Inside: Statistics on ASC Staff Salaries (p. 32)

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

# Concerns Raised on the Valuation of Surgery Centers

## (Advisory Opinion 09-9)

**By Scott Becker, JD, CPA**

This advisory opinion relates to the start up of two simultaneous ASCs, one by a surgeon-owned LLC and one by a hospital. The plan, as indicated in the advisory opinion, is to merge the two ASCs as they become operational and to value the two ASCs based on the then tangible value of the assets of the ASCs. The two ASCs were being developed simultaneously to attempt to avoid certificate of need concerns. It is also likely that there were other ulterior reasons for the approach that are not apparent in the opinion. For example, it is often the case that if a hospital merges its ASC

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# 5 Best Practices for Increasing Volume Through Cultivating Relationships

**By Lindsey Dunn**

In 2006, leaders at Manitowoc (Wis.) Surgery Center decided to shift their marketing dollars ways from traditional venues, like newspaper advertising and billboards, and into advocacy and educational programs that promote the ASC "story" — high-quality, cost-effective care — directly to employers as well as to consumers and community members. Manitowoc's out-of-the box approach has been successful with patient volume increases of 35 percent in one year as a result of its efforts.

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# 66 Women to Know in the ASC Industry

**Margaret Acker, RN, MSN, CASC** — Ms. Acker is CEO of Blake Woods Medical Park, a multi-specialty surgery center in Jackson, Mich., that focuses on general ophthalmology, retina, orthopedics and general surgery. She has more than 20 years of healthcare experience and has served as a staff nurse, nursing supervisor and nursing director. Ms. Acker holds a master's in nursing from Eastern Michigan University in Ypsilanti, Mich. She is active in her community and serves as a board member at St. Luke's Clinic, a free clinic for the underserved in Jackson.

**Rhonda Arnwine, MBA** — Ms. Arnwine is the business development manager for Dallas-based National Surgical Care. She previously served as the manager of organizational development for United Surgical Partners International. Ms. Arnwine has held several other positions in organizational development and human resources throughout her career. She received an MBA from Texas A&M University and currently

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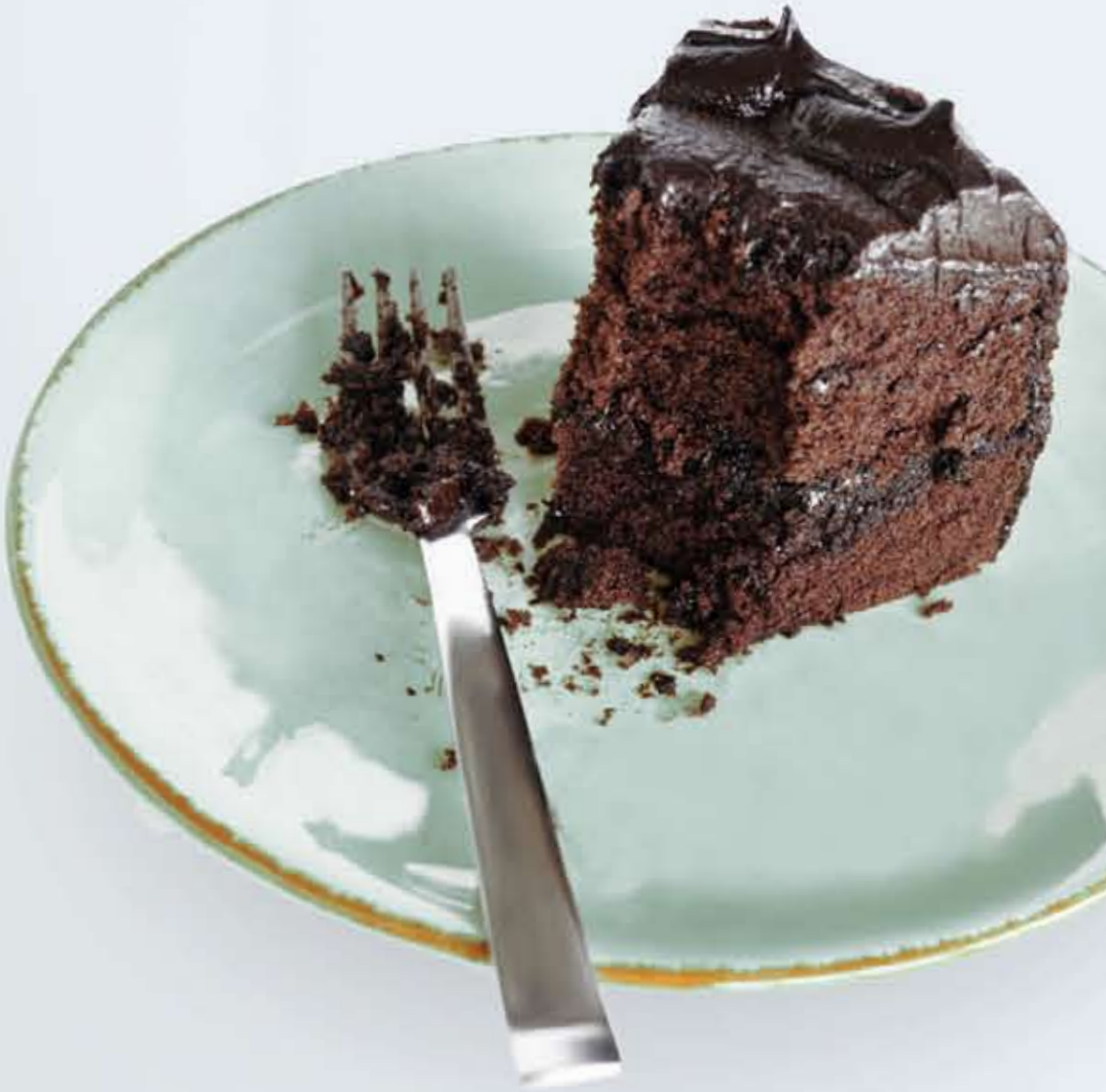

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## FEATURES

# Publisher's Letter

## Re: The Five Biggest Issues Facing Surgery Centers Right Now

**1. Healthcare reform.** Healthcare reform continues to place a substantial cloud over the healthcare provider universe. It is possible that if there is not a "public option," and if healthcare reform does not cause substantial increase in deficits, that a healthcare reform package will not do undue harm to the country and to surgery centers. However, as the debate continues to evolve, it continues to place tremendous uncertainty on the healthcare industry.

**2. Reimbursement.** Surgery centers are facing challenges on reimbursement on several different fronts. Medicaid reimbursement is very low, out-of-network reimbursement is getting much tougher and we are seeing the end of contracts which pay discounts from usual and customary charges.

**3. Case volumes.** While case volumes are holding reasonably steady, the recruitment of new physician and replacement physicians is not getting any easier. Increasingly, hospitals are looking to employ specialists. Also, in many markets, surgical specialists are already aligned with center.

**4. Acquisition market.** The acquisition market for surgery centers seems to be rapidly picking up pace. While the multiples at which transactions are completed are not what they were a couple years ago, there is a renewed interest in acquiring surgery centers on many fronts.

**5. Cost containment and great management.** As revenues become just a little bit tougher, there is an increased emphasis on outstanding management. This includes the management of staffing costs and supplies. This also includes smart buying of equipment and smart managed care contracting.

The surgery center as a whole is holding its own. It is an extremely self-sustaining industry and an industry to be proud of.

Very truly yours,

Scott Becker

**Concerns Raised on the Valuation of Surgery Centers (Advisory Opinion 09-9)** **(continued from page 1)**

into an existing surgery center or otherwise contributes a line of business into a surgery center, that line of business must be valued for purposes of determining the hospital's contribution. Surgeons often object to this. Here, it is likely that the physicians were greatly concerned that that would have a high value and that they would argue that they were paying for cases they actually generated at the hospital. The parties, in putting together this advisory opinion transaction, seemingly developed a situation where both developed an ASC at the same time and then merged them together. This helped reduce the risk that someone would take the position that the hospital's service line had to be valued as part of the contribution. It also put the two parties on the same grounds and made it easy to ask the OIG for an advisory opinion for both ASCs to be valued at tangible asset value

The OIG in the opinion goes on to state some possible concerns with valuations of surgery centers performed based on a cash flow basis approach. This is contradictory to all principles of valuation which rely upon a cash flow analysis or an income approach as one of three cornerstone methods of valuing businesses. In essence, the three standard valuation approaches include replacement or cost approach, a market approach and an income approach (which is often based on a cash flow analysis). Most professionals and the Internal Revenue Service would argue that the income approach for this kind of cash flow is usually the most appropriate method by which to value an ongoing healthy business. Here are certain of the OIG's comments from Advisory Opinion 09-9:

"Our conclusion might be different if the valuation of the respective contributions of the investors included intangible assets. For example, given the circumstances of the Proposed Arrangement, we might be concerned if the valuation were based on a cash flow analysis of the Surgeon ASC as a going concern. Because the Surgeon Investors are referral for the Surgeon ASC, a cash flow-based valuation of that business potentially would include the value of the Surgeon Investors' referrals over the time that their ASC was in existence prior to the merger with the Hospital ASC. The result might be that the Surgeon Investors would receive a greater return on their capital investment than the Hospital, which could reflect the value of their referrals to the Surgeon ASC. (In these circumstances, the Hospital ASC, being newly developed at the time of the proposed merger, may have little or no cash flow record, but we might be similarly concerned with a valuation based on a cash flow analysis of a hospital-owned ASC for which the hospital could influence referrals). We do not assert that a cash flow-based valuation or other valuation involving intangible assets would necessarily result in a violation of the anti-kickback statute; the existence of a violation depends upon all the facts and circumstance of a particular case."

The OIG in its opinion does not say that using a cash flow analysis itself would violate the Fraud and Abuse Statute. It says instead, "We do not assert that a cash flow-based valuation or the valuation of the intangible assets would necessary result in a violation of anti-kickback statute; the existence of a violation depends upon all the facts and circumstances of a particular case."

This is an opinion where we perceive that the OIG may not have fully understood the driving rationale behind putting this type of planned merger together. In missing the understanding of what was really going on, they inadvertently made negative inferences with respect to one of the core methods of valuing a business. This provides some concern because the overwhelming number of transactional valuations in all sectors, including healthcare sectors, are based on some level of income approach or discounted cash flow analysis. ■

*Contact Mr. Becker at (312) 750-6016 or at sbecker@mcguirewoods.com.*

**5 Best Practices for Increasing Volume Through Cultivating Relationships With Employers and Consumers** (continued from page 1)

ASCs around the country that provide high-quality care at a low cost are in a unique position to benefit from recent movements by employers and other entities to promote consumer-driven healthcare, but in order to take advantage of this opportunity, they have to get their message heard by these groups.

Kate Willhite, executive director of Manitowoc, offers the following five best practices for direct contracting with employers and selling them on the ASC "story."

**1. Know your strengths and weaknesses.** ASCs should take inventory of their current strengths and weaknesses. Awareness about the advantages of your facility over others in your area is the first step in preparing for discussions with employers.

"Most consumers are looking for a high-value surgical provider, as judged by quality, price and service; however, many consumers lack the information they need to make informed decisions," says Ms. Willhite. "In response, our business development focus has turned into getting that information out to the community."

In addition to examining possible strengths in regard to billed charges, ASCs should assess their contracts with insurance companies. Ms. Willhite recommends that ASCs identify where they have leverage such as quality outcome measures, complication rates, and patient satisfaction survey results, and then use those strengths to get out from under weak contracts that include inclusion of implants, percent of Medicare fee schedule, auto-renewal, etc.

**2. Prioritize employers for discussions.** Ms. Willhite recommends that ASC leaders prioritize employers to approach based on the savviness of the employer and its human resources executives.

"You have to be active and out in the community. Attend chamber of commerce programs, job fairs and other events. Get to know which employers are hungry for change and are looking for a new perspective on the dollars they're spending for benefits," says Ms. Willhite. "Prioritize your relationships based on who you think is willing to be a change agent. Look for someone who is looking to get aboard quickly and set an example for those on the fence."

Ms. Willhite started her direct contracting campaign by approaching the healthcare decision-makers from one large employer in her area, which she knew to be risk-taking and involved in healthcare reform.

When approaching employers, ASC leaders should clearly explain how a relationship with their facility can benefit the employer.

"I approached them with empathy for the hurdles they were facing; the struggle to keep employee benefits an option at their company. I put myself in their shoes and then gave them the good news — that our surgery center is here to help," says Ms. Willhite.

In addition to providing high-quality, low-cost services, Manitowoc also provides supportive services for employers such as employee-benefit plan design guidance which promotes cost-consciousness and employee/consumer accountability.

As a result, the employer devised a plan that would provide cash incentives to employees that selected the least-expensive provider within their insurer's

network to perform their procedures. The employer began offering anywhere from $150-$1,500, paid directly by the employer, depending upon the procedure, to the employee who selected the high-value provider.

**3. Use employers to drive insurance companies to change.** Once ASC leaders have educated employers on the importance of designing benefit plans that promote cost-consciousness, employers who want to provide these programs should leverage this desire with their insurer and negotiate employee-benefit plan designs that support high-value choices and employee accountability.

The company that Ms. Willhite worked with pushed its insurer to provide online access to contract allowables so that the employees could accurately compare medical costs.

"The employer illustrated to the insurer that they were creating cost-conscious, quality-conscious consumers and how it benefited the insurer," says Ms. Willhite. "The employer pressed the insurer to provide the electronic venue for the transparency necessary to make comparisons among providers."

Transparency is the key to providing consumers with the information they need to make informed decisions, and employers, insurers and providers need to embrace this in order to successfully provide cost savings to consumers. Insurers often do not reveal contracted rates to their members, so comparing out-of-pocket costs, such as the cost of a percentage-based coinsurance, can be particularly difficult for consumers. Additionally, insurers are often wary about publicizing the information because providers will be made aware of other providers' contracted rates.

"Consumers must have access to contract allowables in order to compare the costs of different facilities. Insurers are uneasy about releasing that information," says Ms. Willhite. "Employers need to push them to let go of the reigns and release the information."

The insurer that Ms. Willhite mentions now maintains a Web site specifically for employees of the large company. The Web site contains the employer's contract allowables for 10 different procedures at three facilities — two hospitals and the Manitowoc Surgery Center. For example, a patient undergoing carpal tunnel can log on to the site and see the contract allowables for the procedure at the three different locations. The ASC may have a contracted rate of $1,250, while hospital A and B are contracted at $2,000 and $2,100. Thus, if the employee selects the ASC for the procedure, he or she will receive a cash incentive for selecting the least-expensive provider.

"Providing incentives for patients to use the provider at the lowest contracted rate can benefit ASCs," says Ms. Willhite. "Again, because we have a cost-base plus fair profit reimbursement, it is easy for us to provide the highest-value option 95 percent of the time. Employees being incentivized to choose the high-value option will only help to increase our volume."

**4. Leverage employer relationships during managed care contract negotiations.** Ms. Willhite says that her new-found relationships with employers have improved her negotiations with managed care contractors.

"I have been able to go to the payors and say, 'no, we are not interested in doing a contract based on a percent of Medicare,'" says Ms. Willhite. "Our cultivation of successful employer relationships has allowed us to show that individualized, employer-specific insurance plans can benefit

the insurer, the employer and our center." It comes down to cost, quality and service. Contracts need to be cost-based to incentivize those that are efficient; this, again, can put ASCs in a winning position.

Manitowoc Surgery Center has completely changed its approach to contract negotiations as a result.

"We no longer have the goal of pitting one insurance contract against another and looking for the highest reimbursement rate; now, we're looking for the 'right' rate." says Ms. Willhite. "We've changed the focus to the consumer side. We're looking to find a rate that is fair and will be attractive to the consumer and easy for them to compare to other facilities in their plan, increasing our volumes as a result."

Most insurers and employers prefer to work from a "cookie-cutter" contract, such as a contract that pays a certain percent of Medicare, because these contracts are more efficient, administratively. However, these uniform contracts actually end up costing both parties more than a plan tailored specifically to the employer, says. Ms. Willhite.

"The payors often think it's a lot of work, even though it's beneficial to them in the long run," says Ms. Willhite. "We have all become too complacent in our business activities, and it's time to change. If you're complacent, you're regressing."

Ms. Willhite explains that her facility simply decided to put its relations with employers ahead of relations with insurers and promoted the center directly to the employer.

"Building relationships with employers are a higher priority for us than contracting with insurance companies," says Ms. Willhite. "We are working to get the employer back in a position of being truly informed, and we are no longer beating our heads against the wall with insurance companies who insist on cookie-cutter contracts."

**5. Continue to promote the role of the employer in healthcare decision making.** ASCs should continue to pursue direct relationships with employers by promoting this new role of the employer.

Manitowoc hosts an annual symposium on healthcare redesign and invites local business owners and leaders to attend free of charge. The event features presentations for area CEOs and healthcare experts at a local conference center. At the event, business leaders are encouraged to request transparency from their health plan provider and discuss healthcare access and cost issues facing the community.

The event not only promotes smart healthcare choices within the community, but also promotes the surgery center's services. ■

*Contact Lindsey Dunn at lindsey@beckersasc.com.*

**66 Women to Know in the ASC Industry**
**(continued from page 1)**

is an adjunct instructor for the university. She also serves as the current program chair for the Texas Ambulatory Surgery Center Society and is a member of the ASC Quality Collaboration Expert Group.

**Lisa Austin, RN, CASC** — Ms. Austin is vice president of ASC operations for Pinnacle III and has been an RN for more than 27 years, working in ambulatory care for many of those years. She has extensive ASC operational, development, management and consulting experience and has expertise in facility administration, budget development, regulatory compliance, staff recruitment and retention, policy and procedure development, equipment procurement and implementation and organizational interfacing. Ms. Austin is a board member of the Colorado Ambulatory Surgery Center Association and is currently chairing the committee on emergency preparedness for ASCs in Colorado.

**Glenda Beasley, RN** — Ms. Beasley is the administrative director of the Kentucky Surgery Center in Lexington, Ky., which specializes in ENT, orthopedics, gynecology, plastics, podiatry, oral surgery, endoscopy, pain management, urology and general surgery. Ms. Beasley has been with the center since July 1990 and began her career in outpatient surgery as a circulating OR nurse, eventually becoming an administrator. Ms. Beasley has also worked in many hospital departments throughout her career, including oncology, medical surgical and emergency.

**Regina Boore, RN, BSN, MS** — Ms. Boore is the principal and CEO of Progressive Surgical Solutions. Ms. Boore has more than 25 years of clinical, administrative, teaching and consulting experience in ambulatory surgery. Ms. Boore previously worked as a perioperative nurse, an OR supervisor and as a clinical coordinator for surgical technology and perioperative nurse training programs in California. She received her bachelor's in nursing from California State University at Long Beach and holds a master's degree in human resource management and development from Chapman College in Orange, Calif.

**Karen Barrow** — Ms. Barrow is the senior vice president of business development for Amerinet, where she leads a specialized sales team that promotes Amerinet's services and contracts. She previously served as the vice president of clinical solutions and business development of Amerinet's enterprise solutions division. Ms. Barrow joined Amerinet in 2002 as director of the medical and surgical division and has more than 25 years of expertise in the healthcare industry, including experience as a surgical nurse, first assistant and business coordinator and as an orthopedic, otolaryngology and radiological equipment sales representative for Dow Corning Wright, Smith & Nephew and Viatronix. Ms. Barrow has also consulted and assisted in the development and management of several ASCs, including ambulatory operations for Unity and HealthSouth.

**Carol Blanar, RN, BSN, CNOR** — Ms. Blanar is the administrator of the Sagamore Surgical Medical Complex in Lafayette, Ind., and former director of nursing at the Sagamore Surgery Center. She serves as executive director of the Indiana Federation for Ambulatory Surgical Centers and previously served as IFASC's president for seven years. Ms. Blanar is also a governor-appointed voting member of the nine-member Indiana Hospital Council, where she represents the ASC industry.

**Kathy Bryant, JD** — Kathy Bryant is the president of the ASC Association and in this role leads the activities of the nation's largest ASC membership association. Ms. Bryant also serves as president of the ASF Foundation. Ms. Bryant oversaw the development and implementation of the first ASC-specific credential, CASC

(Certified Administrator Surgery Center). Before accepting her current position with the ASC Association, Ms. Bryant led FASA, one of the two organizations that came together to form the ASC Association in 2008. She previously headed the government relations program of the American College of Obstetricians and Gynecologists and worked for the American Medical Association and the Iowa State Senate.

**Betty Bozzuto, RN, MBA, CASC** — Ms. Bozzuto is executive director of Naugatuck Valley Surgical Center in Waterbury, Conn., and former president and a founding member of the Connecticut Association of Ambulatory Surgery Centers. She is a former board member of FASA. Ms. Bozzuto is also a surveyor for AAAHC and president of Connecticut's Ambulatory Surgery Center Patient Safety Organization. Ms. Bozzuto holds an MBA from the University of New Haven.

**Susan Charkin** — Ms. Charkin is president of Healthcents, an ASC and physician-specialty hospital contracting and consulting group. She has 15 years of experience in senior contracting positions with Health Net, Blue Shield of California, Blue Cross Blue Shield of Washington, D.C., Aetna and MaxiCare. Ms. Charkin is also an author and national speaker on managed care contracting issues and has been published in several journals. She received a master's in public health administration from the University of San Francisco and is a trustee at Navidad Medical Center in Salinas, Ca.

**Marilyn Christian, RN, BSN, CNOR, CASC** — Marilyn Christian is president and COO of Advantage Surgical Partners and has been in the ASC industry for more than 20 years. Ms. Christian previously served six years as vice president of clinical operations and regulatory compliance for a leading ASC company. This followed four years as administrator and director of nursing for a multi-specialty ASC. Ms. Christian's responsibilities in these positions have included all phases of startup, development, perioperative services, business office procedures, budgeting, contracting, quality assurance, benchmarking, plant operations, regulatory compliance, national accreditation, personnel management and vendor relationships.

**Monica Cintado, MBA** —Ms. Cintado is the senior vice president of development for United Surgical Partners International, and she has been with USPI since 1998. Prior to joining USPI, Ms. Cintado provided development and operations support for the international group at HCA. While with HCA, she assisted in the acquisition of Instituto Dexeus in Barcelona, Spain, which later became the first facility acquisition by USPI in 1998. Preceding her joining HCA, Ms. Cintado completed an administrative internship with HealthTrust, which subsequently led her to an assistant administrator role at Nashville Memorial Hospital. Ms. Cintado received her undergraduate degree from Vanderbilt University and an MBA at Rollins College in Winter Park, Fla.

**Rebecca Craig, RN** — Ms. Craig is the CEO and administrator of Harmony Surgery Center in Fort Collins, Colo. Her experience includes more than 10 years in hospital, health system and ASC care in both the clinical and administrative sides. She joined Harmony Surgery Center as clinical director in 2000, moving to administrator in 2001. She currently serves as a member of the Joint Commission Ambulatory Surgery Advisory Council, which provides ambulatory care and office-based surgery professionals with opportunities to offer advice and insight about the accreditation process. Ms. Craig also served as the president of the Colorado ASC Association for three years.

**Rebecca Dean, MA, FACMPE** — Ms. Dean is the executive director of Sportsmedicine Fairbanks (Alaska) and is the owner of Management Solutions, where she serves as a healthcare consultant. Ms. Dean has more than 20 years of experience in senior healthcare management and previously served as CEO for Alaska's largest multi-specialty clinic. Ms. Dean holds the distinction of being the first Alaskan to attain Fellow status from the American College of Medical Practice Executives and currently serves as chair for the American College of Medical Practice Executives board of directors. She is past president of the MGMA Ambulatory Surgery Management Society, past chair of the western section of MGMA and past president of Alaska MGMA. Ms. Dean currently serves on boards for national business industries and often works as a consultant for a national ASC development firm.

**Joyce Deno, RN** — Joyce Deno is the COO, eastern region, for Regent Surgical Health. Ms. Deno has been working in the healthcare industry for 32 years. Before joining Regent, she provided private consulting for a turnaround ASC and for a center seeking accreditation. She also developed, opened and served as the executive director of Loveland Surgery Center in Colorado and previously worked for HealthSouth as a regional director of quality improvement and as an administrator. She received a bachelor's from Bethel College of Nursing in Mishawaka, Ind.

**Joan Dentler, MBA** — Ms. Dentler currently serves as a consultant for ASC Strategies and has 15 years of experience consulting for, developing and operating successful ASCs. Ms. Dentler has worked for more than 25 years in healthcare administration, serving as the hospital liaison for hospital/physician joint-venture surgery centers and as an administrator of both women's health

and pediatric primary care facilities. She holds an MBA from the University of Texas.

**Adena Dorsey** — Ms. Dorsey is the director of patient accounts for National Medical Billing Services and has extensive business management experience and a thorough knowledge of billing and coding principles for ASC claims adjudication. She is a certified professional coder and holds a bachelor's in corporate communication from Lindenwood University in St. Charles, Mo.

**Barbara P. Draves, CASC** — Ms. Draves is an owner and the administrator of The Surgery Center in Middleburg Heights, Ohio. She has opened and run surgery centers for more than 20 years and was a valued administrator and regional director for Medical Care International in the 1980s and 1990s. She previously served as an operations coordinator for three surgery centers and has held several senior positions including president and chairwoman of the Ohio Association of Ambulatory Surgery Centers. She also serves as a board member for the ASC Associations' Board of Ambulatory Surgery Certification.

**Stephanie Ellis, RN, CPC** — Ms. Ellis is the president of Ellis Medical Consulting, founded in 1992. EMC is a healthcare consulting firm providing chart audits for coding and documentation issues, business office operational assessments, research of coverage issues, litigation support, reimbursement research, ASC and physician coding and billing training and the development and implementation of billing compliance programs for healthcare providers. Ms. Ellis has worked with most specialties, assisting ASCs, physician practices, acute care hospitals, surgical hospitals, IDTFs and outpatient clinics around the country in her consulting work. She previously served as a fraud investigator for the Medicaid program in Tennessee.

**Judith English** — Ms. English is vice president of business operations and partner in Surgery Consultants of America and Serbin Surgery Center Billing. She has more than 35 years experience in the healthcare industry and has assisted in the development and management of multiple ASCs. She is the co-author of several articles and columns in industry publications and has been a featured speaker at many national ASC association meetings and seminars. Ms. English is experienced in ASC and medical practice coding, healthcare billing and collections, compliance, HIPAA, credentialing and healthcare billing, and is the collaborative author of ASC policy and procedure manuals.

**Gayle Evans, RN, BSN, MBA, CNOR, CASC** — Ms. Evans is president of Continuum Healthcare Consultants, a firm that specializes in the planning, development and operation of ASCs. With more than 25 years of multi-specialty surgery experience, Ms. Evans is a seasoned professional with management and operations experience at several leading medical facilities, including a 12-room surgery department, mobile lithotripsy services and the first U.S. research unit for biliary lithotripsy. Her background includes management of surgery department operations at Kennestone Hospital in Marietta, Ga., and clinical coordinator for the Stone Treatment Center at Crawford Long Hospital of Emory University where she developed and managed the research program for biliary lithotripsy including inpatient and outpatient protocols. She also served as a clinical specialist for the Stone Center at HCA Coliseum Medical Centers, where she developed policies and procedures for the first HCA mobile lithotripter.

**Melodie Garrobo, CASC** — Ms. Garrobo is the administrator of Golden (Colo.) Ridge Surgery Center and has led the center in its transition from a proprietary ownership model to a joint venture with a local hospital and in several successful process management initiatives. Ms. Garrobo has been an ASC manager for 15 years, seven of which have been spent as an administrator. Ms. Garrobo also sits on the board for the Colorado Ambulatory Surgery Center Association and was instrumental in its development as one of the leading state associations representing the ASC industry.

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**Data as of January 31, 2009.*

**Ann Geier, RN, MS, CNOR, CASC** —Ms. Geier is the vice president of operations for Ambulatory Surgical Centers of America. She has worked in ASCs for more than 25 years. Ms. Geier is currently involved on a national level with the Ambulatory Surgery Foundation, AORN and the ASC Quality Collaboration Expert Group in setting standards for quality of care strategies. She teaches in the AORN Ambulatory Surgery Manager's Certificate Program twice a year and teaches the annual financial management for Ambulatory Surgery Managers course. Ms. Geier is also on the AORN PNDS Data User Base task force, is a surveyor for AAAHC and speaks at national and regional meetings several times a year.

**Mary Ann Gellenbeck, RN, CASC, CNOR** — Ms. Gellenbeck is the COO of Prexus Health and is responsible for operations and quality of care for the company. She holds degrees in surgical technology, nursing and healthcare administration and has more than 28 years of experience in the surgical arena. Ms. Gellenbeck is a member of several associations including the ASC Association and AORN and is an advisory board member for Cincinnati State College.

**Cindy Hall, RN, BSN, CGRN, LCHRM** — Ms. Hall is the administrator of the Jacksonville (Fla.) Center for Endoscopy and has been in the position for more than 10 years. Prior to her position at Jacksonville Center for Endoscopy, Ms. Hall held several nursing positions, including staff nurse at St. Luke's Hospital in Jacksonville and Baptist Medical Center in Jacksonville and head nurse at Digestive Disease Associates, also in Jacksonville.

**Holly Hampe, RN, BSN, MPH** — Ms. Hampe is director of quality and safety for Amerinet. In this position, she is responsible for developing and coordinating company-wide strategy and programs on clinical quality improvement, patient safety and environmentally-friendly initiatives, including contracting strategies. Ms. Hampe's diverse career in healthcare spans more than 25 years and encompasses hospital administration positions in quality, risk management, patient safety, regulatory affairs and nursing. Ms. Hampe is currently a doctoral candidate at Robert Morris University. Her educational background includes a master's degree in health administration from the University of Pittsburgh School of Public Health, a master's degree in risk management from Finch University of the Chicago Medical School and a bachelor's degree in nursing from Penn State University.

**Barbara Ann Harmer, RN, BSN, MHA** — Ms. Harmer is a senior consultant for Healthcare Consultants International, the for-profit subsidiary of the Accreditation Association for Ambulatory Healthcare. She is responsible for providing national and international consulting services for organizations seeking or maintaining compliance with national accreditation standards and other services such as office-based surgery development, assistance with policy and procedure formation, licensure and Medicare certification preparation. Ms. Harmer has worked in healthcare for more than 30 years and has been involved in ASC development since the late 1970s. Before joining Healthcare Consultants International, she was a director of surgical services for Florida Hospital in Orlando and East Pasco Medical Center in Zephyrhills, Fla., and executive director of Surgical Services for Kennedy Health System in Cherry Hill, N.J. She has also worked as administrative director, administrator and nursing director at surgery centers in Pennsylvania, New Jersey, Rhode Island, Virginia, Texas and Massachusetts.



**Lisa Harrington** — Ms. Harrington is the principal and CEO of Langston Healthcare Services and has more than 20 years of experience in the ASC industry. Prior to acquiring Langston in 1996, she served as administrator of an ASC in San Diego, which achieved successful AAAHC accreditation and Medicare re-certification under her direction. Since then, she has assisted many other facilities with state licensing, Medicare certification and accreditation by the AAAHC, the Joint Commission, California's Institute for Medical Quality and the AAAASF. Ms. Harrington is a graduate of the University of Texas at Austin and started her career in the healthcare industry at the University of Texas Medical Branch at Galveston. She is a member of the California Ambulatory Surgery Association and has presented at several national conferences on licensing, certification and accreditation survey preparation.

**Sue Hayes** —Ms. Hayes is the CEO for Colorado Orthopaedic & Surgical Hospital in Denver. Ms. Hayes has worked in the healthcare industry for more than 20 years, beginning as a case manager for the Triumph Over Pain Program at the Rehabilitation Hospital in Colorado Springs. In 1994, Ms. Hayes co-founded Pike Peak Pain Professionals, where she served as president and CEO, guiding it through the initial stages to becoming a viable program. Ms. Hayes then served as the administrator for Dry Creek Surgery Center in Englewood, Colo., and then as administrator at Rocky Mountain Surgery Center, also in Englewood, where she managed the construction, development and operations of the center

**Liliana Lehmann, MBA** — Ms. Lehmann is the administrator of the Hallandale Outpatient Surgical Center in Hallandale Beach, Fla., and has served as the administrator since 2003. Ms. Lehmann holds an MBA from Emory University and a bachelor's degree in biomedical engineering from Tulane University. During her 19 years of experience in the healthcare market, she has held several management and executive positions with Axis Management & Billing Services, Pain Consultants of Florida, Mallinckrodt, Nellcor Puritan Bennett and SpaceLabs Medical.

**Ellen Johnson** — Ms. Johnson is vice president and COO of Facility Development and Management and has more than 20 years experience within the healthcare arena. She has held management positions within a physician management firm and in various departments of a 370-bed suburban regional medical center. She also served as nursing director for a home care agency and a staff nurse in a medical surgical unit and newborn nursery of a community hospital. Prior to joining FDM, Ms. Johnson was director of clinical services and executive director of an emerging group purchasing organization for a physician management company.

**Milla Jones** — Ms. Jones serves as vice president of communications and government relations for United Surgical Partners International.

Ms. Jones has 35 years of healthcare experience, most recently with Baylor Health Care System in Dallas. Her responsibilities include coordinating and managing state and federal advocacy efforts for USPI and its partners and the development of a communication plan that will tell the "USPI story" to the community and USPI employees.

**Sandra Jones, CASC, LHRM, CHCQM, FHFMA** — Ms. Jones is principal and director of management services for Woodrum/ASD and owner and president of Ambulatory Strategies. Ms. Jones has 30 years of experience in the healthcare industry and has overseen or contributed to the successful establishment and development of more than 75 ASCs nationwide. Ms. Jones has also served as president and COO of ASC consulting firms, administrator of freestanding ASCs, regional risk manager and managed care director for a surgery center corporation and president and vice president of acute care hospitals. She serves on the board of the ASC Association, is an accreditation surveyor with the AAAHC and legislative liaison and past president of the surgery center group of the Medical Group Management Association.

**I. Naya Kehayes, MPH** — Ms. Kehayes is the founder and CEO of EVEIA Health Consulting & Management. She is a nationally recognized expert in the area of reimbursement and managed care and insurance contract negotiations for ASCs and surgical practices. Ms. Kehayes is equally proficient in ASC operations and financial management and serves as a financial advisor to several national ASC corporations. Prior to founding EVEIA, Ms. Kehayes was a regional director of National Surgery Centers and maintained administrative responsibility for Seattle Surgery Center and Laser Northwest. She coordinated a corporate managed care resource team nationwide for more than 40 ASCs and was responsible for orthopedic development in the Northwest. Prior to that, Ms. Kehayes was a surgical hospital administrator for Columbia/HCA Healthcare Corporation and held a variety of administrative service positions at hospital and healthcare ancillary service affiliates of Harvard University, Yale University and the University of Rochester.

**Beverly Kirchner, RN, BSN, CNOR, CASC** — Ms. Kirchner serves on the AORN board of directors, has authored many AORN manuals and leads research in collaboration with the organization on violence in the nursing workplace. She serves on a Joint Commission task force charged with rewriting ASC standards and has been named to the Ambulatory Surgery Center Quality Collaboration. As the owner and CEO of Genesee Associates, Ms. Kirchner has been involved in design, development and management of ASCs since 1985.

**Susan Kizirian, RN** — Ms. Kizirian is the COO for Ambulatory Surgical Centers of America and has more than 17 years of experience in all aspects of ASC operations, serving as executive director and as a consultant for ASC management and development. Most recently, she worked with the University of Virginia Health System ASC program. Ms. Kizirian currently serves as lifetime past president emeritus on the board of directors of the Florida Society of Ambulatory Surgery Centers and is past treasurer of the American Association of Ambulatory Surgery Centers and past president of the Ambulatory Surgery Management Society of the Medical Group Management Association.

**Catherine W. Kowalski** — Ms. Kowalski is the executive vice president and COO for Meridian Surgical Partners. Ms. Kowalski has more than 20 years of experience in the healthcare industry. Ms. Kowalski is the former executive vice president of operations and co-founder of Surgical Alliance Corporation, a specialty surgical hospital company founded in 2001. Before Surgical Alliance, Ms. Kowalski served as a co-founder and

vice president, operations and hospital/ancillary services, of OrthoExcel, a hospital management company focused on contractual management of orthopedic hospital business lines. Ms. Kowalski has also served as vice president, operations of MedCenter Management Services, a healthcare management organization specializing in the development and management of orthopedic centers of excellence.

**Beth LaBouyer, RN, BSN, CNOR** — Ms. LaBouyer is the executive director of the California Ambulatory Surgery Association and has been a board member of CASA since 2000. Ms. LaBouyer previously served as director of Feather River Surgery Center in Yuba City, Calif., and as a surgical nurse and manager at Rideout Hospital in Marysville, Calif.

**Julie Lineberger, FACMPE** — Ms. Lineberger is the administrator of Idaho Urologic Institute and the Surgery Center of Idaho. She has focused on medical group practice administration, surgery center administration, consulting and construction project management and has been responsible for the initial Medicare certification and AAAHC accreditation for an orthopedic surgery center, pain management center and urologic surgery center. She is a certified healthcare executive and a fellow in the American College of Medical Practice Executives. Ms. Lineberger has been a member of the Medical Group Management Association since 1996 and has served on the honors selection committee, the leadership development committee and survey operations committee. She is the ACPME college forum representative for the ASC Assembly and is a past-president for the Idaho Medical Group Management Association.

**Debbie Mack, RN, MSN, CNOR, CASC** — Ms. Mack is vice president of operations for National Surgical Hospitals and president of the California Ambulatory Surgery Association. She has more than 25 years of experience in the healthcare industry and worked as an OR nurse, with experience in all surgical specialties. During the course of her career, she has been responsible for many operating room duties including serving as director of surgical services and staff development coordinator in an acute care hospital. Ms. Mack has also served on the CASA board of directors since 2003.

**Deann Manchester** — Ms. Manchester is vice president of development for United Surgical Partners International. Before this role, she served in various other roles at USPI, including director of financial modeling and analysis, where she performed valuations and due diligence for many of USPI's acquisitions and hospital joint-venture de novo projects. She is also the financial operations principal and a licensed registered representative of USP Securities, the broker dealer entity for USPI. Before joining USPI, Ms. Manchester was employed by Columbia/HCA, where she served in various capacities.

**Sarah Martin, RN, BS** — Ms. Martin is regional vice president of operations for Meridian Surgical Partners. She has close to 30 years of healthcare experience, focusing in the ambulatory surgery area for the past decade. Prior to joining Meridian Surgical Partners, Ms. Martin was the regional director of ASCs for Universal Health Services, where she managed both ASCs and specialty hospitals. She also worked as a regional vice president for Symbion Healthcare, covering the Midwest region. She was previously a board member for AAASC and is an avid supporter of state associations, helping to restart the Tennessee Ambulatory Surgery Center Association where she served as president and executive director.

**Dawn McLane, RN, MSA, CASC, CNOR** — Ms. McLane serves as chief development officer for Nikitis Resource Group. She formerly served as a vice president for National Surgical Care and developed and managed more than 10 surgery centers with NSC, Aspen Healthcare and independently. Ms. McLane has worked in the

hospital setting as director of surgical services and as a staff nurse in surgery, ER and OB. She is a AAAHC surveyor for ASC accreditation and Medicare certification and is also a book author and frequent speaker.

**Melody Mena, RN, CNOR** — Ms. Mena is director of surgical services for Southern Regional Health System and administrator of Spivey Station Surgery Center, both located in south metro Atlanta. Ms. Mena began her career as an x-ray technician and later became an operating room nurse. She then ran medical consulting firms for several years. In 2006, Ms. Mena became director of surgical services for the Surgery Center at Mt. Zion, a joint physician/Southern Regional Health System venture. She turned around the struggling ASC and transformed it into a successful profit center, relying heavily on making the center technologically advanced. Her success there led to additional responsibilities as she became director of surgical services for the entire Southern Regional Health System in 2008.

**Elaina Milliken** — Ms. Milliken is the administrator of Eastern Orange Ambulatory Surgery Center in Cornwall, N.Y., a joint venture with Facility Development & Management and community physicians at St. Luke's Cornwall Hospital System, and has served in this position since its inception. Before arriving at Eastern Orange, Ms. Milliken worked as an administrative director for a prestigious New York City medical center. According to her colleagues, her talent and experience has contributed to the successful implementation of operations at Eastern Orange, which includes the pivotal participation with the successful New York State Department of Health inspection and three-year accreditation from AAAHC.

**Evelyn Miller, CPA** — Ms. Miller serves as the vice president of development at United Surgical Partners International. She is responsible for the company's strategic direction of USPI's mergers and acquisitions efforts. She is also responsible for the financial analysis section of the development department, thus overseeing financial projections on all de novo projects. A certified public accountant, Ms. Miller began her career in healthcare as the system controller at All Saints Health System in Fort Worth, Texas (now a part of the Baylor Healthcare System). Before joining USPI, she was executive vice president of Medway Health Systems, overseeing the financial operations of its medical clinics.

**Amy Mowles** — Ms. Mowles is the owner of Mowles Medical Practice Management and is a leading expert with respect to pain management services provided in practices and provided in surgery centers. Ms. Mowles has successfully guided numerous new ventures and established ASCs and physicians' practices through the complicated maze of regulations, licensing, certification and accreditation processes. Her vast experience in managing and marketing physician practices and securing payor relations has helped them operate at maximum efficiency and profitability.

**Linda Peterson, MBA** — Ms. Peterson is CEO of Executive Solutions for Healthcare and has more than 30 years of experience in development and operational management of healthcare organizations. Her previous experience includes executive director for ambulatory care at The Joint Commission, corporate director of development/registered representative for HealthSouth, senior vice president of development for a startup ASC development company and ASC development consultant for a national ASC management and consulting firm. Ms. Peterson areas of expertise include the design, development and operational management of new business and product lines, mergers and acquisitions in the ambulatory service sectors for independent practices, groups, hospitals and integrated delivery systems.

**Randi Pisko RN, BSN, MHSA, CNOR** — Ms. Pisko is CEO of North Carolina Specialty Hospital, a National Surgical Hospital facility, located in Durham, N.C. Ms. Pisko has a 11 years of operating room experience and 16 years of experience in the management of surgical care delivery. She has worked in both non-profit and for-profit arenas, as well as acute care hospitals and ambulatory surgery centers. Ms. Pisko earned an undergraduate degree in nursing from LaSalle University in Philadelphia and a master's degree in health service administration from the University of St. Francis in Joliet, Ill.

**Linda Rahm —** Ms. Rahm is the administrator at Pioneer Valley Surgicenter in Springfield, Mass. The multi-specialty center performs GI, ENT, orthopedics, general surgery, urology and plastics procedures in its two operating rooms and four procedure rooms. Ms. Rahm has been with the center since it opened in 2003. She previously served as COO for multi-specialty group, CEO of a specialty hospital and skilled nursing facility, the administrator of an assisted living complex, regional director for a rehabilitation company and was an occupational therapist for a traumatic brain injury center. Currently, Ms. Rahm serves as the president for the Massachusetts Association of Ambulatory Surgery Centers and has been involved in several National Quality Collaborative projects.

**Lori Ramirez —** Ms. Ramirez is founder and CEO of Elite Surgical Affiliates, which develops, manages and co-owns ambulatory surgical facilities with surgeons. With more than 12 years of experience in surgical development, operations and management, Ms. Ramirez has successfully partnered with more than 350 surgeons, has played a critical role in recruiting more than 100 new surgeons and has been successful in restructuring and turning around failing partnerships. She has extensive experience in creating joint ventures with health systems such as Memorial Hermann in Houston and CHRISTUS Health System in South Texas. Prior to founding Elite, Ms. Ramirez was a senior vice president of United Surgical Partners International, where she was directly responsible for developing the second-largest network of surgical facilities for USPI in Houston. She oversaw 20-plus surgical facilities, including two surgical hospitals, one of which included an imaging center and three breast imaging centers.



**Lisa Rock —** Ms. Rock is president and CEO of National Medical Billing Services and has more than 20 years of experience in healthcare coding and billing. Previously, Ms. Rock served as vice president of business office operations and executive director for an ASC central business office and as director of training, education and communications for Mid-Atlantic Medical Services. While with MAMSI, Ms. Rock conducted all of the physician, ASC and hospital coding and billing training seminars. She also authored training manuals and was the MAMSI representative to the Maryland Ambulatory Surgery Association. Earlier in Ms. Rock's career, she held practice management positions in orthopedic, retina and cardiology professional offices.

**Marcy Rogers, MEd —** Ms. Rogers is president and CEO of SpineMark, Management Technology Resources and American Pain Management. For more than 30 years she has worked with leading healthcare professionals, facilities and medical device manufacturers to advance her goals of improving patient outcomes and satisfaction, as well as developing premier centers of excellence in multiple specialties. Ms. Rogers began building centers of excellence 19 years ago in the field of craniofacial surgery. Her focus on awareness and patient advocacy led her to spearhead legislation to create a National Craniofacial Awareness Week. Thanks to her efforts, U.S. Congress passed the bill in 1990.

**Karen Sablyak, CPA —** Ms. Sablyak is the CFO and executive vice president of management services at Physicians Endoscopy. With 10 years of experience in healthcare finance and operations, Ms. Sablyak's leadership skills and financial acumen have resulted in tremendous results in reporting and management at Physicians Endoscopy. She has particular expertise in billing processes, the development of policies and procedures, and the analysis and interpretation of healthcare financial data.

**Molly Sandvig, JD —** Ms. Sandvig is the executive director of Physician Hospitals of America. She has done an outstanding job advocating for physician-owned hospitals and her leadership on behalf of them has been instrumental in the ongoing debate about the rights for physicians to develop and hold ownership stakes in physician-owned hospitals. Ms. Sandvig also serves as the president of the South Dakota Association of Specialty Care Providers, representing physician-owned hospitals and ASCs in South Dakota. She is currently serving a second term as a governor appointee to the South Dakota Healthcare Commission. Ms. Sandvig is also a co-chair of the governor-appointed subcommittee on Universal Healthcare Access in South Dakota.

**Caryl Serbin, RN, BSN, LHRM —** Ms. Serbin is the president and founder of Surgery Consultants of America and Serbin Surgery Center Billing. Ms. Serbin has more than 25 years of experience in the healthcare industry, with the last 18 years spent in ambulatory surgery administration and consulting. Her companies provide development, management and billing services for numerous freestanding and hospital joint-venture ASC. As a recognized leader in the industry, Ms. Serbin presents extensively at ASC national seminars and association meetings, authors articles on ASC-related topics and contributes regularly to industry publications.

**Lisa Schriver, RN, CNOR —** Ms. Schriver is the administrator of Turk's Head Surgery Center in West Chester, Pa. The center is multi-specialty, freestanding surgery center that offers general surgery, GI, orthopedics, ophthalmology, ENT, urology, gynecology and podiatry. Ms. Schriver started with Turk's Head in 2005 when the center opened as its clinical director and was later promoted to become administrator. Prior to coming

to the center, she had a varied career in nursing and served in various departments including the operating room, endoscopy and perioperative. From there, she moved to a hospital-based ASC and became the nurse manager.

**Debra Stinchcomb, RN, BSN, CASC** — Ms. Stinchcomb is the director of operations preparation and transition management for Health Inventures. She has 25 years of healthcare experience including development, clinical, administrative, operations and sales. The last 14 years have been focused exclusively in the ASC industry with a particular emphasis on multispecialty centers. In that time, she has held positions as an ASC administrator, assistant regional vice president and regional vice president. Her responsibilities have included budget development and management, revenue and expense management, contract negotiation, licensing/certification/accreditation compliance, marketing, risk management, quality improvement and benchmarking. Ms. Stinchcomb is a past chair of the Foundation of Ambulatory Surgery in America and past board member of FASA. She was an AAAHC surveyor from 2001-2007 and is a member of the ambulatory Joint Commission Professional and Technical Advisory Committee.

**Donna St. Louis** — Ms. St. Louis currently serves as a vice president for diagnostics and outpatient services for BayCare Health System, which operates 14 diagnostic centers, four surgery centers, three wellness centers and retail medicine facilities. Before joining BayCare, Ms. St. Louis was a group president for Symbion, with responsibility for more than 45 surgery centers. Prior to her position at Symbion, Ms. St. Louis served as group president for HealthSouth. She presently serves on the board of the ASC Association and on the board of the Florida Society of Ambulatory Surgical Centers.

**Alsie Sydness-Fitzgerald, RN, CASC** — Ms. Sydness-Fitzgerald is chair of the ASC Association and served on the team that negotiated the merger of the two national ASC associations (FASA and AAASC). She has worked hand-in-hand for more than 30 years with ASC professionals throughout the country, including some of most highly-regarded ASC leaders and advocates from the industry's earliest days. Previous experience includes serving in a large number of volunteer ASC leadership and advocacy roles, including serving on Certified Administrator Surgery Center exam committee and chairing the FASA Annual Meeting Program Committee. Ms. Sydness-Fitzgerald retired from full-time employment as the director of clinical operations for HCA Ambulatory Surgery Division in 2005 and presently she owns and operates her own healthcare consulting company, Alsie Fitzgerald Consulting.

**Stephanie Tarry** — Ms. Tarry is senior vice president, business development for Nueterra Healthcare. Since joining Nueterra in 2000, she has successfully recruited physician partners and syndicated 22 ASCs and real estate private placement offerings, of which six have been joint ventures with hospitals. Ms. Tarry is a licensed securities representative knowledgeable in Reg "D" offerings. Her extensive background in finance and accounting allows her to thoroughly understand and explain the financial structure of the partnerships. She began her career with 12 years of banking experience. Before joining Nueterra, she served as the director of treasury for a major Midwestern integrated health system and, before that, as the treasurer for the largest school district in Missouri.

**Linda Van Horn, MBA** — Ms. Van Horn is the president and CEO of 21st Century Edge, a leading healthcare management consulting firm that specializes in working with pain management practices throughout the United States on the business aspects of establishing and improving pain practice operations and profitability. Ms. Van

Horn has more than 20 years of professional experience including six years as the president and CEO of 21st Century Edge, five years as the COO of The Pain Institute, where she helped establish pain management services at 22 locations in two states, and five years as a senior manager at Deliotte & Touche, a major accounting firm.

**Dianne Wallace, RN, BSM, MBA** — Ms. Wallace is executive director of Menomonee Falls (Wis.) Ambulatory Surgery Center and has been in this role for more than 10 years. Her career as a healthcare executive has included leadership roles in hospitals, home health agencies, medical groups and ambulatory surgery. She has presented nationally on issues ranging from leadership to managing a profitable surgery center. Ms. Wallace, a registered nurse, also holds an undergraduate degree in management and a graduate degree in business administration. She has also served as president of the ASC Assembly of MGMA and of the Surgery Center Association of Wisconsin.

**Lisa Weston, CPC-H, LHRM** — Ms. Weston is the director of the ASC coding division for The Coding Network. She employs 20 certified and ASC-experienced coders who code and audit for more than 100 ASCs across the country. Ms. Weston personally selects, trains, tests the proficiency of, and provides quality assurance reviews to these coders. Ms. Weston and her coders serve as the "insourced" coding staff for a number of regional and national ASC management firms, providing them with a corporate-wide level of uniformity and accuracy, ongoing coding, continuous quality improvement and compliance audit reviews of the accuracy of coding performed by others.

**Cindy Young, RN, CASC** — Ms. Young is the administrator of the Surgery Center of Farmington (Mo.). The multi-specialty center, which opened in 1999, has two operating rooms and two procedure rooms. Ms. Young has been at the Surgery Center of Farmington since it opened, starting as a staff nurse and moving into the administrator position in 2002. Prior to coming to the center, she was a nurse at a rural hospital for five years and served for two years in the operating room at the hospital.

**Peggy Zampetti, RN** — Ms. Zampetti is senior vice president of facility development and clinical operations for Titan Health. Ms. Zampetti joined Titan in 1999 from HealthSouth where she served as administrator and regional coordinator for Joint Commission accreditation. Previous positions include administrator and director of nursing for ASC Network. With more than 20 years of experience in ambulatory surgery development and operations, Ms. Zampetti has extensive experience in ASC design and construction to ensure compliance with regulatory requirements. She has personally developed 30 centers nationwide from design and construction to first case and has intimate knowledge of ASC licensure, accreditation and Medicare certification. ■

ADVERTORIAL

# CASE STUDY: MACKINAW SURGERY CENTER, SAGINAW, MI

Mackinaw Surgery Center

In 1998, Saginaw General Hospital merged with its long-time neighbor St. Luke's Healthcare Association to form the 600-bed Covenant HealthCare in Saginaw, Michigan. Nine years later, in 2007, Mackinaw Surgery Center, LLC, became free-standing and independent from Covenant.

In a trend seen nationwide, ambulatory surgical centers play a pivotal role in moving services out of hospitals and into less expensive yet clinically appropriate settings. Studies have proven that such centers have already been a beneficial partner to the Medicare program in constraining Medicare spending growth.

At the Mackinaw Surgery Center, one of the first steps was to seek accreditation. In order to be consistent with Covenant HealthCare's accreditation organization and because he had heard so many positive remarks, the center's administrator Steve Corl selected the Healthcare Facilities Accreditation Program (HFAP).

Two HFAP surveyors arrived at the Mackinaw Surgery Center, and Corl describes them as very friendly, exceptionally knowledgeable, and completely thorough. Always referring to the HFAP manual, the surveyors focused on solutions, not wrong-doing.

This was a breath of fresh air to Corl and his colleagues. The two-day process saved time and substantial money. It can truly be described as win-win.

"The HFAP survey process is straightforward, not vague" Corl said. "Mackinaw Surgery Center knows exactly what the regulatory expectations are without the guess work. This allows our center to be consistent in its operations and at the same time challenges our team to strive to be the best at what we do."

Mackinaw Surgery Center is committed to providing outstanding patient care in the Saginaw area. And HFAP is solidly behind it offering support, information and new ideas.

# 10 Steps to Improving ASC Profitability With Dr. Brent Lambert of ASCOA

**Written by Brent Lambert, MD, and Lindsey Dunn**

The profitability of ASCs across the country varies greatly, with some posting substantial profits while others suffer substantial losses. Industry reports estimate that roughly half of ASCs are just surviving, so it is more important than ever that ASC leaders take steps to increase revenue and reduce costs. Some of the traditional methods used by ASCs in the past to increase profits, such as refinancing debt, are not viable in the current economy. However, the following 10 steps, if implemented properly, can help ASCs significantly boost short- and long-term profitability and improve the likelihood of a center's success, even in today's economy.

**1. Recruit additional physicians.** Recruiting additional physicians is currently the single most important activity ASC leaders can do to improve profitability. Because the pool of available physicians in each market is diminishing, ASCs that are not actively recruiting unaffiliated physicians will find the opportunity to do so rapidly closing. Five to 10 years ago, recruiting physicians was fairly easy, but today, with the proliferation of outpatient facilities, the number of physicians that are not already aligned with an ASC is dwindling. In some markets, there may be no unaffiliated physicians to recruit. If ASCs are located in markets with available physicians, they should attempt to attract those individuals to the ASC.

Adding new investor-physicians further stabilizes an ASC's capital base and the patients that they bring to the center can improve revenue and profitability. ASC leaders should look to bring in physicians who have similar staff and equipment needs as the current owners and users in order to maximize economies of scale. Additionally, if your ASC complies with anti-kickback safe harbors, criteria for new physicians should include the following: 1) They will not discriminate against Medicare or Medicaid patients; 2) They are willing to receive distributions on a pro rata basis based on their ownership without regard to volume or value of referrals; 3) They generate at least one-third of their medical practice income from performing outpatient procedures on the Medicare ASC list; 4) If at a multi-specialty center, they will perform at least one-third of their procedures that can be performed at an ASC at the center they invest in; 5) They will not receive financial assistance from other partners of the center or the ASC itself to acquire their interest in the ASC; and 6) They cannot buy fewer or more shares or buy shares at a higher or lower price based on the volume or value of the referrals they could generate for the ASC.

**2. Review and renegotiate managed care contracts.** Renegotiating managed care contracts is one of the surest ways that ASCs can improve their profitability. Renegotiating contracts is relatively inexpensive. Thus, any reimbursement increases that result will flow directly to the ASC's bottom line. Having strong contracts is more important now than ever as many payors are taking actions to limit out-of-network payment to centers. ASCs should examine their contracts regularly to identify any weaknesses and renegotiate those contracts with payors. In many markets, ASC managers have negotiated rates between 110-150 percent of Medicare or higher. ASCs with contracts that pay a percentage of Medicare should also determine whether they are being reimbursed at national or local rates. In some situations, national rates may shortchange an ASC because local rates are higher. In these instances, ASC leaders may find success in arguing that the local rate is more appropriate.

If an ASC has signed a contract that is not reimbursing at satisfactory rates, the ASC should push for renegotiation. Even if a payor is not willing to pay a higher rate for all procedures, ASC leaders may be able to negotiate a higher payment for specific procedures. For example, a payor may increase reimbursements for more complex procedures or for the high-volume procedures at a center. In addition to negotiating separate fees for specific procedures, leaders can request add-on payments for certain supplies or costly implants. If payors are unwilling to provide reimbursement rates that meet case costs, then ASCs may want to walk away from the contract as treating patients covered by that payor will only take money away from the center.

**3. Know your costs.** Many ASCs do not fully understand their true costs and, as a result, may make decisions that are not in their best interest. ASC managers have the tendency to omit costs from their calculations. For example, when calculating staffing costs, staff benefits and taxes must be taken into account; supply costs must include the cost of shipping and transporting the supplies. Fully understanding both the fixed and variable costs per procedure is tremendously valuable for two reasons. First, this information allows ASC leaders to demonstrate to a payor that reimbursements for a procedure do not meet case costs. Second, it can help educate staff and physicians about avoiding wasteful practices.

Management information software packages are a key way to accomplish accurate case costing. When used appropriately, this software can accurately and easily determine your case costs. Once accurate case costs are available, ASC leaders should work toward reducing these costs. Discussing case costing at every monthly partner meeting and having partners brainstorm ideas to cut costs for every procedure is a great way to approach this task. Introduce your 10 highest volume procedures first and then work through additional procedures at additional meetings. Monthly income statements, including supply and staffing costs, should be distributed to all partners, and the ASC should financially benchmark the center against industry standards for supplies and staffing as a percentage of revenue.

**4. Reduce supply costs.** Many ASCs can reduce their supply costs, and doing so greatly impacts a center's bottom line. Even small supply cost reductions for your highest volume procedures can produce significant financial gain. For example, an ASC with 3,000 cases per year can realize a savings of $150,000 annually by reducing per case supply costs by $50.

Reducing supply costs requires buy-in from physicians on reducing wasteful spending and, if possible, agreeing to standardize the supplies used for each procedure. ASC management must also be willing to evaluate competing bids for supplies, either from group purchasing organizations or from individual vendors. GPOs provide members with negotiating clout that an individual ASC may lack, which may help in lowering your supply costs. However, ASCs may find that, for some supplies, lower prices can be found directly from suppliers. As a result, ASC leaders should still seek multiple competing bids directly from vendors to compare to the cost of the supply through the GPO. Although this can be time consuming, any cost savings that can be realized will directly reduce case costs. Consolidating the purchase of more supplies from fewer vendors will also help to reduce costs. The more an ASC buys from one vendor, the more bargaining power it has to get better pricing.

**5. Reduce staffing costs.** Many ASCs are overstaffed, which produces unnecessary costs. ASCs should review their staffing costs and full-time equivalent personnel and reduce staffing accordingly. As staffing is the biggest expense for many ASCs, this type of reduction can directly benefit a center's bottom line. Paying staff to wait between cases is extremely inefficient and can be easily remedied by switching to part-time staff and scheduling cases appropriately. Additionally, educating physicians about the staffing

costs associated with starting cases late (which is said to be as much as $18 per minute in the OR by some reports) and working to shorten turnover time in the operating room can also benefit the ASC.

Hiring practices should favor part-time staff over full-time staff. Part-time nurses and technicians that can be sent home when cases are done do not require benefits. Also consider cross-training staff to perform more than one function. Even if they are paid more per hour for their additional responsibilities, total staffing costs will be reduced.

ASCs should also compress schedules into fewer days, if possible, or at least reduce gaps in which staff would be paid but not utilized. As a general rule, ASCs should not open the center on days with fewer than six cases. If a day has less than six scheduled cases, they should be moved to a another day. An ASC open only three days a week could be more profitable than a center open five days, if the scheduling of cases for the five-day center was done inefficiently.

In addition to variable costs such as supplies and labor, ASCs should consider the impact of fixed costs, such as the facility's mortgage or lease, on per case costs. If an ASC owns or leases more space than it needs to perform its cases, its leaders should consider alternative uses of the extra space. Some ASCs have leased additional space to investing physicians for medical offices, and others have leased to outside groups, such as physical therapy and sleep study organizations. Leasing out space that is not utilized by your center generates income that reduces case cost and increases profitability.

**6. Limit capital expenditures.** ASCs should limit capital expenditures to only that equipment which is necessary to improve patient care. Equipment that does not directly improve care should not be purchased. Surgeons have the tendency to want the latest technology for performing certain procedures, but these new "gadgets" do not always directly correlate with improved outcomes.

In today's economic climate, it is more important than ever that ASC leaders restrain from making these types of purchases. One strategy that often works is to aim to pay cash out of the ASC's monthly profit distributions (see #7 below) for all new equipment. This prompts physicians to perform a more careful cost-benefit analysis of purchases and is likely to limit excessive expenditures.

**7. Start or convert to a monthly profit-distribution plan.** ASCs that do not already have a monthly profit-distribution plan should use this approach. Distributing profits on a monthly basis is a powerful tool in getting investor physicians to focus on the financial performance of the center. Investors receiving monthly profit checks and financial performance reports are often more willing to eliminate wasteful practices and actively seek out additional, perhaps innovative, ways to reduce costs. A monthly profit distribution plan could include distribution of a moderate monthly amount to investors — just enough to reflect the cash flow improvement of the ASC. Even small distributions — as low as even $500-$1000 per month — can be effective in cultivating a financially responsible mindset among investors.

**8. Offer buyback options.** ASCs should consider regularly offering to repurchase shares held by existing owners who are not safe harbor compliant or are no longer fully involved with the center, either through a reverse auction process or through voluntary or, in some cases, required redemption. An ASC may offer to buy up to a specified amount of shares based on the lowest price at which parties will offer to sell back those shares. Inves-

tors who do not comply with relevant ASC safe harbors or those nearing retirement are good candidates for buyback options.

**9. Amend your operating agreement.** ASC operating agreements should be reviewed on a regular basis and amended if necessary, and ASC leaders should consider adding provisions regarding redemption of shares and competition restriction, if they are already not included in the agreement. As a general guideline, operating agreements should be amended long before there is a perceived need to do so. Otherwise, there may be difficulties in persuading existing investors to vote for changes that may be needed. Agreements may also need amending in response to changes in state and federal laws governing ASC ownership and financial relationships.

If a majority interest of your ASC is owned by physicians who are not safe harbor compliant, either because they are no longer practicing medicine or because they use other facilities regularly, the viability of the center is jeopardized. Limited shares are available to attract new physicians with the potential to increase volume. Thus, ASC owners may want to consider adopting operating agreements that include provisions requiring physicians to redeem their investment if they no longer meet safe harbor requirements or upon their retirement, disability or death.

If an ASC's operating agreement does not include a non-competition covenant, it may benefit from amending its operating agreement to include this. Five to 10 years ago, many ASCs were founded without non-competition covenants, which typically restrict physicians from owning interests or having compensation relationships with other ASCs in a narrowly defined geographic area. However, as interest in outpatient facilities continues to grow, ASCs without these covenants are at risk as strong investor physicians decide to invest in another center or develop their own. Additionally, the diminished pool of unaffiliated investors restricts the ability that ASCs have to bring in additional physicians in to recoup volume and revenue.

**10. Consider strategic partnerships.** Finally, ASCs may benefit by entering into strategic partnerships with third-party management companies or a potential joint-venture party. Independent ASCs that go it alone may not have capable billing and collection systems or administrators with managed care contracting experience, both of which are required for success. ASCs need to be realistic about their own capabilities, and seek out third parties for their expertise, when necessary. ASCs should be careful to evaluate any partners as the quality of various management and billing and collection companies varies substantially.

An ASC may also consider bringing in a hospital joint-venture partner. Hospitals are increasingly recognizing the competition ASCs create for them as well as the value and the efficiency of ASC-based outpatient surgery. As a result, they are now more than ever willing to consider partnerships with ASCs. A hospital partnership can bring more patients to a center and may help obtain managed care contracts that would not be available otherwise. ■

*Dr. Brent Lambert is a co-founder of Ambulatory Surgical Centers of America and is currently responsible for supervising all of its business development. Learn more about ASCOA at www.ascoa.com.*

# 10 Lessons Learned From Turnarounds

**By Tom Mallon, CEO, Regent Surgical Health**

Often working smart is just as important as working hard. Through our experience developing and managing ASCs and physician-owned hospitals nationwide, we've identified 10 common lessons learned in turnaround situations.

The following are a list of the top 10 lessons we have learned for avoiding the red and improving a center's financial health.

### 1. Bad contracts with payors place you in the fast lane to bankruptcy.

Contracting is critical to a center's success. Follow the simple rule that contract rates can never be below costs.

We recommend contracting with every payor who controls more than 10 percent of commercial patients. When negotiating, focus on the rates. Most contracts still trade from old Medicare base rates of 110 percent to 180 percent. Medicare rates, however, can be devastating when most centers need 150 percent to just break even. If payors sell your rates to other payors, you have just written off the most profitable part of your business — the small, out-of-network payors. For example, imagine negotiating an aggressive deal with one payor who represents 10 percent of your business. That payor then sells your contracted rate to 10 other payors who represent two percent each of your business. Now that aggressive deal is being offered to 30 percent of your patients.

The worst contract we have seen was at a facility in Ohio. The prior administrator signed with a national payor under a three-year term with no opportunity to cancel. The rate was 110 percent of Medicare and included anesthesia fees. We ended this contract, increased charges to the 80th percentile, established a separate business office in the surgery center and immediately hired a biller. The changes were significant and the results immediate.

### 2. Without a scientific method for determining a chargemaster, you risk giving away the only high-margin business available.

Most centers set their charges at two to three times the old Medicare rates. With break-even at 150 percent of those rates, these centers need to achieve a collection percentage around 50-70 percent, which is unheard of in this industry.

To set a reasonable market chargemaster, we use the Ingenix database. In facility billing, the data is skewed to the high side, not the low side. That is why carriers will not agree to a blanket 50-percentile reimbursement for out-of-network cases. Nevertheless, using Ingenix rates for facility billing does result in actual collections sufficient to provide solid investor returns.

### 3. Recruiting the right doctors is as much about attitude as it is about specialty.

Physician partners make or break ASCs and small physician-owned hospitals. Often, the founding physician is the spark to start the venture but lacks the relationships necessary to attract enough colleagues. A profitable and functional partnership must have the right number and kind of doctors as well as a business model that keeps them involved over the long term.

Any physician venture needs to have the "A Team" as its core. You cannot attract the A

Team if you start with B players. To find the elite, form a relationship with a senior anesthesia provider who knows all the surgeons in the community. He or she knows who is fast, efficient and cost effective, and is aware of who is difficult to work with. Also, look for the top surgeon in a desirable specialty — either high reimbursement and low to moderate volume (such as spine, orthopedics and ENT) or low reimbursement and high volume (such as pain, GI and ophthalmology).

The business model that works well in today's post-Stark environment is a smaller group of physicians committed to supporting the business and bringing at least one-third of their cases to the center.

### 4. Even with the right surgeons, an inferior management team and administrator can lead to financial disaster.

In the case of one center, surgeons had built the center, hired a management company and opened the multi-specialty center. Although they handled a fair share of specialties in four operating rooms, the center didn't turn a profit in its first two years of operation. Twice, the center issued cash calls.

As the surgeon owners became dissatisfied, they sought a new management company to turn the center around. One of the first things Regent did was hire a new administrator, unify the physicians and bring in new doctors and specialties to support the center. Within six months of Regent's partnership, the center made its first distribution to members.

Three years later the largest healthcare systems in their area approached this thriving center for a hospital partnership. The joint venture has enhanced the center's revenue by providing access to new payors through its managed care contracting. Also, the center has been able to reduce expenses by taking advantage of lower equipment and instrumentation prices through its group purchasing contracts. The three-way partnership makes sense, and each party's expertise is leveraged to contribute substantially to the partnership through cost savings, quality of care and growth.

### 5. Without an exemplary director of nursing, you are like a salmon swimming upstream.

Critical to clinical excellence and cost containment, a director of nursing walks a fine line between the staff's and the owners' competing priorities. The right DON identifies waste and inefficiency and establishes the clinical team's discipline for abiding by the accreditation and quality programs needed to maintain licensure and provide excellent care.

The wrong DON carries a chip on his/her shoulder in regard to the physician partners. Reacting to years of perceived slights by physicians in hospital environments, this person has been trained to "protect the patient" (i.e., tell the doctor what he can and cannot do). This, of course, is not the team spirit that makes our facilities run smoothly. Although these nurses may be excellent from a clinical standpoint, we cannot afford self-righteous and inflexible attitudes. It ultimately hurts patient care.

### 6. An unhappy staff leads to poor patient and physician satisfaction.

Invest in your people. Create a strong human resources program and cultivate an internal culture. Our goal is to select staff based on our corporate values — Respectful caring, Integrity, Stewardship and Efficiency (RISE). These values guide us in our interviews, goal setting, reviews, communication, training and leadership development.

This is a journey for us, not a destination. Over time, we have seen a huge improvement in our staff and our leaders. Without a strong, dedicated employee base, a center has no legs to stand on. Soon after the grand opening of our new Surgical Hospital of Munster, record-breaking rain hit northern Indiana. The chief operating officer contacted employees and enlisted their help to move $1 million in surgical equipment from the first floor to the second before losing power and use of the elevators. In less than 90 days after the flood, the very determined Regent team and hospital staff had the facility ready to reopen.

### 7. ASCs that wait until the end of the month to understand their cash position typically throw money away daily.

In our first turnaround project, we found a vendor account payable for more than $70,000. Based in Santa Barbara, Calif., the vendor sold penile implants. We quickly assessed that Medicare patients received the implants However, Medicare not only refused to pay for the implants, it did not even pay for the procedure because it was unapproved. The lesson here is manage your supply and labor costs.

Our surgery facilities order more than 2,000 SKUs (individual units). To protect ourselves, we use an electronic ordering system that matches our pricing to the agreed upon discount. If the price is incorrect, the system holds the order, giving purchasing time to talk with the distributor. The software also alerts us before a commitment letter expires, allowing us to renew and avoid price increases. Because physicians select implants, this supply is a greater challenge to control. If our physician partners allow us to choose between several vendors, however, we often achieve remarkable discounts.

Labor represents more than one-third of most surgical facilities' costs. Success depends on flexing labor to meet the ebbs and flows of our business. To achieve this, either make a deal with full-time employees to flex in and out based on the case schedule or minimize the number of full-time employees and hire a facility-based registry of per diems. Travelers are not a good option at any time — their unfamiliarity with the facility and surgeons is unacceptable.



### 8. High revenues per case and volume solve almost all problems.

When we look at a turnaround situation, the center is either doing very few cases at a reasonable reimbursement rate or many cases at a low reimbursement rate. These two situations result from very different mistakes.

Too few cases typically indicate that the physician partnership failed. The busiest surgeons either did not join the venture or they left after several years. This leaves a gaping hole in the schedule and creates an unprofitable, underutilized facility.

If a large physician partnership pressures the center to do "all" cases, this also creates underperformance. Administrators often sign contracts without calculating the average reimbursement per case. For example, one center previously performed 800 cases per month and lost more than $1 million per year. The center only achieved an average reimbursement of $850 and performed no out-of-network cases. The center increased its contracts and out-of-network business and increased its profits dramatically.

### 9. Too many ORs can cause gaps in the schedule and unnecessarily high labor costs.

If you open early and have people waiting in between procedures, you're going to run into financial problems. Fully staffed empty rooms drain the economic viability of centers. We engage the board and anesthesia to establish criteria for adding rooms, and we make sure the scheduler supports protocols and communicates any issues to the administrator.

The sooner you realize that outside schedulers are key, the easier it will be to run an efficient, profitable center. In a busy practice, scheduling is a thankless job. Our challenge is to make schedulers' jobs easier, not harder. Market to outside schedulers by visiting them often, developing good relationships, listening to their concerns and making adjustments.

### 10. High debt service facilities with limited working capital equals failure.

In its simplest form, capital structure is the balance between the amount of debt and equity used to fund the facility. The danger in a thinly capitalized transaction surfaces when pre-opening costs exceed budget, revenue ramp-up is longer than anticipated and the eventual level of profits achieved are less than predicted. Without a balance between the amount of debt and equity used to fund the facility, the facility is in danger of not producing enough to pay the bills.

Another aspect of capital structure is the source of the debt capital. We recommend using one source to fund both tenant improvements and equipment. Not only is this easier, it may be less expensive than handling the two separately. In turnaround situations, we frequently see multiple loans and separate leases. The terms and covenants of these various finance sources frequently conflict with each other, making loan administration almost impossible.

Capital structure alone will not guarantee the success of your facility, but if constructed improperly can cause misery in an otherwise well conceived business.

### Conclusion

The biggest lesson that we have learned is that no matter how strong your clinical outcomes, if you don't run the surgery center as a profitable business it will not last long. ■

*Mr. Mallon is the founder and CEO of Regent Surgical Health. At Regent we are proud of our track record: 100 percent of the centers and hospitals we have opened and/or turned around are profitable, and solidly so. Learn more about Regent at www.regentsurgicalhealth.com.*

# ASC Leaders Share Advice and Experiences About 5 Critical Management Issues

Successful ASC leaders draw upon a career's worth of knowledge and experiences when making decisions that impact their centers. Here, four ASC leaders discuss the best advice they have received and the advice they would give to other leaders in their field on five management issues.

## On decision-making:

"Always make decisions based on: first, the patient; second, the business; and third, the staff, because without one and two, you don't have three." — Margaret Acker, CEO, Blake Wood Medical Park Surgery Center, Jackson, Miss.

"Always do the 'right' thing. This means be honorable, weigh your options to ensure your decision is sound ethically, legally and humanely, and is what is best for the facility/organization." — Sarah Martin, regional vice president of operations, Meridian Surgical Partners

## On staffing:

"Surround yourself with nice people who are talented. A nice person can be taught any skill, but a skilled person cannot be taught to be nice." — Barbara Draves, administrator/owner, The Surgery Center, Middleburg Heights, Ohio

"The key to running a successful facility is having a staff that is exceptional with varying talent areas. Have experts in every specialty, and have them cross-train the others so that you don't become solely reliable on one nurse or tech for specific specialties. It's okay to let the doctors have the tech or nurse they feel the most comfortable with on their block days, but make sure you mix in the other techs and nurses to set everyone up for success. Work tirelessly to make sure the relationships between your surgeons and your staff remain positive. It's much easier to keep it that way, than fix it once it goes awry." — James McGehee, administrator, Cleburne (Texas) Surgical Center

## On resignations:

"Once someone has submitted their resignation, let them go. Do not try to get them to stay. They have already made their mental decision to leave, and if they do stay, my experience has been that the stay is brief and they move on. Whatever is causing them to want to move on is still there within them." — Ms. Martin

## On managing:

"I think back to one of my mentors who told me to never get so far away from the frontlines that you lose touch with what you are doing. Whether you are a clinical administrator or a business administrator, take time to go in the back and work side by side or observe your clinical staff on a busy day. As a clinical administrator I try to occasionally work in the clinical area to keep my skills current and build employee relations. The drawback is if you spend much time in the clinical area, you get behind with the administrative side." — Mr. McGehee

"The best decision I've made for my ASC was encouraging the staff to seek certification in their specialties in order to reach to top of our pay scale. We now hold board certifications in every area including medical staff, coding, ambulatory nursing, scrub tech and administration. We have folks actively pursuing CNOR and infection control. This sprouted a Blake Woods Journal Club, and has helped to make our environment one of continuous learning." — Ms. Acker

"Don't let that word 'administrator' go to your head. For a successful ASC you need to be able to mop a floor, change oxygen tanks, shovel snow, schmooze doctors, hug nurses, unload supply trucks, negotiate insurance contracts, understand quality and never take your eyes off the numbers. The simple definition for an ASC administrator reads 'Do Everything.'" — Ms. Draves

## On personal development:

"Develop a great voracious appetite for reading, because it's a daily activity if you plan to stay current." — Ms. Acker

"Mentor and appreciate the employees. You get paid for the work they do." — Ms. Acker

"Have Fun. Running an ASC has to come from your heart. If you are not having fun, find another job." — Ms. Draves ■

# How Much Should a Surgery Center Administrator Be Paid?

**1. Todd Flickema, MBA, senior vice president, Surgical Management Professionals:** You need to first ask what level of an administrator you need for the facility. This will be dictated or at least heavily influenced by the size of the facility, types of cases, number of partners and the political climate of the area all feed into this. For example, at one center you may have a single specialty and the partners may all be from the same clinic. In this situation it may be very prudent to operate the facility with a DON Administrator who has or can be provided with adequate business support.

Then go to the other extreme. The next center may be a large multispecialty center in a competitive market. Now you will be talking about an executive with healthcare management experience. Most of the people that fit this category will either come from or did come from a hospital setting. You are now competing with hospitals for this executive and will be paying salary and benefits commensurate with that level of individual.

We find that many centers we have gone into the owners tend to go the less cost route and in some cases short change themselves. This is understandable as the owners don't always have a full appreciation for the level of complexity of running these centers. The complexity of the industry has really grown quickly and so we think more and more centers may be in that area of either not knowing what they don't know or having that suspicion of maybe there is a better or different way we should be doing things.

**2. Jim Stilley, FACHE, CASC, CEO, Northwest Michigan Surgery Center (Traverse City, Mich.):** First, agree on a common description of administrator. There are all types of administrators, even in the ASC industry. When you have an administrator that can create a desirable "investor and employee" culture, support quality clinical decision making and run a highly successful business ... pay them whatever they want because they are definitely worth it!

Here are some little discussed items that an advanced administrator can do for your center — just of the few things I have done in the last few months in addition to the day-to-day management:

- Negotiate insurance contracts, carving out implants, for under-reimbursed cases resulting in $200,000 in net revenue.
- Lead, cultivate and create revenue streams instead of managing and maintaining existing ones.
- Recruit and retain profitable case generating physicians.
- Renegotiate increased healthcare benefits and coverage at a zero percent increase to center or employees.
- Renegotiate natural gas futures to a fixed rate that saves $2,000 a month in energy cost.
- Select and manage a 401K plan with above 14 percent return in a down market.
- Oversee and successfully refute state government "fishing expeditions" for use tax and personal property tax increases.
- Understand insurance premiums, limits and deductibles for myriad

of insurance policies needed to run a multimillion dollar business. Medical malpractice premiums can be whittled down by understanding how they are created (I cut mine by $20,000 this year).

- Provide leadership in tough situations, i.e., work with and oversee peer review, working toward solutions with physicians and even firing a popular staff member who cannot maintain the high level of patient safety our industry demands.
- Provide behavior counseling and encouragement to staff members (all the time knowing that your evenhanded actions will never be known beyond your office).
- Visit and provide job assurance to four loved and valued team members in the hospital after they are diagnosed with various types of cancer.
- Get called in the middle of the night for myriad of alarms, boiler and air handlers' issues, auto accidents and other staffing dilemmas.
- Work an average of 55-60 hours per week.
- When cases drop 10-15 percent because of a weak economy, develop plans that retain jobs and give positive leadership comments to scared employees who are worried about their household incomes.
- Make the unpopular but needed decisions on low census and staffing levels.
- Find and retain talented RNs and staff members who are priceless while still feeling confident to release those that aren't (many times leaving yourself extended rather than retaining a potential quality issue).
- Ensure that your word is your bond — always under-promise and over-deliver.

As I see it, the real problem with executive pay is that the value is in the eye of the beholder. It isn't until you lose a great CEO/administrator that boards realize their benefit. The decay caused by their loss may not be felt for several years.

**3. Anonymous:** ASC administrators should be paid based on the number of ORs and procedures performed in their ASC. I receive $110,000 per year for six ORs. I think that is a fair wage with 10 years ASC administration experience, and an MBA and CASC.

I think that wage should extend to $130,000 per year as a range. I also do not believe that for six ORs, you should receive less than $95,000 per year.

**4. Anonymous:** I think the compensation should include either 1) an ownership stake if permitted by law or 2) a healthy bonus opportunity to encourage the administrator to focus on the same things that the physicians do.

Those elements work — I know because I have one.

**5. Anonymous:** An administrator salary should depend on the number of ORs, facility volume, geographic location, clinical background and profitability of the center. I find that the salary surveys are often completed by a small number of facilities skewing the results.

I am very active in the New Jersey surgery center community and am often called by head hunters for positions in the tri-state area. For a three-room facility with around 4,500 cases a year, I see most places offering $120-140k as a base salary based on experience. In addition, I have known of centers that give the administrator a bonus from 0.5-2 percent of owner distributions or net profit. I also know of centers that the administrator is able to buy a percent of over a certain period of time. I know several administrators in New Jersey whose year end compensation was between $150-250k. ■

*Note: Share your thoughts on this question by e-mailing Scott Becker (sbecker@mcguirewoods.com) or Rob Kurtz (rob@beckersasc.com).*

# Statistics on ASC Staff Salaries

Here are some interesting statistics on the salaries and hourly wages of staff members at ASCs from VMG Health's *2009 Intellimarker*.

## ASC administrators

1. The average ASC administrator earns $98,940 annually, up about 2.9 percent from last year's average of $96,071, as reported in VMG Health's 2008 Intellimarker. The median is $101,348.

2. Here is the average ASC administrator annual salary by region of the country:
- West — $107,219
- Southeast — $106,299
- Northeast — $100,942
- Southwest — $100,000
- Midwest — $89,000

3. Here is the average ASC administrator annual salary by the number of operating rooms in a surgery center:
- 1-2 ORs — $92,976
- 3-4 ORs — $103,054
- More than 4 ORs — $101,171

4. Here is the average ASC administrator annual salary by the number of cases a surgery center performs in a year:
- Less than 3,000 — $95,306
- 3,000-5,999 — $99,436
- More than 5,999 — $103,126

5. Here is the average ASC administrator annual salary by the total net revenue of a surgery center:
- Less than $4.5 million — $100,000
- $4.5-$7.0 million — $100,877
- More than $7.0 million — $104,084

6. For ASCs that perform more than 50 percent of their cases in orthopedics, the average annual administrator salary was $98,386, with a median of $104,998.

## Nursing staff

7. The average hourly wage for ASC nursing staff was $31.42, up from last year's average of $29.33. The median was $30.79.

8. Here is the average hourly wage for ASC nursing staff by region:
- West — $34.53
- Northeast — $32.01
- Southwest — $30.57
- Southeast — $29.07
- Midwest — $27.36

9. Here is the average hourly wage for ASC nursing staff by the number of operating rooms a surgery center has:
- 1-2 ORs — $31.49
- 3-4 ORs — $30.35
- More than 4 ORs — $31.11

10. Here is the average hourly wage for ASC nursing staff by the number of cases a surgery center performs in a year:
- Less than 3,000 — $33.03
- 3,000-5,999 — $30.57
- More than 5,999 — $30.11

11. Here is the average hourly wage for ASC nursing staff by the total net revenue of a surgery center:
- Less than $4.5 million — $30.35
- $4.5-$7.0 million — $30.17
- More than $7.0 million — $30.89

12. For centers that perform more than 50 percent of their cases in orthopedics, the average hourly wage for ASC nursing staff was $30.88, with a median of $30.80.

## Technical staff

13. The average hourly wage for ASC technical staff was $19.53, up from last year's average of $18.28. The median was $19.09.

14. Here is the average hourly wage for ASC technical staff by region:
- Northeast — $21.81
- West — $21.22
- Southwest — $18.97
- Southeast — $18.67
- Midwest — $18.12

15. Here is the average hourly wage for ASC technical staff by the number of operating rooms a surgery center has:
- 1-2 ORs — $19.35
- 3-4 ORs — $19.48
- More than 4 ORs — $19.20

16. Here is the average hourly wage for ASC technical staff by the number of cases a surgery center performs in a year:
- Less than 3,000 — $20.95
- 3,000-5,999 — $18.87
- More than 5,999 — $18.90

17. Here is the average hourly wage for ASC technical staff by the total net revenue of a surgery center:
Less than $4.5 million — $18.80
$4.5-$7.0 million — $18.84
More than $7.0 million — $19.35

18. For centers that perform more than 50 percent of their cases in orthopedics, the average hourly wage for ASC technical staff was $19.65, with a median of $19.06.

## Administrative staff*

19. The aver.age hourly wage for an ASC's administrative staff was $22.19, up from last year's average of $19.42. The median was $21.65.

20. Here is the average hourly wage for ASC administrative staff by region:
- Northeast — $23.68
- West — $23.30
- Southeast — $23.15
- Midwest — $20.93
- Southwest — $20.57

21. Here is the average hourly wage for ASC administrative staff by the number of operating rooms a surgery center has:
- 1-2 ORs — $22.11
- 3-4 ORs — $22.32
- More than 4 ORs — $20.82

22. Here is the average hourly wage for ASC administrative staff by the number of cases a surgery center performs in a year:
- Less than 3,000 — $22.74
- 3,000-5,999 — $22.47
- More than 5,999 — $21.32

23. Here is the average hourly wage for ASC administrative staff by the total net revenue of a surgery center:
- Less than $4.5 million — $21.72
- $4.5-$7.0 million — $21.68
- More than $7.0 million — $21.06

24. For centers that perform more than 50 percent of their cases in orthopedics, the average hourly wage for ASC administrative staff was $20.91, with a median of $20.84. ■

** "Administrative staff" can include all employees other than nurse and tech FTEs. Depending on what the ASC outsources with respect to back office functions (billing/collections, mgmt services, accounting, HR, etc.), this can include receptionists, administrators, insurance verifiers, schedulers, transcriptionists, coders, billing/collections staff, medical records staff and accounts payable staff.*

*To receive a free copy of VMG Health's 2009 Intellimarker, visit www.vmghealth.com.*

# 12 Critical Areas of Focus to Increase Your ASC's Reimbursement

**By Caryl A. Serbin, RN, BSN, LHRM**

In today's economically challenging environment, it's imperative that your facility is billing and collecting the maximum reimbursement possible (while still remaining compliant). While there are no miracles to increase your bottom line, there are plenty of practical and inventive measures your administrative and business office staff members can institute to generate multiple incremental increases in your facility's earnings. Here are 12 areas of your business operation you can focus on to increase your ASC's reimbursement.

## 1. Fee schedule

Have you reviewed your fee schedule recently? Many ASC fee schedules have deficit areas where they are not charging as much as Medicare would pay. Depending on your findings, this may result in a significant increase in revenue.

Take the time to do a comparison. Prepare a spreadsheet with your fee schedule and the current Medicare ASC fee schedule (wage adjusted for your area). An example (Table 1) is provided below. Determine the multiplier you want to use – this example is using 350 percent. In the last column, select whichever is highest, as demonstrated by the example below: your fee (green) or 350 percent of Medicare (yellow). You can also consider setting a minimum fee such as the $1,200 illustrated in pink as opposed to 350 percent of Medicare. Prepare a recommended fee schedule and present it to your board.

| CPT | DESCRIPTOR | YOUR FEE SCHEDULE | 2009 MCR | 350% OF MCR | SUGGESTED FEE SCHEDULE |
|---|---|---|---|---|---|
| 10121 | Remove foreign body | $2,104.00 | $537.76 | $1,882.16 | $2,104.00 |
| 10180 | Complex drainage, wound | $2,104.00 | $612.58 | $2,144.03 | $2,144.03 |
| 11404 | Exc tr-ext b9+marg 3.1-4 cm | $1,571.00 | $482.66 | $1,689.31 | $1,689.31 |
| 11406 | Exc tr-ext b9+marg > 4.0 cm | $2,104.00 | $537.76 | $1,882.16 | $2,104.00 |
| 20670 | Removal of support implant | $1,571.00 | $482.66 | $1,689.31 | $1,689.31 |
| 20690 | Apply bone fixation device | $2,104.00 | $811.62 | $2,840.67 | $2,840.67 |
| 27816 | Repair ankle fx | $1,000.00 | $82.40 | $288.40 | $1,200.00 |
| 29881 | Knee arthroscopy | $4,090.00 | $901.24 | $3,154.34 | $4,090.00 |
| 31267 | Endoscopy, maxillary sinus | $2,405.40 | $721.74 | $2,526.09 | $2,526.09 |
| 42820 | Remove tonsils and adenoids | $2,405.00 | $745.84 | $2,610.44 | $2,610.44 |
| 45380 | Colonoscopy with biopsy | $2,104.00 | $400.00 | $1,400.00 | $2,104.00 |
| 62310 | Inject spine c/t | $1,571.00 | $310.74 | $1,087.59 | $1,571.00 |
| 62311 | Inject spine l/s (cd) | $1,571.00 | $310.74 | $1,087.59 | $1,571.00 |

Highlighted fees in yellow indicate where 350 percent MCR fully-implemented rate is greater than current fee (green). Consider increasing fee.

Highlighted fee in pink indicates minimum fee of $1200.

*Note:* Depending on area's prevailing fees and your complementation, the multiplier may be varied.

## 2. Payor contracts

Carefully review your contracts. Start working on your negotiations at least six months prior to renewal date — it usually takes that long. Several critical processes and factors to consider in this process include:

- make a list of your ten most common procedures — do case costing;.
- case cost procedures that you do that are cost intensive (i.e., implants, manhours, OR time, costly equipment, etc.);
- if your figures are based on Medicare rates, they are probably the lower rates from 2006 or before; you'll want to aim for fully implemented Medicare rates (2011) if possible;
- implant reimbursement — at least cost plus shipping and handling; and
- multiple procedure discounts — aim for Medicare rules, 50 percent for all procedures after first.

Depending on how long ago you renegotiated your contracts, you may be surprised at the improvement in revenue you can enjoy by doing some upfront homework and persistence.

## 3. Insurance verification

Stress the importance of verifying coverage and benefits to your staff. No verification or lack of sufficient information often negates or delays claim reimbursement. In most cases, verification of Medicare coverage online is fine. However, for most managed care companies, usually it's necessary to make human contact to get all the necessary benefit information. Develop an insurance verification form and incorporate at least the following

| | |
|---|---|
| Verify patient eligibility and SS# | Verify contract holder name and SS # |
| Type of contract – PPO, POS, indemnity | Effective date |
| Network | Pre-existing clause |
| Second opinion clause | Precertification or authorization number |
| Amount of copay or deductible met | Coverage percentage |
| Maximum out of pocket amount | Lifetime benefits |
| Verify claims address | Name of contact person |

For out-of-network patients, workers compensation and other types of cases, additional information is required.

## 4. Patient financial counseling

This is often the first contact between the ASC and the patient, and this call will set the stage for how the patient views the ASC. Be understanding and caring but firm, and follow these best practices:

- Call far enough in advance (minimum of 3 days); be considerate of the fact they may have to adjust their finances.
- Inform them that their company's representative advised you how much of their insurance contract's copay and/or deductible was unmet. Stress the fact that it is their company and their contract but you will gladly submit the claim for them.
- Explain fully their economic responsibility and the center's financial policy of collecting this amount (the fair share) prior to surgery.
- Ask them how they would like to handle payment — offer cash, check, credit cards, healthcare financing (for larger amounts).
- Remember the economy is hitting them hard as well. If necessary, offer the alternative of a signed promissory note with a maximum of 90 days. Holding a note any longer than that is cost prohibitive.
- If they do not have a secondary insurance, remind them that they will also be receiving a statement for the balance that the insurance does not allow.

The success of upfront collections is much greater than trying to collect after the service has been provided. The amount of money that can be saved by not having to send statements is phenomenal.

## 5. Physician dictation

Get your physicians' buy-in on helping the center obtain optimal reimbursement by providing detailed operative notes. Provide your physicians with hints on dictation to obtain better reimbursement, including:

- spelling of patient's name;
- site orientation (left, right);
- description of complexity (more than one compartment, extra time, complications encountered);
- detailed diagnosis;
- size of excision (not just size of lesion); and
- implant description, etc.

## 6. Coding

Having a certified coder is your best choice. Having a certified coder who is experienced in ASC or surgical coding is even better. This type of coder can usually optimize your coding and increase your billable revenue far beyond the possible difference in salary of a less experienced coder. A good coder can:

- read and understand the entire operative note, not just the title;
- be aware of possible procedures that may have been performed but not explained fully;
- asks physician if further details might substantiate additional codes;
- understands compliance in coding and billing, and follows all rules and regulations; and
- ensures that all implants and allowable supplies (i.e. x-rays, drugs, etc.) are coded appropriately.

## 7. Claim filing

Accurate and timely claim filing can increase revenue by sooner realization of spendable income which, in turn, allows revenue investment. Remember these key factors to help ensure efficient claim filing:

- Accurate data entry is imperative. Denials usually delay reimbursement by at least six weeks.
- Delays in filing or refiling a claim cost the center money by increasing reimbursement turnaround time.
- Not meeting timely filing deadlines result in no reimbursement.

## 8. Payment posting

Again, accuracy and timeliness are key. A meticulous payment poster can save your center very large amounts of money. As you are aware, payors often reject claims for incorrect or no reason and underpay or overpay the claims, seemingly at random. A good payment poster is responsible for:

- determining whether payors are paying correctly — this means a thorough understanding of your contracts;
- immediate follow-up on non-payment or incorrect payments. Don't put them aside for another day — delays cost money;
- accurate and up-to-date contractual adjustments; and
- transferring account balance responsibility to secondary insurances and filing immediately, or transferring account balance responsibility to patient and generating statement immediately.

## 9. Insurance collections

This position needs an aggressive and determined person. Payors seem to have an inexhaustible supply of excuses not to pay. The ability to determine what is real and what is smoke in invaluable. Getting promises of payments with dates and making payors deliver on their promises are characteristics of a successful collector. Ideally, depending on prompt payment legislation, electronically filed Medicare claims should be paid within 14 days and electronically filed managed care claims within 30-45 days. Here are a few best practices to help improve your collections:

- confirm receipt of claim early — 15 days after submission;
- resubmit if claim not on file;
- depending on state's prompt payment law, first follow-up at 30 days from submission — check status and get date of payment; and
- follow-ups every 30 days thereafter, at a minimum.

## 10. Patient collections

Getting out an easily understood, accurate and timely patient statement invites prompt patient payments. Confusing and late statements result in the dreaded angry phone call. You worked hard to provide the patient with a caring and comfortable visit to your center; don't risk the "good feeling" they have about the center. Your statement should:

- be professional looking;
- be accurate and easily understood charges and payments;
- include information on what credit cards your center honors; and
- have the phone number to call with any questions displayed prominently.

Make sure the person handling patient financial calls understands the software fully and can bring up the patient account quickly to discuss it with the patient. Financial counselors can often best handle financial calls.

## 11. Outsourcing billing

Another alternative that is gaining popularity is

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outsourcing coding and billing. More frequently, surgery centers across the country are outsourcing these tasks to ASC-experienced billing companies who have certified and experienced reimbursement specialists. The cost of this service is outweighed by the increase in reimbursement and, at the same time, alleviating the stress of finding and retaining high caliber staff members.

## 12. Marketing

The current economy is resulting in a decrease in elective surgery nationwide. Your best choice is to make your facility the surgery center of choice — both to the physicians and to the patients. Involve your center's administrator, business office manager and often the medical director in marketing endeavors that are suitable for your center and your community. You may be tempted to do radio, TV or newspaper advertising; however, these types of advertising are often expensive and may not be aimed at your primary target, which are the physicians, not the patients. Suggestions to increase your visibility to physicians and community members include:

- visits to physicians' offices — both ones who work at your ASC and new physicians in the community. If possible, make an appointment to speak to the physician. Drop off applicable literature, scheduling information, block schedule openings, etc.;
- luncheons at the surgery center for physicians' business office staff — give them a tour. Make them aware of how your surgery center provides excellent care for their patient;.
- ask physician owners to perform community seminars that are of interest to possible surgical candidates (knee scopes, sinus surgery, etc.) and hold these at the surgery center;
- make your presence aware by participating in community health fairs;
- if your health department gives flu shots, ask if they would like to have your nurses assist and give them at the surgery center on a day when there are no patients;
- do a monthly or quarterly ASC newsletter for medical staff members, letting them know about changes in staff members, new equipment, better pricing on supplies, etc. Every issue should have an article on one of the specialties that you do at the center; and
- enhance your reputation as a "center of caring" with patients. Make the experience as pleasant as possible. The best way to market to patients is word of mouth.

It's difficult to quantify the effect of marketing on your center's success. However, positive efforts usually result in positive results. The steps outlined above, along with ideas of your own, not only provide welcome diversions for your administrative staff but improve relations with your medical staff members.

Individually, the suggestions outlined here may only result in incremental improvements; however, taken as a whole, they may amount to the difference between success and failure for your surgery center. Stress to your staff that it's important to the financial success of your surgery center that all areas involved in reimbursement function as a well-oiled machine. In these "tighten-your-belt" times, it's imperative that you have experienced employees who are willing to do what is necessary to refine the processes and optimize reimbursement. ■

*Ms. Serbin (cas@surgecon.com ) is president and founder of Surgery Consultants of America and Serbin Surgery Center Billing, and a leading expert on coding, billing and reimbursement for medical practices and surgery centers.*

# 4 Critical Components of Implementing an Effective Patient Survey Model

**By Paul G Faraclas, MBA**

*Editor's Note: This article is an excerpt of a more comprehensive article on satisfaction survey trends and best practices written by Mr. Faraclas, which is available in its entirety on www.BeckersASC.com.*

As low-cost, high-quality healthcare providers, ASCs must continue to demonstrate excellence to avoid or minimize reimbursement cuts as aggregate healthcare dollars are reduced. In addition, publicly reported data will provide the impetus for other healthcare verticals to narrow the gap in patient safety as they will be forced to confront deficiencies. As competition increases, timely insight from patients, employees and physicians becomes increasingly more critical to ASC market superiority.

Presently this insight is either lacking or underutilized in the ASC industry. This is partially due to facilities being slow to adopt new and more effective sources of patient data collection, assimilation and response. Numerous advances in technology and data collection within this decade provide facilities the opportunity to gather at least 2-3 times the data points collected in legacy approaches in a fraction of the time.

The opportunity to improve operational performance and financial health requires small investments in properly collecting patient data and transforming it to actionable decision-making information. The upside for the ASC community is huge. Global improvements across the ASC sector will allow ASCs to continue to be positioned as a market leader in healthcare. Future programs (e.g. value-based purchasing) will be tied to both process adherence and absence of negative outcomes. While some reimbursement will be tied to scoring, the greater reward for ASCs will be through publicly reported statistics.

Facilities must shift time from reviewing scores to adopting better capture processes and focus more energy in patient issue resolution. The latter provides a wealth of operational effectiveness feedback. An inefficient survey method is counter-productive in terms of effective use of staff time, internal cost and patient loyalty opportunity cost.

If executed properly, your patient, employee and physician feedback serves as input to quality- and process-improvement monitoring. The opportunity to maintain a fluid feedback model is at the industry's fingertips. This insight will no longer be a luxury but a necessity as the rules within healthcare reimbursement and competition continue to evolve.

## Survey effectiveness

There are four components that must all be effective for the entire survey process to be deemed successful: (1) survey content and rationale; (2) the mode of survey administration; (3) leadership access; and (4) patient issue resolution and management.

**1. Content and rationale.** Many legacy surveys that exist for multi- and single-specialty ASCs have not evolved with organization and indus-

try change. A critical success factor is to ensure the final survey deployed reflects facility uniqueness. Each evaluation statement must provide some magnitude of value when responded to. Over time the questionnaire needs to evolve to remove statements providing little or no value. To maintain optimal effectiveness, statements are added to reflect new processes, facility specialty or quality assurance oversight. The survey must contain enough statements to evaluate the entire experience. The facility needs to be able to discern whether individual components of the care continuum are effective and reflect excellence.

Even-scale survey models create a forced response. The patient either agrees, disagrees or has no opinion (not applicable). A middle response of neutral provides no evaluation value and skews both individual and overall scoring. Verbs and adjectives must be consistent. A statement should not attempt to evaluate two different measures. The category responses need to be limited to four options, plus the not applicable choice. Finally, the language needs to be easy to understand and statement with unmistakable clarity.

Two indicators encompass all measures, but do not supersede them. The two patient loyalty indicators measure: (1) if the patient will recommend the facility to others; and (2) if the patient is confident in the care provided. From a clinical standpoint the encounter may have been successful, yet patient loyalty is based on how immediate patient needs were attended to. One negative experience may negate 10 or more positive experiences.

**2. Mode of survey administration.** The mode of administration may negate feedback value. The chance to capitalize on feedback is highly predicated on (1) timing; (2) percent of response; (3) comments provided; and (4) leadership access. The two critical success factors having the greatest impact on effectiveness are timing and percent of response.

Patient feedback is as good as its opportunity to be actionable. A critical success factor for effective surveying is the ASC's ability to follow up with patients in a timely manner. This obviously requires the survey to be returned as promptly as possible.

Mailing surveys poses timing and response challenges. It requires time to provide patient addresses to a third-party, and the survey has an outbound and inbound mail delay. It might take 4-8 weeks from the date of service for a return. Typical response rates for mailed surveys range from 15-30 percent.

Handing out surveys at time of discharge removes the outbound mail delay and timing can be reasonable (1-3 weeks). The response rate, however, ranges from 20-35 percent.

Electronic surveying yields the greatest response (45-65 percent) and from a timing perspective, greatly exceeds all other modes (2-5 days for completed return and view). Electronic surveying is the most cost effective as postage is not required, nor is data-entry upon return.

For most organizations, a combination of electronic surveying and handed-out paper surveying works best. A facility should target collecting e-mail addresses from at least 60 percent of their patients and dispel the myth that older people will not respond electronically. In fact, patients 65-and-older comprise the highest percentage responding age group for electronic surveys.

If current survey administration occurs at the end of the visit while the patient is onsite, *discontinue this practice immediately*. The patient is likely uncomfortable, still medicated and anxious to get home. The feedback in-

cludes survey bias and may exclude helpful information the patient may be reluctant to share given their lack of privacy.

**3. Leadership access.** The survey's ease of use upon receipt varies from mode to mode. A paper survey is cumbersome when self-administered by a facility. Envelopes are opened and entries might not be tallied until the end of the month. More important, the survey with negative feedback might not reach the right person who should follow up with the patient for days, if at all. Organization leadership has challenged the veracity of results, citing that some negative surveys may be discarded upon return and never be addressed.

Electronic surveys and paper surveys administered by a third party provide leadership *immediate* feedback. Sophisticated survey providers alert facility leadership to a separate and distinct collection of surveys containing dissatisfaction as these may warrant immediate follow-up. A best practice affords the facility's gatekeeper to assign the follow-up to the appropriate stakeholder.

**4. Patient issue resolution and management.** The value of the entire survey process lies in the facility's effectiveness at following up with dissatisfied patients, as well as creating a knowledge repository of comments, feedback and follow-up.

First, leadership absolutely needs to be immediately alerted to surveys containing issues. Attending to, dealing with and learning from patient issues provides true actionable data. Disgruntled patients should be contacted by the facility associate that can relate to and address the issue, leaving the patient with the confidence that they were listened to and, if action is required, things will be addressed. Patients appreciate time and energy they believe is sincere. The initial goal is to remedy dissatisfaction as early as possible to protect patient loyalty.

Second, the facility must make patient issue data actionable and learn from issues shared. Salient details from the discussion with the patient, as well as staff accountable for explaining the issue must be documented. The patient's insight gives the facility the chance to review processes to determine if any corrective action is warranted.

Patient issue tracking helps determine if issues are isolated or patterned. An isolated issue may be explainable, yet not be excusable. Patterned issue identification offers an early foray to a process- or quality-improvement initiative. The ability to learn of under-performance at the earliest stage arms the facility with an immediate risk mitigation tool to prevent failure points from perpetuating.

The aforementioned use of patient issue resolution data is transforming insight to "quality intelligence." Leadership must have access to this data through simple and intuitive reporting that is easily shared at risk management and quality assurance meetings. Internal benchmarks are developed with measurable tracking to ensure the issues are corrected and do not resurface.

## Benefits realization begins with leadership

To reach the highest level of benefits realization, leadership must not only buy in but be engaged in the surveying process. Leadership must be active in taking an introspective look at feedback and help define areas of opportunity along with measurable and attainable goals. Leadership must embrace the newer processes and share the importance of improved feedback mechanisms within the organization. A patient-centric model must become hard-wired into the organization's culture. ■

*Mr. Faraclas is president and CEO of CTQ Solutions. Learn more about CTQ solutions by visiting www.ctqsolutions.com.*

# Developing a Bariatrics Program in an ASC

**Written by Renée Tomcanin**

According to the American Society for Metabolic & Bariatric Surgery, around 220,000 people with morbid obesity underwent bariatric surgery in 2008. As recent reports have shown, performing these procedures in an outpatient setting is safe and effective for the right patients.

Many ASCs have considered adding a bariatrics practice to their centers in hopes of providing care for these patients. However, there are many special concerns that come along with this type of sensitive surgery.

## Why should you add bariatrics?

Many reports have indicated that the number of people in the United States who are considered obese or overweight is growing. The ASMBS reports that 34 percent of adults in the United States are affected by obesity and that 67 percent are either overweight or obese. From 2000-2005, the society reports the following increases in the levels of obesity among American adults:

- Obesity (BMI ≥ 30): 24 percent
- Morbid obesity (BMI ≥ 40): 50 percent
- Super obesity (BMI ≥ 50): 75 percent

For many of these patients who are looking to lose weight, bariatric surgery may be their best option. For surgery centers, this means that currently there is a patient pool of more than 100 million people who may be excellent candidates for bariatric procedures, particularly the Lap-Band surgery, says Tom Michaud, CEO of Foundation Surgery *Affiliates*.



In addition to growing the number of procedures your ASC performs by adding this new specialty, providing excellent care to this patient population can lead to more opportunities for other specialties at the center because many patients who come in for bariatric surgery will have other health issues, says Kent Sasse, MD, MPH, FACS, medical director of the Western Bariatric Institute in Reno, Nev., and author of the book, *Outpatient Weight-Loss Surgery: Safe and Effective Weight Loss with Modern Bariatric Surgery*. "Many of these patients will need arthroscopic orthopedic surgery, gynecological surgery or spine surgery," he says. "An ASC that is distinguished as a center that treats overweight and obese patients will often see these patients again as returning customers."

Other conditions that obese and overweight patients may have include osteoarthritis, joint degeneration, venous stasis disease, infertility, pregnancy complications, gastroesophageal reflux disease, chronic headaches, lower back pain and urinary incontinence, according to the ASMBS.

Mr. Michaud says ASCs may even see some ancillary revenue as a result of procedures performed to treat the complications bariatric patients face before and after surgery. Such procedures include EGD and colonoscopies, hernia repair and laparoscopic cholecystectomy, which Mr. Michaud says has a 35 percent post-op incidence rate. Plastic surgery to remove excess skin is often common after surgery as well.

Another reason an ASC should consider adding bariatrics to its services is that the procedures can reimburse very well. According to Dr. Sasse, the amount that payors cover and reimburse for bariatric surgery is on the rise. "Over the last two decades, payors have increasingly covered procedures they see as medically necessary and important," he says.

Mr. Michaud agrees. "With the growing public awareness of the obesity pandemic, bariatric surgery is becoming more accepted by both the general population and insurance companies as part of the treatment continuum," he says. For Lap-Band procedures, reimbursements can range from $12,000-$25,000, depending on insurance and the type of band used.

The economy, however, may also impact these reimbursement rates as it has with other specialties. "We are seeing tighter purse strings from some self-directed employer plans and from individual patients who must cut back on co-pays and variables," Dr. Sasse says.

## Many types of bariatric surgeries can be performed in an outpatient setting

Here are three types of common, bariatric procedures that can safely be performed in an outpatient setting.

**1. Lap-Band.** The most common bariatric surgery that can be performed in an outpatient setting is a Lap-Band, or laparoscopic adjustable gastric band. In this procedure, a silastic "band," or belt, is placed around the upper portion of a patient's stomach, creating a small walnut/egg-sized pouch, which reduces the amount of food a patient needs to feel full, according to Mr. Michaud. The band can be adjusted through an access port by adding or decreasing the amount of saline in the balloon inside the band. These adjustments will be needed 3-6 times in the first year after surgery and then on an as-needed basis, Mr. Michaud says. If necessary, the Lap-Band can be removed, although the surgery is intended to be permanent.

Two types of bands are commonly used in this surgery — the LAP-BAND, manufactured by Allergan, and the REALIZE Band, manufactured by Ethicon Endo-Surgery. The Lap-Band procedure usually takes an hour to perform and requires 3-5 hours of recovery time, says Mr. Michaud.

**2. Laparoscopic Roux-en-Y gastric bypass.** Selected bariatric patients may undergo a laparoscopic Roux-en-Y gastric bypass, says Dr. Sasse. In this surgery, the patient's stomach is made smaller by creating a small pouch at the top of the stomach using surgical staples or a plastic band. The newly created smaller stomach is then connected directly to the middle portion of the small intestine and bypasses three to four feet of the small intestine. The bypassed section of the digestive tract (the stomach and small intestine) is connected to the lower part of the small intestine.

Dr. Sasse notes that these cases can only be performed in surgery centers that can provide 23-hour stays for motivated patients. The complications can include postoperative vomiting, dehydrations and, in rare cases, hemorrhage or anastamotic leak.

**3. Laparoscopic sleeve gastrectomy.** Laparoscopic sleeve gastrectomy is another procedure that can be performed in an outpatient setting, although only a few select patients will undergo this surgery, according to Dr. Sasse. In this procedure, the left side of the stomach (the greater curvature) is separated vertically from the rest of the stomach using surgical staples.

As with Roux-en-Y patients, patients undergoing sleeve gastrectomy require a 23-hour stay. The most common complications are postoperative vomiting and, in rare cases, bleeding or leakage from the staple lines.

## Bariatric patients are a unique patient population and have special needs

The most important consideration for surgery centers looking to offer bariatrics is that these patients will have special requirements and are not like typical ASC patients.

Dr. Sasse says that staff members at the surgery center should undergo extra training as caring for patients who undergo bariatric surgery is unique. This training goes beyond the standard training require to learn how to perform the procedures or use the equipment for the new surgeries.

"Sensitivity training is required because staff members need to learn professionalism in this field," he says. "They need to know how to show empathy and courtesy towards people who are overweight. It is important for a center and its staff to build the right ethos for these patients.

"A strong team can make a favorable impression on people considering weight loss surgery," Dr. Sasse says. "Conversely, off-handed comments can negatively affect the patient's impression of the center." It is important for all ASC staff, not just those who are working directly with the bariatric program, to undergo sensitivity training in this area.

Another aspect of offering bariatrics ASCs must consider is that before surgery, sleep studies are required to make sure that patients are receiving the proper amount of oxygen, says Mr. Michaud.

"Most patients who undergo bariatric surgery will have sleep apnea," Mr. Michaud says. "We require 100 percent of our gastric bypass patients to undergo these studies to see if they will need to be on a [continuous positive airway pressure] machine to make sure they have enough oxygen." If the sleep study indicates the patient has sleep apnea, he or she is then required to use a CPAP machine for two weeks prior to surgery to help ensure proper oxygen levels in the blood.

## Patient selection is critical to the initial success of a program

Dr. Sasse says that when an ASC is just beginning its bariatric program, it should err on the side of caution and choose patients with lower BMIs until the center establishes a good track record and reputation.

"Centers should put an emphasis on quality, quality, quality," Dr. Sasse says. "Adverse outcomes would be potentially damaging when establishing the program."

The objective for centers when starting bariatric programs should be to "work hard with well-qualified patients, ensuring high-quality results," according to Dr. Sasse.

One way to minimize this risk is to build a team of surgeons and anesthesiologists who have worked together in the past to perform all bariatric surgeries, says Dr. Sasse.

"Our center focused from the beginning on becoming experts at the challenges of outpatient surgery [on] morbidly obese people," he says.

## Bariatric surgery requires specialized equipment

Surgery centers that are interested in developing a bariatric program will need to purchase new equipment for these procedures and patients, and it can be a significant capital investment.

Because bariatric surgery patients are overweight, surgery centers should ensure that the seating in their waiting rooms can accommodate these patients comfortably, says Dr. Sasse. Likewise, ASCs should invest in operating tables that can accommodate increased weight.

Most importantly, because these procedures are performed laparoscopically, Dr. Sasse suggests that centers should invest in high quality and high resolution laparoscopy equipment.

Mr. Michaud notes that purchasing two of these instrument sets can cost $80,000 alone. Combined with the other considerations, the total cost can add up to $500,000.

## Bariatric surgery is only one component of the weight-loss program

One of the biggest complications for bariatric surgery in the outpatient setting is that bariatric surgery is only a small part of a patient's overall weight-loss program. As many of these patients are coming from a sponsored program, it may be more difficult for these specialists to "give up" them, says Mr. Michaud.

For patients in these weight-loss programs, surgery is considered as the last resort. The programs, even for patients who do undergo surgery, include a variety of behavior modifications and lifestyle changes that require a team of healthcare providers including bariatricians, dieticians, exercise physiologists and psychologists, according to Mr. Michaud. Patients are often enrolled in these programs for 4-6 months prior to having surgery.



"Most weight-loss programs were independent up until now," Dr. Sasses says. "However, we are seeing the increasing possibility to ingrate."

Mr. Michaud says that most bariatric patients that elect to have bariatric surgery in an ASC are acquired and recruited through surgeon seminars, either at the ASC or through the weight-loss program.

"Surgeons and the ASC can develop a relationship with the program or volunteer to participate in the cost of the program," he says. "It is often beneficial to speak directly to the specialist."

Dr. Sasse notes that surgery centers can use the time it takes to develop a relationship with weight-loss programs to educate the staff on obesity training and treatment and to establish their program in order to prepare the center for these patients.

## Becoming a Bariatric Surgery Center of Excellence

An important consideration for an ASC planning to add a bariatric program is to consider whether it wants to be recognized as a Bariatric Surgery Center of Excellence by the ASMBS, says Dr. Sasse. One of the significant benefits of this designation is that many insurers require an ASC to be a BSCOE in order to be covered under their plan, he says.

In order to qualify, an ASC must perform a minimum of around 125 bariatric cases annually, says Dr. Sasse. Additionally, the center must meet other high standards, including site inspections and proper patient selection. "A center should reflect before jumping in to achieving this goal and consider if the center has the capital investment and patient volume to meet these criteria," he says. ■

*Contact Renee Tomcanin at renee@beckersasc.com.*

# 8 Statistics About Surgery Center Operating Expenses Per Case

Here are eight statistics about a surgery center's operating expenses per case performed, from VMG Health's *2009 Intellimarker*.

1. Total operating expenses
   - Average — $1,344.49
   - Median — $1,293.60

2. Employee salary and wages
   - Average — $344.43
   - Median — $326.55

3. Medical and surgical
   - Average — $306.81
   - Median — $294.58

4. General and administrative
   - Average — $268.23
   - Median — $234.18

5. Occupancy costs
   - Average — $108.88
   - Median — $89.03

6. Taxes and benefits
   - Average — $72.64
   - Median — $70.51

7. Other medical costs
   - Average — $27.92
   - Median — $13.65

8. Insurance
   - Average — $17.01
   - Median — $12.19 ■

*To receive a free copy of VMG Health's 2009 Intellimarker, visit www.vmghealth.com.*

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**Physician Hospitals of America.** For more information, visit www.physicianhospitals.org or contact Molly Sandvig, JD, executive director, at (605) 275-5349 or e-mail info@physicianhospitals.org.

## Accreditation

**The Accreditation Association for Ambulatory Health Care.** For more information, visit www.aaahc.org or call (847) 853-6060.

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**Superior Medical Services.** Visit SMS at www.smsanesthesia.com or call (847) 816-9296.

**Surgical Anesthesia Services.** Learn more about Surgical Anesthesia Services at www.surgical anesthesia.net or call (866) 733-6231.

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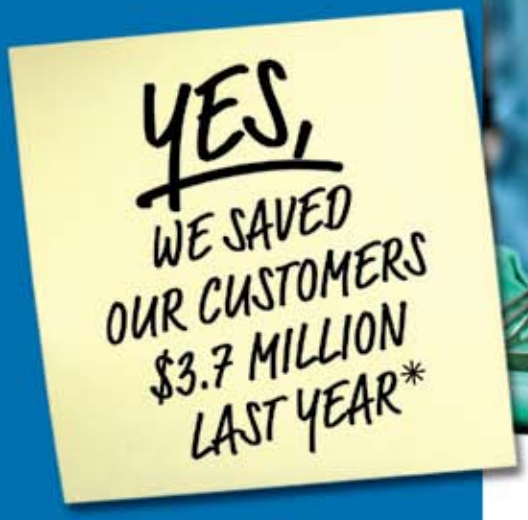


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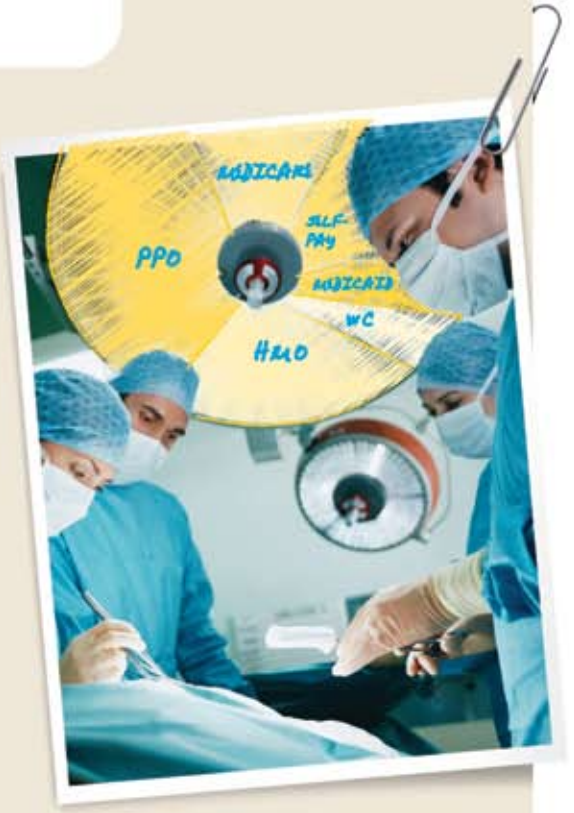


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