INSIDE

INDEX

BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

November/December 2011 • Vol. 2011 No. 9

14 Achievable Goals for ASCs By Year's End

By Rob Kurtz

Here are 14 goals ambulatory surgery centers can work to achieve by the end of 2011, as identified by Joan Dentler, president of ASC Strategies; Reed Martin, chief operating officer of Surgical Management Professionals; and Joseph Zasa, managing and founding partner of ASD Management.

1. Add one more physician to your ASC medical staff. At your next employee staff meeting, ask employees if they know any unaffiliated physicians that might be interested in doing cases at your facility, says Mr. Martin. And at your next medical staff meeting, ask

continued on page 8

10 Ways to Get Paid More for ASC Procedures

By Rachel Fields

Mary Ryan, administrator of Tri-State Surgery Center in Dubuque, Iowa, managed by Health Inventures, shares 10 steps to negotiate profitable contracts and make money on every procedure.

1. Push for "percent of billed charges" contracts as often possible. Ms. Ryan recommends surgery center leaders ask for "percent of billed charges" contracts rather than contracts based on a percentage of Medicare or contracts based on grouper rates, which can be complex and frustrating. She says payors may be more likely to offer this type of contract if they know that other heavy-hitting insurance companies do. "We do all percent of charge contracts with payors

continued on page 10

150 Physician Leaders in the ASC Industry

Here is a list of 150 physician leaders who have made significant contributions to the ambulatory surgery center industry. To view complete profiles, visit www.beckersasc.com/physician-leaders2011. Note: Physicians are listed in alphabetical order by last name.

David J. Abraham, MD. Dr. Abraham is one of the entrepreneurial leaders at The Reading Neck & Spine Center in Wyomissing, Pa. He is a member of the American Academy of Orthopaedic Surgeons, North American Spine Society and the Pennsylvania Orthopedic Society.

Amir Arbisser, MD. Dr. Arbisser is an ophthalmologist and co-founder of Eye Surgeons Associates in Bettendorf, Iowa, where he also serves as board chairman. He recently finished a six-year gubernatorial appointment on the Board of Regents, the governing body of Iowa's public universities.

Richard G. Areen, MD. Dr. Areen serves as president of Sacramento Ear, Nose & Throat and president of the governing body of Sutter River city

continued on page 21

Transcription and Coding Online.

- 2 to 24 hour turnaround on reports
- Early morning delivery of history & physical
- Integrated web coding module with Excel download
- Web-based editing and electronic signatures
- Interfaces with SIS, AdvantX, Vision and HST
- HIPAA Compliant w/ Encrypted PHI

Ask About 2 Months Free Transcription for New Clients!

Over 450 Satisfied Ambulatory Surgery Center Customers.

Surgical Notes

* Certain restrictions and conditions apply to 2 free month offer.

Contact us today toll free (800) 459-5616 or email sales@surgicalnotes.com

Easy web-based editing and electronic signatures.

A BETTER WAY!

MURPHY HEALTHCARE GROUP

www.ASCturnaround.com

THE OLD WAY . . .

. . . You're stressed and working late.

. . . Your center has unused block time.

. . . The docs are bickering; the staff can feel it.

. . . Profits are less than 40 percent and falling.

THE MURPHY HEALTHCARE WAY . . .

. . . You're syndicating new surgeons.

. . . Your center is humming with cases all day.

. . . Patients say they feel like guests.

. . . Profits are growing 30-to-40 percent.

. . . You have dinner at home at 5:30!

At **Murphy HealthCare Group**, we have more than 20 years' experience turning troubled ASCs into happy, efficient, profitable ones. If your center needs to find a better way, call me!

Robert Murphy, CEO
212-937-4911

Photo: *The big guy shaking hands with me is orthopedist Dr. John Vitolo, who has been a surgeon-owner with us for over a decade. Does he look happy, or what?*

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

November/December 2011 Vol. 2011 No. 9

FEATURES

Publisher's Letter

The final *Becker's ASC Review* for 2011 is a robust issue full of practical guidance to help you and your ASC as you finish the year. The issue features stories on achievable goals by year's end; benchmarks on ASC case volume and stats for large ASCs; insight into the future of ophthalmic ASCs and pain management; best practices to get paid more on your procedures; steps to provide great anesthesia and hire an outstanding administrator; and two popular lists — 150 Physician Leaders in the ASC Industry and 125 of the Leading Gastroenterologists in America.

ASC Conferences 2012

We have two outstanding surgery center conferences planned for next year. First, we have our 10th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference. This will be held June 14-15 in Chicago. We will, once again, combine great and interesting keynote speakers including Lou Holtz and Tucker Carlson with a terrific amount of practical and focused guidance.

The 19th Annual ASCs Improving Profitability and Business and Legal Issues will be held Oct. 25-27 in Chicago.

Should you have suggestions for a speaker or topic for either of the meetings, or just simply want more information about the meetings, please feel free to e-mail sbecker@beckershealthcare.com.

Hospital and Health Systems Conference 2012

We are also hosting the third Becker's Hospital Review Annual Meeting — ACOs, Physician-Hospital Integration, Improving Profits and Key Specialties. We have lined up terrific keynote speakers including Mike Ditka, Suzy Welch and Bob Woodward. It will take place May 17-18 in Chicago. Should you have interest in this conference, please also feel free to e-mail sbecker@beckershealthcare.com.

E-Weeklies

In 2011, we continued to grow our number of free E-weeklies. If you would like to be added to any of the following free electronic publications, please email sbecker@beckershealthcare.com and specify which of the E-weeklies you would like to receive (no limit):

- Becker's ASC Review
- Becker's Hospital Review
- Becker's Orthopedic & Spine Review
- Becker's Spine Review
- Becker's Hospital CFO Report
- Becker's Pain Management
- Becker's Operating Room Clinical Quality & Infection Control

* * *

Should you have any questions or comments, please feel free to contact myself at (312) 750-6016 or at sbecker@beckershealthcare.com.

Very truly yours,

Scott Becker

14 Achievable Goals for ASCs By Year's End
(continued from page 1)

your physicians if they know of any surgeons new to the area, unaffiliated with other health systems or not invested in another ASC.

"Meet these potential new doctors at their office and bring their favorite lunch if it helps your cause," he says. "Invite them for a tour to see your facility, your equipment and staff, and to meet with a few of your doctors and anesthesia providers. If they are interested, have a credentialing packet ready and be able to talk about potential investment opportunities down the road."

2. Prepare to take inventory. "Get ready to take inventory at year's end," says Mr. Zasa. "Work with your accountant to see if they need to be onsite when it is taken. We believe it is a good idea to take inventory at least twice per year, particularly if you use electronic inventory programs."

3. Survey your physicians. On at least an annual basis, you should take the time to survey each of the surgeons on your medical staff to find out what is working and what isn't, says Ms. Dentler.

"Pay close attention to the ones who may have reduced utilization, and find out why," she says. "Sometimes there can be simple adjustments to operations that may bring them back into the operating room."

In conjunction with this, she says ASCs should review current block time utilization and make changes to maximize efficiencies.

4. Perform case costing. Mr. Zasa advises ASCs to prepare an analysis of their top three most costly procedures.

"Do it on a per surgeon basis to compare them against their peers," he says. "If possible, obtain benc mark data. The hope is that you can change behavior so that there is standardization on supplies and implants.

5. Reduce your accounts receivable days to 35. To reduce your A/R days, bill as many payors as possible electronically and evaluate your process for correcting electronically submitted claims, Mr. Martin says. Meet weekly with your business office manager and evaluate the follow-up process on the larger claims over 60 days.

"Is the reason for the claim rejection getting corrected? Are the claims worked every two weeks? Are some of your physicians taking too long to dictate operative reports?" he says. "If so, and if a meeting with the physician doesn't improve results, utilize statistics and peer pressure to improve timeliness. Track denials and correct the reason for the denial so that it doesn't keep happening."

6. Clean up, update and/or load current (accurate) data into your IT system. "You need to have a 'real-time' idea of what is going on with your ASC operations," Ms. Dentler says. "Too often reports are built from incomplete or out-of-date data and therefore have little meaning when it comes to making management decisions. Remember: 'garbage in-garbage out.'"

7. Conduct a revenue cycle review. Look at your payor contracts, coding, collections, denials, etc., and set performance goals for the coming year, says Ms. Dentler. "Just because money is coming in, it doesn't mean your collecting every penny," she says. "If you haven't performed a third-party coding/billing review in 2011, you should schedule one before the end of the year. This is important whether you are performing the function in-house or outsourcing. Any good coder/biller — or company — should welcome a third-party audit."

8. Analyze your group purchasing organization. This is a good time to shop group purchasing organizations to ensure that you are getting the best deal for your supplies, Mr. Zasa says. "Make sure that you have an audit tool to objectively check if you are getting the correct GPO pricing," he says.

9. Perform a global analysis of your market. Mr. Zasa advises asking yourself these questions: "Is it time to look at a joint venture with a strategic partner? Does partnering with a hospital make sense? Are your physicians' practices being bought and/or are their referral patterns impacting your center?"

10. Reduce excess medical supply inventory by year's end. Identify all inventory in your ASC with over 45 days usage on hand, Mr. Martin says. "List from highest inventory value over 45 days to lowest and make highest excess inventory items a reduction priority," he says. "Work with vendors to see if you can return for credit or trade the excess inventory."

You should also evaluate any substitution possibilities for this excess inventory and determine if other ASCs or a hospital might buy the excess at a discounted price. Finally, donate inventory not likely to be used, he says.

11. Meet with your local hospital. If your center isn't currently associated with the local hospital, set up an appointment to meet with the CEO and see how you can better work together in the coming year, Ms. Dentler says. "Many hospitals are looking to align with freestanding ASCs to provide lower-cost environments for outpatient surgical cases that aren't appropriate for on-campus ORs."

12. Improve your OR utilization statistics. Taking a few steps can help you significantly improve your OR utilization. Mr. Martin advises ASCs to track late starts, especially the first start of the day because a late start here can have a snowball effect.

"Track block utilization — decrease block for [the] bottom 10 percent utilizers and increase time, if needed, for top 10 percent utilizers," he says. "Review your process for releasing unused block time. [Is] the medical staff and their schedulers aware of openings early enough to fill in gaps in the schedule?"

13. Review your service contracts. This includes management agreements and anesthesia contracts, says Ms. Dentler. "Be sure the scope of services and fees still match your needs and everyone is performing up to the agreed upon standards," she says.

If you don't have performance standards set for your vendors, insist on revising contracts to include them before any extensions. "It is a competitive market out there and you should require quality outcomes the same way your surgeons and patients (and payors) demand it out of you," Ms. Dentler says.

14. Evaluate payor contracting. Consider that it may be time to renegotiate third-party payor contracts, says Mr. Zasa. "Use your cost data to obtain carve outs on high-cost procedures (see #4)," he says. "Be prepared with as much data as possible. Further, audit random claims from the carriers as part of your compliance plan to ensure that they are paying properly." ■

Learn more about ASC Strategies www.ascstrategies.com. Contact Joan Dentler at jdentler@ascstrategies.com.

Learn more about Surgical Management Professionals at www.surgicalmanprof.com. Contact SMP at info@smpsd.com.

Learn more about ASD Management at www.asdmanagement.com. Contact Joe Zasa at joezasa@asdmanagement.com.

10 Ways to Get Paid More for ASC Procedures
(continued from page 1)

as much as possible," she says. "If that kind of contract is the norm in your geographic area, you can say, 'All our contracts with third-party payors are percent of charge.'"

Under a percent of billed charges contract, the payor agrees at the time of contracting to pay on the basis of a percentage of the surgery center's billed charges. This kind of reimbursement can be profitable for surgery centers because it allows ASCs to receive higher reimbursement for cases with higher costs.

2. Understand Medicare reimbursement to negotiate "percentage of Medicare" contracts correctly. Some insurance companies will push for contracts that reimburse surgery centers based on a percentage of Medicare, Ms. Ryan says. This kind of reimbursement can work as long as the surgery center leader has a good understanding of Medicare reimbursement rates for each procedure. "You need to really understand what Medicare reimbursement is and what your costs are, so you can negotiate the correct percentage of Medicare," she says. For example, if the payor is reimbursing at 200-300 percent of Medicare, your ASC should be able to perform cases profitably with that level of reimbursement while accounting for costs.

If your ASC performs cases that will not profit from the offered percentage of Medicare, you need to carve those specific procedures out and negotiate a different rate for them, Ms. Ryan says. "If there are cases that will not make a profit because they have a very high supply cost per case, you need to be able to go into that negotiation and say, 'We're going to do 200 percent of Medicare, but for this procedure, we'll have to get more,'" she says.

3. Expect education from payors on new reimbursement methodologies. If a payor introduces a new reimbursement methodology, or you start contracting with a new payor, you should expect a lot of education on how your reimbursement will work, Ms. Ryan says. She says when her surgery center transitioned to an Enhanced ambulatory payment group system of reimbursement, she found it to be "very arduous." APGs are a patient classification system designed to pay providers on the amount and type of resources used during a patient encounter. Patients in a given APG have similar clinical characteristics and similar resources use and cost, and medical services requiring a higher level of professional and ancillary care are paid a higher rate than those of a lower intensity.

"You need a lot of education from the payor on what your reimbursement rate is going to be," she says. "They'll give you a base rate reimbursement and then a multiplier — say it's three — and then you take the three and multiply it by what they're going to pay you for that specific EAPG," she says. To make EAPG reimbursement work for you, she says you really need to understand your primary payments and how multiple procedure payments are impacted through EAPG. Ms. Ryan says you should also understand whether implants and medications are included in the payments — "there are some that will pay for implants and medications, and you need to get your arms around that if so," she says.

4. Let payors know they'll pay more at the hospital. Freestanding surgery centers lack the leverage of hospitals and surgery center management companies, but you should still be able to negotiate fair rates if you present the cost-savings opportunity to the payor, Ms. Ryan says. "It really comes down to providing the data to the payor and saying, 'This is the amount of money we need to take care of this population,'" she says. "They need to be paying you a certain amount of money, but they will still be paying less than if the patients

were directed to the HOPD." Make sure the payor understands that your surgery center can save insurance companies a significant amount of money if they can negotiate a profitable contract.

She says surgery center leaders should make payors aware of their quality outcomes as well. "Not only is it a financial incentive, but if you've got great quality outcomes, that's important to the patient population," she says. "Especially in this day and age, we're going to see more and more transparency related to patient outcomes and best practices."

5. Perform your cost-cutting before you negotiate contracts. By the time you go to negotiate contracts with a payor, you should already know exactly how much money you need to make on a procedure to make a profit, Ms. Ryan says. This means you should already have gone through your supply and staffing costs and trimmed any waste from your budget.

If you haven't cut costs in your surgery center, payors may think you are asking for excessive levels of reimbursement because your expenses are too high. "As you're negotiating new contracts, you've got to be confident that you've already accessed the best pricing you can for supplies and that you're providing the best value at the lowest cost," Ms. Ryan says.

6. Trend new procedures for the first 3-4 months to compare cost and reimbursement. When you add a new procedure to your surgery center, track charges, costs and net revenue to make sure you are receiving adequate levels of reimbursement compared to your costs, Ms. Ryan says. You may have negotiated contracts without realizing one of your physicians demands the most expensive brand of implant, for example.

"When you add a brand new procedure, you better be following it for three or four months to get a trending of what it looks like by physician and by payor," says Ms. Ryan. This will tell you whether you need to focus on cutting costs, negotiate better reimbursement rates next time around or drop the procedure completely.

7. Look at return on investment for capital equipment purchases. When you negotiate a contract with a payor, think about your equipment expenses as well as your costs-per-case, Ms. Ryan says. This is especially true for new procedures requiring capital purchases to get off the ground. "If you have a management company, ask them to give you information on what other surgery centers have done in the past," Ms. Ryan says. "What types of capital purchases did they need? What kind of disposable supplies and staffing did they use?"

She says knowing your equipment expenses will tell you how much you need to make on each case to make that money back in the long-run. "You need to be able to do a return on investment and see how long it's going to take you to pay for that capital investment," she says. For example, if your ASC is adding ophthalmology and investing in a laser for cataract surgery, you will need to ask for higher reimbursement rates than a surgery center that already has the equipment.

8. Determine how volume and reimbursement work together for your specialties. Volume and reimbursement work together in interesting ways: While no amount of volume can make up for cases that lose money, the right amount of volume can take the place of a high contribution margin for a particular procedure. For example, orthopedics has a high contribution margin but relatively low volume, so the specialty is profitable because the surgery center makes a large profit on each case.

Specialties like ophthalmology, GI and pain management have a lower contribution margin, but the specialties can be profitable if the surgery center can schedule many cases in one day. If you are going to accept a lower reimbursement rate for a specialty, make sure you know your physicians can bring enough volume to make money.

9. Check your percentages of Medicaid and Medicare. Medicare and Medicaid can work for surgery centers, as long as the ASC leaders understand the percentage of each government payor before negotiating commercial contracts. If your surgery center performs a high volume of ENT, look at your payor population to determine how many of your patients will be Medicaid beneficiaries, Ms. Ryan says. Many surgery centers steer clear of Medicaid because the reimbursement rates are too low for ASCs to make a profit. ENT, which concentrates heavily on children, often accepts a high percentage of Medicaid because many Medicaid beneficiaries are minors.

In the case of ophthalmology, look at your expected percentage of Medicare and make sure you can survive on a high volume of Medicare reimbursement if necessary. "For example, retina has a population that's very heavy in Medicare, but it's also very expensive to buy the equipment," Ms. Ryan says. "The capital purchases are huge, so you need to be aware of your payor mix percentages when you're calculating everything."

10. Keep an eye on "questionable" cases. If your surgery center is performing a particular case that seems to be verging towards unprofitable, keep an eye on the case to determine whether you need to send it to the hospital, Ms. Ryan says. Don't let cases sneak onto the schedule without noticing that your ASC is losing money on them. If you notice a particular procedure is high-cost, low-reimbursement, work with your payor continually to determine how you can avoid sending the case elsewhere.

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

Best Practices for ASCs in a Bad Economy: Q&A with Mike Lipomi at Surgical Management Professionals

By Leigh Page

Mike Lipomi is president and CEO of Surgical Management Professionals in Sioux Falls, S.D.

Q: When an ambulatory surgery center loses revenue in this bad economy, how do you figure out when and where to cut services?

Mike Lipomi: That's a very important question, because if an ASC does not precisely figure out what should be cut, it may end up cutting too much or cutting the wrong thing. Then it will be even deeper in the hole. The trouble is that our bad economy is such a huge problem, hanging over all of us, that we tend to blame it for all kinds of stuff. A bad economy can uncover some very real problems within the ASC, but those problems weren't necessarily caused by the bad economy. More likely these are deep-rooted problems that did not harm the ASC in good times but will do so when times get bad.

Sure, volume could fall a little due to the economy, but the underlying problem is that your collections are down or your coding is inaccurate, and you didn't even know that. The irony is that when an ASC cuts staff to be in line with lower volume, the wrong people may be cut, such as staff in the business office. Then the ASC has even fewer staff to root out the collections issue. In trying to solve a relatively minor problem — the lower volume — you have created a whole new problem — fewer staff in key areas — and you still don't have a clue about the original problem: the collections issue.

Q: Isn't it true, though, that the bad economy is having a significant impact on ASCs?

ML: Yes, to some extent that's true. But healthcare is shielded from economic downturns to a great degree. When times get tough, consumers cut discretionary spending, like buying a new car or a boat or taking a vacation, but healthcare is not really discretionary. You can hold off on some surgeries, but eventually you have to get them. And unlike other consumer services, you don't have to pay the full bill for surgery because your insurance is picking up most of the cost. So there are several key forces shielding ASCs from this bad economy.

Q: Is there still something left for ASCs to cut? Didn't they already make a lot of cuts when the recession hit in 2008? Assuming this was done, what is left to cut?

ML: There is still definitely more to cut, and I'll tell you why. It took going through those cuts once for people to understand and appreciate why the cuts were needed and how they are to be carried out. In a sense, they just got started the last time. Now they know how to do it and they've already started going through a change of attitude. For example, it may never have occurred to them before that there is an alternative to throwing away reusable instruments.

Q: What are the typical mistakes ASCs make when carrying out cuts?

ML: They tend to cut staff before anything else. Since salaries are the largest expense item, employees are the first to go. It's a knee-jerk response. In fact, your employees are your most important asset. Friendly, relaxed staff might be the reason why patients and referring physicians prefer your ASC to the hospital or another ASC down the road. And here you go, reducing staff so much that no one feels friendly and relaxed anymore. It might take a while for that change to register on your bottom line, but it could do so eventually.

Q: When you're looking at cutting staff to the right level, how do you know the difference between overworked staff, relaxed staff and staff who don't have enough to do?

ML: That's where benchmarks come in. What is the right staffing level for the specialties and volume you have? Look at the national benchmarks. Maybe you are already at the right staffing level but your problem has to do with finding the right level of salaries or benefits. There are national and even local benchmarks for these things. After all, salary levels in Des Moines are going to be different from salary levels in Los Angeles.

Staffing benchmarks can also help you deal with what I call "FTE creep." You start off with just one scheduler and then, when times are good and your volume is rising, that person needs an assistant, so you hire an assistant scheduler, and then you hire a few more people for other things that have to get done. After all, the money is rolling in. But then volume falls and you still have these extra people. Everyone has some amount of FTE creep because the ASC is such a dynamic place, with shifting volume and changing staff responsibilities.

Virtually everyone has some fat to cut on the staffing side, but my point is that it has to be done judiciously. For example, don't overreact to temporary downturns in business. Volume may be down simply because a couple of key doctors are taking vacation or maybe someone is sick. Before taking any steps, verify that this is more than just an isolated event.

Q: You said an ASC should consider cutting other items besides staff. What else should be considered?

ML: You should definitely look at your overhead and your supplies. People tend to look at these items later, if at all, because they think, "I'm always going to need to keep the lights on and I'm always going to need supplies." The easy pickings seem to be on the salary side. But you can in fact find considerable savings by taking steps like renegotiating vendor agreements, or finding new vendors or persuading your physicians to use a less expensive device.

These strategies take some work, but they don't cut into the muscle and bone of the organization like taking the easy route and cutting essential staff. Persuading physicians to switch their supplies means pinpointing the waste and presenting the information to them. With anesthesia, for example, price every product the anesthesiologists use, and ask them to explain. One anesthesiologist might be ordering a vial with one and half doses because it's convenient to draw up, and then he throws away the extra half dose each time. That's a considerable amount of waste. Or a cataract surgeon may be using a more expensive anesthetic option meant for longer surgery. Or an orthopedic surgeon is using hips that cost $5,000 more than anyone else's hip.

Everyone has heard of these opportunities. It takes time and effort to compile the data, present it to the physicians and have a conversation, but the savings can sure beat taking away the receptionist at front desk, greeting the patients. While you'll save on the minimum wage you pay her, the $8,000

you are paying for a hip could have been reduced to $3,000. Multiply that out by six hips a month and you have a much greater savings than laying off the receptionist and making the place a little bit colder for patients.

Q: Does the bad economy make it easier to justify cuts?

ML: A bad economy can, to some extent, make cuts more natural and more expectable. But you should be watching your expenses all the time. Wasting money simply because you are making a lot of money is no excuse. Also, don't overexploit the bad economy. Don't present staff with some dire scenario on what happens if we don't cut, such as: "We need these cuts and if we don't get them, we're closing." That just causes panic.

Portray the problem as accurately as possible, using data, and then inspire people. Help them understand they have value and they have a role in creating a good outcome for the center. You might say to the surgeons, "Look it, we're not getting the case volume we once had, and our costs are going up and our margin is shrinking. Our goal is to be profitable and strong, and we need you help." Talk to your physicians and staff.

Q: Would it help to bring the whole staff together and have a conversation?

ML: While I do believe in dialog, I don't think it's wise to have a big group meeting. Talking about each person's shortcomings is hard enough to do among peers, let alone in front of everyone else. Instead, I recommend holding a series of meetings of various groups within the organization, outlining expectations that staff need to meet. The CEO meets with the managers and each manager meets with his or her own staff.

Q: Are there examples of cutting too much?

ML: Some things become what I call "icons." They don't cost much but they carry a lot of meaning, and if you cut them, get ready for the consequences! For example, people like cookies in the lounge. If you cut them out, they'll start thinking, "They're asking *me* to cut the cookies but that other group still gets to have their picnic!" It stirs up a lot of anxieties and doesn't produce much in the way of savings. ■

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

6 Reasons Why Independent Hospitals and ASCs Face Similar Challenges on a Different Scale

By Scott Becker, JD, CPA, and Rachel Fields

1. Each is deathly afraid of their key admitting physicians being hired by competitors. Most independent hospitals are very reliant on their top 25 admitting physicians. Most ASCs are very reliant on their top 5-7 admitting physicians. Today, both facilities have great concerns regarding larger systems or hospitals attempting to employ their physicians. The loss of just a small number of physicians can literally be the difference between being profitable and losing money for ASCs and independent hospitals.

2. Each does not have a clear sense as to how they will fit into a changing managed care/ACO world and if they will have a real place in it. According to a 2011 survey of 200 provider organizations, 48 percent reported they were not sure how an ACO would affect their organization. Even some hospital systems that seem ideal for ACO involvement — including the Mayo Clinic, Geisinger Health System and Cleveland Clinic — have declined to participate in "pioneer" ACO programs. Smaller hospitals and surgery centers are feeling pressured to build relationships with hospital systems and payors without knowing exactly how ACO involvement will affect their business.

3. Each has limited resources to invest in capital, plant, equipment and information technology. Increasingly, independent hospitals find themselves in a situation where they have limited profits but have to make large capital investments to improve their physical plant, improve their technology or buy physician practices. ASCs similarly often have limited profits but increased need for improved technology and equipment.

4. Each is often heavily reliant on a small number of physicians or a specific service line. Experts agree that hospitals can rarely be "all things to all patients." This means many facilities rely on revenue from one or two major service lines, a strategy that can work well if the hospital has a significant market share in that specialty. However, this reliance on a small service line can endanger a hospital if physicians move elsewhere, reimbursement drops or a competitor moves in. Similarly, VMG Health reports that the average surgery center relies on its top two physicians for 32 percent of case volume.

5. Each is often strategically asking the question: Should they stay the course or sell. Independent hospitals, which are often dependent on too few physicians and experiencing rapidly changing capital needs and a changing managed care environment, are increasingly having to decide whether they should stay independent or sell to a larger system or for-profit chain. For the same reasons, ASCs are asking whether they should stay the course or sell to a hospital or national chain.

6. Each may have limited ability to withstand big changes in reimbursements and exclusions from contracts due to efforts by systems working with payors. The proposed merger between Pittsburgh-based West Penn Allegheny Health and Highmark made headlines this year, prompting questions about the future of payor-provider relationships. Without the leverage or negotiating clout of large systems, smaller hospitals and surgery centers are sometimes forced to accept inadequate reimbursement and make up for the profit loss with extreme cost-cutting. Contract negotiation is all the more important for surgery centers as historically profitable "out-of-network" centers are forced in-network or drained of case volume. ■

Contact Scott Becker at sbecker@beckershealthcare.com.

7 Observations on the Future of Ophthalmic ASCs

By Leigh Page

Jerome H. Levy, MD, managing director of the Ambulatory Surgery Center of Greater New York, an ophthalmic ASC in the Bronx, and president emeritus of the Outpatient Ophthalmic Surgery Society, makes seven observations about the future of ophthalmic ASCs.

1. More cataract surgeries in ASCs. Surgery volume is rising as baby boomers age, and more of that surgery will flow into ASCs. About 40 percent of cataract surgeries are performed in ASCs now, and with professional fees stagnating, cataract surgeons are expected to move a greater proportion of their cases to ASCs, Dr. Levy says. Surgery centers have two big draws for cataract surgeons: ASC efficiencies will help them move their cases along faster and as surgeon-owners, they will be able to substantially supplement their income by capturing part of the ASC facility fee.

2. More retina surgery in ASCs. The Medicare facility fee for retina surgery was raised as of the beginning of 2011 and another increase is expected in 2012, meaning that more retina surgery is feasible in the ASC, and retina volume in ASCs is expected to rise.

3. Medicare cuts may not affect ASCs. There have been numerous proposals out of Washington to cut Medicare reimbursements, and Congress' debt reduction "super committee" will likely trim Medicare payments this fall. Dr. Levy expects that any Medicare cuts are more likely to affect professional fees rather than surgery centers, but he adds: "There are no guarantees that ASC rates will not be affected and that's why we must become involved in the political process."

4. Premium services won't boom in this economy. Sales of premium intraocular lenses and use of the new femtosecond laser, both of which require higher out-of-pocket payments from patients, cannot surge in this economy. "Our practice and ASC are in a lower middle income area and our patients don't have money for extras," Dr. Levy says. "The practice has a low premium IOL conversion rate, and ASCGNY is not interested in purchasing a femtosecond laser at this time. However, as the technology improves and the cost decreases, it may become more practical."

5. ACOs may have little impact. It is not clear how much accountable care organizations will affect ASCs. "We're just reviewing ACOs and we're not doing anything in a serious manner yet with them," Dr. Levy says. "The concept hasn't jelled well enough."

He thinks ACOs appear to be a lot like HMOs, which did not catch on in New York for commercial payment. However, the prospect of ACOs has spurred mergers and alliances in the area, such as the new alliance between North Shore/Long Island Jewish and Montefiore Medical Center/Albert Einstein Medical College in the Bronx. "If ACOs ever become dominant, they would favor large institutions," he observes.

6. ASCs need a better reimbursement model. CMS uses the CPI-U marker to update ASC payments, which provides consistently lower rates than the market basket rate applied to HOPDs, Dr. Levy says. This means that ASC payments, already 57 percent lower than HOPD payments, will continue to slip further behind. "The Outpatient Ophthalmic Surgery Society is deeply involved in trying to have ASCs included in the market basket update," he says.

7. Yag rates will fall. Rates for Yag capsulotomy, to correct lens capsule clouding after cataract surgery, are likely to fall more. "Many patients need a Yag after cataract surgery," Dr. Levy says. "It is likely that with the lower facility fee, it will still be efficient and profitable for this procedure to continue in the ASC." ■

Learn more about the Outpatient Ophthalmic Surgery Society at www.ooss.org.

Current and Future State of Pain Management: Q&A With Dr. Laxmaiah Manchikanti of the American Society of Interventional Pain Physicians

By Rob Kurtz

Laxmaiah Manchikanti, MD, is the chairman of the board and CEO of the American Society of Interventional Pain Physicians (ASIPP) and the Society of Interventional Pain Management Surgery Centers (SIPMS); medical director of the Pain Management Center of Paducah (Ky.); and associate clinical professor of anesthesiology and perioperative medicine at the University of Louisville, Kentucky.

Q: What do you see as the top issues facing pain management now?

Dr. Laxmaiah Manchikanti: The top issues facing pain management are different for different specialties, even though they do have some similarities. In broad, general terms, pain management is divided into pain medicine and interventional pain management. While both specialties have substantial similarities, they also have significant differences. In pain medicine, there are providers who focus on utilizing opioids only or cognitive behavioral therapy only; some physicians combine these two and also utilize interventional techniques. Similarly, interventional pain management could be practiced by only utilizing interventional techniques, or with opioids, or with cognitive therapy, or combination of two or three.

Overall, the important issues facing pain management are access and survival. Unfortunately, access may become difficult because of the Affordable Care Act (ACA), despite its being touted as improving access. In my opinion, ACA has empowered private insurers. Multiple organizations, such as the Patient-centered Outcomes Research Institute (PCORI) and the Independent Payment Advisory Board, will introduce restrictions on Medicare with certain safety valves. However, those safety valves do not prevent private insurers and all other government payors, except Medicare, to implement their cost-based regulations. Patient access and the survival of interventional pain management practices will be jeopardized due to reduced reimbursement, increased regulations, and increasing costs.

Evidence-based medicine and comparative effectiveness have been touted as the new phenomenon; however, there is no evidence supporting these regulations, neither from the administration, nor from the private healthcare industry which follows and supports them. The costs of managing a practice are tremendous, with increasing inflation, increasing benefit packages, reducing reimbursement, mandatory requirements of electronic medical records, various quality issues and ICD-10. With the May 14, 2009, administrative regulation, interventional pain management has come under attack with expensive infection control measures, which increase the cost of drugs and wipe away all the differential paid for the procedures for offices, and wipe away all the available profits for surgery centers. Hospitals still do reasonably well with higher reimbursement and whole basket rates.

Q: What do you see as the top issues that pain management will likely face over the next year? Over the next five years?

LM: Over the next year, the issues will remain the same. However, they will be complicated by the strengthening of regulations by the authorities, and private payors attempting to influence further reduce Medicare payments.

Within the next five years, we will see numerous changes, but no more major changes. The major changes that have already been implemented will never be reversed even though they have caused irreversible damage. Unfortunately, repealing ACA now will only result in more deleterious effects. However, its repeal would probably help to reduce the budget deficit.

In the next five years, it is imperative that interventionalists develop appropriate evidence-based principles and apply them to our practices and also to our reimbursements for services.

Q: What do you think will be the key clinical/technological developments likely to shape the specialty? What is the future of pain management?

LM: The clinical and technological developments likely to shape the specialty will be related to evidence-based medicine and making sure the policymakers understand what evidence-based medicine is.

It is essential for all medical groups to stop their in-fighting and support real evidence-based principles. Once the principles are laid out, they should be followed.

Overall, I am hopeful but have guarded optimism for the future of interventional pain management.

Q: Are there any regulatory changes you would like to see made concerning pain management?

LM: I would like to see changes in the application of evidence-based medicine principles and the elimination of bias. So-called non-biased individuals are actually full of bias. Just as interventional pain management is considered biased because we provide these services, others who are employed in these organizations also depend on an income. If they do not provide the opinions insurers want, they will never be used again. Consequently, they will lose all their funding, jobs, etc. Thus, bias exists on all sides, at all levels. This has to change.

PCORI is my major concern. It needs to be eliminated or severely restricted. By the same token, the Agency for Healthcare Research and Quality effectiveness programs and the Institute of Medicine are receiving tremendous amounts of funding; funding which is being wasted. Further, the National Institutes of Health is providing research grants to China and other countries for techniques not even performed in America.

ICD-10 is another problem. This is expected to be implemented Oct. 1, 2013. This is extremely complex, taking a human toll, and very expensive. The bottom line is it does not provide any improvement in coding. It will only negatively affect the reimbursements and increase unnecessary fraud and abuse investigations. It has been estimated that this may cost per physician $25,000-$50,000 to implement, which is a large amount considering the cost complexity, declining reimbursements and lack of its need. The bottom line is this has not even been enacted by Congress. On Jan. 16, 2009, HHS issued a regulation that ICD-10 will be introduced as the

HIPAA-named code set. The original language in HIPAA of 1996 required the use of ICD-9, not ICD-10.

We are looking at questioning this authority of the administration to change the Congressional approval.

Q: What excites you most about the specialty right now? What concerns you the most?

LM: The developments in the specialty and the coming together of multiple specialties are exciting issues. Recently, the five specialty groups involved in interventional pain management came together and started a Council of Pain Physician Societies. That is a major achievement.

The major concern is the attack on interventional pain management from inside, as well as outside. All eyes are on interventional pain management. While it is said in general if healthcare growth can be reduced by 1.5 percent, that curve can be bent. In fact, interventional pain management has been reduced much more than that — by 10-14 percent. Even so, the curve is not bending and interventional pain management is under attack. This attack is sometimes justifiable; however, it is extended to a level where it is no longer productive.

Q: What would you say the best pain management physicians are doing now that elevate them above their peers?

LM: The best pain management physicians are constantly providing new literature based on evidence-based principles; providing education to insurers, administration and Congress — though unsuccessfully at times — and donating their resources to prevent further erosion into access issues and working on survival for future. ■

Learn more about ASIPP at www.asipp.org and SIPMS at www.sipms.org.

Blue Shield of California Recommends Use of ASCs Over Hospitals

By Rob Kurtz

Blue Shield of California recommends the use of a network ASC over a network hospital for outpatient surgery as a way to save money in an article in its Sept. *Now I Know* newsletter, found at www.blueshieldca.com/employer/forms-resources/now-I-know-newsletter/newsletter_sept2011.jhtml

The article, titled "Call it out: Switching to ambulatory surgery centers reduces costs," compares the charges for a tonsillectomy at a Los Angeles area network hospital and network ASC as an example of the possible savings when using a surgery center.

The article also provides background information on ASCs and gives examples of some common outpatient procedures performed in surgery centers.

Now I Know is a bi-monthly newsletter for midsize and large employer groups. Blue Shield provides materials to be shared with employees to educate them on how they can save on outpatient procedures using an ASC. ■

Contact Rob Kurtz at rob@beckersasc.com.

Adding a Total Joint Program to a Surgery Center: Q&A With John Brock of NorthStar Surgical Center

By Rob Kurtz

NorthStar Surgical Center in Lubbock, Texas, began offering total knee, uni-knee, total ankle and total shoulder procedures at the beginning of the year. The ambulatory surgery center has performed approximately 10 of the procedures so far. John D. Brock, administrator for the ASC, discusses his surgery center's new program and why it was the right time for the facility to expand its offerings.

Q: What led NorthStar to consider expanding your services to offer total joint replacement?

John Brock: Several of our physician-partners expressed a desire to provide this service to their patients in an outpatient setting. The mindset is that the physicians wanted to provide the appropriate patient seeking this procedure with the same access to outpatient care as the more conventional orthopedic patient. The patient benefits not only from going home much sooner than in the past, but we can perform the procedure for a significantly lower cost. Currently we have two physicians that perform the total knee, three that perform the uni-knee, three that perform the total ankle and one that performs the total shoulder.

Q: Describe the process your ASC went through which confirmed expanding was the right decision and that the time to expand was now.

JB: Our physicians determined that the procedures are now more advanced, less invasive and patient pain is easier to control. Also, our physicians had a significant increase in demand for these procedures in an outpatient setting, which led to us working under the direction of our physicians to structure a program to meet this demand. We also met with the medical supply vendors to facilitate providing these procedures in a cost-effective manner.

Q: Why expand to offer total joint replacement rather than expand in a different direction?

JB: NorthStar Surgical Center is the premier orthopedic facility in this market. We provide sports medicine services to Texas Tech University athletes. We have nine orthopedic physician partners. On staff we have three hand fellows, three foot and ankle fellows and three sports medicine fellows. Expanding in this direction was a natural move.

Q: How have your payors responded to this expansion? What feedback have you received from patients?

JB: The payors where the procedures are allowable have responded favorably. The fact that we're able to perform these procedures at a savings to them is certainly a positive. The patients have responded favorably as well.

Q: What role do you envision your total joint program playing in the long-term financial success and sustainability of your ASC?

JB: It can only help from a multitude of reasons. First, we have found orthopedic procedures to be a great service line for us here at NorthStar. And by growing orthopedics, it can only result in sustaining the financial health of the facility. Finally, there is a halo-effect associated with high-tech procedures of this nature, which I would expect to positively impact other service lines as a result.

Q: For ASCs considering expanding into total joint replacement surgeries, what advice would you offer? For ASCs considering any type of expansion, is there other advice you would offer?

JB: Whether it's expanding into total joints or other service lines, I think the advice would be the same and that's to do your due diligence. In the case of total joints, I would first recommend that the physicians be the drivers of the process. Without their commitment, you're doomed to mediocrity. I would also recommend visiting and consulting other facilities that have successfully implemented the program — this would include learning about their policies, processes and protocols and their relationships with home health agencies for aftercare. ■

Learn more about NorthStar Surgical Center at www.northstarsurgicalcenter.com.

10 Ways a Surgery Center's Budget Can Go Awry

By Rob Kurtz

It's budget-planning season for many ambulatory surgery centers, and that includes the ASCs for Meridian Surgical Partners. Brian Brown, regional vice president, operations, for Meridian, oversees the budget planning for the management and development company's surgery centers in his region. He identifies 10 ways he has seen an ASC's budget planning go awry, and then offers some best practices for how to better prepare for these scenarios.

1. Losing a physician you didn't expect to lose. "If we budget a physician in 2012, and then all of a sudden we get in the middle of 2012 and the physician moves, retires, their practice is purchased by a hospital or there's an unforeseen, life-changing event, now you are left scrambling to hit your budgeting targets," Mr. Brown says.

2. New physician you recruit does not perform as expected and projected. For example, an ASC might recruit a bariatric surgeon to implement a laparoscopic gastric banding program at the center. But if the program isn't as initially successful as hoped and planned for, this recruited surgeon may become disinterested and his or her performance could fall off, Mr. Brown says. The struggles of the program and an underperforming surgeon will both impact budget projections and strategic plans.

3. Adding new procedures that drive up supply costs per case. "Let's say you get into 2012 and all of a sudden you have an urologist who wants to do sacral neuromodulation or you decide to add spine/pain stimulators or laparoscopic gastric banding— procedures with a high supply cost associated with them," Mr. Brown says. "Then the statistics in your budget are going to go awry. If you budgeted $300 in supplies per case and then you start doing cases that cost $10,000 per case, what is that going to do to your budget?"

4. Leases and/or contracts expiring. Considering the number of service contracts, maintenance contracts, equipment leases and warranties on equipment that an ASC is responsible for, it is likely that one, if not more, will expire each year. This will facilitate the renewal or addition of a contract. With so many contracts to keep track of, it is not uncommon for an ASC to miss when one expires.

"Let's say you bought a new piece of equipment in Oct. 2011 that comes with one-year warranty," says Mr. Brown. "Then if you get into Oct. 2012 and you've forgotten about that warranty that's going to expire when you do your budget, then you're going to have this added cost."

"You could also get into a situation where you thought you had warranty coverage but it expired, and if you have an unexpected repair, it can cost thousands of dollars and ruin your projection for a month," he says.

5. Seasonality. Most ASC volume ebbs and flows; it is rare for a surgery center to have a consistent number of cases every month. To budget effectively, it is critical for ASCs to consider the many different factors that could drive volume up or down, says Mr. Brown. This can include:

Physician vacations. "If a physician always takes spring break in March, then you need to plan that in your budget, you need to alter your budget according to volume," he says. "Let's say this applies to a GI surgeon you expect to perform 100 colonoscopies every month. If you project 100 for every month, come March, what's going to happen to your budget if he's only going to have two weeks worth of colonoscopies?"

Reset of deductibles. Most deductibles reset at the start of a new year. As a result, elective surgery in the first few months of the year typically declines as prospective patients try to wait on elective surgery until their deductibles are met, Mr. Brown says. Patients are also often concerned with paying off holiday bills at the start of the year and try to avoid spending more money during this time.

Snow birds. If your ASC is located in a state like Florida where a significant portion of the population only lives for part of the year, this will impact case volume. "We have a situation with snow birds who come to Florida from October until March or April," Mr. Brown says. "If you don't plan your budget accordingly in Florida for the snow-bird season, you're going to miss your budget."

School season. Some specialties are also impacted by seasonality. For example, ENT has a significant number of pediatric patients. "There are a lot of kids who receive care for tubes and tonsils," he says. "When do kids get sick? During school season. So during the summer months, ENT surgery can be down."

6. Wage increases. "If you have a situation in a market where you're going to need to budget higher wage increases than normal, or if you get into the year and you lose personnel and you have to replace them with personnel that are paid more, then your statistics are going to be off from what you expected," Mr. Brown says. "Let's say you have to replace a $25/hour nurse with a $30/hour nurse. Now you'll have a variance in your budget."

7. Survey requires changes. If CMS, OSHA or one of the accrediting bodies conducts a survey at your ASC and identifies areas in need of improvement, it is likely that implementing the changes to address these concerns will cost money, and that will be reflected in your budget, Mr. Brown says. "In the past, a lot of ASCs had their employees launder their scrubs at home," he says. "That's no longer acceptable. You now have to have a third-party laundering service, and that costs the surgery center money."

Very poor survey results might require an outside consultant to come in to the ASC to oversee changes or surveyors might require the temporary closing of the center while problems are fixed, which will significantly affect a budget.

8. Staffing projections. Staffing costs are one of the top two highest costs for an ASC, so budgeting for an appropriate number of staff is critical to maintaining profitability each month. If your volume projections are off, your staffing is likely to be off as well, Mr. Brown says.

"If you predicted your volume to be at 400 cases a month in March and then you only have 300 cases that month and you staffed for 400, you'll have to adjust staffing," he says. "It could also go the other way — you budget staff for 300 cases and have 400 cases, and you'll have to bump up staffing to an appropriate level."

9. Reimbursement changes during the year. Reimbursement fluctuations, while hard to predict, can wreak havoc on a budget. For example, if you have a managed care contract that expires mid-year and it was a contract based on percentage of charges, but the payor decides to change to a grouper schedule following Medicare, your ASC is likely faced with receiving less reimbursement than it projected.

10. Budgeting large purchases. It is important to plan for equipment purchases in your ASC's budget, but sometimes how you intend to make these investments can change based on your cash flow and availability of financing.

"For example, if you thought you were going to purchase something with cash and now you need to finance it, you're now going to incur the associ-

ated interest charges," Mr. Brown says. "Or if you were planning to purchase a piece of equipment and wanted to finance it but now the financing options aren't there, you'll need to come up with the cash."

Keeping your ASC prepared

While it is not possible to address all of these scenarios in your budget planning, there are some steps Mr. Brown advises ASCs to help keep your budget from going awry.

- **Communicate and meet with your physicians.** "Ask them what's going on in their practice," Mr. Brown says. "Ask what they see going on in their specialty going forward. Are there new procedures? Is there a growing or decreasing patient base?"
- **Review all of your contracts.** This includes service, maintenance, equipment and managed care. "If you review all of your contracts, you'll have a better chance to come up with or be prepared with a solution for something happening," he says.
- **Talk to your vendors.** "See if you can get from them price increases that are coming that they know about so you can better predict in the future what's going to happen," he says.
- **Stay informed.** "Keep up on new technology, and new procedures that are coming and that are being allowed in the outpatient setting," he says. "This way you can get carve outs for those procedures and make sure you get reimbursed for them in your managed care contracts so you can maintain your margins for those high-cost supply items," Mr. Brown says. ■

Learn more about Meridian Surgical Partners at www.meridiansurgicalpartners.com.

50 Benchmarks on ASC Case Volume

By Rachel Fields

Here are 50 benchmarking statistics on surgery center case volume, according to data from VMG Health's *Multi-Specialty ASC Intellimarker 2010*.

Total Annual Cases Per Center

All surveyed ASCs

Average cases per year: 4,698

Based on center location

West: 4,471
Southwest: 3,552
Midwest: 3,681
Southeast: 4,330
Northeast: 4,384

Based on ASC net revenue

Less than $4.5 million: 2,800
$4.5 million - $6.99 million: 4,217
More than $6.99 million: 5,592

Based on number of operating rooms

1-2 ORs: 2,319
3-4 ORs: 3,540
More than 4 ORs: 5,598

Case Volume Mix as Percentage of Total Cases

The following statistics demonstrate how common ASC specialties comprise total case volume in all surveyed surgery centers.

ENT: 8 percent of total case volume
GI/Endoscopy: 24 percent
General Surgery: 8 percent
OB/GYN: 3 percent
Ophthalmology: 19 percent
Oral Surgery: 1 percent
Orthopedics: 17 percent
Pain Management: 14 percent
Plastics: 5 percent
Podiatry: 3 percent
Urology: 3 percent
Other: 1 percent

Surgical Cases Per Operating Room

All surveyed ASCs

Average cases per year: 705

Based on center location

West: 543
Southwest: 596
Midwest: 676
Southeast: 676
Northeast: 846

Based on ASC net revenue

Less than $4.5 million: 569
$4.5 million - $6.99 million: 597
More than $6.99 million: 761

Based on number of operating rooms

1-2 ORs: 613
3-4 ORs: 694
More than 4 ORs: 644

% of Cases Performed By Top 5 Physicians

All surveyed ASCs

Percentage of cases performed by top 5 physicians: 53 percent

Based on center location

West: 47 percent
Southwest: 51 percent
Midwest: 52 percent
Southeast: 54 percent
Northeast: 44 percent

Based on ASC net revenue

Less than $4.5 million: 63 percent
$4.5 million - $6.99 million: 53 percent
More than $6.99 million: 44 percent

Based on number of operating rooms

1-2 ORs: 72 percent
3-4 ORs: 53 percent
More than 4 ORs: 43 percent ■

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

150 Physician Leaders in the ASC Industry
(continued from page 1)

Surgery Center in Sacramento. He has been an active participant in state and federal advocacy for the ASC industry.

Dale A. Armstrong, MD. Dr. Armstrong is chairman of the board of Mason City (Iowa) Surgery Center and the president of the Mason City Clinic, where he has visionary ideas for his center. He is board certified in adult and child and adolescent psychiatry.

John Atwater, MD. Dr. Atwater is a spine surgeon at Downstate Illinois Spine Center and McClean County Orthopedics, both in Bloomington, Ill. He treats a wide range of spinal conditions and performs many types of spinal surgery.

Kenneth Austin, MD. Dr. Austin is an orthopedic surgeon at Rockland Orthopedics & Sports Medicine in Airmont, N.Y. His expertise includes treating traumatic and sports-related injuries of the upper and lower extremities, and hip and knee replacements.

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

Norman Douglas Baker, MD, FACS. Dr. Baker is a surgeon at the Ophthalmic Surgeons and Consultants of Ohio in Columbus. He completed his ophthalmology fellowship at Emory University School of Medicine in Atlanta. He is also clinical assistant professor of ophthalmology at Ohio State University.

Joseph Banno, MD. Dr. Banno is the founder and co-owner of the successful Peoria (Ill.) Day Surgery Center and is past chairman of the ASC Association and a current executive committee member. He is a board-certified urologist with the Midwest Urologist Group.

Scott Bateman, MD. Dr. Bateman is an otolaryngologist practicing at Sheridan (Wyo.) Ear, Nose & Throat. He is affiliated with the American Medical Association, Texas Medical Association and American Academy of Otolaryngology.

Robert A. Berger, MD. Dr. Berger is a general and bariatric surgeon practicing with Flagstaff (Ariz.) Medical Center. He has special interest in minimally invasive procedures and bariatric surgery.

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

Todd Beyer, DO. Dr. Beyer is an ophthalmologist and oculofacial-plastic surgeon at Novus Clinic in Tallmadge, Ohio, where he serves as president. He also serves on the board of directors of the Ohio Association of Ambulatory Surgery Centers.

Robert Boeglin, MD. Dr. Boeglin, an ophthalmologist, is the board president for Midwest Eye Institute in Indianapolis and co-founder of Health Venture Management. He completed a glaucoma fellowship at Yale University in New Haven, Conn.

Thomas Bombardier, MD, FACS. Dr. Bombardier is an ophthalmologist and one of the three founding principals of Ambulatory Surgical Centers of America. Prior to founding ASCOA, he established the largest ophthalmic

practice in Western Massachusetts, two ASCs and a regional referral center.

Nader Bozorgi, MD. Dr. Bozorgi has been a leader and pioneer in the field of outpatient surgery since 1973, when he opened one of the first ASCs in the United States. He continues to serve as Magna Health System's CEO.

Richard F. Bruch, MD. Dr. Bruch is a physician with Triangle Orthopedic Associates and James E. Davis Surgery Center, all located in Durham, N.C. He is a past-president of both the Durham-Orange County Medical Society and North Carolina Medical Society.

Michael Bukstein, MD, FACS. Dr. Bukstein is a general surgeon who serves as the board president of the Northeast Missouri Ambulatory Surgery Center in Hannibal. His surgical specialty and clinical interests are general surgery and surgical oncology.

John Byers, MD. Dr. Byers is an otolaryngologist with the Surgery Center of Greensboro (N.C.) and Greensboro Ear, Nose and Throat Associates. He is also medical director of the Surgery Center of Greensboro.

James T. Caillouette, MD. Dr. Caillouette is a board-certified orthopedic surgeon with Newport Orthopedic Institute in Newport Beach, Calif. He is a past president of the California Orthopaedic Association and a former director of the American Association of Hip and Knee Surgeons.

Peter A. Caprise, MD. Dr. Caprise is an orthopedic surgeon at The Orthopaedic Center of Central Virginia in Lynchburg. He subspecializes in arm, hip, knee and shoulder surgery and provides joint replacement, arthroscopic surgery and sports medicine surgeries to his patients.

John Caruso, MD. Dr. Caruso has more than 15 years of neurological surgery experience. As the cofounder of the "Save Our Doctors, Protect Our Patients" campaign, Dr. Caruso initiated and helped create legislation to reimburse physicians for trauma care delivery in Maryland.

Peter Cimino, MD. Dr. Cimino practices orthopedics at Omaha Orthopedic Clinic and Sports Medicine in Nebraska. He subspecializes in orthopedic surgery of the foot and ankle, hip, knee, shoulder and elbow, as well as sports medicine.

James R. Colgan, MD. Dr. Colgan is a urologist and a member of board of managers of Sierra Surgery Hospital. He is also chairman of the board for Carson Ambulatory Surgery Center and founder of Physicians Managed Care.

Christine Corbin, MD. Dr. Corbin is a GYN surgeon and medical director of the Surgery Center at Tanasbourne in Hillsboro, Ore., a Blue Chip Surgical Partners facility. She is the founder and president of Northwest Gynecology Associates.

William Crowder Jr., MD, FACOG. Dr. Crowder, an OB/GYN physician, helped to start the Conroe (Texas) Surgery Center. After re-syndicating and building a new larger facility in 2003, he is currently the chair of the board of managers of that facility.

R. Blake Curd, MD. Dr. Curd is a hand surgeon and chairman of the board of directors of Surgical Management Professionals. He is an active proponent of physician ownership in healthcare and serves as secretary/treasurer for Physician Hospitals of America

Christopher Danis, MD. Dr. Danis, a hand surgeon, initiated Far Hills Surgical Center, where he continues to serve on the board. He previously served as chief of staff at Miami Valley Hospital.

Urfan Dar, MD. Dr. Dar is principal, manager and medical director of Theda Oaks Surgery Center in San Antonio. He is board certified by the American Board of Pain Medicine and the

American Board of Anesthesiology.

Devin K. Datta, MD. Dr. Datta is an orthopedic and spine surgeon at The B.A.C.K. Center. He serves as the chairman of the department of orthopedics at Holmes Regional Medical Center in Melbourne.

Daniel C. "Skip" Daube, MD. Dr. Daube is the director and CEO of Surgical Center of Excellence in Panama City, Fla. He is board certified in otolaryngology and facial plastic and reconstructive surgery and is a member of numerous professional societies.

Philip A. Davidson, MD. Dr. Davidson is the founder and former CEO of Tampa Bay (Fla.) Specialty Surgery Center and now practices orthopedics with Heiden Orthopaedics in Park City, Utah. He subspecializes in cartilage restoration and shoulder surgery.

Tom Deas Jr., MD, MMM. Dr. Deas has served as medical director of two Fort Worth, Texas, ambulatory endoscopy centers since their development. He is president-elect of the American Society for Gastrointestinal Endoscopy and participates in the Surgical Care Affiliates physicians' leadership team.

John DiPaola, MD. Dr. DiPaola is an orthopedic surgeon whose practice focuses on workers with orthopedic injuries. Dr. DiPaola is affiliated with the American Academy of Orthopaedic Surgeons and Oregon Association of Orthopedists.

Douglas R. Dodson, DO. Dr. Dodson practices orthopedics at Alamogordo Orthopaedics and Sports Medicine in New Mexico. His special interests include hip and knee reconstruction, back pain, arthritis, foot and ankle disease, work-related injuries and anterior cruciate ligament injuries.

Stephen E. Doran, MD. Dr. Doran is chairman of the board of Midwest Surgical Hospital in Omaha, and practices with Midwest Neurosurgery & Spine Specialists. He has received national recognition for his research in gene therapy related to the central nervous system.

Ken Drazan, MD. Dr. Drazan is a physician and managing director of healthcare services investments for Bertram Capital Management in San Mateo, Calif. Previously, he was the CEO and founder of Arginox Pharmaceuticals.

Jack Egnatinsky, MD. Dr. Egnatinsky is the president of the AAAHC Board of Officers for 2011/12. He is a board certified anesthesiologist who has held a number of academic and clinical leadership positions within his specialty.

James P. Emanuel, MD. Dr. Emanuel is an orthopedic surgeon practicing with Parkcrest Orthopedics in St. Louis. He subspecializes in the care of the upper extremity and has extensive experience in arthroscopic shoulder reconstruction.

John Fitz, MD. Dr. Fitz is the founder of The Surgery Center of Farmington (Mo.). Although trained in the comprehensive management of eye diseases, Dr. Fitz's particular interests lie in cataract surgery, glaucoma management and surgery and refractive surgery.

Donald W. Floyd, MD. Dr. Floyd is an orthopedic surgeon practicing with Texas Surgical Center in Midland. He is a fellow of the American Academy of Orthopaedic Surgeons and a member of the Texas Medical Association.

John Fontana, MD. Dr. Fontana is an obstetrician/gynecologist practicing at Beaufort (S.C.) OB/GYN. He completed a fellowship at Johns Hopkins University in Baltimore and has held faculty positions at Hershey Medical Center at Penn State University.

Thomas R. Forget Jr., MD. Dr. Forget is a neurosurgeon with the St. Louis Spine Surgery Center, a Blue Chip Surgical Partners facility. He has a special expertise in back injuries, cerebrovascular disorders and cervical spine disorders.

John A. Foster, MD. Dr. Foster is an otolaryngologist practicing with Spartanburg Ear, Nose and Throat in South Carolina. He is medical director and chairman of the board for the Spartanburg ASC and vice chief of the division of otolaryngology at Spartanburg Regional Medical Center.

Robin Fowler, MD. Dr. Fowler is chairman and medical director of Interventional Management Services. He is also the medical director of the Interventional Spine and Pain Management Center in Conyers, Ga. He has an interest in performing epidurals and staying abreast of the innovations in the pain management field.

James L. Fox Jr., MD. Dr. Fox is the founding leader of the Ravine Way Surgery Center in Glenview, Ill., and practices at the Illinois Bone & Joint Institute. He is a board certified orthopedic surgeon who has been practicing for more than 20 years.

Eric J. Freeh, DO. Dr. Freeh practices orthopedics at Alamogordo Orthopaedics and Sports Medicine in New Mexico. He has a special interest in trauma surgery, shoulder injury and osteoporosis and is a former team physician for the Phoenix Suns.

Tom Fry, MD. Dr. Fry, a board-certified orthopedic surgeon, currently sits on the board of Lutheran Campus ASC in Wheat Ridge, Colo., and practices at Colorado Hand & Arm. He is the former chief of hand surgery at Tripler Army Medical Center in Hawaii.

Robert Gannan, MD, PhD. Dr. Gannan is the founder and clinical strategies advisor for Doylestown, Pa.-based Physicians Endoscopy. He established Eastside Endoscopy Center as one of the first outpatient endoscopy centers in Washington State and retired from clinical practice in Dec. 2006.

Tom N. Galouzis, MD, FACS. Dr. Galouzis is the president and CEO of the Nikitis Resource Group and currently practices at Lake Park Surgicare in Hobart, Ind. He was a clinical instructor of surgery at the University of Chicago Pritzker School of Medicine.

David S. George, MD. Dr. George is an ophthalmologist with The Eye MDs of George, Strickler and Lazer, based in Marietta, Ohio. He is a member of the board of directors for the ASC Association and the Outpatient Ophthalmic Surgery Society.

Gregory George, MD, PhD. Dr. George, an ophthalmologist, is the founding principal of SurgCenter Development. Under his leadership, SurgCenter Development has developed more than 60 profitable, physician-owned ASCs.

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

Scott E. Glaser, MD, FIPP. Dr. Glaser is an interventional pain physician and founder of the Pain Specialists of Greater Chicago in Burr Ridge, Ill. He serves as director on the national board of the American Society of Interventional Pain Physicians and was heavily involved in the lobbying efforts required to ensure passage of the NASPER bill.

Edward Glinski, DO, MBA, CPE. Dr. Glinski, a refractive and cataract surgery specialist, is the medical director at Heritage Eye Surgicenter of Oklahoma. He also serves as an accreditation surveyor for Health Facilities Accreditation Program.

Steven A. Gunderson, DO. Dr. Gunderson is CEO/medical director of Rockford (Ill.) Ambulatory Surgery Center. He is a surveyor for the AAAHC and a past member of the board of directors of the Federated Ambulatory Surgery Association.

Nameer Haider, MD. Dr. Haider is a pain management physician with Spinal & Skeletal Pain Medicine and medical director of Sitrin Medical Rehabilitation Ccenter in New York. He performs minimally invasive spinal surgery and laser disc surgery.

John H. Hajjar, MD. Dr. Hajjar is the CEO of Urology Specialty Care in northern New Jersey. He was previously chief of urology at St. Joseph's Hospital in New Jersey and associate professor at NYU Medical Center.

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

Scott Holley, MD. Dr. Holley, a hand surgeon, is the president and founder of Great Lakes Plastic & Hand Surgery in Michigan. He is president of the Michigan Association of Hand Surgery and is a member of numerous professional societies

Stephen Holst, MD. Dr. Holst practices urology at Big Horn Urology in Wyoming. He is affiliated with the American Board of Urology, American Lithotripsy Society, American Urological Association and Rocky Mountain Urological Society.

Gregory Horner, MD. Dr. Horner, a hand surgeon, is the managing partner of Smithfield Surgical Partners and a board member of the California Ambulatory Surgery Association. He is CEO of Hacienda Surgery Center and Pleasanton Surgery Center.

Young B. Huh, MD. Dr. Huh is a gastroenterologist with Gastroenterology Associates, P.C., in Bettendorf, Iowa. He is a member of the American College of Gastroenterology and the American Gastroenterological Association.

Richard Hynes, MD. Dr. Hynes is a spine surgeon who has been serving as president of The B.A.C.K. Center in Melbourne, Fla. He is a spine surgeon at Osler Medical, consultant for Medtronic and a director of the charity TXEDAKA.

Jack E. Jensen, MD, FACSM. Dr. Jensen is an orthopedic surgeon and medical director of Athletic Orthopedics and Knee Center. He has an active role in the Texas Ambulatory Surgical Center Association. He has worked with U.S. Gymnastic Federation, USA Swimming Foundation and Association of Tennis Professionals.

Richard A. Kaul, MD. Dr. Kaul is president of New Jersey Spine & Rehabilitation. He is a minimally invasive spine specialist, with an expertise in the diagnosis and treatment of spinal conditions using minimally invasive techniques.

Karamjit Khanduja, MD. Dr. Khanduja is a colorectal surgeon who serves on the medical staff of Green Street Surgery Center in Columbus, Ohio and practices at Colon & Rectal Surgery. He received training in colon and rectal surgery at Grant Med Center.

Douglas D. Koch, MD. Dr. Koch is medical director of Baylor Vision, the refractive surgery clinical and research group at Baylor College of Medicine in Houston. He is past president of

REGENT SURGICAL HEALTH

CONGRATULATIONS

To Our Physician Partners

For Being Named Among The Top Physician Leaders in the ASC Industry

Douglas R. Dodson, DO, Southern New Mexico Surgery Center | *Alamogordo, NM*

James L. Fox Jr., MD, Ravine Way Surgery Center | *Glenview, IL*

Eric J. Freeh, DO, Southern New Mexico Surgery Center | *Alamogordo, NM*

Scott E. Glaser, MD, FIPP, Palos Surgicenter | *Palos Heights, IL*

James Lynch, MD, Surgery Center of Reno | *Reno, NV*

David J. Raab, MD, Illinois Sports Medicine & Orthopedic Surgery Center | *Morton Grove, IL*

Herbert W. Riemenschneider, MD, Knightsbridge Surgery Center | *Columbus, OH*

Robert Welti, MD, Senior vice president of operations at Regent Surgical Health | *Westchester, IL*

Kent Sasse, MD, MPH, FACS, Surgery Center of Reno | *Reno, NV*

Jeffrey L. Visotsky, MD, FACS, Illinois Sports Medicine & Orthopedic Surgery Center | *Morton Grove, IL*

"We are extremely proud of those honored and all our physician partners who are delivering the highest quality care and leading healthcare in the right direction."

Tom Mallon, Regent Founder & CEO

Tom Mallon, CEO 708.492.0531 | **Jeffrey Simmons, CDO** 707.538.8283
4 Westbrook Corporate Center, Suite 440
Westchester, Illinois 60154

www.regentsurgicalhealth.com

the International Intra-Ocular Implant Club and the American Society of Cataract and Refractive Surgery.

Marc E. Koch, MD, MBA. Dr. Koch is the president and CEO of Somnia Anesthesia, a company that offers cost-efficient anesthesia solutions to hospitals, ASCs and office-based facilities nationwide. He also co-founded Resource Anesthesiology Associates.

Satish Kodali, MD. Dr. Kodali is an ENT physician and one of the physician owners of The Surgery Center in Franklin, Wis. He is president of The Surgery Center's board of managers and was a key player in negotiations during the joint-venture process.

Donald Kramer, MD. Dr. Kramer has developed several successful ASCs in the Houston market and is the founder of Northstar Healthcare, where he is president and medical director for Northstar. He is active in Texas Ambulatory Surgery Center Society.

Timothy Kremchek, MD. Dr. Kremchek is one of the leading shoulder surgeons in the country and is a physician with Beacon Orthopaedics & Sports Medicine in Sharonville, Ohio. He is medical director and chief orthopedic physician for the Cincinnati Reds.

Alan B. Kravitz, MD. Dr. Kravitz is a general surgeon at Montgomery Surgery Center in Rockville, Md., and advisor for Surgical Care Affiliate's supply chain team. He is chairman of the general surgery section at Shady Grove Adventist Hospital .

Peter R. Kurzweil, MD. Dr. Kurzweil, a sports medicine physician, is the founder of the Surgery Center of Long Beach (Calif.). He is the fellowship director for the Southern California Center for Sports Medicine in Long Beach and chairman of the department of orthopedics at Long Beach Memorial Medical Center.

Richard Kube, MD. Dr. Kube is the CEO, founder and owner of Prairie Spine & Pain Institute in Peoria, Ill. He is a fellowship-trained spine surgeon who performs minimally invasive, motion-preserving surgical techniques, including sacroiliac joint surgery.

Brent W. Lambert, MD, FACS. Dr. Lambert, an ophthalmologist, is the founder and CEO of Ambulatory Surgical Centers of America. He previously developed and owned three ambulatory surgical centers, including the first eye ASC in New England.

Gregory Lauro, MD. Dr. Lauro, an orthopedic surgeon, is the president and medical director of Laurel Surgical Center in Greensburg, Pa. He is affiliated with the American Academy of Orthopaedic Surgeons and Pennsylvania Orthopedic Society.

Lance J. Lehmann, MD. Dr. Lehmann is an interventional pain physician with the Pain Consultants of Florida in Hollywood. Dr. Lehmann completed his pain management fellowship at Harvard University's Beth Israel-Deaconess Medical Center in Boston.

Jeffrey Leider, MD. Dr. Jeffrey Leider is a co-owner of Great Lakes Surgical Center and a physician at the American Ear, Nose and Throat Institute in Farmington, Mich. He is a fellow of the American Academy of Otolaryngology and Head and Neck Surgery.

Brad D. Lerner, MD, FACS. Dr. Lerner, a urologist, is the clinical director at Houston-based Summit Ambulatory Surgery Centers. He was one of the first fertility specialists in Maryland and is highly experienced in urologic microsurgery.

Jay R. Levinson, MD. Dr. Levinson serves as medical director of Michigan Endoscopy Center in Farmington Hills. He is board certified in gastroenterology by the ABMS Board of Internal Medicine.

Bruce Levy, MD, JD. Dr. Levy is CEO of Austin (Texas) Gastroenterology and serves on the Texas Ambulatory Surgery Center Society Board of Directors. He was appointed the executive director of the Texas State Board of Medical Examiners, where he served for seven years..

Marshall S. Lewis, MD. Dr. Lewis is an orthopedic surgeon and chief of orthopedic surgery for several different hospitals and also runs a private practice, He also completed an intensive research fellowship in Switzerland.

Stephen Lloyd, MD, PhD. Dr. Lloyd is an internist practicing at South Carolina Medical Endoscopy Center in Columbia, where he has trained over 100 physicians in colonoscopy. He also serves on the Governor's Advisory Council on Aging and the strategic planning committee of the South Carolina Cancer Alliance.

Thomas Lorish, MD. Dr. Lorish, a physiatrist, is the medical director of the Providence Brain Institute in Portland, Ore. He helped establish Providence Stroke Center, Providence Epilepsy Center, Providence ALS Center and Providence Multiple Sclerosis Center.

James Lynch, MD. Dr. Lynch, a spine surgeon and neurosurgeon, is founder of SpineNevada in Reno. He also serves as chairman and director of spine programs at Surgery Center of Reno.He has a professional interest in complex spine surgery, spinal deformities, trauma and minimally invasive surgery.

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

Ajay Mangal, MD, MBA. Dr. Mangal, an ENT physician, is the founder, CEO and a board member of Prexus Health Partners in Hamilton, Ohio. He has been instrumental in developing ASCs and assisting existing centers and hospitals to prosper.

Lee James Marek, DPM. Dr. Marek is a podiatrist at North Point Surgery Center in Fresno, Calif. He is also affiliated with several California hospitals in Taft, Delano, Bakersfield and Ridgecrest.

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

Alfred McNair, MD. Dr. McNair is a gastroenterologist who founded Digestive Health Center in Biloxi, Miss. He completed his medical and specialty training at Stanford (Calif.) University and Columbia University in New York City.

Christopher Metz, MD. Dr. Metz is an orthopedic surgeon at Brainerd Lakes Surgery Center in Baxter, Minn. He has a professional interest in total joint replacement, trauma and shoulder surgery.

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

Jeffrey Michaelson, MD. Dr. Michaelson specializes in orthopedic surgery at the Porretta Center for Orthopaedic Surgery and Providence and Providence Park Hospital. He is especially interested in arthroscopic surgery and sports medicine.

Thomas K. Miller, MD. Dr. Miller is an orthopedic surgeon at the Roanoke (Va.) Ambulatory Surgery Center and Carilion Clinic Orthopaedics. He has specialty experience in sports medicine, arthroscopy and knee and shoulder reconstruction. Dr. Miller has been team physician for the U.S. National Triathlon Team.

Thomas Miller, DPM. Dr. Miller is a podiatrist at the Surgery Center of Beaufort (S.C.). He is also affiliated with Beaufort Memorial Hospital, a Duke Medicine affiliate.

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

Joan F. O'Shea, MD. Dr. O'Shea is a neurosurgeon and spine surgeon and founder of The Spine Institute of Southern New Jersey in Marlton. She has published several papers on treatments for patients suffering from spinal cancers and complex spinal disorders.

Bergein Overholt, MD, FACP, MACG. Dr. Overholt is a physician with Gastrointestinal Associates in Knoxville, Tenn. He served in the Cancer Control Program of the U.S. Public Health Service and developed the flexible fiber-sigmoidscope-colonscope, which earned him the Schindler Award from the ASGE.

Paul D. Pace, MD. Dr. Pace is a hand surgeon practicing at the San Antonio Orthopaedic Group in San Antonio. His special interests include carpal tunnel syndrome, care of wrist and hand fractures, tendon repair and pediatric hand and wrist injuries.

Greg Parsons, MD. Dr. Parsons is the medical director of the Carolina Surgical Center. He has been the president of the physician group for more than 10 years. He was named one of North Carolina's best doctors in 2009 by Best Doctors.

Prakash Patel, MD. Dr. Patel is CEO of Access MediQuip, a national provider of surgical implant management solutions. He previously held positions as CEO of Imericius Healthcare, managing director of Internet Healthcare Group.

Charles Peck, MD, FACP. Dr. Peck is the president and CEO of Health Inventures. He has more than 30 years of healthcare experience as a clinician, internist, rheumatologist, scientist and other roles within the healthcare environment.

Kenneth Pettine, MD. Dr. Pettine is the co-founder of Rocky Mountain Associates in Orthopedic Medicine in Loveland, Colo., and the founder of the new Society for Ambulatory Spine Surgery. He co-invented, designed and patented the Maverick Artificial Disc.

Stanford R. Plavin, MD. Dr. Plavin has served as a member of Ambulatory Anesthesia of Atlanta. He is an active member of local and state anesthesia societies and is the immediate past president of the Greater Atlanta Society of Anesthesiologists.

Thomas J. Pliura, MD, JD, PC. Dr. Pliura is a physician and attorney at law with the company he founded, zChart. He also founded and manages four ASCs. He received the first favorable Medicare Advisory Opinion in the country, certifying that a proposed ASC was exempt from Stark Laws under a rural provider exemption.

William A. Portuese, MD. Dr. Portuese is president of the Washington ASC Association and Washington State Chapter of Facial Plastic Surgeons. He specializes in plastic, cosmetic and reconstructive surgery of the face and neck and has studied recent advancements in facial cosmetic surgery.

Greg Poulter, MD. Dr. Poulter is a spine surgeon at Vail (Colo.) Summit Orthopaedics. He was among the first surgeons to perform minimally invasive spinal fusion. His specialty is advanced adult and pediatric spine surgery.

Thomas E. Price, MD (R-Ga.). Dr. Price is an orthopedic physician who now serves in the U.S. House of Representatives, representing the sixth district of Georgia. He has been an outspoken advocate for patient-centered healthcare reform in Washington, D.C., and developed the Comprehensive HealthCARE Act.

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

David J. Raab, MD. Dr. Raab, a sports medicine physician, is on the board of managers at the Illinois Sports Medicine & Orthopedic Surgery Center in Morton Grove, Ill. He is also an assistant professor at Northwestern University Medical School in Chicago.

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

Wallace Reed, MD. At age 94, anesthesiologist Dr. Reed continues to inspire ASC community members to reach even greater heights in the surgery center industry and lead improvements in healthcare. He is credited with co-founding the nation's first ASC in Phoenix.

Christopher Reising, MD. Dr. Reising is president of the board of directors for Pine Ridge Surgery Center in Wausau, Wis., a Pinnacle III facility. His medical interests include endocrine surgery, advanced laproscopy of bariatrics, surgical oncology and vascular medicine/vascular procedures.

J. Michael Ribaudo, MD. Dr. Ribaudo serves as CEO and chairman of Ballwin, Mo.-based Surgical Synergies. He developed the largest freestanding outpatient surgery center in the country. He has served as executive vice president of Surgical Health and HealthSouth Surgery Centers.

Herbert W. Riemenschneider, MD. Dr. Riemenschneider is the principal physician and urologic surgeon at Riverside Urology in Columbus, Ohio. He is the director of urologic education at Riverside Methodist Hospitals and performed the first prostate cryoablation in Ohio in 1993 and continues to perform the procedure today.

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

Paul L. Rohlf, MD. Dr. Rohlf began practicing at Urological Associates in 1969 and retired in 2007. He has been as president of the American Association of Ambulatory Surgery Centers. He was the initial urologist who obtained the first surgery center certificate of need for a center in Iowa.

L. Edwin Rudisill, Jr., MD. Dr. Rudisill is a hand surgeon practicing with The Hand Center in Greenville, S.C. He is a member of the American Society of Surgery of the Hand and American Society of Reconstructive Microsurgery.

James W. Rust, DPM. Dr. Rust works with Twin Lakes Surgical Center in Daytona Beach and serves on the faculty at Florida State University College of Medicine in Tallahassee. He is a member of the American Podiatry

Medical Association, Florida Podiatric Medical Association and the American College of Foot Surgeons.

Kuldip S. Sandhu, MD, FACP, FACG. Dr. Sandhu is a gastroenterologist at the Sutter Roseville (Calif.) Endoscopy Center in and is president of Capitol Gastroenterology Consultants Medical Group. He completed his gastroenterology fellowship at LAC-USC Medical Center in Los Angeles.

Kent Sasse, MD, MPH, FACS. Dr. Sasse is director of the Western Bariatric Institute in Reno, Nev. He is the founder of the International Metabolic Institute and author of two recent books about weight loss.

Donald Schellpfeffer, MD. Dr. Schellpfeffer is CEO of Medical Facilities Corp., and has almost 20 years of experience with ASCs. He is medical director and a member of Sioux Falls (S.D.) Surgical Center and president of Anesthesia Associates.

Bruce A. Scott, MD. Dr. Scott, an otolaryngologist, is the medical director of SurgeCenter of Louisville (Ky.) and serves on the physician leadership team for Surgical Care Affiliates. He has served on the board of the American Medical Association and Kentucky Medical Association.

Hooman Sedighi, MD. Dr. Sedighi is a physical medicine and rehabilitation physician and an equity partner in Pine Creek Medical Center in Dallas. He is also an equity partner in two Gulf States long-term acute care hospitals in Dallas and DeSoto, Texas.

David Shapiro, MD, CASC. Dr. Shapiro, an anesthesiologist, is a partner with Ambulatory Surgery Co., an ASC consulting company. He is chair of the board of the Ambulatory Surgery Center Association and the Ambulatory Surgical Foundation and serves as medical director and board member of several ASCs.

Joshua A. Siegel, MD. Dr. Siegel is the sports medicine director at Access Sports Medicine & Orthopaedics in Exeter, N.H., and the founding partner and managing member of Northeast Surgical Care. He completed a fellowship in sports medicine at the renowned American Sports Medicine Institute in Birmingham, Ala.

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

Eric J. Stahl, MD. Dr. Stahl, an orthopedic surgeon specializing in sports injuries and shoulder and knee surgery, is the president of Golden Ridge Surgery Center. He practices with Panorama Orthopedics and Spine Center and serves as vice president of the Colorado Ambulatory Surgery Center Association.

Steven Stern, MD. Dr. Stern is a medical director and the vice president of neurosciences orthopedic and spine of United Healthcare. He was previously a lead surgeon at Northwestern Memorial Hospital in Chicago and developed a successful surgery center.

David W. Strege, MD. Dr. Strege specializes in orthopedic surgery at Mid County Orthopaedic – Bellevue in St. Louis. He also serves as a member of the Tissue Advisory Board for Mid-America Transplant Services.

Lewis Strong, MD. Dr. Strong is the president of the Skyline Endoscopy Center in Loveland, Colo., a Pinnacle III facility. He was a founding member of the local physician's health organization and served as its president for four years.

Charles Tadlock, MD. Dr. Tadlock is the founder of Surgery Center of Southern Nevada in Las Vegas and practices pain medicine and anesthe-

siology. He is the CEO of Epiphany Surgical Solutions and an avid developer of surgery centers.

Kevin Tadych, MD. Dr. Tadych, an orthopedic surgeon, is medical director Northwoods Surgery Center in Woodruff, Wis., a Pinnacle III facility. His practice consists of sports medicine, carpal tunnel syndrome, spine disorders and joint replacements.

Larry Teuber, MD. Dr. Teuber, a neurosurgeon, is the founder and physician executive of Black Hills Surgery Center in Rapid City, S.D. He also serves as the president of Toronto, Canada-based Medical Facilities Corp., medical director of Sioux Falls Surgical Hospital and founder and current managing partner of The Spine Center in Rapid City.

George M. Tinawi, MD. Dr. Tinawi is the president of Surgery Center Partners and its management subsidiary, Endoscopy Management Services Organization. He completed his fellowship in gastroenterology at the University of Southern California.

William Tobler, MD. Dr. Tobler is a neurological surgeon and president and director of neurosurgery at The Christ Hospital Spine Surgery Center in Cincinnati. He is a member of numerous professional organizations, including North American Spine Society.

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

Vasudevan Tiruchelvam, MD. Dr. Tiruchelvam is vice-chairman of the York Hospital department of surgery, as well as the president of the York County Medical Foundation, the charitable arm of the York County Medical Society. He helped provide medical attention to survivors of Hurricane Katrina and the tsunami in Sri Lanka.

George Trajtenberg, MD, FACS. Dr. Trajtenberg is a general surgeon at Turk's Head Surgery Center in West Chester, Pa. He has been president of the Chester County Medical Society.

Arnaldo Valedon, MD. Dr. Valedon is the chief ambulatory division and managing partner of First Colonies Anesthesia Associates in Baltimore. He is on the ASC Association's Program Committee for ASCs for 2011 and a member of the Ambulatory Surgery Foundation board.

George A. Violin, MD, FACS. Dr. Violin is the founder of Medical Eye Care Associates in Massachusetts. He devotes most of his practice to cataract surgery, LASIK and related surgeries and was one of the early investigators of epikeratophakia. He is one of the three founding principals of the Ambulatory Surgery Centers of America.

Jeffrey L. Visotsky, MD, FACS. Dr. Visotsky, an orthopedic upper extremity surgeon, is a member of Illinois Bone and Joint Institute and founder of the Morton Grove (Ill.) Surgery Center. He serves as assistant professor of orthopedic surgery at Northwestern University in Chicago.

Clarence B. Watridge, MD. Dr. Watridge is a neurosurgeon and chairman of Semmes-Murphey Clinic in Memphis, Tenn. He also serves on the academic faculty of the University of Tennessee Department of Neurosurgery in Knoxville.

Drigan Weider, MD. Dr. Weider, a sports medicine physician, is a board member of Boulder (Colo.) Surgery Center, a Pinnacle III facility. His practice is Mapleton Hill Orthopaedics in Boulder.

Robert Welti, MD. Dr. Welti, an anesthesiologist, is the senior vice president of operations at Regent Surgical Health in Westchester, Ill. He was previously the medical director and administrator of the Santa Barbara (Calif.) Surgery Center.

Thomas Wherry, MD. Dr. Wherry, an anesthesiologist, is co-founder of Total Anesthesia Solutions. He is also a consulting medical director for Health Inventures and been medical director for the Surgery Center of Maryland in Towson.

Kimberly L. Wood, MD. Dr. Wood is co-chair of the ASC Quality Collaboration and founder of kmdWOOD, which provides consulting services to the ASC industry, including the ASC Association and the ASC QC.

Richard N.W. Wohns, MD, MBA. Dr. Wohns is a spine surgeon and one of the first physicians involved with the development of ambulatory spine practices. He is the founder of South Sounds Neurosurgery in Puyallup, Wash., and Neospine. He was one of the first neurosurgeons in the United States qualified to perform XLIF.

David Zarin, MD. Dr. Zarin is senior vice president, medical affairs, for United Surgical Partners International and one of the founding partners of Texas ENT Specialists in Houston. He has been practicing medicine for more than 30 years and has a special interest in the treatment of sinus disease. ■

Forming a Surgery Center State Association: Q&A With Todd Currier of Wyoming ASC Association

By Rob Kurtz

Todd Currier is the first president of the Wyoming Ambulatory Surgery Center Association, which announced its formation in September.

Q: How long have there been plans to create a state ASC association in Wyoming?

Todd Currier: The ASCs throughout the state have discussed a formal association for many years now and were close to getting one formed about five years ago. The current emphasis for an association started about six months ago.

Q: Why are you starting the Association now?

TC: The current emphasis of our state association is: 1) the need for an exchange of information and collaboration of ideas relating to the ever changing requirements that ASCs are facing; 2) the need for educational opportunities within our state relating to business operations, clinical operations, benchmarking within the state and regulatory issues; and 3) creating a unified focus on the quality, safety, efficiencies and high patient satisfaction that the ASC industry provides to the healthcare consumers in Wyoming.

Q: Why do you think it is important for Wyoming ASCs to have such representation?

TC: Like many other states, our ASCs face issues getting educational opportunities and benchmark information that is helpful to our operations. We want to promote the many benefits of ASCs to the public and our legislators, and to provide a collaborative venue that will only enhance the quality of our centers. ASCs are an essential piece to the healthcare industry as we provide top-notch quality and safe care, have high patient satisfaction, as well as being cost efficient. The Wyoming ASC Association is focused on ensuring that ASCs continue to thrive throughout the state as a viable option for Wyoming patients.

Q: What do you hope to achieve in the first year of the Association?

TC: We want to hold an annual conference (which was scheduled for Nov. 11-12) to provide educational opportunities to our members, as well as create an email forum to exchange ideas regarding policies and procedures, operational ideas, benchmarking and adherence to regulatory issues that arise.

Q: What do you see as some of the top issues facing Wyoming ASCs that you would like to address?

TC: Each and every ASC throughout the state is unique in its operations, but I believe as we evolve we will find the commonalities amongst us and be able to address the most pressing issues that we are faced with. Certainly some of the top issues revolve around the continued education for regulatory changes, Medicare changes and educating the public and legislators on how ASCs are essential and vital to our healthcare environment.

Q: For Wyoming ASCs that are not members yet, what would you say to them about the benefits of joining the Association?

TC: The greatest benefit of becoming a Wyoming ASC Association member is the ability to network with your peers, obtain information that is specific to Wyoming and to participate in the collaboration of ideas and enhancement opportunities that will be provided through the Association. ■

To learn more about the Wyoming Ambulatory Surgery Center Association, contact Mr. Currier at tcurrier@wir.net and (307) 587-2139.

CMS Allows Unrestricted Same-Day Surgery for ASCs

By Rachel Fields

The Centers for Medicare & Medicaid Services has reversed its long-standing limitation on surgery centers performing procedures on the day they are scheduled, according to an Ambulatory Surgery Center Association release.

ASCs will now be allowed to provide patient notifications on the day the procedure is performed, allowing same-day surgeries. ASCA has lobbied for the elimination of this condition of coverage throughout 2011 and says the move will improve patient choice, reduce costs and remove an unnecessary regulatory burden from surgery centers.

The revision is expected to take effect Dec. 23.

"Elimination of the prior-day notification requirement in ASCs has been a top priority for ASCA this year," said ASCA Executive Director William Prentice, in the release. "Our government affairs team and numerous ASCA members have been in regular contact with CMS on this issue, and we are pleased that CMS has elected to make this change. Not only does the new rule promote patient choice and access to care, it also reduces costs to Medicare and its beneficiaries."

For a copy of the CMS rule change, which revises Medicare's Conditions for Coverage for ASCs, visit http://ascassociation.org/sameday.pdf. ■

Contact Rachel Fields at rachel@beckersasc.com.

How to Improve Patient, Physician and Employee Satisfaction at an ASC

By Abby Callard

Most satisfaction issues within an ambulatory surgery center come down to time, says Kris Sabo, executive director of Pend Oreille Center in Ponderay, Idaho, where the patient satisfaction rates are routinely at or above 97 percent. But patients aren't the only moving pieces in a successful ASC. Mrs. Sabo shares best practices to improve a center's patient, physician and employee satisfaction rates.

Physicians

"From a provider standpoint it's all about their time," Mrs. Sabo says. "As long as you recognize that your providers are your customers and that their most valuable resource is time, you've got them."

Part of valuing a physician's time is keeping one step ahead of their needs. Mrs. Sabo remembers one physician who was thinking out loud about needing a pen. Before he knew it, someone had put a pen in his hand. That physician later told Mrs. Sabo that he liked that he never had to ask for anything at the center.

"On the provider side, they're focused on that patient, and they don't want to have to worry about what's next," Mrs. Sabo says.

Patients

Wait times are one of the few complaints Mrs. Sabo says her ASC receives on the center's patient satisfaction survey.

"When we have any dissatisfied patients, it's usually due to a wait," Mrs. Sabo says. "Or as I like to say, a perceived wait time. All patients have their own perception of what is an appropriate time to wait."

While ASC staff members typically cannot control extended wait times due to a delay or a procedure that ran over time, the staff can control how they handle a patient whose procedure has been delayed. The most important thing, Mrs. Sabo says, is to keep the patient updated on the wait. This shows the patient that you are aware of the situation and appreciate that their time is important, she says.

At Pend Oreille, the staff came up with a creative solution when dealing with patients facing a longer than normal wait time. The ASC keeps a stash of $5 gift cards to a local deli to hand out to these patients. Even though it's a small amount, the patients really appreciate it, Mrs. Sabo says.

Employees

Patient satisfaction is often linked to the performance of an ASC's staff. A happy staff often means better service for the patient. So, how do you keep your employees happy?

"Employee satisfaction with their work environment hinges a lot of times on their compensation package," Mrs. Sabo says. "I think ASCs right now are being very challenged as far as how to put together an attractive compensation package that doesn't dip too deeply into profit."

One thing that Pend Oreille has done is move away from a traditional health insurance plan. The ASC has a high-deductible insurance plan without vision or dental, but the center contributes 100 percent to a health reimbursement account. This allows the employees to take charge of their own health care and helps the center keep its costs down, Mrs. Sabo says.

Mrs. Sabo also works to keep her employees happy by providing extra perks, such as ordering lunch for the center, giving the staff free T-shirts with the center's logo on it or holding a staff barbeque.

"These are really inexpensive things to do that show you appreciate them," she says.

Your employees, physicians and patients are your number one marketing tool, Mrs. Sabo says, and when they're dissatisfied, it's a wasted opportunity.

"The members of these three groups live, work and play in this community," she says. "If any of those three entities were dissatisfied, it could mean a very counterproductive marketing effort in our book." ■

Learn more about Pend Oreille Center at www.pendoreillesurgerycenter.com.

6 Thoughts on Private Equity Groups Investing in ASCs

By Rachel Fields

Blayne Rush, president of Ambulatory Alliances, shares six thoughts on the future of private equity groups investing in ambulatory surgery centers.

1. Private equity groups may offer higher prices than hospitals and management companies. Mr. Rush believes that as management companies and hospitals continue to acquire and partner with ASCs, the ASC industry will also see increased interest from private equity groups and financial investors. Historically, ASC management companies and hospitals have competed to offer competitive prices for surgery centers — a competition that may be challenged by private equity groups. "I believe that now and in the future, financial buyers — that is, private equity groups — will outpace all of them as far as price paid," Mr. Rush says.

He says the reason for this higher price can be linked to a few factors. According to Mr. Rush, private equity groups are typically paid on a "two-and-twenty" basis, in which they receive 2 percent of their payment on the amount earned under management and 20 percent of the gain in the value of the fund. Funds are typically set up with a 10-year fund life and six-year investment duration, but if the group does not deploy the money, they are forced to repay the 2 percent management fee.

In many cases, that money has already been spent by the time the group is asked to repay the funds, so groups will be looking for new investment opportunities, Mr. Rush says. "If you get the private equity group into a bidding or auction process, sometimes they'll think, 'If I give half a point more, I'll get the deal versus staying at the bid I'm at right now and not getting the deal,'" he says. "If they have no other deals on the table, they'll give another half point to get that one." This may give the group more motivation than a hospital that seeks to acquire the ASC for strategic purposes.

2. Private equity groups may not understand out-of-network pricing. Surgery centers can also benefit from investment by private equity groups if the groups lack experience in the ASC industry, Mr. Rush says. "They're financial buyers, and they don't have as much industry experience," he says. "They may not understand in-network and out-of-network issues in the way that strategic buyers do."

He says private equity groups may look at a surgery center with a significant amount of out-of-network revenue and value the center based on its out-of-network, rather than adjusting the price as an ASC management company would. "Those sellers can make a significant amount of money when that transaction happens," he says.

3. As the ASC market gets more press, private equity deals will increase in popularity. Mr. Rush says he predicts private equity deals will increase in popularity as the surgery center market gains more attention. "The ASC market is maturing, and there are more people hearing and knowing about it," he says. "Private equity groups are on the prowl to find more areas to deploy that capital they have."

He says that private equity groups have previously purchased or backed management companies, but they may be looking to expand their reach in the ASC industry by pursuing surgery center clusters or even standalone surgery centers. "I think there are more funds out there and more people looking to invest," he says.

4. Surgery center chains will see more action than standalone facilities. Mr. Rush predicts that private equity groups will mostly be looking to invest in clusters of surgery centers or smaller management companies that own 3-4 centers. "Those owners that have multiple centers are in a better position to be involved in a private equity group transaction," he says. However, once the larger clusters of chains have been exhausted, private equity groups may start looking at deals from $1 million to $1.5 million EBITDA. "They may want to buy one surgery center and create a platform and then add to it," he says. "In other words, they'll buy a one- or two-center package and then look to buy a center here or there to add to that package."

5. Strong management teams will be essential. Since private equity groups have financial expertise — but not necessarily ASC management expertise — they will be looking for surgery centers with strong management teams, Mr. Rush says. "They will want surgery centers that have a management team in place that they can turn to and leverage and expand," he says.

In some cases, the private equity group may prop up an executive with ambulatory healthcare experience and use them for insight as they buy platforms. In cases where the surgery center does not have a strong management team, the group may look to buy a larger management company for the use of its management team.

6. Turnaround centers will not be of interest to private equity groups. Mr. Rush says while stand-alone surgery centers may be able to attract private equity groups, turnaround centers will most likely not be of interest to investors. "These guys want a well-run, well-oiled machine," he says. "They don't want to buy into a situation where they need to roll up their sleeves and fix it, because that's not what they do." Under-performing ASCs will be more attractive to ASC management companies, which have the expertise to enter the ASC and make changes to increase profitability, outcomes and physician satisfaction. ■

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

FAQs About Outsourcing ASC Billing & Collections: Q&A With Caryl Serbin of SourceMedical

By Caryl Serbin, RN, BSN, LHRN. Ms. Serbin, executive vice president and chief strategy officer for SourceMedical.

Q: When should an ambulatory surgery center consider outsourcing its billing and collections?

Caryl Serbin: There are several circumstances when an ASC should explore outsourcing its billing and collections. They include the following:

- When struggling to find and retain qualified staff.
- When billing results trail far behind standard benchmarks.
- When revenue is decreasing while volume is increasing.
- If there are compliance concerns.
- When audits reveal significant issues.
- For new centers lacking a strong business office.

Q: What are some of the factors you have seen that convince ASCs to outsource their billing and collections?

CS: As with the situations identified before, an ASC will often turn to outsourcing due to staffing challenges, including a lack of qualified staff members and the sudden departure of a critical member of the business office, as well as the high cost to pay for an extensive, qualified business office team.

There are also non-staffing challenges that motivate this change, including the constant changes in reimbursement by government and third-party payors, volume spikes which keep staff busy on some days but less active on others, and just general frustration with the challenging billing and collections.

Q: What problems does outsourcing really solve?

CS: If you partner with a good billing company, you could eliminate many of the headaches that come from billing and collections. Staffing issues become less of a concern; you practically cut out recruiting, hiring, education, turnover, as well as cost of salary and benefits. As you grow, you will not need to add more staff. Less staff means you can use space in your ASC for other operations, or if you're developing a new center, you can build a smaller facility.

With outsourcing, you also eliminate the headaches that come with technology changes, increasingly complex revenue cycle and regulatory changes, fighting managed care companies over denials and back-up of billing data. This allows an ASC to focus more time on growing volume.

In addition, outsourcing companies will often have the resources to help with other areas of concern for an ASC, including managed care negotiations, state reporting, internal and external auditing, fee schedule development and financial benchmarking.

Q: If an ASC decides to outsource, is there anything relating to billing it needs to keep in-house?

CS: Outsourcing billing does not mean an ASC can forget about all billing and its associated compliance issues. The surgery center will need to at least retain a contact person to get the billing company the information it needs to properly handle the AC's billing and collections. Physicians will still need to dictate operative notes accurately and in a timely fashion. The ASC will need to remain knowledgeable about its accounts receivable and be prepared to become involved if a payor issue arises, such as a failure to honor contract language.

A surgery center will still need to assist with problem solving associated with managed care and continue to perform upfront processes such as registration and insurance verification.

Q: What services should an ASC expect when outsourcing?

CS: On a basic level, most outsourcing companies provide coding from the operative note within 24-48 hours, implant billing, accurate contractual adjustments, daily payment posting, fee schedule analysis and maintenance, resolution of software or clearinghouse issues related to billing, loading of managed care contracts and any updates, compliance and HIPAA programs, timely refund recommendations and enforcement of prompt payment laws.

Optional services may include managed care contracting, state reporting and benchmarking.

Q: What are some of the key qualities an ASC should look for in a billing company?

CS: There are many qualities for a good outsourcing company. ASC billing experience — versus just medical or hospital billing — is definitely a plus, as is experience with your type of center and specialties. Experience in your state can also help if your state has its own set of challenging rules and regulations.

It's definitely worth requesting and then checking references. This will help confirm whether the company you are considering has a good reputation and will be a good *partner* to your ASC. Ask about the experience and credentials of the company's staff members as they will be performing the services for your center. Ask about managed care expertise, software expertise, if they have experience with your clearinghouse and your billing reports.

It's also worth asking about the company's disaster/recovery plans, how they protect and back-up your center's data, how they conduct (and how frequently they conduct) internal and external audits, if they are HIPAA-compliant and how they stay up to date on rules and trends.

Q: What does an ASC need to do to help make this partnership with an outsourcing company successful?

CS: An outsourcing company can only do so much on its own and will need an ASC to truly serve as a partner in this relationship. The center should communicate and meet regularly with its outsourcing company to help foster and ensure a positive working relationship. Timely response to billing company requests is key, as is quickly turning patients over to collections and following up on questions regarding operative notes or transcriptions. Also, providing ongoing education to center staff and physicians about the billing and collections process will help the partnership run smoothly. ■

Learn more about SourceMedical at www.sourcemed.net.

20 Benchmarks for Large ASCs

By Rachel Fields

Here are 20 benchmarking statistics for surgery centers with more than four ORs, according to data from VMG Health's *2010 Multi-Specialty ASC Intellimarker.*

Net revenue: $8,699,000
Total operating expenses: $6,630,000
EBITDA: $1,960,000

A/R days outstanding: 33
A/R turnover: 10.74

Highest percentage of case volume: Ophthalmology (20 percent)

Total cases per center: 5,598
Cases per day: 22.4
% of cases performed by top 2 physicians: 22 percent

Nurse FTE: 16.8
Tech FTE: 8.0
Administrative FTE: 11.8
Total FTE: 31.1

Hourly nurse wages: $31.14
Hourly tech wages: $19.59
Hourly administrative staff wages: $22.32
Administrator salary: $109,235

Nurse hours per case: 5.8
Tech hours per case: 2.7
Administrative hours per case: 4.2 ■

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

6 Steps to Build a Compensation Plan for ASC Employees

By Rachel Fields

John Merski Jr., executive director of human resources for MedHQ, discusses six steps ambulatory surgery center leaders should take to build a compensation plan for each ASC employee.

1. Determine whether you need a compensation review. If your surgery center has never performed a compensation review, you should do one this year, Mr. Merski says. You may also need to perform a compensation review if you notice indicators of dissatisfaction, such as high employee turnover, complaints about salary at your annual employee reviews or comments from the staff that similar positions at other facilities are better-paid.

"Generally the question comes up because when you do exit interviews, staff members say they're leaving for a job that pays more," he says. Once you have identified a problem with your compensation, you can start talking to employees to determine where you fall short.

2. Conduct a formal survey about compensation at your center. Mr. Merski says the ASC should conduct an employee survey that determines the strengths and weaknesses of your compensation plan. For example, perhaps some employees feel fairly compensated, and others don't. Perhaps your salaries are on target, but your benefit plan is meager compared to the local hospital. When employees have completed the survey, go over their answers and identify common themes so you understand the most prevalent areas of dissatisfaction.

3. Analyze 10 factors for every job in your ASC. Mr. Merski says ASC leadership should go through every position at the surgery center and discuss 10 factors that are integral to the development of a compensation plan for each position. These are:

1. Educational requirements: What level of education do you require for the position?

2. Job-related experience, in years: How many years of experience are you looking for, at minimum? How many years of experience would the ideal candidate have?

3. Supervision required for the job: How much supervision does the employee need to perform his or her job?

4. Complexity of the job: How difficult is the job, and how many different tasks does it involve? How complicated is each task?

5. Physical effort required: Does the job require physical effort that can leave employees tired or strained?

6. Physical work environment: Does the job involve a hazardous or unpleasant work environment?

7. Potential impact of the employee's actions on the company: How much does the employee affect the financial and operational health of the ASC with his or her actions? What would happen if he or she made a mistake?

8. Internal contacts: Who does the employee talk with internally? For example, conversations between employees in the hall would demand less compensation than regular meetings with ASC leadership.

9. External contacts: Who does the employee talk with externally? Positions involving patient contact would receive more compensation than office staff who do not talk to customers.

10. Supervision over others: How many subordinates does the employee have, and what degree of supervision do they exercise?

Mr. Merski says these 10 components are used nationwide in the analysis of any compensation plan. "If you don't have these 10 components inside the formula you use, you are probably missing the mark," he says. Go over each component with ASC leadership and determine how much weight each component should carry when deciding compensation.

4. Interview employees and supervisors about the requirements for each job. While you should start by identifying the components of each position yourself, you should also ask for employee input, Mr. Merski

says. "When you go to evaluate these 10 characteristics, you should provide employees with a position information questionnaire that asks them how many years of experience they need to do the job," he says.

Ask the employee to go through each component of the position and explain what they think is necessary to perform the job sufficiently. When you have collected feedback from employees, give the same survey to the employees' direct supervisors and then finally to the management team. "Once you've done all that, you have [gathered] a full, 360-degree view, from the bottom up and the top down," he says. You may discover that you have been hiring nurses with 10 years experience when two years are sufficient, meaning you could be paying your employees significantly less.

5. Triangulate job details with compensation at like entities, cost-of-living expenses and geographical influences. Once you have determined the traits of each position in your ASC, you should triangulate the internal job description with external factors. This would include cost-of-living, meaning the amount employees must spend to live comfortably in your area. Areas with a higher cost-of-living, such as big cities, will need to compensate employees more highly than areas with a lower cost-of-living, such as small, rural towns. You should also look at like entities — both healthcare facilities and non-healthcare facilities. For example, if your ASC staffs a secretary at the front desk, you should look into how much that secretary could make at a hospital as well as at an insurance firm. "The secretary still does the same kind of work at an insurance company, and they might leave to go there if they're getting paid more," Mr. Merski says.

He says geographical influences also play a role. By looking at compensation data from organizations such as the ASC Association and VMG Health, you can determine how much the average nurse makes in the western United States compared to the southeast, for example.

6. Review compensation annually. Every year, your ASC should look at the external factors that impact compensation and shift the entire compensation scale slightly, Mr. Merski says. The scale will often shift up because cost-of-living has increased, meaning every employee will make slightly more than they did the year before. For individual employees, go through the 10 components of their job every year and determine whether any of the components has changed.

For example, if an employee used to supervise one person and now supervises three, he or she probably deserves a pay raise. If an employee has gained certification necessary for his or her position, that might deserve a pay raise as well. Just make sure that your pay raises are based on tangible changes in these 10 components, rather than a feeling on the part of the administration that an employee is performing well. Mr. Merski adds that every ASC position should undergo a complete review every 5-6 years to determine whether the key responsibilities of the role have changed. ■

Learn more about MedHQ at www.medhq.net.

125 of the Leading Gastroenterologists in America

Here are profiles of 125 of the leading gastroenterologists in the United States. They were selected for this list based on the awards they received from major organizations in the field, leadership in those organizations, work on professional publications and distinguished service in a GI ambulatory surgery center. These physicians are listed in alphabetical order by last name. All of those who placed on this list have undergone substantial review from our editorial staff. Physicians do not pay and cannot pay to be selected as a leader on this list. The list is not an endorsement of any individual's or organization's clinical abilities. Note: To view complete profiles, visit www.beckersasc.com/gileaders2011.

Jean-Paul Achkar, MD (Cleveland Clinic). A member of the Gastroenterology and Hepatology Department of the Cleveland Clinic, Dr. Achkar is the principal or co-investigator in a number of research trials in leading peer-reviewed journals. His special interests are Crohn's disease, inflammatory bowel disease and ulcerative colitis.

John I. Allen, MD, MBA (Minnesota Gastroenterology, Minneapolis). Dr. Allen is medical director for quality at Minnesota Gastroenterology and chair of the board of Institute for Clinical Systems Improvement. He is a community private practice councilor of the American Gastroenterological Association and chairs the Clinical Practice and Quality Management Committee of the AGA Institute.

Ashwin Ananthakrishnan, MD (Massachusetts General Hospital, Boston). Dr. Ananthakrishnan works at Massachusetts General Hospital in Boston and the Mass General North Shore Center for Outpatient Care in Danvers. He won the 2011 American Gastroenterological Association research scholar award for a prospective study of diet and risk of Crohn's disease and ulcerative colitis.

Paul K. Anderson, MD (Dallas Diagnostic Association). Dr. Anderson is a member of Dallas Diagnostic Association, a multispecialty group, and is on the medical staff of the Ambulatory Endoscopy Clinic of Dallas, the first licensed freestanding surgery center exclusively for GI procedures in North Texas.

Damian H. Augustyn, MD (Pacific Internal Medicine Associates, San Francisco). Dr. Augustyn is managing partner of Pacific Internal Medicine Associates as well as chief of the medical staff and chair of the medical executive committee of California Pacific Medical Center in San Francisco. He received the American Gastroenterological Association's Distinguished Clinician Award.

Peter A. Banks, MD (Brigham & Women's Hospital, Boston). An international authority on pancreatitis, Dr. Banks is director of both the Center for Pancreatic Disease and the Clinical Research Track at Brigham & Women's Hospital. He is vice chairman of the Digestive Disease National Coalition and immediate past president of the Digestive Disease National Coalition.

Christopher Bartolone, MD (Gastroenterology Associates, Williamsville, N.Y.). Dr. Bartolone is one of 11 physicians at Gastroenterology Associates. He is also on staff at the Endoscopy Center of Western New York, also in Williamsville, a facility with four procedure rooms that is affiliated with Physicians Endoscopy.

J. Sumner Bell III, MD (Gastroenterology Ltd., Norfolk, Va.). Dr. Bell is secretary/treasurer of the American Gastroenterological Association and was president of the Eastern Virginia Medical School. Dr. Bell completed his fellowship at Mayo Clinic in Rochester, Minn.

Fernando Bermudez, MD (Eastside Endoscopy Center, St. Clair Shores, Mich.). Dr. Bermudez is medical director and board member of Eastside Endoscopy Center, a partnership with Physicians Endoscopy, and he is a member of G.I. Medicine Associates. He specializes in diseases of the gastrointestinal tract, liver and pancreas and has a special interest in inflammatory bowel disease and motility disorders of the esophagus.

Henry J. Binder, MD (Yale School of Medicine, New Haven, Conn.). In 2010, Dr. Binder received a $1.8 million grant from the Gates Foundation to study the use of oral rehydration solutions to improve diarrhea control worldwide. He won the 2005 Distinguished Achievement Award from the American Gastroenterological Association for his work on colonic ion transport and diarrhea.

C. Richard Boland, MD (Baylor University Medical Center, Dallas). The chief of the Division of Gastroenterology at Baylor University Medical Center, Dr. Boland is currently president of the American Gastroenterological Association. His focused is on this entity and has identified the unique mutation in the gene that allows colon cancer to occur in multiple family members.

Geoffrey Braden, MD (Gastrointestinal Specialists, Philadelphia). Dr. Braden helped launch Gastrointestinal Specialists, a group practice that now has 11 gastroenterologists. He is chair and journal editor for *Medscape Gastroenterology*. His special interests include inflammatory bowel disease.

Aaron Brzezinski, MD (Cleveland Clinic). Dr. Brzezinski's clinical practice in the Gastroenterology and Hepatology Department at the Cleveland Clinic deals almost exclusively with inflammatory bowel disease, microscopic colitis and celiac disease. He won the Premier Physician Award from the Northeast Ohio Chapter of the Crohn's and Colitis Foundation of America.

Carol A. Burke, MD (Cleveland Clinic). Dr. Burke is director of the Center for Colon Polyp and Cancer Prevention and head of the Section of Polyposis in the Sanford R. Weiss Center for Hereditary Colorectal Neoplasia at the Cleveland Clinic. She is on the board of the American College of Gastroenterology and is an associate editor for the *American Journal of Gastroenterology*.

Robert "Bruce" Cameron, MD (Endoscopy Center at Bainbridge, Chagrin Falls, Ohio). The medical director of the Endoscopy Center at Bainbridge, Dr. Cameron practices with Gastroenterology Associates, which is part of University Hospitals Medical Practices and is a clinical professor of medicine at Case Western Reserve University in Cleveland.

Donald O. Castell, MD (Medical University of South Carolina, Charleston, S.C.). Dr. Castell is director of the esophageal disorders program at the Medical University of South Carolina in Charleston. He is considered one of the foremost experts in esophagology and is the 2010 recipient of Julius Friedenwald medal from the American Gastroenterological Association.

Amitabh Chak, MD (University Hospitals, Cleveland). Dr Chak is director of the Advanced Technology & Innovation Center of Excellence and director of clinical research for the Division of Gastroenterology at University Hospitals. His special interests include endoscopic ultrasonography, gastrointestinal cancer and therapeutic endoscopy.

Lin Chang, MD (University of California, Los Angeles). Dr. Chang is director of the Women's Digestive Health Center at the David Geffen School of Medicine at the University of California. She is a 2009 winner of the AGA Distinguished Clinician Award for her achievements as a clinical academician.

William D. Chey, MD (University of Michigan, Ann Arbor). Dr. Chey is director of the GI Physiology Laboratory and co-director of the Michigan Bowel Control Program at the University of Michigan. He is past chair of the Clinical Practice Section of the American Gastroenterological Association and is a board member of the American College of Gastroenterology.

Delbert L. Chumley, MD (Gastroenterology Consultants, San Antonio). A member of Gastroenterology Consultants, Dr. Chumley is president of the American College of Gastroenterology and co-chaired the college's National GI Carrier Advisory Committee, which oversees federal Medicare payment issues. He is also a past president of the Texas Society of Gastroenterology and Endoscopy.

Bradley A. Connor, MD (Travel Health Services, New York). Dr. Connor is founder and medical director of Travel Health Services, a travel medicine clinic in New York. A past president of the International Society of Travel Medicine, he has served as a consultant to the White House Medical Unit in the Clinton and Bush administrations.

Sheila E. Crowe, MD (University of Virginia, Charlottesville). Dr. Crowe is pro-

fessor of medicine, gastroenterology and hepatology at the University of Virginia and a councilor-at-large of the American Gastroenterological Association. She has collaborated with several investigators interested in gastric cancer that now constitute the Gastric Cancer Working Group.

Stephen Deal, MD (Carolina Digestive Health Associates, Charlotte, N.C.). Dr. Deal subspecializes in gastroenterology with a subspecialty in pancreatic biliary tract diseases and has served on the Quality in Endoscopy Task Force of the American Society of Gastrointestinal Endoscopy and American College of Gastroenterology.

Thomas Deas Jr., MD (Fort Worth Endoscopy Center, Fort Worth, Texas). The president-elect of the American Society of Gastrointestinal Endoscopy, Dr. Deas is the medical director of the Fort Worth Endoscopy Center and Southwest Fort Worth Endoscopy Center, which are both operated by Surgical Care Affiliates.

James H. DeGerome, MD (South Florida Gastroenterology Associates, Boynton Beach, Fla.). The president of Digestive Disease National Coalition, Dr. DeGerome wrote the 2009 book, The Cure for the American Healthcare Malady, which laid out a plan for universal coverage without massive tax increases. He is a winner of the Distinguished Service Award from the Florida Gastroenterologic Society.

Anthony J. DiMarino Jr., MD (Thomas Jefferson University, Philadelphia). Dr. DiMarino is chief of the division of gastroenterology and hepatology at Thomas Jefferson University. His clinical interests are consultative gastroenterology, celiac disease, swallowing disorders and problems of gastrointestinal motility and inflammable bowel disease.

Peter V. Draganov, MD (University of Florida, Gainesville). Dr. Draganov is director of endoscopy at University of Florida. He won the National Quality Week Shands Star Award for exceptional empathy, compassion or advocacy in interactions with patients and the Award for Outstanding Contribution to the Field of Gastroenterology and Hepatology from the American College of Physicians.

Samuel Drake, MD (Gaston Digestive Disease Clinic, Gastonia, N.C.). A member of Gaston Digestive Disease Clinic, Dr. Drake treats hiatal hernias, tumors, ulcers, jaundice, hepatitis, cirrhosis of the liver and disorders of the pancreas, gallbladder and liver.

Marla C. Dubinsky, MD (Cedars Sinai Medical Center, Los Angeles). The director of pediatric IBD Center at Cedars Sinai Medical Center in Los Angeles, Dr. Dubinsky is on the steering committee at IBD Working Group, serving as course director for hot topics there. Her research interests include the immune and genetic influences on the natural history and treatment of inflammatory bowel disease.

Steven A. Edmundowicz, MD (Washington University School of Medicine, St. Louis). Dr. Edmundowicz is chief of endoscopy and director of interventional endoscopy at Washington University School of Medicine and serves as a councilor of the American Society of Gastrointestinal Endoscopy. He is senior associate editor of *Gastrointestinal Endoscopy*.

Glenn M. Eisen, MD (Oregon Clinic, Portland). The Oregon Clinic, where Dr. Eisen practices, is the largest private specialty physician practice in the state, with more than 120 physicians. He is editor of *Gastrointestinal Endoscopy* and served as representative of the American Society for Gastrointestinal Endoscopy on the GERD working group for the AMA physician consortium for performance improvement.

Atilla Ertan, MD (Methodist Hospital System, Houston). Dr. Ertan is on staff at Methodist Hospital System and serves on the editorial board of six different medical journals. He won the Best Physician Award from the Crohn's and Colitis Foundation of America, Distinguished Clinician Award from the American Gastroenterological Association and Master in Gastroenterology Award from the American College of Gastroenterology.

Douglas O. Faigel, MD (Oregon Health and Sciences University, Portland). Dr. Faigel is treasurer of the American Society of Gastrointestinal Endoscopy and chairs the society's Quality Assurance Taskforce. He won the quality endoscopic research award from the American Society for Gastrointestinal Endoscopy.

Francis A. Farraye, MD (Boston Medical Center). Dr. Farraye is clinical director in the gastroenterology section at Boston Medical Center and holds an appointment at Boston University School of Medicine. He is coeditor for Bariatric Surgery: A Primer for your Medical Practice, and associate editor for *Therapy for Digestive Disorders*.

M. Brian Fennerty, MD (Oregon Health & Science University, Portland, Ore.). The section chief of gastroenterology at Oregon Health & Science University, Dr. Fennerty is past president of the American Society of Gastrointestinal Endoscopy. He is editor of *Journal Watch Gastroenterology* and *Reviews in Gastroenterological Disorders* and past associate editor of *American Journal of Gastroenterology*.

Ira L. Flax, MD (Digestive and Liver Specialists, Houston). Dr. Flax co-founded and served as chairman of the Texas Alliance for Digestive Diseases, a regional gastroenterology independent practice association. A managing partner of Digestive and Liver Specialists, he has served on the board of Memorial Hermann Healthcare System in Houston, chaired its gastroenterology section and was chief of staff of Hermann Memorial Hospital in Memorial City.

David E. Fleischer, MD (Mayo Clinic Arizona, Phoenix). Dr. Fleischer is chair of the department of gastroenterology and hepatology at

Mayo Clinic Arizona. His research interests include endoscopy, esophageal cancer, GI bleeding, capsule endoscopy and endoscopic therapy for Barrett's esophagus.

Chris Forsmark, MD (University of Florida, Gainesville). The current chief of gastroenterology at the University of Florida, Dr. Forsmark is past president of the Pancreas Society, the American Pancreatic Association and the Florida Gastroenterologic Society. He also served as chairman of the Pancreatic Disorders Section and was postgraduate course director at the American Gastroenterological Association.

Amy E. Foxx-Orenstein, DO (Mayo Clinic, Rochester, Minn.). Dr. Foxx-Orenstein is a past president of the American College of Gastroenterology and began the College's obesity initiative. Her research and clinical interests include obesity, motility disorders, functional bowel, pelvic floor disorders, eosinophilic esophagitis and pharmacodynamics.

James Franciosi, MD (Cincinnati Children's Hospital). Dr. Franciosi is an assistant professor at Cincinnati Children's Hospital Medical Center. He is winner of the Castell Esophageal Clinical Research Award and the Young Investigator Development Award in Eosinophilic Esophagitis.

James T. Frakes, MD (Rockford Gastroenterology Associates, Ill.). A past president of the American Society of Gastrointestinal Endoscopy, Dr. Frakes is a member of Rockford Gastroenterology Associates. He is the 2007 recipient of the Distinguished Service Award from the ASGE for long-term contributions to the field and was designated a Master of the American College of Gastroenterology.

Robert M. Gannan, MD, PhD (ArtVentive Medical Group, Carlsbad, Calif.). The founder of Physicians Endoscopy, Dr. Gannan has retired from his duties there and now serves on the scientific advisory board of ArtVentive Medical Group. He previously served as director of gastroenterology at the Overlake Hospital Medical Center and president and partner of Northwest Gastroenterology Associates. He also established the Eastside Endoscopy Center, a partnership with Physicians Endoscopy.

Robert A. Ganz, MD (Abbott-Northwestern Hospital, Minneapolis). The foundation chair of the American Society of Gastrointestinal Endoscopy, Dr. Ganz is chief of gastroenterology at Abbott-Northwestern Hospital. He has a special interest in colonoscopy with polypectomy, gastroesophageal reflux disease and flexible sigmoidoscopy.

Ralph A. Giannella, MD (University of Cincinnati College of Medicine). A former president of the American Gastroenterological Association, Dr. Giannella co-supervises the University Hospital gastroenterology clinic and is a professor in the digestive diseases division at the University of Cincinnati College of Medicine.

Francis M. Giardiello, MD (Johns Hopkins University, Baltimore). Dr. Giardiello directs the Colorectal Cancer Registry and Risk Assessment Clinic at Johns Hopkins, where he is also director of the gastrointestinal fellowship program. He is a clinical research councilor at the American Gastroenterological Association.

Gregory G. Ginsberg, MD (University of Pennsylvania School of Medicine, Philadelphia). The current president of the American Society of Gastrointestinal Endoscopy, Dr. Ginsberg is executive director of the Endoscopic Service at University of Pennsylvania School of Medicine. He won the clinical innovator award and the distinguished educator award at Penn Medicine in Philadelphia.

Gary Gitnick, MD (University of California, Los Angeles). As chief of the division of digestive diseases at UCLA School of Medicine, Dr. Gitnick leads the largest gastroenterology division in the world. Previously, he was chief of staff of the UCLA Medical Center and medical director of UCLA Health Care Programs.

David A. Greenwald, MD (Montefiore Medical Center, Bronx, N.Y.). The chairman of the board of the American College of Gastroenterology, Dr. Greenwald is director of the gastroenterology fellowship program at Montefiore Medical Center. He has won the ACG Governor's Award and the American Society for Gastrointestinal Endoscopy's Master Endoscopist Award.

Pedro Greer Jr., MD (Herbert Wertham College of Medicine, Miami). Dr. Greer is one of the founders of a new medical school, Herbert Wertham College of Medicine at Florida International University. A recipient of the MacArthur "Genius" Fellowship and the Presidential Service Award, he was an advisor to Presidents George H.W. Bush and Bill Clinton on healthcare and poverty.

Stephen B. Hanauer, MD (University of Chicago). The chief of gastroenterology at the University of Chicago, Dr. Hanauer is also chair of the IBD Working Group and the FDA Gastrointestinal Drugs Advisory Committee. He is treasurer of the American Gastroenterological Association and a member of the Subspecialty Board of Gastroenterology for the American Board of Internal Medicine.

Gail A. Hecht, MD (University of Illinois at Chicago). Dr. Hecht is section head of the Section of Digestive Diseases and Nutrition at the University of Illinois at Chicago and is past president of the American Gastroenterological Association. Her research interests include the interaction of enteric bacterial pathogens with host intestinal epithelial cells and the mechanisms.

Anne Henkel, MD (Northwestern University, Chicago). An Instructor in medicine-hepatology at Northwestern University Feinberg School of Medicine, Dr. Henkel won the American Gastroenterological Association Research Foundation's research scholars award in 2011 for her studies on the role of endoplasmic reticulum stress in the pathogenesis of NASH.

Reed B. Hogan, MD (GI Associates and Endoscopy Center, Jackson, Miss.). Dr. Hogan is a member of GI Associates and Endoscopy Center. He is an accomplished speaker and writer in the field of gastroenterology and has published numerous articles on the subject.

David A. Johnson, MD (Eastern Virginia Medical School, Norfolk). As a primary advisor for national Medicare GI issues on endoscopy, a CMS advisory committee, Dr. Johnson helped enact legislation mandating colon cancer screening with colonoscopy as the preferred standard. He is a past president of the American College of Gastroenterology and co-chaired the national Gastroenterology Medicare advisors.

Anthony Kalloo, MD (John Hopkins University, Baltimore). Dr. Kalloo is chief of the division of gastroenterology and hepatology at Johns Hopkins University. His interests include therapeutic endoscopy, sphincter of Oddi dysfunction and natural orifice translumenal endoscopic surgery.

Kalle Kang, MD (Overlake Internal Medicine Associates, Bellevue, Wash.). In addition to being one of six GI physicians at Overlake, Dr. Kang performs surgery at Eastside Endoscopy Center in Bellevue, a Physicians Endoscopy Center. He previously taught at the University of Connecticut Medical School in Storrs.

Philip O. Katz, MD (Albert Einstein Medical Center, Philadelphia). Dr. Katz chairs the division of gastroenterology and is associate program director for the internal medicine residency at Albert Einstein Medical Center. The immediate past president of the American College of Gastroenterology, he has been the ACG's representative to the American Board of Internal Medicine.

David A. Katzka, MD (Mayo Clinic, Rochester, Minn.). Dr. Katzka is head of the esophageal interest group in the division of gastroenterology and hepatology at the Mayo Clinic. He is the winner of the 2010 Distinguished Clinician Award from the American Gastroenterological Association and NIH Clinical Investigator Award.

Lawrence S. Kim, MD (South Denver Gastroenterology). Dr. Kim serves on the board of directors of the Accreditation Association for Ambulatory Health Care, Clinical Practice and Economics Committee of the American Gastroenterological Association and Regional Medical Advisory Board of the American Liver Foundation.

Michael L. Kochman, MD (Hospital of the University of Pennsylvania, Philadelphia). Dr. Kochman is the endoscopy training director and co-director of the Gastrointestinal Oncology Program at the Hospital of the University of Pennsylvania. Serving as chairman of the editorial board of *GIE: Gastrointestinal Endoscopy* and editor for the Year Book of Gastroenterology.

Michael K. Koehler, MD (University Hospitals, Cleveland). In addition to practicing in University Hospitals Medical Practices, Dr. Koehler has admitting privileges at UH Case Medical Center and UH Bedford Medical Center and on staff at the Endoscopy Center at Bainbridge in Chagrin Falls, Ohio.

Mark H. Kogan, MD (Northern California Gastroenterology, San Pablo, Calif.). Dr. Kogan has served as chief of staff at Doctors Medical Center in San Pablo and medical director for the Alta Bates Medical Group. He was president of the Alameda Contra Costa Medical Association.

Jeffrey Kutscher, MD (Gastroenterology Consultants of New Jersey, Lumberton). Dr. Kutscher is chief of gastroenterology at Virtua Memorial Hospital in Mount Holly, N.J. He focuses on colon cancer screening and prevention, gastroesophageal reflux disease, inflammatory bowel disease and liver disease.

Loren A. Laine, MD (USC School of Medicine, Los Angeles). The president-elect of the American Gastroenterological Association, Dr. Laine is director of endoscopy and the associate director of the Division of Gastrointestinal and Liver Diseases at USC School of Medicine. Areas of interest include gastrointestinal bleeding and upper gastrointestinal tract injury due to Helicobacter pylori and anti-inflammatory medications.

Louis La Luna, MD (Digestive Disease Associates, Wyomissing, Pa.). Dr. La Luna is medical director of Berks Center for Digestive Health, an outpatient endoscopy center, and the gastroenterology liaison for the cancer committee at Reading (Pa.) Hospital.

Nicholas F. LaRusso, MD (Mayo Clinic College of Medicine, Rochester, Minn.). Dr. LaRusso chairs the Foundation for Digestive Health and Nutrition at the American Gastroenterological Association. He is past president of the AGA and the American Association for the Study of Liver Diseases

Bret A. Lashner, MD (Cleveland Clinic). The co-chair of the Cleveland Clinic Clinical and Translational Science Collaborative Advisory Committee, Dr. Lashner also chairs the Research Committee of the American College of Gastroenterology. He is an associate editor of *The American Journal of Gastroenterology* and *Inflammatory Bowel Diseases.*

James S. Leavitt, MD (Galloway Endoscopy Center, Miami). Dr. Leavitt is a physician at the Galloway Endoscopy Center. He has served as a member of the American College of Gastroenterology's practice management committee.

Jay R. Levinson, MD (Michigan Endoscopy Center, Farmington Hills). Dr. Levinson is the medical director of Michigan Endoscopy Center. He has been recognized as one of the region's most respected gastroenterologists in *Detroit Magazine*'s Top Doc survey.

Blair Lewis, MD (Mount Sinai Hospital, New York). Dr. Lewis was the primary investigator for the first clinical trial of capsule endoscopy for the small intestine and for the first clinical trial for the colon capsule. He chairs the International Conference of Capsule Endoscopy and coordinated the Consensus Conference statements to guide capsule usage.

Gary R. Lichtenstein, MD (University of Pennsylvania School of Medicine, Philadelphia). In addition to being director of the Center for Inflammatory Bowel Diseases at the University of Pennsylvania School of Medicine, Dr. Lichtenstein serves on the editorial boards of *three professional publications focused on gastroenterology.*

Edward V. Loftus Jr., MD (Mayo Clinic, Rochester, Minn.). Dr. Loftus is on the steering committee of the IBD Working Group and has chaired the Patient Education Committee of the Crohn's and Colitis Foundation of America. He is an associate editor of *American Journal of Gastroenterology.*

James F. Martin, MD (Kaiser Permanente San Rafael Medical Center, Calif.). Dr. Martin is the chief of the department of medicine at Kaiser Permanente San Rafael Medical Center. He has won the American Gastroenterological Association's 2010 Distinguished Clinician Award.

Arthur McCullough, MD (Cleveland Clinic). A former president of the American Association for the Study of Liver Diseases, Dr. McCullough chairs the department of gastroenterology and hepatology and is vice-chairman of research and education at the Digestive Disease Institute at the Cleveland Clinic.

Alfred McNair, MD (Digestive Health Center in Biloxi, Miss.). Dr. McNair founded Digestive Health Center. He has practiced at several hospitals in Mississippi, most recently at Ocean Springs Hospital.

Kenneth R. McQuaid, MD (VA Medical Center, San Francisco). Dr. McQuaid is director of GI Endoscopy and is the primary clinician for luminal gastrointestinal disorders at the VA Medical Center. He is treasurer-elect and a member of the governing board of the American Society of Gastrointestinal Endoscopy.

Klaus D. Mergener, MD, PhD (Digestive Health Specialists, based in Tacoma, Wash.). Dr. Mergener is director of GI hospitalist services at Digestive Health Specialists. He is a member of the governing board of the American Society for Gastrointestinal Endoscopy and is a member of the Council of Fellows of the American College of Physician Executives.

Steven J. Morris, MD, JD (Atlanta Gastroenterology Associates). Dr. Morris is CEO and co-founder of Atlanta Gastroenterology Associates. He is past president of the Georgia Gastrointestinal Society and served as chief of staff at Emory University Hospital.

Bergein F. Overholt, MD (Gastrointestinal Associates, Knoxville, Tenn.). Dr. Overholt earned the Schindler Award from the American Society of Gastrointestinal Endoscopy and the William Beaumont Award from the AMA. He founded of Gastrointestinal Associates and is former president of the ASGE.

Daniel J. Pambianco, MD (Martha Jefferson Hospital, Charlottesville, Va.). In addition to being chairman of the endoscopy-motility lab at Martha Jefferson Hospital, Dr. Pambianco is medical director of Charlottesville Medical Research. He is also vice chair of the board of governors of the American College of Gastroenterology.

Henry P. Parkman, MD (Temple University School of Medicine, Philadelphia). Dr. Parkman is director of the GI Motility Laboratory and the Temple Clinical Research Unit at Temple University School of Medicine. He is vice president of the Digestive Disease National Coalition.

Richard Peek Jr., MD (Vanderbilt University Medical Center, Nashville, Tenn.). Dr. Peek is council chair-elect of the American Gastroenterological Association and director of gastroenterology, hepatology and nutrition at Vanderbilt Ingram Cancer Center.

John L. Petrini, MD (Sansum Clinic, Santa Barbara, Calif.). Dr. Petrini is a former board member of Sansum Clinic and is a past president of the American Society of Gastrointestinal Endoscopy.

David A. Peura, MD (University of Virginia, Charlottesville, Va.). A professor of medicine at the University of Virginia Health Sciences Center, Dr. Peura was the 100th president of the American Gastroenterological Association. He ha won the AGA's Julius Friedenwald Medal and Distinguished Educator Award.

Irving Pike, MD (Gastroenterology Consultants, Virginia Beach). Dr. Pike is president of Gastroenterology Consultants. He served as vice president of medical affairs at Sentara Bayside Hospital in Virginia Beach and was on the executive council of Re-Inventing Sentara. He is chairman of the American Society for Gastrointestinal Endoscopy's Ambulatory Endoscopy Special Interest Group.

Scott E. Plevy, MD (University of North Carolina, Chapel Hill). Dr. Plevy is director of the University of North Carolina FOCIS Center of Excellence. He is on the steering committee of the IBD Working Group, was co-director of the Inflammatory Bowel Disease Center at the University of Pittsburgh and has served as basic science section editor for *Inflammatory Bowel Diseases.*

Daniel K. Podolsky, MD (Massachusetts General Hospital, Boston). The chief of the gastrointestinal unit at Massachusetts General Hospital, Dr. Podolsky is also chief academic officer at Partners HealthCare System. He has received Julius Friedenwald medal from the American Gastroenterological Association.

D. Brent Polk, MD (Children's Hospital Los Angeles). Dr. Polk is chair of pediatrics and vice president of academic affairs at Children's Hospital Los Angeles. He chairs the American Gastroenterological Association Institute Council and the National Institutes of Diabetes and Digestive and Kidney Diseases Committee.

John W. Popp Jr., MD (Columbia Gastroenterology Associates, S.C.). Currently the medical director for Centocor Ortho Biotech, Dr. Popp has served as chief of the Division of Digestive Diseases and Nutrition at the University of South Carolina School of Medicine in Charleston and director of the Endoscopy Laboratory at Richland Memorial Hospital in Columbia, S.C.

Daniel H. Present, MD (Mount Sinai Medical Center, New York). Dr. Present is a founder of the Foundation for Clinical Research in Inflammatory Bowel Disease at Mount Sinai. He holds the American College of Gastroenterology's Master award and Crohn's & Colitis Foundation of America's Lifetime Achievement Award.

Douglas K. Rex, MD (Indiana University Hospital, Indianapolis). Dr. Rex is director of endoscopy at Indiana University Hospital and a professor of gastroenterology and medicine at Indiana University School of Medicine in Indianapolis. He was also chairman of the board and president of the American College of Gastroenterologists.

David T. Rubin, MD (University of Chicago). Dr. Rubin is program director for the gastroenterology fellowship at the University of Chicago, principal investigator for several research projects and clinical trials and is a member of the steering committee of the IBD Working Group.

Moshe Rubin, MD (New York Hospital, Queens, N.Y.). Dr. Rubin is director of gastroenterology at New York Hospital. He served as lead investigator in a research study that sought to determine whether vitamin D levels are associated with a person's ability to resolve a C-diff infection.

Anil Rustgi, MD (University of Pennsylvania School of Medicine, Philadelphia). Dr. Rustgi is chief of the Division of Gastroenterology and director of the Joint Center for Digestive, Liver and Pancreatic Medicine at the University of Pennsylvania School of Medicine. He is vice president of the American Gastroenterological Association.

Michael A. Safdi, MD (Ohio Gastroenterology and Liver Institute, Cincinnati). Dr. Safdi helped formulate the first benchmarks for quality endoscopy when he served on a joint committee of the American College of Gastroenterology and American Society for Gastrointestinal Endoscopy.

Robert A. Sable, MD (Riverdale Gastroenterology, Bronx, N.Y.). Dr. Sable has served as the medical staff president of Montefiore Medical Center and St. Barnabas Hospital in the Bronx and currently serves as co-medical director of the Advanced Endoscopy Center, also in the Bronx.

William J. Sandborn, MD (Mayo Clinic, Rochester, Minn.). Dr. Sandborn is vice chair of the Division of Gastroenterology and Hepatology at Mayo Clinic. He chairs the Immunology, Microbiology and Inflammatory Bowel Disease Section of the American Gastroenterological Association.

Robert S. Sandler, MD (University of North Carolina, Chapel Hill). The chief of the division of gastroenterology and hepatology at the University of North Carolina, Dr. Sandler

is also longstanding director of the Center for Gastrointestinal Biology and Disease. He previously served as president of the American Gastroenterological Association.

Bruce E. Sands, MD (Massachusetts General Hospital, Boston). At Mass General, Dr. Sands is medical co-director of the Crohn's and Colitis Center and the Clinical Research and Gastrointestinal Unit. He is vice chair of the Crohn's and Colitis Foundation of America's Clinical Alliance and is a member of the steering committee of the IBD Working Group.

Harry Sarles Jr., MD (Digestive Health Associates of Texas, Garland). Dr. Sarles is secretary of the American College of Gastroenterologists and chairman of the legislative affairs committee for the Texas Society for Gastroenterology and Endoscopy.

Mark A. Schattner, MD (Memorial Sloan-Kettering Cancer Center, New York). Dr. Schattner is president of the New York Society for Gastrointestinal Endoscopy. Practicing at Memorial Sloan-Kettering, he has a special interest in therapeutic endoscopy and specialized nutrition support for cancer patients.

Lawrence R. Schiller, MD (Digestive Health Associates of Texas, Dallas). Dr. Schiller is president-elect of the American College of Gastroenterology. He is member of the board of Digestive Health Associates of Texas and program director of the gastroenterology fellowship at Baylor University Medical Center in Dallas.

Colleen M. Schmitt, MD (Galen Medical Group, Chattanooga, Tenn.). A member of Galen Medical Group, Dr. Schmidt is a councilor for American Society of Gastrointestinal Endoscopy and was course director for the ASGE's Practical Solutions for Successful Practice Management.

Konrad S. Schulze, MD (University of Iowa, Iowa City). Dr. Schulze has won the Award for Sustained Achievement in Digestive Sciences from the American Gastroenterological Association. His interests include the mechanics of gastric filling, phase separation and particle breakdown.

Srinivas Seela, MD (Digestive and Liver Center of Florida, Orlando). Dr. Seela is an assistant professor at the University of Central Florida School of Medicine and has privileges at Florida Hospital in Orlando. His interests include advanced and therapeutic endoscopic procedures.

Nicholas Shaheen, MD (University of North Carolina, Chapel Hill). Dr. Shaheen is president of the North Carolina Society of Gastroenterology and vice-chair of the Clinical Practice section of the American Gastroenterological Association. He has won AGA's Award for Outstanding Achievement in Basic or Clinical Digestive Sciences.

Helen M. Shields, MD (Beth Israel Deaconess Medical Center, Boston). Dr. Shields and is education and training councilor at the American Gastroenterological Association. She was also chair of the Colorectal Cancer Screening Advisory Committee at Beth Israel Deaconess

Corey A. Siegel, MD (Dartmouth-Hitchcock Medical Center, Lebanon, N.H.). Dr. Siegel is the director of the Inflammatory Bowel Disease Center at Dartmouth-Hitchcock Medical Center. He is on the steering committee of the IBD Working Group.

Leonard B. Stein, MD (Long Island Center for Digestive Health, Garden City, N.Y.). Dr. Stein is medical director at the Long Island Center for Digestive Health. He holds an academic appointment at State University of New York at Stony Brook.

Lewis R. Strong, MD (Skyline Endoscopy Center, Loveland, Colo.). Dr. Strong is the president of the Skyline Endoscopy Center, a Pinnacle III facility. He previously he founded the local physician hospital organization and served as its president for four years.

Ian L. Taylor, MD (SUNY Downstate Medical Center, Brooklyn, N.Y.). A past president of the American Gastroenterological Association, Dr. Taylor is senior vice president for biomedical education and research and dean of the College of Medicine at SUNY Downstate Medical Center.

Kalpesh H. Thakkar, MD (Baylor College of Medicine, Houston). Dr. Thakkar won the Quality Endoscopic Research Award from the American Society for Gastrointestinal Endoscopy. His research interests include abdominal pain, gastrointestinal endoscopy and clinical outcome and epidemiology.

Andrea Todisco, MD (University of Michigan, Ann Arbor). An associate professor at the University of Michigan, Dr. Todisco is a winner of the Funderburg Research Award in Gastric Biology Related to Cancer of the American Gastroenterological Association.

Phillip Toskes, MD (University of Florida, Gainesville). Dr. Toskes is past chief of gastroenterology and former chairman of medicine at University of Florida. He is also a past president of the American Gastroenterological Association.

William J. Tremaine, MD (Mayo Clinic, Rochester, Minn.). A professor at Mayo Clinic, Dr. Tremaine is winner of the Distinguished Clinician Award, clinical academic practice, from the American Gastroenterological Association.

Jacques Van Dam, MD, PhD (USC University Hospital, Los Angeles). Dr. Van Dam's research efforts include developing methods for the endoscopic diagnosis and treatment of gastrointestinal cancer. He has been president of both the American Society of Gastrointestinal Endoscopy and the Bockus International Society of Gastroenterology.

John J. Vargo II, MD (Cleveland Clinic). Dr. Vargo is program director of the advanced endoscopy fellowship in the Section of Therapeutic Endoscopy in the Department of Gastroenterology and Hepatology at the Cleveland Clinic. He is a councilor of the American Society of Gastrointestinal Endoscopy.

Ronald J. Vender, MD (Yale Medical Group, New Haven, Conn.). In addition to serving as vice president of the American College of Gastroenterology, Dr. Vender is chief medical officer of Yale Medical Group, the physician practice of the Yale University faculty.

Kenneth K. Wang, MD (Mayo Clinic, Rochester, Minn.). The director of the Advanced Endoscopy Group and Esophageal Neoplasia Clinic at Mayo Clinic, Dr. Wang is also secretary of the American Society of Gastrointestinal Endoscopy. He has served on numerous NIH panels examining Barrett's esophagus.

James J. Weber, MD (Texas Digestive Disease Consultants, Dallas). Dr. Weber is president of Texas Digestive Disease Consultants. He specializes in colorectal cancer prevention and irritable bowel disease.

David C. Whitcomb, MD, PhD (University of Pittsburgh). Dr. Whitcomb's laboratory group discovered the gene causing hereditary pancreatitis and other causes of pancreatic disease. He is chief of the division of gastroenterology, hepatology and nutrition at the University of Pittsburgh and co-founded and directed the Center for Genomic Sciences.

Sidney J. Winawer, MD (Memorial Sloan Kettering Cancer Center, New York). Dr. Winawer is credited with helping to establish national guidelines for colorectal screening. He is former chief of the Gastroenterology and Nutrition Service at Memorial Sloan-Kettering and is a past president of the American College of Gastroenterology.

F. Taylor Wootton III, MD (Digestive & Liver Disease Specialists, Norfolk, Va.). A community private practice councilor of the American Gastroenterological Association, Dr. Wootton is a member of Digestive & Liver Disease Specialists.

Russell Yang, MD (Southern Illinois University School of Medicine, Springfield). In addition to being chief of gastroenterology at UIS School of Medicine, Dr. Yang is a supervising physician for GI in the internal medicine residency program at UIS.

Vincent W. Yang, MD (Emory University School of Medicine, Atlanta). As director of the Division of Digestive Diseases at Emory University, Dr. Yang oversees clinical and academic activities in digestive diseases. He serves as a review member for the study sections in the National Institutes of Health and the Department of Veterans Affairs. ■

Top 10 Gastroenterologic Procedures in Surgery Centers by Volume

By Rob Kurtz

Here are the 10 most-performed ophthalmic procedures in freestanding outpatient surgery centers in 2009, according to SDI's *Free-standing Outpatient Surgery Centers Database* (2009 data year). Procedures are listed by CPT code, long name description and total volume.

Source: SDI's *Free-standing Outpatient Surgery Centers (FOSC) Database*, 2009 Data Year. To learn more about SDI, go to www.sdihealth.com or contact James Doyle at (484) 567-6538 or jdoyle@sdihealth.com .

Note: SDI distinguishes between HOPs (hospital outpatient surgery centers which are on the same campus as a hospital) and FOSCs (outpatient surgery centers which are not on a hospital campus).

The information provided should be utilized for educational purposes only. Please consult with your billing and coding expert. Facilities are ultimately responsible for verifying the reporting policies of individual commercial and MAC/FI carriers prior to claim submissions. ■

CPT Code	Long Name	Total
43239	Upper Stomach-Intestine Scope For Biopsy	2,123,108
45378	Scope Of Colon For Diagnosis	2,094,150
45380	Scope Of Colon With Biopsy	1,533,473
45385	Colsc Flx Prox Splenic Flxr Rmvl Les Snare Tq	1,034,406
45384	Colsc Flx Prox Splenic Flxr Rmvl Les Caut	452,799
43235	Upper Stomach-Intestine Scope For Diagnosis	267,834
43248	Upr Gi Ndsc Insj Gd Wire Dilat Esoph GT Gd Wire	151,450
G0105	Colorectal cancer screening; individual at high risk	138,858
G0121	Colorectal cancer screening; individual not at high risk	118,713
45383	Colsc Flx Prox Splenic Flxr Abltj Les	94,840
43450	Opening Of Esophagus	93,526

Implementing an EHR at an ASC: 5 Thoughts From Robert Lamont of the Surgery Center of Central PA

By Rachel Fields

Implementing an electronic health record can be a daunting task for an ambulatory surgery center, considering the capital needed to purchase hardware and software, train employees and account for productivity loss during implementation. Robert Lamont, CEO of The Eye Center of Central PA and The Surgery Center of Central PA, discusses how his ASC successfully implemented an EHR.

1. Take "soft costs" into account before implementation. Mr. Lamont says while the "hard costs" of implementation — such as the cost of software and hardware — are relatively easy to predict, some ASC administrators may forget to plan for training and staffing costs. "You have an idea how much training is involved, but you're never really sure until you're doing it," he says.

Mr. Lamont says "soft costs" involving staff are broken down into two categories: the extra hourly wages paid to staff while they go through training prior to go-live and the cost of scheduling more staff members at the ASC while the center is running two systems. He says while staffing costs will vary for every center, the most important thing is to plan for greater expenses than you expect.

2. Involve the staff in choosing an EHR. Mr. Lamont says his ASC held a staff meeting where the physicians and administrators explained the plan for implementing an EHR to the staff. "We said, 'Here's what we're going to do. We're required to do this, and we're all going to work together and get on the same page and accomplish this task,'" he says.

From day one, he knew it was essential to have the staff on board if the ASC wanted the EHR to be useful. He says while physicians should head the decision to buy a certain microscope or laser, the staff needed to be involved in EHR selection because they would be using the system every day.

Mr. Lamont says the ASC did its due diligence when selecting a vendor by finding a system that suited the ASC as well as the physician practice. "There are some vendors that only want to deal with large hospital systems, so you have to find the right vendor who will engage in your practice as well as ASC side," he says.

The management team picked a certain number of vendors and then whittled the group down to three or four. Once those had been selected, the management team scheduled some on-site previews of the different systems and asked staff members for their feedback. "When we got it down to two, we had the two final vendors come back and give presentations to the doctors and staff, and then we chose," he says.

3. Expect to transition from paper to EHR gradually. Mr. Lamont says some ASC leaders expect that once they implement an EHR, the center will go paperless immediately. He says in reality, the transition between paper and electronic charting is much more gradual. "One day we were all paper, and then the next day we were 90 percent paper and 10 percent EHR, and we kept working in that direction until we're now almost 100 percent EHR," he says. He says this transition must be gradual because it takes time for staff members to become comfortable with the new system. If you ban paper charts and force staff members to use only the new system, they may feel patient care is jeopardized.

He says ASC leadership made the transition easier by using the system with only a few patients at first. "I would advise [ASCs to test the system on] a few patients here and there and see what works and what doesn't," Mr. Lamont says. "That way, you can fix the problems before they go full-blown live." This will also help nervous employees feel more comfortable with the system before they are expected to use it for every case.

4. Assign someone to take responsibility for the system. "I think the perception is that once you're on EHR, there won't be many issues and it will run smoothly, but that is not the case. Things in EHR need tweaking, and they don't work right all the time," Mr. Lamont says. He says because of these necessary tweaks, it's important to assign someone from the surgery center to oversee maintenance, upgrades and troubleshooting. Mr. Lamont is fortunate to have a full-time IT director at his clinic and surgery center, but he recognizes that many surgery centers may not have the resources for a full-time IT staffer.

Instead, he recommends assigning a staff member as a go-to person or outsourcing an IT consultant who can dedicate a few hours every week to fixing any problems. "If you go into it without these types of people, you're setting yourself up to fail," he says.

He says it's also important to build a good relationship with your vendor so they can assist you when you run into problems. It will be easier to get help if you've established a rapport with the IT representative from your vendor.

5. Bring staff in on weekends to learn and customize the system. Mr. Lamont initially trained some ASC staff members as "super users" who could help to customize the system by building order sets and tailoring op notes to fit the center's needs. Those super users then held weekend sessions to train other staff members on the system. Keep in mind that you will probably need to pay employees overtime to come in and learn the system. Mr. Lamont says this process turned into a good team-building session for employees. "We ordered breakfast and lunch and tried to make it special for everyone," he says. ■

Learn more about The Eye Center of Central PA at http://eyecenterofpa.com.

5 Ways ASCs Can Cut Costs

By Leigh Page

Larry Taylor, president and CEO of Practice Partners in Healthcare in Birmingham, Ala., points to five ways ambulatory surgery centers can cut costs.

1. Revisit implant discounts. Reevaluate surgical implant discounts on a regular basis. Ask for price breaks, reminding the implant company that lower prices can translate into higher case volume and thus increase its business. "One key strategy in reducing implant costs is to develop a capitated plate and screw plan with a key vendor," Mr. Taylor adds. Work with the vendor to establish one price for plates, screws and drill bits, allowing for a greater number of profitable cases going through the ASC.

2. Review pharmacy expenses. Pharmacy expenses are a significant line item in most surgery centers. To assure the best pricing, review the potential for changes in drug purchasing. "Surgery centers often get into purchasing routines that are difficult to break," Mr. Taylor says. Invite competing vendors to propose lower prices for drugs. In addition to reviewing their base price, be sure to include other charges such as shipping rates and important services for the center, such as just-in-time inventory, regular shipping days per week and breadth of supply. Centers can even realize savings by contracting with some vendors outside their GPO, Mr. Taylor says.

3. Ask for utilization reports. Ask vendors to compile a utilization report for the surgery center. Using the report, review trends and purchasing volume to determine whether there are any opportunities for price reductions. "Take the time to review trends on your own and determine cost-effective alternatives to high-volume purchases, especially services at the back of the house," Mr. Taylor says. For example, focus cost-cutting efforts on items and services that are not driven by physician preference, such as traditional or T1 phone service. "We see centers with large expenses in IT that are paying above-market rates," Mr. Taylor says. "Often you can bring down your rates by switching to a new carrier."

4. Don't forget to review office supplies. Cost-reduction strategies used to ignore office supplies, but even this area is fair game in the current economy, Mr. Taylor says. Review prices and utilization of the current office supply vendor and estimate potential savings by moving to a smaller chain. Also, consider recycling opportunities for office supplies. Examine the materials the ASC is throwing away and determine whether the center might be able to reuse them. For example, when medical documentation has been scanned into its final digital format and the paper chart is no longer needed, the center might be throwing out charts, files, tabs and other items.

5. Evaluate equipment service programs. "Equipment service programs can be very lucrative to vendors but may not be useful to the center," Mr. Taylor says. Look at preventative maintenance and response times. For some programs, it might be better to "go bare" and simply not have a service contract, he says. "To understand your ultimate need for these contracts, review the service level you are paying for and figure out the service level you actually need," Mr. Taylor says. Evaluate the cost of such each program and the center's long-term utilization of the program. If servicing was due to misuse of equipment or incorrect processes, handling or storage, an in-service program might correct the problem.

Determine renewal and expiration dates for each maintenance program and mark them on the calendar as a reminder to make a timely review, with an eye to modifying the relationship at the appropriate time, if needed. Finally, when service contracts are up for renewal, remove auto-renewal clauses so that the ASC has an opportunity to review changes before each renewal. "This helps you to better control the relationship," Mr. Taylor says. ■

Learn more about Practice Partners in Healthcare at www.practicepartners.org.

10 Considerations for Providing Great Anesthesia in an ASC

By Rachel Fields

Meena Desai, MD, managing partner of Nova Anesthesia Professionals, discusses 10 important things every ambulatory surgery center leader should know about anesthesia provision in an ASC.

1. Robust triage process is essential. Patient selection is extremely important in an ASC because not all patients are appropriate for outpatient surgery. ASCs should work to identify patients that will not require a transfer to the hospital, which generally means patients with an ASA score of 1 or 2. Dr. Desai says that while most ASCs can identify patients with an ASA score of 4, many surgery centers run into trouble when identifying 3s — those patients with severe systemic disease that could cause surgical complications.

"A lot of ASCs do not do triage well," she says. "The rising rate of obesity causes issues with airway difficulties and obstructive sleep apnea, so we've also got to appreciate changes that affect the triage process." She says that triage should ideally be performed as soon as the patient is scheduled, and the anesthesia provider should be heavily involved. ASC administrators and anesthesiologists should discuss the regulations in their state to determine which patients can be treated at the surgery center. In some states, only patients with an ASA score of 1 or 2 can be treated, while other states allow patients with a score of 3.

Dr. Desai recommends giving nurses algorithms to determine whether patients are appropriate for ASC surgery. "Because [triage] is a non-reimbursable activity, our practice has trained nurses to do it," she says. "The nurses follow certain algorithms that you've designed for them, and then they check in with the physician."

2. Anesthesiologists and surgeons must communicate about clinical decisions. Dr. Desai says hostility between anesthesiologists and surgeons most commonly arises when the two parties fail to communicate about a clinical decision. "For instance, when you tell a surgeon to cancel a patient, they need to know exactly why you want to cancel," she says. "They're usually thinking, 'It's more convenient for me, and you're making it less convenient, and you're also taking revenue from me to somewhere else.'" The anesthesiologist should explain to the surgeon why the patient is not appropriate for outpatient surgery.

Anesthesiologists should also be careful about the way they respond to surgeon questions, Dr. Desai says. "We're often defensive," she says. "They ask a question, and instead of interpreting it as a question, we defend our position." She says if the surgeon asks why the patient needs an EKG, the anesthesiologist should calmly explain why the EKG is necessary. She says this is most easily accomplished if the center's anesthesia providers are included on ASC committees. That way, anesthesiologists will be present for discussions about patient selection, and surgeons will respect anesthesia providers for taking the time to contribute to the discussions.

3. ASC leaders should talk to anesthesiologists about drug shortages. Drug shortages are affecting surgery centers and hospitals across the country, and ASC administrators must discuss the issue with anesthesiologists to make sure center processes are adjusted accordingly, Dr. Desai says. "When we had a propofol shortage, it was important to work with anesthesiologists closely and discuss the [alternative drugs] they would be using," she says. "Anesthesia not only has to use those drugs, but figure out the different mixtures and then inservice the recovery room because patients come out looking different." In a hospital, there may be more facility-wide discussion of drug shortages; in an ASC, the administrator must take responsibility for engaging anesthesiologists on the subject.

4. Standing protocols can speed up patient discharge without anesthesiologist supervision. The two anesthesia-related issues that generally prevent timely patient discharge are nausea and vomiting, Dr. Desai says. "The ASC should get an anesthesiologist to train staff on standing protocols that help the recovery nurse act faster and more efficiently," she says. She says the ASC should apply risk stratification for nausea and vomiting to every patient during the initial phone call. Once the ASC has recorded the patient's risk of nausea and vomiting, the staff can proceed with surgery knowing what to expect. "That makes our nausea and vomiting rate very low and increases patient satisfaction hugely," she says.

She says the ASC should also implement policies around pain, such as a pain scale or a pain score. The physician and anesthesiologist should discuss how the ASC will react if the patient is experiencing pain. For example, the patient might receive oral medication first for mild pain.

5. Every new anesthesiologist should undergo a thorough orientation. When new providers join the group or start working at the ASC, Dr. Desai says they should go through a robust orientation process. "Policies at the ASC often aren't made clear to the anesthesia personnel, "she says. "I think you need to have somebody from the anesthesia group

who will look over those policies and make sure everybody in the anesthesia group knows them." When new anesthesia providers join the ASC, she says they should be oriented to the facility one-on-one rather than just thrown into the mix.

6. Anesthesia groups should be expected to staff providers consistently. Dr. Desai says problems arise when ASC anesthesia groups interchange providers constantly, forcing surgeons and staff to get used to a new provider on a regular basis. "Most providers that come in are hospitalists, and they don't know the ASC," she says. "As a surgeon, you're hesitant as soon as you realize that the anesthesiologist is not familiar with ASCs." She says anesthesia groups should be expected to staff several providers on a consistent basis, and the ASC should ask the group not to introduce a provider without several years of anesthesia experience.

7. Anesthesiologists can give input on CO2 monitoring changes. As of July 1, the American Society of Anesthesiologists recommends that anesthesiologists use end tidal CO2 monitoring for moderate sedation as well as deep sedation, a change from past regulations that only recommended monitoring for deep sedation. "You should involve your anesthesiologist in discussing what you need," she says.

8. ASC leaders should talk to anesthesiologists about standardizing supplies. Just like ASC surgeons, anesthesiologists have preferences when it comes to equipment and drugs, Dr. Desai says. Unfortunately, surgery centers don't have the same capital as hospitals and may struggle to provide several different brands of the same drug. Make sure anesthesiologists are aware of the center's financial situation and the positive effect of standardization. "If you have five anesthesiologists, you should talk to them about the one or two muscle relaxants that you need," she says. "You don't need five different ones, and if they have those discussions with each other, it's a much easier process."

9. ASC anesthesiologists are tailor-made for leadership roles. Anesthesiologists, who spend time at the center on a regular basis and work with every ASC surgeon, are a perfect fit for leadership roles. Dr. Desai says some administrators might assume anesthesiologists are not interested in playing a part in ASC operational decisions, especially if they aren't investors.

On the contrary, she says, many anesthesia providers want to feel more involved with their centers and will put in the time to serve on committees or take medical directorship positions. "While surgeons come in and out and only see things piecemeal, anesthesiologists see everyone's role and every interaction," she says.

10. Remove the obstacles to providing care, and anesthesia providers will be satisfied. Anesthesiologists practice at surgery centers because they enjoy the increased efficiency and decreased bureaucracy, Dr. Desai says. Make sure that you remove all obstacles to providing great care. "Eliminate things that cause mental problems or difficulties ahead of time, like triaging of patients, making sure a case is accurately scheduled and ensuring the anesthesiologists have everything they need," she says. "All those things can contribute to mental distress and frustration." ■

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

Top 10 Compliance Findings Cited in Joint Commission Outpatient Surveys

By Leigh Page

A fairly small number of standards are often cited in Joint Commission surveys of ambulatory facilities, says Virginia McCollum, RN, associate director of the department of standards interpretation at the accrediting agency. Ms. McCollum reports the following standards were the top 10 "requirements for improvement" from Jan. 2011 to July 2011 at 50 different types of ambulatory facilities, ranging from ambulatory surgery centers to sleep labs and imaging centers. "Since these are the most frequently cited observations, this list is a good starting point on what areas to look at within your own organization," she says.

1. Credentialing and privileges (48 percent of inspected facilities). This standard (HR.02.01.03) involves verifying credentials of licensed independent practitioners, including physicians. "Verifying credentials is a very tedious process," Ms. McCollum says. "It has a lot of pieces." For example, the work involves finding the original source of a credential or privilege and checking with the National Practitioner Data Bank every two years.

2. Safe storage of medications (31 percent). Standard MM.03.01.01 requires the facility to safely store medications. This includes making sure medications are stored in a secure place, according to manufacturers' recommendations, and have not expired.

3. Infection control measures (27 percent). This standard (IC.02.02.01) involves implementing infection prevention and control activities when cleaning and disinfecting medical equipment, devices and supplies. For example, surveyors make sure surfaces have been disinfected properly, intermediate and high-level disinfection has been performed and medical equipment, devices and supplies have been stored or disposed of.

4. Infection control surveys (21 percent). Standard IC.01.03.01 requires the facility to perform a risk-analysis on acquiring and transmitting infections. The analysis is based on the facility's geographic location, community and population served.

5. Hand hygiene (21 percent). Referencing a National Patient Safety Goal (NPSG.07.01.01), this standard involves following CDC or World Health Organization guidelines for handwashing.

6. Lab test records (19 percent). This so-called "waived testing" standard (WT.05.01.01) requires keeping records of certain lab tests performed for the facility. For example, results for internal and external controls must be documented in the patient's clinical record and results must be accompanied by reference intervals.

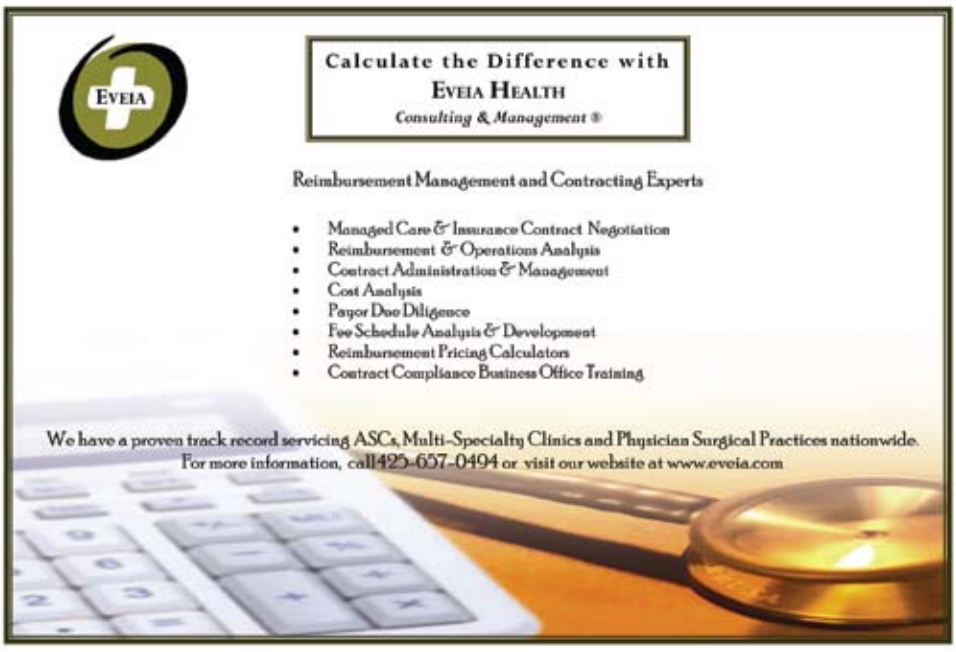
7. Verifying staff qualifications (17 percent). Human resources standard HR.01.02.05 involves verifying qualifications of staff. For example, licenses have to be verified at the primary source.

8. Lab quality control checks (17 percent). This second waived testing standard on the list (WT.04.01.01) requires performing quality control checks for each waived testing procedure performed at the facility. These can include instrument-based testing, quality control checks performed on each day of patient testing and non-instrument control checks.

9. Environment of care (16 percent). The "environment of care" standard (EC.04.01.01) requires the facility to monitor conditions in the environment, such as conducting a proactive risk analysis and performing continual monitoring, internal reporting and investigations. The category also includes monitoring injuries to patient, occupational illness and staff injuries and property damage.

10. Labeling medications (16 percent). Here surveyors apply another National Patient Safety Goal (NPSG.03.04.01) to make sure that all medications and medication containers are labeled with such information as the preparation date and the date and time of expiration. ■

Learn more about the Joint Commission at www.jointcommission.org.



10 Steps to Hire an Outstanding Surgery Center Administrator

By Rachel Fields

William Mulhall, RN, partner with Meritt Healthcare and Chris McMenemy, vice president at Ortmann Healthcare Consultants, discuss the process behind hiring an effective surgery center administrator.

1. Outline the job description. Mr. Mulhall and Ms. McMenemy agree that the first step to hiring a new administrator is deciding what you are looking for. In a surgery center, that generally means deciding whether you want to prioritize a business background or a clinical background. Ideally, your administrator will have knowledge of both areas, but many candidates will have only one, so you have to be prepared to make the choice. "The job description will include information about whether you're looking for someone with a clinical background, or whether you want a purely business person to fill the role of [administrator as CEO]," Mr. Mulhall says.

He says it's acceptable to open the job search to both types of candidates and then narrow down your criteria once you see who applies. "I don't know that you can go out looking for one or the other — you'll get both no matter what you do," he says. "In our most recent situation, 95 percent of the applicants were business-related people without a clinical background, and we ended up hiring someone in the smaller portion of the pool who had both a clinical and a business background."

2. Prioritize ASC experience. Ms. McMenemy says the ideal candidate for an ASC administrator position, unsurprisingly, is a former ASC administrator. However, the pool of available ASC administrators is small, so you will likely interview candidates who come from a hospital background as well. If possible, prioritize those candidates who have spent some time in a surgery center. "There's a different way you have to look at things in an ASC to make it profitable or break even," she says. "Someone who's already been in an ASC is used to that." She says while hospital candidates may make a good fit, physician practice administrators are usually not appropriate for the position unless they have been performing office-based surgery. Ms. McMenemy adds that a strong ASC employee without administration experience could also learn the role of the administrator without too much difficulty.

She says if you can't find someone with surgery center experience, look for a hospital or physician practice employee who seems enthusiastic about the ASC industry. "It's really important to find someone who is passionate about the job," she says. "I've worked with people who seem less passionate about their surgery center than I am, and that's not good." She says if the employee doesn't have ASC experience, look for someone who has completed education and training courses. These signify that your hire will be willing to put in the time to learn the administrator role.

3. Ask physician owners and colleagues for suggestions. ASC physicians and consultants may know of candidates who have the necessary qualifications, Mr. Mulhall says. "We generally have candidates that the physician groups would like to see interviewed, and we usually interview those people first to see where they stand," he says. Interviewing these people first lets physicians know you respect their opinion and want to

find an administrator they like. However, do not think you have to hire someone just because they were recommended by your surgeons.

Ms. McMenemy says if your physician-owners cannot recommend a candidate, you may want to talk to other colleagues in the ASC industry. IT consultants, coding and billing managers and equipment vendors may know of ASC administrators who are unhappy in their current position. "They may hear of something they think is really good, or they can pass your information on to someone they know," she says. "It never hurts to talk to your vendors and colleagues and say, 'Have you heard of anyone that would be a good fit?'"

4. Publicize locally and nationally, if applicable. If talking to physicians and colleagues doesn't turn up the perfect candidate, you can use the local paper and national publications and career sites to publicize as well. Ms. McMenemy says for lower-level positions, Craigslist is helpful, but she doesn't find it as effective for administrators. She says in her experience, administrator candidates tend to find ASC jobs through the local newspaper, national industry publications or sites such as Monster.com or CareerBuilder.com.

5. Conduct a pre-interview. Don't take every candidate who applies in front of your physician group and ask for feedback, Mr. Mulhall says. Instead, go through resumes and select a handful of qualified candidates for a pre-interview. Conduct a phone or in-person interview with those candidates and eliminate the people you know you would not hire.

Ms. McMenemy and Mr. Mulhall say they look for several traits upfront before they bring candidates in front of physicians. First of all, candidates must be personable, enthusiastic and easy to talk to, since these traits are essential for dealing with ASC employees, physicians, patients and consultants on a regular basis. Second of all, candidates must seem to be able to handle stressful situations. In other words, do they seem organized, level-headed and able to delegate, or will they fall apart when they are surprised by an ASC surveyor?

6. Check references and background. Before you take a candidate in front of your physician group, check references and background. You don't want your physicians to get excited about a candidate, only to find out that his or her references are terrible or the candidate lied about something on the resume.

7. Invite physicians to interview the candidate. Once you have narrowed the pool down to 3-5 candidates, ask your physicians if they are interested in participating in the interview process. Ms. McMenemy says physician participation can range from one physician sitting in on the interview to a group of 10 physicians conducting a "town hall"-style interview with each candidate.

When you weed out candidates, Mr. Mulhall recommends looking for traits that would not gel with your ASC physicians. "I can kind of weed out certain people based on what the physicians are going to react well to," Mr. Mulhall says. "I'll talk to them a lot about their past experience which will give me insight into how they deal with the physicians' questions."

8. Ask about prior experience. Mr. Mulhall says you can tell a lot about a candidate by asking pointed questions about prior experience. "I try to talk to them about their past experience and have them give me a real-life example of something they went through at a previous job," he says. "Then they take me through the process of correcting or reconciling the issue within that job." He says this question can help determine whether ASC administrators are able to delegate to other employees, whether they play favorites with staff members and whether they can operate under stress, among other issues.

9. Pitch a salary. Mr. Mulhall and Ms. McMenemy agree that you should go into a salary negotiation with an idea of how much you want to pay your new administrator. They recommend using ASC Association or VMG Health benchmarking data to determine how much administrators are paid in your region or based on your net revenue, case volume or number of operating rooms. Once you have researched the average salary for the position, you can ask the candidate, "What is your salary requirement?" or make an offer. If you ask for a salary requirement, you can either meet the requirement or make a new offer. If you make an offer, the candidate may ask for more money or accept your offer.

Keep in mind that you may have to offer more money if you have a limited pool of candidates. "If we have a significant pool of acceptable candidates, it may drive the [salary] down because we have a lot of people to pick from," Mr. Mulhall says. "If we have a smaller pool of candidates or a very strong candidate, the number may go up because we don't have [many choices]."

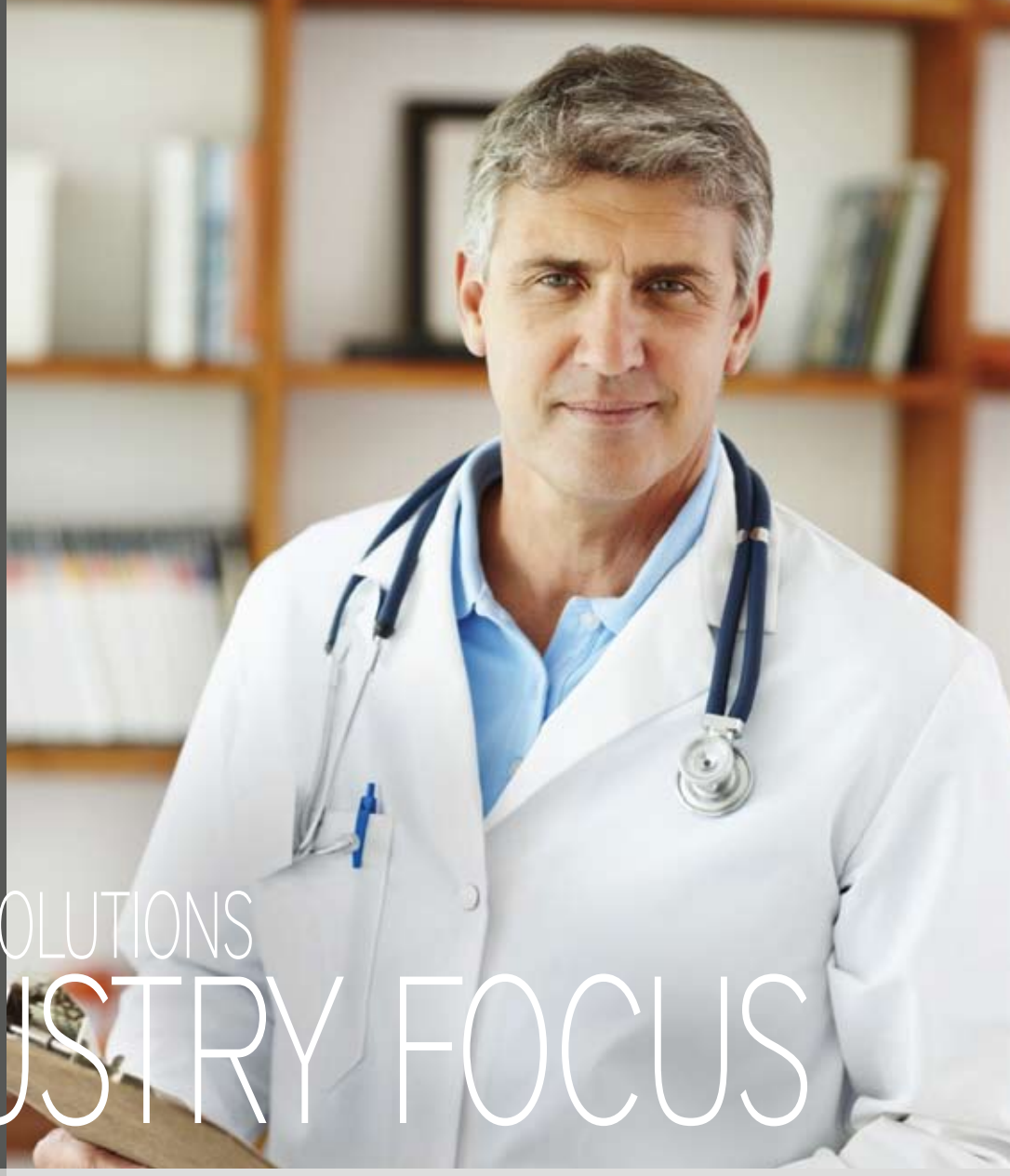
10. Orient the new administrator. An ASC administrator position involves many different tasks, all of which may require some orientation for the new employee. Mr. Mulhall says his company spends time with the new administrator on a day-to-day basis, going over policies and requiring the administrator to research accrediting body rules and CMS guidelines. After a few days of one-on-one instruction, the administrator does an informal sit-down with ASC staff and starts to get acclimated to the daily life of the center.

Ms. McMenemy says her company starts the administrator off with a three-day training program that goes over the goals for the next six months. The company leaders then sit down with the surgery center's lead physician to go over the necessary amount of communication between physician and administrator. "Does he want to be copied on everything, or does he just want a weekly meeting, or does he want the administrator to just call when he's needed?" she says. She says the company also keeps a spreadsheet for the administrator that outlines the necessary tasks to successfully open the surgery center. ■

Contact Rachel Fields at rachel@beckersasc.com.

Advertising Index

Note: Ad page number(s) given in parentheses



INNOVATIVE SOLUTIONS
INDUSTRY FOCUS

Valuations For:

- Business Transactions
- Professional Service Agreements
- Life Sciences
- Real Estate
- Equipment

Transaction Representation

Joint Venture Consulting

Experts in Fair Market Value. Focused in Healthcare. Trusted by Clients.

Evolving obstacles in healthcare have caused fair market valuations to become a critical step in meeting regulatory requirements. Leading hospital systems, attorneys and investors rely on VMG Health as the most trusted valuation and transaction advisory source in healthcare. Contact VMG today and learn how we can help you with all of your valuation needs.

www.vmghealth.com
Dallas 214.369.4888
Nashville 615.777.7300

VMG HEALTH
WE VALUE HEALTHCARE