Inside: 50 ASC Administrators to Know (p. 25)

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Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

Out-of-Network Payment Squeeze: 4 ASC Trends and Challenges

By Lindsey Dunn

Recent moves in some states by insurers to restrict the use of out-of-network facilities by their members have created a headache for many ASCs around the country. Although out-of-network facilities continue to be successful, a growing resistance from insurers against paying billed charges and, in many cases, reasonable and customary rates to out-of-network providers signals a growing challenge for ASCs.

In the early days of ASCs, many insurers were willing to pay billed charges in full or at a slight discount to non-participating ASCs who treated patients with out-of-network benefits, often paying more to out-of-network providers for services than they did to participating providers who were

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Healthcare Reform: An Overview of Key Concepts

By Scott Becker, JD, CPA, and Alison Vratil Mikula, JD

This article describes the overriding goals and concepts discussed in the healthcare reform plans currently under consideration by the Congress. Specifically, the article discusses the concept of a public option as part of healthcare reform, the concept of providing universal coverage and the issue of how to pay for healthcare reform. The article also touches on several other key issues.

1. Overriding goal. Three of the core concepts related to healthcare reform are cost containment, universal access and high quality. There is a common belief that two of the three goals can be readily achieved. For example, one can provide full access and lower cost but not achieve high quality. In contrast, a system can provide high quality and cost containment but

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72 Physician Leaders in the ASC Industry

Here is a list of 72 physician leaders who have made significant contributions to the ASC industry.

David J. Abraham, MD. Dr. Abraham is one of the entrepreneurial leaders at The Reading Neck & Spine Center in Wyomissing, Pa. He is board certified in orthopedic surgery and is a member of the American Academy of Orthopedic Surgeons, North American Spine Society and the Pennsylvania Orthopedic Society. Dr. Abraham received his medical degree from Jefferson Medical College in Philadelphia, completed his surgical internship and orthopedic surgery residency at Thomas Jefferson University Hospital in Philadelphia and a fellowship in spinal surgery in Detroit, Mich.

Damian "Pat" Alagia, III, MD, MBA. Dr. Alagia is the president of Bethesda, Md.-based Safe Sedation, a company that provides anesthesia services to patients, physicians and staff performing surgery in a non-hospital setting. With a

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FEATURES

Publisher's Letter

Healthcare Reform; Safe Harbors; Out of Network; 16th Annual ASC Conference: Improving Profitability and Business and Legal Issues (Oct. 8-10) — Early Registration Discounts

By Scott Becker, JD, CPA

This letter highlights three developments which demonstrate how quickly the world of surgery centers is changing. The letter also provides information about the 16th Annual Improving Profitability and Business and Legal Issues Conference to be held Oct. 8-10, in Chicago. These are as follows:

1. Healthcare reform. Healthcare reform bills, in the House and in the Senate Help Committee, provide for a public option. The public option would decrease average premiums for a family from approximately $917 a month to $738 a month. This reduced premium is estimated to drive a great deal of beneficiaries out of commercial plans and into a public plan. The public plan as part of the House plan provides for Medicare rates plus 5 percent. The Lewin Group estimates that nearly 120 million people would move from commercial plans to this type of public plan. In terms of overall reimbursement, this would reduce aggregate hospital reimbursement by $30 billion and aggregate physician reimbursement by $11 billion

This type of change would represent a huge negative revenue impact on ASCs. This may be similar to situations where states drastically reduced workers' compensation payments which led to large overall revenue decreases to surgery centers.

You can read an article in this issue that discusses healthcare reform which starts on the cover of this issue.

2. Reversal of safe harbor decision. The 7th Circuit Court of Appeals recently reviewed a case involving a Dr. DeBartolo and Health South Corp. related to the Joliet Surgical Center. There, a physician had brought an action claiming that he had been wrongfully terminated from a surgery center for failure to comply with amended safe harbor requirements that were part of the surgery center operating agreement. The federal court determined that he had no cause of action under the federal statute and dismissed his claim. The 7th Circuit Court of Appeals, after an extensive review of safe harbor issues and a discussion of ASCs in some detail, decided the claims brought by Dr. DeBartolo were really state law claims and not federal law claims. Thus, it reversed the decision of the federal court which had held in favor of the surgery center. It further indicated that the case should be decided in the state court not federal court. Thus, Dr. DeBartolo is free again to bring his action but in state court.

3. Out of network. Payors are increasingly using several new methods and more aggressive actions of recoupment to drive down out-of-network reimbursement to surgery centers. They are redoubling their efforts by trying to recoup payments made for out-of-network visits and to stop payments made to out-of-network providers. In addition, they are reducing payments to such providers. This continues to evolve. There is an article on out-of-network issues which starts on the cover of this issue.

4. ASC Communications, Ambulatory Surgery Foundation, ASC Association and *Becker's ASC Review* are hosting the 16th Annual ASC Conference on Improving Profitability and Business and Legal Issues (Oct. 8-10). The conference is held at the Westin Hotel on Michigan Avenue in Chicago. We have an outstanding lineup of speakers and expect an outstanding event. There are approximately 97 speakers and 72 sessions. The conference will talk at some length about healthcare reform and its impact on ASCs. It will also cover a great deal of practical guidance issues and give owners and administrators information that they can use immediately to improve their surgery centers. Should you desire to register for the conference, please call (703) 836-5904 or register online at http://www.ascassociation.org/chicagoOct2009.cfm. You are also free to take a discount of $100 off the price of the conference if you register by Sept. 1; just reference this letter.

Very truly yours,

Scott Becker

P.S. To sign up for the *Becker's ASC Review* E-weekly, go to www.BeckersASC.com; for the *Becker's Hospital Review* E-weekly, go to www.BeckersHospitalReview.com; and for the new *Becker's Orthopedic & Spine Review* E-weekly, go to www.BeckersOrthopedicandSpine.com. You can also e-mail Scott Becker at sbecker@mcguirewoods.com and indicate which of these e-weeklies you would like to receive.

Out-of-Network Payment Squeeze: 4 ASC Trends and Challenges
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performing services at contracted rates. Although this continues to be true in some areas of the country and for some insurers, in the past few years, other insurers have begun to find ways to reduce these payments drastically.

As private insurers look for ways to reduce costs, they have increased their efforts to target out-of-network providers in a number of ways. Some large health plans are taking steps in many markets to curtail the ability of ASCs to treat patients out of network. Some insurers are trying to substantially reduce, withhold or, in some cases, even recoup reimbursements paid to out-of-network providers. In many situations, the insurers also oppose efforts by providers to reduce patient copayment or coinsurance responsibility and increasingly take the position that if the patient is not required to pay, then the payor is not required to pay either.

ASCs need to be aware of four of these practices and be proactive in resisting them, when possible.

1. Pressuring physicians to refer in-network

ASCs that have avoided contracting with insurance networks are at risk for losing out-of-network volume.

"We are beginning to see efforts by some insurers to pressure physicians to refer to in-network facilities," says Thomas Michaud, chairman and CEO of Foundation Surgery *Affiliates*. "In several states, insurers, such as Blue Cross, have sent letters to physicians who have a pattern of referring to out-of-network facilities and basically threatening to revoke the physician's contract if the pattern continues."

Jeffrey Shanton, director of billing for American Surgical Centers, says that Horizon Blue Cross Blue Shield of New Jersey recently terminated 17 physicians from one out-of-network ASC in the state for referring to the out-of-network facility.

"The physician contracts almost certainly contain non-cause termination language, which is how the insurer is able to terminate the contracts," says Mr. Shanton. "However, in this case, Blue Cross did not seem to have another reason for the termination other than referral patterns. As a result, there are some efforts here in New Jersey to take this issue to court."

Some physicians have already begun to fight back against these practices with some success. In Texas, the state Attorney General investigated BCBS's practice of rating physicians based on claims data, which resulted in lower ranking for physicians who referred out of network. BCBS recently settled the investigation by agreeing to cease using claims data to determine affordability.

In Georgia, a group of ASCs recently filed a class-action lawsuit against BCBS of Georgia, alleging that the insurer reimbursed out-of-network providers at only a fraction of usual and customary charges despite the fact that members paid increased premiums for coverage at these facilities. A decision on the case has yet to be rendered.

Other physicians, however, have yielded to the insurers threats.

"Some physicians will just finally say, 'enough,' and refer the patients to in-network providers, which can sometimes end up costing the insurers more," says Linda McKinney, owner of LMc Solutions, Inc., a California healthcare consulting firm specializing in payor contracting. "A good example is a patient who has outpatient surgery at an in-network hospital versus an out-of-network ASC — it's likely that the cost of care in this example is actually greater to the insurer."

According to Ms. McKinney, pressuring physicians is one of many "strong-arm" strategies used by insurers to "get everyone contracted and pay everyone at contracted rates."

Since individuals with out-of-network benefits pay for the ability to use providers outside their network, leaders within the ASC industry object to efforts by insurers to restrict patient choice.

"At the end of the day, these policies are more expensive than an HMO," says Mr. Michaud. "Someone pays more for the option to have choice. Insurers who try to direct patients to a specific facility or threaten physicians based upon referrals are blatantly acting against the law. The patient has the right to select where he or she wants to go."

Some insurers also use fee schedules to incentivize physicians to refer to in-network facilities. For example, Blue Cross of California's PPO fee schedule is a two-tier fee schedule: Physicians who routinely refer patients to out-of-network providers without proper prior authorization are penalized with a lower fee schedule for their services, says Ms. McKinney.

Some ASC industry sources also report that representatives from certain insurers have called patients directly to inform them about the additional costs associated with using an out-of-network facility. Such actions may be, in effect, an attempt to persuade the patient to use an in-network provider.

2. Bifurcated deductibles

ASC leaders also report an increasing number of patients with separate in-network and out-of-network deductibles, which may discourage members from using out-of-network providers.

"Four to five years ago, most of the patients we treated had a single deductible of, say, $2,000," says Mr. Michaud. "Today, we see some patients who have separate in-network and out-of-network deductibles, both at the same amount we were seeing for one deductible in years past. This can be especially frustrating for patients, especially if they are looking at scheduling a surgery toward the end of the year and therefore face 'starting-over' again in using down the other deductible."

Mr. Michaud recommends that physicians take a professional approach in discussing surgery facility options with patients who have these split deductibles. "Our physicians present each patient with a form that lists where they are credentialed and then discuss options," he says. "A physician can say 'here is where I prefer you go' and then work with the patient in perhaps scheduling the procedure after the new year or explaining why the increased fee may be worth it for a better patient experience."

3. Capped out-of-network benefits

Another way that some insurers have successfully reduced payments to out-of-network providers is by capping members' out-of-network benefits. Although reimbursement rates vary greatly by state and are subject to state laws and regulations regarding reimbursement, insurers in several states have already begun to set maximum reimbursements for out-of-network providers.

Blue Cross of California recently capped out-of-network benefits for all out-of-network ASCs at $381 per procedure, according to David Thoene, vice president of business development at Titan Health.

In New Jersey, Mr. Shanton says Horizon BCBS of New Jersey began implementing an out-of-network fee schedule for ASCs in 2004 that caps reimbursement rates at 130 percent of Medicare.

Mr. Shanton says that although these percentages may seem adequate to the average consumer because they are above Medicare's rates, it is important to remember that Medicare fees are usually much lower than commercial payor rates and even payments double or triple Medicare may not recoup the facilities' costs to perform some procedures.

Insurers can add language to their policies that caps the out-of-network benefit offered by their plans as well, says Ms. McKinney.

Reduced or capped out-of-network payments benefit insurers and hurt out-of-network providers, but it is important to keep in mind that the reason insurers with plans designed to cap these benefits remain active is because they are attractive to employers looking to reduce insurance premiums and healthcare benefits overall.

"I think that providers often lose sight of the impact of the employers' contractual relationship with the insurance company," says I. Naya Kehayes, founder and managing member of EVEIA HEALTH Consulting & Management. "The contract between the employer and the insurance company and the premiums that are paid are typically based upon the in-network and out-of-network benefits that are included in the benefit design of the plan that the employer purchases. By reducing out-of-network benefits, employers can reduce premiums, thereby saving themselves and their employees money."

CIGNA recently released a statement to providers stating, "most plan sponsors have elected to incorporate in their plan a Maximum Reimbursable Charge provision that caps reimbursement for covered services received from non-participating providers." CIGNA plans to cap these benefits in one of two ways: As a customer-elected percentile applied to a range of charges for a procedure in the applicable geographic area using a third party database of billing records or as a percent of schedule amount, ranging from 110-200 percent, using a Medicare-type methodology.

As more employers select to reduce these benefits, out-of-network ASCs may need to rethink their strategy. "These reduced benefits create a disincentive for the providers to remain out of network," says Ms. Kehayes. "The benefit of out-of-network reimbursements may decline quickly and not be beneficial anymore.

"While an individual is entitled to use their out-of-network benefits to select an ASC that may offer a better environment for a procedure, I think we will begin to see more reductions in this benefit as insurers and employers look for ways to reduce premiums," she says.

4. Leasing of insurance networks

A final way the insurers have begun to reduce payments to out-of-network providers is to lease insurance networks. Insurance networks, such as Interplan, Concentra or Cofinity, give providers access to a payor and its members in return for discounted services. For example, an insurance network's contract might state that a provider will perform services at 75 percent of billed charges. However, they limit a providers' ability to seek out-of-network charges for services.

Second-tier networks have grown in popularity, but providers that sign with them should be clear about the benefits as well as the risks before signing a contract, according to Ms. McKinney.

"Second-tier networks operate like this: If a provider decides not to contract with a patient's insurance plan, but that insurer has leased a second-tier network to which the provider does have an agreement with, the insurer will pay the second-tier network's rate, not an out-of-network rate," says Ms. McKinney. "Second-tier networks can be beneficial in that they can give a provider access to a greater number of patients and the potential for increased case volume. On the flipside, this additional caseload comes at a price that the provider may not necessarily be aware of until after the patient is served."

How ASCs can respond

ASCs that opt to continue treating out-of-network patients can help ensure that they draw out-of-network patient volume and are reimbursed for these procedures by offering discounts, verifying benefits and requesting payment upfront.

Mr. Michaud says that his centers may reduce the overall rate, rather than waiving deductibles or co-insurance fees, because they want to uphold the co-insurance ratios set forth by the patient's insurance plan.

The waiving of out-of-pocket costs for out-of-network commercially insured patients is practiced by ASCs; however, any ASC considering this should analyze its own state laws, says Andrew Wachler, Esq., of Wachler & Associates. ASCs should examine their states' false claims laws, anti-inducement laws, anti-kickback laws and unfair competition laws in addition to their state Attorney General's opinions and state case law in order to determine if there are rules that could that create legal entanglements for the centers.

It is also very important that ASCs verify insurance benefits for out-of-network patients, whenever possible.

"We pre-certify every patient and check for inpatient and outpatient deductibles, including how much of the deductible is used and then determine what their bill will be before the day of surgery," says Mr. Michaud.

However, insurers in some states have restricted access by out-of-network providers to benefit information, according to Mr. Shanton. "In New Jersey, out-of-network ASCs cannot verify benefits or find out the deductibles of Blue Cross patients, which makes it very difficult for us to determine what type of payment we're working with."

Some insurers' plans actually require preauthorization for payment. "In California, some Blue Cross plans will not pay for a procedure performed at an out-of-network facility without preauthorization," says Ms. McKinney. "However, Blue Cross typically does not require prior authorization for outpatient surgeries. It's very confusing for providers. If it's not required for outpatient surgeries, the facility may not think it needs to get the authorization and then later finds out it won't get paid at all."

ASCs that have patients with capped or inadequate out-of-network benefits should consider requiring patients to pay upfront for their out-of-pocket expenses or work with patients to develop payment plans before the procedure takes place.

This is especially important in some states, such as California, where out-of-network reimbursements often go directly to members, and the member is responsible to pay the facility, says Ms. McKinney.

ASCs that want to rely heavily on out-of-network patients and even those that enjoy continued access to the occasional out-of-network patient must be forward thinking in their continued response to shrinking out-of-network reimbursement rates and the reduced access to out-of-network patients.

"Here in New Jersey, where the majority of ASCs remain out of network, we are literally fighting for our lives," says Mr. Shanton. "ASCs need to have a united front. If one or two centers jump ship and contract, the remaining centers could be boxed out from signing with that carrier in the future. We have to band together and fight for the continued success of our centers." ■

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Healthcare Reform: An Overview of Key Concepts
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not provide full access. However, it is difficult to achieve all three elements. Pres. Obama has stated that his two basic requirements for a healthcare bill are that the bill expand insurance coverage and make medical care more affordable. In essence, access and cost containment as opposed to quality are his two key goals.

Three core healthcare reform plans are currently being debated in Congress. A House of Representatives plan, a Senate Finance Committee plan and a Senate Health Education, Labor and Pension plan.

The means of paying for healthcare reform include certain easily achievable savings from efforts such as attacking fraud and abuse, reducing waste and adding information technology. These concepts tend to be politically appealing but do not cover the costs of significant healthcare reform.

Other ways to achieve savings that could help fund healthcare reform include rationing care, lowering reimbursement to providers and/or increasing taxes. Each of these approaches is, politically, much more challenging.

2. A public plan. There are three core models for a public plan. First, there is the type of public plan included in the healthcare reform proposal currently under consideration by the House of Representatives. This uses Medicare infrastructure and pays providers Medicare plus 5 percent to providers.

A second core plan is a weaker public program that acts like an insurer but cannot access Medicare rates. In essence, it uses some of the existing Medicare infrastructure but must negotiate provider rates independently.

A third public plan, called a "trigger plan," only commences if certain criteria are met.

The view of providers and payors toward introducing a public plan is generally very negative. Payors tend to view the public plan as providing significant competition for enrollees. The typical premiums that would be part of the public plan are estimated to be $100-$200 a month less for a family or individual than comparable commercial plan premiums.

For example, the Lewin Group estimates that a family on a public plan would pay $738 a month versus $917 a month on average. This lower cost option means that when a public plan is fully integrated into the system, one would see a significant number of beneficiaries migrate away from commercial plans and into the new public plan. The Lewin Group estimates that 122 million Americans would, in year three of the public option, migrate to a pubic plan from commercial plans. This type of migration, coupled with lower rates paid to providers, would lead to substantial drops in income for hospitals, physicians and other providers. The Lewin Group estimates that this type of migration together with the "Medicare plus 5 percent" fee schedule will lead to a drop in hospital income of approximately $31 billion by the third year of the public plan and a drop in physician income of approximately $16,200 per physician, totaling approximately $11.5 billion for all physicians collectively. In light of these predictions, it comes as no surprise that physicians and hospitals overall have great concern regarding the adoption of a significant public plan.

The House Plan and the Senate HELP Plan each include very substantial public options. The Senate Finance Committee, led by Sen. Max Baucus (D), has resisted calls by many Democrats to include in its reform proposal a government-run insurance plan that would compete with private payors.

Four perspectives on a public plan are as follows. These provide some insight into the differing views toward the introduction of a public plan.

a. Karl Rove (Against) reports that "[t]he Lewin Group estimates 70 percent of people with private insurance — 120 million Americans — will quickly lose what they now get from private companies and be forced onto the government-run tools as businesses decide it is more cost-effective for them to drop coverage." (Karl Rove, How to Stop Socialized Health Care, *Wall Street Journal*, (June 11, 2009) http://online.wsj.com/article/SB124467554761003963.html

b. Robert Reich (For) "…The public option has become such a lightening rod. The American Medical Association is dead-set against it, Big Pharma rejects it out of hand, and the biggest insurance companies won't consider it. No other issue in the current healthcare debate is as fiercely opposed by the medical establishment and their lobbies now swarming over Capital Hill.

"Of course, they don't want it. A public option would squeeze their profits and force them to undertake major reforms. That's the whole point. Critics say the public option is really a Trojan horse for a government takeover of all health insurance. But nothing could be further from the truth. It's an option. No one has to choose it. Individuals and families will merely be invited to compare costs and outcomes. Presumably they will choose the public plan only if it offers them and their families the best deal — more and better health care for less. Private insurers say a public option would have an unfair advantage in achieving this goal. Being the one public plan, it will have large economies of scale that will enable it to negotiate more favorable terms with the pharmaceutical companies and other providers. But why, exactly, is this unfair? Isn't the whole point of cost containment to provide the public with health care on more favorable terms? If the public plan negotiates better terms – thereby demonstrating that drug companies and other providers can meet them — private plans could seek similar deals.

"But, say the critics, the public plan starts off with an unfair advantage because it's likely to have lower administrative costs. That may be true – Medicare's administrative costs per enrollee are a small fraction of typical private insurance costs – but here again, why exactly is this unfair? Isn't one of the goals of healthcare costs containment to lower administrative costs? If the public option pushes private plans to trim their bureaucracies and become more efficient, that's fine." (Why We Need a Public Health-Care Plan, *Wall Street Journal*, June 24, 2009)

c. The Commonwealth Fund (For) recently published a study in which it compared estimated impacts of a public plan with (1) reimbursement at Medicare levels, (2) a public plan with reimbursement between Medicare and private levels and (3) a purely private system.

Estimates indicate that premiums for the public plan choice in the Public Plan with Medicare Payment Rates path would initially be 25 percent below those currently available for a comparable benefit package in the private individual/small firm market and 16 percent lower under the Public Plan with Intermediate Payment Rates scenario.

Private plan premiums would initially be 3 percent lower within the exchange as it facilitates the process of choosing plans and reduces administrative costs, especially for individuals and small businesses. (Karen David, Cathy Schoen, and Stuart Guterman, *Fork in the Road: Alternative Paths to a High Performance U.S. Health System,* The Commonwealth Fund, June 2009)

d. David Burda, editor of *Modern Healthcare* (Against) commented as follows:

i . With Medicare and Medicaid patients representing more than half all hospital business, how did hospitals do it? [Record profits in 2007] We'll let MedPAC explain. In its March report, MedPAC said that starting in 2000, hospitals had "regained the upper hand in price negotiations (with private insurers) because of hospital consolidations and consumer backlash against managed care." Consequently, the rates paid by private insurers to hospitals rose so much that by 2007, private payers were reimbursing hospitals on average more than $1.32 on the dollar, according to MedPAC. Or, hospitals' profit margin on patients covered by private insurance was 32%.

ii. If you're still not convinced it would be a financial disaster, consider this: The new public insurance program would compete with private insurer plans by charging less for health benefits. If the public plan is taking in less revenue per enrollee, it certainly is not going to pay out more per enrollee for care. The new plan would be an even worse payer than Medicare or Medicaid. Then, where would providers turn to charge more to cover the shortfalls? To the fewer private plans whose ranks were thinned by competition from the new public health insurance program? Good luck with that, as they would be far less generous as they fight for survival against the new government program. (*Public Enemy Number 1 — A New Public Insurance Program Likely Will Shortchange Providers*, June 29, 2009)

3. Covering the uninsured. Most people generally agree with the concept of covering the uninsured as a goal. In fact, this was the core goal of the Massachusetts plan which assures coverage to essentially all people in Massachusetts.

There are generally considered to be three large groups of the uninsured. These include people that are Medicaid eligible but not properly enrolled in Medicaid, people that are the working poor (in essence, people who if they bought healthcare insurance would use up such a substantial percentage of their income that they would be not able to afford other necessities) and, third, people that choose not to buy coverage but aren't Medicaid eligible or working poor. This last group includes people who are eligible but for whom insurance may be very expensive or they cannot obtain insurance (for example, they may have pre-existing conditions that preclude them from obtaining insurance) and people who choose not to buy insurance.

The Massachusetts plan provided individual and employer mandates. For individuals, it required people to buy health insurance. The Massachusetts plan also included efforts to help sign up the Medicaid eligible and provided significant subsidies for the working poor to buy insurance. The great problem with the Massachusetts plan to date is that it is far more expensive than previously anticipated.

A federal plan for covering the uninsured is likely to include certain types of mandates for individuals to buy insurance and for businesses to offer insurance. The mandates for individuals would include subsidies to the work-

ing poor (i.e., for people with low incomes up to approximately 300-400 percent of the federal poverty level), as well as a standardizing of Medicaid eligibility (e.g., 115 percent of the federal poverty level) so nationally there is one level of eligibility for Medicaid coverage. There will also be rules that prevent payors from denying coverage based on pre-existing conditions.

The federal plan will also include employer mandates. These may require employers above a certain size to provide coverage to their employees (i.e., at least at a low level of basic benefits, and pay for at least half of those costs for full-time employees).

The general business community's thoughts on mandatory coverage for employers is quite negative. That stated, Wal-Mart has come out in favor of a mandatory coverage concept:

Wal-Mart breaks with business and fosters mandate

"Wal-Mart Backs Drive to Make Companies Pay for Health Coverage" (*Wall Street Journal*, July 1, 2009, Janet Adamy and Ann Zimmerman). "We are for an employer mandate which is fair and broad in its coverage," said the letter, signed by Wal-Mart Chief Executive Mike Duke. Andrew Stern, president of the Service Employees International Union, also signed the letter, along with John Podesta, who led Pres. Obama's transition team and is chief executive of the Center for American Progress, a liberal-leaning think tank.

The National Retail Federation, the industry's main lobby, said it was "flabbergasted" by Wal-Mart's move. "We have been one of the foremost opponents to employer mandate," said Neil Trautwein, vice president with the Washington-based trade group. "We are surprised and disappointed by Wal-Mart's choice to embrace an employer mandate in exchange for a promise of cost savings."

"Mr. Trautwein said an employer mandate is 'the single most destructive thing you could do to the healthcare system shy of a single-payor system,' under which the government handles healthcare administration … The group believes forcing companies to provide insurance will raise costs for its members.

"Under the plans being discussed in Congress, small businesses would either be exempt from the mandate or face a less-onerous requirement. The U.S. Chamber of Commerce said most of its members oppose an employer mandate, and it doesn't think Wal-Mart's stance will change that. "The kind that the groups in this letter support is the worst incarnation, the most dangerous policy," said James Gelfand, senior manager of health policy for the group, which represents three million businesses."

4. Paying for healthcare reform. There are several different possible ways of paying for healthcare reform. These include reductions in reimbursement (e.g., the pharmacy industry has pledged $55 billion in reductions, the hospital industry has pledged $155 billion in reductions and certain other reductions have also been discussed). The other substantial methods that are being looked at to pay for healthcare reform include taxing healthcare benefits (these are not currently taxed) or taxing healthcare benefits above a certain amount. The Democrats generally oppose taxing healthcare benefits. Sen. Baucus of the Senate Finance Committee has indicated an interest in taxing healthcare benefits above a certain amount. In essence, if someone receives more than $17,000 a year or $25,000 a year in healthcare benefits, they would be taxed on benefits in excess of such amount.

Sen. Barbara Boxer (D), in contrast, has opposed the concept of taxing healthcare benefits.

> "Working people in many cases have given up raises in pay and instead have gotten health benefits," said Senator Barbara Boxer, Democrat of California, who is up for re-election next year. "So it seems unfair to now tax their benefits. I think that would be changing the rules in the middle of the game in a way that is so harmful and would set them back, so I have a real problem with that." (Democrats Divide Over a Proposal to Tax Health Benefits, *New York Times*, July 8, 2009)

The other core method for paying for healthcare benefits is an increased tax rate for high earners. This is an integral part of the House and Senate HELP Plan for paying for healthcare reform.

5. Other key issues. Certain of the other key issues that are part of healthcare reform include (1) the concept that an insurer cannot bar people with pre-existing conditions from coverage, and limiting insurers' ability to rate individuals and charge premiums based on differences in health conditions; (2) small group market reform essentially making it much easier for small business groups to obtain coverage; (3) a Web site portal that would provide a uniform place where individuals and businesses can compare benefits and costs of coverage from insurance companies (and exchange); (4) benefit rules and concepts providing minimum benefits and standardizing packages to be broken down into categories by lowest level, low, medium and high (in essence, standardizing benefits packages such that it is easier for people to shop for insurance); (5) subsidies to buy insurance or provide coverage for businesses or individuals; (6) standardizing Medicaid eligibility rules nationwide based on percentage of income; (7) creating a Medicare coverage option for people that are less than 65 years but older than 55 years; (8) possible incentives for preventative and healthy lifestyle; and (9) employee and employer mandates for full-time employees that require employers to buy at least the low option of coverage and cover at least 50 percent of the cost.

This provides a summary of some of key issues being debated as part of healthcare reform. Should you have additional questions or wish to discuss this further, please contact Scott Becker at (312) 750-6016 or sbecker@mcguirewoods.com. ■

Mr. Becker and Ms. Mikula are attorneys with McGuireWoods.


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background in OB/GYN, he received his MBA from Johns Hopkins University in Baltimore and provides expert advice about business principles as they apply to anesthesia management and to healthcare as a whole. Dr. Alagia has acted as the primary strategist and spokesperson on programs involving physician-centric organizations on topics from the management of female pelvic disorders to medical liability reform to the structuring of joint ventures between healthcare organizations. He is a fellow of the American College of Surgeons and the American College of Obstetricians and Gynecologists and was the former president of the Medical Society of the District of Columbia.

Dale A. Armstrong, MD. Dr. Armstrong is chairman of the board of Mason City (Iowa) Surgery Center and the president of the Mason City Clinic, where he has visionary ideas for his center. He is board certified in adult and child and adolescent psychiatry. Dr. Armstrong received his medical degree from the University of Oklahoma College of Medicine in Oklahoma City, Okla., and completed his residency in adult psychiatry and his fellowship in child and adolescent psychiatry at the University of Oklahoma Health Sciences Center.

Ken Austin, MD. Dr. Austin is a practicing orthopedic surgeon with Rockland Orthopedics & Sports Medicine in Airmont, N.Y., and is the president of the Ramapo Valley Surgical Center in Ramsey, N.J. He received his medical degree from New York University School of Medicine and completed his surgical internship and orthopedic residency at the NYU/Bellevue Medical Center. He then went on to complete a fellowship in surgery of the knee and sports medicine at Harvard's Massachusetts General Hospital in Boston. His expertise includes treating traumatic and sports-related injuries of the upper and lower extremities and joint replacements of the hip and knee.

Norman Douglas Baker, MD, FACS. Dr. Baker is a surgeon at the Ophthalmic Surgeons and Consultants of Ohio in Columbus. He is board certified in ophthalmology. Dr. Baker earned his medical degree from Ohio State University College of Medicine in Columbus and completed his residency in ophthalmology at Ohio State University department of medicine and his fellowship at Emory University School of Medicine, department of ophthalmology, glaucoma section, in Atlanta. He is also a member of the Ohio State Medical Association, the Columbus Ophthalmological and Otolargyngological Society, the American Academy of Ophthalmology, the American Glaucoma Society, the American College of Surgeons and the American Academy of Pharmaceutical Physicians. Dr. Baker is clinical assistant professor of ophthalmology at Ohio State University.

Joseph Banno, MD. Dr. Banno is the founder of the successful Peoria (Ill.) Day Surgery Center and is past chairman of the ASC Association and a current executive committee member. He is a board-certified urologist with the Midwest Urologist Group. He received medical degree from the University of Chicago and completed a general surgery residency at Saint Francis Medical Center in Peoria and then entered University of Chicago's comprehensive urology program. He is a clinical instructor of urology at the University of Illinois College of Medicine. His special interests include impotency, stone disease and correction of prostate disease. During the last few years, Dr. Banno has been involved in developing the world's first mobile ASCs. He is married and has six children. His interests include aviation, cycling, skiing, tennis and hunting.

Tom Bombardier, MD. Dr. Bombardier is a board-certified ophthalmologist and is the COO and one of the three founding principals of the Ambulatory Surgical Centers of America. Prior to founding ASCOA, he established the largest ophthalmic practice in Western Massachusetts, two ASCs and a regional referral center. Over the past 15 years, he has been a real estate developer in Cape Cod, Mass. Dr. Bombardier is a graduate of Amherst (Mass.) College and Albany (N.Y.) Medical College and completed his residency at the Louisiana State University in Baton Rouge, La.

Nader Bozorgi, MD. Dr. Bozorgi has been a leader and pioneer in the field of outpatient surgery since 1973, when he opened one of the first ASCs in the United States. This paved the way for a system of ASCs that provide anesthesia, pain, bariatric lap band and support services, under Magna Health Systems. Dr. Bozorgi continues to serve as Magna Health System's CEO, overseeing the daily operations of three active multi-specialty, Chicago-area ASCs and related physician and support services.

Richard F. Bruch, MD. Dr. Bruch is a physician with Triangle Orthopedic Associates, the North Carolina Specialty Hospital and the James E. Davis Surgery Center, all located in Durham, N.C. He received his medical degree from the University of Illinois College of Medicine in Chicago. Dr. Bruch is certified by the American Board of Orthopaedic Surgery. He is a member of the American Academy of Orthopaedic Surgeons and the American Orthopaedic Foot and Ankle Society. Dr. Bruch is a past-president of both the Durham-Orange County Medical Society and the North Carolina Medical Society and currently serves on the North Carolina delegation to the American Medical Association. Dr. Bruch serves on the State Health Coordinating Council.

Michael Bukstein, MD, FACS. Dr. Bukstein is a general surgeon who serves as the board president of the Northeast Missouri Ambulatory Surgery Center in Hannibal, Mo. He received his medical degree from University of Missouri Medical School in Columbia, Mo., and completed his residency at the University of Wisconsin in Madison, Wis. Dr. Bukstein served as chief resident in surgery and surgical oncology at University of Missouri Medical Center and Ellis Fishel Cancer Center in Columbia. He is a diplomat of American Board of Surgery, fellow of American College of Surgeons and member of the Hannibal Clinic. Dr. Bukstein's surgical specialty and clinical interests are general surgery and surgical oncology.

John Caruso, MD. Dr. Caruso has more than 16 years of neurological surgery experience. Since completing residencies at the Eastern Virginia Graduate School of Medicine and the University

of New Mexico, Dr. Caruso has been in private practice with Neurosurgical Specialists, LLC, in Hagerstown, Md. He has developed his own surgery center and is actively involved in the national affairs of Blue Chip Surgical Partners. He is an outstanding speaker, physician and leader.

John Cherf, MD, MPH, MBA. Dr. Cherf, an orthopedic physician at the Neurologic & Orthopedic Hospital of Chicago, maintains a multidisciplinary practice focusing on musculoskeletal medicine. His practice is open to non-spine general orthopedics with a special interest in disorders of the knee. He has both owned and operated surgery centers successfully and now serves as both a practicing orthopedic physician and a leading national thinker on trends in orthopedics. Dr. Cherf earned his medical degree and a master's degree in public health from Northwestern University, where he also completed his internship and residency. He continued his specialty training with a sports medicine fellowship at The Orthopedic Specialty Hospital in Salt Lake City, Utah. Dr. Cherf returned to Northwestern University where he earned an MBA at the Kellogg School of Management.

Brian Cole, MD, MBA. Dr. Cole is one of leading knee physicians in the country. He is a professor in the departments of orthopedics and anatomy and cell biology at Rush University in Chicago and section head of the Cartilage Restoration Center at Rush at the Rush University Medical Center. He received his medical degree and MBA from the University of Chicago, and completed his residency at The Hospital for Special Surgery in New York, N.Y., and his sports medicine fellowship at the University of Pittsburgh. He specializes in arthroscopic shoulder, elbow and knee surgery and has a specific interest in arthroscopic reconstruction of athlete's shoulder (rotator cuff, instability and arthritis), elbow and knee. Dr. Cole serves on the board of the American Academy of Orthopedic Surgeons.

James R. Colgan, MD. Dr. Colgan is a member of board of managers of Sierra Surgery Hospital, a hospital/physician joint-venture surgical specialty hospital in Carson City, Nev. He is also chairman of the board for Carson Ambulatory Surgery Center, founder of Physicians Managed Care, medical director and board member of Physicians Select Management and serves as a director on the board of Physician Hospitals of America. Dr. Colgan received his medical degree from the University of Southern California School of Medicine in Los Angeles. He completed his residency at the Los Angeles County Hospital and is board certified in urology.

R. Blake Curd, MD. Dr. Curd, a leader in the physician-owned hospital field, is an upper extremity and general orthopedics physician with the Orthopedic Institute in Sioux Falls, S.D., and serves as a director on the board of Physician Hospitals of America. Dr. Curd completed his fellowship training at the Indiana Hand Center, the largest free standing center dedicated to hand/upper extremity care, research and education in the world. He is also serves as the interim executive director of Surgical Management Professionals.

Christopher Danis, MD. Dr. Danis is in his twentieth year of practicing hand surgery in Dayton, Ohio. Ten years ago, he initiated Far Hills Surgical Center, a hospital-physician joint-venture ASC in Dayton where he continues to serve on the board. He received his medical degree at Wright State University Medical School and his general surgery training in the integrated residency program in Dayton. He then completed a plastic surgery residency at William Beaumont Hospital in Detroit, Mich. Dr. Danis is certified by the American Board of Plastic Surgery.

Daniel C. Daube, MD. Dr. Daube is the director and CEO of the Surgical Center of Excellence in Panama City, Fla., and he is a smart, hands-on leader. He also practices with the Gulf Coast Facial Plastics and ENT Center in Panama City and is on the clinical faculty at Tulane University Medical Center. Dr. Daube received his medical degree from the University of New

Mexico School of Medicine in Albuquerque, N.M., and completed his residency in otolaryngology at the University of New Mexico Hospital. He completed his fellowship in facial plastic and reconstructive surgery at Louisiana State University in Baton Rouge, La. Dr. Daube is board certified in otolaryngology and facial plastic and reconstructive surgery and is a member of numerous professional societies.

Philip A. Davidson, MD. Dr. Davidson is the founder and former CEO of Tampa Bay (Fla.) Specialty Surgery Center and now practices orthopedics with Heiden Orthopaedics in Park City, Utah. For more than a decade, Dr. Davidson has been acknowledged as one of the nation's foremost orthopedists treating articular cartilage disorders. He specializes in cartilage restoration and shoulder surgery, with extensive experience in the area of tissue transplantation, including allografts, xenografts and the usage of autologous growth factors. He received his medical degree from Cornell University Medical College in New York, N.Y., and completed his orthopedic residency at Baylor College of Medicine in Houston and a sports medicine fellowship at the Kerlan-Jobe Orthopedic Clinic in Los Angeles. He is an official consultant of Major League Baseball and the National Football League, having been jointly appointed by the players' and owners' groups from these leagues.

John W. Dietz, Jr., MD. Dr. Dietz is an orthopedic spine surgeon with OrthoIndy and the Indiana Orthopaedic Hospital in Indianapolis. Dr. Dietz has served on the OrthoIndy board of directors since 2000. When OrthoIndy decided to develop IOH, he chaired the planning committee and then served as the chairman of the board of managers. He also serves as a director on the board of Physician Hospitals of America. He received his medical degree from the Duke University School of Medicine in Durham, N.C., and completed an internship in general surgery and a residency in orthopedic surgery at Madigan Army Medical Center in Tacoma, Wash. Dr. Dietz is an inventor and has been awarded patents on surgical instruments used in endoscopic spine surgery. He is a member of the American Academy of Orthopaedic Surgeons and the North American Spine Society and is a fellow of the Scoliosis Research Society.

Stephen E. Doran, MD. Dr. Doran is chairman of the board of Midwest Surgical Hospital in Omaha, Neb., and practices with Midwest Neurosurgery & Spine Specialists, also based in Omaha. Dr. Doran is also a clinical assistant professor of surgery at University of Nebraska Medical Center. He is board-certified by the American Board of Neurological Surgeons, and his special areas of interest include spinal instrumentation, stereotactic and functional neurosurgery, deep brain stimulation and disorders of the spine. Dr. Doran received his medical degree from the University of Nebraska Medical Center and completed both his internship and residency at the University of Michigan Medical Center in Ann Arbor, Mich.

Ken Drazan, MD. Dr. Drazan is a physician and managing director of healthcare services investments for Bertram Capital Management based in San Mateo, Calif., which includes GENASCIS among its portfolio companies. He has been a leader and he is also an investor in different businesses that serve the ASC market. Previously, Dr. Drazan was the CEO and founder of Arginox Pharmaceuticals. He was a leading academic liver transplant surgeon and basic scientist at Stanford University and UCLA. Dr. Drazan currently serves as chairman of Arginox Pharmaceuticals and Kuratek. Dr. Drazan received his medical degree from the State University of New York.

Robin Fowler, MD. Dr. Fowler is the medical director of Interventional Spine & Pain Management, based in the Atlanta area, and he has developed several different surgery centers in Georgia, Texas and New Mexico. He is also an active staff member at the Newton and Rockdale Medical Centers. Dr. Fowler spent five years establishing concurrent successful careers in the pharmaceuti-

cal industry and construction contracting before returning to earn his medical degree. He completed a residency in anesthesiology at Emory University in Atlanta and a fellowship in Emory's interventional pain program.

Dr. Fowler serves as a thought leader in pain management and is asked to speak at top medical universities, hospitals and community programs around the country. He has also served as an advisor for pain management to several private insurance carriers.

James L. Fox, Jr., MD. Dr. Fox is the founding leader of the Ravine Way Surgery Center in Glenview, Ill., and practices at the Illinois Bone & Joint Institute. He is a board-certified orthopedic surgeon who has been practicing for more than 20 years. His clinical interests include general orthopedic surgery, including fracture care and arthroscopy, as well as orthopedic oncology. Dr. Fox received his medical degree from Columbia University College of Physicians and Surgeons in New York. He completed a fellowship in orthopedic oncology at Sloan-Kettering Memorial Cancer Center in New York, and joint replacement at Rush Presbyterian St. Luke's Hospital in Chicago. He completed his residency with, and serves as associate clinical professor at, Northwestern University Medical School in Evanston, Ill.

Robert Gannan, MD, PhD. Dr. Gannan is the founder and clinical strategies advisor for Doylestown, Pa.-based Physicians Endoscopy. He is a nationally recognized expert in endoscopic procedures. Dr. Gannan established Eastside Endoscopy Center as one of the first outpatient endoscopy centers in Washington State. He retired from clinical practice in Dec. 2006. Dr. Gannan is a regular speaker at national meetings of gastrointestinal physicians regarding practice and development trends. He received his medical degree from the University of Rochester (N.Y.) School of Medicine and Dentistry.

David S. George, MD. Dr. George is an ophthalmologist with The Eye MDs of George, Strickler and Lazer, based in Marietta, Ohio. His special interests include topical cataract surgery and glaucoma and diabetic eye care. He is a member of the board of directors for the ASC Association and the Outpatient Ophthalmic Surgery Society. Dr. George received his medical degree from Ohio State University in Columbus, Ohio, and completed his internship at Riverside Hospital and his residency in ophthalmology at the Ohio State University College of Medicine.

Tom N. Galouzis MD, FACS. Dr. Galouzis is the president and CEO of the Nikitis Resource Group and currently practices as a general surgeon at Lake Park Surgicare in Hobart, Ind. Previously, he served as associate staff in the department of surgery as a clinical instructor of surgery at the University of Chicago Pritzker School of Medicine, where he received his medical degree.

Scott E. Glaser, MD, FIPP. Dr. Glaser is a well-respected pain specialist and founder of the Pain Specialists of Greater Chicago in Burr Ridge, Ill. He serves on the board of the American Society of Interventional Pain Physicians and was heavily involved in the lobbying efforts required to ensure passage of the NASPER bill. Dr. Glaser was one of the first instructors selected by the International Spinal Intervention Society, the first society to provide training by experts in the performance of spinal injections. As an instructor, he teaches other physicians minimally invasive spinal procedures on cadavers at national courses. He also presents continuing medical education lectures at ASIPP meetings. Dr. Glaser received his medical degree from Indiana University School of Medicine in Indianapolis. He completed his anesthesia residency and fellowship at Northwestern University Medical School in Chicago.

John R. Harvey, MD, FACC. Dr. Harvey formed the Oklahoma Cardiovascular Associates (formerly the Heart Group of Oklahoma), a 40-man cardiovascular group in Oklahoma

City, Okla. He is currently president and medical director of the Oklahoma Heart Hospital in Oklahoma City and serves as a director on the board of Physician Hospitals of America. Dr. Harvey received his medical degree from the University of Oklahoma College of Medicine in Oklahoma City and completed a fellowship in cardiology at University of Oklahoma Health Sciences Center in Oklahoma City, and interventional cardiology at Beth Israel Hospital in Boston. He served on the boards of the American College of Cardiology, the American Heart Association and the Oklahoma Foundation for Cardiovascular Research.

Scott Holley, MD. Dr. Holley is the president and founder of Great Lakes Plastic & Hand Surgery in Portage and Battle Creek, Mich. He is board certified in general surgery, plastic surgery and holds the certificate of added qualification as a specialist in hand surgery. Dr. Holley is president of the Michigan Association of Hand Surgery and is a member of numerous professional societies. He received medical degree from the Indiana University School of Medicine in Indianapolis and completed residencies in general and plastic surgery at the University of Cincinnati Medical Center. He completed fellowships in hand and microsurgery at the Kleinert Institute in Louisville, Ky., burn surgery at the Shriner's Hospital in Cincinnati and cosmetic surgery with Drs. Baker, Stuzin and Gordon in Miami.

Jack E. Jensen, MD, FACSM. Dr. Jensen is a board-certified orthopedic surgeon and medical director of Athletic Orthopedics and Knee Center, an integrated healthcare plaza specializing in the care of knees, and the founder of a surgery center in Houston. He has a very active role in the Texas Ambulatory Surgical Center Association and remains an extremely solid contributor to the ASC industry. He received his medical degree from Kansas University, and completed his orthopedic surgery residency at the University of Texas and a fellowship in sports medicine at the University of Oregon. Dr. Jensen has served as an orthopedic consultant to the U.S. Gymnastic Federation, team physician to Karolyi's Gymnastics, the USA Swimming Foundation, the Association of Tennis Professionals and orthopedic physician to numerous Olympic and professional athletes.

Marc E. Koch, MD, MBA. Dr. Koch is the president and CEO of Somnia Anesthesia Services based in New Rochelle, N.Y., where he focuses on ensuring that all efforts further the company's mission of offering high-quality, cost-efficient anesthesia solutions to hospitals, ASCs and office-based facilities nationwide. Dr. Koch co-founded Resource Anesthesiology Associates in 1996. He is both a brilliant physician as well as a leader in the anesthesia area. He graduated with honors from the State University of New York at Stony Brook and completed his internship at Winthrop University Hospital in Mineola, N.Y., and a residency in anesthesia at the Yale University School of Medicine in New Haven, Conn. Dr. Koch is a board-certified anesthesiologist.

Donald Kramer, MD. With a medical practice spanning more than 25 years, Dr. Kramer has developed several successful ASCs in the Houston market and is the founder of Northstar Healthcare, which develops and, in conjunction with physician partners, owns and operates significant ASCs in concentrated markets. He serves also as president and medical director for Northstar. Dr. Kramer is an active member of the Harris County Medical Society, Texas Medical Association and Texas Ambulatory Surgery Center Society, and previously served on the faculty of Baylor College of Medicine and The University of Texas Medical Branch in Galveston. He received his medical degree from Jefferson Medical College in Philadelphia.

Timothy Kremchek, MD. Dr. Kremchek is one of the leading shoulder surgeons in the country and is a physician with Beacon Orthopaedics & Sports Medicine in Sharonville, Ohio. He has developed tremendous plans and thoughts around operating surgery centers and building and marketing brands for orthopedic surgeons and for surgery centers. Dr. Kremchek currently serves as the director of sports medicine for the TriHealth System of Good Samaritan and Bethesda Hospitals. He serves as team physician to many professional sports teams, including the Cincinnati Kings professional soccer team. Dr. Kremchek received his medical degree from the University of Cincinnati.

Peter R. Kurzweil, MD. Dr. Kurzweil is the founder of the Surgery Center of Long Beach (Calif.) and is an internationally recognized orthopedic surgeon with expertise in arthroscopic and reconstructive surgery of the knee and shoulder and the treatment of athletic injuries. He is the fellowship director for the Southern California Center for Sports Medicine in Long Beach. He is team physician for California State University in Long Beach, the Long Beach Ice Dogs, a professional hockey team in the IHL, as well as several local high school football teams. Dr. Kurzweil is also a designated "Neutral Orthopedic Surgeon" for the National Football League and served as team physician for the Long Beach StingRays of the American Basketball Association. He received his medical degree from the University of Rochester (N.Y.) School of Medicine and Dentistry, and completed his residency at the Columbia-Presbyterian Medical Center in New York and his fellowship in sports medicine, arthroscopic surgery, knee and shoulder reconstruction and replacement at the Southern California Center for Sports Medicine.

Brent Lambert, MD. Dr. Lambert has revolutionized approaches to ASC management. He is the chairman of the board and a founder of Ambulatory Surgical Centers of America and takes a hands-on approach to ASC management. Dr. Lambert is a board-certified ophthalmologist. He is a graduate of Harvard College, Columbia University College of Physicians and Surgeons, Harvard Medical School and Massachusetts Eye & Ear Infirmary residency program. Prior to the founding of ASCOA, Dr. Lambert was the developer and owner of three ASCs, including the first eye ASC in New England.

James J. Lynch, MD, FACS. Dr. Lynch is the president, founder and CEO of SpineNevada based in Reno, Nev., and he also serves as the direc-

tor of spine service for Regent Surgical Health. He is a board-certified neurological surgeon who specializes in complex spine surgery, cervical disorders, degenerative spine, spinal deformities, trauma, tumor infection and minimally invasive spine surgery. He is on staff at St. Mary's Hospital and Renown Medical Center, both located in Reno. Dr. Lynch is a frequent lecturer at national meetings on spine topics related to ASCs. He earned his medical degree from Trinity College in Dublin, Ireland, and completed a residency at the Mayo Clinic in Rochester, Minn. Dr. Lynch completed spine fellowships from Mayo Clinic, Queen Square in London and Barrow Neurological Institute in Phoenix, Ariz.

Thomas Lorish, MD. Dr. Lorish is the medical director of the Providence Brain Institute in Portland, Ore. He is a physiatrist and tremendous leader of their efforts to move towards an ASC effort and philosophy. With his help, Providence has become one of leaders in ASC joint ventures in the country. Dr. Lorish earned his medical degree at Oregon Health & Science University in Portland and completed a residency in physical medicine and rehabilitation at the Mayo Graduate School of Medicine in Rochester, Minn. He is a past president of the Oregon Medical Association's Physical Medicine and Rehabilitation Section and has served on the Oregon Physical Therapy Licensing Board.

Lance J. Lehmann, MD. Dr. Lehmann is an interventional pain physician who spends a tremendous amount of time studying business and healthcare. He is a physician with the Pain Consultants of Florida in Hollywood, Fla. Dr. Lehmann completed his pain management fellowship at Harvard University's Beth Israel-Deaconess Medical Center in Boston and is a former instructor in anesthesiology and pain management at Harvard University. He received his residency training in anesthesiology and critical care at the University of Miami and completed an internship in internal medicine at Yale University's Greenwich (Conn.) Hospital. He is board certified in pain management by the American Board of Anesthesiology and the American Board of Pain Medicine.

Laxmaiah Manchikanti, MD. Dr. Manchikanti is the medical director of the Pain Management Center of Paducah (Ky.) and Ambulatory Surgery Center in Paducah. He is the CEO and chairman of the board of the American Society of Interventional Pain Physicians. Through his work with various organizations, Dr. Manchikanti has been instrumental in the preservation of interventional pain management through specialty designation, mandatory Carrier Advisory Committee representation, reimbursement and the passage of NASPER. He graduated from Gandhi Medical College at Osmania University Hyderabad in India, and completed his internship and residency in anesthesiology at Gandhi Hospital in Hyderabad, India, Youngstown (Ohio) Hospital and Allegheny General Hospital in Pittsburgh. He completed a fellowship in anesthesiology and critical care medicine at the University of Pittsburgh.

Ajay Mangal, MD, MBA. Dr. Mangal is the founder, CEO and a board member of Prexus Health Partners, and is also a board-certified ENT physician. As a hands-on executive at Prexus, he has been instrumental in developing ASCs and assisting existing centers and hospitals to prosper. He is on staff at Butler County Medical Center, Fort Hamilton, Mercy Fairfield and Cincinnati Children's Hospitals. Dr. Mangal received his medical degree from The University of Iowa College of Medicine in Iowa City, Iowa. He completed his residency in Otolaryngology Head & Neck Surgery from The University of Cincinnati (Ohio). Dr. Mangal received his MBA from Xavier University in Cincinnati.

Thomas D. Meade, MD. Dr. Meade is a senior partner with the physician group that drives the Surgery Center of Allentown (Pa.), OAA Orthopedic Specialists. He specializes in knee surgery, both sports injuries and joint replacements (with the rare exception of displaced clavicle fractures, where he is recognized as a leading expert in surgical treatment). He holds academic positions at Thomas Jefferson University in Philadelphia, Penn State University and Lehigh Valley Hospital in Allentown. Dr. Meade received his medical degree from Jefferson Medical College in Philadelphia, and he completed his internship at The Allentown (Pa.) Affiliated Hospitals, his residency at

Thomas Jefferson University Hospital in Philadelphia and a sports medicine fellowship at the Cincinnati (Ohio) Sports Medicine and Orthopedic Center. He is board certified and a member of numerous professional societies.

Keith Metz, MD, JD, MSA. Dr. Metz is a practicing clinical anesthesiologist and medical director at Great Lakes Surgical Center in Southfield, Mich. Dr. Metz serves on the board of directors for the ASC Association and was program committee chairman for the association's first meeting held in San Antonio. In 2003, Dr. Metz organized a group of surgeons to develop an ASC in southeast Michigan. The physicians obtained a CON, purchased land, built a facility, obtained state licensure and Medicare and AAAHC certification. The current facility has four licensed ORs and one procedure room and performs approximately 7,000 procedures annually with about 25 surgeons.

Thomas K. Miller, MD. Dr. Miller is an orthopedic surgeon at the Roanoke (Va.) Ambulatory Surgery Center and the Roanoke Orthopaedic Center. He has specialty experience in sports medicine, arthroscopy and knee and shoulder reconstruction. Dr. Miller has been team physician for the U.S. National Triathlon Team and the Salem Red Sox baseball team. He is board certified in orthopedic surgery and holds academic appointments as assistant professor of medical specialties, orthopedics, at Virginia College of Osteopathic Medicine in Blacksburg, Va., and as clinical associate professor of orthopedic surgery at the University of Virginia in Charlottesville, Va.

William C. Mobley, MD, FACS. Dr. Mobley is a practicing urologist with Davenport, Iowa-based Urological Associates. He is certified by the American Board of Urology and is a fellow of the American College of Surgeons. Dr. Mobley received his medical degree from the Medical College of Georgia School of Medicine in Augusta, Ga., and completed his residency at the University of Iowa Hospitals & Clinics in Iowa City, Iowa. He is a member of the Iowa Medical Society, the American Urological Association, the American Association of Clinical Urologists, the American Fertility Society and the American Medical Association.

Eric Monesmith, MD. Dr. Monesmith has performed extensive studies on total knees performed in surgery centers and hospitals and is a practicing physician with OrthoIndy in Indianapolis. He specializes in the treatment of arthritic knees and hips. A graduate of Indiana University School of Medicine in Indianapolis, Dr. Monesmith completed his residency in orthopedic surgery at Loyola University Medical Center in Chicago. Afterward, he completed the Aufranc Fellowship in constructive joint surgery at the New England Baptist Hospital in Boston. He then was awarded the Schwartz Traveling Fellowship and studied cartilage transplantation in Gothenburg, Sweden, and hip replacement in Exeter, England. Dr. Monesmith is a past president of the Indiana Orthopaedic Society.

Daniel B. Murrey, MD. Dr. Murrey is a leader at OrthoCarolina and the OrthoCarolina Spine Center in Charlotte, N.C. He specializes in treatment of both surgical and nonsurgical spinal disorders, with special interest in cervical spine surgery, spinal deformities and disk replacement. He is involved in teaching and training other surgeons as well as in developing new spine technologies. Dr. Murrey is a graduate of Harvard Medical School in Boston and completed his orthopedic surgery residency at Vanderbilt University in Nashville, Tenn., and his fellowship in spine surgery at Carolinas Medical Center in Charlotte, N.C.

Bergein Overholt, MD, FACP, MACG. Dr. Overholt is a physician with Gastrointestinal Associates in Knoxville, Tenn. He served in the Cancer Control Program of the U.S. Public Health Service and developed the flexible fibersigmoidscope-colonscope, which earned him the Schindler Award from the ASGE and the William Beaumont Award from the AMA. Dr. Overholt has served as president of the ASGE and the American As-

sociation of Ambulatory Surgery Centers and is a founding member and past president of the Tennessee Society for Gastrointestinal Endoscopy. He was the chief of staff at St. Mary's Medical Center from 1981-1983. Dr. Overholt serves as the medical director of the laser department of the Thompson Cancer Survival Center. Dr. Overholt received his medical degree from the University of Tennessee Medical School and completed his internship, residency and fellowship in gastroenterology at the University Hospital in Ann Arbor, Mich.

Greg Parsons, MD. Dr. Parsons is the medical director of the Carolina Surgical Center, a joint venture with Tenet Health Systems in Rock Hill, S.C. He has been on the staff of the center since its beginning in 1989 and has been the president of the physician group for more than 10 years. He was instrumental in the hiring of Joe Zasa, the co-founder of Woodrum/ASD, to manage the center. Recently, the center was revitalized by adding 14 new physicians. Dr. Parsons, in conjunction with Tenet and Woodrum/ASD, has led this redevelopment process and it has resulted in a dramatic resurgence for the center.

Kenneth Pettine, MD. Dr. Pettine is the co-founder of Rocky Mountain Associates in Orthopedic Medicine in Loveland, Colo. He has an extensive background in spinal surgery, research and rehabilitation and is board certified. Dr. Pettine co-invented, designed and patented the Maverick Artificial Disc, a new technology for neck and back intervertebral disc replacement. He received his medical degree from the University of Colorado School of Medicine in Denver and completed his residency and his master's degree in orthopedic surgery at the Mayo Clinic in Rochester, Minn. He completed his fellowship at the Institute for Low Back Care in Minneapolis.

Larry Pinkner, MD. Dr. Pinkner was the long-term leader of the American Association of Ambulatory Surgery Centers. He was a founder of the Surgery Center of Baltimore. He was a leader in the ASC Association and has overall been a tremendous asset to the surgery center business. Dr. Pinkner has now retired.

Thomas J. Pliura, MD, JD. Dr. Pliura is a physician, healthcare lawyer and the founder and manger of four ASCs, with a potential fifth under development. Additionally, he is the founder of zChart EMR, an electronic medical records related company. Dr. Pliura received his medical degree from the University of Illinois College of Medicine in Chicago and Peoria, Ill., and his juris doctorate from the University of Illinois College of Law in Champaign, Ill. He is a member of the American Medical Association, the Illinois State Medical Society and the McLean County Medical Society. In 1998, he sought and received the first favorable Medicare Advisory Opinion in the country, certifying that a proposed ASC was exempt from Stark Laws under a rural provider exemption.

Thomas E. Price, MD (R-Ga.). Dr. Price is an orthopedic physician who now serves in the U.S. House of Representatives, representing the sixth district of Georgia. Dr. Price has been an outspoken advocate for patient-centered healthcare reform in Washington, D.C., and developed the Comprehensive HealthCARE Act, designed about positive changes to provide access for all Americans to affordable, quality healthcare. Prior to serving in Congress, he was medical director of the Orthopaedic Clinic at Grady Memorial Hospital in Atlanta, teaching resident doctors in training, and was in private practice for nearly 20 years. Dr. Price received his medical degree from the University of Michigan in Ann Arbor, Mich., and completed his residency in orthopedic surgery at Emory University in Atlanta.

David J. Raab, MD. Dr. Raab is the founder of the Morton Grove (Ill.) Surgery Center and an orthopedic surgeon with Illinois Bone and Joint Institute in Des Plaines, Ill. He specializes in orthopedic surgery in sports medicine, total joint replacement and arthroscopy, among other areas of interest. Dr. Raab received his medical degree from Northwestern University Medical School in Chicago and completed his internship and residency in orthopedic surgery at Northwestern. He completed a fellowship in sports medicine at the Minneapolis Sports Medicine Center.

Herbert Riemenschneider, MD. Dr. Riemenschneider is founder of Knightsbridge Surgery Center in Columbus, Ohio. He is a urologic surgeon, a dedicated patient advocate and an innovator in delivering superior urologic care. He currently is a member of the faculty at Ohio State University in Columbus, clinical assistant professor of Urology at OSU's College of Medicine and director of urologic education at Riverside Methodist Hospitals. He performed the first prostate cryoablation in Ohio. Dr. Riemenschneider received his medical degree from the OSU College of Medicine and completed his residency in urology at Indiana University in Indianapolis.

J. Michael Ribaudo, MD. Dr. Ribaudo has more than 27 years of experience as a surgeon, healthcare executive and real estate developer and currently serves as CEO and chairman of Ballwin, Mo.-based Surgical Synergies. He is a pioneer in the development of physician-owned ASCs and has served as executive vice president of Surgical Health Corp. and HealthSouth Surgery Centers. Dr. Ribaudo graduated from Louisiana State Medical School with graduate medical school training at Emory University in Atlanta, Washington University in St. Louis, Mo., and New York University. He received postgraduate training at Harvard Law School in Cambridge, Mass., Kellogg Business School at Northwestern University in Evanston, Ill., and Stanford (Calif.) Graduate School of Business.

Paul Rohlf, MD. Dr. Rohlf was the initial urologist who obtained the first surgery center certificate of need for a center in Iowa. While he is now retired, he is a strong leader in the surgery center industry, a former president of the American Association of Ambulatory Surgery Centers and he deserves special mention in this list.

L. Edwin Rudisill, Jr., MD. Dr. Rudisill is one of the leading hand surgeons in the country and practices with The Hand Center in Greenville, S.C. He received his medical degree from Bowman-Gray School of

Medicine in Winston Salem, N.C. and completed his orthopedic training with the Greenville (S.C.) Hospital System. He completed a hand and microsurgery fellowship was completed at the University of Alabama at Birmingham. Dr. Rudisill holds a certificate of added qualifications in surgery of the hand and is a member of the American Society of Surgery of the Hand, American Society of Reconstructive Microsurgery and is board certified by the American Board of Orthopaedic Surgery.

Michael E. Russell, II, MD. Dr. Russell is an orthopedic surgeon with Azalea Orthopedics and is a board member at the Texas Spine & Joint Hospital in Tyler, Texas. He received his orthopedic training at the University of Texas Southwestern Medical School at Dallas. He completed his residency in spine surgery at The Carolinas Medical Center at Charlotte (N.C.). Dr. Russell is board certified and serves as a director on the board of Physician Hospitals of America.

Kuldip S. Sandhu, MD, FACP, FACG. Dr. Sandhu is a gastroenterologist at the Sutter Roseville (Calif.) Endoscopy Center in and is president of Capitol Gastroenterology Consultants Medical Group. He received his medical degree from Punjabi University, Patiala, India, and completed his internship and his residency in internal medicine at MLK-Drew Medical Center in Los Angeles. Dr. Sandhu went on to complete his fellowship training in gastroenterology at LAC-USC Medical Center in Los Angeles.

Kent Sasse, MD, MPH, FACS. Dr. Sasse is one of the leading bariatric physicians in the country, serves as the director of the Western Bariatric Institute in Reno, Nev., and is an attending surgeon at several hospitals in the area. Dr. Sasse is the author of the 2009 book titled *Outpatient Weight-Loss Surgery: Safe and Effective Weight Loss with Modern Bariatric Surgery*. He received his medical degree from the University of California, San Francisco, a master's in health and medical sciences at UCSF-UC Berkeley Joint Medical Program and an MPH in epidemiology from UC-Berkeley School of Public Health. Dr. Sasse completed his residency at the UCSF department of surgery and his fellowship at the Lahey Clinic department of colon and rectal surgery in Burlington, Mass.

David Shapiro, MD, CPHRM, LHRM, CHC. Dr. Shapiro is a partner in Ambulatory Surgery Company, an ASC consulting firm, and is the chair of the Ambulatory Surgery Foundation and chair-elect of the ASC Association. Previously, Dr. Shapiro held the position of senior vice president of medical affairs for Surgis, an ASC management company, serving as the corporate medical director for more than 20 facilities.

Thomas A. Simpson, MD, FACS. Dr. Simpson is chairman of the board of directors for the Iowa City Ambulatory Surgery Center and led the board of this multi-specialty ASC as it came together to plan and develop the ASC with Mercy Hospital. He also serves as president of the board of directors for Mercy of Iowa City Regional PHO and is a former president of the Iowa Academy of Otolaryngology. Dr. Simpson received his medical degree from the University of Iowa College of Medicine in Iowa City, Iowa.

Eric J. Stahl, MD. Dr. Stahl, a board-certified orthopedic surgeon specializing in sports injuries and shoulder and knee surgery, is the president of Golden Ridge Surgery Center in Golden, Colo. During his military service in France, he was the physician for the climbing school and the mountain rescue team in Chamonix. Dr. Stahl completed his internship and surgical residency at St. Joseph Hospital in Denver and his orthopedic residency at Mount Sinai Hospital in Cleveland, Ohio, and Phoenix, Ariz.

Steven Stern, MD. Dr. Stern is a Harvard-trained orthopedic physician. He is the medical director and the vice president of neurosciences orthopedic and spine of United Healthcare. Prior to coming to United Healthcare, he was a leading surgeon at Northwestern Memorial Hospital in Chicago and has developed a very successful surgery center.

Charles Tadlock, MD. Dr. Tadlock is the founder of Surgery Center of Southern Nevada in Las Vegas. He is also the CEO of Epiphany Surgical Solutions and an avid developer of surgery centers.

Larry Teuber, MD. Dr. Teuber, a neurosurgeon, is the founder and physician executive of Black Hills Surgery Center in Rapid City, S.D., one of the country's most successful small surgical hospitals. He also serves as the president of Toronto, Canada-based Medical Facilities Corp., and is founder and current managing partner of The Spine Center in Rapid City. Dr. Teuber received his medical degree from the University of South Dakota in Vermillion, S.D., and completed his general surgery internship and neurosurgery residency at the Medical College of Wisconsin in Milwaukee. Dr. Teuber served for 17 years in the U.S. Army and Army Reserve as an aviation and medical officer.

George M. Tinawi, MD. Dr. Tinawi is the president of Surgery Center Partners and its management subsidiary, Endoscopy Management Services Organization, which he founded with Samuel Marcus, MD. He was a practicing physician in Mountain View, Calif., from 1986-2004. As a practicing physician, Dr. Tinawi developed a clear understanding of the business issues faced by physicians in today's challenging environment. A graduate of the Medical School of University of Aleppo in Syria, Dr. Tinawi completed his residency in internal medicine at the University of Massachusetts Medicine Program in Worcester, Mass., and his fellowship in gastroenterology at the University of Southern California in Los Angeles. He is board certified in both internal medicine and gastroenterology.

George A. Violin, MD, FACS. Dr. Violin is the founder of Medical Eye Care Associates in Massachusetts. He devotes most of his practice to cataract surgery, LASIK and related surgeries and was one of the early investigators of epikeratophakia, a precursor of current LASIK technology. Dr. Violin is one of the three founding principals of the Ambulatory Surgery Centers of America and is affiliated with Caritas Norwood Hospital, Faulkner/Brigham and Women's Hospital and Massachusetts Eye and Ear Infirmary and New England Medical Center. He graduated from Columbia University College of Physicians and Surgeons in New York, N.Y., and completed his ophthalmic residency at Massachusetts Eye and Ear Infirmary in Boston.

Jeffrey L. Visotsky, MD, FACS. Dr. Visotsky is a member of Illinois Bone and Joint Institute and founder of the Morton Grove (Ill.) Surgery Center. He is a board-certified orthopedic surgeon and specializes in conditions of the hand, elbow and shoulder, arthroscopy shoulder/elbow, shoulder reconstruction and replacement, among other areas. Dr. Visotsky serves as assistant professor of orthopedic surgery at Northwestern University in Chicago and an instructor in the physicians assistant department of the Finch University of Health Sciences Chicago Medical School. He received his medical degree from Northwestern University and completed his residency in orthopedic surgery at McGaw Medical Center in Chicago and his fellowship in hand and upper extremity microsurgery at the Baylor College of Medicine in Houston.

Robert Welti, MD. Dr. Welti is the corporate medical director and COO, Western region, for Westchester, Ill.-based Regent Surgical Health. He served as the medical director and administrator of the Santa Barbara (Ca-

lif.) Surgery Center and was affiliated with Santa Barbara Cottage Hospital for 20 years. A board-certified anesthesiologist, Dr. Welti earned his medical degree from Stanford (Calif.) University School of Medicine, where he also served his internship and residency and completed his fellowship in cardiothoracic anesthesia at Emory University Hospital in Atlanta.

Thomas Wherry, MD. Dr. Wherry is co-founder of Total Anesthesia Solutions, a company dedicated to addressing the emerging anesthesia subsidy crisis and developing innovative anesthesia service solutions for practitioners, hospitals and major health systems. He has worked with Health Inventures since 1996. In addition to his roles as medical director for the Surgery Center of Maryland and consulting medical director for Health Inventures, he has collaborated with professionals in the United Kingdom, Japan and Kuwait to improve the delivery of ambulatory surgery. Dr. Wherry earned his medical degree from the University of Cincinnati (Ohio). He completed a residency in anesthesiology at Johns Hopkins Hospital in Baltimore, Md. He received additional training in ambulatory and pediatric anesthesia and pain management and earned a one-year certificate in The Business of Medicine from Johns Hopkins University School of Medicine. Dr. Wherry is board certified in anesthesiology and pain management.

Richard N.W. Wohns, MD, MBA. Dr. Wohns is a spine surgeon and one of the first physicians involved with the development of ambulatory spine practices. He is the founder of South Sounds Neurosurgery in Puyallup, Wash. He also founded Neospine, a spine ASC development company, which is currently part of Symbion Healthcare. His areas of expertise in the field of neurosurgery include brain tumor and skull base surgery, numerous complex minimally invasive spinal surgical techniques, teleradiology, computer-based neuronavigation and stereotaxis. He was one of the first neurosurgeons in the United States qualified to perform the revolutionary XLIF technique for minimally invasive lumbar fusions. Dr. Wohns attended medical school at Yale University School of Medicine and completed his neurosurgery residency at the University of Washington in Seattle. He also holds an executive MBA from the University of Washington and is currently pursuing a law degree from Seattle University School of Law. ■

THANK YOU TO ASCOA, THE SPONSOR OF

50 ASC Administrators to Know

This article provides condensed profiles of 50 outstanding administrators at surgery centers across the country. To read the complete profiles, visit www.beckersasc.com/50-asc-administrators-to-know.html.

Peggy Alteri, RN, BSN, MPS, CASC (Holdings, Syracuse and Camillus, N.Y.). Ms. Alteri is the administrator and CEO of Holdings, which operates two freestanding ASCs located in Syracuse, N.Y., and Camillus, N.Y. Ms. Alteri is the president of the New York State Association of Ambulatory Surgery Centers and is a surveyor for AAAHC. She owns her own consulting company and offers guidance to freestanding ASCs all over New York State. "I have gone from nurses' aide in a nursing home to ICU supervisor to vice president of clinical services to CEO and administrator of the surgery centers," she says. "I have definitely found my niche in ASCs."

The relationship she sees between the staff and surgeons is one of Ms. Alteri's favorite aspects of working as an administrator. "They clearly work together to the patient's benefit. I am always in awe of these relationships and how well they work together," she says.

Ms. Alteri enjoys many parts of her job as administrator, including the flexibility her position allows her, so that she can be responsive to the needs of the staff and surgeons at the centers. "The board of directors fully supports my efforts in running the centers and this clearly makes the job more enjoyable. I love to read the patient satisfaction surveys and share them with the staff," she says.

Brent Ashby, CASC (Audubon Surgery Center, Colorado Springs, Colo.). Mr. Ashby is the administrator of Audubon Surgery Center, Audubon ASC at St. Francis and Women's Surgical Center, all located in Colorado Springs, Colo. Mr. Ashby has been with Audubon Surgery Center since it opened in June 2000, and he opened the two other ASCs in Sept. 2008. Previously, Mr. Ashby was the administrator of the Provo (Utah) Surgical Center for seven years. He practiced law at a large firm in Phoenix.

Under Mr. Ashby's leadership, the surgery centers have been able to undertake several initiatives that have led to their success. "We have a staff profit-sharing program that allows the employees to feel like owners when it comes to profit distributions. They have a greater sense of ownership with this program," he says. Mr. Ashby and the centers have also refused to contract with payors who are unwilling to offer reasonable payment rates, particularly for orthopedic procedures and implants.

Mr. Ashby's favorite aspect of serving as an administrator is developing and maintaining a vision for the future in a market that is constantly on the move. "Because healthcare is ever-changing, I find it a challenging and stimulating endeavor to plan ahead to better position our facilities for success," he says.

Lisa Austin, RN, CASC (Peak One Surgery Center, Frisco, Colo.). Ms. Austin is the administrator for Peak One Surgery Center facility located in Frisco, Colo., and serves as vice president of operations, Western region for

Pinnacle III. She started out at Pinnacle III as a director of operations, serving as an administrator for many of the company's new centers. Additionally, Ms. Austin is a board member of the Colorado Ambulatory Surgery Center Association and chairs the emergency preparedness committee.

Recently, with the help of her staff, Ms. Austin prepared Peak One for AAAHC accreditation. "We were able to transition a staff that had no ASC experience, only hospital, and have them understand ASCs as a cost-effective alternative to surgery in the hospital," she says. "Now, people truly understand and are proud of the concept of the center."

Ms. Austin credits the center's success to her staff. "We have a great, mature group of nurses who have been in the community for many years," she says. The staff and physicians have no "class system," meaning that no staff member feels more important than any other member, according to Ms. Austin. "When everyone comes into work, they are focused on patient care. It's a close-knit community."

Louise Barker, RN, BSN (Central Louisiana Ambulatory Surgical Center, Alexandria, La.). Ms. Barker is the administrator and CEO of Central Louisiana Ambulatory Surgical Center in Alexandria, La., a multi-specialty facility with six operating rooms, two GI suites and one procedure room. CLASC performed 15,000 procedures in 2008. The specialties at the facility include orthopedics, interventional pain management, ENT, plastic surgery, gastroenterology, podiatry, urology, ophthalmology, neurosurgery, gynecology, general surgery and dental surgery.

Ms. Barker began her career in nursing and gained valuable supervisory and surgical experience at two large hospitals in Alexandria. She joined CLASC in March 1985 as the director of nursing and helped the facility begin operations. In the early years of the center, Ms. Barker achieved CNOR status and assisted in all clinical nursing areas. She quickly worked her way up to her current position.

In 2005, CLASC transitioned from a 10,000 square-foot facility to a 30,000 square-foot facility. In addition to managing the surgery operations, Ms. Barker was instrumental in overseeing the development and construction of the new facility. "It is due to her organization and planning skills that the facility experienced no loss of operating days during the move from one building to another," says Linda Wright, CFO of CLASC.

Glenda Beasley, RN (Kentucky Surgery Center, Lexington, Ky.). Ms. Beasley is the administrative director of the Kentucky Surgery Center in Lexington, Ky. With a background in nursing, she has worked in many hospital departments throughout her career, including oncology, medical surgical floor and emergency department. She started her career in outpatient surgery as a circulating OR nurse and worked her way up to administrator.

Ms. Beasley has overseen significant growth at KSC. The biggest challenge she has experienced was the building of their current facility in 2006. "The KSC board of directors allowed me to have a large part in the development of the building and its patient flow and design," she says. "I was involved in all aspects, including procurement of equipment, supplies, flooring, paint and windows. It was exciting and a lot of work but definitely worth all the extra hours and anxiety."

Ms. Beasley says that her staff plays a significant role in making KSC so successful. "In an outpatient surgery center, the atmosphere is much more structured and organized, and the staff thrives on routine," she says. "The staff has the ability to deliver the best patient care that can be offered in a healthcare setting."

Sandy Berreth, RN, MS, CASC (Brainerd Lakes Surgery Center, Baxter, Minn.). Ms. Berreth is the administrator of Brainerd Lakes Surgery Center located in Baxter, Minn. She has been in ASC management for 10 years, but her career has spanned many facets of the healthcare industry. She worked for 12 years in the "open heart room," and for 10 of those years in she was in a middle manager position. After earning another

degree, she started an ASC for the hospital where she worked before earning yet another degree and arriving at her current position.

When it comes to managing her staff, Ms. Berreth says, "I'm obsessive-compulsive, and I expect my staff to feel the same passion I feel about the highest quality healthcare and customer service." She notes that she has a list of accountabilities and competencies that her staff is held responsible to know and implement. "The best and smartest [people] will work their hardest if they know they are valued. They will be your resources for best initiatives that will lead to the best and safest care."

She says that her favorite part of working as an administrator is having the "ability to change what needs to be changed." "It's the Serenity Prayer in practice: Change what can be changed, accept what has to be accepted and have the wisdom to know the difference," she says.

Steven Blom, RN, CASC (Specialty Surgery Center, San Antonio, Texas). Mr. Blom is the administrator at the Specialty Surgery Center in San Antonio, Texas. Prior to coming to the Specialty Surgery Center in Oct. 2000, Mr. Blom started his career as an ICU nurse and progressively moved up the management ladder. He spent most of his career in critical care and cardiac catheterization labs.

Mr. Blom oversaw the construction of the center's new facility in 2005. "It was a great opportunity to start from scratch," he says. He also notes that the project was completed on time, cutting down on the amount of time the surgery center was closed. "We were shut down for a weekend," he says. "We closed the doors on the old location on Friday and were back to work at the new location on Monday."

One of Mr. Blom's favorite aspects about being an administrator is the people he gets to works with on a daily basis. Mr. Blom also enjoys the variety his job allows. "I can work on contractual issues with payors or provide back up when we're short," he says. "You never know what the day will bring."

Nancy Burden (Trinity Surgery Center, Tampa Bay, Fla.). Ms. Burden is the administrator for Trinity Surgery Center and director of ambulatory surgery for BayCare Health System, which operates four surgery centers in Florida. She started with Trinity when it opened in 1996. Prior to joining the center, she was a nurse manager and a PACU and quality improvement nurse at a freestanding ASC. She also held other PACU and ICU nursing positions before moving into the ambulatory surgery industry.

An emphasis on adding a personal touch and responding to physician needs is just a few of the ways which Ms. Burden says her center has found success. "Our staff and anesthesiologists care about our physicians, so it is a friendly and efficient place for them to work. No hassles, smiling faces, quick turnovers and happy patients all go to making their day a success," she says.

Ms. Burden also thrives on the organizational side of her duties as administrator. "Call me crazy, but I'm an organizer, so it suits me to oversee contracts, policies, board communications and the like. I actually like to analyze, implement and communicate regulatory requirements," she says.

Nancy Calhoun, RN, CNOR (Roanoke Ambulatory Surgery Center, Roanoke, Va.). Ms. Calhoun is the administrator at Roanoke (Va.) Ambulatory Surgery Center. Prior to coming to the ASC industry, she spent 21 years as a hospital nurse, serving in a variety of roles including OR nurse, head nurse of ENT and neurological surgery and clinical team leader of neurology, plastics and GYN. Ms. Calhoun then accepted a position as clinical team leader at an off-site ASC.

The positive feedback Ms. Calhoun receives from patient survey cards and personal notes of thanks are her favorite aspects of her job as administrator. "We are compared to the hospital all of the time, and the patients are so grateful to have the positive experience here that they say they do not or have not had there," she says. "That is the greatest reward ever, when you feel you are appreciated by those that you care for. We never had that personal communication when at the hospital."

Ms. Calhoun also notes the appreciation her physicians have for the center. "They love it here and are like different people than what I experienced when working with them at the hospital," she says.

Brenda Cyrulik, CASC (Eastland Medical Plaza Surgicenter, Bloomington, Ill.). Ms. Cyrulik is the administrator at the Eastland Medical Plaza Surgicenter, in Bloomington, Ill., a joint venture between St. Joseph Medical Center in Bloomington and 26 physician investors. Ms. Cyrulik has been at Eastland since 1999, when the center was fully owned

by St. Joseph. Prior to coming to Eastland, she served as a surgery manager at BroMenn Medical Center in Normal, Ill., and worked for two years as a circulating staff nurse at Gailey Eye Surgicenter in Bloomington, Ill.

Ms. Cyrulik makes every attempt to balance the needs of the patients, physicians and staff that have any association with the center. "I consider all three of these groups as having equal importance and continually put all the energy I have into actively seeking input and feedback, really listening, openly communicating the needs as I understand them and serving as an agent for change when needed," she says. "Over the years, frank conversations have typically lead to solid, trustworthy relationships and created a positive energy."

When it comes to working at her center and serving as administrator, Ms. Cyrulik notes that "contagious enthusiasm is alive and well in our positive work environment." "Everyone involved looks more for ways to make ideas work than looking for reasons why they won't," she says.

Eric Day, MBA, ATC, LAT (The Center for Special Surgery, San Antonio, Texas). Mr. Day is the administrator at The Center for Special Surgery at the Texas Center for Athletes medical complex in San Antonio, Texas. He started his career as an athletic trainer in the Austin market for HealthSouth Corp. He made the transition into administration with the help and support of those he worked with and began to work with outpatient rehabilitation and diagnostic imaging centers. From there, he began working with orthopedists at ASCs and was able to learn about the different aspects of the business.

Mr. Day credits his "dedicated staff that provides great care to our patients" for its success. He notes that the center is always willing to try new things. "I have managers whom are very motivated and get the jobs done in a timely manner," he says. "I have physicians whom are very supportive of the staff and the goals that we have set for the center. No day is exactly like the other at our center."

Mr. Day loves his daily interaction with the people at the center and ensuring that patients leave the ASC happy with their experience. The Center for Special Surgery is doing well in a market that is "full of ASCs," according to Mr. Day. "We are lucky that we are supported by the physicians in our building, and they keep the center going."

Jean Day, RN, CNOR (Boulder Community Musculoskeletal Surgery Center, Boulder, Colo.). Ms. Day is administrator of the Boulder (Colo.) Community Musculoskeletal Surgery Center. According to her colleagues, she provides unparalleled leadership to the surgery center, which specializes in orthopedics and pain management.

One colleague says, "Her unique collaborative management style affords surgery center personnel a rare opportunity to execute day-to-day operations under team leads in the pre-op, OR, PACU, and pain management clinic. When faced with difficult decisions, Jean gathers the necessary data, presents the information to the board and is more often than not asked to 'do what appears to be most appropriate,' underscoring the level of trust she has garnered from physician and hospital investors alike."

Gregory P. DeConciliis PA-C, CASC (Boston Out-Patient Surgical Suites, Waltham, Mass.). Mr. DeConciliis is the administrator of Boston Out-Patient Surgical Suites in Waltham, Mass., which is partially owned by a group of surgeons, Ambulatory Surgical Centers of America, the New England Baptist Hospital in Boston and the center's anesthesia group. He is a licensed physician assistant and worked at New England Baptist prior to assuming the role of administrator at the center. He continues to remain on staff at the hospital and assists with surgical procedures at the center.

Mr. DeConciliis enjoys working with his staff. "We are very fortunate to have a nursing and technical staff that are not only intelligent and extremely proficient in their respective areas but also have an uncanny ability to make every single patient feel as if they are a family member. This has led to extremely high levels of patient satisfaction, with, on average, over 97 percent of patients rating their experience as 'excellent' and over 99.99 percent of patients rating their experience as at least 'good,'" he says.

Mr. DeConciliis notes that no two days are the same at the center, a part of his job that he loves. "I find that every day I learn something new from someone or something but also hope that my close interaction with the staff and the surgeons help to keep them on track and add to their happiness in their jobs and also help to provide the best possible patient care that we all can as a team," he says.

Joan M. Dispenza, MSN, CASC (Ambulatory Surgery Center of Western New York, Amherst, N.Y.). Ms. Dispenza is the administrator of the Ambulatory Surgery Center of Western New York in Amherst, N.Y. The center is multi-specialty, and physicians there perform oph-

thalmology, orthopedics, plastic surgery, ENT, podiatry and pain management. It opened in Oct. 1999.

Ms. Dispenza has been with the center since it opened. In her role as administrator, she functions as the chief operating and financial officers. She is responsible for day-to-day operations and strategic and long-range planning. Prior to her current position, Ms. Dispenza was the director of ambulatory care services at Kaleida Health in Buffalo, N.Y., and director of nursing at the Millard Fillmore Gates Circle Hospital in Buffalo. Ms. Dispenza received her master's of science in community health administration and her bachelor of science in nursing from D'Youville College. In 2002, she is took the first national exam for surgery center administrators and is CASC certified. She is also a surveyor for AAAHC.

Under Ms. Dispenza's leadership, her center expanded from two operating rooms to six rooms.

Carolyn Evec, RN, CNOR (The Surgery Center at Beaufort, Beaufort, S.C.). Ms. Evec is the administrator at The Surgery Center at Beaufort (S.C.). Prior to coming to the center, Ms. Evec opened a surgery center in Missouri and served as the nurse manager at that location for 2.5 years. She has 30 years of nursing experience and primarily worked in the OR. She has held various management positions including director of surgery, director of medical and surgical services, vice president of patient services and director of rural health clinics.

Ms. Evec has helped improve efficiency at her center in many ways. "With the help of the staff, we developed an ordering system for supplies that now involves all of the staff and eliminated a part-time staff position," she says. "We now order supplies two days a week, and it takes only about an hour to complete the process."

Ms. Evec says, "I love the privilege and challenge of being involved in all aspects of the operations of the center. Coming from a clinical background, I have really enjoyed learning and being responsible for the business side of operations as well. I enjoy the fact that every day is different and that I have the ability and support of the medical staff to effect change when needed."

Michael Gossman, BSBA, CASC (Cedar Lake Surgery Center, Biloxi, Miss.). Mr. Gossman is the administrator at the Cedar Lake Surgery Center in Biloxi, Miss. Before coming to Cedar Lake in 2005, he served as administrator at Methodist Ambulatory Surgery Center in New Orleans, where he oversaw the start-up of the center, supervising construction, staffing, writing policies and establishing supply levels. He also established the Lake Forest Surgery Center in New Orleans.

In 2004, Mr. Gossman founded the Mississippi Ambulatory Surgery Association with a small group of supporters and served as its president from 2004-2008. "During that time, we managed to introduce a bill into the legislature regarding prompt payment of insurance claims," he says. "While it did not pass, it allowed all of us to understand the process. We also successfully halted some major negative changes to workers' compensation reimbursement for ASCs and are now able to sit with the Mississippi Workers' Compensation Committee as they make their decisions which will affect us." Currently, the association includes 18 centers and is a major sponsor in the Gulf States ASC Conference & Trade Show, now in its second year.

Mr. Gossman enjoys working with the "great group of professionals who are constantly striving to do their jobs better," he says. "We get an unbelievable number of complimentary patient survey cards which we post for all to see. It's very satisfying to have patients want to come to your center for surgery. My staff makes my day everyday."

Sherry Hardee, RN (Upper Cumberland Physicians Surgery Center, Cookeville, Tenn.). Ms. Hardee is the administrator at Upper Cumberland Physicians Surgery Center in Cookeville, Tenn., a multi-specialty center with two operating rooms and three procedure rooms. The center opened in 2004. Ms. Hardee has worked at Upper Cumberland for two years and has 30 years of nursing experience. Prior to coming to her current ASCs, she has held positions in operating rooms, office nursing, risk management and home health. She also has 20 years' experience in supervision and management positions.

Kenny Spitler, senior vice president of development for HealthMark Partners, says, "Sherry does an excellent job balancing the countless demands of being an administrator in a growing multi-specialty ASC. At any moment, Sherry could be checking in a patient, working in the recovery room, or meeting with a physician. She is genuinely concerned about every patient and every member of her staff. No matter what happens in a day, Sherry leaves you with the comfortable and calming feeling of 'everything will be okay.'"

Ms. Hardee credits her success and the success of the center to her "knowledgeable, dedicated and efficient" staff. With their assistance, Ms. Hardee enjoys that as administrator she can "ensure we give high quality, cost effective care to our community."

Carolyn R. Hollowood, RN, BSN, CNOR, RNFA, CASC (City Place Surgery Center, Creve Coeur, Mo.). Ms. Hollowood is the administrator of City Place Surgery Center in Creve Coeur, Mo. She has been a part of the center for 10 years. Prior to coming to City Place, she was a RN first assistant at an acute care center. She has 20 years of nursing experience.

Designing and building the new center has been one of the highlights of Ms. Hollowood's career. "I oversaw construction for half a day, everyday, wearing a hard hat, safety glasses and a vest," she says. She is also proud of the fact that she oversaw a smooth transition to the new center. When orchestrating the move, she proudly says that the ASC only lost one half-day in cases.

Ms. Hollowood says one element of her job that she loves is the opportunity to introduce new procedures and concepts into the daily operations at her center. "The autonomy you have as an administrator is a great thing, especially when you see that you can implement something that will make

a positive difference in the care of the patient," she says. "It's very rewarding to see the results."

Jennifer Hunara (Surgery Center of Allentown, Allentown, Pa.). Ms. Hunara is the administrator of the Surgery Center of Allentown (Pa.). The center is a joint venture between 27 physicians and the Ambulatory Surgery Centers of America. Ms. Hunara has been with the center since its inception and came on six months before its opening. Her prior roles were as the executive director of surgical services for Robert Wood Johnson University Hospital Hamilton, and the business manager of perioperative services for Lehigh Valley Hospital & Health Network. Both of these jobs have provided her with the skill set to be successful in her current role.

Ms. Hunara lauds her management team as critical to the success and growth of the center. "We've all been in it together since the beginning," she says. "Each of us brings different strengths to the table, which makes us an incredibly cohesive group."

Ms. Hunara also notes the success of the ASC's "Commitment to P3" program, which was designed by management and staff, and focuses on the center's dedication to its three customer groups — patients, physicians and personnel. "It was an effort in culture building," she says. "We sat down as a group and discussed what we liked and didn't like from our past jobs, and from that made a commitment to be different in how we looked at service to our customers."

Lisa Kelley, RN, MBA (Summerlin Bend Surgery Center, Ft. Meyers, Fla.). Ms. Kelley is the administrator at Summerlin Bend Surgery Center, which is partnered with the Ambulatory Surgical Centers of America. Prior to coming to Summerlin Bend, she served in a variety of positions in hospitals, such as chief nursing officer, COO, director of quality management and regional director of quality and resource management in Florida and the northeastern states.

Ms. Kelley has led her center to success by ensuring the quality program of the facility is a product of everyone, including patients, staff and physicians. "I always follow through on the suggestions or comments or constructive criticism and make decisions involving everyone's input," she says.

Ms. Kelly tries to "find the smartest, enthusiastic staff possible," she says. "People with great attitudes are a joy to work with in such a high energy, intensive atmosphere." She enjoys the autonomy her position as administrator

provides. "Every day there is a new challenge to stretch your critical thinking and problem-solving skills, and you learn from each experience," she says.

Cindy Ladner, BSN, CAPA (Shawnee Mission Surgery Center, Shawnee Mission, Kan.). Ms. Ladner is the administrator at Shawnee Mission (Kan.) Surgery Center and Shawnee Mission Prairie Star Surgery Center in Lenexa, Kan. She has served as administrator of Shawnee Mission for five years. Prior to entering the ambulatory surgery industry, she served as a nurse and nurse educator at a day surgery center before "falling into" her role as administrator. Ms. Ladner has also served as a nurse in the PACU area and in various surgical services throughout the hospital setting.

Ms. Ladner is proud of leading her center through Joint Commission accreditation. "When we made the decision to become accredited, the whole staff became engaged in the process. They really stepped up to accomplish this goal," she says. "Our first survey went well, and the surveyor was appreciative of the care that went into operations at our center."

Ms. Ladner says her favorite part of being an administrator is that there is always something to learn, especially in a multi-specialty center. She says the building and opening of a new center was a rewarding learning experience. "I also like being accountable for the total operations of the center," she says.

Rosemary Lambie, RN, MEd, CNOR (SurgiCenter of Baltimore, Owings Mills, Md.). Ms. Lambie is the administrator at the SurgiCenter of Baltimore, located in Owings Mills, Md. She has been with the SurgiCenter of Baltimore for 16 years, starting out as the director of surgical services and then moving into the role of administrator three years ago. She has been a perioperative nurse for the past 35 years and began her career as a staff nurse in an inpatient OR, moving up to become the head nurse of a hospital OR.

Ms. Lambie also understands and has experienced challenges an ASC faces when it runs into tough financial obstacles. "Success is not always easily achieved," she says. "Over the course of the past 20 years, we have had to make some difficult decisions including downsizing when volumes shifted."

In spite of some difficult decisions she has had to make, Ms. Lambie enjoys her job, especially her involvement in both the clinical and business aspects of the center. "I am actively involved in the decision making process and have the support of my corporate and physician investors," she says. "As compared to leadership role in a hospital setting, there is much more autonomy and trust for leadership in an ASC setting."

Diane Lampron, RN (The Surgery Center at Lutheran, Wheat Ridge, Colo.). Ms. Lampron is administrator of The Surgery Center at Lutheran in Wheat Ridge, Colo. She took over the administrative role of this ASC approximately one year ago.

Her colleagues speak highly of her leadership skills. One says, "Underlying her quiet, calm demeanor is a woman who clearly knows where she's headed and how she intends to get there."

Ms. Lampron works closely with physicians, hospital leaders and employees to create a culture that affords patients affordable, high quality care. Her colleagues say one of her strengths is the ability to assess cost per case and mentor materials management personnel to assist with expense reduction. One colleague says, "She works diligently with physicians in the surrounding area and has recently recruited a valued spine surgeon to add additional volume required to transition the center from one that is merely surviving to one that is thriving."

Liliana R. Lehmann, MBA (Hallandale Outpatient Surgery Center, Hallandale Beach, Fla.). Ms. Lehmann is the administrator of the Hallandale Outpatient Surgery Center (HOSC) in Hallandale Beach, Fla. She has been with HOSC since 2003. "I have been closely involved since this center was just a vision. Being in charge of developing and then receiving all of the accreditations with 'flying colors' is a great accomplishment," she says. "Establishing and maintaining accrediting body/state licensure standards has been very satisfying."

Ms. Lehmann has been successful in developing and implementing financial goals and objectives at HOSC. "By being involved in all aspects of the ASC, I have been able to coordinate, recommend and guide various financial and operational factors in order to achieve the required outcomes," she says.

The team vision of the HOSC staff that is "perceived by patients, physicians and vendors alike" is Ms. Lehmann's favorite aspect of the center. "We are all here to provide excellence, safety, quality, satisfaction, integrity and efficiency. Our patients, physicians and surveyors observed it and mentioned it to us in more than one occasion," she says.

Robert McDavitt, RN, MBA, CASC (Spring Surgery Center, Montgomery County, Texas). Mr. McDavitt is the administrator of the Spring Surgery Center in Montgomery County, Texas. He has been an administrator since 2003, and has worked with National Surgical Care and assisted a center enter into a corporate partnership with AmSurg. Mr. McDavitt is also a registered nurse and worked in the emergency department and ICU.

Part of what Mr. McDavitt thinks makes him a strong leader is his willingness to examine other industries for examples of effective business practices.

"I usually try to look outside of healthcare to other business models for inspiration," Mr. McDavitt says of his leadership style. "The other thing that I have figured out is that building strong partnerships with credible,

qualified vendors and great physician relationship skills are critical to success in the surgery center business."

Mr. McDavitt appreciates the bonds he has created with physicians, staff and companies that he has worked with, especially while building Spring Surgery Center. This appreciation has carried over into his management style. "I try to stay humble and help others whenever I can because, goodness knows, I have been blessed with people helping me," he says. "I try to take my clinical knowledge, use good financial judgment and make decisions as a team, rather than an individual."

Kelli McMahan, RN (Litchfield Hills Surgery Center, Torrington, Conn.; Bone & Joint Orthopedic Surgery Center, Wausau, Wis.; Northwoods Surgery Center, Woodruff, Wis.). Ms. McMahan serves as the administrator for three facilities in two states: the Litchfield Hills Surgery Center in Torrington, Conn.; the Bone & Joint Orthopedic Surgery Center in Wausau, Wis.; and the Northwoods Surgery Center in Woodruff, Wis. She is also the vice president of operations, Eastern region, for Pinnacle III.

Prior to joining Pinnacle III, Ms. McMahan developed and managed a large physician-owned orthopedic surgery center for 13 years in Fort Wayne, Ind. She joined Pinnacle III in 2006 and began as director of operations and assisted with several development projects.

Ms. McMahan says one of the highlights of her job is working with the employees at all three of her centers. "The employees love caring for the patients and also enjoy keeping our physicians happy," she says. "I enjoy working with the employees and having them take ownership of their facilities and their work practices. Once the staff understands the goals for the surgery center, they put every effort into making their work environment the best possible for their patients and their physicians."

Joe Majerus (Lakewalk Surgery Center, Duluth, Minn.). Mr. Majerus is the administrator of Lakewalk Surgery Center in Duluth, Minn., a multi-specialty ASC that specializes in orthopedics, plastic surgery, gastroenterology, oral surgery, ophthalmology and pain management. He has been with center since it opened in 1999 and oversaw its building and development. Prior to coming to Lakewalk, Mr. Majerus served as a CFO for a hospital in Minnesota.

Mr. Majerus has seen success in creating an efficient ASC by training his nursing staff to work both in the center's six operating rooms, three procedure rooms and 18 private recovery areas. "Building our six ORs exactly the same along with providing quality and technically current equipment in each has kept our scheduling of multi-specialty cases flexible and efficient," he says.

Mr. Majerus' favorite aspect of being an administrator is the variety of subjects he tackles and the range of responsibility he has on a daily basis. "We are an independent ASC and contract out very few things, so I end up managing our very own version of surgery center operations," he says.

Melody Mena (Spivey Station Surgery Center, Jonesboro, Ga.). Ms. Mena is the administrator of Spivey Station Surgery Center in Jonesboro, Ga., and the managing director of surgical services for Southern Regional Health System, based in Riverdale, Ga. The center originally

was opened 1998 by Georgia Baptist Health System. In 2000, the center became a joint venture between Southern Regional Health System and its physicians. Ms. Mena has been the administrator at Spivey Station since 2005.

One approach that Ms. Mena says has been valuable to her success as an administrator is to write four-year strategic plans for her businesses, including the surgery center. "Our first four-year plan was focused on operational and financial improvements such as resolving issues of nonpayment for implants, lowering expenses, addressing aggressive management of our contracts, automating the center by going paperless and implementing business intelligence tools, and finally re-branding and marketing the center effectively," she says. "We did so well, we grew right out of our existing space and opened our new facility in April."

Ms. Mena's says the favorite component of her ASC is the staff and physicians who "believe in being the best and make it happen everyday." She also enjoys being an administrator because she is "able to implement a vision that raises the bar of the future of healthcare."

Laura Baxley Millard, RN, BS, CPHQ (Vail Valley Surgery Center, Vail, Colo.). Ms. Millard is the administrator of the Vail Valley Surgery Center in Vail, Colo. She has been at Vail Valley since Jan. 2006. In her 25 years in the healthcare industry, she has served as the CEO of a surgical hospital, administrator at another ASC, a government auditor and a critical care nurse. She has also held leadership positions in the insurance industry.

At Vail Valley, Ms. Millard has worked hard to improve staff recruitment and retention, and undertake new projects to improve the efficiency of the ASC. She recently led an initiative to convert monitors to high definition within the center, and developed a program to significantly enhance block utilization and case volume. Additionally, she has facilitated significant improvements to the revenue cycle. Coming up with these solutions is one part of her job that she enjoys. "I love the constant challenge to improve in all areas — clinically, operationally and financially," she says.

Another aspect of her job that Ms. Millard enjoys is the opportunity she gets to work with "world-renowned surgeons who are continuously on the cutting edge," she says. "The expectations are extremely high, but the rewards are absolutely worth it."

Beth Miller, RN, CASC (Eastside Endoscopy Center, St. Clair Shores, Mich.). Ms. Miller is the administrator of the Eastside Endoscopy Center in St. Clair Shores, Mich. She started as the nurse manger with Eastside when the center opened. She moved her way up to become the business manager and finally to her current position as administrator. Prior to coming to Eastside, she worked at a local hospital for 16 years, working nine of those years in endoscopy where she served as assistant manager. Ms. Miller is the first administrator in Michigan to receive CASC certification.

Under Ms. Miller's leadership, Eastside has implemented many programs that have helped the ASC succeed. For example, she and the medical director developed a staff incentive plan in which the staff receives a percentage of the centers' profits if certain goals are met. Other initiatives include a successful, comprehensive quality assessment program. "The staff participates and is committed to the program and takes pride in their accomplishments," she says.

Ms. Miller is proud that her centers have been able to remain financially successful in spite of reimbursement cuts for GI procedures. "This is due to an increasing caseload and by finding creative ways to cut expense without compromising patient care," she says.

Elaina Milliken (Eastern Orange Ambulatory Surgery Center, Cornwall, N.Y.). 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. According to her colleagues, she has been instrumental in turning the center, which consists of four operating rooms and two procedure rooms, into a superb operational entity.

Before arriving at Eastern Orange, Ms. Milliken previously 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 the three-year accreditation from AAAHC.

Ms. Milliken works in collaboration with FDM staff and strives to identify opportunities with her team to maintain the center at optimum operations as well as balancing the needs of the members of the joint venture. A colleague says, "She accomplishes these goals by utilizing her talents for organization coupled with her awesome sense of humor and her flair for exceptional people skills. Her can-do attitude enables her to maintain the many aspects of running the center in an efficient and cost effective manner."

Melodee Moncrief, RN, BSN, CASC (Big Creek Surgery Center, Middleburg Heights, Ohio). Ms. Moncrief is the administrator for the Big Creek Surgery Center in Middleburg Heights, Ohio, a member of Foundation Surgery *Affiliates*. She has more than 15

{ healthcare challenge no. 247 }

IF DR. NELSON THE SURGERY CENTER OWNER AND MEDICAL DIRECTOR NEEDS TO REDUCE COSTS ON PHARMACY PURCHASES BY TEN PERCENT SO THAT HE CAN FIND THE CAPITAL TO PURCHASE NEW EMR TECHNOLOGY, HOW CAN HE INSTITUTE QUALITY MEASUREMENT AND ASSURANCE PRACTICES?

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years of experience in the ASC industry after previously serving as a nurse's aid and an ICU nurse at a hospital.

For each of the 20 physicians working at the center, the staff tries to make each one feel as though they are the only surgeon at the center. "We try to make it our whole team approach. Not one person's idea is any better or more important than another's," Ms. Moncrief says.

Ms. Moncrief and her staff also take this approach with patients. "We make each patient feel as though he or she is the only patient here," she says. This has led to a positive patient response, especially when it comes to the pediatric cases at the center. "We have children who come into the center and are screaming, but by the time they leave they are smiling," she says. "Many people ask how we do that, and it is due to our knowledgeable and friendly staff."

David Moody, RN, BA (Knightsbridge Surgery Center, Columbus, Ohio). Mr. Moody is the administrator at Knightsbridge Surgery Center in Columbus, Ohio. Mr. Moody has been with the center for five years. Prior to coming to Knightsbridge, Mr. Moody, who also has a background in nursing, operated a number of refractive centers that performed LASIK eye surgery. He was also an administrator at a hospital in Columbus.

Mr. Moody enjoys the latitude his job allows him and likes that he has the ability to "wear multiple hats." "I'm not just an administrator," he says. "I can be a scrub nurse or an OR nurse. I love interacting with the physicians."

He also notes that he enjoys working with everyone at his center, from the management company, Regent Surgical Health, to the physicians, to the clinic staff. "I have a great group of physicians who I consider friends and professional partners," he says. "I can go on vacation and trust that my incredible staff runs everything the way it should be run."

Michael Pankey, RN, MBA (Ambulatory Surgery Center of Spartanburg, Spartanburg, S.C.). Mr. Pankey is the administrator of the Ambulatory Surgery Center of Spartanburg in Spartanburg, S.C., a joint venture with Spartanburg Regional Hospital. He served as administrator and clinical resources manager at different locations. His background is in nursing, and he worked in the operating room at several hospitals. He served for 10 years in the U.S. Army Reserve. Mr. Pankey also served as the president of the South Carolina Ambulatory Surgery Center Association.

Mr. Pankey has seen his center through many successes. One achievement that he is particularly proud of is the addition of GI to his center in its second year. "We introduced propofol anesthesia to the specialty in our area," he says. "This makes our patients more comfortable and our GI practitioners more efficient. This specialty now accounts for 30 percent of the business in the center."

For Mr. Pankey, running an efficient business and providing quality care to the community are his favorite aspects of his job. "My clinical director has told me that she can tell that I enjoy watching an efficient process," he says. "I guess she is right. I love to watch the staff at Waffle House. They seem to have an ability to control confusion. I guess looking at a busy surgery center must look a lot like that to an outsider."

Robert A. Puglisi, CASC (Huntington Valley Surgery Center, Huntington Valley, Pa.). Mr. Puglisi is the administrator at Huntington Valley (Pa.) Surgery Center, which is managed by Foundation Surgery *Affiliates*. He has 15 of years experience in the healthcare industry and worked for a healthcare consulting firm as a senior consultant specializing in physician practice acquisitions and physician billing enterprises. Prior to joining Huntington Valley in Aug. 2003, he was employed as a project manager for Philadelphia-based Independence Blue Cross.

One of the keys to Mr. Puglisi's success has been physician education regarding the daily operations of the facility. "They understand how and why things run the way they do," he says. "I try to keep the physicians abreast of costs, reimbursement levels and political trends that could affect them. I also try to be transparent with everything we do at the center."

The aspect Mr. Puglisi enjoys most about his job as administrator is the multitude of responsibilities he is asked to assume. "I enjoy working through daily issues," he says. "This morning, I was on the roof resetting the air conditioning. This afternoon, I have an insurance contract to negotiate. "

Linda Rahm (Pioneer Valley Surgicenter, Springfield, Mass.). Ms. Rahm is the administrator at Pioneer Valley Surgicenter in Springfield, Mass. Previously, she 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. Ms. Rahm serves as the president for the Massachusetts Association of Ambulatory Surgery Centers. She enjoys the opportunities she has had with her involvement in National Quality Collaborative projects.

A colleague says of her leadership, "She is an extremely talented woman, well versed in negotiations, efficiency and overall cost savings measures. She is very active with the legislation in Massachusetts legislature and has done a tremendous amount of work for the MAASC fighting legislation, holding fundraisers and speaking at the State House and working to improve our overall well-being."

Ms. Rahm sees continued success for her center. "I see a lot for the future of my center, including adding ophthalmology, expanding ENT and moving into an EMR. Most significant is getting our state license, allowing us to *finally* serve the Medicaid population equal to those under private insurance or Medicare," she says.

Barbara L. Ramsey, RN MSN CASC (Rush SurgiCenter, Chicago). Ms. Ramsey is the administrator of Rush SurgiCenter in Chicago. She has been with Rush SurgiCenter since Feb. 2002. Ms. Ramsey has worked exclusively with freestanding ASCs since 1996 and also has a nursing background in critical care and emergency medicine. She has assumed many leadership roles including charge positions, director of nursing and administrator since 1999.

While at Rush SurgiCenter, Ms. Ramsey has overseen many initiatives including the implementation of the EMR and a comprehensive orientation plan, which includes teaching new graduates and adding a clinical educator position. Other efforts have included the initiation of a new recruitment and retention plan for staff including better benefits, cross-training and establishing and implementing educational labs for the residents at the center. "Our biggest initiative, though, is acknowledging the value each member of our team brings to the success of our center," she says.

Ms. Ramsey's favorite aspect of her center is the staff. "They are my inspiration, my success, my challenges and the reason this center is a success it is," she says. "I often say I have 52 children and only gave birth to two. I am very proud of all their accomplishments. We are family."

Anne Roberts, RN (Surgery Center at Reno, Reno, Nev.). Ms. Roberts is the administrator at the Surgery Center at Reno (Nev.). The surgery center also has a unique ownership model which consists of physician partners with a majority ownership, a hospital partner — Saint Mary's Hospital in Reno — and a managing partner — Regent Surgical Health.

Ms. Roberts began her career as a nurse in the emergency department, spending 16 years as a staff nurse and 10 years as the manager of a busy ED seeing 55,000 patients annually. "The experience in the ED setting has provided me with the ability to multitask, manage multiple, often competing priorities while fostering the provision of patient care, managing a complex budget, mentoring of employees and continuous assessment of the services being provided," she says.

Over the past few years, Ms. Roberts has overseen significant growth at her ASC. Recently, it obtained AAAHC accreditation and went through all of the process changes necessary to receive this recognition of patient safety excellence. In addition, the center has created a "progressive spine program, pain management program and excellent orthopedic service line," she says. "We started an outpatient bariatric program shortly after we took over the facility. I am very proud of the excellent care we provide to our patients with a focus on exceeding the physician and patient's expectations."

Marcy Sasso (Ambulatory Surgical Center of Union County, Union, N.J.). Ms. Sasso is the director of operations at the Ambulatory Surgical Center of Union County in Union, N.J. Prior to her current position, she held various roles at other surgery centers including operations manager, pain management liaison and administrator, financial and legal administrator for a physician private practice, and office manager for an outpatient physical therapy facility.

In 2000, Ms. Sasso and a fellow administrator started, and now co-chair, a surgery center coalition of administrators. "We felt we needed others to help with our day-to-day questions," Ms. Sasso says. "Now, we have over 65 other centers as members. We share amazing information which ultimately benefits all of the centers."

Ms. Sasso says efficient communication is critical to her success as an administrator. Some of the ways in which Ms. Sasso has demonstrated her communication skills are by creating an informative Web site for the center and a patient satisfaction program that is conducted in both English and Spanish. She has an open-door policy for all of the ASC's staff and encourages continuing education for the staff. She says that the center cross-trains all staff, enabling them to take on projects that allow them to use their strengths. "We had a receptionist that used to do infection control for a hospital," Ms. Sasso says. "She teamed up with one RN who expressed interest in infection control, and it's a dynamite team."

Maria Sample, CASC (Roper Hospital West Ashley Surgery Center, Charleston, S.C.). Ms. Sample is the administrator at the Roper Hospital West Ashley Surgery Center in Charleston, S.C. She spent her career concentrating on surgical services and started out as an operating room nurse, "circulating and scrubbing on all types of procedures in community hospitals and a regional trauma center," she says. Ms. Sample became involved in perioperative education and then held a supervisory role in a surgical services department within a hospital.

Ms. Sample says the staff is the essential piece to the success of a surgery center. "Although competency is essential, I have found the most important attributes for a staff member to possess is a 'can do' attitude and the ability to be a team player," she says. "Staff can be, and should be, instrumental in streamlining processes that result in operational efficiencies, which in turn result in physician and patient satisfaction."

Ms. Sample enjoys many aspects about serving as administrator, but she says her favorite part of the job is "the ability to lead or respond to internal and external changes that ultimately impacts the lives of many, including our patients, our physicians and our staff."

Catherine Sayers, RN (Skyline Endoscopy Center, Loveland, Colo.). Ms. Sayers is the administrator for Skyline Endoscopy Center, a single-specialty GI endoscopy center, in Loveland, Colo. Ms. Sayers is also director of clinical operations for Pinnacle III and has developed or managed 13 single- and multi-specialty ASCs throughout the country. Prior to working for Pinnacle III, she was director of surgical services at the Orthopaedic Center of the Rockies in Fort Collins, Colo., where she managed the ASC and a 10-bed recovery center.

One of Ms. Sayers' most successful initiatives as an administrator has been implementing an employee-incentive plan. "Through this plan, employees share in the distributions paid to investors," she says. "They receive a percentage of the distributed amount if they have met pre-established goals and criteria. I believe this program provides incentive for the staff to be cost conscious, efficient and work as a team. They are rewarded as a member of the ASC team; therefore, they truly feel like an integral part of the ASC."

Ms. Sayers says her staff at Skyline is a crucial asset to the center's success. "Every staff member is dedicated to providing the highest quality care and excellent customer service," she says. "They are lead by an exceptional nurse manager, who is a joy to work with, and they function as a dynamic team."

Lisa Schriver, RN, CNOR (Turk's Head Surgery Center, West Chester, Pa.). Ms. Schriver is the administrator of Turk's Head Surgery Center in West Chester, Pa., a physician-hospital joint venture. She started with the center in 2005 as the clinical director and moved up to become administrator. Previously, she had a varied career in nursing and served in various departments. From there, she moved to a hospital-based surgery center and became the nurse manager.

One of the biggest changes for Ms. Schriver has been the transition and re-syndication of her center with Blue Chip Surgical Partners. "Prior to their coming on board, I was frustrated and had actually resigned my previous position to return to a hospital as a staff nurse in the OR," she says. "I laugh now because that would not have lasted long; based on my background and my need to keep climbing the ladder or to find projects that need spearheading."

Ms. Schriver enjoys her role as an administrator because of the changing nature of her job. "Everyday is different, and I can use my sense of adventure to tackle each day. Some days this never-ending change is overwhelming, but at a basic level it really very much appeals to my personality and who I really am," she says.

Dennis Simmons, MBA (Wayne Surgical Center, Wayne, N.J.). Mr. Simmons is the chief operating officer for the Wayne (N.J.) Surgical Center. Previously, he worked for several healthcare management and consultant companies and served in a variety of roles including senior vice president, COO and director. Mr. Simmons also worked as a paramedic in the emergency services department for Austin, Texas, and served as director of the department.

Under Mr. Simmons' leadership, Wayne Surgical has experienced significant growth, including the acquisition of the Elite center. The center is 100 percent physician-owned and started out with seven physician owners and currently has more than 40 owners. The center also began a lithotripsy program several years ago.

Mr. Simmons and Wayne Surgical have also been at the forefront of litigation against insurance companies, such as *Garcia, et al. v. HealthNet of New Jersey, Inc.*, which, according to Mr. Simmons, "challenged the entire ACS industry in New Jersey." Additional cases are pending against insurance companies and their reimbursement policies, he adds. "Our future at Wayne is working to define reimbursement and ASC regulations in New Jersey with the state and insurance companies and finding a middle ground," he says.

Lynda Dowman Simon (St. John's Clinic, Springfield, Mo.). Ms. Simon is the administrator at St. John's Clinic in Springfield, Mo. Prior to coming to St. John's, she worked for 13 years at a local hospital in the open heart center and urology. She spent four years in a telephone triage room before making the move to the ASC industry.

Ms. Simon created the successful "Hiring for Fit" program in which she and her staff learned how to ask "negative" questions to potential hires. "It tells you a lot about the personalities of the people you are interviewing," she says. "I want to see how someone can make a positive out of a negative. If they are able to take a challenge and give a nurturing answer, I know they will be good caregivers and are in touch with the needs of the patient."

Ms. Simon says she truly enjoys her position as administrator. "There are so many facets I can get into and wrap my fingers around," she says. "I

get to do so much from helping incorporate changes in service to working shoulder-to-shoulder with nurses in recovery." Ms. Simon encourages other RNs who feel like they have something to offer surgery centers to look into management. "There are so many ways to apply what you know and make a better environment for the staff," she says.

Jim Stilley, CASC (Northwest Michigan Surgery Center, Traverse City, MI). Mr. Stilley is the CEO of Northwest Michigan Surgery Center. Previously, he was an executive director with National Surgical Care and was a Lieutenant Commander in the U.S. Navy. He has also worked in the hospital setting. Mr. Stilley currently serves as the president of the Michigan Ambulatory Surgery Association.

With operating a center as large as NMSC, Mr. Stilley has taken a "back-to-basics" approach. "I received some excellent counsel from Dawn McLane, who was my vice president when I was with Aspen [Healthcare] and NSC," he says. "She's pretty thorough, and she taught me how to keep the investor physicians happy and productive."

Staffing costs is one area that Mr. Stilley has worked hard to keep under control. "Working with the staff to keep flexibility first and foremost when it comes to staffing needs has been essential to our success," he says. "They are smart, loyal and, by and large, happy! I am very blessed to have such a great team; they are truly second to none."

Stephanie Stinson, RN, BSN, CASC (Strictly Pediatrics Surgery Center, Austin, Texas). Ms. Stinson is the administrative director of the Strictly Pediatrics Surgery Center in Austin, Texas. The center opened in April 2007 and is an exclusive, pediatric-only ASC. "I am very proud of the fact that there is only a handful in the country," she says. Ms. Stinson has been a nurse for 16 years and has served as a staff nurse in the neurology/surgical ICU, surgery and the recovery room.

Ms. Stinson says of her center, "It is an atmosphere created here by a very caring staff that tries really hard to provide a fun, non-threatening environment. In fact, when siblings come for their sister's/brother's surgery, they leave stating they want to come have surgery. If we have kids leaving here saying things like that, it really makes you proud of your organization, and it gives you a sense of pride that you must be doing something right," says Ms. Stinson.

Ms. Stinson loves the challenges that she experiences on the job and learns something new every day in her position. "One minute you may be recovering a patient, educating the staff on policy and procedure changes, credentialing a new physician or processing HR paperwork on a new employee and that was all in the first hour of your day. I love the fact that you as an individual are always stimulated mentally and physically," she says.

Dianne Wallace, RN, BSM, MBA (Menomonee Falls Ambulatory Surgery Center, Menomonee Falls, Wis.). Ms. Wallace is the executive director and CEO of the Menomonee Falls (Wis.) Ambulatory Surgery Center, a joint venture between a local community hospital and two larger medical groups. Ms. Wallace has administrative experience in hospitals, home health, medical groups and ambulatory surgery. Prior to serving in administrative roles, she spent a number of years working as a registered nurse in hospital inpatient, outpatient, emergency room, home-health and long-term care settings. She served as past president of the Wisconsin Surgery Center Association and the MGMA ASCA executive committee.

While at MFASC, Ms. Wallace has overseen much of the growth at the center, including the creation of the GI center. "MFASC performed primarily surgical procedures," she says. "About six years ago we opened our new GI center. We were able to double our case volume within a couple of years after adding this specialty. We have also added and expanded pain as a service."

Ms. Wallace has also enacted a staff cross-training program that has proved very beneficial. "Staff cross-training has been successful at maximizing efficiencies and avoiding position cuts in this down economy," she says. "We have successfully achieved three, 3-year AAAHC accreditations in the past 10 years."

Christine Washick (Orthopedics and Sports Surgery Center, Appleton, Wis.). Ms. Washick is the director of operations at the Orthopedic and Sports Surgery Center. She began working at the center in June 2006 as a staff PACU nurse. In 2007, she was appointed to clinical coordinator before moving to her current position in 2009. "I have had an awesome opportunity to learn about our ASC from the ground up," she says.

In March 2008, Ms. Washick played an instrumental role in the ASC adding partial knee replacements to its list of procedures. "Since April 2009, we have successfully incorporated total knees into our joint program. We have plans to perform our first total hip by Aug. 2009," she says.

Ms. Washick loves the comprehensive care that her center can offer their patients. "We offer many entities such as physical therapy, MRI, orthotics and sports medicine in addition to surgical services," she says. "Patients often mention that they feel welcomed and that they feel that our staff are there just for them." Additionally, Ms. Washick says that the physicians at the center are open to staff bringing their ideas about personal patient care to them.

Ginger White, RN, BSN, MSHA, CASC (Rockwall Surgery Center, Rockwall, Texas). Ms. White is the administrator of the Rockwall (Texas) Surgery Center, which opened in Sept. 2004. Prior to coming to the center, she served in a variety of roles at hospitals, starting as an OR tech before moving into management and serving as the director of outpatient services for small and large hospitals. She later became assistant director of nursing for a 555-bed hospital before becoming the director of physician services, including physician recruitment, for the hospital. Ms. White also served as administrator of the children's hospital, located within the facility.

Ms. White has used her hospital experience to help her to institute cost-saving measures at her center in order to increase profits. She also developed new programs to sustain the organization through developing a team to provide quality care. She enjoys working the physicians and staff members she works with on a daily basis and who were critical in making these initiatives successful.

When it comes to her role as administrator, Ms. White says, "I enjoy the challenge [of overseeing operations at the center], mixed with the creativity [needed] to integrate processes and programs with staff, physicians and patient care."

Cindy Young, RN, CASC (Surgery Center of Farmington, Farmington, Mo.). Ms. Young is the administrator of the Surgery Center of Farmington (Mo.). She has been at the Surgery Center of Farmington 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 OR at the hospital.

"I absolutely love my job," says Ms. Young. "I love ambulatory surgery. I found my niche." She credits the success of her center and herself to the staff and physicians. "We work together as a family," she says.

She also credits a part of her success to the support she receives from Woodrum/ASD, which manages the center. "If it wasn't for them giving me the administrator opportunity and supporting me, I wouldn't be where I'm at," she says. ■

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PROGRAM SCHEDULE

Pre Conference – Thursday October 8, 2009

11:30am – 1:00pm	Registration
1:00pm – 5:15pm	Pre-Conference
5:15pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Main Conference – Friday October 9, 2009

7:00am – 8:00am	Continental Breakfast and Registration
8:30am – 5:15pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:15pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 10, 2009

7:30am – 8:15am	Continental Breakfast
8:15am – 1:00pm	Conference

Thursday, October 8, 2009

Concurrent Session A
Improving Profits, Turning Around ASCs, and Benchmarking

1:00-1:45pm
Turning Around an ASC, Key Lessons from Case Studies — Brent Lambert, MD, Principal, Ambulatory Surgical Centers of America

1:45-2:25pm
Running Your ASC Smarter - Benchmarking - Improving Revenues per Case, Reducing Hours per Case, Supply Costs per Case, Staffing and More — Susan Kizirian, COO, Ambulatory Surgical Centers of America and Tom Bombardier, MD, FACS, Founder of Ambulatory Surgical Centers of America

2:30-3:15pm - KEYNOTE
Driving a Business to Success, Lessons from Jack Welch and GE and The Importance of Effective Communication — Bill Lane, Former Speech Writer to Jack Welch

3:20-4:00pm - KEYNOTE
The Payors View of ASCs and Paying for Healthcare — Steven Stern, MD, VP Neuroscience, Orthopedic and Spine, United Healthcare

4:05-4:35pm
3 Ways to Improve Profits in ASCs — Larry Taylor, CEO, Practice Partners in Healthcare

4:40-5:15pm
Selling Shares to Physicians - Business and Legal Issues — Larry Taylor, CEO, Practice Partners in Healthcare, Elissa Moore, Associate, McGuireWoods LLP and Melissa Szabad, Partner, McGuireWoods LLP

Concurrent Session B
Business Planning for ASCs; Spine, Orthopedics and Pain

1:00-1:45pm
Business Planning for ASCs — Tom Mallon, CEO, Regent Surgical Health and Jeff Simmons, President, Western Division Regent Surgical Health

1:45-2:25pm
Minimally Invasive Spine Surgery in ASCs — Greg Poulter, MD, Peak One Surgery Center and Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

3:20-4:00pm - KEYNOTE
How to Work with Generation Y — Bruce Bright, Lt. Colonel, Introduced by Bart Starr

4:05-4:35pm
Orthopedics - The Forecast for the Next Five Years — John Cherf, M.D., Dept. of Orthopedics, The Neurological & Orthopedic Hospital of Chicago

4:40-5:15pm
Building Outstanding and Profitable Pain Management Centers, Making Pain Profitable — Robin Fowler, MD, Interventional Spine and Pain Management Ambulatory Surgical Center, Inc.

Concurrent Session C
GI, ENT, Bariatrics and Specialties

1:00-1:45pm
ASCs and Gastroenterology - What to Do Now? — John Poisson, Executive VP, Physicians Endoscopy

1:45-2:25pm
Assessing and Improving the Profitability of ENT in ASCs— Jim Corum, Vice President Operations, Healthmark Partners and Mark Mashburn, MD, SurgiCenter of Baltimore

4:05-4:35pm
Building a Successful Bariatrics Program - 10 Keys to Success — Tom Michaud, CEO, Foundation Surgery Affiliates

4:40-5:15pm
What are the Best Specialties to Add to Your ASC and Why — John Marasco, Principal and Owner Marasco and Associates and Rob McCarville, Principal, Medical Consulting Group, LLC

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Concurrent Session D
Billing, Coding and Contracting for ASCs

1:00-1:45pm
A Case Study Approach - How to Transform Your Billing and Collections — Caryl Serbin, CEO, Serbin Surgical Center Billing

1:45-2:25pm
Hidden Ways Your ASC is Leaving Money on the Table - 20 Ways to Improve an ASCs Coding — Stephanie Ellis, President Ellis Medical Consulting, Inc.

4:05-4:35pm
The Impact of the Economy on ASC Contracting and the Importance of Contract Compliance — Naya Kehayes, CEO & Stephanie Ream, Director of Reimbursement Analysis, Eveia Health Consulting and Management.

4:40-5:15pm
The Global Economy - Can You Make Outsourcing to India Work for Your Center? — AJ Mangal, CEO, Prexus Health Partners, and Mike Griffin, CFO, Prexus Health Partners

Concurrent Session E
Buying and Selling ASCs and Hospitals, Valuation Issues For ASCs

1:00-1:45pm
Key Issues in Buying and Selling ASCs - Price, Buyers, Hospitals and More — Henry Bloom, Founder, The Bloom Organization, Robert Goettling, ESQ, The Bloom Organization, Todd Mello, Principal & Co-Founder Healthcare Appraisers, Tom Hall, CEO NovaMed and Gregg Beasley, President, Medical Care America, An HCA Affilate

1:45-2:25pm
7 Key Legal and Business Issues — Scott Becker, JD, CPA, Partner, McGuireWoods LLP

4:05-4:35pm
Compliance Plans, HIPAA, Red Flags and More — Amber Walsh, Associate, McGuireWoods LLP and Melissa Szabad, Partner, McGuireWoods LLP

4:40-5:15pm
Medical Real Estate Values - Current Trends in the Valuation, Financing and Sale of Healthcare Related Real Estate — Chris Matthews, President, RM Crowe

Concurrent Session F

1:00-1:45pm
10 Ways to Keep Your Staff Happy and Retain Great Employees — Joe Zasa, President, Woodrum/ASD and Glenda Beasley, Administrator, RN, Kentucky Surgery Center

1:45-2:25pm
10 Things You Need to Know About the Revised Medicare Conditions of Participation — Joyce Deno, Chief Operating Officer, Eastern Division Regent Surgical Health

4:05-4:35pm
10 Things You Need to Know About Joint Commission Accreditation — Michael Kulczycki, Executive Director, Joint Commission

4:40-5:15pm
Using Data and Dashboards and Key Statistics to Manage for Success — Raj Chopra, Principle and CFO, The C/N Group

Friday, October 9, 2009

7:00-8:00am
Registration & Continental Breakfast

8:00am
Introductions — Scott Becker, JD, CPA, Partner, McGuireWoods

General Sessions - Keynote Presentations

8:15-9:00am
The Best Ideas for ASCs Now — Brent Lambert, MD, Principal, Ambulatory Surgical Centers of America, Tom Mallon, CEO, Regent Surgical Health, Richard Francis, CEO, Symbion and Richard Pence, President and COO, National Surgical Care

9:05-10:00am
The Politics of Healthcare Reform — Norman J. Ornstein, Resident Scholar, American Enterprise Institute

10:05-11:00am
Exhibits Open

11:05-11:45am
Key Concepts to Improve the Profitability of ASCs - A Focus on Orthopedics, Gastroenterology and Ophthalmology — Barry Tanner, CPA, President and CEO, Physicians Endoscopy, Naya Kehayes, CEO, Eveia Health Consulting and Management, Buddy Bacon, CEO, Meridian Surgical Partners and Bill Southwick, President and CEO, HealthMark Partners

11:50-12:30pm
Washington Update — Kathy Bryant, President, ASC Association

12:30-1:30pm
Networking Lunch

Concurrent Session A
Improve Profits and Fixing ASCs

1:30-2:00pm
Turning Around an ASC - A Case Study from Panama City — Joe Zasa, President, Woodrum ASD and Daniel "Skip" Daube, MD, Founder of The Surgical Center for Excellence in Panama City, Florida, Gulf Coast Facial Plastics

2:05-2:35pm
Marketing Your ASC and Attracting Patients and Physicians — Mike Lipomi, CEO, RMC MedStone Capital

2:35-3:35pm
Exhibits Open

3:40-4:15pm
Digging in Deeper - Finding New and Old Ways to Increase Surgical Volume — Gary Rippberger and Julie Bell, Hawthorn Surgery Center

4:20-5:00pm
Current Challenges in Financing ASCs and Financing Acquisitions and Expansions — Robert Westergard , CFO, Ambulatory Surgical Centers of America and Michael Karnes, CFO and Co-Founder, Regent Surgical Health

Concurrent Session B
Specialty Issues - Orthopedics, Pain Management, Spine and Bariatrics

1:30-2:00pm
Key Tips for Success - Orthopedics in ASCs - What Works and What Doesn't — Greg DeConciliis, PA-C, CASC, Administrator, Boston Out-Patient Surgical Suites

2:05-2:35pm
Pain Management in ASCs - Clinical and Business Issues — Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago

2:35-3:35pm
Exhibits Open

3:40-4:15pm
Assessing and Improving the Profitability of Orthopedics and Spine in ASCS — Luke Lambert, CASC, CEO, Ambulatory Surgical Centers of America

4:20-5:00pm
Bariatrics - The Next Five Years — Kent Sasse, MD, MPH, FACS, Medical Director of the Western Bariatric Institute

Concurrent Session C
Specialty Issues - Anesthesia, Opthamology ENT and General Surgery

1:30-2:00pm
5 Tips for Managing Anesthesia in Your ASC — Marc Koch, MD, President and CEO, Somnia

2:05-2:35pm
Key Thoughts on Improving the Profits of Ophthalmology in ASCs — John Fitz, MD, Surgery Center of Farmington

2:35-3:35pm
Exhibits Open

3:40-4:15pm
ENT in ASCs, Profitability and Business Issues — Naya Kehayes and Matt Kilton, Eveia Health Consulting and Management

4:20-5:00pm
General Surgery in ASCs Current Trends and Opportunities— George Trajtenberg, MD, Turks Head Surgery Center and Jeff Leland, CEO, Blue Chip Surgical Partners

Concurrent Session D
Contracting, Billing and Coding

1:30-2:00pm
New Ideas For Payor Contracting for ASCs - Using CMS Methodology to Negotiate Greater Payments from Commercial Insurers — Dan Connolly, MHS, ARM, Vice President of Development & Payor Contracting, Pinnacle III

2:05-2:35pm
How to Audit Your Billing Process — Caryl Serbin, CEO, Serbin Surgical Center Billing

2:35-3:35pm
Exhibits Open

3:40-4:15pm
Key Steps to Maximizing Patient Satisfaction — Margaret Acker, CEO, Blake Woods Surgery Center

4:20-5:00pm
How to Accurately Project Reimbursement from Insurance and to Use This Knowledge to Improve Collections — David W. Odell, CPA, President, MedBridge Surgery Center Billing

Concurrent Session E
Hospital, Physician Owned Hospitals, Physician Issues, and Legal Issues

1:30-2:00pm
ASC Valuations - Current Trends and How to Value ASCs — Greg Koonsman, Principal, VMG Health and Jon O'Sullivan, Principal VMG Health

2:05-2:35pm
Physician Owned Hospitals Washington Update — Molly Sandvig, Executive Director Physician Hospitals of America and Brett Gosney, CEO, Animas Surgical Hospital, President of PHA

2:35-3:35pm
Exhibits Open

3:40-4:15pm
Acquisition Strategy, ASC Acquisitions in the Current Economic Environment, How Buyers Value ASCs — Evie Miller, Vice President of Development, USPI, Peter Fatianow, Director of Merger and Acquisitions, Health Inventures, Greg Koonsman, Principal, VMG Health, Moderator Scott Downing, Partner, McGuire Woods

4:20-5:00pm
Converting an ASC to an HOPD - Does it Make Sense and How Do You Make it Happen? — AJ Mangal, CEO, Prexus Health Partners and Peter Laterza, General Counsel, Prexus Health Partners

Concurrent Session F

1:30-2:00pm
How to Effectively Measure and Track Patient Quality — David Shapiro, MD, Ambulatory Surgery Company, LLC

2:05-2:35pm
10 Ways to Cut Costs in an ASC — John Goehle, CASC, MBA, CPA and Ed Hetrick, CEO, Facility Development and Management

2:35-3:35pm
Exhibits Open

3:40-4:15pm
A Step by Step Guide to Recruiting Physicians — Chris Bishop, VP, ASCOA and Dan Pereles, MD Orthopedic Surgeon & Medical Director for Surgery Center of MD in Silver Spring, MD.

4:20-5:00pm
How to Make an HOPD Operate as an ASC - Transforming Your ASC by Adopting an ASC Operational Platform — Rick Dehart, CEO, Pinnacle III and Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

Saturday, October 10, 2009

7:30-8:20am Continental Breakfast

8:15 - 9:00am - KEYNOTE
The Financial World's View of ASCs — Craig Frances, MD, Summit Partners

9:05 - 9:45am - KEYNOTE
Physician Hospital Joint Ventures and the ASC Business - 5 Lessons from the Front Lines— Joe Clark, Executive Vice President, Surgical Care Affiliates

Concurrent Session A
Improve Profits and Fixing ASCs

9:50-10:30am
ASC Leadership - How Physician Leaders Should Maximize Their Contribution to the ASC — Tom Yerden, CEO, TRY Ventures

10:35-11:10am
The 10 Statistics Your ASC Should Examine Each Week — Greg Cunniff, CFO, National Surgical Care

11:15-11:50pm
Physician Management Company Relationships - Communications and Marking the Center Highly Successful — Dennis Pappas, MD, Outpatient Care Clinic, Introduced by Holly Ramey, VP Operations, Surgical Care Affiliates

11:55-1:00 pm
5 Current Issues - Can I Shoot My Partner? What Will be the Impact of Health Care Reform be? Should I Sell? Do I Need a Hospital Partner? Legal Q & A — Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Concurrent Session B
Specialty Issues

9:50-10:30am
So You Want to Start an ASC - The Challenges in 2009 — Lori Ramirez, Founder and CEO of Elite Surgical Affiliates

10:35-11:10am
Healthcare IT - The Stimulus Package and Opportunities for ASCs — Marion Jenkens, CEO, QSE Technologies

11:15-11:50pm
Working Proactively to Avoid Reactive Situations and Achieve Great Patient Safety Outcomes — Holly Hampe, Director of Quality and Safety, Amerinet

11:55-12:30
Recruiting Specialists - Key Thoughts on Recruitment — Jeff Peo, VP, Ambulatory Surgical Centers of America

12:30-1:00 pm
Internal Controls/Audit - Internal Controls that are Necessary to Prevent Fraud at Your ASC - A Real Life Experience as told by Sam Rice, MD, Treasurer, Doctors' Surgery Center of Apple Valley, Inc.

Concurrent Session C
Specialty Issues

9:50-10:30am
How to Add Spine to an ASC and How to Make Spine Profitable — Joe Stapleton, MD and Jordi Kellogg, MD, East Portland Surgery Center. Introduced by Jeff Leland, CEO, Blue Chip Surgical Partners

10:35-11:10am
3 Core Models for Delivering Anesthesia Services - Should ASCs Profit from Anesthesia, Trends and Observations — Scott Becker, JD, CPA, Partner, McGuireWoods LLP

11:15-11:50pm
Electronic Medical Records - What you Don't know Can Kill You — Kevin McDonald, Source Medical

11:55-12:30 pm
Calculating the Possible Impacts of Healthcare Reform — Thomas Ealey, CPA, Associate Professor ALMA College

Concurrent Session D
Contracting, Billing and Coding

9:50-10:30am
HOPD or Freestanding or Somewhere in Between — Joan Dentler, President, ASC Strategies

10:35-11:10am
How Automating the Procedure Documentation and Coding Process can Reduce Costs, Improve Accuracy of Documentation and Coding for Increased Revenues, and Maximize Workflow Efficiencies — Rebecca Craig, CASC, Administrator, Harmony Surgery Center and Cindy Hall, Administrator, Borland Groover Clinic

11:15-11:50pm
The Correct Use of Modifiers in ASC Billing — Stephanie Ellis, President Ellis Medical Consulting, Inc.

11:55-12:30
The Economics of Outsourcing Billing, Collections and Contracting — Tom Chirillo, CEO, Healthcare Business Solutions

12:30-1:00 pm
CMS RAC Audits - Are You Ready for Your Upcoming RAC Audit — Cathy Montgomery, President, Excellentia Advisory Group LLC

Concurrent Session E
Hospital, Physician Owned Hospital, Physician Issues, and Legal Issues

9:50-10:30am
Effective Cost Cutting and Benchmarking for Your ASC - 5 Examples — Robert Welti, MD, Chief Operating Officer, Western Division Regent Surgical Health

10:35-11:10am
Buying and Selling Hospitals, Valuations, Diligence and Other Issues — Carstein Beith, Managing Director, Cain Brothers and Dave Felsenthal, Co-Founder, Principle Valuation

11:50-1:00 pm
Driving Revenues Up by Driving Denials Down - Advantage Healthcare Solutions, a detailed analysis of cost cutting in operations and in expansions — Speaker to come.

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Glenda Beasley, Administrator, RN,
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Julie Bell, Hawthorn Surgery Center

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Tom Bombardier, MD, FACS,
Founder of ASCOA

Lt. Colonel Bruce Bright,
Director of Business Development,
The Sanders Trust

Brian Broker, MD

Kathy Bryant, President,
ASC Association

John Cherf, M.D.,
Dept. of Orthopedics,
The Neurologic & Orthopedic
Hospital of Chicago

Tom Chirillo, CEO,
Healthcare Business Solutions

Raj Chopra, Principle and CFO,
The C/N Group

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Dan Pereles, MD Orthopedic Surgeon
& Medical Director for Surgery Center
of MD in Silver Spring, MD.

John Poisson, Executive VP,
Physicians Endoscopy

Greg Poulter, MD,
Peak One Surgery Center

Lori Ramirez, Founder and CEO of
Elite Surgical Affiliates

Sam Rice, MD, Treasurer,
Doctors' Surgery Center of Apple
Valley, Inc.

Molly Sandvig, Executive Director,
Physician Hospitals of America

Kent Sasse, MD, MPH, FACS, medical
director of the Western Bariatric
Institute

Caryl Serbin, CEO,
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David Shapiro, MD,
Ambulatory Surgery Company, LLC

Jeff Simmons, President, Western
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Federal Court Rules Physician Suit Against Surgery Center for Enforcing Safe Harbor One-Third Tests A Decision for State Court

The 7th Circuit Federal Appellate Court has ruled that a recent lawsuit brought forth by a physician partner of an Illinois surgery center when the center attempted to revoke his partnership because he failed to perform one-third of his cases at the center did not involve federal issues and instead should be heard in state court. This case is particularly significant because it is one of the few written opinions that involves the buying out a surgeon for failure to comply with ASC safe harbors.

Hansel DeBartolo, MD, a surgeon at Surgicare of Joliet, a HealthSouth surgery center, brought forth the suit against HealthSouth and the center after Surgicare notified him that it was exercising a clause in his agreement that allowed it to buy out his shares in the center because he did not meet the one-third requirement.

Dr. DeBartolo brought forth the case in federal district court, which dismissed the suit. He then appealed to the federal Appellate Court.

The 7th Circuit Appellate Court ruled the that federal district court should not have heard the matter originally because it involved state law contract claims, as opposed to federal issues. The 7th Circuit Appellate Court overruled the lower court decision and remanded the case back to the lower federal court with instructions that the federal court did not have authority to even hear the matter.

The physician can now bring the suit as a state law contract claim in state court, as opposed to federal court.

Read the Appellate Court's complete ruling at www.beckersasc.com/pdfs/courtruling.pdf. ■

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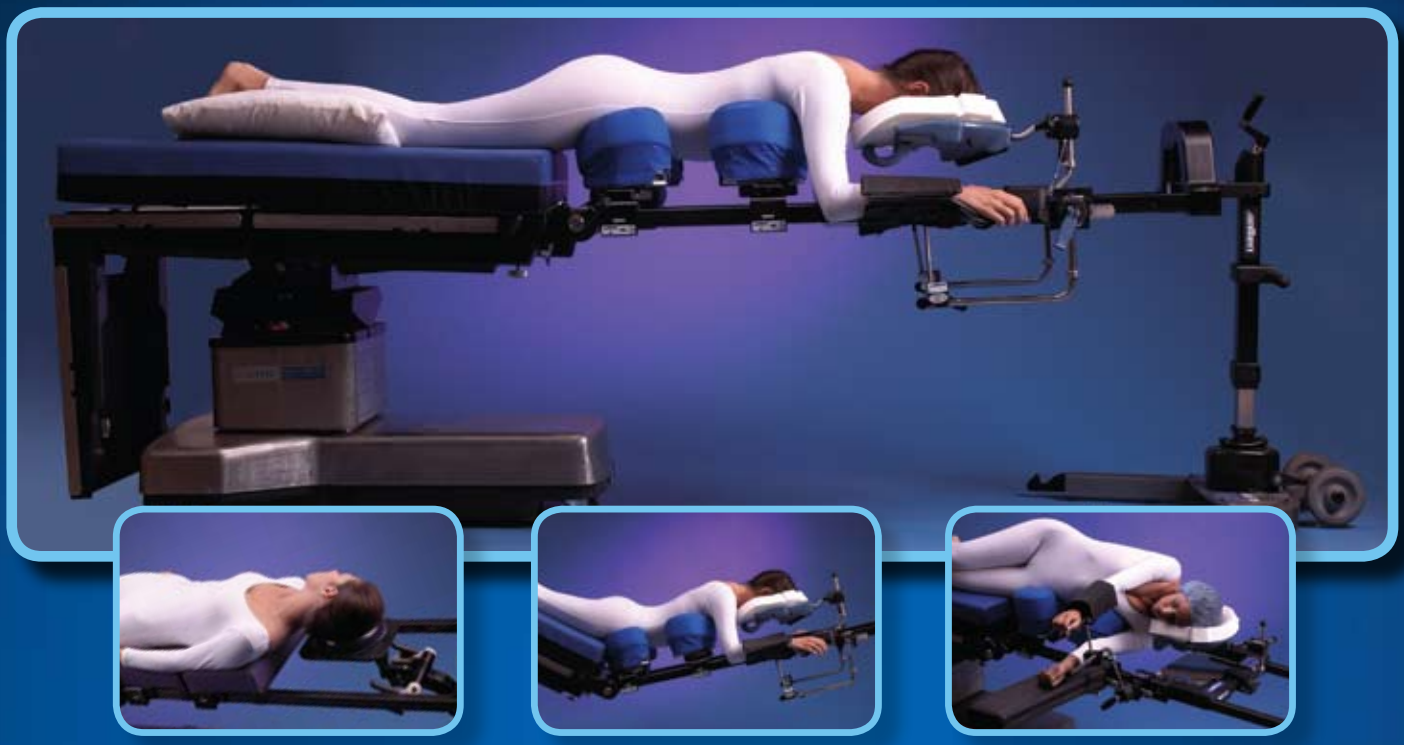

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 1. Lynch, J. (2009, May). Is It Time to Add Spine? Outpatient Surgery.

D-770463-A1 August 10, 2009

CEO Spotlight: Q&A With Jane Keller of Indiana Orthopaedic Hospital

Jane Keller, RN, CEO of the Indiana Orthopaedic Hospital in Indianapolis, has been in the healthcare field for more than 20 years, working first as a trained RN in the operating room and later specializing in orthopedics. Here, she discusses some of the decisions, challenges and accomplishments that have shaped her career.

What is the best decision you've made in your current position?

The best decision I made as CEO was to surround myself with a knowledgeable management team. They are smart, talented people who share the same values and vision of our organization. They are willing to challenge the conventional wisdom and think creatively and innovatively, and they make me better at my job.

What is the most difficult decision you've had to make in your career?

Without a doubt, the most difficult decision for me was to move into administration full time. As a nurse, caring for patients is my passion as well as my profession. I'm thrilled that I accepted the challenge of leading IOH because now I care for my patients in a strategic sense, working with our physicians and our entire staff to create a patient-focused, healing environment.

What is your proudest accomplishment at your organization?

Our proudest accomplishment is achieving our HealthGrades rating each year for total joint replacement, placing us among the top hospitals in the country in this specialty. This complements our hospital's HCAHPS results for patient satisfaction, which continues to recognize the overall patient experience at IOH as one of the best in our area. These measurements show that our physicians and staff are committed to providing high quality, patient-focused orthopaedic care to our patients.

What is the best part of your job?

The best part of my job is hearing from our patients that they and their families had a wonderful experience and received wonderful treatment from the staff. These are folks who were in the hospital — and they enjoyed the stay. I read their e-mails and comments, and I'm especially grateful when they recognize the nurses and other caregivers by name. This allows us to recognize those individuals for the great job they do.

What is the most significant obstacle your organization has faced and how did you overcome it?

The ongoing legislative battle with those who want to close physician-owned hospitals. As the CEO of a hospital owned by physicians, I continually struggle to understand why opponents of physician ownership — which has a century-long tradition in this country — want to deny patients greater and more convenient access to high-quality care in a patient-focused setting and threaten the economic contribution we make to our communities.

What do you anticipate as the biggest challenge you will face in the future?

Our biggest challenges in the next few years will be surviving the challenge to physician ownership; continuing to provide the level of care we committed to when we opened IOH, while facing the unknown of healthcare reform; and the issue decreasing reimbursements for that care. In addition, patients are becoming sophisticated healthcare consumers who will be 'shopping' for their healthcare needs in the next several years. We will have to be creative in gaining our share of that market.

What is one thing that you wished you would have known before taking on this position?

That my life would be consumed with meetings!

What is your biggest goal for your organization in the upcoming year?

Our biggest goal is delivery of safe, high quality care to our patients. We also continue to maximize operational efficiencies at IOH, making sure we are prepared for the healthcare reform that is coming. We continue to look at supplies, implants and contracts to make sure we are getting the best value for our dollar — which helps lower the cost of healthcare overall. ■

Learn more about Indiana Orthopaedic Hospital at www.orthoindy.com.

Compliance Guidelines Related to Selling Units in an ASC to Physician Investors

By Scott Becker, JD, CPA

This article provides guidance on selling units in an ASC to physician investors. This is based on federal cases related to the syndication of interests in hospitals, labs, and joint ventures and Office of Inspector General comments related to ASCs. In the ASC sector, centers face the combination of the ASC safe harbor (for which compliance in a multi-specialty ASC requires the performance of a certain number of outpatient cases at the center) and the divergent concepts in the federal Anti-Kickback Statute Fraud (e.g. that an investor cannot be required to refer cases to an entity in which he or she is an investor). A longer form of this paper is available. If you would like a copy, please e-mail Scott Becker at sbecker@mcguirewoods.com.

A. Actions and statements to avoid

1. Do not offer less or more shares or a higher or lower price based on the number, volume or value of referrals a physician can generate.
2. Do not reallocate shares based on the volume or value of referrals.
3. Do not focus on individual distributions being tied to the number of patient referrals. Never make any indications that could lead a potential investor to believe that referrals or performance will determine an individual's "piece of the pie." Focus on overall distributions and profits.
4. Physicians should not be allowed to invest based upon the fact that they can generate referrals for another physician who may use the center.
5. Avoid providing physicians with estimates as to the amount of revenue that will be generated from their referrals or from another physician's referrals.
6. Except as to compliance with the one-third tests, do not develop investor eligibility determinations based on the number of potential referrals. In evaluating physicians, examine compliance with all of the safe harbor criteria.
7. Do not create "target lists" of physicians based on their ability to make high amounts of referrals.
8. When creating target lists, avoid making notations indicating the potential number of referrals, the growth potential of the physician's practice, that a certain physician is a good target (based on referrals), etc.
9. Avoid using age as an influencing factor when targeting physicians.
10. Subject to non-discrimination rules, consider excluding Medicare and Medicaid referrals from any internal revenue and investment analysis.
11. Do not offer remuneration or special treatment under various disguises, such as directorship contracts or discounted lease arrangements, in order to induce investors.
12. Do not pressure a physician investor to shift their current referral patterns.
13. Do not make any indications to investors that low-referring physicians will be pressured to withdraw.
14. Units should be sold at fair market value.

B. Actions that can be taken

1. Offer equal amounts of units per investor.
2. Offer units at the same price per unit.
3. Offer units at the then fair market value per unit.
4. Provide investor with the current financial statements and not their potential revenues.
5. Offer units to only physicians that will comply with the safe harbors — meet all tests and not just the one-third tests.
6. Clarify that the hospital or management company partner does not generate referrals for the ASC.
7. Review investors against compliance with the requirements of the safe harbors.
8. An ASC may ask physicians why they choose not to use the ASC. ■

Anesthesiologist Involvement in an ASC: Q&A With Howard Balkenbusch of Associated Anesthesiologists of Fort Wayne

Howard (Skip) Balkenbusch, CEO of Associated Anesthesiologists of Fort Wayne, Ind., offers his thoughts on the hotly debated topic of anesthesiologists' involvement with ASCs.

Q: Should anesthesiologists own interests in an ASC?

Howard Balkenbusch: Of course. The fact that anesthesiologists do not generate referrals fails to consider their role in costs and efficiencies. Though this often counter-intuitive to the surgeon's thought pattern the anesthesiologists have the ability to significantly impact drug costs, surgeon satisfaction, OR schedule efficiency and patient recovery time (impacting staff/facility costs). The amount of ownership allocated would be more of an internal discussion but the goal is to optimize alignment towards specific performance incentives. The lack of aligned incentives is one of the most troublesome parts of our healthcare delivery system.

Q: Should anesthesiologists be employees of centers, independent contractors of centers or completely outsourced?

HB: I think anyone of the three options can work with the right people. In the surgery center setting some objectives that are critical may be valued differently in the hospital setting. The objective of safe anesthesia remains paramount. Anesthesiologists that have strong experience with critically ill patients may be more adept at handling the occasional patient crash in an ASC setting and therefore current critical care experience can be an asset to the ASC setting. Beyond being a fundamentally sound clinician, the anesthesiologist must also help create and sustain an environment that is perceived as desirable to surgeons. That is, they would preferably be affable and have the mindset of working in a fast-paced and efficient environment. Turnover times need to be minimal and, as most ASC's know, the ability to either wake the patient up or recover from a regional anesthetic in minimal time is helpful to both the center and the patient.

Q: So the question becomes how does an ASC best control these highly desirable attributes?

HB: The answer will likely vary depending on your anesthesia provider resources. Some 'groups' can readily provide this need, others cannot. Options to employ or exclusively contract simply depends on availability within the specific community. If employment is not the model then the 'anesthesia group' must be able to work flexibly with pricing issues- especially for those services that are 'pre-pay' or otherwise non-insured such as cosmetic surgery. A strategic approach to pricing will help assure the final 'product' is marketable. Smart groups will try and meet these needs, otherwise an ASC may need to look at the possibility of another group or anesthesiologist employment, again assuming that the 'right' kind of anesthesiologists are available.

Q: What should be our primary focus when considering anesthesiologists and anesthesia services?

HB: Safe anesthesia care is always foremost. The other attributes for anesthesia services delivered in an ASC setting rely on anesthesiologists that contribute to the overall success of the center through cost containment, a smooth running operative schedule and promotion of surgeon and patient satisfaction. Every member of the team should be aligned to create a good experience for the patient. Anesthesiologist ownership certainly contributes to the alignment of a well-managed ASC. ■

Mr. Balkenbusch (sbalkenbusch@choiceonemail.com) is CEO of Associated Anesthesiologists of Fort Wayne, a group with nearly 35 physicians and primarily provides services on the Lutheran Hospital campus and surrounding surgery centers. Contact him at (260) 442-3500.

Anesthesiologist Dr. Sterling Wood Discusses Anesthesia Challenges and Opportunities for ASCs

New Jersey-based, board-certified anesthesiologist Sterling "Chip" Wood, MD, partner at Atlantic Ambulatory Anesthesia Associates and executive vice president and chief medical officer of Trinity Surgical Worldwide, discusses challenges and opportunities for anesthesia services in ASCs.

Dr. Wood on the biggest challenges for anesthesia in ASCs...

The biggest challenge anesthesia groups face is probably reimbursement and dealing with issues regarding whether or not to contract with certain payors, and these issues, in turn, can affect ASCs. Deciding to remain an out-of-network anesthesia provider can be challenging because payors may pressure their in-network facilities to contract with in-network anesthesia providers. These decisions make a big difference for us because going in-network will cut our fees considerably. We try to offset these challenges by creating other benefits for the ASC, such as offering cutting-edge anesthesia solutions, which may draw more patients into their center.

On whether ASCs should employ their own anesthesiologists...

In my opinion, most ASCs that are profitable work with an anesthesia group. This is the biggest difference between hospitals and ASCs in regard to anesthesia. Some hospitals provide a salaried wage to their anesthesiologists and there is no real incentive to be efficient. As ASCs look for additional revenue streams, some are considering bringing on salaried anesthesiologists and handling the billing and reimbursement for these services themselves. This type of arrangement promotes a hospital mentality — why should salaried anesthesiologists care if they do one or 20 cases in a day? When you use an anesthesia group, there is an incentive for everyone to be more efficient because it improves everyone's bottom line.

On the best opportunities for anesthesia in ASCs...

The biggest opportunity for anesthesia in ASCs is the advances that anesthesia providers are taking in improving a patient's surgery experience. We are doing a lot of regional and peripheral nerve blocks, which reduce the time patients need to be in the recovery room and help to make their overall experience more pleasant. Patients seek out a better experience and will be attracted to the ASC as a result of this improved experience. Additionally, these types of blocks and pain pumps, which we're using more and more, generate direct revenue for the ASC.

On how ASCs and anesthesiologists can best partner...

Anesthesia groups should be concerned with making themselves as valuable as possible to ASCs. The role of the anesthesia provider has greatly changed over the last few decades. As we move away from salaried models, anesthesia providers have the opportunity to make themselves more valuable to ASCs and other facilities. We're no longer that physician that just sits in the back. There is a lot more opportunity for us to be involved in the whole processes. Now, our groups work with ASCs to market the centers. Because our profitability is linked to the volume and profitability of the ASC, we work with the center to think of ways to bring in more patients. By offering cutting-edge technologies that draw in patients and opportunities for ASCs to generate additional revenue from services, anesthesia groups really can become valuable to ASCs. Our goal is to make our anesthesia group an asset rather than just another piece of necessary "equipment" needed for surgery. ■

8 Statistics About Operating Expenses as a Percent of a Surgery Center's Total Net Revenue

Here are some common operating expenses for ASCs and the average and median percentage they represent of the center's total net revenue from VMG Health's *2008 Intellimarker*.

1. Total operating expenses
Mean — 81.8 percent
Median — 77.0 percent

2. Employee salary and wages
Mean — 25.2 percent
Median — 23.8 percent

3. Medical and surgical
Mean — 21.3 percent
Median — 21.2 percent

4. Occupancy costs
Mean — 8.3 percent
Median — 6.9 percent

5. General and administrative
Mean — 7.6 percent
Median — 7.1 percent

6. Taxes and benefits
Mean — 5.5 percent
Median — 5.0 percent

7. Other medical costs
Mean — 3.1 percent
Median — 1.3 percent

8. Insurance
Mean — 1.4 percent
Median — 1.0 percent

To receive a free copy of the VMG Health *2009 Intellimarker*, the single best benchmarking resource in the ASC industry, visit www.vmghealth.com. ■

Overcoming the Anesthesia Provider Shortage: Q&A With Marc Koch of Somnia Anesthesia

A critical shortage of anesthesia providers is currently impacting hospitals, ASCs and other surgical facilities throughout the United States. Here, Marc Koch, MD, MBA, president and CEO of Somnia Anesthesia, discusses how surgery facilities can adapt to overcome this provider shortage.

Q: There have been a number of reports in the news over the past few years describing a shortage of anesthesia providers throughout the United States. Just how great is this shortage?

Marc Koch: Right now, the U.S. Department of Health and Human Services estimates a nurse anesthetist shortage of approximately 5,000, and this is expected to worsen over time. Additionally, there has been a decrease in the number of medical students entering anesthesiology residency programs and a "graying" of current practicing anesthesiologists. According to some estimates, 85 percent of the approximately 30,000 practicing anesthesiologists today are 45 or older. These are not welcoming statistics.

Q: Will this shortage stabilize or continue to get worse?

MK: We have certainly not hit bottom yet. As baby boomers age and require surgery, the demand for anesthesia providers will grow, further restricting the current supply of providers. In addition, as more and more operating rooms develop outside of the hospital setting, we will see this demand magnified as an increasing number of facilities compete for these providers.

Q: What does this mean for the provision of anesthesia services?

MK: To start, we will see increases in anesthesia costs. Additionally, I believe we will find fewer and fewer anesthesia providers willing to work holidays, weekends and nights or be on-call. As a result, leaders of hospitals and other facilities may feel like they are forced to choose between directing more funds toward anesthesia or delaying procedures. In fact, in a recent ASA study, approximately half of hospital administrators reported reducing, redirecting or delaying OR procedures due to inadequate anesthesia support. The bottom line is that hospitals and other facilities will have to pay more and more to get less and less coverage.

Q: How are hospitals and other facilities responding to this shortage?

MK: If hospitals continue to maintain their current financial models for anesthesia services, they will eventually be forced to choose between pro-

viding additional funding for anesthesia or reducing or delaying surgeries. Finding additional funds for anesthesia is becoming increasingly difficult in today's tight market, and reducing the number of surgeries hurts the bottom line because it restricts volume.

Q: Are there other options for hospitals and other facilities besides increasing funding or reducing volume?

MK: Facilities that use a MD/CRNA cooperative model, where anesthesiologists and certified nurse anesthetists work together to provide services, will be best equipped to handle the anesthesia provider shortage. Hospitals and other facilities should consider outsourcing to anesthesia management companies to staff their anesthesiology departments. Anesthesiology management companies can help provide complete coverage and work to increase collections for anesthesiology services. The main point is that hospitals and other surgical facilities do not have to choose between spending more money or reducing volume.

Q: What should hospitals and other surgery facilities consider when selecting an anesthesia management company?

MK: Hospital and ASC leaders need to request data that proves the quality of the service group. Statistics on coverage and surgeon satisfaction are important indicators of the quality of an anesthesia service provider. It is also critical that hospitals check references and look for providers who have existing contracts with third-party payors. You should request to see payor rates and look for providers that have reimbursement rates that exceed your pre-existing rates. ■

Dr. Koch is president and CEO of Somnia Anesthesia, a physician-owned and operated clinical anesthesia management company servicing healthcare facilities nationwide. Learn more about Somnia at www.somniaanesthesiaservices.com

Free Webinar — Attacking the Anesthesia Stipend: How to Get More Coverage and Better Quality for Less Cost

Somnia Anesthesia and ASC Communications, publisher of *Becker's Hospital Review* and *Becker's ASC Review*, present a free Webinar on "Attacking the Anesthesia Stipend: How to Get More Coverage and Better Quality for Less Cost." This program will take place Oct. 27 at 2:15 p.m. EST.

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10 Steps to Prepare for and Respond to Anesthesia Subsidy Requests

By Rob Kurtz

As surgery centers and surgeons struggle with a Medicare payment system which reimburses at rates that are often barely high enough to break even on procedures, let alone make a profit, it is easy to overlook how reimbursement declines, along with rising costs and increases in the number of Medicare patients, is affecting another critical member of the surgery team: Anesthesiologists.

For many years, anesthesiologists were fiscally solvent providing services at hospitals and later ASCs, but over the last decade, anesthesiologists and their groups have seen a steep decline in revenue as Medicare and private payors tightened reimbursement rates, while at the same time higher reimbursing procedures left the hospitals for ASCs (and lower reimbursement). This revenue decline has occurred at the same time that groups have seen starting salaries for certified registered nurse anesthetists and newly-graduated anesthesiologists nearly double, says Thomas Wherry, MD, principal of Total Anesthesia Solutions, an anesthesia consulting and management firm.

As a result of decreasing profits and increasing costs, anesthesiologists have sought — and in many cases received — subsidies from hospitals for their services, with many of these subsidies now surpassing $1 million annually, says Steve O'Neill, president of Delmarva Healthcare Solutions, a healthcare consulting and ASC management/development firm and principal of Total Anesthesia Solutions. While most surgery centers are not yet paying subsidies, this is likely to become an issue and potential financial challenge that many ASCs will encounter in the future.

To help you prepare for the day when your anesthesiologist approaches you to talk about a subsidy, it is important to understand why this may soon affect your ASC. It is also valuable to understand 10 steps you can take to prepare for and respond to your anesthesia provider requesting a subsidy.

Beginning of subsidies

It was around 2000 when anesthesia providers started approaching hospitals for subsidies on top of their contractual arrangement, particularly in smaller to moderate-sized markets where there is less anesthesia competition and also fewer procedures, says Mr. O'Neill.

"The reason why this is such a major challenge to the smaller markets in the country is the fact that most of the bread and butter surgery that's going to the ASCs is coming directly out of the hospital," he says. "Anesthesiologists are being asked to cover more rooms, and incur more costs serving the same amount of cases and the same individuals that they served a year ago prior in the main hospital.

"From their perspective, there really isn't any opportunity to grow their units and off-set this additional cost," he says. "Unfortunately, they need to make it up somewhere and they need to get a stipend to remain whole."

Under the anesthesia "unit" system, each anesthetic is billed a specific base unit per case plus one time unit per 15-minute increment. Base units are determined by the acuity of a case.

ASC cases tend to be less acute and have a base unit of around 3 to 5. Thus, an average ASC case will be billed (base + time) 7 to 8 units while a hospital average case will be billed out at 11 to 12 units. However, despite the difference in units per case, the provider can do better in an ASC as surgery centers pack their day full of cases.

Hospitals have been willing to give the anesthesia providers their stipend to help offset this difference and keep the providers because the alternative is not a comforting thought.

"The CEOs that we have talked to are very nervous, upset and angry (about paying stipends), but they are happy with the clinical care and hear horror stories from their colleagues who lost anesthesia coverage," says Dr. Wherry. "They want to maintain local control and have a local relationship, and they are willing to pay this money to avoid losing the group."

Effect on surgery centers

The good news for surgery centers is that they are still very desirable working environments for anesthesia providers.

"There is no shortage of providers — both nurse anesthetists and anesthesiologists — that are willing to take a little less money to work in a 9:00–5:00 or 7:00–3:00 work environment with no call and no weekend," says Dr. Wherry. "With more choices, it's minimizing the full impact of the need for a subsidy."

But this is not true for every surgery center, especially some of those that share anesthesia providers with their hospital owners.

"It's definitely trickling down to the surgery center arena, especially the joint-ventured ASCs and the hospital-owned ASCs," says Mr. O'Neill.

In these scenarios, some hospitals are expecting the ASC to pay for a proportionate share of the subsidy.

"What we're hearing from hospital CEOs recently is the hospital has been subsidizing the ASC, but now it is going to stop and the ASC is going to have to start kicking in their fair share," says Dr. Wherry. "It's going to get worse as the population continues to age and there's a greater amount of Medicare recipients. Anesthesia payments from Medicare are extremely low and (the anesthesia groups) are not going to be able to make up the shortfall with the managed care contracts."

Even surgery centers that are not involved in these joint-venture scenarios may not be able to avoid subsidies for much longer.

"In some markets, the income guarantee/stipend is so high at the hospital level that the surgery center is not very attractive and that's where some ASC are struggling" to retain their anesthesia providers, he says. "Suddenly that surgery center, which was very enticing 5–10 years ago, is not as enticing because an anesthesiologist can go to the hospital, get the day off after call, is not as busy and can make more money than at the surgery center."

10 steps to follow

It is likely only a matter of time until your ASC is asked to subsidize its anesthesia provider, if it hasn't already faced this request. Here are 10 steps to take that will help you prepare for that request, know how to respond to the request and even potentially prevent or postpone hearing the request.

1. Engage the anesthesia group

Anesthesia providers ask for subsidies when they are struggling financially. Unfortunately, says Dr. Wherry, many ASCs do not have a good understanding of the success or struggles of their anesthesia providers, so the ASC is not exploring ways to ensure their anesthesiologists are seeing strong returns on their work.

"I would strongly recommend that the management of any center should develop a relationship with the anesthesia group," he says. "It sounds obvious but many are not doing it, surprisingly since anesthesia is such an important component of the surgery center."

Management should identify a point person within the anesthesia group and start having a regular dialogue on how the group is performing and its experience at the ASC.

"You want to understand how the group is doing financially; is the center a good thing for them; are they having problems; and how's their reimbursement, without getting into specifics," says Dr. Wherry. "If the management company and or administrator showed an interest in the viability of my group and my practice … speaking as an anesthesiologist, that would go a long way."

Include your anesthesia provider in discussions about scheduling efficiency and allocation of block times, for example, as these components of your operation can have an effect on the anesthesiologist's financial performance.

"That doesn't cost the management anything to include the anesthesiologist in that process," says Dr. Wherry. "That alone would go a long way in keeping things at bay."

2. Reward your anesthesiologists

Surgery centers can make a number of inexpensive gestures to show appreciation for their anesthesiologists, says Dr. Wherry.

"It's little things like providing an office with Internet access," he says. "Or if it's a profitable center, I've never understood why ASCs don't provide some sort or incentive or bonus program for the group for hitting certain performance measures such as patient or staff satisfaction, or managing cost issues."

An ASC may even want to consider naming one of its anesthesiologists as the center's medical director and paying a small stipend for the work. This is likely to help develop a closer relationship with the anesthesiologists,

which may encourage discussions on important issues such as financial challenges before problems turn into crises.

"The problem is the vast majority of ASCs view anesthesia groups and providers as a contracted service; they don't really view them as team members," says Mr. O'Neill. "I think any successful ASC management group or administrator will say that the center works better if anesthesia is part of the team and they help in making the day-to-day decisions."

3. Ask for and understand anesthesia's specific needs

If an anesthesia provider asks about a subsidy, do not hesitate to ask why exactly the provider is struggling and try to find out the particulars of the situation, getting down to the provider's daily needs.

"What the ASC needs to understand from the group is what does the group need per day as a whole," says Dr. Wherry. "During a ramp-up, for example, where you have two busy rooms and cases are starting to spill over into a third room, anesthesiologists may say they can't afford to hire a CRNA (for the third room) because there's not enough cases to pay for that CRNA. But if rooms one and two are busy enough, there may be more than enough of that revenue as a whole to cover the cost. You have to consider all three rooms.

"Try to understand how many cases the group needs per day as a whole to cover its costs — how many units does it really need to cover each room per day; it's better to talk in units than cases," Dr. Wherry says.

4. Require full disclosure

If, despite all of your efforts, you are unable to keep your anesthesiologist group financially secure and you are asked and agree to provide a subsidy, do not do so blindly. It is perfectly reasonable to ask the group to fully disclose its financial records so you can understand why the subsidy is necessary, says Dr. Wherry.

"I've seen stipend subsidies given when the group hasn't really disclosed what the problem is — they don't want to show their finances," he says. "I don't know how you can ask for multi-hundreds of thousands of dollars without that. When I deal with my hospital administrator, he has full access to my billing company so he can see where we're at and how we come up with a budget."

It is critical that your surgery center involve its accounting team or find someone who understands budgets to review the group's financial records. This will put you in a place to truly understand the group's position.

5. Consider a third-party representative

With hundreds of thousands of dollars potentially tied to a stipend, it is very easy for emotions to run high and the relationship between the facility and anesthesia group to become strained. One option to help prevent this is to find a third-party representative to come in and help determine a fair stipend and any parameters the group must meet to receive the stipend (see step 8).

"In order to take the emotion out and understand what the need is and what the right dollar amount is for both sides, I think it's often worth seeking out a neutral party to access actual need and what the actual coverage requirements are," says Mr. O'Neill. "This will help broker a deal where both sides can feel it's a win-win."

6. Understand the factors that should influence stipends

The subsidy that is provided should not just be based upon the group's revenue. If the group is failing to capture the reimbursement it deserves or is overspending, it is not the facility's responsibility to make up the group's shortcomings.

A third-party representative — or someone within the facility with knowledge of providing anesthesia and perhaps running a group — should assess whether the anesthesia group's subsidy request is appropriate based on the group's internal efforts to maximize its revenue and minimize costs.

Some questions Dr. Wherry suggests assessing about the group includes:

- Is the group's productivity appropriate?
- Is the billing appropriate?
- How aggressive is the group at pursuing good third party contracts?
- Is the group staffing efficiently?

"All of that should impact the subsidy; all of those need to be answered in determining the subsidies, and I think sometimes organizations don't look at all that," Dr. Wherry says. "(Some groups) say, 'here is our budget, here's how much we're making and you need to make up any difference.' That's a really dangerous approach because then it almost becomes an entitlement."

7. Avoid one-way deals

Stay away from case/volume guarantees and money guarantees, Dr. Wherry suggests.

"What's the incentive for the anesthesia group to be aggressive in billing and not to cancel cases inappropriately," he says. "Guarantees become a disincentive. You really want some sort of shared risk where 'we'll help you, but it's not if you don't earn $30,000 this month, we'll make up the difference.' That's where I've seen ASCs get burned."

This is why it is beneficial to tie the stipend or subsidy to the group's performance, Dr. Wherry says.

"I would strongly encourage any ASC or hospital — when entering into an arrangement — to try to get something in return, whether it is showing up on time, high satisfaction, good outcomes, participation in committees or accreditation help," he says. "It really should be tied into performance."

It is not unreasonable to make the financial performance of the ASC the first requirement necessary for the anesthesiologist group to receive a subsidy, says Mr. O'Neill.

"You don't want to be paying them extra as the center is losing money," he says.

8. Determine fair and attainable measures

If you are going to tie the subsidy to performance, both parties need to agree to the performance measures the group must meet. "We suggest calling the stipend or subsidy a Mission Support payment which will go a long way in supporting the payment to performance. These measures should be measurable, attainable and not too easy," says Mr. O'Neill.

"These have to be something under their control," he says. "So something like turnaround time is not always the best performance measure because there are so many things that impact turnaround time. It's not fair just to measure the anesthesiologists on something out of their control."
Reasonable performance measures may include:

- showing up to the facility on time;
- staying until the patients leave;
- committee involvement;
- providing in-service training to staff;
- patient satisfaction (with surveys that include a rating for anesthesia); and
- surgical outcomes such as postoperative nausea and vomiting rates.

Once the measures are agreed upon, you will want to put them in a well-defined contract. Also, depending upon which performance measures are chosen, the anesthesiologists would likely appreciate an invitation to become involved with the ASC's efforts to improve efficiency in these areas, says Mr. O'Neill.

9. Keep subsidy contracts short-term

Subsidy contract terms should run between six-month and one-year terms. If the ASC is ramping-up and adding an operating room, consider a six-month term as it will give both sides an opportunity to revisit the contract after several months of use of the new room. This term may also help serve as motivation for your surgeons.

"The surgeons want to fill those rooms because they don't want to lose the group," says Dr. Wherry. "It helps the ASC management to motivate the surgeons to ramp-up volume because if they don't, they're still going to be paying the anesthesiologists whatever was brokered."

The longest subsidy or stipend contract you will probably want to sign is one year, with a review process that starts about three months before the contract expires, says Dr. Wherry. This will allow ample time for a complete review of the ASC's and the anesthesia group's operations and profits. If the ASC is performing well, and the anesthesia group is benefiting from this growth, the ASC may want to explore whether a subsidy is still necessary or if providing a fair bonus or sharing of the profits for good work is a workable alternative.

"I don't think ASCs are doing enough of that," he says. "They're not committing to anything. If the ASC has a bad year, no money is paid. If the ASC has a great year, why not give the anesthesiologists a small piece of the pie? That's a better arrangement as it's on more of a risk-sharing basis."

10. Know your alternatives

Depending upon the relationship you have with your anesthesia provider, a subsidy request can come at any time — and unexpectedly. And the provider may expect an answer fairly soon after informing you of the need for a subsidy. It is worthwhile to regularly research alternatives for your anesthesia provider just in case you cannot satisfy a request for a subsidy and ultimately lose the service of your current group.

"It's important to understand your alternatives," says Mr. O'Neill. "You don't have to put out (requests for proposals) or shop for other groups. However, it's good to know your alternatives when you get to that point" of (discussing a subsidy). ■

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Value of Single-Specialty Surgery Centers:
Q&A With Richard Jacques of Covenant Surgical Partners

Richard Jacques, president and CEO of Covenant Surgical Partners, discusses the pros and cons of single-specialty ASCs.

Q: What are some of the benefits of single-specialty ASCs versus multi-specialty centers?

Richard Jacques: To me, there are two significant benefits to single-specialty ASCs. The first benefit has to do with downside risk. In single-specialty centers, individual physicians typically retain a significant portion of the surgery center, so they are motivated to use the center and are more likely to see the center as an extension of their practice. In these situations, it is rare that a physician would leave the ASC. As a result, volume is unlikely to decrease due to the loss of a physician. This isn't the case with large, multi-specialty ASCs, where investing physicians may only own a small portion of the facility.

Another benefit of single-specialty ASCs is that it takes less effort to grow these centers. We don't have to syndicate or attract a large number of physicians as a multi-specialty center would need to do. A single-specialty center that can bring in 1-2 non-affiliated physicians (meaning they don't have an ownership interest in another single-specialty center) in a 5-6 year period can increase volume by as much as 30-40 percent.

An additional benefit of single-specialty centers is greater efficiency. A center that focuses on one specialty or two complementary specialties has a staff and facility that are specifically trained and designed for that specialty, which leads to more efficient care.

Q: What are some drawbacks of maintaining a single-specialty center?

RJ: The biggest drawback is that you are limited in regard to expansion, both in facility size and the number of physicians you can bring in. A single-specialty ASC may only have two or three ORs with full schedules, leaving little room for bringing in additional physicians or procedures.

Additionally, in a single-specialty ASC, the facility management and administrators don't have as much control as they might have in a large, multi-specialty ASC. Because physicians are more invested emotionally and financially in these centers, management and administrators are required to create consensus for decisions and develop deeper and stronger relationships with the physician partners.

Q: What types of specialties are most profitable right now in the ASC setting?

RJ: Single-specialty ASCs are popular and will continue to grow in popularity, in my opinion. Of the approximately 6,000 ASCs today, about 55 percent of them are single-specialty. Eye, GI and pain centers are the most popular. Plastic surgery ASCs are also very popular, but they are sort of an anomaly because those are mostly an extension of the physician's practice where there is no facility fee. There are also a small number of orthopedic- and urology-only centers, but not nearly to extent of eye, GI and pain. To be profitable, a single-specialty orthopedic ASC requires a very large group of physicians, because of the costs involved. Eye, GI and pain centers can typically be profitable with fewer physicians.

The key to profitability is volume. Because GI cases are non-invasive, these physicians tend to do a lot of cases, so you don't need a lot of physicians doing them to be profitable. In this specialty, 2-3 physicians can justify their own center. What prevents physicians from having a profitable single-specialty center is if they don't have the volume to warrant their own center.

Q: How do you see the profitability of single-specialty ASCs changing in the future?

RJ: I think reimbursements will continue to come down or at least stabilize. I don't see that changing. However, ASCs are still a low-cost site for service. In a market where we're trying to pay for an aging population, ASCs are a solution to a problem because they can reduce costs. I see the future being very bright for GI and ophthalmology, because of this aging population. I also see a bright future for pain management as well. I am very bullish on the future of single-specialty ASCs. I see more physicians trying to participate in these as well. At smaller, single-specialty centers, they get better scheduling and the staff has a better understanding of each physician's preferences.

There is some concern about what is going on politically with healthcare reform, but I believe if you're doing the right thing and providing something that is good for healthcare and for the economy, then you'll continue to have success. ASC reimbursement rates are 59 percent of hospital outpatient departments today, so we're clearly a low-cost option, and because of that, ASCs are very well positioned to be a solution to the healthcare crisis. ■

Learn more about Covenant Surgical Partners at www.covenantsurgicalpartners.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

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