr. Hajjar studied medicine at Georgetown University School of Medicine in Washington, D.C. where he graduated in 1981. He completed his surgical and urological training at New York University Medical Center in Manhattan. After spending some time researching the genetic aspects of kidney cancer, Dr. Hajjar decided to focus his energies on clinical urology and patient care. Since 1987, Dr. Hajjar has been practicing urology in northern New Jersey, where he has developed a reputation as a skilled urologic surgeon and is currently the CEO of a large multi-specialty practice called Sovereign Medical Group. In 1992, he pioneered the first ambulatory surgery center in Bergen County. In 1999 he received his MBA from the University of Tennessee in Knoxville, with specialization in office-based ASCs. In 2005, he founded Surgem, a development and management company that has equity and manages 12 surgical centers, with another seven in the construction and development phase. He holds appointments and actively practices urology at The Valley Hospital in Ridgewood, N.J., and St. Joseph's Hospital in Paterson, N.J.

George Tinawi, MD (Surgery Center Partners). 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.

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 to 2007 and now serves on the board. He earned a master's degree in exercise science from the University of Florida in Gainesville.

Michael Doyle (Surgery Partners). Mr. Doyle is CEO of Surgery Partners, where he is responsible for overseeing the firm's day-to-day operation and continued growth. He has experience developing and managing hospitals, surgical centers, rehabilitation facilities and imaging centers. Throughout his career, Mr. Doyle has been a hands-on manager with a wealth of healthcare knowledge, and he applies his practical experience of managing and developing healthcare services to his current position. In 2012 he led the Surgery Partners team in the successful acquisition and integration of NovaMed. Mr. Doyle earned a bachelor's degree in physiotherapy from Dalhousie University in Nova Scotia, Canada, and an MBA from Troy (Ala.) State University.

Andrew Hayek (Surgical Care Affiliates). Mr. Hayek serves as president and CEO of Surgical Care Affiliates and is a member of the SCA board of directors. SCA operates 145 surgical facilities in partnership with more than 2,000 physicians and 30 health systems. Prior to SCA, Mr. Hayek served as president of a division of DaVita Inc., a renal dialysis provider, and as president and COO of Alliance Healthcare Services Inc., a diagnostic imaging and radiation therapy provider. Mr. Hayek also worked at Kohlberg Kravis Roberts & Co., a private equity firm, and the Boston Consulting Group, a strategy consulting firm, prior to joining SCA. He currently serves on the board of directors of Senior Home Care, a home healthcare company, and the board of advisors of Sg2, a healthcare consulting company. Andrew earned his bachelor's degree from Yale University.

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.

Rodney H. Lunn (Surgical Health Group/PhyBus). Mr. Lunn serves as the CEO of PhyBus, LLC and Surgical Health Group and is considered by many as the original pioneer of the contemporary ambulatory surgery center concept, having transformed the traditional ASC into a practical, successful business model. During his 25-year career in the ASC industry, he has developed over 150 ASCs throughout the United States. Mr. Lunn has also served in numerous chief management roles for various healthcare companies. His experience also includes founder, director, and senior vice president of AmSurg, vice president of finance and CFO of American Medical Centers, CFO of INA (now Cigna) Healthplan of Texas, and vice president of HealthAmerica in Florida.

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 management, development and consulting services for physician owned ambulatory surgery centers, surgical hospitals and physician clinics, both with and without equity ownership. The company currently works with 18 surgical facilities 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.

J. Michael Ribaudo, MD (Surgical Synergies). Dr. Ribaudo 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. Ribaudo had graduate medical school training at Emory University in Atlanta, Washington University in St. Louis and New York University in New York City.

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.

Kyle Burtnett (Tenet Healthcare). Mr. Burtnett serves as vice president of outpatient services for Tenet Healthcare. He joined Tenet in 2003 as an associate in its leadership development program and has filled several roles since then, including key work on quality and growth initiatives, before being named chief of staff to the CEO and, later, a vice president. Mr. Burtnett is a graduate of the U.S. Air Force Academy and a former air force officer. He earned his MBA from the University of Southern California.

Krystal Mims (Texas Health Partners). Ms. Mims is president of Texas Health Partners. She serves on the executive team of Texas Health Resources and oversees the management and coordination of care for five of Texas Health's most successful joint ventures. Since joining Texas Health Partners in 2004, Ms. Mims participated in the development of each of these projects and oversaw the operations from

groundbreaking to successful operations. Ms. Mims is an advocate for physician leadership within the healthcare organization and works closely with physician and clinical leaders in her role as president.

Tom Yerden (TRY Health Care Solutions). Mr. Yerden serves as CEO of TRY Health Care Solutions. During his more than 31 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 more than 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.

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 U.S. and United Kingdom. More than half of the facilities in the U.S. are jointly owned facilities with non-profit healthcare systems and hospitals. Prior to joining USPI in 1998, Mr. Wilcox served as CEO of United Dental Care, president of the Surgery Group of HCA, president and CEO of the ambulatory surgery division of HCA and president, COO and director of Medical Care International.

Ann Deters (Vantage Outsourcing). Ms. Deters is CEO of Vantage Outsourcing, a cataract outsourcing service serving hospital and surgery center clients throughout the country. Vantage provides clients with ophthalmic equipment, trained ophthalmic surgical coordinator technicians, intraocular lens and other cataract surgery supplies and products. Vantage Outsourcing is recognized for saving healthcare organizations more than $93 million in capital and supply costs to date. Ms Deters draws from her experience operating an ASC in Missouri and consulting with hospitals and ASCs across the United States to further Vantage's mission of reducing healthcare costs and increasing healthcare quality. Ms. Deters has been recognized in healthcare publications as a leader in the industry. She also has earned a prestigious entrepreneur award, *INC 500*'s "Fastest Growing Small Business of the Year," and was featured in an *INC Magazine* article. Today, Ms. Deters has positioned Vantage Outsourcing, a certified woman-owned business, to be a leading cataract outsourcing partner in the future of healthcare reform. ■

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6 Steps to Building a Bonus Program for ASC Administrators, Clinical Directors and Staff

By Rachel Fields

The question in today's healthcare market should not be, "Should we offer incentive bonuses?" says Greg Zoch, managing director and partner with Kaye-Bassman. He says while the baby boomer generation generally doesn't count on bonuses as part of their compensation, younger generations expect to be incentivized to perform "above and beyond" their normal duties. "It doesn't really matter whether we like it or we don't like it," he says. "If you want to keep the top performers that you have at your center, you need to give them bonuses. Think of it in terms of motivating the right kinds of behavior and as a retention tool."

So aren't annual raises enough? Mr. Zoch says that while raises reward employees for longevity and doing their daily jobs, bonuses reward employees for performing at extraordinary levels. "If a raise is the mechanism to retain good employees and reward them for good behavior, then a bonus is the way to recognize and reward exceptional behavior," he says. "You don't give somebody a bonus for mediocrity — for simply showing up and doing exactly what they're told to do."

He says building a bonus program comes down to two basic questions: How much do I give, and how do I know when it's been earned? He says the answers will differ based on whether you're looking at bonuses for administrators and clinical directors or surgery center staff, such as RNs, surgical techs and others.

Administrators and clinical directors

1. Divide bonuses into distinct areas that are important to your center's needs. Mr. Zoch says bonuses for administrators and clinical directors could be divided into three parts, with each part worth one-third of the total bonus. This way, the ASC leader can focus his or her energy on meeting the most important goals for the center. If the leader falls short in one area, he or she can still receive a partial bonus for achieving success in the other areas. Mr. Zoch says the goals should be distinctly different; for example, if the bonus is totally dependent on the administrator meeting her budget, problems with reimbursement or the economy could make it impossible to achieve a bonus. That could be frustrating and not fairly reward success in other important areas. He recommends dividing bonus goals into areas such as:

- **Completing a major project or initiative.** If the surgery center has a major accreditation survey or a renovation project to complete, the board could assign a bonus based upon successful completion of the survey or project. This benefits the surgery center because the project is essential to its success, and it keeps the administrator or clinical director on-task despite the distractions of daily operations.
- **Meeting or exceeding budget expectations.** Staying within a budget is essential to maintaining surgery center profitability, so budget expectations should always be part of an administrator's annual bonus program, Mr. Zoch says. He says including a budget component in the expectations is important to make sure that you generate profits that allow you to pay the bonus. "If the budget's not met and staffing hours or supply costs are out of control, you may not have the money to pay the bonus," he says.
- **Improving a surgery center benchmark unrelated to budget.** Mr. Zoch recommends assigning a portion of the bonus to an area of improvement unrelated to finances, to ensure that administrators and clinical directors can be rewarded for significantly improving the center even if the center's financial perfor-

mance is below budget. For example, he says the board might incent the administrator to improve physician or patient satisfaction scores. "You should incentivize things that you really care about and that are important to you," he says. "If satisfaction scores are low and that's an issue you care about, you can incentivize the administrator to increase them by 5 or 10 percent. If you are unsure of what areas to improve, discuss ideas with the administrator or at a regular board meeting." Mr. Zoch says that benchmarks can be very important "culture-builders" and help you attract and retain the best people.

2. Assign a specific amount of money to each area. Mr. Zoch says administrators and clinical leaders should know the dollar amount of their potential bonus at the beginning of the year. This way, the leaders can work towards a clear goal and be aligned with the priorities and expectations of the board. He says that while some ASCs choose to divide the bonus equally between the three areas, some assign higher values to areas with more difficulty. He says the board can also give the administrator "stretch goals" or "enhancers". With this method, the satisfactory completion of a goal would earn them a pre-determined amount, but "hitting the cover off the ball" could earn them a higher amount. "Maybe you could enhance the bonus by saying, 'If we hit 100 percent of our budget, one-third of your anticipated bonus will be $8,000. But if we hit 120 percent of the budget, you will earn $10,000."

3. Typical bonuses for administrators are 15-25 percent of base salary and 10-15 percent of base salary for clinical directors. Mr. Zoch says there are certainly outliers and other bonus models, including those tied to distributions, but generally bonuses fall between 15 and 25 percent of base salary for administrators and between 10 and 15 percent of base salary for clinical directors. According to VMG Health data, the mean salary for an ASC administrator in 2011 was $109,184. Based on this salary, the average bonus for an ASC administrator should fall somewhere between $16,377 and $27,296.

Surgery center staff

1. Consider a profit-sharing program. Mr. Zoch says profit-sharing is a common way of giving bonuses to staff. In this model, ASC leadership sets aside a certain percentage of the center's profits each year creating a bonus pool. At the end of the year, or quarterly, it is divided among the employees. He says the bonus pool is sometimes divided evenly among all employees but sometimes doled out according to longevity or position.

"It could be that everyone gets the same amount, or that all RNs get the same and all techs get the same," he says. "It could also be that you get a bigger share with more longevity. So the person with five years' tenure gets a bit more than the person with two years' tenure." He says profit-sharing can incent staff to work hard throughout the year, because they'll understand that money they can save the facility along the way through efficiency and paying attention to waste will contribute directly to their bonus.

2. Make sure the bonus you're giving to tenured employees is attractive. Mr. Zoch says that unlike administrators and clinical directors, staff members do not necessarily need to know exactly how much they're going to make as a bonus, since their individual contribution is much harder to measure. "And there's something a bit mysterious and exciting about not knowing," he says. He cautions that giving out the same amount every year can send the message that hard work has no real effect on their bonuses.

Instead, he says surgery centers should distribute bonuses based on the surgery center's profitability and each department's success during the year. "I like tying bonuses to profits, but it should be a large enough amount to put a smile on their face. When you hand a tenured OR nurse a bonus of $100, it could be a real disappointment," he says. He recommends making sure the bonus is at least several hundred dollars. A tiny bonus could actually damage employee morale. "Giving a tiny bonus is like giving a waiter a 25-cent tip," he says.

3. Find an alternative to bonuses if your ASC isn't profitable. If you simply can't give your staff bonuses because you don't have enough money, then plan an event to celebrate the team and the culture at your ASC. "Maybe have an annual picnic and include families," he says. "If you provide food and beverages for a picnic, you'll probably spend very little compared to the good-will and camaraderie you'll create." He says these celebrations can feel almost as good as financial rewards when you don't have enough money for a financial 'thank you'. "I know of an ASC that has an 'employee appreciation day' each year and the docs wash all the employee's cars," Mr. Zoch says. You have no idea how big a charge the staff gets from this event and how they look forward to it each year."

"Regardless of what you do for bonuses, do something," says Mr. Zoch. "Healthcare is a team sport and keeping top talent on your team is, in part, a financial consideration. It's human nature to want recognition and appreciation for exceptional performance. And money is a traditional way of showing that recognition and appreciation. If you don't take care of your team financially, someone else just might." ■

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153 Orthopedic- and Spine-Driven ASCs to Know

153 Orthopedic- and Spine-Driven ASCs to Know

Here is a list of 153 ambulatory surgery centers driven by orthopedic and spine procedures.

Advanced Ambulatory Surgery Center (Redlands, Calif.). Physicians of Arrowhead Orthopaedics founded Advanced Surgery Center to treat patients with orthopedic and pain management needs. The 6,300-square-foot facility includes three operating rooms — two large and one small used mainly for procedures — as well as a nine-bed PACU and pre- and postoperative area. Arrowhead Orthopaedics physicians have a special focus on a variety of subspecialties, including joint replacement, extremities care, spine surgery and sports medicine. The practice also includes the Arrowhead Bone Health Institute, physical therapy and imaging services.

Ambulatory Surgical Care Facility (Aurora, Ill.). This ASC opened in December 2010 in partnership with Marque Medicos, a provider of care for Chicago's Hispanic population. At the center, five surgeons and an internist provide services in orthopedic procedures, including spine surgery, interventional pain, reconstructive plastic surgeries and hand and foot surgeries. The 4,000-square-foot surgery center offers a translator for every patient.

Andrews Institute Ambulatory Surgery Center (Gulf Breeze, Fla.). The Andrews Institute Ambulatory Surgery Center was founded as a joint venture between physicians and Baptist Health Care. It is affiliated with Andrews Institute for Orthopaedics & Sports Medicine, founded by James Andrews, MD, who is renowned for his work with professional athletes and serves as team physician for the Tampa Bay Rays. The facility has eight operating rooms with digital equipment, high definition camera and video systems for visualization during surgery. Physicians at this multispecialty surgery center focus on orthopedic surgery, sports medicine and pain management, among other procedures.

Arkansas Specialty Orthopaedics Surgery Center (Little Rock, Ark.). The center is affiliated with Arkansas Specialty Orthopaedics, which has foot and ankle, hand and upper extremity, hip and knee replacement, joint and shoulder replacement, orthopedic first care, orthopedic trauma, orthopedic spine and sports medicine services. Physicians at the surgery center are able to perform arthroscopic procedures. The physicians are also owners of the Arkansas Specialty Orthopaedics Physical and Occupational Therapy and Arkansas Specialty Orthopaedics MRI Center.

Baltimore Spine Center. Surgeons at Baltimore Spine Center perform minimally invasive outpatient spine care, such as cervical fusions and lumbar microdiscectomy. Orthopedic surgeons also perform knee and shoulder arthroscopy, rotator cuff repair and ACL repair. There are 13 physicians performing cases at the center, including four neurosurgeons. There is also pain management procedures performed at the center.

Bayou Region Surgical Center (Thibodaux, La.). The center's largest service lines are orthopedics and ENT, although it also hosts neurology, general surgery, plastic surgery, GI, ophthalmology and pain management. Bayou Region has three ORs and one endoscopy room, with potential for a fourth room. The ASC operates as a 50-50 partnership between physician-investors and a subsidiary of the local community hospital, Thibodaux Regional Medical Center. It is managed by ASD Management.

Bellin Orthopedic Surgery Center (Green Bay, Wis.). Bellin is a joint venture between physicians of Orthopaedic Associates of Green Bay, Green Bay Orthopedics and Bellin Health, an integrated healthcare delivery system. Orthopedic & Sports Medicine Specialists of Green Bay specializes in repair of a wide range of orthopedic problems including the knee, ankle, shoulder and hip. The center, which began treating patients in March 2010, recently opened a third OR. The clinical medical team includes 10 physicians and Bellin Health is the official healthcare provider of the Green Bay Packers.

Bellingham (Wash.) Surgery Center. Bellingham Surgery Center was opened in 1986 by a group of physicians and previously owned by Whatcom Medical Bureau, now called Regence. Symbion Ambulatory Resource Centers acquired the center in 1999. The ASC participates in Symbion's internal monitoring and tracking systems on patient care, safety, operations, quality improvement and patient satisfaction. It also benchmarks on a national level through the Federated Ambulatory Surgery Association. It is accreditation through Joint Commission and Medicare certified.

Bend (Ore.) Surgery Center. A four-OR center with three procedure rooms, this facility is 100 percent physician-owned, with 35 owners and 60 users who perform more than 10,000 cases annually. The ASC opened in 1997 and moved to its new 20,000-squre-foot location in October 2005. While driven by orthopedic, spine and pain management procedures, the multispecialty center hosts ENT, general surgery and gynecological surgery as well. In July 2009, the Bend Surgery Center Foundation was created to provide scholarships for local students interested in pursuing healthcare. The surgery center also sponsors several local groups, including Volunteers in Medicine and Boy Scouts.

Blue Bell (Pa.) Surgery Center. This four-OR, multi-specialty ASC opened in September 2008 and specializes in orthopedics and spine. It has 22 physi-

cian owners, including six orthopedic surgeons. It also hosts ENT, pain management, plastic surgery, general surgery, ophthalmology and gastroenterology. Blue Bell sees approximately 225 patients per month and is managed by Ambulatory Surgical Centers of America. The center is led by administrator Vicki Edelman, who has been with the project since its construction phase. It is accredited by the Accreditation Association for Ambulatory Health Care.

Blue Ridge Orthopaedic & Spine Center Ambulatory Surgical Center (Warrenton, Va.). Blue Ridge Orthopaedic & Spine Center's ambulatory surgical center physicians perform knee and shoulder arthroscopies, carpal tunnels and pain management procedures. The facility includes an x-ray machine for guided injections and two physiatrists. The facility is accredited by the Accreditation Association for Ambulatory Health Care. The practice of Blue Ridge Orthopaedic & Spine Center also includes aquatic physical therapy, massage therapy, rehabilitation and medical nutrition therapy.

Boston Out-Patient Surgical Suites (Waltham, Mass.). BOSS opened in July 2004 and specializes in orthopedics and pain management. The center sold majority interest to AmSurg in 2010 and has maintained profit margins above 50 percent. It features 19 orthopedic surgeons from five practices: Greater Boston Orthopedic Center, Longwood Orthopedic Associates, Boston Sports, Excel Orthopedic Specialists, Shoulder Center, Cartilage Repair Center Arthroscopy Sports Medicine & Minimally Invasive Associates and Pro Sports Orthopedics. The center is lead by administrator Gregory DeConciliis. BOSS is accredited by the Accreditation Association for Ambulatory Health Care.

Boulder (Colo.) Surgery Center. The center, opened in 2005, is a partnership between physician-owners and Boulder Community Hospital. With 21 surgeons, the facility covers orthopedics, podiatry and pain management. The physicians come from CU Sports Medicine, Colorado Hand & Arm PC, Boulder Orthopedics, Orthopedic Professional Association, Boulder County Foot and Ankle Care, Mapleton Hill Orthopedics and The Hand Center. ASC administrators focus on teamwork and keeping staff numbers small to facilitate a vested interest in the success of the center. Boulder Surgery Center is accredited by the Joint Commission.

Capital Region Ambulatory Surgery Center (Albany, N.Y.). Capital Regional Ambulatory Surgery Center opened in November 2000. It includes four operating room and one procedure room. Physicians from The Bone and Joint Center, Capital Regional Spine and Capital Regional Orthopaedics perform cases at the center. The physicians focus on minimally invasive spine surgery, sports medicine and extremities care. The facility is accredited by the Accreditation Association of Ambulatory Health Care.

Carrillo Surgery Center (Santa Barbara, Calif.). Carrillo Surgery Center was founded in 2005 by Alan Moelleken, MD, who also founded and chairs the Tri-County Spine and Orthopedic Conference. There are several procedures performed at the two-OR facility, including lower extremity surgeries, general orthopedic procedures and interventional pain management. Surgeons also perform more unique procedures in the outpatient setting, including total knee replacements, minimally invasive posterior spinal fusions with posterior/transforaminal lumbar interbody fusions, sacroiliac joint fusions and cervical artificial disc replacements. Carrillo Surgery Center is accredited to keep patients for 23 hour stays, which allows for some of the more complex procedures. There are six physicians performing cases at the center as well as two anesthesiologists who most frequently provide services.

Cascade Orthopaedic Ambulatory Surgery Center (Auburn, Wash.). Cascade Orthopaedic Ambulatory Surgery Center was established in 1999 and moved to a new facility in October 2000. Founded by the surgeons of Cascade Orthopaedics, the surgery center includes three operating rooms and fully equipped preoperative and postoperative anesthesia care units. Surgeons perform several orthopedic procedures, including arthroscopic surgery, at the center on a daily basis. Cascade Orthopaedics also includes a spine center, diagnostic imaging, physical therapy, massage therapy and ultrasound services. The center is Medicare-certified and accredited by the Accreditation Association for Ambulatory Health Care.

Cedar Park (Texas) Surgery Center. Physicians at Cedar Park Surgery Center perform orthopedic, spine, pain management and general surgery procedures, as well as urology and gynecology. The surgery center was opened in 2011 and includes five operating rooms and medical office space. The 10,000-square-foot facility selected Arise Healthcare as its operating partner. At the surgery center, physicians can perform minimally invasive spine stabilization, advanced biologics in spinal reconstruction, artificial disc replacement, degenerative scoliosis surgery, rotator cuff repair, Bankart procedure and hip and knee replacements.

Center for Ambulatory Surgery (West Seneca, N.Y.). With four surgery suites, five endoscopy suites and space available for more growth, this 18,000-square-foot center provides outpatient surgical services to a large area of greater Western New York. In addition to orthopedics, the ASC covers gastroenterology, general surgery, ophthalmology, gynecology, podiatry, urology and reconstructive surgery. Its current annual volume equals more than 15,000 procedures. It is a 50-50 equity partnership between 16 physician-owners and The C/N Group, which provides management services, including all administrative functions of the facility. It is accredited by the Accreditation Association for Ambulatory Health Care.

Central Park Surgery Center (Austin, Texas). Its physician-partners include six orthopedic surgeons from Austin Sports Medicine and Austin Bone and Joint and two neurosurgeons from The Spine and Rehab Center. Several additional physicians are actively credentialed to use the center. The center is managed by Symbion. In addition to orthopedics, it hosts pain management, ENT, general surgery and plastic surgery. It is accredited by the Joint Commission.

The Center for Orthopedic Surgery. The Center for Orthopedic Surgery was developed and operated by physicians at Southern California Orthopedic Institute and is located within the institute. There are 32 physicians at the practice, performing a variety of orthopedic surgeries. The center pioneered the development of arthroscopic surgical procedures, particularly in the shoulder, wrist and ankle. Additional services include physical therapy and MRI. Physicians at the center are also involved with the Southern California Orthopedic Research and Education Center, a non-profit established in 1998 for research, education and publishing ventures. The Center for Orthopedic Surgery was accredited by the Accreditation Association of Ambulatory Health Care.

The Christ Hospital Spine Surgery Center (Cincinnati). This freestanding ASC, featuring 13 neurosurgeons and one pain management physician, is a partnership between the Mayfield Clinic, The Christ Hospital and United Surgical Partners International. When Mayfield Clinic founded the ASC in 2007, it was the first freestanding center in the region to provide spine surgery. Since then it has performed more than 10,000 spine procedures, which include single- and multi-level lumbar laminectomies, single- and multi-level anterior cervical discectomies and fusions and single-level spinal cord decompression. The surgery center features three operating rooms, one pain management suite and 11 pre- and postoperative patient rooms.

Christiana Spine Center (Newark, Del.). Physicians at Christiana Spine Center perform minimally invasive spinal procedures in their outpatient facility, which has its main office on the Christiana Hospital campus. Christiana Spine Center has been operating in that location since June 2000 and the surgery center is accredited by the Accreditation Association for Ambulatory Health Care. In addition to clinical care, the nine physicians are also engaged in research to further their field.

Citrus Park Surgery Center (Tampa, Fla.). This two-OR center covers spine and orthopedic surgery as well as pain management and plastic surgery. One of this center's surgeons, Robert Nucci, MD, is founder of the Nucci Spine and Orthopedic Institute in Tampa. Dr. Nucci focuses on minimally invasive outpatient lumbar fusions and multi-level outpatient cervical disc replacements. He was among the first physician to actively employ Bio-Plex in his surgeries, a standard that is now used in a wide range of orthopedic surgeries. His partner is Wendell J. Bulmer, DO, one of only a handful of surgeons in the Tampa Bay area to offer hip arthroscopy.

City Place Surgery Center (Creve Coeur, Mo.). City Place Surgery Center is a free-standing ASC that has been certified by Medicare and accredited by the Accreditation Association for Ambulatory Healthcare. The facility, led by administrator Carol Hollowood, opened in 2000 and became a Meridian Surgical Partners facility in October 2010. The 19 physician investors at City Place Surgery Center's 13,200-square-foot ASC focus on orthopedic procedures. The center includes four operating rooms.

Commonwealth Outpatient Surgery Centers (Fairfax and Herndon, Va.). Physicians at Commonwealth Outpatient Surgery Centers perform an average of 4,400 surgeries per year between the two ASCs — one located in Fairfax, Va., and the other in Herndon. The surgery centers are accredited by the Accreditation Association for Ambulatory Health Care. The physicians of Commonwealth Orthopaedics perform cases in the surgery center. They have a special interest in outpatient orthopedic surgery, pain management and spine care. The practice was established in 1994 as a merger between four physician groups and continued to grow over the next several years. It opened its first ASC in 1999 and the second in 2001.

Concord (N.H.) Orthopedics Surgery Center. The ASC was opened in February 1995. It is a collaborative effort between the physicians of Concord Orthopaedics and the Concord Hospital. Concord Orthopaedics surgeons have a special interest in foot and ankle surgery, hand surgery, orthopedic traumatology, osteoporosis, pediatric orthopedics, rheumatology, scoliosis, spine care, sports medicine and total joint surgery. The practice also includes X-ray, MRI, electrodiagnostic testing and spinal injections.

Crane Creek Surgery Center (Melbourne, Fla.). Crane Creek Surgery Center was founded in 2008 by physicians from Osler Medical Group and Blue Chip Surgical took over management a year later. The 14,000-squre-foot surgery center includes four operating rooms and two procedure rooms. Surgeons perform orthopedics, spine, general surgery, pain management and urology. Surgeons perform complex spinal procedures and diagnostic testing. In addition to the surgical facility, there is an auditorium for educational programs for the public and staff, as well as a venue for training visiting residents and physicians. The facility also includes an O-Arm Imaging System from Medtronic.

Delmarva Surgery Center (Elkton, Md.). After opening in 2008, Delmarva Surgery Center began treating patients in 2009 and achieved Accreditation Association of Ambulatory Health Care accreditation in 2010. This ASC has one operating room and three procedure rooms, with the average number of encounters increasing each year by 500. Despite having a payor mix of 80 percent Medicare and Medicaid, the surgery center continues to sustain growth and passed a survey by the State of Maryland Department of Health and Mental Hygiene. In the near future, the surgery center plans to open a

three-procedure room surgery center in Newark, Del. Recently, the ASC participated in the AAAHC low back pain benchmarking study.

D.I.S.C. Sports and Spine Center (Marina del Rey, Calif.). This center, opened in 2007, features 20 physicians, including seven spine surgeons and eight orthopedic surgeons. To reduce infections in this 7,200-square-foot facility, the air throughout center is constantly cleansed by a 100 percent HEPA filtration system, surpassing conventional standards. DISC recently opened a second surgery center in Newport Beach, Fla. DISC is the official medical services provider for the U.S. Olympic Team and the official sports and spine center for the Los Angeles Kings. It is accredited by the Accreditation Association of Ambulatory Health Care

DuPage Orthopaedic Surgery Center (Warrenville, Ill.). DOSC is owned and operated by physicians of OAD Orthopaedics. The practice encompasses 22 physicians, including four spine surgeons. Surgeons perform arthroscopy, small joint surgery, microsurgery, lumbar microdiscectomy and fracture care in the surgery center. Since the facility opened in 2006, it has doubled the number of ORs from two to four. DuPage Orthopaedic is accredited by Accreditation Association for Ambulatory Health Care.

East Portland Surgery Center (Portland, Ore.). Specialists at East Portland Surgery Center provide orthopedic, neurosurgery, general surgery and pain management services. The surgery center is affiliated with Legacy Health, United Surgical Partners International and led by administrator LeeAnn Bezek. Additional services include ear, nose and throat specialists and ophthalmology. The surgery center has four operating rooms and two treatment rooms. It is accredited by the Accreditation Association for Ambulatory Health Care and is Medicare certified.

East Surgery Center (Bradenton, Fla.). Coastal Orthopedics & Pain Management was founded in 2000 and opened its 10,000-squre-foot East Surgery Center in 2009. The surgery center includes two operating rooms and one procedure room. All types of orthopedic and pain management cases are performed at the center, including a large volume of arthroscopy and hand surgery procedures. There are currently nine physician partners and 14 physicians bringing cases to the ASC. Physicians at the center include team physicians for the Tampa Bay Buccaneers, USA Soccer and Pittsburgh Pirates. The surgery center doesn't include ancillary services, but the Coastal Orthopaedics & Pain Management offices have additional services such as physical therapy, imaging and orthopedic bracing equipment.

Eastwind Surgical (Westerville, Ohio). The 10,350-square-foot Eastwind Surgical facility opened in 2007 as a multispecialty surgery center. It was established by the physicians of Central Ohio Neurological Surgeons and accredited by the Ohio Association of Ambulatory Surgery Centers and Accreditation Association for Ambulatory Health Care. The center became a Meridian Surgical Partners facility in July 2011. The facility is among the only surgery centers in Ohio to offer the Axis Jackson Surgical Table for spinal procedures. The surgeons perform several procedures, including lumbar discectomy and decompression, anterior cervical discectomy, carpal tunnel release, epidural steroid injections, facet blocks and sacroiliac joint injections. Eastwind is under the leadership of administrator Lynn Feldman.

Edmonds Orthopedic Outpatient Surgery Center (Edmonds, Wash.). The outpatient surgery center of Edmonds Orthopedic Center is accredited by the Accreditation Association for Ambulatory Health Care. Physicians affiliated with the center have a range of special interests, including minimally invasive knee surgery, sports medicine and shoulder care. The ASC includes three operating rooms, one diagnostic room and a dedicated radiographic C-arm. Edmonds Orthopedic Center also includes physical therapy and hand therapy services as well as MRI.

Englewood (Colo.) Surgery Center. Englewood Surgery Center is located on Colorado Comprehensive Spine Institute's main campus and provides customized spine care. Physicians have a special interest in several areas of spine care, including minimally invasive spine surgery, cervical disc replacement and spinal fusion. The ASC includes six physicians who provide spine surgery and pain management. The practice also includes physical therapy and MRI.

Everett (Wash.) Bone & Joint Surgery Center. Everett Bone & Joint Surgery Center was established in 2000 as the first freestanding orthopedics-focused ambulatory surgery center in Snohomish County to receive the Joint Commission accreditation. It was founded by the surgeons of Everett Bone & Joint, a Proliance Surgeons practice. The physicians have a special focus on sports medicine, extremities care and spine care. The practice also includes X-ray and MRI.

Evergreen Orthopedic Clinic Surgery Center (Kirkland, Wash.). Evergreen Orthopedic Surgery Center includes physicians who subspecialize in sports medicine, spine and extremities care. The surgery center is on the first floor of the facility, with the second floor housing Evergreen orthopedic Clinic and Evergreen Orthopedic Physical Therapy. MRI diagnostics is also available at the surgery center, which is accredited by the American Association of Ambulatory Health Care.

Executive Woods Ambulatory Surgery Center (Albany, N.Y.). The physicians of Northeast Orthopaedics established Executive Woods Ambulatory Surgery Center in 2000. The facility has three operating rooms and is accredited by the Accreditation Association for Ambulatory Health Care. Surgeons perform several procedures at the facility, including arthroscopic surgery, ACL reconstruction, foot surgery and hand procedures. Northeast Orthopaedics is an 18-physician group with six office locations that include X-ray facilities.

Front Range Orthopedic Surgery Center (Longmont, Colo.). Founded in 1970, Front Range Orthopedic Surgery Center is designed for orthopedic surgery and services. It is located on the Longmont Medical Campus and physicians provide care in several orthopedic areas, including hand, shoulder, spine, sports medicine foot and ankle and joint replacement. The surgery center features digital imaging, MRI and electronic medical records. The ASC is accredited by the Accreditation Association of Ambulatory Health Care and certified by Medicare.

Frontenac (Mo.) Surgery Center & Spine Care. Frontenac Surgery Center & Spine Care is led by Administrator Kelly Miller. The multispecialty surgery center includes 11 physicians who have a special interest in orthopedics, spine and pain management, among other specialties. The surgery center is an affiliate of United Surgical Partners International and accredited by the Accreditation Association for Ambulatory Health Care. It has two operating rooms and three procedure rooms.

Greenspring Surgery Center (Baltimore). Opened in January 2007, Greenspring Surgery Center has one operating room and two procedure rooms. The 6,300-square-foot facility is affiliated with Blue Chip Partners and accredited by the Accreditation Association for Ambulatory Health Care. The 15 orthopedic and spine surgeons at the center perform a variety of procedures, including knee arthroscopy, ligament repair, shoulder impingement treatment and lumbar and cervical spine surgery. The facility also includes pain management.

Hand Surgery Center (Clifton, Ohio.). Eight hand surgeons use this center, which was founded in 1998. It is a joint venture between Hand Surgery Specialists and TriHealth, a healthcare system made up of 360-bed Bethesda North Hospital and 460-bed Good Samaritan Hospital. Hand Surgery Specialists has locations in Greater Cincinnati and Northern Kentucky and serves about 25,000 outpatients a year. Hand Surgery Center has the maximum Accreditation Association for Ambulatory Health Care accreditation.

The Hand Surgery Center (New York City). The Hand Surgery Center is led by Charles P. Melone, MD, the director of hand surgery at Beth Israel Medical Center in New York City. The surgery center services approximately 10,000 patients and physicians perform 1,800 operations annually. Procedures performed at the ASC include correction for complex upper extremity disorders, distal radius fractures, arthritis and problems associated with scleroderma. The physicians also have a special interest in treating sports injuries and have provided care for professional athletes.

High Pointe Surgery Center (Lake Elmo, Minn.). High Pointe Surgery Center performed its first case in February 1999 and Surgical Management Professionals joined the center in 2000. The ASC was originally founded by several independent physician groups and Lakeview Hospital. The surgery center includes five operating rooms and one procedure room where physicians perform cases such as knee and shoulder arthroscopy, pain management procedures and laminectomies. Surgeons at the center performed their first unicompartmental knee replacement and plan to begin performing total knee replacements in the next four to six months. In the future, the surgery center plans to incorporate cervical fusions and total shoulder and hip replacements into the mix as well. There are 25 physician owners and 36 physicians performing cases at the center.

Honolulu (Hawaii) Spine Surgery Center. This Symbion center involves three orthopedic surgeons and five neurosurgeons. It hosts such services as hand surgery, minimally invasive spine procedures, neurosurgery, interventional orthopedics and pain management. The 7,800-square-foot center opened in 2007. Honolulu Spine Surgery Center has two ORs and a private recovery room, and provides a wide variety of equipment for minimally invasive surgeries.

Hyde Park Surgery Center (Austin, Texas). Hyde Park Surgery Center was opened in June 2008 and is 100 percent physician-owned. The facility was founded by four orthopedic surgeons who wanted a place where they could provide the community with an outpatient center devoted to healthcare services, according to Administrative Director Jami Osterlund, RN. There are three operating rooms in this multispecialty facility where orthopedic surgeons perform various procedures, such as shoulder and knee scopes. The hip and knee surgeons are looking to begin performing total joint replacements in the center, which also offers 23 hour observation suites. Spine surgeons perform anterior cervical discectomy with fusion.

Illinois Sports Medicine & Orthopedic Surgery Center (Morton Grove, Ill.). The center has four ORs and one procedure room. It includes 18 orthopedic surgeons, nine podiatrists, three pain management physicians and 15 anesthesiologists. The orthopedic surgeons cover arthroscopies, ACL reconstructions, arthroplasties, carpal tunnel releases, meniscectomies, open reduction internal fixations, arthroscopic Bankart procedures and rotator cuff repairs. Spine procedures performed at the ASC include laminectomies, microdiscectomies, anterior cervical discectomies and fusions. There is an on-site laboratory and radiological services. The facility is accredited by the Accreditation Association for Ambulatory Health Care.

Institute for Minimally Invasive Surgery (Dallas). The Institute for Minimally Invasive Surgery was opened in the fall of 2011 and includes two operating rooms for spine surgery and pain management procedures. The 9,255-square-foot facility is also host to an O-arm Spine Surgical Imaging system with StealthStation Navigation. The center was founded by independent physicians and Meridian Surgical Partners, and physicians perform minimally invasive discectomies and decompressions, cervical disc replacement, laser and endoscopic discectomy and interventional pain management procedures. Led by administrator Linda Sanchez, this surgery center is a member of the ASC Association.

The Institute of Orthopaedic Surgery (Las Vegas). Established by physicians at Desert Orthopaedic Center, the ASC opened in May 2002. It has four ORs and one procedure room. Its 18 physician-owners practice at Desert Orthopedic Center, which focuses on sports medicine. Surgeries at the ASC include on knees and shoulders, hand, foot and ankle procedures. A 2008 focus survey by the Nevada Bureau of Licensure and Certification found the institute to have zero regulatory deficiencies. It accredited by the Accreditation Association for Ambulatory Health Care.

Kerlan-Jobe Surgery Center (Los Angeles). This center, affiliated with Kerlan-Jobe Orthopaedic Clinic, is used by 19 physicians, five of whom are in spine. With four ORs located directly below the practice, the ASC specializes in sports medicine, foot and ankle procedures. The center also has a 23-hour recovery area for patients. The physicians of Kerlan-Jobe Orthopaedic Clinic include team physicians for the Los Angeles Dodgers, Kings, Lakers and other professional sports teams.

Knoxville (Tenn.) Orthopaedic Surgery Center. Opened in January 2010, Knoxville Orthopaedic Surgery Center was founded by the physicians of Knoxville Orthopaedic Clinic. The practice, which was founded in the mid-1930s, includes subspecialists in sports medicine, extremities care, adult reconstructive surgery, spine and pediatrics. KOSC is a four-operating room facility and has one procedure room. It is a division of OrthoTennessee. Knoxville Orthopaedic Clinic also includes OrthoTennessee Therapy and the providers are the orthopedic surgeons for the University of Tennessee athletic department.

KSF Orthopedic Surgery Center (Houston). KSF offers 12 physicians with many subspecialty services. The three-OR facility has been affiliated with United Surgical Partners International since 2007. USPI owns 45 percent of the facility and KSF physicians own the rest. After opening as a practice in 1976, KSF physicians performed some of the first arthroscopic procedures in the Houston area. The practice also features complete orthopedic radiologic imaging, physical therapy and a hand therapy rehabilitation center.

Lakewood Surgery Center (Lakewood, Wash.). Lakewood Surgery Center has the Joint Commission's Gold Seal of Approval. The physicians of Puget Sound Orthopaedics performed 1,500 surgeries there in 2007. The 5,500-square-foot facility includes two operating rooms and onsite physical therapy. The physicians have a special interest in several procedures, including shoulder surgery, knee surgery and hand surgery.

Laser Spine Institute (Tampa, Fla.). Based in Tampa, Laser Spine Institute also includes ASCs in Wayne, Pa., Scottsdale, Ariz., and Oklahoma City. It boasts an electronic medical record system, imaging services, a physical therapy department, family waiting room with free catered breakfasts and lunches, zero-gravity chairs and computers with Internet access. Surgeons treat a number of degenerative spine conditions, including spinal stenosis, herniated disc and pinched nerve.

Lattimore Community Surgicenter (Rochester, N.Y.). Lattimore Community Surgicenter was established in 1990 and is currently one of the oldest free-standing surgery centers in the Rochester area. It is accredited by the Accreditation Association for Ambulatory Health Care and Medicare-certified. In addition to orthopedic surgery, physicians at the center provide podiatry, general surgery and plastic surgery. There are four operating rooms and two procedure rooms.

Lewis & Clark Outpatient Surgery Center (Lewiston, Idaho). Lewis & Clark Orthopaedic Institute was founded in 1973and has grown significantly since then. The physicians of Lewis & Clark Orthopaedic Institute began construction on their outpatient surgery center in 2003 and opened its doors in 2004. The surgery center is owned by five of the physicians and includes two operating rooms and a minor procedure room. The physicians anticipate a case load of 2,000 outpatient surgeries per year. The practice also includes imaging services.

Loveland Surgery Center (Loveland, Colo.). Loveland hosts about 3,400 orthopedic, spine, pain management and ENT procedures annually. It has seven physician-owners. The center's spine program was an early adopter of the level-three Prestige cervical artificial disc replacement, the Coflex device, the multi-level NeoDisc replacement and the Dynamic Stabilization System for a posterior lumbar fusion, according to Sue Sumpter, administrator of the center. Loveland Surgery holds a convalescent license, allowing it to cover more complex surgeries. The surgery center is accredited by The Joint commission.

Marietta (Ohio) Surgery Center. This two-OR center, operated by Regent Surgical Health since 2005, currently has seven physician-owners and focuses on orthopedics and pain management. It was founded by five orthopedic surgeons in June 2000. In 2010 it merged with Marietta Memorial Hospital. Employee satisfaction stands at 88.8 percent and patient satisfaction at 98 percent, as reported to CTQ Solutions. The surgery center includes six large surgical suites and four specialty procedure rooms. The center is accredited by the Accreditation Association for Ambuatlory Health Care.

Mayfield Spine Surgery Center (Cincinnati, Ohio). Founded in 2005, Mayfield Spine Surgery Center is a free-standing ASC that provides spine, neurosurgery and pain management services to the Cincinnati area. The medical staff also includes physiatrists and anesthesiologists. Procedures performed at the ASC include minimally invasive discectomies and spinal fusions. The center features three operating rooms, one pain procedure suite and 11 patient rooms. Each patient room includes amenities such as a flat screen television for the patient's pre- and post-operative stays at the center.

Memorial Spine & Neuroscience Center (South Bend, Ind.). Memorial Spine & Neuroscience Center offers minimally invasive spine surgery, peripheral nerve surgery and pain management procedures. There are seven physicians affiliated with the facility, which is located outside of Memorial Hospital.

Middlesex Center for Advanced Orthopedic Surgery (Middletown, Conn.). Physicians bring sports medicine, foot and ankle and general orthopedic cases to Middlesex Center for Advanced Orthopedic Surgery. The facility is 50 percent owned by Middlesex Hospital and 50 percent owned by Orthos Holding Company, which includes 11 physicians. The surgery center is accredited by the Accreditation Assocaition for Ambulatory Health Care and also includes pain management interventions.

Midlands Orthopaedics Surgery Center (Columbia, S.C.). Midland Orthopaedics has been in existence for more than 30 years, with its free-standing surgery center celebrating its fifth anniversary this year. The practice includes several orthopedic surgeons subspecializing in sports medicine, upper extremity, shoulder surgery, foot and ankle, pediatric and spine surgery. Midlands Orthopaedics also offers MRI services, and the surgery center features digital operating rooms, pre- and postoperative areas and minimally invasive surgery capabilities.

Midland Surgical Center (Sycamore, Ill.). Midland Surgical Center is a joint venture between a local health system, five orthopedic surgeons and Regent Surgical Health. It hosts eight orthopedic surgeons, two podiatrists, one plastic surgeon, four ophthalmologists and one pain management specialist. Spine procedures offered at Midland include nerve biopsy, disc decompression, laminotomy, vertebral copectomy and vertebroplasty. Orthopedic procedures include ligament repair, tendon repair, bone grafts, arthroscopy, ACL repair or reconstruction, partial knee replacements, meniscectomy, carpal tunnel release and rotator cuff repair. The facility has two operating suites has three-year accreditation from the Accreditation Association for Ambulatory Health Care.

Millennium Surgical Center (Cherry Hill, N.J). Millennium Surgical Center was opened in October 2007 and includes orthopedics, spine, pain management and podiatry. The facility is accredited by The Joint Commission. Surgeons perform a variety of procedures, including disc nucleoplasty, minimally invasive spine surgery, partial knee replacement, rotator cuff repairs and knee ligament reconstruction. There are 25 physicians affiliated with the center.

Minimally Invasive Spine Institute Health Campus (Dallas). This 48,000-square-foot center just opened in April 2011. It features four ORs, one minor procedure room and 16 recovery areas — all of which are private rooms. As part of a phased opening, it started with self-pay patients and then began accepting private insurance patients. It will be fully open to all patients summer 2011. The facility takes a holistic approach to healthcare by providing a full spectrum of treatment options, from physical therapy to surgical intervention. It is among the first in Texas to host endoscopic laser spine surgery.

Missoula Bone & Joint Surgery Center (Missoula, Mont.). The facility specializes in orthopedic and plastic surgery and is located next to the offices of Missoula Bone & Joint, an eight-physician orthopedic practice. Founded in 2001, this freestanding surgery center was the product of a collaboration between Missoula Bone & Joint and one independent physician, all board certified. The center includes two operating rooms where physicians perform several procedures, including trigger fingers, ACL repairs, knee and shoulder scopes, rotator cuff repairs and carpal tunnel releases. There are currently nine physician partners who all perform cases in the center, which is located next to the physician's clinic. The clinic includes physical therapy, digital x-ray, orthopedic urgent care and MRI.

Moore Clinic Orthopaedic Surgery Center (Columbia, S.C). Moore Clinic Orthopaedic Surgery Center is a 17,000-squre-foot, four operating room and one procedure room facility. The center, which opened in December 2007, traces its roots back to Austin Moore, the inventor of the total hip. The surgeons perform more than 4,800 cases annually and the center is managed by Practice Partners in Healthcare. The center's nurse manager, Staci Merritt, RN, performs daily clinical and operational tasks to facilitate the physician's surgical schedules and team needs. "Each team member contributes to each patient experience, customer service and clinical care," says Larry Taylor, CEO of Practice Partners.

Musculoskeletal Surgery Center (Tornton, Colo.). Physicians at Musculoskeletal Surgery Center have a special interest in orthopedics, podiatry and pain management procedures. Surgeons are also able to perform disc arthroplasty at the center. The center was founded in 2001 and includes three pre-operative stations, two operating rooms, two procedure rooms and it can accommodate for 23-hour stays in its licensed convalescence center. Musculoskeletal Surgery Center is a HealthONE ASC and is lead by Administrator Deborah Stewart, RN, and medical director Douglas Beard, MD.

Neurological Institute Ambulatory Surgery Center (Savannah, Ga.). The Neurological Institute Ambulatory Surgery Center includes multiple operating rooms and a procedure room There are 10 physicians credentialed to perform cases at the center. The physicians have a special interest in minimally invasive procedures, artificial disc replacement and spinal fractures. It is accredited by the Accreditation Association for Ambulatory Health Care.

NeuroSpine and Pain Surgery Center (Ft. Wayne, Ind.). NeuroSpine is a joint venture between neurosurgeons and the physical medicine physicians of the NeuroSpine and Pain Center and Lutheran Hospital of Indiana. Opened in January 2007, NeuroSpine and Pain Surgery Center concentrates on solutions for neck and back surgery to treat low back pain, upper back pain, neck pain and muscle pain. In

addition to the center's nine neurosurgeons, the center includes physical medicine and rehabilitation specialists. The facility houses three ORs, one procedure room, 10 pre- and postsurgical rooms and six recovery beds, allowing privacy and support during recovery. Patients have the ablity to stay over night if necessary.

New Mexico Orthopaedic Surgery Center (Albuquerque, N.M.). New Mexico Orthopaedic has eight ORs and two treatment room after a recent expansion. The surgery center includes physicians who perform orthopedic surgery, pain management and podiatry. Led by administrator Jeff Thompson, the center's partners include more than 20 physicians and its corporate partner, United Surgical Partners International. The facility, which is accredited by the Joint Commission, is currently planning a $3.5 million expansion.

Northeast Surgical Center of Newington (Newington, N.H.). Northeast Surgical Center of Newington was established in 2000 and accredited by the Accreditation Association for Amubatory Health Care. The free-standing ASC is physician owned and affiliated with Access Sports Medicine & Orthopaedics in Exeter, N.H. The center includes a 470-squre-foot dignital operating suite and offers a variety of outpatient surgeries. Access Sports Medicine & Orthopedcis also includes an open MRI, rehabilitation services, interventional physiatry, sports enhancement training, athletic training, a concussion program and other rehabilitation. They include team physicians for the 2012 U.S. Ski Team.

NorthStar Surgical Center (Lubbock, Texas). NorthStar Surgical Center was established in 2001 by physicians in the Lubbock area. Orthopedics procedures at this Symbion center include rotator cuff repair, ACL repair, meniscus repair, lateral knee release and clavicle excision. There are 31 physician partners with the surgery center who focus on a variety of specialty procedures. Surgeons have treated a wide variety of patients at the surgery center, including professional athletes. Last year, the surgery center expanded to include total shoulder, knee and ankle replacement procedures.

OA Surgery Center (Portland, Maine). OA Surgery Center expanded in 2003, adding two operating rooms with digital technology. It is the surgery center of the physicians for the OA Centers for Orthopaedics, who focus on providing care for a variety of orthopedic conditions. At the surgery center, surgeons perform knee, shoulder, spine, wrist, hand and foot surgery. They also care for patients with orthopedic trauma and fracture needs. The practice also includes an advanced on-site X-ray suite, new procedure rooms and MRI availability. The ASC is accredited by the Accreditation Association for Ambulatory Health Care.

OAK Surgical Institute (Bradley, Ill.). OAK Surgical Institute is an orthopedic-driven surgery center with two operating suite sand eight pre- and post-surgical recovery bays. It was founded as a collaborative partnership between Orthopedic Associates of Kankakee and Riverside Medical Center and is housed in the former Kankakee County Health Department. It is the only surgery center in Kankakee and Iroquois counties in Illinois and physicians perform orthopedic and pain management procedures at the center. The center has achieved accreditation from AAAHC and includes a team physician for the Chicago Bears.

Oklahoma Center For Orthopaedic & Multi-Specialty Surgery (Oklahoma City, Okla.). The center has four ORs, two treatment rooms and 10 beds. It is an affiliate of United Surgical Partners International and is partnered with local physicians and Integris Health, which includes Integris Baptist Medical Center and Integris Southwest Medical Center. The center also includes imaging services. Led by CEO Teri Philbrick, the ASC is accredited by the Joint Commission.

Olympia (Wash) Orthopaedic Associates Surgery Center. The center is affiliated with Olympia Orthopaedic Associates. The center was built in 2002 and is accredited by the Accreditation Association for Ambulatory Health Care. Over the past year, the practice has been constructing a new facility to house a bigger surgery center, which is scheduled to open this year. The practice also includes diagnostic imaging, physical therapy and interventional pain management. Physicians focus on a variety of orthopedic subspecialties, including extremities care, joint replacement, sports medicine and spine surgery.

Orlando Orthopaedic Outpatient Surgery Center. This new center opened in Sept. 2010. It has four ORs and a pain management center. In addition to orthopedic and spine surgery, the center hosts pain management and podiatry. The center is affiliated with Orlando Orthopaedic Center, made up of 17 physicians. The practice has several locations and divided into centers for spine, joint, hand, foot and ankle, pediatric, sports medicine, oncology and physical therapy.

OrthoGeorgia Ambulatory Surgery Center (Macon, Ga.). OrthoGeorgia was established as the Macon Orthopaedic and Hand Center in 1961 and has since grown to include an on-site ambulatory surgery center. The 17,000-squre-foot facility includes three operating rooms, a procedure room and eight recovery rooms. Surgeons at the facility specialize in orthopedic, hand, hand microvascular and spine surgery. They perform approximately 4,000 cases annually and served patients from 122 counties in Georgia last year. The facility is Medicare-certified and accredited by the Accreditation Association of Ambulatory Health Care.

Orthopaedic and Neurological Center of Greenwich (Greenwich, Conn.). The Leona M. and Harry B. Helmsley Ambulatory Surgical Center, operating under the name Orthopaedic and Neurological

Center of Greenwich, is a joint venture between Orthopaedic & Neurosurgery Specialists in Greenwich and Greenwich Hospital. The surgery center includes four operating rooms that have high definition video cameras for arthroscopic procedures. The physicians perform knee and shoulder arthroscopy, ACL reconstruction, extremities care and minimally invasive spine procedures.

Orthopaedic & Spine Specialists Ambulatory Surgery Center (York, Pa.). The Orthopaedic & Spine Specialists Ambulatory Surgery Center has five operating rooms, four pain procedure rooms and a pre- and postoperative area for patients. The physicians at OSS have a special interest in orthopedics, sports medicine and spine care. The practice includes diagnostic imaging, rehabilitation, physical therapy and orthopedic urgent care.

Orthopedic Associates Ambulatory Surgery Center (Oklahoma City). Orthopedic Associates Ambulatory Surgery Center was built in 186 and has been updated continuously since then. The center is home to the physicians of Orthopedic Associates in Oklahoma City, who have a special interest in sports medicine, arthroscopic surgery, extremities care, fracture care, joint replacement and trauma. The physician-owned surgery center is Medicare-certified.

Orthopaedic Associates of Wisconsin Surgery Center (Waukesha, Wis.). Orthopaedic Associates of Wisconsin opened a new surgery center in March 2007 designed for treating orthopedic patients. The center includes surgical equipment for arthroscopic procedures and an MRI for diagnostics. Physicians at the center subspecialize in spine, shoulder, hand, hip, knee, foot and ankle, sports medicine and trauma care. The group also includes physical therapy and athletic training services for the rehabilitation process.

The Orthopaedic Center at Springhill (Mobile, Ala.). This 78,000-square-foot facility is a joint venture between physicians and one of the local hospitals. With four ORs and two procedure rooms, this ASC is affiliated with Alabama Orthopaedic Clinic, a group of 20 orthopedic specialists in Mobile. In addition to orthopedics, specialties include pain management and plastic surgery. According to Administrator Dean Brown, the center has been profitable and has been Accreditation Association for Ambulatory Health Care -accredited since its first year of operation in 2004.

Orthopaedic Outpatient Surgery Center (Des Moines, Iowa). The Orthopaedic Outpatient Surgery Center is jointly owned and operated by Des Moines Orthopaedic Surgeons and Iowa Health-Des Moines. The facility was specifically designed for orthopedic procedures and includes diagnostic testing. There are 23 physicians in the practice who specialize in sports medicine, joint replacement, spine surgery, general orthopedics and pain management. The center includes six operating rooms and serves more than 350 patients each month. The center is accredited by the Accreditation Association for Ambulatory Health Care.

Orthopaedic South Surgical Center (Morrow, Ga.). This center, operated by United Surgical Partners International, hosts orthopedic surgery, spine and pain management. The facility has three ORs and one treatment room. In 2010, it was a finalist in the Clayton County Chamber of Commerce Small Business of the Year contest. Led by administrator Andrea Fann, the facility is accredited by the Accreditation Association for Ambulatory Health Care.

Orthopaedic Surgery Center of Ashville (Ashville, N.C.). The Orthopaedic Surgery Center of Ashville has three operating rooms

where physicians perform orthopedic, hand and spine surgery along with pain management procedures. The center is Medicare-certified and accredited by the Accreditation Association for Ambulatory Health Care. Physicians from Ashville Orthopaedic Associates, Blue Ridge Bone & Joint, Carolina Hand & Sports, Appalachian Foot & Ankle, Blue Ridge Foot Center, Smoky Mountain Foot Clinic and Carolina Spine & Neurosurgery Center perform cases at the ASC.

Orthopaedic Surgery Center of La Jolla (Calif.). This is the orthopedic ASC of Surgery One, a network of four outpatient surgery centers in the San Diego area. The ASC hosts 10 spine surgeons, 18 orthopedic surgeons and five pain management physicians. Surgeons perform joint replacement, arthroscopy, spine surgery and general surgery at the facility. he surgery center is accredited by the Accreditation Association for Ambulatory Health Care.

Orthopaedic Surgical Center of the North Shore (Peabody, Mass.). This 16,500-square-foot facility was the first independent orthopedic ASC in the state. The center was opened in 2004 and since 2005, surgeons have performed 32,000 surgeries in the facility. John Powell established the sugary center and now serves as its CEO. The surgery center includes board-certified orthopedic surgeons from Sports Medicine North as well as gastroenterologists, pain management physicians and a urologist. Operating rooms include high definition technology.

Fairfield Surgical Center (Fairfield, Conn.). The center is affiliated with Orthopedic Specialty Group, which has 17 surgeons working at three locations. Physicians at the center perform arthroscopic surgery of the ankle, knee, shoulder, elbow and wrist ligament. Knee reconstruction procedures include both anterior and posterior cruciate ligament procedures. Additional services include hand surgery, rotator cuff repair, foot and ankle surgery, fracture management and Carticel cartilage replacement. The center is accredited by the Accreditation Association of Ambulatory Health Care.

Orthopedic & Sports Institute Surgery Center (Appleton, Wis.). This center features a recovery area that is a designated skilled nursing facility, allowing total joint surgery to be performed in the ASC. The center is owned by seven surgeons and an anesthesiologist at the Orthopedic & Sports Institute of the Fox Valley. In addition to the ASC and physicians' offices, the institute hosts an MRI, physical therapy and orthotics. The group also provides pain management and includes a podiatrist. The center is accredited by the Accreditation Association for Ambulatory Health Care.

The Orthopedic Surgery Center of Arizona (Phoenix, Ariz.). The Orthopaedic Surgery Center of Arizona is a physician-owned facility including 15 orthopedic surgeons. The surgeons partnered with Cornerstone Surgical Partners to develop the facility, which is accredited by the Accreditation Association for Ambulatory Health Care. Physicians at the surgery center focus on sports medicine, total joint replacement and lower extremity care. The group includes team physicians for Arizona Cardinals, Arizona Diamondbacks and Phoenix Coyotes.

Surgical Center of Greensboro/Orthopaedic Surgical Center (Greensboro, N.C.). When this facility opened in 1993, it was the first freestanding ambulatory surgical center on the East Coast dedicated to orthopedic surgery. Surgical Center of Greensboro/Orthopaedic Surgical Center Surgical Center of Greensboro, have a total of 13 ORs. The center is a member of Surgical Care Affiliates. The two centers' recovery care center, opened in 1988, provides overnight care to those patients needing additional recovery time. The surgery center is accredited by The Joint Commission. The 34 orthopedic physicians affiliated with the center, with a special interest in joint replacement and sports medicine.

Orthopedic Surgery Center of Orange County (Newport Beach, Calif.). The Orthopedic Surgery Center of Orange County is jointly owned by the Orthopedic Specialists of Southern California and Hoag Hospital, and an affiliate of Hoag Orthopedic Institute. The center was opened in 1999 and is focused on providing orthopedic and musculoskeletal care. Services at the surgery center include sports medicine, hand and wrist, foot and ankle and total joint surgery. The center includes 30 physicians.

Orthopedic Surgery Center of San Antonio (Texas). The Orthopaedic Surgery Center of San Antonio is the surgery center of The San Antonio Orthopaedic Group, which was established in 1947. Ancillary services at the ASC are comprised of MRI and CT scans as well as physical and hand therapy. The group also offers industrial rehabilitation, work hardening and work conditioning. The physicians have a professional interest in arthroscopic surgery, sports medicine and extremities care.

Pacific Heights Surgery Center (San Francisco). Pacific Heights Surgery Center was opened in 2003 to serve patients with orthopedic needs. The facility is accredited by the Accreditation Association of Ambulatory Health Care and certified by Medicare. Physicians performing cases at the center have a special interest in hand surgery, foot and ankle care and sports medicine. Surgery center operations are overseen by Chris Tormey, RN, director of clinical operations.

Parkway Surgery Center (Hagerstown, Md.). Opened in August 2006, Parkway offers comprehensive spine treatments and non-invasive spine surgical procedures. The ASC was founded by the physicians of Parkway Neuroscience and Spine Institute. With nine physician owners and 10 surgeons performing cases at the center, it is part of the Blue Chip Surgical Center Partners network. The center includes one operating room and one procedure room where physicians perform several procedures, including facet injections, nerve blocks, laminotomy, laminectomy, discectomy and spinal fusion. The center includes five operating rooms and one treatment room. It is accredited by The Joint Commission and includes an MRI and CT scan.

Peak One Surgery Center (Frisco, Colo.). While orthopedic surgery makes up the majority of procedures at this center, it also features seven other specialties. The center is a partnership between Summit Surgical Group and St. Anthony Summit Medical Center in Frisco. The ASC's orthopedic medical staff includes 10 orthopedic surgeons from Vail Summit Orthopedics & Sports Medicine and The Steadman Clinic, also in Vail. The center is accredited by the Accreditation Association for Ambulatory Health Care.

Peninsula Surgery Center (Newport News, Va.). This multispecialty center features four ORs and five orthopedic surgeons. It was founded in 2003 as a joint venture with Riverside Medical Center and hosts orthopedics and spine surgery and sports medicine. Orthopedics procedures include arthroscopy of the knee, shoulder, ankle, or elbow as well as fracture and tendon repairs. Orthopedic surgeon Boyd Hynes, MD, was the first surgeon in the community to perform outpatient total knee replacement at Peninsula Surgery Center. Surgeons at the center also perform partial knee replacements and anterior cervical spine procedures. The surgery center also has a C-arm and X-ray machine. In addition, the center hosts general surgery, plastic surgery and genecology.

Piedmont Surgery Center (Greenville, S.C.). Ambulatory Surgical Centers of America developed Piedmont Surgery Center, which hosted its first case in September 2008. Of its 12 physicians, three focus on spine surgery. Neurosurgeons associated with the center perform complex spinal surgery with instrumentation, microscopic disc surgery, reconstruction of traumatic spine injury and percutaneous spinal instrumentation. It is accredited by the Accreditation Association for Ambulatory Health Care.

Premier Orthopaedic Surgery Center (Nashville, Tenn.). This eight-year-old ASC, with two ORs and one procedure room, is affiliated with Premier Orthopaedics and Sports Medicine, which has 30 physicians. Only orthopedic surgeons from the practice use the center. With Symbion as a partner, the center has 11 physician-investors and is about to add another one. In the area of spine, the center hosts one- and two-level anterior cervical discectomy and fusion and does some laminectomies. It is accredited by Accreditation Association for Ambulatory Health Care.

Premier Orthopedic Surgery Center (Albany, Ga.) Premier Orthopedic Surgery Center is the ASC of Premier Orthopedcis, which

includes four physicians who have special interest in spinal disorders, sports medicine, joint reconstruction and minimally invasive surgery. The ASC is accredited by the Accreditation Association for Ambulatory Health Care. The practices also includes physical therapy services and team physicians for a local high school.

Ravine Way Surgery Center (Glenview, Ill.). Ravine Way, focusing an orthopedics and pain management, was founded in 2006 as a joint venture between the physicians of Illinois Bone & Joint Institute and NorthShore University Health Systems. It features three ORs, one procedure room and a staff of 21 physicians. There are 19 physician partners and 24 physicians who perform cases there, many of which are known for their participation in organizations such as the American Academy of Orthopaedic Surgeons. Ravine Way is successful because of a strong commitment from its physicians-owners and a strong management team and experienced staff, according to Administrator Melody Winter-Jabeck. It is accredited by the Accreditation Association for Ambulatory Health Care.

Reading Surgery Center (Wyomissing, Pa.). With three ORs and one procedure room, Reading hosts seven orthopedic surgeons as well as physicians in pain management, podiatry, gynecology, ophthalmology and plastic surgery. Physicians at the center performed more than 6,700 cases in 2009, including spine cases such as laminectomies and anterior cervical discectomies and fusions.

Regional Hand Center of Central California (Fresno, Calif.). Regional Hand Center of Central California was incorporated in 1999 and moved to its current location in 2003. Founded by a an independent physician and associated with SourceMedical, Regional Hand Center of Central California includes two operating rooms for patients with hand, wrist and forearm disorders. Randi Galli, MD, is currently the facility's owner, and he has added qualification in surgery of the hand by the American Board of Surgery. The center also includes hand, wrist and elbow therapy services.

Renaissance Surgery Center (Bristol, Tenn.). This Symbion center hosts minimally invasive spine surgery, neurosurgery, pain management, plastic surgery and general surgery. Three neurosurgeons, two from Highlands Neurosurgery in Bristol and one from Bristol Neurosurgical Associates, use the center. The center is licensed by the Tennessee Department of Health Services and the Centers for Medicare and Medicaid Services. The center is lead by administrator Elizabeth Trivett, RN, and business office manager Judy Cole.

Roanoke (Va.) Ambulatory Surgery Center. The facility, which opened in Nov. 2002, has three ORs and 18 physician-investors. Its surgeons practice at Roanoke Orthopaedic Center, which has been part of Carilion Clinic since 2009 and has four orthopedic surgeons, two physician assistants and one certified athletic trainer. In addition to orthopedics, it also hosts ENT, pain management and urology. It is affiliated with Virginia Orthopaedic.

Rockford (Ill.) Orthopedic Surgery Center. This facility is affiliated with Rockford Orthopedic Associates, which has 18 orthopedic surgeons and two podiatrists. The center opened in 2004 and by 2009 it was logging 2,800 surgical cases and more than 5,300 procedures. The practice also includes rehabilitation services and the physicians participate in research studies. In Feb. 2011, the center was awarded three-year term accreditation by the Accreditation Association for Ambulatory Health Care.

San Francisco Surgery Center. This center was recently the first ASC to host MAKOplasty, a new robotic system that assists in partial joint replacement, allowing the patient to walk out of the recovery room within two hours of the surgery. The procedure was successfully performed by Kevin R. Stone, MD, of the Stone Clinic in San Francisco, and John H. Velyvis, MD, of the Coon Joint Institute in St. Helena, Calif. In orthopedics, the center covers upper extremity surgery, lower extremity surgery, spine surgery, endoscopic and open arthroscopic surgery. It also covers pain management, microsurgery, reconstructive plastic surgery, cosmetic surgery and general surgery.

Sheboygan (Wis.) Surgery Center. With three ORs and two procedure rooms, this center is focused on orthopedic surgery. It is a joint venture between eight local surgeons and St. Nicholas Hospital, a member of The Hospital Sisters Health System based in Springfield, Ill. ASD Management opened the center in 2008 and provides ongoing management. It was Sheboygan County's first new construction, multispecialty, free standing surgery center. The 14,660-square-foot facility is accredited by the Accreditation Association for Ambulatory Health Care.

Short Hills Surgery Center (Milburn, N.J.). This ASC is home to seven spine surgeons among more than 70 physician partners in orthopedic surgery and seven other specialties. It features six ORs, two minor surgery rooms and 24 recovery beds. The 25,000-square-foot ASC opened its doors in February 2005 and the medical staff have treated more than 30,000 patients. Short Hills is accredited by the Accreditation Association for Ambulatory Health Care.

Slocum Center for Orthopedics & Sports Medicine (Eugene, Ore.). Slocum Center's affiliated practice, Slocum Center for Orthopedics and Sports Medicine, was formed in 1995 by combining two orthopedic groups. The practice is named for Donald B. Slocum, MD, who championed new orthopedic approaches. Additional services at the practice include a therapy center, concussion program, MRI and a pharmacy. Physicians have special interest in shoulder, elbow, hip, knee and spine care.

Somerset Surgical Center (Bridgewater, N.J.). The center was founded in 1995 by a group of orthopedic surgeons and pain management physicians. It was the first orthopedic ASC in the area. As the center's reputation grew, it began to bring in patients from across the country, including professional athletes. It is affiliated with Somerset Orthopedic Associates, which has seven physi-

cians. It is accredited by the Accreditation Association for Ambulatory Health Care. The practice also includes physical therapy and a Spine Institute.

South Shore Surgery Center (Lynbrook, N.Y.). South Shore Surgery Center opened in October 2002 and was founded by independent physicians, physician groups and a managing partner. There are four operating rooms and one procedure room in this multispecialty center, dominated by orthopedic procedures. The most common procedures include sports medicine repairs, such as arthroscopic shoulder and knee surgeries, as well as extremities care, pain management, podiatry and percutaneous discectomy. Surgeons at South Shore Surgery Center perform Carticel Implantation, a unique procedure that uses the patient's own cells to repair cartilage injuries in the knee. The center's anesthesia group also provides regional blocks for most orthopedic cases. Currently, the surgery center includes 16 physician partners and 38 physicians perform cases at the ASC.

Southern New Mexico Surgery Center (Alamogordo, N.M.). Southern New Mexico Surgery Center has two orthopedic surgeons with two ORs and one procedure room. The center uses state-of-art, minimally invasive techniques. Orthopedic procedures include knee and shoulder arthroscopies, open shoulder surgery, anterior cruciate ligament repairs, fasciotomy and treatment of hand disorders. It is recognized by the Accreditation Association for Ambulatory Health Care. There are 10 physician partners.

Southern Orthopaedic Surgery Center (Fayetteville, Ga.). The Southern Orthopaedic Surgery Center opened in 2007 by eight physician members of Southern Orthopaedic Specialists. The orthopedic surgeons see patients with a broad range of injuries and conditions, including scoliosis and back pain, sports medicine and total joint replacement. Anesthesia services at the ASC are provided by Piedmont Anesthesia Associates. The center is accredited by the Accreditation Association for Ambulatory Health Care.

Southwest Spine Institute Ambulatory Surgery Center (Mount Pleasant, S.C.). Southwest Spine Institute Ambulatory Surgery Center is South Carolina's only ASC dedicated specifically to spine health. The facility was designed by Don Johnson, MD, and Steve Poletti, MD, to address patients with spine-specific issues, including total disc replacement. In addition to outpatient surgery, Southwest Spine Institute includes imaging, fluoroscopy and physical therapy. The surgery center is accredited by the Accreditation Association for Ambulatory Health Care and Medicare-certified.

Spalding Surgical Center of Beverly Hills (Beverly Hills, Calif.). Physicians and surgeons at Spalding Surgical Center of Beverly Hills provide orthopedic surgery, pain management, plastics and reconstructive procedures. The facility is Medicare certified and state licensed.

Spine Centers of America (Fair Lawn, N.J.). Spine Centers of America, affiliated with New Jersey Back Institute, operates three surgical centers with a team of certified endoscopic spine surgeons. It delivers the newest proven techniques in endoscopic spine surgery, specializing in minimally invasive procedures. Founder and Head Surgeon Bryan J. Massoud, MD, has performed more than 1,000 minimally invasive spine surgeries for maladies such as cervical and lumbar disc herniations, thoracic disc herniations, spinal stenosis, failed back surgery syndrome, spondylolisthesis, scoliosis and infections. He also instructs orthopedic residents and colleagues in new procedure and endoscopic techniques. Spine Centers of America opened its new Advanced Spine Surgery Center in Union, N.J., in Nov. 2010.

The Spine Institute of Southern New Jersey (Marlton, N.J.). Surgeons at The Spine Institute of Southern New Jersey perform spinal surgery, which includes lumbar discectomy, lumbar laminectomy, posterior lumbar interbody fusion and anterior lumbar interbody fusion. The ASC's staff are focused on providing one-on-one care. Orthopedic surgeons include Joan O'Shea, MD, and Steven B. Kirshner, MD. Dr. Kirschner was the first spine surgeon in New Jersey to perform lumbar total disc replacement and the first to implant a flexible rod system in 2004.

Spine Surgery Center of Eugene (Eugene, Ore.). The Spine Surgery Center of Eugene was opened in 2007 by Glenn L. Keiper Jr., MD, founder of KeiperSpine, and several associates. Dr. Keiper has focused on motion-sparing techniques, which has helped him develop new technology for spine surgery. Physicians perform minimally invasive spine procedures. The surgery center is lead by Administrator and CEO P. Evelyn Cole, MHSA, CASC. The center is accredited by the Accreditation Association for Ambulatory Health Care.

Squaw Peak Surgical Facility (Phoenix). Desert Institute for Spine Care was founded by spine surgeon Anthony Yeung, MD, in 1998 to complement his practice, Desert Institute for Spine Care. Surgeons at the two-operating room surgery center perform several spine procedures, including endoscopic transforaminal thoracic and lumbar spine decompression and ablation and therapeutic injections. The surgeons also perform a dorsal endoscopic rhizotomy surgery developed by Dr. Yeung, using the Yeung Endoscopic Spine Surgery system. The surgeons are team spine surgeons and consultants for several professional athletic teams, including the Arizona Diamondbacks, Colorado Rockies, Kansas City Royals, Seattle Mariners, Los Angeles Dodgers and Cincinnati Reds.

St. Louis Spine Surgery Center. Physician investors with St. Louis Spine Surgery Center partnered with Blue Chip Surgical Partners to establish their 6,700-square-foot facility in 2007. It was acquired by Meridian Surgical Partners in February 2012 and contains two operating rooms. The 10 physicians perform a variety of neurosurgery and pain management procedures. St. Louis Spine Surgery Center is led by administrator Debbie Wooten and is located in a medical office building.

St. Matthews Surgery Center (Louisville, Ky.). The center, with three pre-op rooms and six recovery rooms, specializes in the knee, hip, shoulder, foot and spine surgery. Surgeons of the Louisville Orthopaedic Clinic established the surgery center in partnership with Baptist Hospi-

tal East. The ASC includes three preoperative rooms and six recovery rooms as well as two surgery suites designed specifically for orthopedic patients. Louisville Orthopaedic Clinic also includes MRI, X-ray and physical therapy. The surgery center is accredited by the Accreditation Association for Ambulatory Health Care.

Stateline Surgery Center (Galena, Kan.). This two-OR center is primarily involved in orthopedics cases and is home to six orthopedic surgeons, one spine surgeon, one hand surgeon and one pain specialist. Opening in March 2010, it is housed in an $8 million, 52,000-square-foot building with physician offices and exam rooms, a gym and MRI services. The ASC has four large overnight rooms to allow for additional recovery time needed by spine patients.

Surgical Center at Columbia Orthopaedic Group (Columbia, Mo.). The physicians of Columbia Orthopaedic Group have ownership in the Surgical Center at Columbia Orthopaedic Group. The ASC opened its doors in July 2008 and more than 20 surgeons perform procedures there. The facility includes four operating rooms and 23-hour overnight observation capabilities. Surgeons perform several procedures, including knee and hip replacement, shoulder surgery, fracture repair, extremities care and pain management. The surgery center is certified by Medicare.

SurgiCare of Miramar (Miramar, Fla.). SurgiCare of Miramar is a multispecialty ASC opened in March 2010. The 11,000-squre-foot facility is a freestanding surgery center with four operating rooms and an affiliate of Surgem. Driven by orthopedics, pain management and podiatry, the surgery center also includes ophthalmology, GI and general surgery. The physicians of Orthopedic Specialists of South Florida bring their cases there. The facility is accredited by the Accreditation Association for Ambulatory Health Care.

Surgery Center at Doral (Miami). Surgery Center at Doral was founded in 2008 as a joint venture between Alejandro Badia, MD, and a management company. Orthopedic surgeons perform outpatient total joint replacements and small joint arthroscopy, among other procedures. There are currently four physician partners and five additional physicians operating at the surgery center. The center's orthopedic urgent care center OrthoNOW includes a therapy center and onsite MRI imaging.

Surgery Center of Allentown (Pa.). This multispecialty ASC, one of the largest in the state, is a joint venture between physicians and Ambulatory Surgery Centers of America. Having opened in April 2007 with five ORs and 25 staff members, it has grown to seven ORs with a staff of more than 55. The center has one orthopedic spine surgeon, four orthopedic hand surgeons and seven orthopedic sports medicine physicians. To keep in shape, the ASC prepares for its state department of health inspection in January and again in August. It is recognized by the Accreditation Association for Ambulatory Health Care.

Surgery Center of Kalamazoo (Kalamazoo, Mich.). Surgery Center of Kalamazoo was founded in 2004 by a group of independent physicians and Ambulatory Surgery Centers of America as the managing partner. In 2007, NovaMed, now known as Surgery Partners, purchased the four-operating room surgery center. While the center is driven by orthopedic procedures, physicians also perform pain management, podiatry, ENT and gynecological surgery at the ASC. Currently, surgeons perform unicompartmental knee replacements in the surgery center and kyphoplasty. In the near feature, total shoulder replacements may also be performed at the ASC. There are 14 surgeon owners and 20 surgeons who bring cases to the center.

Surgery Center of Maryland (Silver Spring, Md.). There are two neurosurgeons and 28 orthopedic surgeons at this center, which is affiliated with Ambulatory Surgery Centers of America. In orthopedics, the ASC covers knee arthroscopy, shoulder arthroscopy and anterior cruciate ligament repair. It covers carpal tunnel release and several other procedures in hand surgery. Surgery Center of Maryland is a multispecialty ASC recognized by the Accreditation Association for Ambulatory Health Care and physicians perform 3,500 procedures per year among all specialties. The surgery center has four operating rooms and one procedure room.

Surgery Center of Reno (Nev.). The spine surgeons at SpineNevada partner with Surgery Center of Reno to perform minimally invasive procedures. The ASC is the only free-standing ASC in Reno with direct hospital access if transfers are necessary, with an underground tunnel connecting it to Saint Mary's Hospital intensive care unit. Physicians also perform orthopedic surgery and pain management at the center.

Sutter Alhambra Surgery Center (Sacramento, Calif.). This three-OR ASC, a partnership with Surgical Care Affiliates and Sutter Health, is limited to orthopedic and pain management. It has more than 20 orthopedic surgeons and recently achieved re-accreditation by the Accreditation Association for Ambulatory Health Care.

Surgery Center of Wisconsin Rapids (Wis.). Surgery Center of Wisconsin Rapids opened its doors in 2006 and is the surgery center of Wisconsin River Orthopaedic Institute. Managed by ASD Management, the center covers orthopedic and pain procedures. In Sept. 2007 and again in Aug. 2010, it achieved a three-year accreditation from Accreditation Association for Ambulatory Health Care. The center is currently working on adding an ophthalmology service line. The practice also includes MRI and therapy services.

Tallgrass Surgical Center (Topeka, Kan.). This multispecialty center focuses on sports medicine and hosts a great deal of ACL reconstructions. Kurt R. Knappenberger, MD, an orthopedic surgeon, is the current president of the surgery center while anesthesiologist William E. Gitchell, MD, serves as medical director. Surgeons have been performing the partial knee replacement procedure for several years in addition to arthroscopy, hand surgery, fracture care and pain management injections. The center has three ORs and one procedure room. The center is accredited by the Accreditation Association for Ambulatory Health Care.

Texarkana (Texas) Surgery Center. This Symbion center is a large multispecialty center with five ORs and two procedure rooms. The ASC has been in operation since 1995 and added a neurosurgery program a few years ago. In addition to neurosurgery, surgeons perform orthopedic hand procedures, general surgery and pain management. The ASC is accredited by the Accreditation Association for Ambulatory Health Care.

Texas Orthopedics Surgery Center (Austin). Texas Orthopedics Surgery Center was founded in 2002 and is owned and operated by the physicians of Texas Orthopedics. The physicians have a special interest in sports medicine, spine care, extremities care and rheumatology. The practice is also the official sports medicine providers for the Texas Stars hockey team. The surgery center is accredited by The Joint Commission. In addition to the surgery center, Texas Orthopedics includes physical therapy, imaging services and a pharmacy.

Texas Surgical Center (Midland). Texas Surgical Center was opened in October 2003 and is currently owned and operated by a group of 12 surgeons, including nine orthopedic surgeons. The multispecialty ASC includes two operating rooms with hi-definition technology and one treatment room. Diagnostic services include two C-arms and one mini C-arm for fluoroscopy. The center is lead by Administrator Laurie Bailey, RN, CNOR, CASC, Governing Body Chairperson John C. Dean, MD, and medical director Donald W. Floyd, MD.

TRIA Orthopedic Center (Minneapolis). TRIA is a comprehensive center for orthopedic diagnosis, treatment, surgery and rehabilitation opened in March 2005. It is a partnership between Park Nicollet Health Services, The Orthopaedic Center and the University of Minnesota Physicians. The 100,000-squre-foot facility includes more than 40 orthopedic physicians who have subspecialties in sports medicine, acute injury, shoulder, knee, spine, extremities and fracture care. Sports Medicine physicians have current and previous affiliations with the Minnesota Vikings, Twins and Timberwolves.

Tri-City Orthopaedic Center (Richland, Wash.). This USPI facility, with two ORs and one treatment room, covers orthopedic surgery and pain management. It is affiliated with six-physician Tri-City Orthopedic Clinics. Tri-City's clinical tech-

nology includes computer-assisted surgery navigation for total knee replacement, minimally invasive surgery, arthroscopic shoulder reconstructions and minimally invasive spine surgery. It is accredited by Accreditation Association for Ambulatory Health Care and led by Administrator Scott Faringer.

Tucson Orthopaedic Surgery Center (Tucson, Ariz.). In operation since 2002, this 11,500 square-foot facility specializes in orthopedic and pain management procedures. A joint venture between Tucson Orthopaedic Institute and Tucson Medical Center, the center features four ORs and hosts 19 surgeons. The ASC is currently oenwed and operated by TMC and accredited by the Accreditation Association for Ambulatory Health Care.

Two Rivers Surgical Center (Eugene, Ore.). Two Rivers Surgical Center opened in 2006 and was acquired by Surgical Management Professionals in 2008. The 7,911-square-foot facility is under the leadership of administrator Angel Kellum and was designed specifically for outpatient spine procedures. Two Rivers Surgical Center includes two operating rooms and six physician owners. The ASC has met standards for Medicare certification and is accredited by the Accreditation Association for Ambulatory Health Care. Two Rivers is also a member of the ASC Association.

Upstate Orthopedics Ambulatory Surgery Center (Syracuse, N.Y.). The physicians of Upstate Orthopedics perform orthopedic and pain management procedures at Upstate Orthopedics Ambulatory Surgery Center. Their 100,000 squre-foot facility includes the ASC, imaging services, custom orthotics and prosthetics, physical therapy, occupational therapy and a lab for blood work. There are 16 orthopedic surgeons who have a special interest in sports medicine, extremities care and spine.

Vail Valley Surgery Center (Vail, Colo.). Vail Valley Surgery Center is a joint venture between Vail Valley Medical Center and 21 physician-partners, including orthopedic surgeons from The Steadman Clinic. The facility, which opened in 2002, has four ORs and one procedure room. In spring of 2012, the facility expanded to a new location in Edwards, Colo. Vail Valley completes more than 4,000 cases annually, mostly in orthopedics, and treats some of the nation's top athletes.

Valley Surgery Center (Steubenville, Ohio). Opened in July 2002, Valley Surgery Center is owned by 14 local surgeons who partnered with Symbion Healthcare in September 2004. The facility features three ORs and one procedure room. It has 28 credentialed physicians. In addition to orthopedics, it hosts ENT, ophthalmology, general surgery, podiatry, gynecology, plastics, urology and pain management.

Virginia Beach Ambulatory Surgery Center (Virginia Beach). The Virginia Beach Ambulatory Surgery Center is a for-profit outpatient surgery center that opened in October 1989. The ASC is a joint venture between physician partners and Sentara Health System to provide multispecialty care for adult and pediatric patients. Orthopedic services at the ASC include arthroscopy, ACL repair, carpal tunnel release, fracture repair and rotator cuff repair. The surgery center is accredited by the Accreditation Association of Ambulatory Health Care.

West Kendall Surgery Center (West Kendall, Fla.). In June 2003, a group of physicians founded West Kendall Surgery Center along with their business partner. Surgery Partners purchased the center in 2005. West Kendall includes four operating rooms and surgeons typically perform shoulder, knee, hip, wrist, ankle and elbow arthroscopies there. The center also includes physicians who perform pain care injections and open tendon repairs and bone fixation. The physicians have presented at local and national meetings and D. Kalbac, MD, is a U.S. World Soccer team physician. The ASC currently includes 13 physician partners and four non-physician partners who perform cases there.

West Lakes Surgery Center (Clive, Iowa). This multispecialty center is a joint venture between Mercy Medical Center and multiple area physicians. It has seven ORs, two procedure rooms and two overnight recovery suites. Besides orthopedics, specialties include dermatology, endoscopy, ENT, gastroenterology, general surgery, gynecology, pain management, plastics and podiatry. It is accredited by the Accreditation Association for Ambulatory Health Care.

West Park Surgery Center (Cape Girardeau, Mo.). West Park Surgery Center was formed in association with the physicians from Brain & NeuroSpien Clinic of Missouri and Blue Chip Surgical Center Partners. Surgeons at the center perform anterior cervical discecetomy and fusion, microdiscectomy, carpal tunnel, ulnar nerve transposition and pain management procedures. The surgery center includes five physicians.

William B. Mulherin Surery Center (Athens, Ga.). The William B. Mulherin Surgery Center was established in 2007 by the physicians of Athens Orthopedic Clinic. William B. Mulherin, MD, founded AOC in 1966 and the physicians named their surgery center after him. AOC manages operations at the center, which is accredited by the Accreditation Association of Ambulatory Health Care. The physicians include orthopedic consultants for the University of Georgia. In addition to the surgical center, AOC includes an MRI imaging facility, occupational and physical therapy and is currently working on a Sports Performance & Rehabilitation Center.

Wilmington (N.C.) SurgCare. This Symbion center has seven ORs, up from three when it opened in 1994, and three procedure rooms used by 83 active physicians, 19 of whom are owners. Twenty of the physicians are in orthopedics and the center also hosts general surgery, plastic surgery, endoscopy, ophthalmology, urology, pain management, ENT and gynecology. Wilmington SurgCare received Symbion's "Facility of the Year" award in 2007 and has also earned three "President's Awards" from its management company for reaching established benchmarks. ■

5 Steps for Optimizing Key ASC Benchmarks

By Laura Miller

Every surgery center keeps track of their statistics and has access to data from other centers, compiled either by an outside source or their management company. However, without a proper understanding of what the data is telling them, it's difficult for administrators to make improvements and exceed average numbers.

"You don't manage a surgery center through a spreadsheet," says Joseph Zasa, JD, co-founder and managing partner of ASD Management. "You use a spreadsheet to identify areas that need to be improved and you use it as a diagnostic tool to show what areas may require attention."

When it's done right, benchmarking against yourself can give you invaluable insight for the future. "Trending where the facility is by itself gives you a clearer indication of something that might be a positive or negative trend," says Steve Whitmore. "If it's negative, administrators should investigate and correct that situation."

Here, industry experts discuss how surgery center administrators can apply benchmarking data most effectively for full process and system improvement.

1. Pick the most important metrics for your center's improvement. ASC administrators are faced with a barrage of benchmarks on a daily basis and are constantly examining data points in different ways. "I walk into centers and they are looking at 85 different metrics," says John R. Seitz, president and CEO of ManageMyASC, and Tamar Glaser, RN, of ManageMyASC.com. "They cover so many things that nobody pays attention to any of them. Administrators need to pick the ones that are most important and solve those issues immediately."

Examine the different metrics you collect and choose which ones are most urgent for the center to address. For example, tracking income per minute is largely useless because of the surgery center's economy of sale. "ASCs have fixed costs and if you can get over that hurdle you can really change things," says Mr. Zasa. "The first thing to look at is the number of cases performed at the center because a lot of data is case-driven."

In addition to case volume statistics, the other key area is collections. Track your revenue cycle in its most basic form to see how many dollars you collect. "Without case volume and collections, you don't have a successful center," says Mr. Seitz. "Find what matters for you and focus on those metrics. It might be case start times, cases per day or overtime hours."

When choosing your areas for improvement, make sure they are appropriate for measuring. "We believe strongly that if it's important, you have to measure it," says Jeff Leland, CEO of Blue Chip Surgical Partners. "Identify the half-dozen benchmarks that you really want to keep track of. The most important thing is to measure them."

2. Pay most attention to benchmarks from similar centers. It's important to know the national benchmarks for surgery centers, but it doesn't make sense to compare dissimilar centers. For example, ASCs doing 100 cases per month will have a different per patient data than centers doing 1,000 cases per month. "Benchmark yourself against similar centers with similar case volume and specialties," says Mr. Zasa. "Focus on getting really good benchmark data to see how you are doing. There are only a handful of key statistics that really matter."

The most important statistics to have a bearing on the success of a surgery center are:

- Gross billings: whether your fee schedule is on track, too high or too low. "Make sure the fee schedule is right because that's how insurance companies pay you," says Mr. Zasa. "If your gross charges are off, you are leaving money on the table. Adjust the fee schedule so it's higher per month."
- Revenue per patient: the average revenue generated per patient. "This is absolutely critical and based on the kinds of cases you do and your payor mix," says Mr. Zasa. "If the revenue is bad, you aren't collecting right or you have bad contracts. Make sure you don't have a systematic problem. There are 12 key processes to run in surgery centers; make sure all yours are running properly."
- Hours per patient: the number of hours spent on each patient. "For plastic surgery it's going to be high; for endoscopy it's going to be lower," says Mr. Zasa. "Make sure you are benchmarking with your peers and really focusing on benchmarking around your case mix. Patient safety is paramount, but in our experience the best run and most efficient centers score high in patient safety and staffing benchmarks. They are not mutually exclusive."
- Supply costs per patient: the average cost of supplies for each patient. "This is specialty mix driven; orthopedics will be higher and GI and pain management will be lower," says Mr. Zasa.
- Accounts receivable days: the number of days it takes to collect on accounts receivable. Measuring this statistic properly tells you if you have an A/R problem. If you suspect that you do, you must look at your internal systems that include timing of billing, post surgery collections and follow up, prior to surgery collections of copays and deductibles, follow up on denials. Alternately, it can be issues with insurance companies. Use the statistic to dig deep and find out what is really occurring," says Mr. Zasa.

There are plenty of national benchmarks for surgery centers, but administrators may need to pay for more regional or specialized statistics. "It's always helpful to benchmark against regional numbers if you can get your hands on them," says Steve Whitmore.

3. Have a clear goal to reach. Once you've selected a few key metrics and benchmarked your center against other similar centers, define a clear pathway for your center to meet that goal, says Mr. Seitz.

For example, if you want to reduce costs associated with overtime, make the rule that employees can't take more than 30 hours of overtime per pay period. If you are trying to up your collects, set a goal of $830,000 per month. If you want to increase case volume, define a goal of 550 cases per month, depending on your center.

"If you have cases running late, you should look at causes such as room turnover time or physicians arriving late for the procedure or the prior case just took more time to complete," says Mr. Whitmore. "These factors affect nursing hours per case which correlates to financial benchmarks being missed"

4. Decide how often to track your progress. Once a goal is set, make sure you are tracking your progress regularly. By the end of the month, you should have a good idea about whether your center is on target to meet your goals or not. "Most people wait until the month is over before figuring out whether they've met their goals," says Mr. Seitz. "Instead, track your progress at regular intervals."

For example, if the goal is to collect $830,000 for the month, check your progress on the 15th of every month. At that point, you should have collected at least $400,000. If you aren't on track to fulfill your monthly goal, take action to change that before the month is over.

"Go back through and communicate where you are so the problem can be fixed," says Mr. Seitz. "If your goal is a collection goal, meet with the billing people and see where you need the money to come in."

5. Communicate whether you are meeting your goals effectively. Make sure you are sharing benchmarking data and goals with the right people so improvements will be made.

"If you are measuring collections per day, you should be sharing that information with people who are actually doing the collections," says Mr. Seitz. "If you are measuring cases, you should be sharing that with the physicians. For every metric, decide who you need to share it with so they can buy into it and improve it. It doesn't do any good to collect this information and share it only with the board."

Once the strategic goals are in place, communicate progress to employees on a daily, weekly or monthly basis. "Post results on the bulletin board, have a company meeting or publish it in the newsletter," says Mr. Setiz. "Have a plan for how you are going to communicate. I am currently tracking overtime at a surgery center every day. If they know I'm tracking every day they'll make sure to reduce that number."

When you share your results, you can also show employees how you measure up. "We share our benchmarking data with everyone and try to monitor our performance," says Mr. Leland. "Further we base compensation to some extent on how well the surgery center compared against the benchmarks." ■

Learn more about ASD Management at www.asdmanagement.com.

Learn about ManageMyASC at www.managemyasc.com.

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32 Statistics on Surgery Center Operating Expenses

By Rachel Fields

Here are 32 statistics on surgery center operating expenses, according to VMG Health's *Multi-Specialty ASC Intellimarker 2011*.

As a percentage of net revenue

Employee salary and wages: 22.7 percent
Taxes and benefits: 5.2 percent
Occupancy costs: 7.5 percent
Medical and surgical: 20.9 percent
Other medical costs: 1.5 percent
Insurance: 0.8 percent
General & administrative: 15.4 percent
Total operating expenses: 73.1 percent

Per square foot

Employee salary and wages: $108.92
Taxes and benefits: $25.24
Occupancy costs: $34.27
Medical and surgical: $103.02
Other medical costs: $7.17
Insurance: $3.90
General & administrative: $81.68
Total operating expenses: $364.31

Per operating room

Employee salary and wages: $421,820
Taxes and benefits: $96,670
Occupancy costs: $129,090
Medical and surgical: $401,430
Other medical costs: $28,420
Insurance: $14,860
General & administrative: $325,840
Total operating expenses: $1,418,130

Per case

Employee salary and wages: $358.60
Taxes and benefits: $82.62
Occupancy costs: $122.45
Medical and surgical: $353.16
Other medical costs: $24.69
Insurance: $12.52
General & administrative: $282.00
Total operating expenses: $1,236.03 ■

Learn more about VMG Health at www.vmghealth.com.

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5 Factors That Attract Physician Investors to Surgery Centers

By Taryn Tawoda

Surgery centers immersed in physician recruitment should focus on anticipating and meeting the prospective physician's needs, says Blayne Rush, president of Ambulatory Alliances, a management firm that focuses on surgery center brokerage and physician recruitment.

"Physicians are looking to get a return on their investment," he says. "They're looking for somewhere that is easy for them to practice, where their patients are happy and taken care of, and that has a strong and positive reputation in the marketplace."

Mr. Rush shares five appealing factors that physicians look for when choosing to invest in a surgery center.

1. Show that the surgery center is profitable. Interested physicians will want to know if the center is profitable or has developed a plan to achieve profitability, says Mr. Rush. "Some physicians will say that they don't do a lot of procedures and just want to use the center as a tool to provide easy access for my patients, but for the most part, they want to know that there's a plan in place to ensure that the center is profitable," he says.

Profitable surgery centers should show the center's balance sheet to potential physicians, and those that are less profitable should present the physician with a plan for performance growth. "You have to say, 'Here's what 200 more orthopedic cases would do to the bottom line. If you came on board and we added 200 cases, this is what the typical cases pay, these are the expenses that we'd have to add to the center to bring those cases on, and this is what the profits would look like,'" says Mr. Rush. "Show what the center's future performance would look like based on those added cases."

2. Show that the surgery center is conveniently located. Prospective physicians will also weigh location and convenience when determining whether to invest in a center. They will consider the distance from the clinic to their office, the ease of bringing patients to the center given where their patient pool is located and the flexibility of staff and operating room scheduling, says Mr. Rush.

3. Show that the center is transparent. From an investment standpoint, physicians are looking for operational transparency. "How transparently is the center operated?" Mr. Rush says. "Do physicians get to see the books? Are they involved in the decision-making process of what equipment to buy, how to divvy up the block time or what days the center is open? Where is the money coming from, and where is it going? Who owns what percentage of the surgery center?"

Physicians will also want to know that they can market themselves independently of current investors. "Some don't want joint marketing efforts, because they don't want their name associated with another physician," Mr. Rush says.

4. Show that the center staff members are consistent. According to Mr. Rush, physicians want to feel comfortable and familiar with the clinical staff members, and they want to know that the same staff members will be available consistently without turnover. "Physicians don't want to see different staff and team each time they go to the center," he says. "They want to know that the anesthesia providers, nurses and surgical techs are consistent. A physician might say, 'I'm familiar with this anesthesia provider, he knows how I work, and I don't want a different provider to show up instead.'"

5. Show that the center's other physicians are invested and involved. Prospective physicians will want to know that current physicians are not only invested in the center, but performing surgeries, says Mr. Rush. "They want to see that the physicians that are there now are committed to the success of the center — that they are active in doing cases, active in managing and active in making the center a success. It's very important to them that they know going in who the physicians are and that they have a say-so in who the new physicians are going forward." ■

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Learn more about Ambulatory Alliances at www.ambulatoryalliances.com.

Why Are Your Physicians Taking Cases Elsewhere? 5 Signs of Disengagement

By Taryn Tawoda

Increasing pressures in the outpatient surgery setting — ranging from regulations and quality measures to issues surrounding payors and reimbursement — can make physicians feel less engaged in the practice of medicine, according to Bob Uslander, MD, an entrepreneur and the founder of Doctors On Purpose, an organization dedicated to coaching and mentoring professionals to achieve balance in their careers and lives. "It puts a different emphasis on what doctors are doing," he says. "They are being told that they have to satisfy everybody, and satisfying patients doesn't always relate to providing them the right care." This can lead to physicians feeling disconnected from the practice of medicine and from the surgery center environment, he says.

Dr. Uslander discusses three common signs of physician disengagement, and how to address these physicians collaboratively and effectively.

What are the signs of physician disengagement?

1. Physicians complain more often. Physicians who are feeling disengaged from the center tend to feel trapped and, as a result, may adopt a "victim" mentality, Dr. Usland says. "They tend to complain about a lot of the things that are happening, and the complaining is a sign of not feeling like they have the power to change anything," he says. "They complain to anybody who will listen, but typically not to patients, because they don't want to give them that burden."

Physicians may complain about the competence of the staff, for example, or about patients being difficult and unreasonable. "They might say that the primary care doctors are not getting them the medical clearance that they need, or that the lab is not getting them what they need in time, or that electronic medical records are difficult to deal with," says Dr. Usland. "They tend to complain about all of the processes in the system instead of trying to be the solution or engage in meaningful discussion."

2. Physicians receive more patient complaints. Disengaged physicians will often start receiving more patient complaints about them, says Dr. Uslander. "The patients feel like there is not a connection and that the doctors don't care, and they tend to be quicker to complain about the experience they have," he says.

If a patient experiences a long wait to see a physician, for example, a disengaged physician may not acknowledge or apologize for the wait time. "They don't make a human connection, and the patients just feel like nobody cares. They feel as though their time is valuable, but nobody respects that," Dr. Uslander says.

3. Physicians are less enthusiastic about collaboration and teamwork. The staff members working with the disengaged physician will often perceive that something is "off" about his or her behavior. The physician may consistently arrive late to work, show signs of not prioritizing their work, complain, or repeatedly make excuses for not completing tasks. "The staff that they work with will know it," says Mr. Uslander. "It will be clear that the physician is not being part of an effective team."

How can disengaged physicians be reengaged?

1. Designate a committee to talk to the physician. Every surgery center should identify individuals or groups in the organization who can engage the disengaged physician in a discussion, says Dr. Uslander. "It's all based around having a system of communication and not allowing issues to go on without some action," he says.

If a surgery center is part of a hospital, there may already be an existing wellness committee that can facilitate the discussion. Independent surgery centers should create a committee that consists of the operations director and several others who hold leadership positions at the center and are committed to creating a collaborative, cohesive culture, says Dr. Uslander.

2. Ask open-ended questions that focus on improvement. Conversations with a disengaged physician must be focused on helping him or her as opposed to assigning blame, says Dr. Uslander. "The first question that will open things up is, 'How can we as an organization best support you?'" he says, adding that a fairly broad opening question shows that the surgery center is looking to help create an atmosphere of success while allowing the physician to identify areas for improvement. According to Dr. Uslander, an appropriate follow-up question would be: What do you think you can do to best serve the needs of the organization? What can you do differently?

3. Prioritize collaborative, sensitive communication. "The real goal of an organization is to have everybody moving forward with shared values," says Dr. Uslander. "There should be an environment where everybody is honored for their individual things to give, where there isn't a big hierarchy, and where each person feels that they have an important role." If this message is emphasized, he says, then the pressure to make and execute all decisions — which can often lead to feeling overwhelmed and disengaged — will be removed from the physician.

"Physicians are not the ones who are supposed to be answering all of the questions," he says. "They want to be an important part of the team, but they don't have all the answers." ■

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6 Strategies for Seamless Surgery Center Expansion

By Taryn Tawoda

Traci Albers, administrator at High Pointe Surgery Center in Lake Elmo, Minn., and Linda Phillips, RN, administrator at Southgate Surgery Center in Southgate, Mich., discuss strategies for completing an organized and profitable ambulatory surgery expansion.

1. Collect staff member feedback in the early stages. The expansion at High Pointe Surgery Center included a larger staff lounge and locker rooms, both of which were planned with ongoing feedback from employees. "Our staff lounge went from a small room to a beautiful new space with a kitchen. We also added spacious, modern locker rooms with additional restrooms," says Ms. Albers. "The additions made the staff feel appreciated and happy."

To gather initial design feedback, Ms. Albers says the center posted expansion plans on a bulletin board with an attached sheet for staff to write down suggestions. Staff members could also discuss feedback directly with designated department representatives who attended design meetings with the architect, contractors and management leading up to the expansion, she says.

This process allowed the center to incorporate specific staff member requests into the overarching vision for the expansion. "We told the architect that we wanted a calm, quiet environment," says Ms. Albers. Additional staff requests included a "homey living environment appropriate for families" in the front office.

2. Communicate often with staff members throughout the expansion process. Because changes occurred frequently during expansion, Ms. Albers says frequent communication with staff and physicians was crucial. "We had six remodeling phases, and there was something changing every week," she says. "We stayed operational through the whole thing; therefore communication was imperative."

Important rooms were often unavailable during the remodeling process, and staff members needed to be aware of how to handle patients on those days. "There was one point where we lost three phase two rooms — how would we accommodate patients on that day?" says Ms. Albers. "We had to recover patients in atypical locations, like pre-op. We had to adjust workflow and normal routines." Communication was necessary to keep all staff members organized and informed of these changes, she says.

3. Keep patients informed of the expansion progress. Patient satisfaction scores at High Pointe Surgery Center did not drop throughout the remodeling process despite the occasional need to use substitute

rooms, says Ms. Albers. "I attribute that to the staff, because they informed patients why we're doing this expansion and emphasized that the surgery center will be better when it's done," she says. "They did an exceptional job of managing patient perception throughout the entire process."

4. Don't overlook the addition of storage spaces. With a heavy focus on revenue-enhancing expansion, storage space is typically one of the first things eliminated when cutting building project costs, says Ms. Albers. But while storage space does not generate revenue, it is a significant staff satisfier that should not be overlooked. "We've been short-sighted in looking at our storage needs — more space would have been beneficial for us but because of the limited footprint we had to work with, we had to make difficult choices on what stayed what was eliminated," she says. "You really do need storage in ancillary spaces to support the ORs."

5. Pay attention to small details in the early phases. Simple details like locks and door stoppers are easy to overlook but can end up being significant daily inconveniences for the staff if not appropriately planned. "When the OR staff was hauling garbage into closets, we realized we needed hold-open doors," says Ms. Albers.

It is also a good idea to double-check assumed measurements before proceeding with remodeling. "We installed privacy doors in pre- and post-op rooms, and we assumed that they were wide enough to fit gurneys and wheelchairs," she says. "But we should've taken a closer look at dimensions early on — we ended up making modifications to the doors to give us additional space. Little things like that make a big difference to staff on a day-to-day basis."

Ms. Phillips says she wishes Southgate Surgery Center had incorporated space for a second receptionist at the front desk and a private room to meet with families. "When you're doing your floor plan, you never think of everything you should plan for, and there's always something you wish you would've thought of," she says. "I wish I could have added two more rooms for pain cases."

6. Expand with the future in mind. Ms. Phillips says it is important to incorporate the surgery center's long-term goals into any plans for expansion. "In three years, my goal is to add another specialty, for example," she says. "When new physicians come on board, they trial you and don't bring in as many patients. But we made two overflow bays, just in case we get busy, or just in case someone has an extended recovery time. Now, we're at the point where those are regularly used bays, so it was a good thing that we added them." If it is possible to build for the future without taking up a large amount of non-productive space, the surgery center should do so, said Ms. Phillips.

In the business office, Ms. Phillips planned for extra phones, faxes and copiers. "We installed a phone jack in every spot where somebody could potentially sit, even without adding phones at the time," she said. The expansion also included several multi-purpose rooms equipped with a built-in wraparound desk and overhead shelving to handle present and future employees. "We made it so that multiple people — transcription, billing, marketing and finance employees — could work in that room when we needed them, and it has been immensely useful," she says. ■

Trending Toward Hospital Employment: Where Do Spine Surgeons Fit? Q&A With Dr. Robert Bray

By Taryn Tawoda

Robert S. Bray, Jr., MD, a neurosurgeon and the CEO of DISC Sports & Spine Center in Marina del Rey, Calif., discusses the past, present and future state of spine surgeon employment.

Q: What trends have you seen over the years in the employment of spine surgeons?

Dr. Robert Bray: I've been in spine practice for a long time, and I have seen a massive change in the structure of healthcare delivery medicine. Years ago, you could work in academics or private practice — there were two options. Then HMO structures developed over time — you could be an employee of a large, hospital-based HMO, and that was a good choice for many people. But then the pool of money shrunk, and that is part of the "healthcare crisis" that was created. The cost of healthcare has gone up, premiums have gone up. Insurance companies started paying a lot less to doctors. Medicine was one of the only businesses in the world where you saw a drop in income.

One of the advents of ways to deal with that was hospitals starting to figure, "We need a bigger piece of this pool. We'll hire physicians on a salary and make a profit off of them." As a result, hospitals increased their net revenue piece by beginning to own the physicians.

So hospital-based employment became an ever-rising piece — you saw 40 to 50 percent of physicians coming out of practice and becoming employed by a hospital.

Q: What was your response to the rising trend towards hospital employment?

RB: An alternative — and my response — to hospital employment has been DISC Sports and Spine Center. I put a group of private practitioners together that included 40 physicians specializing in spine, pain management, orthopedics and sports medicine, and it became one of the largest independent groups in the country. I've tried to create an entity in which private practice could thrive.

The short answer is that the hospitals employing physicians take a large market share, and they take newer people out of practice because they don't know how to run a business. These physicians don't want to go to an HMO structure or academia, so they get employed by a hospital

Now, structures like DISC are evolving all over the country. In ambulatory surgery centers, we own the ORs, we do the surgeries in our own ORs. We had to take back a piece of the technical fees in order to survive, and we had to become competitive with the hospital. The top quality people are gravitating toward these evolving structures where the business of medicine is done by a structure with enough power to compete with a hospital. But to do everything outpatient requires a massive business investment — it costs about $7.5 million to build and be turned profitable.

Q: How are other specialists affected by hospital employment? How does this tie into the employment of spine surgeons?

RB: Anesthesia has become a difficult topic. Hospitals are cutting contracts with anesthesia groups, and they restrict the entire hospital to that group. My anesthesiologists can't get on the staff of a hospital because they all have structures exclusive to a group. So, where does the pain management guy go? How does he get credentialed? You have to be credentialed in a Joint Commission-approved facility, but you can't get in as a staff member anywhere.

With spine, where does this whole thing end? Will I be next, not able to go on staff at a hospital? Structures like mine will form working relationships with hospitals. The two parties will stop competing and start sitting down to figure out where it really stands. It has begun in some places — hospitals buy groups but leave some autonomy.

Q: What do you predict will happen with hospital employment in the future?

RB: None of my doctors are employees — they are all stockholders in the surgery center and practice. Hospital administrators will say they can handle the business and management end, that doctors should be doctors. For many people it is a good answer, or the numbers in hospitals wouldn't be so high. But I think the top specialists will tend to want to have a structure where they can do things the way they want to and own a bigger piece of the business. ■

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10 Steps to Increase the Value of a Surgery Center

By Rachel Fields

Hospital mergers and acquisitions increased 12 percent in 2011, according to a Levin Associates report, with surgery center deals following suit. More healthcare facilities are likely to sell part or all of their business, meaning leaders must understand the factors that impact valuation. Here Jason Ruchaber, CFA, ASA, partner with healthcare valuation firm HealthCare Appraisers, discusses the three levers of valuation — earnings, risk and growth — and 10 steps for a hospital or surgery center to increase its value.

Earnings

1. The more money you make, the more you're worth. Mr. Ruchaber says the correlation between earnings and value is pretty straightforward: The more money you make, the higher your valuation. He says to increase value, a hospital or surgery center should have a solid understanding of their financial position and be able to articulate the steps they are doing to maintain and/or enhance earnings. "When we're doing financial analysis, we want to see a center or hospital that has a good grasp of what they're doing financially," he says. This means creating budgets and analyzing variances, evaluating costs on a regular basis, and understanding the contribution margin of different case types/service lines.

2. Understand how you compare to others. Mr. Ruchaber says benchmarking is essential for surgery centers and hospitals to determine if their finances are in line, and a key component of the valuation process. He says when valuing a facility, he frequently asks questions like, "How do your staff costs per case compare to your competitors in the area? How does reimbursement vary by surgical specialty?" He also asks questions about any outliers on the facility's financial records, such as a month with particularly high or low case revenue or non-recurring expense. He says facilities that are able to explain outliers will generally command a higher value than facilities that do not understand why finances are fluctuating. "Great facilities frequently measure and know where they stand relative to others and understand why variances exist," he says.

3. Hire a CPA. Don't depend completely on your facility staff to keep your finances in order, Mr. Ruchaber says. He recommends "routinely engaging an accounting firm to assist, compile, review, or in the best case, audit the financial statements." He says this helps a valuation firm or buyer know that financial information is accurate and reported under generally accepted accounting rules.

4. Enhance profitability with "quality earnings." Not all earnings are created equal, Mr. Ruchaber says. "You want to pursue high-quality earnings that are sustainable and not overly risky," he says. He says his company looks for earnings that don't have a risk of substantially changing based on only one or two changes in the environment.

For example, some facilities depend heavily on an out-of-network reimbursement strategy, meaning they don't contract with payors and instead bill higher out-of-network rates. This strategy may generate significant profits, but due to increased pressure from payors on referring physicians and patients, out-of-network cases are harder to come by. "The reason out-of-network is so risky is that the likelihood it will change is al on the downside," Mr. Ruchaber says. "Reimbursement for these cases is unlikely to go up. However, when payors stop paying these charges or when a facility transitions to in-network, it'll have an immediate and material impact on the bottom line."

Risk

1. Understand why your metrics are changing. Some aspects of a healthcare facility's business are unpredictable. "It's not always possible to predict whether someone's going to come in with a heart attack, stroke, etc.," Mr. Ruchaber says. "It's important to understand the business metrics that show signs of a problem." He says the main way to mitigate risk is to understand your business: If you can explain why revenue is down or readmissions are up for the month, you will be less susceptible to sudden, unexplained changes that negatively impact the bottom line.

For example, he says a hospital with high readmission rates might actively track the diseases most likely to result in readmissions, then target those diseases to lower rates. Even if readmissions stay high in some areas, you should be able to isolate those areas and say, "We know readmissions are up because of this area" rather than, "We really don't know what's going on."

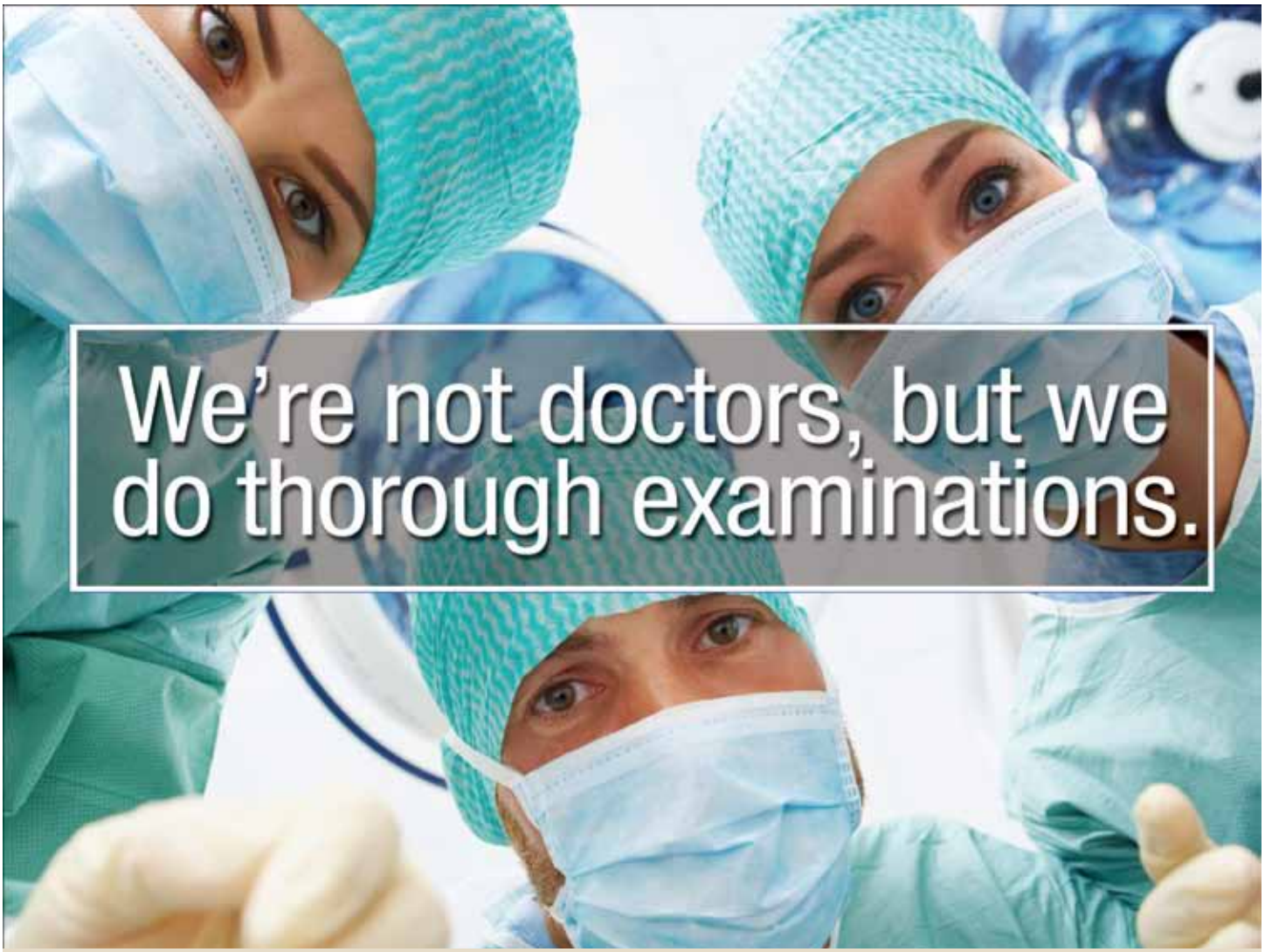
2. Diversify sources of revenue. Mr. Ruchaber says facility risk increases when revenue depends on a few key specialties, physicians or payors. If the majority of a hospital's business

comes from a cardiology service line, the hospital will suffer financially if reimbursement rates drop, a scandal prevents patients from coming to the hospital, or high-volume cardiologists leave.

"From a finance standpoint, risk is really evaluated based on the likelihood that the actual results will deviate from the expected results, and by how much," Mr. Ruchaber says. He says a strongly diversified facility is less likely to deviate materially from the "expected results" line. Facilities that are not well diversified will are subject to more significant "ups and downs," which poses greater risk to an investor.

3. Improve payment processes. You may have payors that take a long time to pay claims, driving up your A/R and creating more risk for your facility. Mr. Ruchaber says while most facilities cannot control their payor base, which depends on the employers and major insurance companies in the region. However, they can ensure proper coding and billing processes are in place and work with individual payors to improve contracted rates and payment times. "If an individual payor is taking longer than others, you may be able to improve the value of your business by improving the efficiency of the payment process and getting your A/R balances down," he says.

4. Credential dependable physicians and hire great staff. Nothing can hurt a facility's finances as quickly and irreparably as a bad reputation, Mr. Ruchaber says. If your facility has a scandal surrounding a quality issue, patient volume and physician referrals will drop significantly. If your facility has rude staff, disruptive physicians or other unprofessional behavior, you will lose affiliated physicians and their patients. "Make sure the credentialing process is set up to bring in top-quality physicians," Mr. Ruchaber says. "Though increased volumes may be desirable, centers need to understand the risk they take in bringing on disruptive doctors."



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He says the facility should also concentrate on patient relations. Most centers believe that they are doing a good job, but few actually take the time to actually evaluate this from a patient's perspective. When Mr. Ruchaber walks into a facility on a site visit, he first examines the reception and waiting areas for signs of trouble. If possible, he tries to observe interactions between the staff and patients, but he also evaluates his own interaction. "Do I have to wait for ten minutes to talk to the receptionist, or am I greeted quickly? Is the tone pleasant and cheerful or stressed and curt?" he says. He also looks to see if the facility has its front office organized and in good order? "What's going on behind the front desk can be a reflection of what happens in the ORs," he says.

He also looks at the cleanliness and condition of the other areas seen by patients. "Surgery is stressful, and when a patient can look around and see that attention is given to the minor details, it adds a level of comfort to the overall experience," he says. He says good customer service mitigates risk and enhances profit, both of which increase value.

Growth

1. Understand where potential for growth exists. "All things equal, higher growth equals higher value," Mr. Ruchaber says. "The highest multiples are generally paid for those centers demonstrating strong growth." Because growth is key to a successful valuation, he says his company looks for facilities that understand where they can expand case volume and recruit physicians. "It's about understanding the demands of the community and the population base," he says.

He says he likes to see a facility that puts together budgets and actively pursues different strategic initiatives, whether they're business, clinical or expansionary. He says growth is also related to the quality of the institution; a facility with high-quality equipment, updated operating rooms and capable staff is more likely to attract physicians and patients than one in need of significant upgrades.

2. Be wary of growth that comes with substantial risk. Not all growth is good growth, Mr. Ruchaber says. He says the three "levers" of valuation — earnings, risk and growth — are so closely interwoven that certain kinds of growth do not result in greater value. "While they're focusing on the growth lever, they may also be increasing the risk lever," he says.

For example, he says some surgery center choose to implement spine procedures because reimbursement rates are high and the specialty was only recently introduced to ASCs. "Spine takes a bit of capital expenditure and extra training for staff, and the volume may not materialize" he says. "We don't want to see a surgery center trying to bring in volume at the risk of its patients, spending too much on capital and opening up too many ORs when they don't have the volume guaranteed."

He says hospitals and surgery centers should never base growth on the idea of, "If you build it, they will come." You have to know whether the service is needed and wanted in the community before spending money and time on implementation. ■

Learn more about HealthCare Appraisers at www.healthcareappraisers.com.

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8 Steps to Maximize the Price of Your Surgery Center

By Laura Miller

Joan Dentler, president and CEO of Outpatient Strategies and ASC Strategies, discusses the key steps for physician owners when selling part or all of their surgery center to a hospital or corporate partner.

1. Focus on the value of your center to the future buyer. Whether the future buyer of the surgery center is a hospital or management company, you want to focus on what the facility could provide them. Even though the surgery center may have been very busy and profitable for physician partners in the past, focusing on the past doesn't make the center valuable in the future.

"Make it easy for the potential buyers to see how the purchase would benefit them," says Ms. Dentler. "No buyer really cares how good of an investment the surgery center has been for you."

Instead, focus on where opportunities lie in the future for the buyer and discuss any strategic advantages the surgery center would have for its new owners. If the new owner is a management company, they could bring better vendor contracts, reduce expenses or help the center recruit new surgeons to increase patient volume for enhanced revenue. If the potential new owner is a hospital, the surgery center could alleviate crowded operating rooms with out the cost of new construction or introduce them into a new market.

2. Tailor your presentation to its audience. Selling to a management company is different from selling to a hospital, and different qualities appeal to each entity. Management companies are looking for ways they can improve the center to increase revenue and profitability while hospitals are more concerned with the strategic advantage a center could bring to the marketplace.

"Surgeons often want to talk about how much money the center has made them and how great it is, but if it's already so great then the management company may not see any opportunity there," says Ms. Dentler. "Show management companies where the growth will be. Show them how far you've taken the center and then how they can help you take it to the next level."

From the hospital perspective, surgeons can gain leverage through logistical merits. The value of the surgery center would be the highest if the center is within 35 miles from the hospital campus, so the facility can be receive provider-based designation from CMS. "Hospitals will want to know if the facility meets the specifications to become a provider based department of the hospital," says Ms. Dentler. "Most management companies now want to partner with hospitals as well. Even if the management company is buying the surgery center, they are looking to see if it would fit into the portfolio to sell to the hospital sometime in the future."


Joan Dentler

If the surgery center is outside of the 35-mile radius, the hospital could keep it a free-standing ASC and consider itself expanding into a new market. "Some hospitals want to buy an ASC in a competing market and put their flag in the ground," says Ms. Dentler. "If it is successful, they may build physician offices and other ancillary services around it."

If the center includes high-volume or noteworthy surgeons in the community, that can add value to a hospital wanting to align with those physicians. Finally, if the surgery center is operating in a certificate of need state, the value to both hospitals and management companies increases dramatically.

3. Spark interest from multiple potential buyers. Surgery centers looking to sell should have multiple potential buyers to bid up the price. If buyers aren't already knocking at your doorstep, create a simple prospectus and send it out to several parties, including:

- Physicians
- Private investors
- Management companies
- Hospitals and health systems
- Payors

All these may be interested in acquiring all or part of the center. "It's never a good idea to take the first and only offer you receive without doing at least a little more 'fishing' for other interested buyers," says Ms. Dentler. "The best situation for owners is to have multiple suitors who end up in a bidding war."

4. Highlight opportunities to grow. If there is unused capacity at your surgery center, discuss how the ORs could be filled in the future. Identify surgeons who aren't currently involved with the center but could bring cases in the future. "Have a list ready for the hospital or management company to show them you've done your homework," says Ms. Dentler. "Give them the opportunity to see which surgeons in the community could potentially bring business there in the future."

If the center is at capacity, identify places where you can cut costs. However, it's important to confirm that any cost cutting won't come at the expense of quality. "Show the buyer where the ASC could cut without sacrificing quality," says Ms. Dentler. "For example, with the addition of a management agreement the center should be able to reduce administrative staff."

Providing additional ways the center could drive case volume under new ownership also allows the buyer to see potential in the future.

5. Reassure buyers you won't leave the center. Buyers are often worried that they'll cut a big check to the physicians for the center and as soon as the transaction is final, the surgeons will retire or spend more time on the golf course than in the operating room. "Give the buyer confidence that existing surgeons aren't going anywhere," says Ms. Dentler. "The buyer is looking forward and wants to know how the next 10 years will go."

If the senior surgeons who currently drive patient volume are nearing retirement, give the buyer insight into your succession planning. There should be physicians prepared to take over an aging surgeon's caseload once he retires.

6. Have your own valuation performed. Physicians often balk at the expense of performing their own valuation of the center, especially if the buyer provides one. However, each valuation expert is different and bringing multiple perspectives to the table can make a difference when it comes time for negotiations.

"The valuation company that the buyer uses will be reputable, but you still want to do your own valuation," says Ms. Dentler. "Three different companies could look at the center three different ways. Surgeons are often swayed by people coming in and offering them a big check. They should spend a little of that money for a valuation and have experts on their side."

However, surgeons must be realistic about what their surgery center is worth. Demanding a higher price than the center's worth will drive others away. "Understand and be realistic about the value of your center to a potential buyer," says Ms. Dentler. "Don't let ego or emotion get in the way of a good business deal. As I tell clients, it is similar to a person thinking their house is more valuable because they raised their children there; it doesn't work that way."

7. Remember that it's a seller's market. Right now, the ASC industry is in a seller's market, so you may not need to pay extra for a broker. "Doctors need to know it's a seller's market and there is no shortage of buyers out there," says Ms. Dentler. "Be wary of high broker fees that are based on a percentage of the sales price and take money out of the owners' sale proceeds. It's a seller's market in the ASC industry, so finding interested buyers isn't difficult. In many cases, you don't need a broker's help to create interest or identify potential buyers for your center."

Another area of negotiation should be any services agreements that are required by the buyer as part of the sale. These are typically for things like management, billing and/or IT services "Be sure you understand exactly what the scope of services will be, how they will be delivered to the center," says Ms. Dentler. "The ASC industry has matured and here are now many different ways services can be provided and fees for these services are structured these days — e.g. declining or capped fees, shorter contract terms, performance incentives, etc."

8. Look at how the agreement after taxes and how it impacts individual physicians. Each physician should have their personal counsel and tax advisors analyze the deal before making it final. Just having one surgeon go through the deal isn't good enough because it may impact each surgeon differently. "Make sure the partners review the final deal with their personal attorneys and tax advisors so that everyone truly understands all of the personal implications of the sale and has taken into account the 'after-tax' amount of the final offer," says Ms. Dentler. "Ask your tax advisor if there is a different way to structure the sale so it's better for the sellers." ■

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Building a Physician-Hospital Joint Venture Overseas: 6 Points on Regent Surgical Health's Irish Partnership

By Rachel Fields

In December 2010, Regent Surgical Health CEO Tom Mallon received an email from an overseas hospital consultant. Recognizing Regent's experience in facilitating physician/hospital joint ventures, the consultant asked if Regent would be interested in working with a group of physicians in Ireland. The consultant quickly followed up with a phone call to discuss the opportunity and overall concept. Since 2010, Regent has been working to facilitate a physician/hospital joint venture which will culminate in the establishment of a dedicated neuroscience presence in a community (private) hospital based setting.

On Feb. 28, 2012, Regent entered into a 10-year agreement between Hermitage Medical Clinic, one of Ireland's premier privately owned hospitals, Accelitech, the leading developer of Stereotactic Radiosurgery (CyberKnife) Programs in the U.S., and Ireland's leading neurosurgeons and radiation oncologists. "The partnership between Hermitage Medical Clinic and the local surgeons is the first physician/hospital joint venture of its kind in Ireland," according to Eamonn Fitzgerald, CEO of Hermitage Medical Clinic.

Here are six points on the company's partnership with Accelitech, Hermitage Medical Center and the Irish neurosurgeons involved in the deal.

1. Regent's first answer was "no." Regent was initially retained to facilitate the development of a privately held inpatient hospital dedicated to the diagnosis and treatment of neurologic and neurosurgical disorders. The company's original task was to give the physicians a "reality check" and determine if the proposed hospital venture, as designed, was worthy of investment given Ireland's challenging economic environment and highly regulated permitting and construction process, coupled with a highly evolved national insurance program that provides coverage to 48% of the population.

As the unbiased third party, Regent leadership reviewed physician practice patterns, related surgical volumes, payor mix and revenue projections. The collective data was then reviewed and downloaded into Regent's database. The outcome of Regent's first and most important task was to tell the physicians, "No." Despite the physicians' best intentions, the numbers simply did not work, and an alternate strategy for a much-needed service needed to be designed and implemented.

2. Breaking new ground with a physician/hospital joint venture. The majority of Ireland's private hospitals are "privately" held by local investors. Partnerships and joint ventures between physicians and hospitals are relatively unheard of in Ireland, and Regent believes this is the first joint venture of its kind to be established in the country. "Ireland's current healthcare delivery system does not align the interest of the physician with those of the hospital. Historically, physicians would try to do a project only to be met with resistance from the hospital or the payor community. Conversely, hospitals would try and implement programs in absence of the physician, which is a recipe for failure," says Michael McKevitt, senior vice president of business development for Regent Surgical Health. "There had never been a pure project whereby a private or public hospital had elected to partner with an existing group of specialists around a specific service line and related technology."

"Due to the originality of the arrangement, Regent and Accelitech invested lots of time gathering insights from the physicians and the payor community prior to moving forward with investment," adds Mr. McKevitt. "Based on our experience in working with hospitals and healthcare organizations, our role is to educate stakeholders on the strategic need to provide the highest standard of care at the lowest cost. Thus insuring both physicians and hospitals to not only survive but thrive in a challenging economy."

3. Getting insurance providers on board. As stated, 48 percent of the population in Ireland is enrolled in the government's health program, and the other 52 percent of the population is privately insured, with one insurance company (VHI) insuring the vast majority of patients. Regent and Accelitech, on behalf of the proposed partnership, needed to quantify demand for a dedicated neurosurgical service. "We did an inventory of the neurosurgery and radiation oncology physician community and then set out on the task of meeting with physicians nationally to gauge interest and support," explains Scott Milligan, chief development officer for Accelitech. "Concurrent with our efforts, neurosurgery leadership, directed by Danny Rawluk, MD, was required to meet with VHI clinical leadership and educate them on the merits of a dedicated neurosurgery program and the expansion of covered services." Knowing that the proposed service would ultimately reduce the cost to provide care, each of the country's insurance carriers expanded coverage to its enrollees.

Mr. McKevitt says Regent was surprised by the high level of private insurance present in the Irish marketplace. "The existence of private insurance made it possible to create a private service around neurosurgery," he says. "It's more similar to the U.S. than some of the other European markets. From a process standpoint, this project may have moved faster for us had we not elected to meet with the insurance providers to verify coverage and the expansion of services. One can never assume coverage, and we had to provide clinical evidence that the proposed service was fundamentally sound from a clinical and financial perspective, especially for those cases that require CyberKnife technology."

He says that in an environment where a handful of payors dominate the market, any problems with reimbursement will have a significant effect on profitability.

4. Outpatient surgery is necessary in Ireland and beyond. "One of the most surprising things about Ireland was the absence of outpatient surgery centers," said Mr. Mallon. "There are no freestanding surgery centers in the country. I think we also found that there are significant inefficiencies in the healthcare system, given the economic condition of the country and the weight of paying for the government programs."

Mr. Mallon says one of the biggest questions in Irish healthcare today is: How do you control the cost of healthcare when you have a long waiting list of patients? He says the simplest way to reduce healthcare costs in this scenario is to reduce access to physicians. "This ignores the fact that the easiest way to reduce the cost of care is to build freestanding ambulatory surgery centers that are clean and efficient," he says.

5. The distance creates some challenges. Scott Milligan, chief development officer for Accelitech, says that one of the most significant hurdles for his company will be the implementation of the CyberKnife Stereotactic Radiosurgery System in the surgery center. "The biggest challenges we face are training of staff and various health specialists to utilize the equipment and bring the program live," he says. "It's not like we're flying to Toledo, where there's a small gap in distance."

But he says despite challenges with implementation, there is room for significant growth for CyberKnife in the Irish market. "It's an extremely underpenetrated market with a lack of technology," he says. "From that perspective, you would expect there to be a higher demand in a location in Ireland than we would see here in the U.S."

6. The joint venture creates a strong foundation for growth. So what's ahead for the Regent partnership with Accelitech, Hermitage Medical Center and neurosurgeons? "We are fortunate to have Hermitage Medical Clinic as our partner in this venture," says Joyce Deno-Thomas, senior vice president of clinical operations. "Since opening in 2007, HMC has established itself as a leader in providing a higher standard of care to the Irish community. It is a tremendous facility with an exceptional staff; we are simply building upon a foundation of clinical excellence."

Regent is accessing current clinical capabilities from which a timeline for implementing expanded neurosurgical services will evolve. As part of the expansion, Hermitage will provide a dedicated operating theater with the latest technology. Additionally, the neurosurgeons are organizing themselves into a separate group practice model with the intent of increasing patient access and individual productivity. Collectively, the physicians will be partners in Neurosurgery Ireland, which will have its own identity in the market and be incorporated into a larger neuroscience program. ■

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

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Health Inventures Expands Business With New Service Lines

By Rachel Fields

Surgery center management and development company Health Inventures is diversifying its business with the addition of several new service lines, according to Christian Ellison, senior vice president.

The company is adding services lines in the areas of perioperative management and anesthesia services, physician services and human resources, according to Mr. Ellison.

Health Inventures officially launched the services last summer with the unveiling of its new website and has been marketing the services for the last nine months. He says the company's experience with surgery center management puts it in a good position to assist hospitals and physicians with provider alignment and OR optimization.

"The ability for doctors and hospitals to work effectively together is going to be critical to each of those entities' success long-term," he says. "In terms of running physician-led organizations, we have a track record of delivering results and seeing what works and what doesn't." ■

Learn more about Health Inventures at www.healthinventures.com.

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4 Options for Physician/Hospital Partnership: Thoughts From Dr. Chuck Peck of Health Inventures

By Rachel Fields

Hospitals and physicians are increasingly looking to partner in the face of healthcare reform, reimbursement reductions and market saturation. Here Chuck Peck, MD, CEO of Health Inventures, discusses four options for hospital/physician partnership.

1. Hospital/physician ASC joint venture. An increasingly common model of physician/hospital partnership is the surgery center joint venture, in which a physician group and a hospital each own a percentage of the ASC and benefit from its profits. Physicians are partnering with hospitals in order to gain negotiation leverage with payors and vendors, prepare for changes through healthcare reform and gain amenities such as electronic medical records. Hospitals are looking to partner with physicians on surgery centers to build relationships with local physicians, expand their market share and move appropriate cases to a high-quality, low-cost environment.

The division of ownership varies in hospital/physician ASC joint ventures. In many cases, the hospital prefers to own a majority of the surgery center, which generally benefits the surgery center's reimbursement rates and vendor contracts. Industry experts warn surgery center leaders to include clear guidelines on ASC operations in the contract: Physicians may want to maintain control over hiring staff, purchasing supplies and other operational decisions.

A joint venture that includes a hospital, physician group and ASC management company can benefit all three parties by providing hospital clout along with management company expertise. This type of joint venture generally starts with the formation of a separate company — a "holdco" — that is 51 percent owned by the hospital and 49 percent owned by the management company, or a 50/50 split, Dr. Peck says. The holdco then owns the majority of the surgery center, and the physicians own the rest. This allows the hospital to maintain majority ownership of the surgery center while giving most of the operational control to the management company and physicians. Alternatively, the management company can invest directly in the ASC alongside the hospital and physicians.

2. Clinical co-management of a service line. Clinical co-management means that independent physicians contract with a hospital to jointly manage a clinical service, such as an orthopedics service line. "It's typically what I would call a dyadic management structure, with the physicians driving the clinical quality initiatives and achieving economic benefit through achieving quality results," says Chuck Peck, MD, CEO of Health Inventures. In this situation, the physician group acts as a sort of "general contractor" for the hospital and is paid a pre-determined amount based on fair market value, rather than receiving distributions from the service line. The physicians may also negotiate a bonus structure that rewards them monetarily for meeting quality targets or improving satisfaction.

Management and operation of the service line is then divided between the physician leaders and some staff from the hospital. "They're paired with an administrator and manager, and the service line includes the inpatient and outpatient sides," Dr. Peck says. This model could also include a management company to provide some of the required administrative services.

3. Physician employment. Physician employment is becoming increasingly popular as hospitals seek greater control of their referrals from physicians. Younger physicians, on the other hand, are often looking for more stability than an independent practice can provide, and hospitals that can provide attractive salaries are likely to scoop up those providers from the market. Dr. Peck says there are certain hospitals and health systems that allow employed physicians to have an arrangement with the surgery center that allows them to receive distributions, though this model is uncommon. "Most hospital systems basically take the position that if you're my employee, you're not going to receive income from another source," Dr. Peck says.

In some cases, however, he says physicians have pushed back and the hospitals have allowed a joint venture arrangement. In this case, the joint venture ownership and any related expectations would be included in the physicians' employment contracts.

4. Physician administrative services company. In this situation, the hospital or health system offers services to an independent medical practice for fair market value. "For example, an independent practice might desire the billing services or electronic medical records that an independent practice doesn't want to be bothered with or can't afford to implement," Dr. Peck says. "This model allows physicians to remain independent but access the professional services they will need to survive and thrive."

Under this model, the hospital benefits by strengthening its relationship with its physicians through the support it provides the practices. It can also be a great forum through which to implement clinical integration. Dr. Peck says a further step would be to include the physicians and, potentially, a management company in the ownership of the services company in order to create aligned incentives among all the stakeholders without the physicians have having to become employed. ■

Learn more about Health Inventures at www.healthinventures.com.

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10 Statistics on the Ambulatory Surgery Center Industry

By Rachel Fields

Here are 10 statistics on the surgery center industry in the United States, according to VMG Health's *Multi-Specialty ASC Intellimarker 2011*.

Number of freestanding ASCs in the United States: 5,876
Number of freestanding ASCs developed every year: Approximately 200
Percentage of ASCs owned/managed by multi-facility chains: 22.3 percent
Total ASCs owned/managed by multi-facility chains: 1,312 ASCs

Largest owner/operator of surgery centers: AmSurg (with 208 facilities in 2011)
Number of states with CON laws as of 2011: 26
State with the highest number of Medicare-certified ASCs as of 2011: California (668 ASCs)
Percentage of surgery cases performed in the outpatient setting in 2009: 63 percent
ASC reimbursement as a percentage of HOPD reimbursement in 2003: 87 percent
ASC reimbursement as a percentage of HOPD reimbursement in 2011: 56 percent ■

Learn more about VMG Health at www.vmghealth.com.

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Expanding Health Inventures Past ASC Management & Development: Q&A With Senior Vice President Christian Ellison

ASC management and development company Health Inventures is in the midst of major changes. Last summer, the company introduced three new service lines: perioperative management, physician services and human resources. This diversification takes the company well beyond the bucket of surgery center management — an interesting and powerful move in a healthcare industry increasingly focused on the "continuum of care." Here Christian Ellison, senior vice president of corporate development for Health Inventures, discusses what drove the change and how the company is reaching out to clients old and new.

Question: What drove Health Inventures to diversify its business, and where did you start?

Christian Ellison: Chuck Peck became our CEO in the beginning of 2011, and his strategy was to diversify our business beyond ambulatory surgery development and management — to really evolve with the needs of our hospital partners. Health Inventures has been focused almost entirely on physician/hospital joint ventures since 1995, which is longer than any other surgery center company in having that exclusive focus. When we looked at what we do really well and what will be important to our customers in the future, we viewed it not as running surgery centers, but as really helping doctors and hospitals work well together.

We started looking at other areas where we can leverage our ability to do that. One area is the hospital surgical environment — really helping hospitals optimize the performance of their inpatient operating rooms, providing consulting as well as interim management services. Another area within that bucket is working with hospitals on optimizing their anesthesia relationships. A lot of them are paying subsidies to anesthesiologists, which is usually caused by inefficiencies in the OR or supply and demand of anesthesiologists. We are helping hospitals and physicians work through that.

Q: In what other areas are you expanding?

CE: The second area is physician services, and it probably falls into two areas. One is physician/hospital integration, which means working with doctors and hospitals to find ways to work together more effectively. In some cases that means direct employment, and in some cases it would take the form of some other model. The other area is helping physician practices run more effectively from an operational perspective, and that would apply to hospital-owned physician groups and independent physician practices. Those services would include consulting as well as long-term management.

The third area of expansion is human resources. We've always had a human resources company that employs staff in our surgical facilities, and we are taking that to the market and selling it to other small healthcare businesses, physician practices or surgery centers that we don't operate. We will help them by providing outsourced HR services. That service will provide value because we're more than your typical professional employer organization; we understand the healthcare business.

Q: When did Health Inventures start offering these services?

CE: We officially launched them last summer, when we went live with our new website. We've been marketing these services to varying degrees over the past nine months. We do have customers in each of these areas beyond our core ASC business, so it's been a slow, deliberate ramp-up over the last nine months, and we're taking hold now in the market.

Q: How did you go about introducing these services to the market? Did you start with existing customers or pursue new territory right away?

CE: We first introduced this to our existing customers. They know us and they trust us, and they're willing to take a chance on us doing different things. We run three surgery centers for OhioHealth, and they just contracted with us, so we've been able to leverage our relationship with that health system. Once we contacted our existing customers, we started marketing more aggressively to the marketplace.

We've gone to past customers, where we had good, strong relationships, and we're also taking on new customers. We had our first perioperative consulting engagement back in the fall of 2011 with a new customer to the company. We signed the first long-term physician practice management contract with an orthopedic group in the Northwest this spring. ■

5 Tactics to Negotiate Better Reimbursement Rates for ASC Orthopedic Cases

By Rachel Fields


Rob Janeway

Orthopedic cases rely on successful payor contracts to be profitable, due to high implant costs that can quickly derail profitability from a good reimbursement rate. Rob Janeway, Industry Relations & Contracts Manager for MedBridge, discusses five tactics for ASC administrators and leaders to negotiate profitable payor contracts for orthopedic cases.

1. Understand your vendor costs before payor negotiation. Never go into a payor negotiation without a thorough understanding of your implant and supply costs, Mr. Janeway says. "If you know the implant cost will be expensive, you want to know that you're not going to worry about bringing the case on," he says. "You should know the costs for the cases you are doing, as well as the cases you could be doing but aren't because they require high-cost equipment and implants."

He says a good strategy for payor negotiations is to "ask for what you need, and know your historical case data." If a payor isn't accommodating, you should always have data on your implant costs available at the negotiation. "It's always best to come equipped with information on your implant costs and volume," he says. "Your payor contracts should always ensure the costs of implants are covered."

2. Collect data on cases that your physicians take to the hospital. You may be able to convince payors to give you a higher reimbursement rate if your physicians take ASC-eligible cases to the local hospital. According to a May 2012 report from Objective Health, the 2012 Medicare payment rate for shoulder arthroscopy was $1,201 for ASCs, which is 42 percent lower than the $2,085 price tag for the same procedure in hospitals.

Since payor rates often follow a percentage of Medicare, your payor will likely pay significantly more to send an orthopedic case to the hospital than to your ASC. Your payor may also need to be educated about the benefits of sending certain cases, such as total joint replacements, to surgery centers. Minimally invasive surgery has enabled ASCs to perform procedures that were previously untenable in an outpatient setting, so bring a physician to the negotiation to explain which cases are appropriate for your center.

3. Know which implants you perform most commonly, as well as your high-cost outliers. Look at historical data to determine your most commonly-used implants and your most expensive ones. "Sometimes you have a certain procedure that requires fixation, and you may only have ordered a device once in the last two or three years, but it costs $3,000," Mr. Janeway says. "You need to know about those outliers when walking into a negotiation." Be sure to look at your most common implant cases as well as your most expensive implants: High case volume can mean high costs over time, even if the individual implants cost less than your center's average.

4. Understand your payor's strategy for paying implants. "Each payor has a different strategy for paying implants, and you should know the strategy before negotiating reimbursement rates," Mr. Janeway says. Some payors don't give carve-outs and instead offer a bundled rate for the procedure, which makes it important to know your costs so that you don't go over budget on implants and supplies. Some payors will pay the implant based on the invoice, while others will only pay for implants when certain medical criteria are met. He says certain payors impose a minimum threshold in the contract. "Only if they cost above a certain dollar amount will they be reimbursed," Mr. Janeway says. "If they're telling you that you need to hit at least $500 in implants to be paid, you need to know how often your cases will involve implants with less than that dollar amount. Don't be afraid to educate them."

Inversely, he says some payors place a cap on implant costs and will only pay up to a certain dollar limit. "If that's not meeting your center's needs because your implants are generally more expensive, you need to come to the table with that information," Mr. Janeway says.

5. Be careful with payors who use groupers for orthopedic rates. Some payors use fee schedules modeled on the old APC grouper rates, which frequently place orthopedic procedures in lower group numbers than appropriate. "It's very important know where your procedures fall into that fee schedule, especially if it's based off a grouper system" he says. If your orthopedic procedures are in a lower group than is profitable for your ASC, you need to know so that you can negotiate carve-outs for those procedures. ■

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Aetna Files $20M Lawsuit Against California ASC Company for Alleged Overbilling

By Rachel Fields

Insurance company Aetna has filed a $20 million lawsuit against a Northern California surgery center firm, claiming the company is overbilling the payor, according to a Sacramento Bee report.

The lawsuit, filed in Santa Clara County, claims Bay Area Surgical Management recruited physicians to invest in its seven outpatient facilities in a scheme to help physicians profit by sidestepping state laws. The payor alleges the surgery center firm overbilled Aetna, billing $66,100 for a bunion repair, $6,642 for a colonoscopy and $23,301 for a knee arthroscopy.

Bay Area Surgical Management denies Aetna's allegations and says the insurance company is using the lawsuit to strong-arm patients away from its facilities. ■

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Negotiating Reimbursement in Office-Based Surgery Centers: Q&A With Dr. Cory Lessner and Dr. Andrew Shatz

By Taryn Tawoda

Surgeons at SightTrust Eye Institute, a recently opened freestanding surgery center in Sunrise, Fla., will perform cataract and premium intraocular lens procedures despite the fact that such procedures are not typically recognized or reimbursed by payors if performed in a physician's office.

Cory M. Lessner, MD, president and CEO of SightTrust Eye Institute, and medical director Andrew Shatz, MD, discuss the strategy behind launching an office-based surgery center, including the process of securing reimbursement for these procedures.

Q: What prompted you to open an office-based surgery center that performs cataract and premium intraocular lens procedures, particularly given that procedures like cataract surgery have not been recognized by insurance companies if performed in a physician's office?

Dr. Cory Lessner and Dr. Andrew Shatz: The idea of opening an office-based surgery center was born from the need to address two major concerns that we had: one financial and the other philosophical. On the financial side, building out an ambulatory surgery center that would follow Medicare's requirements for OR size, elevator weight, egress and others would have necessitated moving our cataract practice off-site, thus separating it from our LASIK center. This would have made it more difficult to share our technical and administrative staff, and would have unacceptably inflated our costs. Additionally, we felt that a cataract and premium intraocular lens-only center could be run more efficiently, with a smaller physical plant and staff than an ASC.

Philosophically, SightTrust Eye Institute has built its reputation as a premium lens center both by providing excellent surgical results and by creating a calming atmosphere for our patients. Since our office is accredited by the Accreditation Association of Ambulatory Health Care as well as licensed by our state Board of Health, we are held to the same standards as ASCs. This should make it appealing for insurance companies to allow their insured members to use our center.

Q: Generally speaking, can you elaborate on the financial and professional benefits of operating an office-based surgery center?

CL and AS: One of the greatest benefits of operating our own office-based center is the ability to perform surgeries in a relaxing environment for both patients and staff. There are fewer layers of governance and management, and changes can be implemented in real-time. Since our office staff also doubles as our surgical staff, there is a continuity of care from the initial evaluation through the post-operative visits that our patients appreciate. Financially, the initial start-up costs of an office-based surgery center are less than those of an ASC, and it can become operational and certified more quickly.

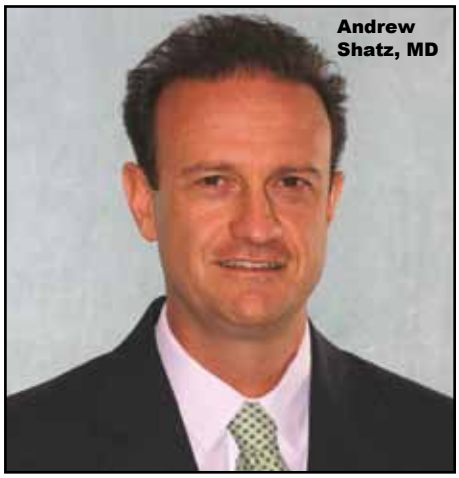
Q: You mentioned that you've designed a fully accredited facility that follows the same health and safety rules as ambulatory surgery centers. Can you elaborate on these rules?

CL and AS: Our center has recently become accredited by the AAAHC, as well as licensed by the State Board of Health. As such, we are regulated by the same rules and standards as ASCs. Additionally, we are OSHA certified, and since we do not perform biopsies we do not need CLIA certification.

Q: You also mentioned that your present challenge is to seek recognition from third-party payors and obtain fair reimbursement. What are the steps you will take to achieve this recognition, and how will you work toward establishing fair reimbursement?

CL and AS: We believe that since our center follows the same guidelines as ASCs, and we are performing the same surgeries with the same standards of care, it should be reimbursed at a similar rate. This would allow us to cover rent, staff salaries, disposable supplies and implants. Since an office-based surgery center should be more efficient than an ASC, we would be able to accept a slightly reduced reimbursement, while offering our patients a significantly more enjoyable experience.


Cory M. Lessner, MD


Andrew Shatz, MD

In order to change the status quo, we are directly contacting insurance carriers and making our case that they could save hundreds of millions of dollars annually as an industry in whole if they would provide a facility reimbursement for accredited office-based surgery centers. We are also working on showcasing our center to insurance executives so that they can see the benefits of in-office surgery as both a cost-saving enterprise as well as a truly enjoyable experience for their members. ■

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5 Things to Know About Acquiring an O-Arm for Spine ASCs

By Laura Miller

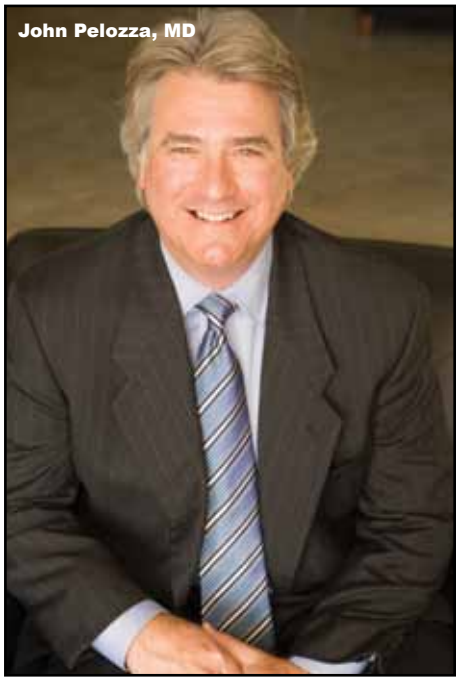
Michael J. Musacchio, Jr., MD, and John H. Peloza, MD, opened their ambulatory surgery center, Institute for Minimally Invasive Surgery, last October with a vision of incorporating emerging technologies that would rival any hospital operating room. This vision included the purchase of an O-arm in their initial budget. Dallas-based IMIS, which is affiliated with Meridian Surgical Partners, is the first and only surgery center in the United States to purchase an O-arm.

"We've built our model focusing on the highest quality patient care using evidence-based medicine and results-driven decision making," says Dr. Musacchio. "Our practice has been successful because patients are happy with their outcomes. Purchasing an O-arm for our surgery center aids us in the delivery of the same outcomes in an ASC as in the hospital setting."

Dr. Musacchio discusses five points on bringing O-arm technology into an ASC.

1. It allows surgeons to recreate hospital ORs in the ASC. Hospitals with advanced spine care programs are increasingly acquiring O-arms to enhance their surgical capabilities. This technology allows surgeons to take intraoperative fluoroscopic images. The machine develops two and three dimensional images of the patient's anatomy, allowing surgeons to navigate the procedure more accurately and improve precision in implant placement. The images can be updated during to operation to improve landmark identification. At the completion of the surgery the images are updated again to confirm the accuracy of implant placement and extent of decompression before waking the patient from sedation.

"With this technology we can perform more complex surgeries through minimally invasive techniques with greater safety and accuracy," says Dr. Musacchio. "The image is a virtual representation of the patient's anatomy at the time of surgery, enabling us to plan the least invasive approach before making the incision. The benefit is that we have the ability to do more complex cases, including fusions, while minimizing blood loss and tissue disruption."


John Pelozza, MD

At IMIS, Dr. Musacchio performs a wide spectrum of procedures from small percutaneous surgeries to more complex procedures like lumbar fusions. The patients are all discharged within 23 hours, due in part to the minimally invasive approach with the O-arm and advancement in postoperative pain management.

2. Surgeons can check accuracy before patients leave the OR. Traditionally, surgeons depend on two dimensional fluoroscopic images at the end of the surgery to evaluate implant placement; however, there are limits to this technology. With O-arm technology, surgeons can confirm implant placement with a 3-D reconstruction comparable to a CT scan

"Before leaving the operating room we obtain one last O-arm spin so we know exactly where the instrumentation is," says Dr. Musacchio. "This is a huge benefit because we can spin the O-arm while the patient is still in sterile conditions and under anesthesia. If a screw is not in ideal position we can reposition it right then.

Therefore, we are confident of where the instrumentation is and what we've done."

3. Incorporate equipment purchase into your business plan. O-arm technology is a significant expense for any surgery center, but the expense can be recouped in a short time depending on the number of spine cases surgeons can bring into the center. Dr. Musacchio and Dr. Peloza built the cost into their budget when building the center because they knew it would be an integral part of the care they provide.

"We opened our surgery center last October and in the planning phases we built the O-arm into our budget," says Dr. Musacchio. "We were willing to make the capital investment for our center because we can perform more complex cases, leading to a higher revenue per case average at the ASC. We understood that providing the highest level of care available would cost more money upfront, but we make that up in revenue and successful patient outcomes."

Spine surgery can be one of the more lucrative procedures in a surgery center. Due to the nature of the procedures, it reimburses higher than other less complex procedures. However, insurance companies are tightening their guidelines for approving some spinal surgeries such as fusions.

"The best way to make sure your surgeries are covered is to have clear indications," says Dr. Musacchio. "We're having trouble with getting approval for some spinal procedures for patients with degenerative disc disease, which isn't necessarily a bad thing. We are doing what is best for the patients, which often is following a conservative approach to care."

The O-arm doesn't increase approval for spinal fusions, but surgeons can use it when approval is granted for the primary procedure. "When we built our center, we didn't want to just perform simple discectomies and small surgeries; we wanted to be able to perform surgeries across the spectrum including spinal fusions, disc replacements, motion preserving instrumentation and revisions surgeries," says Dr. Musacchio. "In the hospital, we use an O-arm for those procedures, so we wanted an O-arm for our surgery center."

4. O-arm technology can be an attraction for patients and physicians. Surgery centers often have the same problems as community hospitals when purchasing O-arm technology: it's expensive and the center must have a high volume of spine surgeries to justify the purchase. However, the technology can be attractive to patients and appealing to physicians who want to take their cases outpatient.

"The O-arm opens up all types of possibilities for surgery centers," says Dr. Musacchio. "It's a good marketing tool for the center because it can drive a campaign to increase patient flow. The O-arm can also be a driving force in recruiting surgeons to join the center."

In addition to attracting spine surgeons, the O-arm technology could become useful in other specialties with complex cases such at otolaryngology and orthopedics. For now, IMIS includes two spine surgeons and three pain management physicians, but Dr. Musacchio says they are open to expanding.

"We are open to growth in different specialties, but our focus is on minimally invasive procedures," says Dr. Musacchio. "We want to work with surgeons in other specialties that share our vision of providing the highest quality, evidence based, results driven care with state of the art technologies. We made an investment in the O-arm technology to make sure we are following that vision."

5. Not every patient is good for the outpatient setting. Even though O-arm technology can improve the procedure, not every patient is a good candidate for outpatient surgery. Patients with extensive medical comorbidities or those in need of extensive procedures that will take more than a 23 hour recovery before discharge should be performed in the hospital instead.

"Knowing your limitations pre-operatively is key. We don't perform outpatient surgery on patients with extensive comorbidities or those who need extensive multilevel surgeries. These patients typically require a longer post-operative stay and are better suited for the in patient hospital setting," says Dr. Musacchio. However, Dr. Musacchio estimates that about 90 percent of the procedures he performs in his practice are done in an outpatient setting. ■

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5 Ways an Inventory Management System Can Improve Efficiency in ASCs

By Jon Pruitt, vice president of procurement solutions at Provista

This article is written by Jon Pruitt, vice president of procurement solutions at Provista, LLC.

ASC administrators have their magnifying glasses out and are closely examining their operations to find new ways to reduce costs, improve volume and expand services. For most surgical centers staff salaries and benefits represent ACS's largest fixed cost. However, keeping talented professionals is so critical to growth and attracting new patients that administrators consider it a last resort for cost cutting. What operators might not realize, though, is that implementing an inventory management system can help them significantly reduce costs as their supply chain represents their second largest operational expense. Implementing an inventory management system not only improves efficiency, it also reduces the hassle factor for those responsible for supply chain activities in the ASC.

One of the factors complicating inventory management is that often the responsibility for managing materials is a part-time job for several people, but no one's full time occupation. Since it's not a formalized job function, centers may adopted an ad hoc approach based on immediate need and continue that process. For example, some ASCs use spreadsheets to track products and expenses simply because it's how things were done in the past. The problem with manual inventory management systems is that they can be inconsistent or poorly documented which reduces staff productivity as people search for documentation to reconcile price differences between the purchase order and the invoice, or wait for purchasing information to be scanned or faxed. Not only that, if data is being entered by hand it's a given that mistakes will occur.

A surprising result of a Provista survey conducted in late 2011 was that a slight majority of ASC manager respondents, about 53 percent, still use a paper system to manage their materials inventory. Another 23 percent use a spreadsheet to track purchases, and 18 percent use their distributor's ordering platform to manage purchasing. Fewer than half use inventory management software, most of which are integrated with their practice management or electronic medical record systems.

So why make the switch? Here are five ways an inventory management system can help ASCs achieve a more efficient supply chain:

1. Simplifies the ordering process. An automated system eliminates time-consuming paper processing and provides easy-to-use applications that foresee supply thresholds and automatically prepares re-orders. This saves staff a great deal of time identifying what materials your center is running low on and filling out reorder forms. Another pitfall of using a piecemeal approach of tracking supplies is that purchases may be duplicated in different systems potentially resulting in too much of one product or another.

2. Reconciles cost paid with contract price. No more guessing about whether you are over-paying for a specific product. Many inventory management systems automatically generate reports and easy-to-use dashboards that provide instant information on price reconciliation information so you can easily monitor pricing consistency across multiple locations.

3. Centralizes purchasing for multiple locations. ASCs with multiple locations enjoy the added value of a centralized system that aggregates supply purchases to achieve best tier pricing. The system can also direct delivery of ordered supplies to the correct location so that you're not paying additional shipping or delivery charges to distribute materials to different sites.

4. Establishes a formulary. Utilizing an inventory management system's infrastructure, you can create a product formulary, to improve the ASC's ability to monitor adherence to contract purchases and identify costly variances for follow-up and resolution. Not having a centralized, consistent source of information is not only inefficient but can also lead to overpayment and missed opportunities for quantity discounts.

5. Provides a complete purchasing solution – not just medical-surgical supplies. An inventory management system can provide the same efficiencies regardless of the product or supply type. Cumulatively, this saves a lot of time and reduces waste and overpayment.

Using a comprehensive inventory management system can benefit ASCs by providing clear insight into actual usage and costs and by ensuring that operators are not overpaying for goods and services. Implementing an inventory management system will help ASC leaders achieve their overall business goals of reduced operating costs and improved performance. At the end of the day, ASCs that are run efficiently are better positioned to grow and serve their patients. ■

Jon Pruitt is the vice president of procurement solutions at Provista, LLC, a leading supply chain improvement company.

5 Issues in the CRNA Supervision Debate: Anesthesiologists Weigh In

By Taryn Tawoda

The debate over whether certified registered nurse anesthetists should be allowed to administer anesthesia without physician supervision is among the most contentious issues in anesthesia care today. The conflict stems from a 2001 Medicare and Medicaid regulation change that allows states to "opt out" of a requirement that nurse anesthetists be supervised. So far, 17 states have chosen to waive the requirement.

Proponents of the opt-out say that it will improve access to medical care for patients in rural and medically underserved areas. Critics argue that the opt-out could harm patients because nurses and anesthesiologists receive distinctly different medical training.

Three anesthesiologists — Meena Desai, MD, of Nova Anesthesia Professionals in Villanova, Pa.; Thomas Wherry, MD, of Surgery Center of Maryland in Silver Spring; and Randall Maar, MD, of Children's Hospital Colorado in Aurora and a member of the ASA Board of Directors — lend their opinions on five of the most contentious issues in the CRNA supervision debate.

1. Will the opt-out improve access to rural care?

According to Dr. Maar, a common argument in the debate is that removing the CRNA supervision requirement will enable more nurses to practice in rural hospitals, thus increasing medical care in underserved areas where anesthesiologists are scarce. "This is not true in Colorado," he says. "There are just as many — if not more — anesthesiologists than nurse anesthetists affected in the hospitals. At least five of the rural hospitals [in Colorado] are anesthesiologists-only. I want to know how the government is improving access in those hospitals when they're already fully staffed by anesthesiologists."

2. How does physician/CRNA education affect the debate?

According to Dr. Desai, the discrepancy in medical training and education received by CRNAs and Anesthesiologists accounts for differing and poorer quality of care and is often overlooked by the public and government officials. "There is a huge difference in education, which matters for leadership," she says. "CRNAs get two and a half years of medical education, while Physician Anesthesiologists have eight. There are definitely differences in the quality of care. I think that the public, and perhaps elected officials, are misled into thinking otherwise."

Dr. Maar agrees. "A flawed argument is that nurses are the equivalent of physicians and are a perfectly acceptable substitute for anesthesiologists," he says. "Nurses are not physicians. There's a great difference in the education and training of a nurse as compared to a physicians. Anesthesia care is extraordinarily complex, and when one examines all the component portions of an anesthetic, there is no question that there needs to be medical decision making as the essential element of that anesthesia care."

3. How will patient safety be affected by the opt-out?

According to Dr. Maar, the most significant issue in the CRNA debate is the impact of the lack of supervision on patient safety. "We know from the Silber study [Jeffrey H. Silber et al. Anesthesiologist Direction and Patient Outcomes. Anesthesiology. 2000 Jul; 93(1):152-63] that as the degree of supervision is lessened, patients do worse," he says. "Our primary motivation to challenge these opt-out decisions is to not allow the 30 years of hard work that anesthesiology has done to improve patient care in the OR to be rolled back."

Anesthesia care begins well before anesthesia and surgery, Dr. Maar says. Anesthesiologists are responsible for medical decisions made on the patient's condition for the procedure, whether additional testing is required, whether changes in therapy are warranted and whether the surgery should be performed at all. "All of those are medical decisions that only a physician should make," he says.

According to Dr. Desai, the increasing complexity of anesthesia care necessitates that Anesthesiologists have to be perioperative physicians handle the complexity of anesthesia cases. "[Anesthesiologists and CRNAs] have worked together as a care team for a very long time, but they are not perioperative physicians and they do need to be supervised," she says. "Anesthesia has changed into a perioperative specialty — it involves preselection, intraoperative and postoperative phases to make the surgical process safe. I do not believe the education of CRNAs allows them to do patient selection carefully, as they don't have the breadth of medical knowledge required."

Dr. Desai adds that CRNAs are typically not trained to lead in an emergency or disaster situation. "Because of that, patients can suffer harm in an unsupervised situation," she says.

4. Does opting out help to cut costs?

Proponents of the CRNA opt-out argue that it will allow hospitals to cut costs associated with recruiting anesthesiologists and draw from a larger pool of available CRNAs, particularly as hospitals expand or add additional services in different locations. "It gives the hospital or contracted anesthesia group an alternative to provide anesthesia service in a more cost-effective way, and it gives more flexibility," says Dr. Wherry.

Dr. Desai, however, believes that current reimbursement standards prevent the CRNA opt-out from being cost-effective. "CRNAs get paid per case exactly the same as anesthesiologists do," she says. "It's a complete fallacy that there is a cost saving to the medical system." In rural hospitals, she adds, CRNAs are paid a differential under a Medicare incentive to attract more nurses to scarcely populated, medically underserved areas. In the opt-out, I believe we are trading poor quality of anesthesia service for the same dollar amount. Additionally, access to care is not a problem, as a physician is always present for surgery and can be the physician supervisor of the nursing staff.

5. Can the opt-out improve staffing flexibility?

Dr. Wherry says that in Maryland, CRNAs have worked independently for years. The state requires the CRNA have a collaboration agreement with a physician, and the physician is not required to be an anesthesiologist.

CRNAs have been directly reimbursed by Medicare since 1989 through Part B of Medicare, he adds. "CRNAs often sign over their billing rights to a group or a hospital, and it is important to keep in mind CRNAs and anesthesiologists are reimbursed through Part B of Medicare," Dr. Wherry says.

Dr. Wherry then lays out the issue of "opt out" and Medicare Part A. The opt out issue applies to reimbursement to inpatient hospitals, critical access hospitals, and ambulatory surgery centers for the care they provide to beneficiaries through Part A of Medicare, he says. In order for hospitals to be reimbursed by Medicare, they must be compliant with CMS's conditions for

participation. There are also conditions for participation for critical access hospitals and ambulatory surgery centers. Each of these conditions calls for the CRNA to be supervised by the operating physician or an anesthesiologist unless the state's governor has "opted out" of the supervision requirement. Part A of Medicare does not provide any reimbursement to the surgeon or anesthesiologist who provides supervision for the CRNA in order for the facility to be compliant with Medicare Part A conditions for participation.

In states that have not opted out, the facility can comply with Medicare Part A conditions for participation by the surgeon supervising the CRNA, he says.

"Really, all states do with the opt-out is remove a technicality and a political barrier, but it's not going to change the overall practice," he says. "So it might give a group in opt-out states a certain comfort level in the hospital rules and regulations. CRNAs can then work without any supervision, and it takes away any stress that the surgeon may be feeling that they're somehow responsible." ■

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OIG: Anesthesia Arrangements With ASCs Could Lead to Trouble

By Laura Miller

Two proposed arrangements between anesthesiologists and physician-owned facilities could lead to administrative sanctions, according to a Department of Health and Human Services Office of Inspector General release.

In the situation, the anesthesia provider would pay management services fees to an outpatient surgery or endoscopy center, and the outpatient center would provide preoperative nursing assessments, space for the anesthesia provider's staff and billing assistance, on a per-patient basis and excluding patients in federal healthcare programs.

"In short, the Centers would be paid twice for the same services, and the additional remuneration paid by the Requestor in the form of the Management Services fees could unduly influence the Centers to select the Requestor as the Centers' exclusive provider of anesthesia services. Based on the facts presented here, we think there is risk that the Requestor would be paying Management Services fees with regard to non-Federal healthcare program patients to induce the Centers' referral of all of its patients, including Federal healthcare program beneficiaries," said Chief Counsel to the Inspector General Gregory E. Demske, in a letter from the OIG.

In the second arrangement, outpatient center owners create a subsidiary to provide anesthesia services to patients and hire the anesthesia provider as an independent contractor for their services. This would create a situation where the physician owners receive profit from anesthesia services. The OIG would not issue a positive opinion on the relationship.

"The OIG has stated on numerous occasions its view that the opportunity for a referring physician to earn a profit, including through an investment in an entity for which he or she generates business, could constitute and illegal inducement under the anti-kickback statute," Mr. Demske said.

OIG said the anti-kickback statute could be implicated in both situations. While there are several safe harbors that could potentially apply to PCs and LLCs, Mr. Demske said "No safe harbor would protect the remuneration on the Subsidiaries would distribute to the Centers' physician-owners under Proposed Agreement B." ■

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Operating a Surgery Center in a Saturated Market: Q&A With Lee Memorial's Dave Cato

By Laura Miller

Lee Memorial Health System's Outpatient Surgery Center opened in November 2011 in the middle of a unique market. While the market in Fort Myers, Fla., was saturated with physician-owned single specialty ASCs, Lee Memorial's center is 100 percent owned by the hospital and serves as a multispecialty surgery center. While the surgery center is still a part of the larger Lee Memorial organization, it isn't located on the hospital's main campus.

After 18 months of running the center, Vice President of Outpatient Operations at Lee Memorial Health System Dave Cato discusses the challenges and opportunities he's found operating a surgery center in his unique market.

Q: Why did Lee Memorial Health System decide to build an outpatient center?

Dave Cato: We felt we could offer the market something that wasn't out there: a place for unaffiliated surgeons to come where they can be neutral and perform surgery. The surgeons don't have an investment in the surgery center and our contracts from a payor standpoint are outstanding, so surgeons want to do cases with our system. We run the facility like an ambulatory surgery center from an efficiency and patient satisfaction standpoint.

We track patient satisfaction — it's 96 percent and above — and our on-time starts and room turnover are very important for the surgeons who operate there. We have 96 percent to 100 percent on time starts and our turnover time averages 11 minutes. Even doing multispecialty cases, we do a good job. We have tried to emulate the efficiencies and patient satisfaction you would get from a typical surgery center in our market.

Q: How is performing cases at the surgery center different from performing them at the hospital's outpatient department?

DC: Before we built the surgery center, we were only able to perform outpatient surgery on our acute care campuses. If you have emergency services at the same place as acute care, it slows efficiency and processes for surgeons only doing outpatient cases. We had 9 percent to 10 percent of the market share and we felt we could enter the outpatient surgery market more robustly. The surgery center is currently 100 percent owned and operated by the hospital.

Q: Without a financial investment in the surgery center, what incentive do surgeons have to sure the center successful?

DC: Even though there is no ownership by the physicians, we need to engage and partner with the physicians to make sure the surgery center is successful. There is a multispecialty group that we have a co-management agreement deal with. They don't own equity, but they manage the center for us, which drives a great deal of the success. It's both physician-drive and administration-driven because we work together as a team. We were able to accomplish that out of a management agreement — not equity.

The key to our success is the clinical and efficiency metrics. They are paid a base management fee and then they have a clinical incentive fee that is tied into six metrics: patient satisfaction, transfer rates, antibiotic administration, first case starts, turnover time and wrong site surgery. We wouldn't have the same results without having partnership within this group. It's been a great partnership.

Q: In addition to the physicians in the co-management arrangement, who else brings cases to the center?

DC: We have a mix of physicians—both physicians from our co-management partnership and employed surgeons bring their cases to the surgery center. There are other independent physicians who aren't on our medical staff but chose to bring cases to the surgery center, including orthopedic surgeons, hand surgeons, general surgeons, pain management physicians and plastic surgeons. The reason we get some of the third group is based on the performance and atmosphere we've created. Physicians want to do their surgeries here.

Oftentimes, people who have a choice choose to come with us based our results. Word-of-mouth between surgeons has spread our reputation. We have success based on performance and surgeons talk to each other. Patients also talk to surgeons and tell them about the positive experiences they had at our center in the past.

Q: Are there any challenges you've experienced over the past year-and-a-half?

DC: Our center is a convenient location for patients, but for some surgeons it's worked against us. Depending on where the surgeons are located, traveling to the outpatient surgery center isn't convenient. Some surgeons try to plan an outpatient day so they don't have to go from the hospital to the surgery center. What outweighs that is surgeons know they can do more cases in the surgery center.

Q: Is there anything your center does to become more attractive to surgeons?

DC: The factors surgeons are most interested in are patient satisfaction, on-time starts and turnover times. If they can come out to us and do six cases in four hours where they might have only been able to do four cases in four hours somewhere else, they are more efficient. They are also highly concerned with patient satisfaction.

The anesthesia team also does a tremendous job of facilitating the intake. Those are the main items surgeons are concerned about.

Q: Was there anything that surprised you after the surgery center was up and running?

DC: The number one thing that hit me was the scheduling aspect of it. They are all elective cases and we need to have conversations with insurance companies to make sure the procedure is authorized. We expected cases to be scheduled at least a week out, sometimes a month prior to surgery. We found it was necessary to adjust this expectation because surgeons called and wanted to schedule surgeries in a lot shorter time than we anticipated.

We needed to be more flexible to make sure we could schedule the cases on a shorter timeframe. Now we schedule cases three days out. When the first of the month roles around we may only have 150 cases scheduled, but by the end of the month we have 300 performed. From the health system perspective, that was surprising; however that's what the surgeons and patients needed. We worked with them and adjusted our process to make access easy to our center.

Q: What re your strategic goals for the center over the next few years?

DC: The two most important things are to continue partnering with physicians to help manage and run day-to-day operations. Having a very effective clinical director in place is crucial. We'll also need to partner with the physicians to look at how payment reforms coming down the pipe will affect them and the facility.

Additionally, we will continue to have outstanding customer service and our efficiency will be maintained by everyone on staff. That's the key to our success going forward, regardless of payment reforms. ■

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