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BECKER'S
ASC REVIEW
Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

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5 Surgery Center Specialties Predicted to Grow in 2011

By Rachel Fields

Every year, certain ambulatory surgery center specialties grow and others diminish as CMS approves new procedures and reimbursement rates change. Here three ASC industry veterans discuss five specialties that will likely see increased profitability and adoption in surgery centers in 2011.

1. Spine. Spine is currently one of the most attractive specialties for ASCs, according to Naya Kehayes, managing principal and CEO of

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10 Proven Ways to Profit From Gastroenterology

By Leigh Page

Here are 10 proven ways to profit from gastroenterology in 2011.

1. Open doors on evenings or weekends. Add hours to the end of the day or open the facility on weekends. Barry Tanner, president and CEO of Physicians Endoscopy in Doylestown, Pa., says his company manages several facilities that have regular Saturday hours. "Weekend hours for a busy facility can prove very successful," he says. "They are great for patients." Saturday hours, which typically are limited to mornings, are routinely the first slots to be booked for the whole week, he adds.

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What Should Your ASC Pay Its Employees?

By Rachel Fields

How much an ambulatory surgery center pays its employees depends on various factors, including center location and amount of revenue, presence of bonuses and incentives and movement of compensation across the industry. Here are five questions every ASC should ask to help determine appropriate employee salaries.

1. Where are you located?

Physical location and presence of competing facilities plays a large role in determining employee salaries at a surgery center. If a center is located in a community with several competing surgery centers, the ASC will likely have to set its wages at the same level as the other facilities to ensure robust recruitment and retention. If the ASC is located in the same community as a hospital, matching salaries may be more difficult. Most surgery centers would struggle to offer salaries that compete with a local hospital or health system, but ASCs that pay significantly

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WHAT ARE *YOUR* SYMPTOMS?

Is your surgery center headed for trouble?

ARE YOU . . .

. . . Working overtime and feeling stressed?
. . . Stuck with unused block time at your ASC?
. . . Failing to syndicate new physicians?
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- Ed O'Byrne, Administrator
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BECKER'S
ASCREVIEW
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FEATURES

Publisher's Letter

13 Key Legal Questions for Hospital-Physician Relationships; 6 Questions Being Asked by ASCs

Publisher's Letter:Given increased integration activity amongst physicians and hospitals and the increased amount of governmental resources targeting such relationships, we have put together a short piece that is an overview of questions that should be asked from a regulatory and business perspective with respect to physician-hospital relationships. Many, if not most, of the questions are also applicable to surgery centers.

We have also noted six key questions being asked by ASCs.

1. 13 Key Questions — Hospital/Physician Relationships

The following 13 questions can be used as barometers to help assess legal compliance from a Stark Act, Anti-Kickback and Tax Exempt entity perspective. The core laws apply whether the physician is to be employed, co-managed or integrated with a hospital through other affiliation models.

1. Is the relationship truly needed? E.g., is a medical director necessary for the position? What value will this position add? Has the position been manufactured as an excuse to provide compensation to physicians?
2. Is the position and payment wholly unrelated to referrals or the intent to retain business? If any one purpose of a payment is in exchange for referrals, it can be deemed unlawful.
3. How comparable is the position to other positions in the hospital when it comes to specialties of lower financial value? I.e., is a position only funded because it relates to high value or volume specialties?
4. How comparable is the position to those at competing hospitals?
5. Is the payment fair market value? If so, what evidence supports this? Is there a third-party valuation or objective, external evidence to defend the value?
6. Has the relationship between the hospital and the physician been approved by internal parties who are unrelated to the outside parties involved? I.e., is the physician who will receive such payment not part of the committee or board approving such payment?
7. Does the relationship meet a Stark Act exception and an anti-kickback safe harbor? If a non-employment arrangement, is the relationship set to pay a fixed aggregate amount per year and not vary per the year? Many safe harbors require that aggregate payments be set in advance.
8. Can a rebuttable presumption under the Internal Revenue Code be obtained that the relationship doesn't create private inurement or excess benefit?
9. Has the hospital's compliance officer, or legal counsel, approved the relationship?
10. Is there a contracting file with legal and valuation approval? Has there been a comprehensive and detailed review of legal concerns?
11. Will the relationship be viewed in the context of an organization that has a culture of compliance?
12. Is there a short memo that supports the true need for the relationship?
13. Can this relationship be considered standard for the system, or is it highly creative and unusual?

2) 6 Key Questions Being Asked of ASCs

In the ASC context, six of the key current questions being asked are:

1. Can the practice or ASC profit from anesthesia and pathology?
2. What will co-management pay?
3. Should we sell our ASC or practice? To a hospital or national chain?
4. How can we price shares to sell to new physicians?
5. Can we stop partners from becoming hospital employees?
6. What place does our ASC have in an ACO?

Should you have any questions about these issues or any other subjects, please contact me at (312) 750-6016 or at sbecker@mcguirewoods.com.

Very truly yours,

Scott Becker

ASCOA ambulatory surgical centers of america℠

ASCOA is a privately-held, physician-owned ASC management and development company based in Hanover, Mass., which currently operates 36 surgery centers across the United States. The company has several more under development. In total, ASCOA has developed or turned around more than 60 ASCs.

The company was formed by Brent Lambert, MD, Tom Bombardier, MD, and George Violin, MD. It is now led by CEO Luke Lambert, CFO Robert Westergard and Drs. Lambert and Bombardier.

Its leadership team has years of experience in real estate, staffing, training, equipping, licensure, accreditation and compliance. ASCOA works with client ASCs needing a turnaround to correct major problems such as poor management, inefficiencies caused by overbuilding and loose scheduling, lack of surgeon recruitment and lower-than-optimal reimbursement per case.

The ASCOA model keeps the control of the ASC with the physician-partners. ASCOA owns a minority share in each surgery center it develops or turns around.

"The physician principals of ASCOA are dedicated to achieving for our ASC physician partners the highest quality of patient care and the best financial returns in the industry," says Dr. Brent Lambert. "We do this by staying at the forefront of our industry as we navigate the changes in our healthcare system." www.ascoa.com

5 ASC Specialties Predicted to Grow in 2011 (continued from page 1)

Eveia Health Consulting & Management. Data from Healthcare Appraisers' 2010 ASC Valuation Survey backs up her claim: According to responding ASC companies, orthopedic spine is the second-most desirable specialty in ASCs. She says the migration of laminectomies and the growing interest in anterior cervical discectomy and fusion will present a great opportunity for spine centers as more insurance companies feel comfortable moving the cases to ASCs. "Some payors are even open to the potential of surgery centers discharging bigger spine cases to skilled nursing facilities," she says. "If there's a contractual relationship with an in-network skilled nursing facility that can be aligned with a surgery center, some payors are open to that discussion."

Goran Dragolovic, senior vice president at Surgical Care Affiliates, agrees that spine will see more attention over the next few years as minimally invasive procedures advance. "We believe we have just scratched the surface of [minimally invasive spine]," he says. He says in order to move minimally invasive spine into the ASC, surgeons must be comfortable moving their cases into the outpatient arena. "We are seeing that orthopedic surgeons as a totality are moving at a more rapid pace than neurosurgeons, but we have also seen an increased openness in neurosurgeons in bringing cases to our facilities."

Joe Zasa, managing partner at ASD Management, says an ASC planning to add spine should be ready to go through all its contracts and ensure the appropriate codes and carve-outs are included. "You can still do [spine cases] in the surgery center, but you've got to set fees for them that are appropriate and market-driven," he says.

2. Orthopedics. Mr. Dragolovic says CMS' decision to transition ASC reimbursement methodology from the grouper methodology to HOPD APC rates has introduced procedures not previously covered in the ASC by Medicare. According to the Healthcare Appraisers' survey, general orthopedics is the most desirable specialty for ASC companies, with 94 percent of respondents approving of orthopedics. "Number one, it has opened the door to a large number of procedures that were not permitted to be done in the surgery center, and secondly, it has started to remedy some of the reimbursement inequities for some procedures," he says. One of the specialties to benefit from this transition is orthopedics. Today, arthroscopies and ACL reconstruction in orthopedics pay more appropriately to ASCs than in the past. Mr. Zasa also predicts that partial knee replacements will move into ASCs as they sit on the "cutting edge" of the specialty.

Ms. Kehayes predicts that the transition of these procedures into ASCs will depend in part on the relationship between the payor and the local hospital. "When you pull these higher acuity types of cases out of a hospital setting, this poses some concerns to insurance companies in certain markets about whether the hospital is dependent upon those types of surgeries for their sustainability," she says. "At the end of the day, the insurance company needs the hospital in their network in order to sell insurance and provide all services in their network to their members." She says this issue applies to procedures such as total joint surgery, spine surgery and any cases that represent a large revenue stream to hospitals, which may become more attractive to ASCs as technology advances.

3. Bariatrics. The FDA's decision to lower the patient body mass index necessary for bariatric surgery was one of the biggest developments for ASCs in the past 12 months, Mr. Dragolovic says. Previously, the FDA recommended Lap-Band surgery for healthy patients with a BMI or

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the C/N GROUP, inc.
A HEALTHCARE SERVICES COMPANY

The C/N Group is a family-owned and -operated ASC management and development company which was founded in 1980 and is based in Merrillville, Ind. The company focuses on the development, ownership and operation of healthcare facilities including ASCs, medical office buildings, and diagnostic imaging centers.

C/N Group is owned and managed by the Chopra family — Ravi, Raman and Rajiv — and employs more than 200 people among its Western New York, Northwest Indiana and North Texas regional markets.

During its initial years of operation, the firm's primary focus was physician practice management and consulting, after which it expanded its services to include the development and day-to-day operation of healthcare facilities. It has developed of dozens of outpatient centers and more than 500,000 square feet of healthcare-oriented space.

While the firm is actively involved in several new opportunities within its core ASC, medical office and imaging segments, it also plans industry and geographic extensions going forward.

"We are continuing our mission of partnering with physicians and hospitals to enhance the art and science of healthcare delivery," says Ravi Chopra, C/N Group's CEO. "2011 will see us move into growing industry segments such as outpatient radiation oncology centers and into new surgical specialties including spine within our existing ASCs." www.thecng.com

over 40 or a BMI or 35 with at least one co-morbidity. The recommendation has now been altered to include patients with a BMI of 30 or above with at least one co-morbidity. According to Allergan, the company that manufacturers the Lap-Band, approximately 37 million Americans have a BMI of 30-40 with at least one co-morbid condition.

"This basically has expanded the market [of weight-loss surgery patients] by 11 million people, and it has expanded the right segment of the market," Mr. Dragolovic says. "ASCs are suited well to perform Lap-Bands on people who did not have a tremendous amount of complicated co-morbidities." In other words, ASCs can safely perform Lap-Band surgery on less obese patients, whereas more obese patients may pose risks that require surgery to be performed in a hospital setting. Mr. Dragolovic predicts surgery centers — especially those that already provide weight-loss surgery — will profit significantly from the market expansion.

4. OB/GYN. While OB/GYN ranked low on the Healthcare Appraisers survey for desirability in 2010, Ms. Kehayes believes OB/GYN presents a significant opportunity for surgery centers that can move vaginal and total hysterectomies out of the hospital setting. "Vaginal hysterectomies are a little easier for surgery centers to do, but total hysterectomies are not out of the question," she says. Total hysterectomies are more likely in the ASC setting if the center is located in a state with extended recovery care or 23-hour care, she says. If a surgery center already books a large number of OB/GYN cases, Ms. Kehayes recommends talking to surgeons about whether they would be comfortable bringing hysterectomies to the center. "If the answer is yes, go to the payors and talk to them about it," she says. "It could be a win-win to move hysterectomies out of the hospital."

Mr. Dragolovic says OB/GYN has also benefited from the move to HOPD APC rates, as hysteroscopies and laproscopies have become more profitable for surgery centers.

5. ENT. Ms. Kehayes continues to see a progression of cochlear and BAHA implant procedures into ASCs, although she says BAHA procedures are moving more quickly. She says while these procedures may be approved for the ASC setting, the biggest challenge may be convincing physicians to move these cases when appropriate. "As CMS has approved some of these bigger cases, like cochlear and BAHA, a lot of [the task] is educating the physicians to ensure they are paying attention to the full gamut of codes that are now approved." She says she is regularly surprised by how many ASCs do not pay attention or realize the opportunity that may exist with newly-approved codes.

She recommends ENT centers talk to their ENT physicians and let them know that cochlear and BAHA implants are now on the ASC approved list and can be performed in the center. If physicians are interested in moving the cases over from a hospital, payors should be willing to work with the center because these cases often result in a meaningful cost savings. Contracts may need to be negotiated if they historically were not set up with adequate rates for these services. The 2010 Healthcare Appraisers' survey reports that 76 percent of responding ASC companies felt ENT was a desirable specialty, making in the fourth most popular on the list. ■

Contact Rachel Fields at rachel@beckersasc.com.

10 Proven Ways to Profit From Gastroenterology in 2011
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Extending hours of operation at Berks Center for Digestive Health in Wyomissing, Pa., has allowed patients to come in later in the day, according to John Gleason, the administrative director of the center. The center has also added weekend hours. However, a center would have to have enough volume to stay open through the afternoon to be open in the evenings, says Eric J. Woollen, vice president of managed care at Practice Partners in Healthcare, based in Birmingham, Ala. "It would not be practical to send staff home for a few hours during a lapse in cases and have them come back in the evening," he says. "Since GI centers can start as early as 6 in morning, volumes would have to be pushing the seams to go into the evenings."

When all is said and done, GI centers must have high volume to survive, Mr. Woollen adds. "For a single-specialty GI center, volume drives reimbursement," he says. Mr. Tanner agrees. He calculates that if a GI procedure room operated just eight hours a day, it would produce about 16 cases per day or roughly 4,016 cases per year. "While full utilization is usually not possible, due to cancellations and no-shows, it is certainly reasonable to aim for 80 percent utilization or about around 3,200 cases annually," he says.

2. Stay single-specialty. Mr. Tanner is a proponent of single-specialty GI centers. "We still believe that single-specialty has the advantage of efficiency and quality from many perspectives, including staffing, block-scheduling, training, equipment and supplies, patient satisfaction and benchmarking," he says. "Many of these issues will be even more key as healthcare continues to evolve and accountable care organizations gain traction." As ACOs attempt to manage the full cycle of care for each type of patient, they will need to bundle GI patients in practices with the procedures they receive in GI ASCs.

Multi-specialty centers may be less efficient, he adds. "Mixing utilization with specialties that have longer OR times makes it more difficult to schedule efficiently," Mr. Tanner says. GI cases such as colonoscopy and EGD usually last 15-30 minutes and recovery lasts about 45 minutes, but orthopedics or podiatry procedures can take much longer. Single-specialty can also help attract GI physicians. "All things being equal, would a GI physician rather be in a single-specialty GI facility if that opportunity exists? I think that the answer would be a definite yes," he says. "However, from a physician recruitment standpoint, I don't believe that physicians will chose to practice in any particular area simply due to the availability of a single-specialty ASC."

Mr. Woollen believes both single-specialty and multi-specialty scenarios can be successful for GI. "This is one of those cases of 'flip a coin, pick heads or tails,' " he says. "If the current physician-utilizers are maxed out in the volume of cases they are bringing to the ASC and you still have open time, then you may want to consider adding a specialty. A GI case doesn't pay as well as say an orthopedic case." But he added that the projected volume and reimbursement of a new specialty has to be worth buying the new equipment and training staff to handle the cases. "If you are a high-volume GI center and you are efficient, you may not need to bring in another specialty," Mr. Woollen says. "Single-specialty ASCs can take advantage of synergies and run efficiently. It is less complicated." These centers have the same types of cases, same expectations and same turn-around times.

3. Market colonoscopies. Under the healthcare reform law, insurers are required to cover the entire cost of screening colonoscopies, but do most Americans know that? "We are beginning to see an increase in marketing in general," Mr. Tanner says. "Marketing definitely does have its place and we know that it can have a positive impact." Much of colonoscopy marketing would be done at the practice level because the focus is on making patients aware of the need and the care that GI-physicians provide.

Mr. Tanner believes marketing can be implemented in part through e-mail and social media. "In today's information age, characterized by instant feedback, I believe that up-to-date patient-communication portals are the key," he says. "As healthcare changes, and as patient awareness grows and patients do more homework on their own, prior to consulting with a physician, I believe physicians are starting to see a need for remaining relevant in today's electronic age."

ASCs should perform community outreach, looking into the areas of the community that are not getting screened for colon cancer, according to Rick Jacques, president and CEO of Covenant Surgical Partners. Marketing will be a challenge, however. A report in the *Archives of Internal Medicine* found that sending email messages and Web-based risk assessment tools to patients about colorectal tests and even following up with phone calls had only modest success.

4. Renegotiate payor contracts. GI-negotiators advise that many payors, if pressed, would agree to increase their fees, especially if the facility can demonstrate high quality. "I simply believe that all contracts should stand on their own," Mr. Tanner says. "While there are numerous elements of all contracts that are similar, rates can vary geographically and demographically, based upon several factors that are not directly tied to CMS reimbursement."

While Medicare payments to GI centers fell in the past four years during the phase-in of the Outpatient Prospective Payment System, many private payors stayed with the old grouper system to pay GI ASCs. This has been a godsend to GI centers. "We try to avoid any third-party payor contracts getting linked to Medicare OPPS," Mr. Tanner says. Mr. Woollen cautions that centers need to make sure that contracts that stay with Medicare groupers need to account for inflation since 2007, when the groupers ended. "Read the contract carefully to make sure it isn't referring to current Medicare rates and always research your costs," he says. If the payor wants to switch to OPPS, "remind them that other procedures, such as general surgery and pain management, are also in that group," he says. "If you lower the whole category you're going to penalize other specialties as well."

When GI centers negotiate for groupers, their biggest selling point is that their costs are much lower than the hospital's. In fact, at Northwest Michigan Surgery Center in Traverse City, Mich., the price of a colonoscopy is about half that of the local hospital, according to CEO Jim Stilley.

5. Sign up more GI physicians. "Gastroenterologists have an incentive to become partners in an ASC if they have not already done so," Mr. Woollen says. With Medicare reimbursements falling, "GI docs want to find a way to earn those revenues back," he says. "Give them a trial run. They can come in, do some procedures and see how it works. But if they bring in only five cases a month and you need 20 cases, it may

not be a good fit." If these physicians do work out, Mr. Tanner says they might be fast-tracked to ownership status, giving them a firm stake in the enterprise. "We often see ASC ownership being made available to physicians in the first one to three years, but it can be quite variable," he says. "In areas where it is particularly difficult to recruit, we tend to see shorter wait times to ASC ownership." The physician can earn a substantial amount of ancillary income from an ASC ownership, sometimes as much as he earns in professional fees, according to Mr. Jacques.

"Unaligned gastroenterologists are still out there, but overall, the pool has been shrinking," Mr. Woollen says. "There are not many left who have not already invested in an ASC or joined a hospital system. However, some practicing physicians may relocate to the area and newly graduated physicians may arrive." Newly minted physicians tend to join existing groups. "If the partnership is expanding, the ASC can benefit," he says.

6. Engage your employees. An ASC that engages employees can help the center reach optimum levels of efficiency. This can be done through frequent staff meetings, engaging in staff recognition and openly encouraging physician participation, Mr. Tanner says. OR teams who work closely with physicians can reach optimum efficiency levels. "The physicians are typically very busy and often not very proactive in terms of team-building and staff-management," he says. "The ASC administrative team needs to establish the overall tone of the facility and work constantly to set a positive example and to reinforce the style, the character and the overall atmosphere of the ASC." For example, Kendall Endoscopy and Surgery Center in Miami provides opportunities for physicians and staff to socialize and create strong bonds, such as at yearly holiday parties.

7. Improve patient satisfaction. Patients' opinions about the care they receive "are almost always heavily influenced by how they are treated at the front desk right through to recovery and discharge," Mr. Tanner observes. "It is the interactions they have all along the way that help them to judge the quality of care." That first 30 seconds when the patient walks through the door can often be the determining factor. "Much of this is well within the control and responsibility of ASC administration," he says.

In satisfaction surveys, patients often provide thoughtful suggestions to help the ASC improve, Mr. Woollen says. Patients' criticisms can turn into useful advice. One example might be a patient saying he did not have a separate room to discuss issues, which is an important consideration in complying with the HIPAA privacy law. When reviewing patients' responses to surveys, "look for good ideas," he says. He adds that patient satisfaction surveys are moving from paper to digital format, which gets a slightly higher response rate, with about one-third of surveys filled out and returned.

8. Reach out to referring physicians. Affiliated GI practices should be encouraged to reach out to primary care physicians who refer cases to them. "Ease of patient referrals is a major concern," Mr. Tanner says. "The professional practice should be tracking and carefully monitoring physician referral patterns." When referrals become difficult, wait times lengthen and patients complain about how they were received. "This can have devastating effect on referral patterns," he says. To address this problem, some GI practices have designated "practice representatives" who work as liaisons with primary care practices, he says. The representatives stay in touch with referring physicians and their staff and assist them to make the patient experience a great success.

9. Work with the hospital. Mr. Tanner says GI-driven ASCs need to develop closer relations with hospitals. In past years, "many ASCs have prospered by removing case volume from the hospital," he says. "Now I believe there is a need for a more cooperative and collaborative relationship with the hospital that involves more coordination of care."

With the advent of ACOs, hospitals may reach out to ASCs to build partnerships, he says. But even if they don't join ACOs, hospitals have developed a fair amount of market power. In markets with significant physician employment at hospitals, "the hospital is a formidable influence on referrals," Mr. Tanner says. "This trend cannot be ignored. Nor can one of the underlying motivations of the hospital, control over referral patterns. Determining strategically how to work with and interact with the hospital and its employed physicians may become a critical survival factor." Mr. Woollen agrees that relationships with hospitals have become more important. "Because hospitals now have many primary care physicians, it's important to reach out to them," he says.

10. Consider a joint venture with a hospital. Hospitals have been forging joint ventures with surgery centers, even acquiring total ownership and turning them into hospital outpatient departments. But when converting to an HOPD, gastroenterologists lose their entire ownership share and thus give up an important alternative source of income. Joint ventures with hospitals, on the other hand, can be promising. "We have a GI center in the hospital space," Mr. Woollen says. "It takes an enlightened hospital to partner in one and it can be an tricky relationship for a surgery center unless the hospital agrees to be a partner."

Mr. Tanner adds: "We now actively seek ways to partner with the hospital while still retaining physician independence. There need to be physician-controlled incentives to deliver highly efficient high-quality care."

Mr. Woollen warns, however, that it may not be possible for a partnering ASC to share the hospital's substantial leverage in managed care contracts. If the center is under a separate tax-identification number from the hospital, the insurer will probably require a separate contract. "The decision is up to the insurers," he says, "but they are not going to want to pay hospital rates to an ASC if they can help it." The center can, however, use the hospital's leverage for other payor issues, such as overcoming payment delays and getting the responses to its queries, he says. ■

Contact Leigh Page at leigh@beckersasc.com.

What Should Your ASC Pay Its Employees?
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less than the local hospital may risk losing staff members.

In situations where the ASC must compete with a hospital, many surgery center administrators advise touting the surgery center's other benefits in lieu of providing competitive salaries. ASC staff members have holidays and weekends off and generally leave the center in the afternoon, rather than working late hours and coming in on Saturdays. Surgery centers often provide a more tight-knit atmosphere and a less bureaucratic structure for employees with suggestions or requests.

Geographic location also plays a role in compensation, according to data from VMG Health's *2010 Multi-Specialty ASC Intellimarker*. According to the survey, staff members in surgery centers in the Western United States (defined as California, Oregon, Washington, Idaho, Nevada, Montana, Wyoming, Utah and Arizona) make more than staff members in any other area of the country, at an average of $29.01 for all staff members. Here is a breakdown of nurse, tech and administrative staff salaries in different areas of the country:

Nurse staff
West: $35.33
Southwest: $31.34
Midwest: $27.51
Southeast: $29. 36
Northeast: $31.32

Tech staff
West: $22.24
Southwest: $19.33
Midwest: $18.38
Southeast: $18.84
Northeast: $20.34

Administrative staff
West: $24.21
Southwest: $21.30
Midwest: $21.62
Southeast: $22.96
Northeast: $24.15

2. Will you offer bonuses to employees?
Some surgery center administrators choose to offer bonuses to staff members to incentivize and reward hard work. According to the ASC Association's *2010 ASC Employee Salary & Benefits Survey*, the majority of managers are eligible for bonuses:

- Administrators – 75 percent
- Business office managers – 63 percent
- Directors of nursing – 64 percent
- Materials managers – 53 percent

The way a bonus is determined will affect how much the employee is paid in total compensation. For example, some surgery centers choose to distribute bonuses based on a percentage of total profits at the end of the year, meaning employees benefit if the center succeeds financially. Others put a certain percentage of the manager or employee's salary "at risk," so total possible compensation is determined at the beginning of the year but only a certain amount is guaranteed unless goals are met. It makes sense to gauge how bonuses will affect an employee's total compensation to make sure your ASC is paying a competitive salary without going over budget on staffing costs.

3. How is industry-wide compensation changing over time?
Make sure your center keeps an eye on industry trends to make sure your salaries are still competitive. Average compensation for a nurse in 1999 is likely to be significantly different from compensation in 2010, so stay updated on current salary reports. For example, registered

nurse salaries increased 1.1 percent in 2010 over 2009 to a median salary of $60,500, while salaries for business office managers, anesthesiologists, instrument technicians and operating room technicians stayed constant, according to the ASC Association salary survey.

For most ASC positions, 2009 salaries saw a jump from the previous year. Operating room technicians saw their salaries increase from an average of $38,230 annually to $40,000 annually, while licensed practice nurses increased from $37,958 to $39,500 and receptionists/admitting clerks increased from $27,560 to $28,662. The only salaries to decrease in 2010 were medical director salaries, which dropped four percent to a median salary of $28,800.

These changes — mostly ranging from 1-4 percent — may not seem significant, but they add up over time. In addition, a new nurse faced with a $2,000 higher salary at another facility is likely to choose employment elsewhere unless you can provide an outstanding rationale for your compensation decision.

4. How much revenue do you bring in?

When benchmarking your center against other centers across the country, make sure to look at centers with similar revenue streams. If your ASC has two operating rooms and net revenue of $4,000, you are unlikely to offer the same salaries as a seven-OR center with significantly higher revenue. According to VMG Health's survey, ASCs with more than $6.99 million in annual net revenue pay their employees an average of $26.60 per hour, compared to $25.81 per hour for ASCs with less than $4.5 million in net revenue. Nurses in ASCs with greater revenue make significantly more per hour than nurses in less profitable centers, at $31.65 per hour compared to $29.82 per hour.

No matter how your ASC compares to other centers across the country, your salary costs should always fit your budget. If your revenue is down, you may have to explain to employees that bonuses must be eliminated or salaries must be frozen while efforts are made to increase profits. If net revenue is down in your area because of decreased reimbursement or other issues, you may find that other local surgery centers are experiencing similar issues and are limiting their compensation as well.

5. How will you reward credentials?

It is important to establish how you intend to compensate employees for coming to the center with certain credentials. You want pay to be fair and equitable across the center, which means rewarding employees with similar education levels and credentialing in a similar manner. Some positions have various credentials and certifications associated with their roles that are compensated differently across the healthcare system. For example, registered nurses with critical care certifications can earn up to $32.88, while registered nurses with advanced cardiac life support certifications generally top out at $31.86 per hour, according to data from PayScale. Basic life support certification can earn nurses from $21.56-$29.56 per hour, while nurses with CPR certification can earn from $22.20-$30.76.

Coders are also compensated differently depending on credentials. The American Association of Professional Coders examined average coding salaries for 16 different coding credentials and found that salaries differed significantly based on credential. Statistics on salaries for employees with the job title "coder," divided by credential, are listed below:

CPC-A: $32,792
CPC: $39,953
CPC-H: $42,930
CPC-P: $45,750
CPC-1: $50,543
CASCC: $41,591
CANPC: $41,574
CCC: $40,250
CEDC: $50,000
CEMC: $45,000
CGSC: $42,500
CHONC: $35,357
COBGC: $43,690
COSC: $41,912
CIRCC: $45,595
CPMA: $42,937

The examples of registered nurses and coders indicate that different credentials demand different levels of compensation. Be aware that employees who come into the center with higher education, certification or credentialing may expect more than the industry average, and make sure your center pays consistently to avoid staff dissatisfaction and turnover. ■

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SCA
Surgical Care Affiliates

Surgical Care Affiliates (SCA) focuses on surgery centers, surgical hospitals and hospital system partnerships. A new leadership team has helped to transform the company during the past three years by developing a culture focused on patient care and physicians, hiring more than 25 new senior leaders and building systems and infrastructure in areas like clinical systems, supply chain systems and informatics.

SCA has been partnering with large not-for-profit health systems. SCA currently partners with 20 not-for-profit health systems, including Sutter Health (eight ASCs in partnership), Catholic Health Initiatives (three ASCs in partnership across two markets) and St. Barnabas (a recently announced partnership covering northern New Jersey). SCA also partners with one of the five pilot accountable care organizations in the country — Monarch Healthcare in Orange County, Calif.

SCA has also launched a new product aimed at helping independent surgery centers reduce the cost of surgical supplies and streamline their supply ordering process. The product is called Surgical Supply Savings Solution (S4) and includes an Amazon.com-like web interface and access to SCA's direct supply contract portfolio.

SCA's leadership team includes Andrew Hayek (president and CEO), Joe Clark (EVP and chief development officer), Michael Rucker (EVP and COO), Gregory Cunniff (EVP and CFO), Rich Scharff (EVP and general counsel), Rob Jardeleza (Sr. VP), Linda Lansing (Sr. VP), Shannon Blakeley (Sr. VP and president of the California ASC Association) and Goran Dragolovic (Sr. VP).

This leadership team has increased its investment in clinical systems and clinical support, improved physician satisfaction rates and led a turn-around in the company's financial performance, achieving three straight years of earnings and cash flow growth.

"We are committed to outstanding patient care, serving our physicians and improving the healthcare system by improving care and lowering healthcare costs," says Mr. Hayek. "We are very proud of our administrators and leadership teams at our centers and hospitals; they are achieving outstanding results clinically and operationally. Our role is to provide outstanding support to them as they care for patients and serve our physicians." www.scasurgery.com

health inventures.

Characteristics of a Successful Physician/Hospital Joint-Venture ASC

By Rob Kurtz

Tri-State Surgery Center, located in Dubuque, Iowa, is a physician/hospital joint-venture ambulatory surgery center. The ASC is managed by Health Inventures. It is a multi-specialty facility with three ORs, two GI suites and on track to do about 5,000 cases this year.

Mary K. Ryan, CASC, MBA, is administrator for the surgery center and has worked in it since its inception in 1998. She discusses the history of the ASC and how it has maintained success as a joint-venture ASC for more than 12 years.

Q: How did this joint-venture ASC come to fruition?

Mary Ryan: There's a large medical group in the Dubuque area called Medical Associates Clinic and Health Plans. In 1997, the physicians progressively envisioned an ASC in their new medical office building on the west side of Dubuque so they looked to the local hospital — Mercy Medical Center — to partner with because of the certificate-of-need legislation in Iowa. In hindsight, it was fortunate for the center to be set up this way since that seems to be the direction that the industry is moving.

In 1998, the ASC opened up as a department of the hospital for a few months and then in November it transitioned into a 50/50 joint venture between the physicians and hospital. . Health Inventures manages the ASC and has been the management company since the inception of the center and was involved in setting up the whole structure.

I was part of the Health Inventures' team from the beginning. Many of the staff members used to work at the hospital and transitioned over to the ASC as we were not only familiar with and respected this large physician group, we were excited about an opportunity to be a part of something new and wonderful for Dubuque. This was such an exciting time as we built a very knowledgeable and experienced team that would deliver exceptional care. I was fortunate enough to be hired as the director of nursing and then was able to grow into the administrator role a couple of years later.

Q: Why have the physician group and hospital been able to work well together for the ASC?

MR: We've been fortunate in that the leadership positions from the hospital and the physician group have been very supportive of the separate ASC entity. Our legal entity is a 50/50 deal between the two. We have three administrative members from the hospital on our board and three physician members from the clinic side as voting members. They have been able to come to the table with their surgery center hat on which has been an enormous benefit to the center itself. Sometimes they come to the table making decisions that impact the ASC which may not be the best possible decision with respect to their own organization. When everybody comes to sit at the table with the same goal in mind, it certainly makes it a lot easier for the ASC to succeed and thrive. This, in turn, means success for both organizations as well.

They also have two other joint ventures they parent together, which helps them to really maintain a strong working relationship. These include Tri-State Occupation Health services and the Family Care Network.

Q: A concern for hospitals entering into joint ventures is a loss of case volume to the ASC. How has this issue been addressed?

MR: Our hospital parent really rose to the occasion from the beginning. When we first opened, there were a lot of unknowns as to the large possible volume that was going to be transitioning from the hospital setting that would now be done at the ASC. They were able to backfill pretty quickly with more higher-acuity patients and different service lines.

Also, our ASC really looks at our specialty mix and payor mix very closely, and benchmarks the types of cases we're doing. Back in Jan. 2010, the ASC board decided that based on the new Medicare payments we were going to receive that it didn't make fiscal sense to continue to do Medicare GI procedures. That large case volume — we've predicted to be around 700 cases — was then transitioned out of the ASC and back into the hospital environment. It was a large in-flow of patients for the hospital in a short period of time. We complement the types of cases we do and try hard not to duplicate the types of procedures at both places.

It's really an ongoing collaborative effort between the two groups (physician group and hospital). If they did not work like this, the relationship could be difficult.

Q: What are some of the ways the ASC benefits from the hospital partnership?

MR: It's really easy for me to pick up the phone and give the hospital's human resources department a call to ask questions, for example, especially when we have questions about our pension, which the team is lucky to be able to participate in. There's a lot of information, knowledge and skill-sharing back and forth. Not only HR issues but we also tap into the laundry services, biomedical engineering and transcription at the hospital at fair market value. We tap into things already done very well at the hospital which would not make sense for us to try to replicate.

Also, ASCs sometimes run into situations when they don't have the instrumentation or the sterile supplies they need. It's nice to look to your hospital partner for sharing.

Q: What is an area you have been targeting for improvement between the ASC and the hospital?

MR: Referring the previous statement, it's important to remember to not over-ask for items. What we really try to do here is make sure that not only are we in this relationship for borrowing and obtaining resources from the hospital but also to make sure the hospital is aware of the resources we have here at the ASC that perhaps it doesn't make sense for the hospital to also own. We'll purchase or own [a resource] and maybe loan it to them for fair market price. That's been something we've been working really hard on and is something we can probably do better.

Q: What do you think is critical to starting the joint-venture relationship off on the right foot?

MR: When you start talking about doing a joint-venture, make sure both parties come to the table and explain what they can bring to the relationship, what are their individual strengths. Make sure every time you get together, you're talking about what each partner is bringing that adds value. If you explore that early on, then you don't have to build that or look for it as you work through the process. From the physicians' perspective, they're bringing the patients so it is important to identify what the hospital partner is going to do to help support the entity.

One of the things I'm referring to is payor contracting. Is that something the hospital can bring to the table? Can it introduce [the ASC] to some of the major players in the market and help perhaps get a better reimbursement contract than what the ASC might be able to negotiate on its own?

Also, what kinds of resources and equipment can each entity bring to the table? The hospital's HR management — is that something the ASC tap into to? Consider equipment and supplies — does it really make sense for both [the ASC and hospital] to acquire a lot of the same equipment or is it worthwhile to set some up an agreement so we can make sure we're both utilizing one piece of equipment? . We lease our space from the physician group and are located within one of their medical office campuses, so we are able to utilize many of their resources as well. This includes IT support, maintenance services, printing, some janitorial services and access to their loading dock. So you can tell how integrated and committed both entities are with respect to the success of our center. ■

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

5 Key Legal Issues Affecting Surgery Center Joint Ventures

By Rachel Fields

Scott Becker, JD, CPA, partner with McGuire Woods LLP, discusses five issues that can affect the legality of hospital/physician ASC joint ventures.

1. Percentage of hospital ownership. According to Mr. Becker, there are several different arguments about the necessary percentage of hospital ownership of a joint venture ASC. Generally, a hospital, whether a for-profit or not-for-profit, does not need to own 51 percent of the joint venture, though that level of ownership can help in managed-care contracting and tax-exempt concerns. Tax-exempt concerns can generally be addressed through control of management rather than ownership, he says.

"Some hospitals will say, 'We're told by our lawyers that we have to own more than 51 percent to make sure this doesn't harm us from an exempt in-

come standpoint,'" Mr. Becker says. "The much more important issue is: Does the hospital have sufficient control to ensure the joint venture serves community/charitable purposes?" He says the IRS is primarily concerned with whether the hospital can exert control over the surgery center to force it to serve and prioritize community/charitable purposes.

Mr. Becker says in some cases, an ASC management company and the hospital set up a venture together that facilitates hospital control. For example, the hospital might own 51 percent of the hospital-management company venture (holdco), which, in turn, owns 51 percent of the ASC joint venture. While the hospital may only own 26 percent of the joint venture overall, the hospital attempts to maintain sufficient control of the ASC by controlling the venture through the holdco.

2. Anti-trust issues. A key issue is whether a hospital and ASC can jointly contract to obtain better rates from managed care payors. Increasingly, payors examine the ownership of the hospital in the ASC and the extent of clinical and financial integration between the hospital and ASC.

Under case law, it has traditionally been perceived that 80 percent or more hospital ownership makes it impossible for the hospital and surgery center to conspire with each other, while 50-80 percent hospital control may meet different determinations from region to region. A hospital that owns less than 50 percent of a surgery center must demonstrate significant control or clinical and/or financial integration if the two entities are to be able to approach payors together.

Mr. Becker also notes that payors may react very differently in dealing with managed care contracting for hospital/ASC joint ventures. "If the hospital is a core provider that works extensively with the payor, the payor may immediately be very receptive," he says. "Other payors say unless the hospital owns a large percent, the ASC and the hospital have to be treated as totally separate."

3. Determining fair market value. If the surgery center is being formed from an existing hospital department, the valuation placed on the new free-standing joint venture must be fair market value, Mr. Becker says. There are multiple ways of determining fair market value, but the hospital must make sure the fair market value price has been researched and can be defended. Further, as units are sold to new physicians, they also must be sold at not less than fair market value.

4. Medical staff relations. In forming a hospital/physician ASC joint venture, the hospital and center must determine how medical staff issues will be handled by each entity. Most joint ventures keep medical staff for the surgery center entirely separate from the hospital. Others require that the surgery center physicians take call at the hospital. According to Mr. Becker, many joint ventures use two separate medical staff but require that physicians on staff at the surgery center hold admitting privileges at the hospital so that patients can be transferred easily in case of an emergency at the surgery center. There may also be an overlap in credentialing between the two facilities.

5. Physician acquisition and investment. A more recent issue for hospital/physician ASC joint ventures concerns the acquisition of physicians in the local community. If the hospital starts employing physicians, will those physicians still be allowed to invest in the surgery center? "Many hospitals do not allow it," Mr. Becker says. "We believe that as long as the physician has to meet the same requirements as other physicians and isn't forced to invest in the center or helped to invest in the center, it should largely be acceptable." If acquired physicians are not allowed to invest in the surgery center, that could prove fatal for the center's business in some situations, he says. ■

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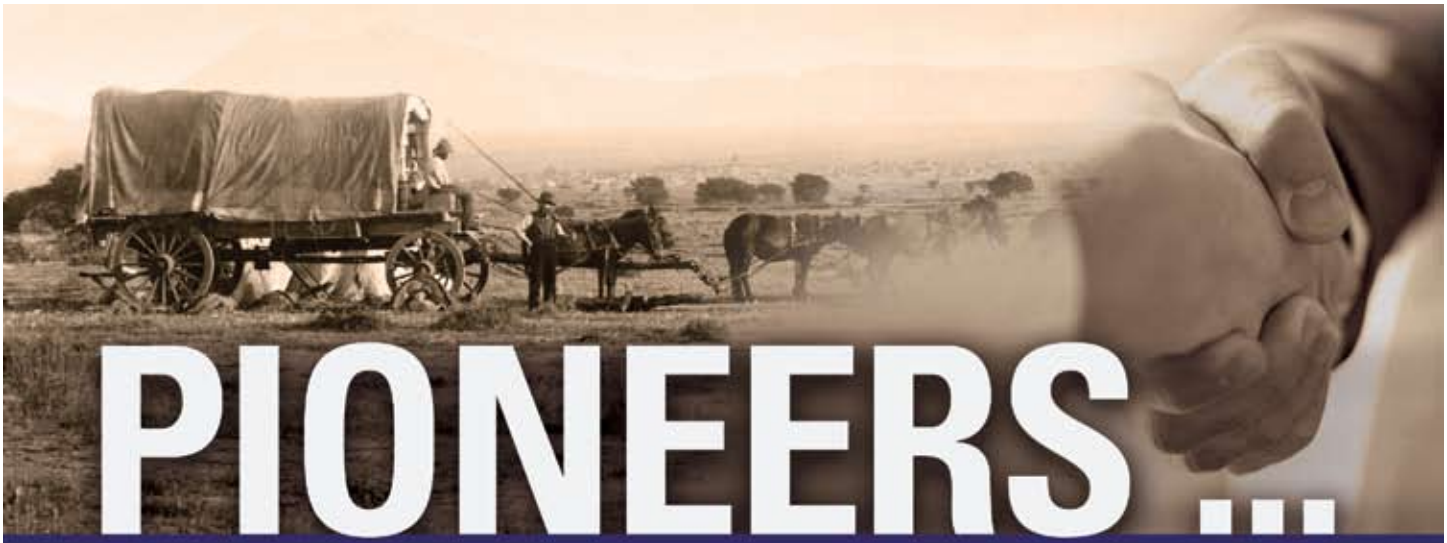

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6 Benefits for an ASC With a Hospital Partner

By Leigh Page

Boulder (Colo.) Surgery Center, covering orthopedics, sports medicine and pain management, is co-owned by its physicians and 265-bed Boulder Community Hospital. Most of the 21 affiliated physicians are owners of the center, which has three ORs and a pain management suite.

Here Jill Sellars, business manager at the ambulatory surgery center, lists six benefits of Boulder Surgery Center's relationship with the hospital.

1. Allowing physician autonomy. The hospital opened an HOPD in 2000, but a few years later, orthopedic surgeons at the facility started to make plans for their own ASC. "They didn't feel they were getting enough block time on the schedule," Ms. Sellars says. "The hospital's response was, 'Let's not lose you. Let's become collaborating partners.' " The hospital and physicians opened the ASC in 2005 under a 50-50 ownership plan with the hospital as "silent partner," not involved in day-to-day management.

2. Accessing favorable payor rates. The ASC uses the clout of the hospital to get very favorable contracted rates from payors. The contracts are separate, but "the same people who negotiate the contract for the hospital negotiate our contracts," Ms. Sellars says. While the ASC's rates are not as favorable as the HOPD's, they are much better than what ASCs typically get. "We have an incredible advantage in negotiations," she says.

3. Collaborating on schedules. "The hospital and the ASC work together on scheduling," Ms. Sellars says. "If a case can't be done at the ASC, it will go to the hospital." She is on the phone with the surgery scheduler at the hospital several times a day, discussing cases. "There's a lot of back and forth," she says. If one of them can't fit in a case, the other will take it up, as long as it is clinically appropriate and there is an opening on the schedule.

4. Accepting cases so patients pay less. Since surgery rates are lower at the ASC than at the hospital, hospital financial counselors often send cases to the ASC when the patient has to pay high out-of-pocket charges but earns too much money to qualify as an indigent case. Ms. Sellars is frequently on the phone with financial counselors discussing these cases.

5. Trading equipment and supplies. Although the ASC is responsible for its own purchasing, in a pinch it can trade equipment and supplies with the hospital's surgery suites just across the street. "They borrow from us and we borrow from them," Ms. Sellars says. "If we don't have a kit for a specific surgery, such as an allograft, we call on the hospital to see if we can get one from them."

6. Sharing services. While the ASC pays for its own services, it shares volume discounts used by the hospital for certain services, such as dictation and telephones. The hospital is installing an electronic health records system, but the ASC won't be connected to it, at least for now. "We may have to join it in the future, but the surgeons here prefer paper records," Ms. Sellars says.

Are there any negatives to linking up with a hospital? "I can't think of any," she says, "except maybe that some physician-owners might not like having to share profits with the hospital." However, she has not heard these concerns from her surgeons. ■

Learn about Boulder Surgery Center at www.bouldersurgerycenter.com.

5 Ways to Build a Great Hospital/ASC Joint Venture

By Rachel Fields

Jim Stilley, CEO of Northwest Michigan Surgery Center in Traverse City, Mich., discusses five ways his ASC has worked with Munson Medical Center to build a strong relationship and reap the benefits of a joint venture.

1. Maintain the difference between hospital and ASC culture. In the beginning, Mr. Stilley says neither the hospital nor the ASC surgeons fully understood the structure of a hospital-ASC joint venture, and the two parties had different goals. "Some emerging hospital/ASC joint ventures are having problems because they struggle to identify the physician-centric nature of the center," he says. He says the hospital now collaborates with the center to produce policies that fit with the ASC's culture.

2. Install a completely separate leadership structure. If possible, separate hospital and ASC leadership to give the ASC more control over its culture. Mr. Stilley is the CEO of Northwest Michigan Surgery Center, and the board membership is comprised of some the center's physicians and hospital leadership. Northwest Michigan Surgery Center staff members are also employed by the surgery center and not the hospital.

3. Alter hospital policies to fit the ASC's needs. Many hospital/ASC joint ventures struggle because the ASC adopts hospital policies without tweaking them to fit the center's physical location, layout, staffing structure and culture. When hospital policies are moved over to the NMSC, Mr. Stilley says both parties consult federal and state guidelines to determine what must be done and what can be altered. For example, the ASC altered policies for preop screening of anesthesia delivery because the hospital inpatient setting required a different method of screening than the ASC.

4. Don't encourage competition. A hospital and an ASC that enter a joint venture may be historical rivals, but Mr. Stilley says once the center has been established, ASC administrator should encourage employees to let go of that competition. "You're not really competing on the same playing field as the hospital, and we had to back off on that competition," he says.

5. Ask for help when you need it. The whole point of a hospital/ASC joint venture is the positive changes it brings for both facilities, so don't be afraid to take advantage of them. When Mr. Stilley's center needs a radiology or pharmacy consultant, the center uses a hospital consultant. When the center was nominated for a national award, the hospital helped the ASC by creating a poster presentation through its marketing department. ■

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10 Traits of Highly Successful Surgery Center Administrators

By Rachel Fields

A great administrator is essential to the success of an ambulatory surgery center. Tasked with reducing costs, increasing revenue, boosting morale, satisfying surgeons and preparing for the future, administrators must be capable in multiple areas if they are to lead an extraordinary facility.

Five ASC industry veterans discuss 10 of the traits that make highly successful surgery center administrators.

1. They respond quickly. Great administrators are responsive to their physicians and personnel, says Greg Zoch, partner and managing director at Kaye/Bassman International Corp., an executive search firm specializing in the ASC industry. When they hear about a problem, they provide a solution as soon as possible, rather than listening to give an appearance of commitment and then immediately forgetting the issue when the employee leaves the administrator's office. If an administrator does not follow up on problems, employees will stop bringing them up, and issues will fester and grow until dissatisfaction has spread across the facility. If an administrator regularly provides prompt solutions or supports employees in resolving the issues themselves, staff members will trust the administrator to respond appropriately when a serious issue arises.

Linda Deeming, facility administrator of Longmont (Colo.) Surgery Center, says a fast response time is essential when responding to patient issues as well. If you ignore a patient complaint, you can expect the patient will talk to their friends and family and could damage your ASC's reputation in the community. If you jump on the issue immediately and apologize and offer a solution, you will show your respect for the patient's business.

2. They hold themselves and others accountable. "Great administrators accept responsibility, and they also expect it from others," Mr. Zoch says. He says the promotion of accountability is a symbiotic relationship: If administrators show leadership by taking responsibility for their actions, physicians and staff members will see it and take responsibility themselves.

Administrative accountability means accepting responsibility when something goes wrong, even if the problem is not directly linked to the administrator's actions. "Even if it's a failure of the infection control program, the leader always holds himself accountable for the failure being

able to occur," Mr. Zoch says. "A good leader will say, 'I let you down by allowing an environment to exist wherein this could occur. Now what are we going to do to fix it?'" Once accountability has been established, a great administrator will move on to a solution rather than lingering on the problem. Understanding the root cause of a problem is useful, Mr. Zoch says; pointing fingers or assigning blame is not.

3. They can articulate a clear vision of the future. Joseph Zasa, co-founder and managing partner with ASD Management, says a successful administrator will have a clear idea of the center's direction and will not easily flip-flop on that vision. "They convey the mission of the center in a clear fashion and follow through," he says.

Mr. Zoch says a great administrator will articulate the vision so well that employees and physicians at the center will buy into the vision too. "Their buy-in will be visible in the way they approach their jobs, as well as in their attitudes and their quality of work," Mr. Zoch says. He says the center's vision should be a team vision rather than the administrator's individual agenda.

However, the ability to articulate this vision does not mean the administrator should articulate it constantly. "The last thing I want is somebody who's going to sit in their office all day and create pie charts and talk about the direction of the center and then leave the day-to-day operations to the staff," Mr. Zasa says. The center's mission and vision should be articulated semi-regularly and then demonstrated through cost-cutting actions, recruitment or relationship-building with other facilities.

4. They pay attention to detail. It is a rare leader who can keep an eye on the details while understanding the bigger picture of the center's direction — but Mr. Zoch says both qualities are essential for a top administrator. "They can drill down and focus on the details, but they can also back off and let people do their jobs," he says. "It's about delegating and respect. The poor manager gets into the details and then micromanages and never lets go." He says an effective administrator will understand the details of the surgery center and keep up-to-date on financials and performance — but will not meddle in duties that belong to other members of the team.

Mr. Zasa agrees that the ASC administrator should be able to control the key cost indicators that drive a center's success. "You need somebody there on site who's focused on supply costs, physician satisfaction, clinical objectives — all the key things that make centers good," he says.

5. They understand their employees. The ASC industry is a people-oriented business, Mr. Zasa says. "Particularly with the staff and the surgeons, you can't treat them all the same," he says. "Great administrators are really good with people and [are able] to motivate them to meet the objectives of the center." He says when people think of motivation, they often think of inspirational speeches, but the real work can be much more subtle than that. Great administrators understand what drives different personalities, and they know whether to lead by example, give direct coaching or ask for suggestions based on the individual. He says this level of understanding also helps when an administrator needs to deal with an upset employee.

Stephanie Stinson, administrative director for Strictly Pediatrics in Austin, Texas, agrees that personal relations are the biggest driver in administrator success. "The biggest thing is how you talk to someone," she says. "Sometimes you have to bring people in and talk to them more like they're your family than they're your employee. You can't forget that we are all humans and everyone is going to make mistakes." She says a great administrator will also recognize when employees do well. If the administrator recognizes employee achievement and makes those successes known to peers and physicians, everyone will feel motivated to work harder and appreciated for their efforts.

6. They are driven to learn about the business. Ms. Stinson says in her 10 years in the ASC business, she has had to learn a lot about operating a successful center. "It took a lot of long, hard hours because I wanted to learn it," she says. "That's part of being successful. It's a very demanding position, and you have to have the drive to succeed."

She says one of her biggest challenges was adjusting to the pediatric-driven nature of her ASC. "I had no pediatric experience other than nursing school, and I came to start a facility when it was a concrete slab going to all pediatrics," she says. "I had to learn everything, especially about how you approach pediatric physicians." This quality is essential because the administrator role requires so many different areas of knowledge.

William Prentice, executive director of the Ambulatory Surgery Center Association, says this drive also applies to credentialing. Since the Certified Administrator Surgery Center credential was first awarded in 2002, more than 500 people have elected to become CASC-certified. "Credential holders and many others in the ASC industry routinely tell us that the credential helps them instantly identify those administrators who 'know what they're talking about' and have mastered the unique and complex skill set involved in managing an ASC," he says. "They also say that the certification program has contributed in significant ways to recognizing the unique and valuable role that ASCs play in the U.S. healthcare system today."

7. They get their hands dirty. A great ASC administrator will not always be holed up in his or

her office, crunching numbers and keeping out of sight, Mr. Zoch says. Great administrators will show willingness to put on scrubs and find out what's happening in the back of the house.

Mr. Zasa agrees: "They lead by example," he says. "They don't have princess syndrome where they sit in their office telling everyone else what to do. They're back there helping people turn rooms." Mr. Zasa says administrators who do not pitch in during busy times will end up with dissatisfied staff. "If they leave the day-to-day running of the center to the staff, staffing costs will be out of control and staff will be upset all the time because the director doesn't even get in the back with them," he says.

8. They can sense small changes in the tone of the ASC. Great administrators don't have to be told that staff members are unhappy or physicians are considering hospital employment; they already know, Mr. Zoch says. Administrators should be constantly watching the tone of the surgery center to determine whether changes need to be made. "They're responsive to things that most people wouldn't even notice. They can feel the wind shift a little bit," he says. "It may be something subtle in the mood that seems to be off one day." While the administrator might not react immediately to the shift, they will keep an eye on the change to see if it continues.

The same is true in the healthcare industry overall. A poor administrator will ignore major changes to the industry, such as the advent of accountable care organizations, decreases in reimbursement and the uptick of physician employment, by pretending that everything will be fine. A strong administrator will notice these trends and determine whether the center can survive without major operational changes — or whether partnership with a hospital or management company is essential considering the climate.

9. They don't play favorites. Choosing "favorite" staff members is the surest way to turn employees against you, Mr. Zasa says. If an administrator favors one nurse over another nurse and shows that favoritism, the center risks losing the unhappy nurse and creating a chasm between employees. "Great administrators are fair and equitable to all staff members," he says.

Ms. Deeming agrees that treating employees fairly is the best way to handle a dispute between disagreeing staff members. Great administrators invite employees to their office individually to discuss their perspective on the problem, rather than pitting employees against each other. They don't say, "This employee was talking about you behind your back," but rather ask if the staff member has input on the atmosphere at the center and then take the answer seriously, she says.

10. They don't crumble in hard times. The last few years in healthcare have been difficult, especially for small surgery centers with limited case volume and declining reimbursements. But strong administrators have weathered the storm, Mr. Zoch says, and they've done it without ruining relationships or destroying morale. "Too often, when layoffs occur or people are flexed off, it's not done with a degree of empathy or the greatest finesse," he says. "From a human as well as a business perspective, it's good to sit down with the team and explain why things are changing. It communicates respect and value, and it allows you to keep the really good people that you want to keep on board."

He says a great administrator will explain that the center simply doesn't have enough work for all its staff members, and everyone will have to decrease their hours for awhile to make up for lost revenue. "If they feel like it's an edict from on high, they're more likely to look for other work," he says. "If they're brought into the fold and they understand the big picture, they feel like they're part of the team and part of the solution." ■

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8 Observations on Current ASC Transaction and Valuation Trends

By Rob Kurtz

Todd J. Mello, ASA, AVA, MBA, partner with HealthCare Appraisers, shares eight observations on current ambulatory surgery center transaction and valuation trends.

1. Consolidation of large management and development companies. As the opportunities to acquire individual ASCs become tougher, the larger M&D companies with capital are looking to acquire other M&D companies and their portfolio of ASCs, Mr. Mello says. One recent example of this growing trend is the acquisition of National Surgical Care by AmSurg.

2. Diversification of M&D companies. The AmSurg acquisition may indicate M&D companies are looking not only to grow but also to diversify their portfolios, Mr. Mello says. "AmSurg has traditionally been a single-specialty company — predominantly GI and ophthalmology — and with the acquisition of NSC, that represents a bit of change in strategy for AmSurg to look toward multi-specialty."

3. Out-of-network ASCs still under the spotlight. OON ASCs have been a hot topic for quite some time, and the "resistance" within the marketplace for purchasing OON centers has heightened. "There's still a lot of discussion and concern about the ability of these OON centers to sustain the income stream," Mr. Mello says. "The question is when will that earning stream stop? There's so much uncertainty. We know it's going to come down. But we don't know when and we don't know to what magnitude, so from a valuation perspective, that translates into additional risk … which would drive down value."

4. Valuation of OON ASCs under projected in-network rates. "We're seeing anybody who might be willing to buy a predominantly OON ASC to essentially convert, on paper, to in-network and then put a typical market multiple, as opposed to putting a typical market multiple on the OON earning stream," Mr. Mello says.

5. Hospitals buying ASC physicians outright. More hospitals are looking to acquire all of an ASC as opposed to a percentage of the physician-owners' shares. "The hospital's expectation is once they can buy it outright, it becomes a department of the hospital, and they can bill cases at the hospital fee schedule, which is typically higher than the ASC rate for most procedures."

6. Creation of management arrangements to maintain acquired physicians' interest. Hospitals cannot legally pay physicians for the increase in revenue that usually occurs when an ASC becomes a department of a hospital following an acquisition. "This leads to a concern regarding how the hospital keeps the doctors interested if the physicians no longer own equity in the center," Mr. Mello says. "What we're seeing there is basically creation of certain management companies whereby the physicians may provide certain services to what formerly was the ASC but now operates as a department of the hospital post-acquisition. This helps keep the physician tied in to the success of the department."

7. Compensation tied to productivity. Unlike the employment-model trend last seen in the 1990s, Mr. Mello says hospitals are becoming more disciplined in tying compensation paid

to employed physicians to productivity requirements, probably based on advice of counsel and valuation firm alike, to help keep physicians motivated to work.

8. Increase in hospital-employed physician deals. Mr. Mello says he is seeing more physician employment deals with hospitals. This is occurring not as frequently with surgical specialists commonly found in ASCs but primarily in the cardiology area. While this does not necessarily have a huge impact on ASCs, as hospitals continue to employ physicians, Mr. Mello expects to see an even greater increase in activity of hospitals buying out physician/hospital ASCs because the hospital will wants to keep all specialties under its umbrella.

"With pressure in reimbursement, we do see the employment model picking back up," Mr. Mello says. "The cardiology ones are predominantly driven by the changes in diagnostic imaging reimbursement. But we are also seeing large, multi-specialty groups being acquired — surgical, family practice and non-surgical acquisitions. Over the last 24 months, physician practice acquisition activity has really picked up. I think it's fear of reimbursement and the unknown." ■

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

smp SURGICAL MANAGEMENT PROFESSIONALS ™

SMP is based in Sioux Falls, S.D. SMP specializes in ownership, development and management of ASCs and surgical specialty hospitals. SMP currently manages 11 surgery centers and hospitals throughout the United States and Canada.

SMP provides comprehensive services to ASCs and specialty hospitals including revenue cycle management, clinical services, managed care contracting, human resources and information technology. SMP recently announced that it is now providing billing services for physicians and plans on providing facility and physician managed care contracting review and negotiations later this year.

SMP is under the direction of President and CEO Michael Lipomi, MSHA. SMP leadership includes Chief Operating Officer Reed Martin, CFO Allison Bolger and V.P. of Clinical Services Mary Sturm. The leadership team has over 100 years of collective service in the healthcare industry with an emphasis in surgery center and hospital management.

SMP offers its services to facilities where it has an ownership interest as well as non-owned facilities. Services include feasibility studies through full service management. SMP also offers a wide range of selected consultative services.

"Working for physicians who have a working knowledge of what it takes to develop a successful surgery center or hospital provides many benefits to SMP leadership and our facilities," says Mr. Lipomi. "Having the very best executives and staff keeps things moving forward and allows us to achieve the clinical and financial excellence we strive for in every relationship." www.smpsd.com

100 Orthopedic- and Spine-Driven ASCs to Know

Here are profiles of 100 orthopedic- and spine-driven ASCs. Surgery centers are listed in alphabetical order by name. *Editor's note:* To view the complete profiles of these ASCs, visit www.beckersasc.com/orthospine2011.

Ambulatory Surgical Care Facility (Aurora, Ill.). This ASC opened in Dec. 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.

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.

The BACK Center (Melbourne, Fla.). "BACK" stands for "Back Authority for Contemporary Knowledge." It is affiliated with Brevard Orthopaedic Spine and Pain Clinic. It has 10 physicians, including four orthopedic surgeons. In 2009, the BACK Center consolidated into one full-service spine center, diagnostic testing and two satellite locations.

Bayou Region Surgical Center (Thibodaux, La.). The center's largest service lines are orthopedics and ENT, and additional services include neurology and pain management. Bayou Region has three ORs and one endoscopy room, with potential for a fourth room.

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. Practice physicians focus on a wide range of orthopedic problems including the knee, ankle, shoulder and hip.

Bellingham (Wash.) Surgery Center. This center, with four ORs and an eight-bed recovery room, is connected to the community medical record and the community PAC digital imaging system. The ASC participates in Symbion's internal monitoring and tracking systems on patient care, safety, operations, quality improvement and patient satisfaction.

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. In addition to orthopedics and spine, it hosts general surgery, ENT, ophthalmology, GI, pain management, plastics, pediatric dentistry, podiatry and oral maxillofacial surgery.

Blue Bell (Pa.) Surgery Center. This four-OR, multi-specialty ASC opened in Sept. 2008 and specializes in orthopedics and spine. It has 22 physician owners, including six orthopedic surgeons. Blue Bell sees approximately 225 patients per month and is managed by Ambulatory Surgical Centers of America.

Boston Out-Patient Surgical Suites (Waltham, Mass.). BOSS opened in July 2004 and specializes in orthopedics and pain management. It features 19 orthopedic surgeons from five practices.

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 center also includes physiatrists who subspecialize in the treatment of spine-related pain.

Cedar Park (Texas) Surgery Center. Services at Cedar Park Surgery Center include pain management, spine and neurosurgery, orthopedics, general surgery and urology. Orthopedic and spine surgery services include Bankart procedure, amputation and minimally invasive spine surgery.

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. It is a 50-50 equity partnership between 16 physician-owners and The C/N Group.

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. The center is managed by Symbion.

The Center for Orthopedic Surgery (Van Nuys, Calif.). The center was developed and operated by physicians at Southern California Orthopedic Institute and is located within the institute. The center pioneered the development of arthroscopic surgical procedures, particularly in the shoulder, wrist and ankle.

The Christ Hospital Spine Surgery Center (Cincinnati). This ASC is a partnership between the Mayfield Clinic, The Christ Hospital and United Surgical Partners International. Its neurosurgeons perform lumbar laminectomies, anterior cervical discectomies and fusions and single-level spinal cord decompression.

Citrus Park Surgery Center (Tampa, Fla.). This two-OR center covers spine and orthopedic surgery as well as pain management and plastic surgery. Surgeons at the ASC perform several procedures, including minimally invasive spine surgery and hip arthroscopy.

City Place Surgery Center (Creve Coeur, Mo.). Founded in 2000, this 13,200-square-foot orthopedic surgery center has four ORs and 19 physician partners. It joined Meridian Surgical Partners in Sept. 2010.

Concord (N.H.) Orthopedics Surgery Center. The ASC was opened in Feb. 1995. It is a collaborative effort between the physicians of Concord Orthopaedics and the Concord Hospital. The surgeons cover foot & ankle surgery, hand surgery, orthopedic traumatology, osteoporosis, pediatric orthopedics, spine care, sports medicine and total joint surgery.

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.

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. Since the facility opened in 2006, it has doubled the number of ORs from two to four.

East Portland Surgery Center (Portland, Ore.). Specialists at East Portland Surgery Center provide orthopedic, neurosurgery, general surgery and pain management services. The surgery center has state-of-the-art technology in the four operating rooms and two treatment rooms.

Eastwind Surgical (Westerville, Ohio). Eastwind Surgical was established in 2007 as a surgery center for neurosurgical and pain management procedures. Surgeons perform lumbar and cervical discectomy, decompression, ulnar nerve decompression, discography and myelography. The ASC partners with Central Ohio Neurological Surgeons.

Evergreen Orthopedic Surgery Center (Kirkland, Wash.). Evergreen Orthopedic Surgery Center includes physicians who subspecialize in sports medicine, spine and extremities care. The Evergreen Orthopedic Spine Institute provides minimally invasive and complex surgical revision and non-surgical treatment.

Front Range Orthopedic Surgery Center (Longmont, Colo.). Founded in 1970, physicians at Front Range 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.

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. Hand Surgery Specialists serves about 25,000 outpatients a year.

Honolulu (Hawaii) Spine Surgery Center. This Symbion center involves three orthopedic surgeons and five neurosurgeons. The 7,800-square-foot center opened in 2007. It has two ORs and a private recovery room, and provides a wide variety of equipment for minimally invasive surgeries.

Houston Orthopedic Surgery Center (Warner Robins, Ga.). The center consists of two ORs, a sub-sterile area, four preoperative rooms and five PACU beds. Procedures include anterior cruciate ligament reconstruction, carpal tunnel release, trigger finger release and spine surgery.

Illinois Sports Medicine & Orthopedic Surgery Center (Morton Grove, Ill.). The center has four ORs and one procedure room. The orthopedic surgeons cover arthroscopies, ACL reconstructions, arthroplasties, carpal tunnel releases, meniscectomies and spine procedures.

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.

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 clinic established a fellowship program in 1973, and it is now one of the largest in the country, with more than a dozen fellows.

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. The ASC also features complete orthopedic radiologic imaging, physical therapy and a hand therapy rehabilitation center.

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 and a physical therapy department. Surgeons treat a number of degenerative spine conditions, including spinal stenosis, herniated disc and pinched nerve.

Louisville (Ky.) Orthopedic Surgery Center. The center, with three pre-op rooms and six recovery rooms, specializes in the knee, hip, shoulder, foot and spine surgery. Its surgeon-partners are part of Louisville Orthopedic Clinic. The clinic also provides imaging and physical therapy.

Loveland Surgery Center (Loveland, Colo.). Loveland hosts about 3,400 orthopedic, spine, pain management and ENT procedures annually. It has seven physician-owners. Loveland Surgery holds a convalescent license, allowing it to cover more complex surgeries.

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.

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. Procedures performed at the ASC include minimally invasive discectomies and spinal fusions.

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, pediatric and spine surgery. It also offers MRI services.

Midland Surgical Center (Sycamore, Ill.). Midland is a joint venture between a local health system, five orthopedic surgeons and Regent Surgical Health. Physicians at the surgery center offer an array of orthopedic and spine procedures, including ACL repair and vertebroplasty.

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. The facility takes a holistic approach to healthcare by providing a full spectrum of treatment options, from physical therapy to surgical intervention.

Missoula (Mont.) Bone and Joint Surgery Center. The facility specializes in orthopedic and plastic surgery and is located next to the offices of Missoula Bone & Joint, an eight-physician orthopedic practice. Their subspecialties include sports medicine, joint replacements, hand and microvascular surgery, foot and ankle reconstruction and spine care.

Moore Orthopaedic Clinic Outpatient Surgery Center (Lexington, S.C.). This two-OR, 14 physician center, opened in late 2007. Developed and managed by Practice Partners in Healthcare, the center scores very high in all categories of patient experience. The center has access to electronic medical records.

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. The facility houses three ORs, one procedure room, 10 pre- and postsurgical rooms and six recovery beds.

New Mexico Orthopaedic Surgery Center (Albuquerque, N.M.). New Mexico Orthopaedic has six ORs and one treatment room for orthopedic surgery, pain management and podiatry. The center's partners include more than 20 physicians and its corporate partner, United Surgical Partners International. The facility is currently planning a $3.5 million expansion.

Northeast Surgical Care (Newington, N.H.) This one-OR surgery center has three orthopedic surgeons and one ophthalmologist. In planning stages more than 10 years ago, the center faced a great deal of resistance from a local hospital system. However, the one OR frequently functions at maximum capacity.

NorthStar Surgical Center (Lubbock, Texas). Clinical staff members at this multispecialty center are cross-trained in other specialties but there are crews who primarily focus in orthopedics. Orthopedics procedures at this Symbion center include shoulder, knee and hand surgery.

Practice Partners™ In Healthcare, Inc. Surgery Centers

Practice Partners in Healthcare develops, manages and purchases a minority ownership interest in ambulatory surgery centers. The company was founded by Larry Taylor, president and CEO, in 2005.

PPH currently has more than a dozen surgery centers in operation or in the development and construction phase. The company has a physician focused-model providing expertise in operational, clinical, financial and regulatory performance of new and existing surgery centers. PPH has experience in both CON and non-CON states.

The company, which charges no development fees, is also involved in developing and managing physician-owned and hospital/physician joint-venture surgery centers, and has experience in turnaround situations or ASCs that are underperforming, developing plans of correction under the company's "performance guarantee".

"Practice Partners in Healthcare's primary goal is to develop and operate exceptional ASCs for our partners and exceed all customers' expectations," says Larry Taylor. www.practicepartners.org

OA Surgery Center (Portland, Maine). The two operating room surgery center includes MRI, CT scans and x-ray diagnostic services. The physicians subspecialize in knee, shoulder, spine, hand, foot and hip replacement surgery. The team also includes orthopedic trauma and fracture care physicians.

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.

Olympia (Wash) Orthopaedic Associates Surgery Center. The center is affiliated with Olympia Orthopaedic Associates. Founded in 1970, the practice has 13 physicians, making it the largest full-service orthopedic group in the South Puget Sound area. On-site diagnostic tools include X-ray, nerve conduction studies, open and extremity MRI.

Orlando Orthopaedic Outpatient Surgery Center. This new center opened in Sept. 2010. It has four ORs and a pain management center. The center is affiliated the 17 physicians of Orlando Orthopaedic Center. The practice is divided into centers for spine, joint, hand, foot and ankle, pediatric, sports medicine, oncology and physical therapy.

Orthopaedic Associates of Wisconsin (Waukesha, Wis.). Orthopaedic Associates of Wisconsin opened a new surgery center in 2007. The center includes surgical equipment for arthroscopic procedures and an MRI for diagnostics. 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.

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.

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. It hosts spine surgeons, orthopedic surgeons and pain management physicians.

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 thriving facility now hosts 11 orthopedic surgeons from Sports Medicine North in Peabody as well as three pain management specialists, a podiatrist and urologists.

Orthopedic Specialty Group Surgery 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, along with other procedures.

Orthopedic & Sports 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.

The Orthopedic Surgery Center of Arizona (Phoenix, Ariz.). This center was developed by 15 orthopedic surgeons and Cornerstone Surgi-

cal Partners. All ASC physicians, nurses and healthcare professionals are actively involved in operational decision-making at the center.

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. Orthopaedic Surgical Center and its sister center, Surgical Center of Greensboro, have a total of 13 ORs. The center is a member of Surgical Care Affiliates.

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. The center was opened in 1999 and services include sports medicine, hand and wrist, foot and ankle and total joint surgery.

Orthopedic Surgery Center of San Antonio (Texas). The Orthopaedic Surgery Center of San Antonio at The Orthopaedic Institute offers a full range of orthopedic services, including arthroscopic surgery. Ancillary services at the ASC are comprised of MRI and CT scans as well as physical and hand therapy.

Parkway Surgery Center (Hagerstown, Md.). Parkway offers comprehensive spine treatments and non-invasive spine surgical procedures. With four neurosurgeons and three physiatrists, it is part of the Blue Chip Surgical Center Partners network. The center includes five operating rooms and one treatment room.

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, and medical staff include physicians from The Steadman Clinic in Vail, Colo.

Peninsula Surgery Center (Newport News, Va.). This multispecialty center features four ORs and five orthopedic surgeons. The center hosts orthopedics and spine surgery and sports medicine. It is a partnership between area surgeons and Riverside Health System.

Physicians Day Surgery Center (Naples, Fla.). This 8,500-square-foot facility was founded in 1998. Entirely physician-owned, it performs approximately 3,000 cases annually, mostly in orthopedics, ENT and general surgery.

Piedmont Surgery Center (Greenville, S.C.) In addition to spine, the center covers ophthalmology and ENT. Of its 12 physicians, three focus on spine surgery. The center, developed by Ambulatory Surgical Centers of America, hosted its first case in Sept. 2008.

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. With Symbion as a partner, the center has 11 physician-investors and is about to add another one.

Ravine Way Surgery Center (Glenview, Ill.). Ravine Way, focusing an orthopedics and pain management, opened in 1996. Now its surgeons perform approximately 1,600 cases annually. It features three ORs, one procedure room and a staff of 21 physicians.

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

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.

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.. It is affiliated with Virginia Orthopaedic.

Rockford (Ill.) Orthopedic Surgery Center. This facility is affiliated with Rockford Orthopedic Associates. The center opened in 2004 and by 2009 it was logging 2,800 surgical cases and more than 5,300 procedures. It has been running at near capacity and its leadership has been reviewing plans for expansion.

St. Louis Spine & Orthopedic Surgery Center (Chesterton, Mo.). The 6,000-square-foot center, affiliated with Symbion, hosts orthopedic surgery, spine surgery and pain management. It is home to four orthopedic surgeons and four spine surgeons. It features two operating rooms, four spine surgeons and three orthopedic surgeons.

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 center also covers upper extremity surgery, lower extremity surgery and spine surgery

Sheboygan (Wis.) Surgery Center. With three ORs and two procedure rooms, this center is focused on orthopedic surgery. The 14,660-squre-foot facility is a joint venture between eight local surgeons and St. Nicholas. ASD Management opened the center in 2008 and provides ongoing management.

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 Feb. 2005.

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.

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 and it now brings in patients from across the country, including professional athletes. It is affiliated with Somerset Orthopedic Associates.

Southern New Mexico Surgery Center (Alamogordo, N.M.). This ASC 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, anterior cruciate ligament repairs, fasciotomy and treatment of hand disorders.

Southern Orthopaedic Surgery Center (Fayetteville, Ga.). The Southern Orthopaedic Surgery Center opened three years ago by 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.

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. Founder and Head Surgeon Bryan J. Massoud, MD, has performed more than 1,000 minimally invasive spine surgeries.

The Spine Institute of Southern New Jersey (Marlton, N.J.). The center has a 0 percent infection rate for 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.

Stateline Surgery Center (Galena, Kan.). This two-OR center is primarily involved in orthopedics cases. 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.

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.

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, among other procedures.

Surgery Center of Reno (Nev.). This multispecialty ASC has a strong orthopedics program with 16 orthopedic surgeons. Its spine program has two spine surgeons who offer minimally in-

vasive surgeries. By combining multiple disciplines, the center is able to offer a team approach to find the best treatment for those suffering from back or neck pain.

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.

Surgery Center of Wisconsin Rapids (Wis.). Surgery Center of Wisconsin Rapids opened its doors in 2006. Managed by ASD Management, the center covers orthopedic and pain procedures.

Tallgrass Surgical Center (Topeka, Kan.). This multispecialty center focuses on sports medicine and hosts a great deal of ACL reconstructions. Surgeons have been performing the Uni-Knee replacement procedure for several years. The center has three ORs and one procedure room.

Texarkana (Texas) Surgery Center. This Symbion center has five orthopedic-hand surgeons and two neuro-spine surgeons. It is a large multispecialty center with five ORs, two procedure rooms and 65 credentialed physicians.

Texas Surgical Center (Midland). Texas Surgical Center was opened in Oct. 2003 and is currently owned and operated by a group of 12 surgeons. Surgeons perform orthopedics, hand, spine and pain management. The ASC includes two operating rooms with hi-definition technology and one treatment room.

TRIA Orthopedic Center (Minneapolis). TRIA is a comprehensive center for orthopedic diagnosis, treatment, surgery and rehabilitation. The center includes more than 40 orthopedic physicians who have subspecialties in sports medicine, acute injury and fracture care. Specialists are involved in research at the Bio-Skills Lab and the TRIA Orthopaedic Research Institute.

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. Its clinical technology includes computer-assisted surgery navigation, minimally invasive surgery and arthroscopic procedures.

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 from the institute.

Two Rivers Surgical Center (Eugene, Ore.). Formerly named Northwest Neurospine Institute, Two Rivers Surgical Center opened in July 2006. The 7,911-square-foot facility, acquired by Meridian in Aug. 2008, was specifically designed for outpatient spine procedures, using two ORs.

Vail Valley Surgery Center (Vail, Colo.). A joint venture between Vail Valley Medical Center and 21 physician-partners, Vail Valley Surgery Center focuses on orthopedics. The facility, which opened in 2002, has four ORs and one procedure room. Vail Valley completes more than 4,000 cases annually, mostly in orthopedics, and treats professional 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 Sept. 2004. The facility features three ORs and one procedure room. It has 28 credentialed physicians.

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.

Wildwood Surgical Center (Toledo, Ohio). This is an 18,000 square-foot multispecialty surgery center with five ORs. The facility, operated by ProMedica Health System, is home to 50 physicians performing about 6,000 procedures per year. The facility's orthopedic program is part of the Orthopaedic Institute at ProMedica.

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.

Yakima (Wash.) Ambulatory Surgical Center. This three-OR, physician-owned multispecialty facility has about 30 full-time and part-time employees. Opened in 1998, it averages 3,500 surgeries a year. It recently recruited two new orthopedic surgeons and one neurosurgeon. ■

ASD MANAGEMENT
LOS ANGELES | DALLAS

ASD Management is a privately-held and -funded ASC management and development company. Since its roots in the late 1970s, the firm has developed hundreds of new centers and redeveloped existing centers in 45 states.

The company serves ASCs throughout the United States from its main offices in Dallas and Los Angeles, and currently operates 25 centers. Managing partners Robert Zasa and Joseph Zasa lead a team which includes specialists in nursing, reimbursement, operations and facility management, business office, staffing, certification and accreditation, licensing and managed care contracting.

ASD Management focuses on hospital/physician joint ventures, de novo development and turnaround strategies for existing ASCs. The company's "turnaround SWAT team" focuses on overcoming obstacles and implementing successful strategies. ASD Management provides ongoing management to help ensure long-term profitability and stability.

The company has developed proprietary databases and benchmarking tools that it uses to measure the success of its ASC partners.

"We are tremendously grateful for our enduring relationships with clients and colleagues," says Mr. Robert Zasa.
www.asdmanagement.com

5 Ways to Improve Anesthesia Quality in ASCs

By Rachel Fields

Quality of anesthesia provision can affect patient satisfaction, quality outcomes and finances in a surgery center. Richard P. Dutton, MD, executive director of the Anesthesia Quality Institute, discusses five ways ambulatory surgery centers could improve anesthesia quality — on behalf of their individual facilities and the industry as a whole.

1. Track adverse anesthesia events. According to Dr. Dutton, anesthesia has a long history of quality outcomes and patient safety. In most facilities, the anesthesia process happens without any safety issues or adverse events, a trend that Dr. Dutton calls "a blessing and a curse." On one hand, a lack of patient safety issues is wholeheartedly positive compared to specialties that are rife with potential complications. On the other hand, a lack of issues means that facilities struggle to collect data and document results.

"If your rate of myocardial infarction is already one in hundreds of thousands, you have to study a lot of patients and get a huge amount of data to even know you have a problem," he says. In ASCs, where patients are generally healthy and most procedures occur without complications, pinpointing areas of weakness is even more difficult.

Dr. Dutton says surgery centers can help identify problem areas in anesthesia provision by answering a few basic questions on every procedure. "You can always make it a binary by asking, "Did something bad happen?" and answering, 'Yes' or 'No,'" he says. By recording every time a patient has a major allergic reaction to an anesthetic or an unexpected respiratory or cardiac event during an anesthetic, surgery centers can contribute to a volume of data that will show trends in anesthesia safety. He says most ASCs probably implement a review every time a serious adverse event occurs, but on a national level, those reviews need to be aggregated to determine when and why adverse events occur.

2. Work to reduce post-operative nausea and vomiting. If surgery centers want to improve anesthesia provision from the perspective of the patient, they need to improve their identification, prevention and treatment of post-operative nausea and vomiting, Dr. Dutton says. He says PONV often suffers from a lack of attention because the issue seems trivial when compared to other measures, such as mortality following aortic valve repair. Still, PONV has undergone significant research by the academic community, and anesthesia providers have access to strong evidence on how PONV should be identified and treated.

The issue is also significant for surgery centers because PONV contributes to decreased patient satisfaction. "It's a big dissatisfier, and in ASCs, it's even more important because safety is assumed and the discriminator is whether or not the anesthetic made the patient sick," he says.

He says PONV also has a negative impact on center finances. If a patient experiences sickness, he or she is less likely to return to the center, and the extra time spent in the recovery room slows down ASC processes and costs more money. Dr. Dutton says surgery centers should carefully screen every patient for PONV risk factors. For example, centers should ask whether the patient has experienced PONV before and whether the patient smokes; a history of PONV can increase the likelihood of a re-occurrence, and smoking actually decreases the likelihood of PONV. Females are also more likely to experience symptoms, and some operations are more commonly associated with patient sickness.

Patients with risk factors should receive prophylactic treatment with one of the four classes of medication that are known to be effective in preventing PONV. Finally, the surgery center needs a good protocol for how to react when a patient gets sick in the PACU.

3. Find out how patients feel about pain management efficacy. Pain also plays a significant role in ASC patient satisfaction, though it is harder to predict and treat because "best practices" are less established for pain management than for PONV. Pain is more complicated because risk factors have much greater variability based on procedure and individual patient. "It's a much harder area to work in scientifically, and clearly one of the things we need to measure is 'did we adequately manage the patient's pain?" Dr. Dutton says. He says a lack of national data means ASCs may find it difficult to benchmark against other facilities; instead, centers should track data over time and look for internal improvement. Surgery centers can determine the efficacy of pain management by asking patients 24 hours after surgery, "Over the past 24 hours, on a scale of 1-10, how often has your pain been managed?"

4. Consider changes to traditional anesthesia practices. New developments in anesthesia provision can decrease the likelihood of patient pain, Dr. Dutton says, but these developments may require some adaptation from the ASC. For example, if a surgery center performs an epidural on a total knee patient and leaves the epidural catheter in, the patient will go home pain-free, whereas general anesthesia will leave the patient in a lot of pain when they wake up. "The ability to send patients home with catheter-based nerve blocks has made a huge change in this business, but with 5,000 surgery centers out there, some have caught on and some haven't," he says. "It's one of those major changes in practice that takes 10 years to get to everybody."

He says surgery centers should consider whether they want to implement some of these technological advancements, based on the amount of time and capital available at the facility. For example, ultrasound-guided regional anesthesia is increasingly popular but requires significant physician training and the purchase of an ultrasound machine. He says while placing a continuous femoral nerve catheter may be just as easy to perform with ultrasound if providers are used to the procedure, the staff must still be trained on talking to the patient and answering questions about the catheter after surgery. Surgery centers should evaluate the necessary finances and provider buy-in before implementing regional anesthesia.

5. Track overall patient satisfaction with anesthesia provision. In addition to tracking satisfaction with pain management and PONV, Dr. Dutton says ASCs should measure overall patient satisfaction with anesthesia. Satisfaction can be affected by a number of factors, including provider attitude, case delays, patient warmth and patient comfort. "ASCs actually do this much better than anybody else," he says. "We've been paying attention to this for much longer than anybody else, including in actually gathering and having the data."

He says ASCs should continue to gather data on overall satisfaction by asking, "On a scale of 1-10, how would you rate your anesthesia experience?" The patient can then elaborate on any reasons for dissatisfaction. ■

Learn more about the Anesthesia Quality Institute at www.aqihq.org.

9 Key Legal Issues Facing Endoscopy Centers

By Scott Becker, JD, CPA, and David M. Wolff, JD, McGuireWoods

Between healthcare reform, increased enforcement under the Anti-Kickback Statute, less patience on the part of physician leaders for underperforming ambulatory surgery centers, reduced reimbursement from Medicare, increased interest in pathology and anesthesiology relationships, and increased pressure from payors on out-of-network arrangements, it is a very interesting time to write about the legal issues facing endoscopy centers.

Barry Tanner, the Chief Executive Officer of Physicians Endoscopy (www.endocenters.com) indicates that there are approximately 800 single-specialty endoscopy centers in the country and likely another 1,000 centers that perform endoscopy procedures. Mr. Tanner also notes that there is an increased interest in joint venture endoscopy centers, often with both hospitals and professional management companies.

The following provides a brief overview of some of the key legal issues facing endoscopy centers and other ASCs.

1. Anti-Kickback and Stark issues. The government over the last few years has initiated huge increases in the funds allocated to healthcare fraud enforcement [1]. In the past, fraud enforcement focused heavily on billing and collections issues. Now, however, significant fraud and abuse resources are also being put towards the review of relationships between hospitals and physicians. The ASC industry has begun to see some level of investigation of fraud and abuse on the physician relationship side, and the ASC industry is ripe for more investigative resources to be directed toward it.

ASCs continue to see the evolution of different types of possible situations which could run afoul of the fraud and abuse laws. Such situations often relate to circumstances where parties are trying to sell ASC shares to physicians at prices that may be below fair market value, circumstances where ASCs are leasing equipment on a per-click basis from physicians [2], and circumstances where parties want to sell different quantities of ASC shares to different physicians or pay different types of medical director fees to different physicians.

Over the next few years, as the government allocates more money to anti-fraud initiatives, it will be increasingly important to keep an eye on what types of activities ASCs, physicians and hospitals are engaging in and what types of activities the government is particularly targeting.

(a) Safe harbors — non-compliant physicians. Over the past few years, parties have become more aggressive in trying to redeem physicians who are not safe-harbor compliant under the Anti-Kickback Statute. Existing compliant physician owners have increasingly become less patient with non-safe harbor compliant physician owners.

To redeem a party for non safe harbor compliance, the center's operating agreement must require such compliance. In many situations, the parties are advised to offer non-compliant physician owners full value for their shares, even if such full value is not required under the ASC's operating agreement. The parties may also give such non-compliant physician owners a long notice period in which the non-compliant physicians may come into compliance with the safe harbor. In addition, it is important that safe harbor concepts generally not be applied in a discriminatory manner. Rather, the safe harbor concepts should be consistently applied to all physician owners if the center is going to enforce the concepts and use them to redeem parties. Further, there are cases where the use of the safe harbor concepts have been challenged by physicians. It is critical that redemption be truly based on safe harbor compliance.

The safe harbor for single specialty centers does not require that a physician perform 1/3 of his or her cases at the center he or she is invested in.

(b) Safe harbors — indirect referrals. The government continues to express great discomfort with indirect referral sources and non–safe harbor compliant physician owners. That said, the government is very cautiously addressing cross-referral relationships as evidenced by the Office of Inspector General issuing a positive advisory opinion to a hospital-physician joint venture where only a small number of the orthopedic physicians were not safe harbor compliant (i.e., four out of eighteen physicians were not safe harbor compliant). There, in fact, the OIG prohibited the referral of cases from the non-compliant physicians to parties that could receive such referrals and then use the surgery center for those cases. In reaching its conclusion, the OIG said:

"In the circumstances presented, notwithstanding that four Inpatient Surgeons will not regularly practice at the ASC, we conclude that the ASC is unlikely to be a vehicle for them to profit from referrals. The Requestors have certified that, as practitioners of sub-specialties of orthopedic surgery that require a hospital operating room setting, the Inpatient Surgeons rarely have occasion to refer patients for ASC-Qualified Procedures (other than pain management procedures, which are discussed below). Moreover, like the other Surgeon Investors, the Inpatient Surgeons are regularly engaged in a genuine surgical practice, deriving at least one-third of their medical practice income from procedures requiring a hospital operating room setting. The

Inpatient Surgeons are qualified to perform surgeries at the ASC and may choose to do so (and earn the professional fees) in medically appropriate cases. Also, the Inpatient Surgeons comprise a small proportion of the Surgeon Investors, a majority of whom will use the ASC on a regular basis as part of their medical practice. This Arrangement is readily distinguishable from potentially riskier arrangements in which few investing physicians actually use the ASC on a regular basis or in which investing physicians are significant potential referral sources for other investors or the ASC, as when primary care physicians invest in a surgical ASC or cardiologists invest in a cardiac surgery ASC." Advisory Opinion No. 08-08 (issued July 18, 2008).

The arrangement at issue did not meet every requirement of the safe harbor in question. However, certain other factors led the OIG to conclude that, although the arrangement posed some risk, the safeguards put in place by the parties sufficiently reduced the risk of illegal kickbacks to warrant granting the positive advisory opinion.

(c) Buy-in pricing for junior physicians and new physicians. Parties continue to look for ways to reduce buy-in amounts for junior physicians. Increasingly, there are arguments for lower valuations based on the impact of the changing economy on endoscopy centers and the uncertainty of profits going forward. It is also possible for junior physicians to buy fewer shares, to obtain loans from third-party lenders (provided such buy-ins are not guaranteed or supported by any other investor or the ASC), and to engage in opportunities like recapitalizations to further reduce the cost and value of the center. Again, a key issue is ensuring that the ASC is not selling shares to junior physicians at below fair market value to induce the referral of cases or the retention for cases. While it is not uncommon for practice buy-in prices to be set at relatively low amounts, the price of shares at the endoscopy center level should be set at fair market value.

(d) Sale of additional shares to highly productive physicians. Endoscopy centers often see situations where a physician who produces proportionately more than he or she owns wants to buy additional shares in the center. In general, it is very hard to facilitate this. It is possible for that physician to try to buy additional shares from other partners. However, the other partners cannot sell their shares to the high producing physician simply to help keep his or her cases at the center. If existing partners want to sell shares for reasons unrelated to retaining volume, then it is not illegal for them to sell shares to such high producing physicians. The sale of such shares should always be made at fair market value, and not preferentially to high producing physicians. Gastroenterology practices often seek ways to distribute an endoscopy center's profits based on referrals. There is no clear safe way to accomplish this.

(e) Profiting from anesthesia and pathology. Increasingly, endoscopy centers and physicians are looking for ways to profit from ancillary services such as anesthesia or pathology. There are certain ways in which an ASC can lawfully profit from anesthesia services in a legal manner. However, there are certain other ways, which are of more significant concern with respect to the legality of profiting from anesthesia services. This area has recently come under attack by the American Society of Anesthesiology. Alexander A. Hannenberg, MD, president of the ASA, wrote the following in his June 16, 2010 letter to the Inspector General of the United States:

"First, under the 'company model,' since the owners of the facility also own the anesthesia company and have a stake in the profits of this separate company, they have an incentive to increase utilization of anesthesia services, which will result in an increase in federal health care costs. When the surgeons or gastroenterologists performing procedures in the facility are the owners, they are making clinical judgments about the necessity of anesthesia services for their procedures in the context of a financial interest in the volume of anesthesia services provided in the facility. It is hard to imagine a more obvious conflict of interest or illustration of the hazards of self-referral. Such hazards obviously include the costs of care but also the potential for subjecting patients to unnecessary anesthesia. In addition, under the "company model," anesthesia providers are required to pay remuneration to the facility for their services. These profits distributed to the facility owners are estimated to be as high as 40% of the anesthesia fees. The fees paid to anesthesia providers are often less than what they would have earned under a fee-for-service model where they would bill directly. Anesthesia providers are unable to economically compete with the 'company model' and are forced to provide an illegal kickback to the facility should they accept pressures from facilities to contract accordingly. Because of the continuing increased pressures that anesthesiology group practices face in complying with the 'company model' . . ., we respectfully request the Office of Inspector General to issue a Special Advisory Bulletin regarding this model.

The laws with respect to profiting from pathology services are less clear. There is an ability often for gastroenterology practices related to endoscopy centers to perform pathology services in their own offices and to profit from such services. However, there is a whole range of analysis that must be performed to ensure that such efforts comply with the Anti-Kickback Statute, the Stark Act, and the Anti-Markup Provisions.

(f) "Per-click" relationships. There have traditionally been several different types of "per-click" arrangements for such items as gamma knives, lithotripters, lasers, CT and MRI scanners and other types of equipment. However, the government has now outlawed most per-click relationships (at least in the Stark Act context). Although the changes to the Stark Act and the accompanying regulations do not necessarily apply to ASCs, the analysis and concerns are applicable under the Anti-Kickback Statute to ASCs. Centers

for Medicare & Medicaid Service offered an explanation of its position in the commentary to the new rules:

"At this time we are adopting our proposal to prohibit per-click payments to physician lessors for services rendered to patients who were referred by the physician lessor. We continue to have concerns that such arrangements are susceptible to abuse, and we also rely on our authority under sections 1877(e)(1)(A)(vi) and 1877(e)(l)(B)(vi) of the Act to disallow them.

We are also taking this opportunity to remind parties to per-use leasing arrangements that the existing exceptions include the requirements that the leasing agreement be at fair market value (§411.357(a)(4) and §411.357(b)(4)) and that it be commercially reasonable even if no referrals were made between the parties (§411.357(a)(6) and §411.357(b)(5)). For example, we do not consider an agreement to be at fair market value if the lessee is paying a physician substantially more for a lithotripter or other equipment and a technologist than it would have to pay a non physician-owned company for the same or similar equipment and service. As a further example, we would also have a serious question as to whether an agreement is commercially reasonable if the lessee is performing a sufficiently high volume of procedures, such that it would be economically feasible to purchase the equipment rather than continuing to lease it from a physician or physician entity that refers patients to the lessee for DHS. Such agreements raise the questions of whether the lessee is paying the lessor more than what it would have to pay another lessor, or is leasing equipment rather than purchasing it, because the lessee wishes to reward the lessor for referrals and/or because it is concerned that, absent such a leasing arrangement, referrals from the lessor would cease. In some cases, depending on the circumstances, such arrangements may also implicate the anti-kickback statute." [3]

(g) Medical directorships. Medical directorships should be used only if the medical director is providing true medical direction. An endoscopy center should generally only have one medical director unless there is a legitimate reason for the need for multiple medical directors. The fees paid to medical directors must be fair market value, and such arrangements must not be intended to provide kickbacks in exchange for the referral of cases.

2. HIPAA. The Health Insurance Portability and Accountability Act continues to be updated in a manner that adds additional burdens. One of the biggest burdens in the most recent HIPAA amendments requires that a patient be notified of any sort of inadvertent breach of disclosure of confidential information. Previously, centers and healthcare providers could decide, on a case-by-case basis, whether or not to notify the patient of an inadvertent breach. Now, patients must be notified of any breach. Further, under the newly revised HIPAA, patients have the right to receive medical records with little cost even if the center must incur costs to provide the medical records.

3. Antitrust issues. There are two antitrust issues that are most prevalent in the ASC industry. First, there is a question as to whether a hospital and physicians can jointly contract to try to obtain better rates from managed care payors. Here, the key issue is ensuring that the two entities can be considered as one entity for purposes of the antitrust laws, which makes them legally incapable of conspiring with each other. There is a significant difference in legal interpretations on this issue across the country. For example, if a hospital owns 80 percent or more of an ASC and has substantial control of the ASC, there are very strong arguments that conspiring together is not possible from an antitrust law perspective (i.e., the hospital and endoscopy center are effectively one entity). However, when the ownership is between 50 percent and 80 percent, the determination differs by region of the country. Further, the amount of control the hospital has over the ASC is a critical component of the ultimate determination. Where a hospital owns less than 50 percent of the ASC, it may still be possible for the hospital and ASC to effectively be considered one entity, but the hospital must have very substantial control of the ASC. Mr. Tanner notes that a key issue in bringing a hospital into a joint venture relates to what positive impact the hospital can have on endoscopy center pricing.

The other common antitrust issue facing ASCs arises when an ASC is excluded from certain payor contracts due to aggressive hospital competition. Here, the challenge for the ASC is showing that the hospital does not merely provide simple competition, but rather that it has conspired to harm the physician-owned ASC or made an effort to monopolize the market. This can be a very expensive process of gathering facts to prove such a conspiracy exists.

4. Medical staff bylaws. Medical staff bylaws issues constantly arise in the ASC context in several distinct situations. One such situation is the issue of determining whether or not to waive a provision of the medical staff bylaws in order to allow a physician to remain on or join the medical staff even though he or she does not technically meet a specific prerequisite qualification. There are pros and cons to granting periodic waivers of such provisions for specific physicians. A second situation is the issue of how to remove a physician from the medical staff due to some sort of medical conduct issue or other issue. In such a situation, to obtain the protections of the Healthcare Quality Improvements Act, it is critical for an ASC to precisely follow its medical staff bylaws procedures and also follow the rules of HCQIA.

A third situation related to medical staff bylaws is the issue of how the removal of a physician from the medical staff under the bylaws impacts the redemption of such physician from the ASC as an owner. Here, there is commonly a requirement in the ASC's operating agreement that a physician member must be on the medical staff in order to be an owner in the ASC. It is critical that the two components of such requirement be somewhat divided from each other. In essence, this means that an effort must be made first to make sure that the decision under the medical staff bylaws is handled separately and is not a sham or trumped up to force a buy back. Then, once the medical staff issue is resolved, redemption pursuant to the ASC's operating agreement may be addressed. [4]

5. Hospital outpatient department transactions and "under arrangements" deals. Over the last few years, "under arrangements" — a type of transaction where an infrastructure company provided all ASC services to a hospital — became very popular. This was because it allowed the hospital to continue to charge hospital outpatient department rates and allowed the physicians, in part, to own the infrastructure company and stay aligned with the hospital. In addition, physicians were getting paid as well as they would typically be compensated in an ASC (i.e., billing their professional services). In essence, this type of structure abrogated the benefit to CMS of the lower payment rate for ASC services. The Department of Health and Human Services changed a number of related Stark Act provisions and specifically outlawed this type of arrangement.

ASCs are now examining situations in which an ASC sells its assets to a hospital and develops what is titled a "co-management" relationship. Such a relationship provides the physician or physician group compensation for managing the service of the hospital, but allows the hospital to really be the owner and provider of the services and to provide the services at hospital outpatient department rates. The great challenge in these relationships is assuring that they proceed at fair market value and that physicians are compensated for reasonably needed services and not just in exchange for generating business. Another substantial challenge posed by these relationships will be maintaining success three to five years after a transaction is completed. Because such "co-management" relationships are not as congruent in terms of interests as a true joint venture, there is an increased challenge to the long term success of such relationships.

6. Out-of-network reimbursement. The ability to profit substantially from out-of-network patients is continuing to decrease. While many parties profit from out-of-network payments, payors are being increasingly aggressive regarding recoupment, collection of appropriate co-payments from patients and increasing co-payment and deductible responsibilities. Thus, the ability to make substantial profits or have serious negotiation leverage through the use of out-of-network arrangements continues to be hampered. On the out-of-network side, ASCs are seeing increasing situations where payors are issuing audit letters to centers, developing no pay policies on out-of-network consultations or services, or paying ASCs just a fraction of what they would generally expect to be paid. ASCs, on their end, are increasingly making efforts to work with State departments of insurance to explain how the cutting off of out-of-network reimbursements precludes patients from accessing true PPO benefits. There are a few cases that discuss whether or not payors have responsibilities to pay providers when providers are serving patients out-of-network and in some situations reducing co-payments. This is an evolving area that is expected to become combative.

7. Physical plant relationships. Increasingly, third-party accreditation firms and CMS surveyors are taking a much stricter approach towards grandfathering in outdated physical or non-compliant plant conditions. In many situations, these physical plant conditions may have pre-existed certain changes in certification rules that now require different structures, sizes and other types of accommodations. Notwithstanding the fact that many older facilities pre-dated such rules, surveyors are sometimes demanding that such facilities be brought up to code immediately. This can provide real challenges and significant expenses to existing ASCs.

8. Quality and safety issues. With the focus on the improper use of syringes at one center and quality and infection control generally, it is critical that endoscopy centers focus heavily on proper clinical procedures. The hepatitis outbreak, for example, at the Endoscopy Center at Southern Nevada has led to class actions and investigations as to that center and the closure of that center.

9. Healthcare reform. No one knows exactly what the ultimate impact of healthcare reform will be on endoscopy centers and other ASCs. However, in the short term, it does not appear that healthcare reform will have an immediate negative impact on endoscopy centers. In fact, because the reform legislation mandates certain incentives for certain preventative care, such as requiring new insurance plans (i.e., plans established on or after September 23, 2010) to cover and eliminate co-pays, deductibles and co-insurance amounts for preventative treatments such as colonoscopies, and because there is no public option, it is not clear that there will be an immediate negative impact at all.

However, in the long term, healthcare reform raises concerns for endoscopy centers and other ASCs. First, although healthcare reform is expected to expand insurance coverage, it is widely anticipated that a substantial number of such newly insured people will be added to the coverage pool at low rates. A second concern is that healthcare reform will put pressure on commercial payors to further reduce costs, which would likely lead to lower reimbursement for endoscopy centers. A third-long term concern is the extent of the impact healthcare reform will have on the independent practice of medicine. Certain of the concepts set forth in the healthcare reform initiatives involve integrative efforts between hospitals and physicians to develop accountable care organizations and other efforts that allow for the joint packaging of care. These efforts, together with other payment incentives for hospitals, are leading to more employment of physicians by hospitals. This reduction in the pool of physicians means a reduction in the lifeblood of endoscopy centers and other ASCs.

It should be noted that certain of the leading professionals in the endoscopy arena, such as Mr. Tanner, believe that the impact of healthcare reform on endoscopy centers will be muted. ■

[1] See Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Departments of Justice and Health and Human Services Team Up to Crack Down on Health Care Fraud (Nov. 5, 2010), available at http://www.justice.gov/opa/pr/2010/November/10-ag-1256.html

[2] While not necessarily illegal, the lease fees must be fair market value and there must be very strong arguments to defend the practice as not intended to induce referrals under the Anti-Kickback Statute.

[3] 73 Fed. Reg. 48713-48714 (August 19, 2008).

[4] 45 C.F.R. §147.130 (2010)

Preparing Your ASC for ICD-10: 6 Initial Steps

By Rachel Fields

Lolita M. Jones, RHIA, CCS, independent coding and billing consultant, discusses six initial steps ambulatory surgery centers should take to prepare for the transition to ICD-10.

1. Form an ICD-10 steering committee. The first step in preparing for ICD-10 is to form a steering committee that includes representatives from nursing, billing and coding, physician leadership, administration and business operations. Since physician schedules are often packed, be sure to choose a physician who can really dedicate time to ICD-10 preparation. "That would be a physician who has a little more free time than the other physicians — maybe someone who's semi-retired and has a little more flexibility," she says. "It has to be more than in name only." The steering committee will be responsible for key action items involving ICD-10, including budget and training.

2. Plan for significant implementation cost. While current data on ICD-10 implementation in ASCs is hard to find, Ms. Jones cites data from 2009 MGMA study that predicted a three-physician practice would spend $84,000 to transition to ICD-10. "You could easily round that up to $100,000 for a single-specialty ASC, and for a multi-specialty, you're looking at going above and beyond," she says. ICD-10 costs include upgrades to existing software, databases and applications (SDA), consultants for training and assistance in the assessment of your existing SDA. Many of these costs will depend on your vendors' plans for ICD-10, Ms. Jones says.

3. Decide whether to train staff on ICD-10-PCS. ICD-10-PCS is a code set designed to replace volume three of ICD-9-CM for inpatient procedure reporting. The system will be used by hospitals and by payors rather than outpatient facilities, but Ms. Jones says ASCs should consider the possibility that commercial payors will want ICD-10-PCS codes. "I don't feel comfortable saying ASCs should ignore [ICD-10-PCS]," she says. "If the payor is exempt from HIPAA, they're still within their rights to request those codes."

4. Inventory all software, databases and applications in your facility. Once your steering committee is in place, you should identify the name, vendor and functionality for all software, databases and applications in the ASC. "Many ASCs have a separate product for accounting and a separate product for billing and another product for claims submission and clinical documentation," Ms. Jones says. "If they have one system that provides all of that, that's great because you're dealing with one vendor, but the reality is that most ASCs select [the product] that works best for a particular process and you end up with a ton of products." She says this process may take time; your ASC probably uses software without even thinking about its connection to ICD-10. Be thorough and ask each staff member to identify SDA you may have forgotten.

5. Contact your vendors. Once you have made a list of your vendors, you need to contact each one and ask about their ICD-10 implementation plans. "What do they need to do to [their] product? Do they need to expand field sizes or reconfigure reports? How will it affect their data dictionaries? How long will the vendor be able to support both ICD-9 and ICD-10? What kind of feedback are they going to accept on things that need to be tweaked before implementation?" she says. These are all questions you should ask to understand how the vendor will work with your ASC to prepare for the transition. Some vendors may require your facility to sign a new contract, possibly at an increased rate.

Ms. Jones advises ASCs to ask vendors to submit a plan for ICD-10 in writing. "I wouldn't rely on a vendor rep who says they're working on it," she says. "Get it in writing from the vendor on their letterhead." Ask the vendor for a plan, a projected timeframe and a contact person within the vendor organization, then establish expectations to keep in touch every two months in 2011 and every month in 2012.

6. Consider the clinical impact of ICD-10. In order to schedule the appropriate amount of training, your ASC should consider the impact of ICD-10 on documentation. Ms. Jones recommends ASCs use ICD-10 general equivalency maps to identify their most commonly-reported ICD-9 diagnosis codes and then identify the corresponding codes in ICD-10. "Look at documentation that will be required to continue coding those conditions effectively under ICD-10," she says. "For example, there are major changes to reporting of Barrett's Esophagus, which is a very common condition in [GI ASCs]. There are also a number of changes in documenting colon polyps."

A steering committee member should work with physicians to discuss additional documentation for ICD-10 codes. Start by addressing a topic at each departmental meeting, and ask physicians to start including more detail in their notes. "It's not wrong to put additional information in the H&P on a patient who, for example, has asthma as a co-existing condition," she says. "My recommendation would be to start building it in so that, come Oct. 1, 2013, the physicians don't even bat an eye."

ICD-10 may also have clinical implications beyond physician documentation. If your ASC reports quality improvement monitors on a state or national level, you may see QI initiatives change under ICD-10. Medical necessity guidelines may also change for certain payors, so a staff member should watch for publication of revised guidelines. ■

Learn more about Ms. Jones at www.EzMedEd.com.

Electronic Health Records: What Does it Mean and Do We Have to Go There?

By Ann O'Neill, Director of Clinical Operations, Regent Surgical Health

Ambulatory Surgery Centers will be required to implement Electronic Health Record systems (EHR) within the next few years. Participation in Medicare/Medicaid will depend on it. This article will explore the definition of EHR, what the prime driving forces are behind mandated EHR systems, and how we can heed the warning and plan ahead for successful implementation of EHR systems in our centers.

Definition

EHR = EMR + HIS + CIS + CPR (Electronic Health Record = Electronic Medical Record + Health Information System+ Clinical Information System+ Computerized Patient Record). All the acronyms that have been used in the last four decades to define the electronic storage of patient information have now been rolled into one. The term EHR used to mean an office-based patient documentation system. The Federal government has usurped the EHR label and has given it back to the healthcare industry as the final acronym for describing any of these electronic patient data systems.

Quoting the Centers for Medicare and Medicaid Services: An Electronic Health Record (EHR) is an electronic version of a patient(')s medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting. (www.cms.hhs.gov/EHealthRecords/

Ann's simplified definition: Capture and/or storage of patient specific medical information in a digital format, which is queriable and transferable to and from other computer systems.

Driving forces

On Feb. 17, 2009, President Obama signed into legislation the American Recovery and Reinvestment Act of 2009 (ARRA), aka the "Stimulus Bill". Lesser known is that, embedded in ARRA, the Health Information Technology for Economic and Clinical Health Act (HITECH) was created. ARRA also made permanent the Office of the National Coordinator for Healthcare Information Technology (ONC) to set policy and standards, as well as direct, oversee, and measure success of the implementation of EHRs.

ONC established the first set of policies and standards for these systems later in 2009, defining mandated Meaningful Use criteria and Certified EHR requirements (HITECH phrases). EHRs must meet strict conditions for data documentation, clinical decision support, data management, and sharing of data. The legislation allows for Meaningful Use criteria to be expanded by ONC every two years during the initial six year roll-out, making it increasingly challenging for EHR systems to be compliant. The second set of requirements is currently in the final stages of development.

The HITECH Act was pushed into place by CMS without forewarning. CMS maintains a vision for a national health record for patients. The goal is to be able to create lifetime individual medical records that are accessible by any provider, anywhere. Our military health system has a similar goal and is on the way to achieving it. CMS expects utilization and quality reports to eventually be submitted from provider EHR systems directly to CMS. CMS is also expecting EHRs to help decrease healthcare costs. Because CMS reimburses big dollars to these entities, acute care hospitals and physicians' offices are the targets in the first round of mandates for nationwide providers to implement fully integrated EHR systems. The second round will no doubt target ambulatory surgery centers.

EHRs are not an unfunded mandate. There is some ARRA money available to a facility once a properly implemented system is in use. The HITECH act provides for different levels of compensation based on the percentage of Medicare patients served, the facility designation, and the timeliness of implementation. Providers can instead opt to be compensated based on their Medicaid population through funds given to each state. Meeting Certified EHR and Meaningful Use requirements are a prerequisite to any funding. Those affected by the current mandate are required to implement EHR systems by this year (2011) in order to receive full credit. Compensation decreases with delays in EHR installation. If these facilities do not implement EHRs they not only lose out on payment for installation of EHRs, they will also be penalized through decreased Medicare reimbursement for patient care. These penalties are scheduled to increase each year until CMS certification is jeopardized. Acute care hospitals and physician offices must have EHR systems in place, meeting Meaningful Use criteria, by the end of 2014 and 2015 respectively to avoid CMS penalties.

Planning ahead

The bad news is ASCs will be federally mandated to implement EHRs. The good news is EHRs can bring benefits to our business processes, our patients, and our owners. EHRs, when properly implemented, are actually strategic investments, helping facilities gain efficiencies and improve the

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Regent's management team also includes Chief Operating Officer Nap Gary; Chief Development Officer Jeff Simmons; and three senior vice presidents: Michael McKevitt (business development), Joyce (Deno) Thomas (operations) and Robert Welti, MD (operations).

The company employs a limited liability company business model, which places the control of the business in the hands of the physician partners. Regent provides a wide range of management and development services including hospital joint ventures, turning single-specialty ASC into multi-specialty centers, experience with neurosurgery, orthopedic and spine centers and turnaround situations.

Regent follows a corporate value system it calls RISE, which stands for respectful careful, integrity, stewardship and efficiency.

"As the ASC business evolves, facilities will either respond to changes or become stagnant," says Mr. Mallon. "Regent positions ASCs to better respond to changing market conditions. We bring parties together and structure and manage deals effectively so interests are correctly aligned and the venture enjoys long-term success." www.regentsurgicalhealth.com

quality of services provided. It is important to realize that even a small EHR project takes 1-2 years to implement successfully. Implementing an effective EHR system before the mandate arrives will bring maximum benefit to a center. Leadership needs to start that process now. EHR projects are costly in money and other resources. Due diligence in planning is key to effective stewardship during project execution.

Below is a brief description of a recipe for success with an EHR project:

- Define the project goals
- Calculate the budget and return on investment based on those goals
- Identify the stakeholders and project champions.
- Create a selection committee with pre-determined structure and purpose
- Select the EHR system

Once the EHR system is selected, disband the selection committee and form an implementation team, again with a pre-defined structure and purpose. This group will take the project through EHR go-live, and some team members will continue in EHR supporting roles after the system is in use. Thoughtfully detailed project organization will smooth the transition from conception through go-live.

Future articles will discuss in more depth the ROI and the steps required for successful EHR projects. For now, remember ASCs are better positioned to address implementation of EHR systems than most acute care hospitals and physician practices were when the HITECH act became law. Let's take advantage of this opportunity to learn from others' experience by planning ahead and acting sooner. (A helpful page with many links to resources regarding EHRs is on the Health Information Systems Society's website at www.himss.org/EconomicStimulus.) ■

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

7 Best Practices for an Effective Malignant Hyperthermia Transfer Plan

By Rob Kurtz

Malignant hyperthermia is a rare occurrence in ambulatory surgery centers, but when it occurs, the ASC must be prepared to respond properly and without hesitation. Time lost trying to determine how to respond to the crisis could lead to a lost life. One critical component for an adequately prepared ASC is an effective MH transfer plan.

Cynthia A. Wong, MD, professor and vice chair of the Department of Anesthesiology for the Northwestern University Feinberg School of Medicine in Chicago, is also an Malignant Hyperthermia Association of the United States (MHAUS) Hotline consultant. She has personally been involved as a consultant in at least one MH case in an ASC that resulted in a patient death because she believes there was an inadequate transfer plan in place.

She identifies the following seven best practices for ASCs to help ensure an effective transfer plan.

1. Determine when you will initiate the transfer of the patient. If you have MH occurring in your ASC, do you have a protocol to follow to determine when and how you will get the patient to the backup organization? "It's better not to transfer a critically ill patient in the middle of an MH crisis," Dr. Wong says. "It would be better to actually treat the MH crisis before the patient was transferred but that's a hard thing to do in an ambulatory care center because most of them don't have the ability to measure blood gases or other labs and there are fewer number of people to help out in an emergency."

2. Ensure transfer vehicle is properly equipped to treat MH patients. "Patients are going to be transferred in some sort of vehicle — whether it's an ambulance or air transport — and my understanding is there are different levels of care capabilities in these ambulances," Dr. Wong says. "It seems appropriate that arrangements be made to transfer the patient in an ICU-type ambulance where the EMTs are capable of supporting ventilation and administering intravenous medications."

3. Identify a suitable backup facility. You need to not only know what institution is serving as your backup for transfer, but if you're going to transfer an MH patient or someone who possibly has MH, Dr. Wong says you need to ensure you are sending the patient to a backup institution with the capabilities of treating MH. This likely means an organization with ICU facilities.

4. Communicate directly with the people who should and will receive the MH patient. With MH, every moment is critical — time spent in your ASC, during the trip over to the backup organization and at the backup facility. It is the responsibility of the ASC to not only arrange for transfer of the patient but to make sure the patient ends up at the backup organization in the correct hands and as quickly as possible.

"You can't spend time when MH is happening calling the hospital operator and figuring out how to get a hold of these people," says Dr. Wong. "You have to know ahead of time — with the telephone number written down and readily available — that you can call this hospital and know the person you're talking to is going to have something to do with admitting the patient you're sending. This direct communication is particularly important."

She says you need to know who is going to be the receiving service and/or physician. In many hospitals, patients are transferred through the ED as opposed to directly to an ICU. If the patient goes directly to an ED, it is important to understand that the admitting physician — likely an ED physician — is not necessarily the physician in the hospital who has expertise in MH. "That would be the anesthesiologist," says Dr. Wong. "You need to know who at the ambulatory care center is going to communicate with whom at the other end. We recommend that there be direct physician-to-physician or at least direct anesthesia provider-to-physician communication."

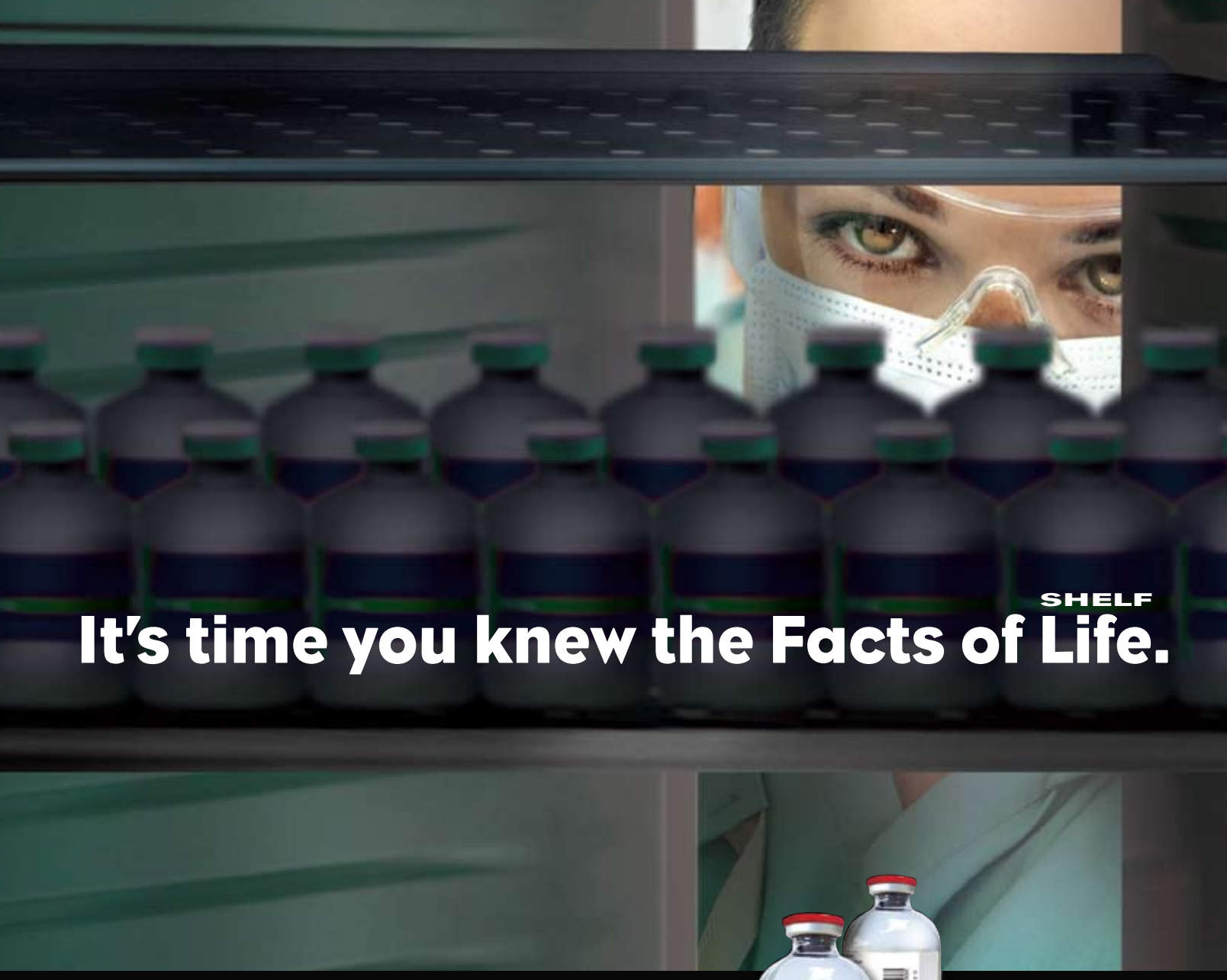
5. Provide an MH report form. A valuable tool to provide the backup organization to help with a smooth transfer is a report form from the ASC that provides important details directly relating to the MH incident — such as anesthetic agents used and the amount of dantrolene given to the patient — in addition to standard information about the patient provided during transfers.

6. Develop a plan for patients you suspect might have MH. "Even if you don't think a patient has MH but there are indications it may be MH, there has to be some sort of plan for how you're going to watch these patients," says Dr. Wong. "At a hospital we would watch them in the recovery room for a few hours before we decided what the appropriate care is and that's not always a viable option for many ambulatory care units."

She says decisions for how to move forward in instances like these are usually made on a patient-to-patient basis. If there are any questions or concerns, she advises organizations to call and discuss the circumstances with an MH hotline consultant, which ASCs can reach any time at (800) MH-HYPER. "What to do next will depend on the patient, how sick they are from a baseline perspective, how suspicious we are that they actually had MH and how critical it is that we measure lab values as part of that diagnosis," Dr. Wong says. "That's not something most ambulatory care centers can do easily. If that is a critical part of the differential diagnosis or deciding how we are going to further manage this patient, in almost all likelihood they are going to be transferred.

7. Incorporate the transfer plan into your MH drills. If you're going to conduct an MH drill and want to simulate the entire experience, Dr. Wong says it would be worthwhile to include the transfer element in the training. "Calling all of those telephone numbers and making sure you're getting hold of the right people might be a good addition to your drill; it's going beyond just giving dantrolene in the OR," she says. ■

Editor's note: Visit MHAUS at www.mhaus.org for many MH related tools and resources, including a poster developed by MHAUS and the Ambulatory Surgery Foundation on "Transfer Plans for Suspected MH Patients" for ASCs.



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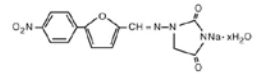
MK176C

Dantrium® Intravenous

(dantrolene sodium for injection)

DESCRIPTION: **Dantrium Intravenous** is a sterile, non-pyrogenic, lyophilized formulation of dantrolene sodium for injection. **Dantrium Intravenous** is supplied in 70 mL vials containing 20 mg dantrolene sodium, 3000 mg mannitol, and sufficient sodium hydroxide to yield a pH of approximately 9.5 when reconstituted with 60 mL sterile water for injection USP (without a bacteriostatic agent).

Dantrium is classified as a direct-acting skeletal muscle relaxant. Chemically, **Dantrium** is hydrated 1-[[[5-(4-nitrophenyl)-2-furanyl]methylene]amino]-2,4-imidazolidinedione sodium salt. The structural formula for the hydrated salt is:



The hydrated salt contains approximately 15% water (3-1/2 moles) and has a molecular weight of 399. The anhydrous salt (dantrolene) has a molecular weight of 336.

CLINICAL PHARMACOLOGY: In isolated nerve-muscle preparation, **Dantrium** has been shown to produce relaxation by affecting the contractile response of the muscle at a site beyond the myoneural junction. In skeletal muscle, **Dantrium** dissociates the excitation-contraction coupling, probably by interfering with the release of Ca++ from the sarcoplasmic reticulum. The administration of intravenous **Dantrium** to human volunteers is associated with loss of grip strength and weakness in the legs, as well as subjective CNS complaints (see also PRECAUTIONS, Information for Patients). Information concerning the passage of **Dantrium** across the blood-brain barrier is not available.

In the anesthetic-induced malignant hyperthermia syndrome, evidence points to an intrinsic abnormality of skeletal muscle tissue. In affected humans, it has been postulated that "triggering agents" (e.g., general anesthetics and depolarizing neuromuscular blocking agents) produce a change within the cell which results in an elevated myoplasmic calcium. This elevated myoplasmic calcium activates acute cellular catabolic processes that cascade to the malignant hyperthermia crisis.

It is hypothesized that addition of **Dantrium** to the "triggered" malignant hyperthermic muscle cell reestablishes a normal level of ionized calcium in the myoplasm. Inhibition of calcium release from the sarcoplasmic reticulum by **Dantrium** reestablishes the myoplasmic calcium equilibrium, increasing the percentage of bound calcium. In this way, physiologic, metabolic, and biochemical changes associated with the malignant hyperthermia crisis may be reversed or attenuated. Experimental results in malignant hyperthermia susceptible swine show that prophylactic administration of intravenous or oral dantrolene prevents or attenuates the development of vital sign and blood gas changes characteristic of malignant hyperthermia in a dose related manner. The efficacy of intravenous dantrolene in the treatment of human and porcine malignant hyperthermia crisis, when considered along with prophylactic experiments in malignant hyperthermia susceptible swine, lends support to prophylactic use of oral or intravenous dantrolene in malignant hyperthermia susceptible humans. When prophylactic intravenous dantrolene is administered as directed, whole blood concentrations remain at a near steady state level for 3 or more hours after the infusion is completed. Clinical experience has shown that early vital sign and/or blood gas changes characteristic of malignant hyperthermia may appear during or after anesthesia and surgery despite the prophylactic use of dantrolene and adherence to currently accepted patient management practices. These signs are compatible with attenuated malignant hyperthermia and respond to the administration of additional i.v. dantrolene (see DOSAGE AND ADMINISTRATION). The administration of the recommended prophylactic dose of intravenous dantrolene to healthy volunteers was not associated with clinically significant cardiorespiratory changes.

Specific metabolic pathways for the degradation and elimination of **Dantrium** in humans have been established. Dantrolene is found in measurable amounts in blood and urine. Its major metabolites in body fluids are 5-hydroxy dantrolene and an acetylamino metabolite of dantrolene. Another metabolite with an unknown structure appears related to the latter. **Dantrium** may also undergo hydrolysis and subsequent oxidation forming nitrophenylfuroic acid.

The mean biologic half-life of **Dantrium** after intravenous administration is variable, between 4 to 8 hours under most experimental conditions. Based on assays of whole blood and plasma, slightly greater amounts of dantrolene are associated with red blood cells than with the plasma fraction of blood. Significant amounts of dantrolene are bound to plasma proteins, mostly albumin, and this binding is readily reversible.

Cardiopulmonary depression has not been observed in malignant hyperthermia susceptible swine following the administration of up to 7.5 mg/kg i.v. dantrolene. This is twice the amount needed to maximally diminish twitch response to single supramaximal peripheral nerve stimulation (95% inhibition). A transient, inconsistent, depressant effect on gastrointestinal smooth muscles has been observed at high doses.

INDICATIONS AND USAGE: **Dantrium Intravenous** is indicated, along with appropriate supportive measures, for the management of the fulminant hypermetabolism of skeletal muscle characteristic of malignant hyperthermia crises in patients of all ages. **Dantrium** Intravenous should be administered by continuous rapid intravenous push as soon as the malignant hyperthermia reaction is recognized (i.e., tachycardia, tachypnea, central venous desaturation, hypercarbia, metabolic acidosis, skeletal muscle rigidity, increased utilization of anesthesia circuit carbon dioxide absorber, cyanosis and mottling of the skin, and, in many cases, fever).

Dantrium Intravenous is also indicated preoperatively, and sometimes postoperatively, to prevent or attenuate the development of clinical and laboratory signs of malignant hyperthermia in individuals judged to be malignant hyperthermia susceptible.

CONTRAINDICATIONS: None.

WARNINGS: The use of **Dantrium Intravenous** in the management of malignant hyperthermia crisis is not a substitute for previously known supportive measures. These measures must be individualized, but it will usually be necessary to discontinue the suspect triggering agents, attend to increased oxygen requirements, manage the metabolic acidosis, institute cooling when necessary, monitor urinary output, and monitor for electrolyte imbalance.

Since the effect of disease state and other drugs on **Dantrium** related skeletal muscle weakness, including possible respiratory depression, cannot be predicted, patients who receive i.v. **Dantrium** preoperatively should have vital signs monitored.

If patients judged malignant hyperthermia susceptible are administered intravenous or oral **Dantrium** preoperatively, anesthetic preparation must still follow a standard malignant hyperthermia susceptible regimen, including the avoidance of known triggering agents. Monitoring for early clinical and metabolic signs of malignant hyperthermia is indicated because attenuation of malignant hyperthermia, rather than prevention, is possible. These signs usually call for the administration of additional i.v. dantrolene.

PRECAUTIONS:

General: Care must be taken to prevent extravasation of **Dantrium** solution into the surrounding tissues due to the high pH of the intravenous formulation and potential for tissue necrosis.

When mannitol is used for prevention or treatment of late renal complications of malignant hyperthermia, the 3 g of mannitol needed to dissolve each 20 mg vial of i.v. **Dantrium** should be taken into consideration.

Information for Patients: Based upon data in human volunteers, perioperatively, it is appropriate to tell patients who receive **Dantrium Intravenous** that symptoms of muscle weakness should be expected postoperatively (i.e. decrease in grip strength and weakness of leg muscles, especially walking down stairs). In addition, symptoms such as "lightheadedness" may be noted. Since some of these symptoms may persist for up to 48 hours, patients must not operate an automobile or engage in other hazardous activity during this time. Caution is also indicated at meals on the day of administration because difficulty swallowing and choking has been reported. Caution should be exercised in the concomitant administration of tranquilizing agents.

Hepatotoxicity seen **with Dantrium Capsules:** **Dantrium** (dantrolene sodium) has a potential for hepatotoxicity, and should not be used in conditions other than those recommended. Symptomatic hepatitis (fatal and non-fatal) has been reported at various dose levels of the drug. The incidence reported in patients taking up to 400 mg/day is much lower than in those taking doses of 800 mg or more per day. Even sporadic short courses of these higher dose levels within a treatment regimen markedly increased the risk of serious hepatic injury. Liver dysfunction as evidenced by blood chemical abnormalities alone (liver enzyme elevations) has been observed in patients exposed to **Dantrium** for varying periods of time. Overt hepatitis has occurred at varying intervals after initiation of therapy, but has been most frequently observed between the third and twelfth month of therapy. The risk of hepatic injury appears to be greater in females, in patients over 35 years of age, and in patients taking other medication(s) in addition to **Dantrium** (dantrolene sodium). **Dantrium** should be used only in conjunction with appropriate monitoring of hepatic function including frequent determination of SGOT or SGPT.

Fatal and non-fatal liver disorders of an idiosyncratic or hypersensitivity type may occur with **Dantrium** therapy.

Drug Interactions: **Dantrium** is metabolized by the liver, and it is theoretically possible that its metabolism may be enhanced by drugs known to induce hepatic microsomal enzymes. However, neither phenobarbital nor diazepam appears to affect **Dantrium** metabolism. Binding to plasma protein is not significantly altered by diazepam, diphenylhydantoin, or phenylbutazone. Binding to plasma proteins is reduced by warfarin and clofibrate and increased by tolbutamide.

Cardiovascular collapse in association with marked hyperkalemia has been reported in patients receiving dantrolene in combination with calcium channel blockers. It is recommended that the combination of intravenous dantrolene sodium and calcium channel blockers, such as verapamil, not be used together during the management of malignant hyperthermia crisis.

Administration of dantrolene may potentiate vecuronium-induced neuromuscular block.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Sprague-Dawley female rats fed **Dantrium** for 18 months at dosage levels of 15, 30, and 60 mg/kg/day showed an increased incidence of benign and malignant mammary tumors compared with concurrent controls. At the highest dose level (approximately the same as the maximum recommended daily dose on a mg/m2 basis), there was an increase in the incidence of benign hepatic lymphatic neoplasms. In a 30-month study in Sprague-Dawley rats fed dantrolene sodium, the highest dose level (approximately the same as the maximum recommended daily dose on a mg/m2 basis) produced a decrease in the time of onset of mammary neoplasms. Female rats at the highest dose level showed an increased incidence of hepatic lymphangiomas and hepatic angiosarcomas.

The only drug-related effect seen in a 30-month study in Fischer-344 rats was a dose-related reduction in the time of onset of mammary and testicular tumors. A 24-month study in HaM/ICR mice revealed no evidence of carcinogenic activity.

The significance of carcinogenicity data relative to use of **Dantrium** in humans is unknown.

Dantrolene sodium has produced positive results in the Ames S. Typhimurium bacterial mutagenesis assay in the presence and absence of a liver activating system.

Dantrolene sodium administered to male and female rats at dose levels up to 45 mg/kg/day (approximately 1.4 times the maximum recommended daily dose on a mg/m2 basis) showed no adverse effects on fertility or general reproductive performance.

Pregnancy: Pregnancy Category C: **Dantrium** has been shown to be embryocidal in the rabbit and has been shown to decrease pup survival in the rat when given at doses seven times the human oral dose. There are no adequate and well-controlled studies in pregnant women. **Dantrium Intravenous** should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor and Delivery: In one uncontrolled study, 100 mg per day of prophylactic oral **Dantrium** was administered to term pregnant patients awaiting labor and delivery. Dantrolene readily crossed the placenta, with maternal and fetal whole blood levels approximately equal at delivery; neonatal levels then fell approximately 50% per day for 2 days before declining sharply. No neonatal respiratory and neuromuscular side effects were detected at low dose. More data, at higher doses, are needed before more definitive conclusions can be made.

Nursing Mothers: Dantrolene has been detected in human milk at low concentrations (less than 2 micrograms per mL) during repeat intravenous administration over 3 days. Because of the potential for serious adverse reactions in nursing infants from dantrolene, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Geriatric Use: Clinical studies of **Dantrium Intravenous** did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS: There have been occasional reports of death following malignant hyperthermia crisis even when treated with intravenous dantrolene; incidence figures are not available (the pre-dantrolene mortality of malignant hyperthermia crisis was approximately 50%). Most of these deaths can be accounted for by late recognition, delayed treatment, inadequate dosage, lack of supportive therapy, intercurrent disease and/or the development of delayed complications such as renal failure or disseminated intravascular coagulopathy. In some cases there are insufficient data to completely rule out therapeutic failure of dantrolene.

There are reports of fatality in malignant hyperthermia crisis, despite initial satisfactory response to i.v. dantrolene, which involve patients who could not be weaned from dantrolene after initial treatment.

The administration of intravenous **Dantrium** to human volunteers is associated with loss of grip strength and weakness in the legs, as well as drowsiness and dizziness.

The following adverse reactions are in approximate order of severity:

There are rare reports of pulmonary edema developing during the treatment of malignant hyperthermia crisis in which the diluent volume and mannitol needed to deliver i.v. dantrolene possibly contributed.

There have been reports of thrombophlebitis following administration of intravenous dantrolene; actual incidence figures are not available. Tissue necrosis secondary to extravasation has been reported.

There have been rare reports of urticaria and erythema possibly associated with the administration of i.v. **Dantrium**. There has been one case of anaphylaxis.

Injection site reactions (pain, erythema, swelling), commonly due to extravasation, have been reported.

None of the serious reactions occasionally reported with long-term oral **Dantrium** use, such as hepatitis, seizures, and pleural effusion with pericarditis, have been reasonably associated with short-term **Dantrium Intravenous** therapy.

The following events have been reported in patients receiving oral dantrolene: aplastic anemia, leukopenia, lymphocytic lymphoma, and heart failure. (See package insert for **Dantrium** (dantrolene sodium) **Capsules** for a complete listing of adverse reactions.)

The published literature has included some reports of **Dantrium** use in patients with Neuroleptic Malignant Syndrome (NMS). **Dantrium Intravenous** is not indicated for the treatment of NMS and patients may expire despite treatment with **Dantrium Intravenous**.

For medical advice about adverse reactions contact your medical professional. To report SUSPECTED ADVERSE REACTIONS, contact JHP at 1-866-923-2547 or MEDWATCH at 1-800-FDA-1088 (1-800-332-1088) or http://www.fda.gov/medwatch/.

OVERDOSAGE: Because **Dantrium Intravenous** must be administered at a low concentration in a large volume of fluid, acute toxicity of **Dantrium** could not be assessed in animals. In 14-day (subacute) studies, the intravenous formulation of **Dantrium** was relatively non-toxic to rats at doses of 10 mg/kg/day and 20 mg/kg/day. While 10 mg/kg/day in dogs for 14 days evoked little toxicity, 20 mg/kg/day for 14 days caused hepatic changes of questionable biologic significance.

Symptoms which may occur in case of overdose include, but are not limited to, muscular weakness and alterations in the state of consciousness (e.g., lethargy, coma), vomiting, diarrhea, and crystalluria.

For acute overdosage, general supportive measures should be employed.

Intravenous fluids should be administered in fairly large quantities to avert the possibility of crystalluria. An adequate airway should be maintained and artificial resuscitation equipment should be at hand. Electrocardiographic monitoring should be instituted, and the patient carefully observed. The value of dialysis in **Dantrium** overdose is not known.

DOSAGE AND ADMINISTRATION: As soon as the malignant hyperthermia reaction is recognized, all anesthetic agents should be discontinued; the administration of 100% oxygen is recommended. **Dantrium Intravenous** should be administered by continuous rapid intravenous push beginning at a minimum dose of 1 mg/kg, and continuing until symptoms subside or the maximum cumulative dose of 10 mg/kg has been reached.

If the physiologic and metabolic abnormalities reappear, the regimen may be repeated. It is important to note that administration of **Dantrium Intravenous** should be continuous until symptoms subside. The effective dose to reverse the crisis is directly dependent upon the individual's degree of susceptibility to malignant hyperthermia, the amount and time of exposure to the triggering agent, and the time elapsed between onset of the crisis and initiation of treatment.

Pediatric Dose: Experience to date indicates that the dose of **Dantrium Intravenous** for pediatric patients is the same as for adults.

Preoperatively: **Dantrium Intravenous** and/or **Dantrium Capsules** may be administered preoperatively to patients judged malignant hyperthermia susceptible as part of the overall patient management to prevent or attenuate the development of clinical and laboratory signs of malignant hyperthermia.

Dantrium Intravenous: The recommended prophylactic dose of **Dantrium Intravenous** is 2.5 mg/kg, starting approximately 1-1/4 hours before anticipated anesthesia and infused over approximately 1 hour. This dose should prevent or attenuate the development of clinical and laboratory signs of malignant hyperthermia provided that the usual precautions, such as avoidance of established malignant hyperthermia triggering agents, are followed.

Additional **Dantrium Intravenous** may be indicated during anesthesia and surgery because of the appearance of early clinical and/or blood gas signs of malignant hyperthermia or because of prolonged surgery (see also CLINICAL PHARMACOLOGY, WARNINGS, and PRECAUTIONS). Additional doses must be individualized.

Oral Administration of Dantrium Capsules: Administer 4 to 8 mg/kg/day of oral **Dantrium** in three or four divided doses for 1 or 2 days prior to surgery, with the last dose being given with a minimum of water approximately 3 to 4 hours before scheduled surgery. Adjustment can usually be made within the recommended dosage range to avoid incapacitation (weakness, drowsiness, etc.) or excessive gastrointestinal irritation (nausea and/or vomiting). See also the package insert for **Dantrium Capsules**.

Post Crisis Follow-Up: **Dantrium Capsules**, 4 to 8 mg/kg/day, in four divided doses should be administered for 1 to 3 days following a malignant hyperthermia crisis to prevent recurrence of the manifestations of malignant hyperthermia.

Intravenous **Dantrium** may be used postoperatively to prevent or attenuate the recurrence of signs of malignant hyperthermia when oral **Dantrium** administration is not practical. The i.v. dose of **Dantrium** in the postoperative period must be individualized, starting with 1 mg/kg or more as the clinical situation dictates.

PREPARATION: Each vial of **Dantrium Intravenous** should be reconstituted by adding 60 mL of sterile water for injection USP (without a bacteriostatic agent), and the vial shaken until the solution is clear. 5% Dextrose Injection USP, 0.9% Sodium Chloride Injection USP, and other acidic solutions are not compatible with **Dantrium Intravenous** and should not be used. The contents of the vial must be protected from direct light and used within 6 hours after reconstitution. Store reconstituted solutions at controlled room temperature (59°F to 86°F or 15°C to 30°C).

Reconstituted **Dantrium Intravenous** should not be transferred to large glass bottles for prophylactic infusion due to precipitate formation observed with the use of some glass bottles as reservoirs.

For prophylactic infusion, the required number of individual vials of **Dantrium Intravenous** should be reconstituted as outlined above. The contents of individual vials are then transferred to a larger volume sterile intravenous plastic bag. Stability data on file at JHP Pharmaceuticals indicate commercially available sterile plastic bags are acceptable drug delivery devices. However, it is recommended that the prepared infusion be inspected carefully for cloudiness and/or precipitation prior to dispensing and administration. Such solutions should not be used. While stable for 6 hours, it is recommended that the infusion be prepared immediately prior to the anticipated dosage administration time.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration.

HOW SUPPLIED: **Dantrium Intravenous** (**NDC** 42023-123-05) is available in vials containing a sterile lyophilized mixture of 20 mg dantrolene sodium, 3000 mg mannitol, and sufficient sodium hydroxide to yield a pH of approximately 9.5 when reconstituted with 60 mL sterile water for injection USP (without a bacteriostatic agent).

Store unreconstituted product at controlled room temperature (59°F to 86°F or 15°C to 30°C) and avoid prolonged exposure to light.

Rx only.

Prescribing Information as of November 2008

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12 Critical Questions for Malignant Hyperthermia Preparation

By Rob Kurtz

Malignant hyperthermia is an uncommon disorder that presents in an ambulatory surgery center utilizing general anesthesia. Preparation for management of this condition needs to be a significant part of ASC patient safety protocols, and this preparation needs to be proper and complete. Blue Chip Surgical Partners Vice President of Operations Regina E. Dolsen, RN, BSN, MA, suggests ASCs address the following 12 questions to help accomplish this objective.

1. Do you have an MH cart or kit, and is it properly stocked? This should contain the required and non-expired drugs (dantolene), equipment, supplies and forms. It should be immediately accessible to all operating rooms.

2. Do you have organizational protocols for treating patients with known history of MH? Has your ASC determined whether you will perform procedures on a patient with a known history of MH? "You should have a policy stating this," says Ms. Dolsen. "You should also have, as part of your pre-assessment, questions you will ask of all of your patients to try to learn to any MR history they might have."

3. Do you have a point person that is responsible for your MH preparation? This includes maintaining equipment, supplies and ensuring training. "It can be the safety officer, but sometimes other people will own that particular activity and it becomes a part of their role to keep things current," Ms. Dolsen says. "They go regularly onto the MHAUS (Malignant Hyperthermia Association of the United States) website to see what's new and changed and they're responsible for the checking and maintaining the cart. You just want someone to own that cart and that role within the facility so they're the go to person for questions, the person who looks for the resources, update guidelines, finds new tools, etc."

4. How do you prepare for an MH event? "It should be a hands-on drill," she says. "It should include the mixing of the dantrolene and physically preparing it. You literally conduct the drill. You walk through the steps, you don't just do it on paper. That's really the best way to prepare."

5. What is the education/training program for new employees and annual training for existing employees? This ties in with the necessary drilling, Ms. Dolsen says. "Make sure you keep your training tools updated and provide time for questions and answers rather than just sit your staff down in front of a machine to watch an educational video," she says. "There are a lot of self-learning modules that cover MH. They're good but make sure you provide time for questions and answers and remember that this doesn't replace the hands-on drill. That's critical."

6. Do you have a role for your consulting pharmacist in the training/setting up or keeping protocols current? Ms. Dolsen says she has seen some facilities have their consulting pharmacist participate in the annual education on MH. "People don't tend to think about using their consulting pharmacist," she says. "He can be a good resource, depending on his skill set, to help you with education and training. It's also a good role for him to review the cart as part of his risk assessment when he's in a facility covering all of the meds. That can be helpful."

7. What is the role of anesthesia? Has your ASC clearly defined the responsibility of anesthesia? "Every facility manages it different," Ms. Dolsen says. "Some anesthesiologists take a big role in this and actually do the training. Even if training falls to the consulting pharmacists or clinical nursing, you still need to have the role of anesthesia defined because in the event MH occurs, they usual control how the event is managed and become the team leader."

8. Do you have visual aides on the cart or in a designated area which reviews the steps for recognizing the situation, and providing immediate treatment? "There are resources out there, primarily from MHAUS, and they're very effective," says Ms. Dolsen. "MH is something we hope to never see in our lifetime but when it does occur, we don't have time to open the policy book. Those visuals are very well done and can play a vital role in saving a person's life."

9. Do you know about the MH Hotline? Described as the "most notable and important of MHAUS' services," the Hotline provides medical professionals with access to MH experts who can be reached for help with MH crises around the clock. The number: (800) MH-HYPER ((800) 644-9737).

10. Do you have concise forms to use during an event? "It's a good idea to continually review and update your documentation records to chart during an event so they're simple to use and they're clear," Ms. Dolsen says. "MH is an emergency event and people are usually not reviewing that form on a regular basis. It's worth including as part of your drills actually documenting on the form as that will help tell you whether your form is useful or not. We've run into convoluted forms that, in an event, do not work."

11. Do you have specific transfer protocols? "They really should take it beyond their normal transfer agreement protocol," says Ms. Dolsen. See "7 Best Practices for an Effective Malignant Hyperthermia Transfer Plan" on p. X to learn more.

12. What methods are in place for cost-effective management of supplies and medications? Oftentimes since the MH cart is not used and the event is not seen, both fortunate circumstances, the dantrolene expires. You should consider using these expired medications as part of your for training drills, says Ms. Dolsen. She also advises discussing with your vendors cost-effective ways to acquire items you need for MH hands-on training with the understanding that these items are not for actual patient use. ■

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