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

September/October 2011 • Vol. 2011 No. 7

7 Predictions From ASC Physicians on the Future of Surgery Center Physician Ownership

By Rob Kurtz

Considering the growing trends of physician employment by hospitals and hospital acquisition and integration of ambulatory surgery centers, seven ambulatory surgery center physician-owners discuss whether they expect to still maintain ownership in an ASC in five years, as well as the factors that could facilitate a change in ownership.

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Top Priorities of ASC Administrators: Thoughts From 10 Surgery Center Leaders

Ten surgery center leaders and industry experts share their thoughts on the top priorities for ASC administrators now.

Margaret Acker, administrator of Southwest Surgical Center in Byron Center, Mich.: I think the most important thing administrators can do now is read and participate in their state and national ASC organizations. I think it important to network with others and share information that benefits patients. We all wonder how

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125 Women to Know in the ASC Industry

By Rachel Fields

Here are profiles of 125 women leaders in the ambulatory surgery center industry. Names are listed alphabetically.

Margaret Acker, RN, MSN, CASC. Ms. Acker is the administrator of Southwest Surgical Center, a multispecialty freestanding ASC in Grand Rapids, Mich. She was formerly CEO with Blake Woods Medical Park Surgical Center in Jackson, Mich., a multispecialty, physician-owned center. She has worked in the ASC industry for over a decade as a consultant, administrator and presenter. Ms. Acker holds a master's degree in nursing from Eastern Michigan University and serves on the "approver committee" for the American Society of Ophthalmic Registered Nurses continuing education. She also serves on the board of directors for St. Luke's Clinic, providing healthcare for the poor and medically underserved.

Amy Allard, BSN, MPH, RN. Ms. Allard is administrator of Ramapo Valley Surgery Center in Ramsey, N.J. The center opened in the fall of 2005, and

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Answering Questions regarding the New FDA Guidance on Liquid Chemical Sterilant Processing and the STERIS System 1E™

By Barbara Trattler, RN, MPA, CNOR, CNA

On June 30, updated U.S. Food and Drug Administration (FDA) provided new guidance and recommendations for liquid chemical sterilant processing. This is important for healthcare facilities that process critical devices and are evaluating options to replace the STERIS System 1®. At Advanced Sterilization Products (ASP), we've received so many questions regarding the effect this new guidance will have for healthcare facilities that we felt it important to provide our advice.

NEW FDA GUIDANCE REGARDING LIQUID CHEMICAL STERILANT PROCESSING:

- "FDA believes that **sterilization with liquid chemical sterilants does not convey the same sterility assurance as sterilization** using thermal or gas/vapor/plasma low temperature sterilization methods."
- "FDA recommends that the use of liquid chemical sterilants be limited to reprocessing only critical devices that are heat-sensitive **and incompatible with sterilization methods such as steam and gas/vapor/plasma low temperature processes**."
- "**Biological Indicators are not appropriate or required for monitoring liquid chemical sterilization process.** They are generally used for monitoring traditional sterilization processes where an SAL 10^{-6} is achieved. FDA has not cleared any biological indicators for monitoring liquid chemical sterilization process."

Q. Does this affect the deadline to transition away from the STERIS System 1®?

A. No. The deadline remains February 2, 2012. However, this updated guidance affects your replacement options. The STERIS System 1E™ is a liquid chemical sterilant processing system, and according to FDA, liquid chemical sterilant processing systems should be used only to reprocess critical devices that are heat-sensitive and incompatible with other sterilization modalities, such as steam or gas/vapor/plasma low temperature sterilization methods.

Q. Will the FDA clear a Biological Indicator for the STERIS System 1E™?

A. The FDA noted that Biological Indicators are not appropriate or required for monitoring liquid chemical sterilization process. The STERIS System 1E™ is a liquid chemical sterilant processing system.

Q. How can my healthcare facility assure the sterility of our heat-sensitive critical devices?

A. The ASP STERRAD® NX® System uses a hydrogen peroxide gas plasma sterilization process that provides the sterility assurance level (SAL) of 10^{-6} that you re quire for processing heat-sensitive critical devices and providing your patients the highest standard of care. The STERRAD® CYCLESURE® 24 Biological Indicator (BI) provides evidence of proper sterilization conditions as recommended by AAMI, AORN and CDC. Even more, the STERRAD® Systems materials and lumens claims extend even beyond heat- and moisture-sensitive devices.

Q. What if I already purchased a STERIS System 1E™?

A. ASP offers a variety of replacement programs and financing options designed to help you, including trade-in options for your STERIS System 1E™ or STERIS System 1®. Contact your local representative or call 888.783.7723 to find out about financial options to upgrade to an ASP solution.

Q. Can ASP help me transition?

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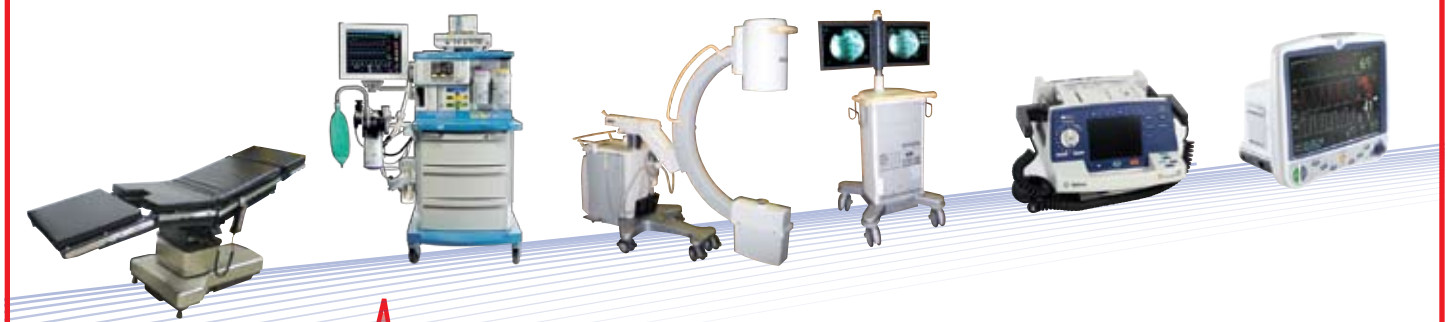

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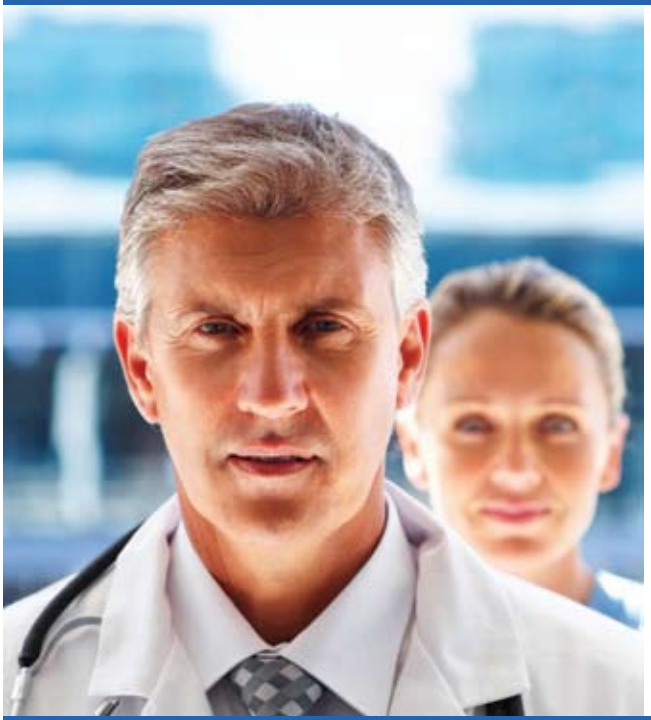

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Photo: *The big guy shaking hands with me is orthopedist Dr. John Vitolo, who has been a surgeon-owner with us for over a decade. Does he look happy, or what?*

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ASCREVIEW
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Publisher's Letter

9 Observations On the ASC Market; 18th Annual ASC Conference – Improving Profitability and Business and Legal Issues (Oct. 27- 29; Chicago)

ASCs are seeing more uncertainty than at anytime in the last decade. This month's publisher's letter provides several observations related to the ASC market, and also provides information on the 18th Annual ASC Conference – Improving Profitability and Business and Legal Issues conference, the ASC industry's premier fall event taking place Oct. 27-29 in Chicago.

1. Key questions being asked by ASCs. Three key questions we are often asked are 1) will healthcare be dominated by vertically integrated systems? 2) will reduced reimbursement of specialties drive more physicians towards employment? 3) are we seeing the extinction of entrepreneurial physicians?

2. Private equity interest. The ASC market remains of great interest to several private equity funds. There continues to be significant interest in the ambulatory surgery business. However, investors seem to be more interested in ambulatory surgery center chains with a specific focus — e.g. pain management, orthopedics, or spine — than in general surgery chains. While the ASC industry faces certain challenges, tremendous consolidation opportunities and significant cost benefits associated with moving surgeries from inpatient to outpatient venues exist. In the last 24-36 months, TPG Capital invested in Surgical Care Affiliates and H.I.G. Capital invested in Surgery Partners. One year later, in January 2011, Surgery Partners then bought NovaMed, AmSurg Corp. bought National Surgical Care and LLR Partners invested in a platform of fertility driven ASC businesses.

3. Health systems. We still see health systems with ASC strategies. As a core strategy, we see some health systems attempt to develop or acquire, often with a management company, 5-7 ASCs. There, they try and develop a broader market alternative to physician employment and use it as a means to align with physicians and earn income. In the past two months, health systems across the country have added surgery centers to their list of facilities in an attempt to expand market share and build relationships with physicians. A joint-venture partnership between United Surgical Partners International and San Francisco-based Catholic Healthcare West added three Arizona ambulatory surgery centers to its portfolio in July, and an HCA acquisition of The Colorado Health Foundation gave the hospital operator full ownership of 13 ASCs in the metro Denver area. Kaiser Permanente San Diego recently broke ground on a new ambulatory surgery center included in a $60 million medical office building, which will house specialty care providers, nuclear medicine and a GI procedure suite.

4. Two key headwinds/Three biggest challenges. The ASC industry faces two serious headwinds. First, on the revenue side cases are harder to come by as there is a reduction of available independent doctors. There are approximately 100,000 surgeons in the United States that would be available for ASC ownership. There are close to 5,000 plus surgery centers, many of those having 10 to 30 physicians per center. This means that a large number of the independent physicians are surgeons already spoken for. Regent Surgical Health estimated in an August presentation that the

number of available investors per surgery center has dropped in recent years from an average of 40-60 to an average of 12-20. A 2011 Medscape Physician Compensation Report found that more than 25 percent of orthopedic surgeons have already invested in a surgery center; for ophthalmologists, the number jumps to 27 percent, and for gastroenterologists, to 40 percent.

On the reimbursement side, we are also seeing negative trends from out of network and general reductions in reimbursement. In states like New Jersey, surgery centers continue to move in-network as legislation threatens to impose additional requirements on out-of-network ASCs. This means physicians and surgery centers must adjust their profit expectations as they negotiate less profitable in-network contracts or face significant reductions to OON reimbursement levels.

The three biggest challenges in large part overlap with these headwinds are 1) challenges with reimbursement from payors; 2) challenges relating to physician employment by hospitals and recruitment of physicians; and 3) increased CMS and state regulation.

In terms of physician employment, we are seeing key differences from market to market and specialty by specialty. In some specialties, there is rapid evolution toward employment — e.g. cardiology, primary care, obstetrics and gynecology and certain other specialties. According to Merritt Hawkins' *2011 Review of Physician Recruiting Incentives,* family practice was the most requested physician search by medical specialty last year, gaining substantial traction over its popularity in 2006. Family practice was followed by internal medicine, hospitalists, psychiatry, orthopedic surgery and OB/GYN. The recruiting incentives for these specialties are also increasing as demand spikes: The average income offered to orthopedic surgeons in 2010/11 was $521,000, compared to $519,000 in 2009/10 and $413,000 in 2006/07. Once a hospital in one county or area starts to employ physicians, the other system often needs to respond to that effort.

5. Six best specialties. It is often perceived that the six best specialties for surgery centers are orthopedics, spine, GI, ENT, ophthalmology and pain. According to the 2010 ASC Valuation Survey, conducted by HealthCare Appraisers, general orthopedics is the most desirable specialty for ASC management companies, earning a 94 percent approval rating. General orthopedics is closely followed by its sister specialty, orthopedic spine, which received an 88 percent approval rating in the survey. ENT, ophthalmology and pain management followed close behind with 76 percent each, and GI rounded out the top six with a 70 percent approval rating. These specialties are prized for different reasons, namely profitability and efficiency. For example, both general orthopedics and spine command high reimbursement per case, whereas ophthalmology offers short case and turnover times.

6. Turnarounds. As far as the turnaround market goes, there is an increasing number of centers that need to be turned around. However, it is harder and harder to actually turn them around due to lack of available physicians and the lack of upside reimbursement. According to HealthCare Appraisers' ASC Survey 2010, 29 percent of surgery center management companies prefer to acquire turnaround centers at lower multiples and asset values. However, this percentage is significantly lower than the number (41 percent) who are now looking to acquire established facilities with immediate cash flow.

7. Pricing of deals. We often see majority centers still selling at 6-7.5 EBITDA range. Out of network centers see much lower multiples, often 3-4 times EBITDA. Hospitals most often buy at reasonably high prices if they wish to convert to HOPD and/or reap higher reimbursement. Finally, hospitals recognize that every loss of an in-patient case takes six to eight outpatient cases to make up the revenues. Thus, as hospitals do see decreases in inpatient cases, they are more aggressive about trying to find outpatient cases and implant ASC strategies.

8. Co-management and 100% hospital-Acquired ASC. There are a great number of questions as to what can be paid and is a co-management company truly needed. There are several different models that hospitals and physician groups can pursue around co-management. In a direct contract model, for example, the hospital owns the service line and enters into a management agreement with the physician group. The physician group then provides management services for a fee, and a governance committee is appointed to oversee the relationship. In this scenario, the governance committee is present only to provide oversight, not to serve as an active manager. In a joint venture model, on the other hand, the hospital and physicians form a "newco" which contracts with the hospital. The profits from the newco are then split between the hospital and the physician group. This type of arrangement sometimes depends on the number of physician groups involved.

Compensation for co-management services is generally divided into two levels of payment: a base fee and a bonus fee (based on quality and performance). Both fees must be consistent with fair market value, and to meet safe harbors for the Anti-Kickback Statute, compensation must be set in advance. This means hospitals can only reward physicians with bonuses if the minimum and maximum bonus amount is decided in advance, rather than based on a percentage of collections. Physicians should also not be compensated for clinical duties through a co-management arrangement.

9. Accountable care organizations. It remains unclear whether ASCs will have a positive role with ACOs. On the one hand, the development of ACOs will tend to favor lower cost providers such as ASCs. However, many of the ACOs will be driven by hospital systems that are much more focused on steering all possible cases to hospitals.

* * *

Included with this issue is a brochure for the 18th Annual Ambulatory Surgery Centers Improving Profitability and Business and Legal Issues Conference. This is the ASC industry's premier fall event. This conference brings together great surgeons, administrators and ASC business and clinical leaders to discuss how to improve their ASCs and their bottom line. We have an outstanding agenda this year, with 132-best-in-the-ASC business speakers and 90 sessions. We have also included three keynote speakers: Sam Donaldson, Bill Walton and Adrian Gostick.

Should you have any questions or desire to join us this year, please register in one of the following ways:

1. Contact the Ambulatory Surgery Foundation at (703) 836-5904;
2. Fax the registration found in the brochure to (703) 836-2090;
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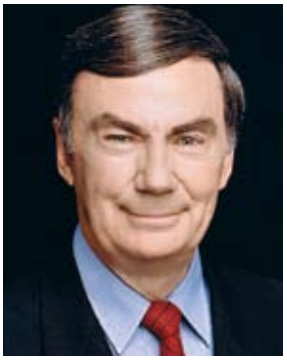
Through dynamic presentations and unparalleled networking, this celebrated conference, now in its 18th year, provides participants with expert intelligence to lead in today's challenging market.



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7 Predictions From ASC Physicians on the Future of Surgery Center Physician Ownership **(continued from page 1)**

Ken Austin, MD, orthopedic surgeon and president, Ramapo Valley Surgical Center in Ramsey, N.J. "I do expect to maintain my ownership in some form five years from now. I am not yet anxious to jump on the band wagon and sell. Maintaining ownership and, [more importantly], control, is important.

"Hospitals tend to run much like the government. They have difficulty staying proactive and tend to get bogged down in layers of unnecessary bureaucracy. They are good at filling out the correct paperwork, but they lose sight of patient care and patient satisfaction along the way, let alone keeping the surgeons happy. Hospitals have a habit of making the surgeon an afterthought.

"As a private facility, we are able to cater to our patients and surgeons alike and provide the highest level of personalized care possible. That's a hard combo to match."

Brad Lerner, MD, urologist and medical director, Summit Ambulatory Surgical Centers in Maryland. "I would still expect to maintain ownership of our ASCs in the next five years although there is a higher likelihood that this may change from our present structure of 100 percent physician ownership. The pursuit of a hospital or hospital system partner may be dictated by a change in our ability to continue to control the care and flow of patients. This has already been impacted by the growing trend of hospitals employing not only primary care physicians but also surgical subspecialists as well.

"The ability to maintain ownership would likely allow the physician-owners to better control daily operations as well as to direct the methods of providing high quality, cost effective care in an ASC setting. There would likely be less control if a majority ownership was not maintained. However, there certainly may be benefits to partnering with a hospital or hospital system given the uncertainty of the future of healthcare, current trends of hiring more hospital employed physicians and the potential impact of accountable care organizations.

"Partnering with a hospital or hospital system in a formal manner may provide increased financial security, the ability to become part of a larger purchasing group to improve buying power and potential ability to increase reimbursement rates. Partnering with a hospital or hospital system may also lessen the chance of having them hire their own competing surgical specialists as well."

Allen Hord, MD, anesthesia/pain management, West Paces ASC in Atlanta, an Interventional Management Services partner center. "There is a trend for medical specialists and surgeons who do mostly inpatient procedures to become hospital employees. However, I do not believe that pain specialists or surgeons who do mostly outpatient procedures will follow this trend. These specialists are generally fiercely independent and tend to want more control than is possible as a hospital employee.

"In two previous experiences in hospital-contracted (although not employed) groups, I found that the hospitals rarely acted in the economic best interests of their doctors. They want to control the revenue stream and reap all the benefits. However, I do believe that there will be a trend toward hospital/physician joint ventures, where doctors maintain control of the surgery center."

Kenneth Pettine, MD, spine surgeon and founder, The Spine Institute and Loveland (Colo.) Surgery Center: "As far as surgeons being employed by hospitals, that is a trend, but if you look at this historically, generally what happens is the hospital becomes unhappy or unsatisfied with the situation. Usually it takes about a year or two. What happens is you take a physician who is working 60-80 hours a week in private practice. Let's say his income is a couple million dollars. The hospital buys him out and a contract is negotiated, but it's based on the fact that this physician was doing 400 cases a year at the hospital.

"Now he's an employee and he decides he's not going to work 60-80 hours a week. He's going to spend more time with his family. Maybe he's never been on any of the hospital committees and decides to join a few. Now he has committee meetings so he can't be in clinic or operating as often as he used to. Historically what happens is the physician's volume goes from 400 cases a year to 200 cases a year. Generally after about two years of this, the hospital is the one that divorces the situation by saying the physician is not fulfilling his side of the bargain.

"I think this whole thing is a trend that will go by the wayside, and I think there's going to be a huge resurgence in doing spine surgery in ASCs. With physician income dropping and overheard increasing, there is a very renewed interest by surgeons in passive outcome. To obtain this income, there are physician-owned distributorships — those are under great scrutiny. I don't see that as the future. However, if you have ownership in an ASC, you can do a similar arrangement at your ASC as far as the implant costs go and there are no Stark issues. A surgeon can accomplish what you would do with a POD through an ASC — do exactly the same thing as far as acquiring implant profits — without any of the legal problems.

"I think that is definitely a better avenue for surgeons. I think there's going to be a very renewed interest in ASCs. I think spine surgeons are looking for passive income and what I'm describing is perfect. It is profitable to do spine surgery at an ASC for both the spine surgeon and other owners. In addition, implant costs can be a source of additional passive income. Include 12-minute turnaround times and overall efficiency, patient satisfaction and this situation is too good for a spine surgeon not to desire. We just need to educate surgeons to realize they can duplicate exactly what we have accomplished.

"I have no intention of changing my ownership stricture. In fact, I just want to own more."

Rollins Tindell, MD, ophthalmologist, Surgicare of Mobile (Ala.), an affiliate of Surgical Care Affiliates: "I'm not aware of any hospitals purchasing eye practices and I'm not sure why I would partner with a hospital if I'm not employed by them. I truly believe surgery center companies run surgery centers much better and more efficiently than a hospital can run an ASC.

"I have no desire to join the ranks of a hospital unless something comes up that makes it worthwhile, whether it's financially better or better from a patient access standpoint. At this point in time in our area, there is no benefit to partnering with a hospital. Since we're a big practice, we continue to bring new partners in so there's no problem with replacing old partners when they retire. I can understand if some centers are getting weighted toward the older age group and not bringing young people in, so there's nobody to buy them out. Then they might sell to a hospital at that point, but that's not a problem with us. Every young physician that comes in immediately wants to be a part of the surgery center."

Joshua A. Siegel, MD, orthopedic surgeon and director sports medicine, Access Sports Medicine and Orthopaedics in Exeter, N.H. "I believe that the consolidation that is taking place in the entire healthcare industry will require institutions to grow through acquisitions or partnerships. This is not exclusive to ASCs and includes hospital mergers and acquisitions. Local hospitals have found that the healthcare industry is not immune to the economic conditions facing the rest of the country. Medicaid reimbursement, regulations and pressure from insurance companies are forcing hospitals and ASCs to look at their models and strategically assess their opportunities.

"Looking forward, healthcare will be required to show efficacy in outcomes and value for its costs. The fragmented, parochial nature of the healthcare system including ASCs require capital to modernize and grow beyond what small, local systems can deliver.

"I believe medicine will always be individualized from a delivery of care aspect, but economically, partnering will create growth and economies of scale that will be critical for the survivability of ASCs in the future."

David J. Abraham, MD, orthopedic surgeon, The Reading Neck & Spine Center in Wyomissing, Pa. "I don't want hospital partners. I try to look at the bigger picture, and I'm not making decisions about my ASC based on security. With a hospital partner, basically what you're doing is saying, 'I want to team up with the 800-pound gorilla and we're going share bananas. I'm going to behave just like him so I can have a profitable ASC and he can crush me when he wants to.' I don't believe in that. I think that's just contributing to the power these organizations already have, not to mention the fact that it totally devalues the physicians' profession and I won't give in on that. I will never sacrifice an independent facility for the perceived benefit of security.

"This is a catastrophe for the profession. We don't understand the implications of physicians as a profession becoming employees. We don't understand the impact of the mega-monopoly called the hospital institution. The hospitals are the largest government-subsidized monopoly in our country and we don't need a monopoly in healthcare right now. The Obama bill essentially makes healthcare a guaranteed monopoly by withdrawing any sense of competition that in our capitalistic society is supposed to drive down healthcare costs.

"Talk to business owners who employ more than 150 people and who are self-insured. Where is the money in healthcare going? It's going to the hospitals. They are shaking down our economy and our business owners and charging them ever-increasing costs. The only sense of competition is going to come through the entrepreneurial spirit of capitalism and competition to be able to include the patient in the decision of how to spend the healthcare dollar, have them experience some liability and have them say, 'I'm not going to go to the hospital and pay $15,000 for a knee scope when I can to go an ASC and pay $2,000.'

"As physicians, as a profession, become more employed, it takes away their ability to participate in the market forces that should be present in our economy to lower healthcare costs. The hospital is the enemy of every American who is paying health insurance right now but unfortunately they play on an emotion of need. They hide behind their not-for-profit status. My [local] hospital — Reading Hospital and Medical Center — posted a gross income for the first time of over $1.3 billion with an operating margin of over $120 million in profit. Those numbers are ridiculous. That's money siphoned off of this local economy that business owners and subsequently workers have to bear the cost of. The money has to come from somewhere.

"To me, this is a monopoly where we are all experiencing the effects, we're all paying into this monopoly and it's wrong. Then there's the concept of a certificate of need, which is insanity. The concept that you need to go to the government to open a business is wrong. Why is healthcare not looked at like any other business? Our country does not historically tolerate monopolies and yet the government has done anything it can do to protect the hospital monopoly." ■

Contact Rob Kurtz at rob@beckersasc.com.

Top Priorities of ASC Administrators: Thoughts From 10 Surgery Center Leaders
(continued from page 1)

the ASC will fit into the new healthcare reform. I believe we must be knowledgeable and able to join as one collective voice to ensure we are heard in Washington.

My concerns will probably be the same as most administrators, but here they go:

- Hospital systems recruiting and eventually employing surgeons. These doctors no longer can bring patients to the ASCs.
- Inability to fairly contract or fairly with insurances controlled by hospitals
- How to remain profitable while paying significantly more for supplies and staff —especially healthcare benefits. It is ironic — we sit on the provider side and the employer side. We collect less for our services and pay more for staff benefits.
- What impact will ACOs have on freestanding ASCs? The ambiguity, with no ability to learn more or do more, is frustrating.
- As most ASC RNs aren't young, how do we recruit and retain qualified RNs?
- What will the requirement for EMR in ASCs really be? Should we move forward, or hold out until we know?

Jessica Cooley, sales executive of strategic accounts for Provista: The uncertainty in the reimbursement for health care services highlights the importance for taking a strategic approach to the management of your supply chain. The ASC chains I work with are focused on incorporating information technology to manage inventory, purchasing and their revenue cycle. Also, several are exploring ways to focus their supply utilization by standardizing products used across locations, looking for opportunities to aggregate purchases with suppliers to take advantage of the best pricing tiers available and reducing supply waste by creating custom procedure kits. A good way to approach supply chain improvement is to schedule periodic business reviews with your distribution partner and GPO representative.

Pam Ertel, president of the Pennsylvania Ambulatory Surgery Association: The top items for me are:

1. Implementation of electronic health records.
2. Be politically astute. Keep abreast of state and regulatory issues that pertain to ambulatory surgery facilities. Get to know your local politicians.
3. Develop a strategic plan for obtaining benchmarks.
4. Maintain a dashboard of outcomes.
5. The most important: Provide a quality environment that focuses on customer satisfaction. Be the choice for providing outstanding patient care.

Steve Henry, administrator of Fremont (Neb.) Surgical Center: Two of the top priorities are to work with vendors to find ways to lower costs of supplies and implants and to continue to recruit new physicians. In addition, for those surgery centers who are partnered with hospitals, [administrators must] continue to ask them to earn their percentage through payor negotiation, joint recruitment among new physicians and other contracted service lines.

Bob Kahn, CEO of Orthopedic Specialists of Texarkana: [The most important thing an ASC administrator can do right now] is to keep the ASC solvent and maintain current levels of physician productivity at the ASC.

Stuart Katz, FACHE, CASC, executive director of Tucson Orthopaedic Surgery Center: Take a deep breath and relax. Many of us often find themselves in a series of dilemmas which require thoughtful processing, and we do not make time to fix issues once and for all. I am of the opinion that healthcare is like a merry-go-round, in that there are not many new problems, just the same old ones that keep coming back around. We are measured or should be measured on our ability to slow down the merry-go-round so that we are not dealing with the same problems day-to-day, week-to-week or month-to-month. Finding permanent solutions to issues can be life-saving, and the life one saves might be your own.

The other important item for any administrator is understanding what you don't know so that you can get assistance from either within or out-

side your organization. You cannot be a "jack of all trades," as there is not enough time in the day to do it all. Knowing your limitations is very important.

Brad Lerner, MD, FACS, clinical director at Summit Ambulatory Surgery Centers in Houston: Important things that ASC administrators should be doing now:

1. Exploring potential partnerships with hospitals/hospital systems.
2. Exploring potential new lines of service to bring into the ASC that make sense from a clinical and cost effectiveness standpoint.
3. Pursuing competitive bidding to look to decrease both supply and service costs in the ASC.
4. Maximizing use of supportive staff and OR time — look to expand hours if demand is there, and look at staggered scheduling for staff to optimize staffing and avoid over-staffing.

Mike Lipomi, president and CEO of Surgical Management Professionals: [Administrators must] pay attention to the smallest detail and every penny spent.

Sarah Martin, vice president of operations for Meridian Surgical Partners: The ASC administrator must look at the big picture. It is easy to get caught up in the financial or clinical aspect of the role specifically and then neglect environment of care issues. The administrator must surround himself with strong managers and staff that can assist in keeping the big picture in view. With the new focus on ASC quality, the administrator is going to need to allocate resources to ensure quality is met and reported properly, in addition to ensuring positive financial and clinical outcomes.

Holly C. Ramey, group vice president for Surgical Care Affiliates: [Administrators must] hold the team accountable to the highest quality of care and engage/partner with physicians. ■

Contact Rachel Fields at rachel@beckersasc.com.

State of the ASC Industry and Ambulatory Surgery Center Association: Q&A with Bill Prentice of ASCA

By Rob Kurtz

Bill Prentice is the executive director of the Ambulatory Surgery Center Association.

Q: Now that you've been serving as the executive director of ASCA for more than six months, what's your impression of the ASC industry?

Bill Prentice: My initial views of the industry have only been solidified in the sense that I really value where ASCs fit in the healthcare marketplace. I'm particularly gratified that my initial observations about what a great healthcare delivery model they are have been confirmed.

Q: What are your key takeaways from the first half of the year for ASCA and the industry as a whole?

BP: The first six months for me was a time of assessment—assessing both the resources we have here within the association as well as the capabilities of the industry to promote itself and its core values, to both the public and patients as well as to policymakers here in Washington, D.C.

Second, it's a matter of putting together the right infrastructure to succeed in Washington in terms of advocacy. That was of primary importance and something I spent a lot of time on. Working with the ASC Advocacy Committee, which is an industry-supported effort to improve our federal advocacy on behalf of ASCs, along with putting a team in place here in the Association, has occupied a lot of my time. I feel very happy with where we are right now.

A good indicator of that is the fact that we were able to get our [Ambulatory Surgical Center Quality and Access Act of 2011] bill introduced recently and we're starting to develop good cosponsors for the bill. I wanted to make sure we had a team in place so that after we got the bill introduced, we could actually develop momentum for it, rather than just introducing it and letting it sit there.

I do find it disconcerting and am continually concerned about the inability of policymakers in Washington to recognize the value of ASCs in the system. I think the proposed CMS rule is yet another indication that they still do not understand the value of supporting this industry and the positive economic impact that ASCs could have on the system. We could be saving Medicare billions of dollars if they would do more to promote utilization in ASCs.

Q: What are your objectives and the objectives for ASCA for the rest of this year and going into 2012?

BP: At the top of my list is working with CMS on the proposed rule for this year and, in particular, the new quality reporting requirements. There are certainly some head-scratching elements to the proposed rule in terms of the timeframe they propose to implement quality reporting. So, we need to get straight with them, and we need to do that soon.

In addition, and slightly more long-term, we do have additional needs on the quality front. We have dramatically increased funding this year for the ASC Quality Collaboration (ASCQC). I think there's still more we need to do there. Quality is of incredible importance to this industry. We provide high quality care, and we must do a better job of proving that to policymakers and patients.

We must devote a lot of time and attention to how we can make the ASCQC as robust as possible in terms of developing additional quality measures that can get endorsed by the National Quality Forum. As we do, we need to make sure that we are reaching out to all stakeholders to assure we're all on the same page and are taking the right steps to measure quality at the facility level.

I also want to improve the educational resources we offer our facilities. Whether that is through phone seminars, webinars and the sessions we have at ASCA's meetings throughout the year, or the publications and online resources we offer, I want to make sure we're providing our facilities with the tools that allow them to be successful and provide an optimal patient experience.

Q: What do you see as the other top challenges for ASCs going forward?

BP: We need to do a better job of promoting the value of using ASCs to policymakers. We do not receive the respect we deserve from policymakers.

That's a continual challenge for us, and we need to make them understand what a valuable role we play, particularly in a time of scarce budget dollars. Part of that is lobbying, and part of it is communications. I think we need to do a better job of defining ASCs, whether that's through the media or directly to policymakers, and that's something we'll be spending a lot more time on as well going forward.

Q: What do you think individual ASCs should be doing to benefit themselves and the industry?

BP: First and foremost, ASCs need to join ASCA. The only way we, as an industry, are going to be able to achieve our shared goals is by working together. We are a small piece of the healthcare pie, and if we are not all working together, the likelihood of succeeding in our goals is pretty dim.

By working through the Association, joining ASCA and pooling our resources, ASCs will be better positioned for success. Every ASC must get involved, supporting ASCA's advocacy efforts by participating in our grassroots efforts, which means meeting with members of Congress and state lawmakers and getting them to know and understand the ASC industry. We have the ability at the Association to help any center develop good relationships with their lawmakers and can give them the resources they need to explain to their lawmakers how valuable ASCs are to the healthcare system. If every ASC would take the few hours a year that it takes to support our advocacy efforts, there is no telling how much we could accomplish.

Learn more about ASCA at www.ascassociation.org. ■

8 Ways to Make Yourself an Effective Administrator

By Leigh Page

Kathy Leone, administrator of Saint Vincent Endoscopy Center in Erie, Pa., lists eight ways to become an effective administrator.

1. Remember to get input. Listen to feedback, including the negative variety, and be willing to change when needed. Employees can provide some of the most valuable feedback, but only if they feel that they can speak up and share their thoughts. Ms. Leone tries to make herself available to staff and to maintain a friendly, receptive approach.

2. Admit your ignorance. "Give yourself permission to not know something," Ms. Leone says. "If I don't know something, I'm going to ask. It might look silly but that's better than not being aware of what I need to know." It helps to have someone to go to with questions, such as the ASC's management company.

3. Have a passion for what you do. Having a passion for the job makes it easier to get through the occasional bad day. "When the day has been tough, what makes me want to come into work the next day is the passion I have for what I do," Ms. Leone says. "This is not something you can teach; it's just part of you."

4. Be well organized. "Being well organized is huge for an administrator," Ms. Leone says. "You don't want to have last-minute fire drills." Administrators have certain "must do's" like meeting payroll and following the surgery schedule. Then there are regular deadlines for tasks such as meeting regulatory requirements. And then there are minor duties that also cannot be missed, such as getting a TB test. Everyone has her own way of keeping track. Ms. Leone keeps a "to do" list and starts new files every quarter for quality, infection control and peer review committees and for the board, and she fills each one with pertinent material.

5. Hire great staff. The right staff can make all the difference in a surgery center. "Hire them, train them," Ms. Leone says, "and then get out of their way." While the administrator still has to be involved, "you have to let your staff feel that you trust their judgment." Hire employees who have good people skills. If they are going to be dealing with patients, "they can't be too reserved," she says.

6. Be clear with employees. An administrator needs to speak up when a staff member is making a mistake. "It's important to comment to employees when they are not meeting expectations," Ms. Leone says. "If I allow it, I enable it." After six months of the same mistakes from an employee, the administrator shouldn't be noticing the behavior for the first time.

7. Commit to patients. A commitment to patients is essential for every ASC administrator because having a good experience is what brings people through the door. "If a patient is sitting waiting for a procedure, give them a smile," Ms. Leone says. "A smile doesn't cost anything." She views patients as if they were her own family members. "Our patients should get the highest quality of care we can give," she says.

8. Commit to quality. The administrator needs to be committed to clinical and operational benchmarking, staff education and accountability. When staff members have been educated, it's important to follow up to make sure they have absorbed the information. "Did they get the meaning of it?" Ms. Leone says. To maintain the highest quality, staff members should be accountable for what they do. ■

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8 Procedure Types That Can Add Volume to Your ASC

By Leigh Page

Trey Parsons, RN, vice president of clinical operations for ASD Management in San Diego, Calif., identifies new procedures that can add volume to an ambulatory surgery center.

1. Selected spine procedures. Spine procedures currently being performed in ASCs are cervical fusions, lumbar fusions, discectomies and laminectomies. Some ASCs are also hosting vertebroplasties and kyphoplasties, but it is often difficult to get insurance coverage for these.

2. Lap bands. Laparoscopic adjustable gastric bands, commonly referred to as a lap bands, received FDA approval in 2001. "Payors are increasingly offering coverage for lap bands because they recognize that they can reduce long-term healthcare costs for obese and diabetic patients," Mr. Parsons says. Some payors are limiting coverage to facilities that have been designated centers of excellence by board certification bodies for colorectal surgeons. The center of excellence designation requires the ASC to meet certain standards. Gastric bypass surgeries, on the other hand, will remain inpatient procedures.

3. Sling procedures. Urology-oriented ASCs are starting to add sling procedures, which correct urinary incontinence in women and traditionally were an inpatient procedure. "The condition primarily affects younger women who have just gone through childbirth," Mr. Parsons says. "Their bladders have collapsed and the sling lifts the bladder back up." The sling itself costs $700-$1,200, which is usually covered by private insurance. As sling and other procedures for female incontinence become more popular, some urologists are even beginning to limit their practices to this field.

4. Implanting pacemakers for incontinence. To treat older female patients with incontinence, urologists have been implanting pacemakers that function much like cardiac pacemakers. Surgeons insert the guide wires through fluoroscopy. "This is perfect for an ASC," Mr. Parsons says. "It's not something that a hospital would want to tie up its OR with." The implants are expensive, costing $14,000 each, but they are Medicare-reimbursed. ASCs with a lot of volume in this procedure would have to have substantial cash on hand, because the pacemakers have to be bought first and before applying for reimbursement.

5. Minimally invasive general surgery. General surgeons are beginning to perform laparoscopic cholecystectomies and hernia repairs on an outpatient basis. "Bringing these procedures out of the hospital and into the ASC depends on how comfortable physicians are with doing them on an outpatient basis," Mr. Parsons says. Some of these laparoscopic surgeries are in danger of turning into open surgery, which would require the hospital venue. This necessitates rigorous patient selection. But laparoscopic technology has improved and the volume is there because "there are a lot of gallbladder surgeries out there," Mr. Parsons says.

6. Laparoscopic-assisted vaginal hysterectomies. Gynecologists have kept their practices hospital-based because a lot of their work involves open procedures that have to be done in the hospital. But the advent of laparoscopic-assisted vaginal surgery has the potential for bringing these cases into the ASC. Since the major complication of this surgery is bleeding, good patient selection is crucial and the number of appropriate cases may initially be fairly low. However, as physicians get more comfortable with laparoscopic-assisted surgery, ASC-based volume may take off.

7. Partial arthroplasties on shoulders. Orthopedic surgeons have been starting to perform partial shoulder arthroplasties in ASCs. The high level of initial pain in this surgery previously limited it to inpatient venues, but now enough local anesthetics can be delivered to patients through catheters to get over initial pain. In contrast, many orthopedic surgeons still will not perform total knees and total hips on an outpatient basis. Patients tend to be Medicare beneficiaries, and Medicare won't reimburse for these procedures on an outpatient basis. Younger patients, however, would be better candidates for ASCs and private insurers may cover ASCs for this. "We're a more active society and people are going to wear out their joints faster," Mr. Parsons says.

8. Implanting spinal cord stimulators. Implanting spinal cord stimulators is an outpatient procedure typically done using a local anesthetic and a sedative. The implant costs about $10,000 and some private insurers cover it, while others still do not. ■

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

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5 Steps to Build a More Successful Surgical Practice: Insight From Ophthalmologist Dr. Gary Foster

By Rob Kurtz

Gary Foster, MD, ophthalmologist at The Eye Center of Northern Colorado, is a volume cataract and refractive surgeon in Colorado. He is a principle investigator in numerous research projects to enhance eye treatment and also serves a consultant for several different eye research companies.

Dr. Foster identifies five steps physicians must take to build a successful surgical practice.

1. Know thyself. To build a strong practice, Dr. Foster says a surgeon must understand which parts of his or her practice bring the most joy. "If it's interacting with entire families or individuals from the cradle to the grave and having a longitudinal relationship with patients, then it would be counterproductive for a surgeon to specifically try to build a high volume surgical practice," he says. "Whereas if you find that you love surgery more than all the other parts of eye care, then it would make sense to emphasize that part of the practice."

He says it is not uncommon for individuals to take steps to grow the surgical part of their practice when in reality that is where they have the most anxiety. "I have found that I love helping patients with surgery," Dr. Foster says. "I am actually more relaxed in the OR than in the clinic so focusing on a surgical practice has been unifying for me.

"Some people think they're supposed to have high volume and they start running down a pathway that doesn't lead to joy in their life," he says. "There's no way you can sustain effort or excel if it doesn't reflect your true inner desires."

2. Respect and care for your patients. Dr. Foster says one of the most valuable lessons he was taught was that the way physicians treat their first 100 patients in their practice sets a basis for how their described and appreciated in their community and determines the course and trajectory of the practice.

"This bears special focus and attention," he says. "It had been a long since I saw my first 100 patients but recently I've became involved with a new practice where the ophthalmologist left town and I'm going through that same process again in a town outside of where I live. It's very obvious to me that the first 100 patients will absolutely determine if that's a success or not. Patients are all coming to meet the new guy … and they're all walking back out and talking to the other patients that came to this same office and making a determination on whether they will come see me or not. I can feel it very acutely."

These 100 patients are critical for establishing your reputation as thereafter people will come in with some pre-conceived notions about you based on how you treated your earlier patients, he says. "You can't have a mulligan on your first 100 patients, but you can make a goal on what will happen for your next 300 patients and change the direction of your practice," Dr. Foster says. "As your surgical volume grows, care must be taken to maintain and grow the quality of the experience each patients has as well as the quality of their outcomes. This requires that a surgeon never loses sight of why he or she went into medicine — to help patients. It comes down to care and respect for your patients and their individual needs."

3. Anticipate and manage the transitions. As your practice surgical volume begins to grow, you will eventually reach a stage where you're at the natural limit for how much surgery you can do in a week. Your time will be limited because of the need to allocate hours for preoperative visits, consults and postoperative visits. At some point a surgeon can no longer solve this bottleneck by working more hours.

When you reach one of those natural limitations, you must make a decision about whether you're going to grow your surgical volume or top out, Dr. Foster says.

"If you're going to continue to grow your surgical volume then you have to make certain sacrifices," he says. "Changes in staffing or flow could be required. It could mean that someone else is doing more of the primary care and sending the patients to you when it's time for cataract surgery or that someone else is helping you with the postoperative care so you have more slots to see surgical patients." Making changes consistent with your values at these watershed periods

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allows progress towards goals with fits and starts, while anticipating and preparing for them before they even occur allows for seamless progress.

4. Do great surgery. "Doing great surgery revolves largely around the principal of practice," Dr. Foster says. "The more surgery you do, the better you become. It follows the principles outlined in the book *Outliers*: To be great at anything you need to spend around 10,000 hours practicing that art. A surgeon that has done 3,000 cases will justifiably feel like they are a very good surgeon, while a surgeon that's done 10,000 cases will feel like they're a *much* better surgeon than when they had done 3,000. No surgeon that has done the cases would dispute this."

He says there are some improvements in surgery that come incrementally but he has observed significant improvements in surgical skill coming in quantum leaps, usually around every 1,500-2,000 cases. "I just competed one of those jumps earlier this year and feel that I am about a 15 percent better surgeon this year than a year ago," Dr. Foster says.

There are steps you can take to accelerate the process, just as with any skill that requires hand-eye coordination, judgment and wisdom combined all at once, he says. They include gaining additional training, doing site visits to watch great surgeons, studying book techniques and studying video clips of yourself or obtaining video of other surgeons. However, in the end, Dr. Foster says, there's no substitute for hours at the scope. "I have not sensed that the improvement that comes with volume ever stops, no matter how many cases you have done," he says.

Note: Dr. Foster warns that there is a danger in growing your surgical referral network ahead of your surgical abilities, especially with the more challenging cases. Referring doctors will not be keen to weather your building years if there are more skilled and collegial surgeons in the area. The quality of the relationship with the referring doctors and the overall care offered to patients would have to overcome this awkward phase for the network to endure.

5. Surround yourself with superstars that compliment your weaknesses. This step harkens back to step one of "know thyself," Dr. Foster says. "If you're going to have a high-volume surgical practice, there's a certain amount of division of responsibility that's inherent in doing that so that precise surgery occurs and with great customer care," he says. "That requires you surround yourself with superstars and allow them to shine in the process."

For example, if a surgeon has great surgical skills but does not have a healing personality, he or she would need to be surrounded by individuals who possess this trait so patients are able to have that component of their surgical experience. If a surgeon is less organized by nature, he or she would need to be surrounded by individuals who are profoundly organized, otherwise important details will be omitted, which will likely impact the outcome and quality of care.

"This sounds intuitive but if you think you have to be the sun, the moon and the stars on the team, then you will likely not be able to tolerate having any other superstars on your team," Dr. Foster says. "That [approach] places an absolute limitation on how far your practice can and will grow." ■

Learn more about The Eye Center of Northern Colorado and Dr. Gary Foster at www.eyecenternoco.com/site/about/doctors.htm.

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10 Steps to Profitable and Successful ENT in Surgery Centers

By Rachel Fields

Tim Shannon, vice president of operations for Blue Chip Surgical Center Partners, discusses 10 ways surgery centers can profit from ENT while improving patient safety and satisfaction.

1. Ensure robust volume. ENT does not have the reimbursement power of specialties such as orthopedics or spine, but it can be profitable for surgery centers if the facility can guarantee volume. Mr. Shannon says depending on contracts, ENT physicians should be expected to bring approximately 250 cases to the center each year to offset the cost of expenses and initial start-up fees. Because revenue for ENT cases is limited, volume is key to ensuring profitability. "Reimbursement isn't great, but if you have good volume, you can certainly make it beneficial," he says.

2. Plan for $100,000 per ENT room. A multi-specialty ASC looking to add ENT should plan on spending approximately $100,000 per ENT room. This would cover equipment and supplies, including a microscope, sinus shavers, rigid scopes and instrument trays. "If you have volume to support additional rooms, you can take that number and multiply it by the number of rooms," Mr. Shannon says.

3. Negotiate strong contracts. While ENT does not have the same implant considerations as other specialties, robust payor contracts are still essential to profitability. Mr. Shannon estimates that ASCs can expect to see anywhere from $300-$700 in per-case reimbursement after expenses, but the number depends heavily on negotiation. Make sure your contract manager is familiar with the cost of each procedure and the savings to the insurance company.

4. Focus on profitable procedures. The best ENT cases for surgery centers are those that are quick and easy to perform — namely tonsils, adenoids and tubes. While most ENT surgeries, with the exception of larger thyroid procedures, are appropriate for ASCs, those that require more time may be less profitable due to reimbursement issues.

5. Plan a sizable waiting and recovery area. ENT-driven surgery centers will see a lot of pediatric patients, meaning both the waiting and recovery areas must be large enough to accommodate family members. "ENT tends to come with a lot of extra volume in terms of people," Mr. Shannon says. "Make sure you have enough room to support the family when they come in, because it's very important to the child that there are familiar faces around when they wake up."

6. Decrease turnover times. Efficiency is the name of the game in ENT, and thus short turnover times are essential to keep cases moving. Mr. Shannon estimates that turnover for tubes will take approximately five minutes, while turnover for tonsils and adenoids will take around 10-12 minutes. These numbers obviously vary based on the physician and staff members, but ASCs should make sure to have enough supporting supplies and equipment to perform consecutive procedures.

7. Dedicate a nurse to each pediatric patient. ASCs that focus strictly on adult patients may use one nurse to cover multiple patients in the recovery area. The nurse can move back and forth from patient to patient as they wake up and recover from anesthesia. Because ENT cases are often performed on children, however, ASCs should be prepared to dedicate one nurse to each child in the recovery area. "With pediatrics you want to have more nurse staffing to make sure you're covered," Mr. Shannon says. "When a child wakes up, you don't know if it will be nice and easy or if the child will [panic] in unfamiliar territory."

8. Find providers with PALS certification. ASCs that perform ENT should find staff members with Pediatric Advanced Life Support certification. While pediatric anesthesiologists will have PALS certification, at least one other staff member should also hold the certification in case anesthesia is not able to be in the recovery room.

9. Pair ENT with a specialty that performs longer cases. ENT can work well in a multi-specialty ASC when paired with other specialties that require more case time. "That way, you can have ENT in one room doing short cases, and another specialty, like general surgery, spine or orthopedics, working in the other room on longer cases," Mr. Shannon says. "The specialties are not competing for the same recovery room beds."

10. Tout ASC efficiency to local ENT physicians. Physician recruitment is a challenge for most surgery centers, and ENT is so surgery center-appropriate that some markets may have saturated the local physician population. However, Mr. Shannon says surgery centers have an advantage in ENT physician recruitment because of the specialty's natural efficiency. "Doctors like ASCs because they're quick and easy, and in hospitals, they get bogged down due to emergency procedures," he says. Talk to providers about your ASC's case times and turnover times to demonstrate the benefits of performing ENT in a surgery center. ■

Learn more about Blue Chip Surgical Center Partners at www.bluechipsurgical.com.

Surgery Center Administrator Recruitment Checklist: 13 Questions to Ask Candidates

By Rob Kurtz

If your ambulatory surgery center is in the market for a new administrator, here are 13 questions Dawn Q. McLane, RN, MSA, CASC, CNOR, regional vice president of Health Inventures, suggests you ask candidates. Administrators can use this checklist as a guide for information they might want to know before going into an interview and questions they might want to ask about the ASC.

1. Have you held previous administrator positions and, if so, how many years of experience do you have? "If they have held previous administrator positions, what type of ASC — single-specialty, multi-specialty?" says Ms. McLane. "What specialties have they worked with in the past? I think it's important to know that. If it's a heavily orthopedic center I'm recruiting for, then have they worked with orthopods before? If I'm working with a GI center, have they worked with GI physicians before?"

2. How large were the previous ASC(s) you worked in? "Was it a two-OR ASC or five-OR center?" she says. "The more ORs usually means a busier center and more responsibility" for the administrator.

3. Do you have clinical experience, business office experience or both? "I definitely want to know this," she says. "If they have clinical experience, is it in the operating room or the perioperative area? This helps me get a good feel for where they're coming from. Is their expertise in the OR or are they a PACU nurse? They think differently, they perceive the surgery center differently."

4. What kind of experience do you have with payor contracting? "Have they had someone do it for them in the past?" Ms. McLane says. "Maybe they worked at an ASC where the hospital partner did all of the contracting for the surgery center. You want to know at what level they have been involved in payor contracting."

5. Are you CASC (Certified Administrator Surgery Center) certified? "That tells me a little bit about their competency level and it tells me they're interested enough in being an administrator to get the credential," Ms. McLane says.

6. Where is the ASC(s) you previously worked at located? "You want to know what geographic area they have worked in and are they familiar with the area we're recruiting to," she says. "Have they worked in this state before? Are they familiar with the state rules and regulations for our particular state? Not that they can't learn the state rules, but if they already have a familiarity then that's a plus."

7. Do you have experience working in diverse areas? "For example, I have a [California center] with a very high Vietnamese population and many of the physicians who work there are Vietnamese," she says. While candidates for administrator at this center would not necessarily need to speak Vietnamese, "they need to have a cultural competence that demonstrates an understanding of how to manage in a culturally diverse organization with a very large international population," she says.

8. Are you familiar with our market? "This is pinpointed more toward the candidate's knowledge of local / regional payors and competition within the market," says Ms. McLane. "Who are the payors in your market, who is the competition in your market and are they familiar with them at all?"

9. (For ASCs with a management company with expectations/requirements): Are you prepared to work in the corporate environment? "That's something that's very important to know," Ms. McLane says. "If they've never worked in a corporate culture before where there's a corporate manager or RVP, they might struggle with the expectations of a corporate entity. Some people who have never worked in that environment feel that the corporate entity is just creating more work for them and they don't always support the corporate entity or understand and appreciate the benefits

"If the person doesn't have experience working at a corporate entity, I would ask them to tell me what they think the value-adds that a corporate entity brings to this relationship," she says. "It's not for everyone. Some people much prefer a very independent way of managing and others love having the corporate entity's support."

10. (For ASCs with a hospital or health system partner with expectations/requirements): Are you prepared to work with a hospital/health system? "You want to know they can communicate effectively and how they will deal with a hospital or healthcare system partner," Ms. McLane says. "What kind of experience they have in that area?"

11. (For ASCs with a board that has expressed specific needs or expectations): Do you meet the requirements of our board? "That could be something like the ASC board wants only to interview clinical candidates and maybe they are not willing to consider candidates without an RN," she says. "I've had that happen before, where the board has only wanted to interview someone with a clinical background or financial background. I think sometimes it just has something to do with an experience in their recent history. ."

12. Can you handle the specific challenges of our center? "Every center has a unique personality. It has specific needs they desire to be a met," says Ms. McLane. "It may be a center that's in its first year of operations and will need someone who can move them successfully through the startup period. Maybe it's a mature center that's starting to decline, physicians are retiring or are moving away from the community and there hasn't been a good recruitment process in place in the past and now the center needs to recruit and to implement a succession plan.. It could be an ASC with a disengaged investor body and we need someone with the talent, experience and a personality to talk to the doctors and engage them again.

"Each center has its own individual personality," she says. "The person you're hiring as the administrator, must understand the unique challenges for that center and you must determine whether their talents and personality will be a match with the specific culture and needs of your center."

13. (For ASCs expecting a dual role for their administrator): Are you prepared to also hold the position of director or nursing or business office manager? Some small centers may not have a DON or BOM and may expect the administrator to assume dual roles," says Ms. McLane. "That all feeds into the type of qualifications and competencies you're looking for in your administrator." ■

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

10 Key Points to Consider When Selling Interest in an ASC

By Leigh Page

Matt Searles, managing partner at Merritt Healthcare, offers 10 key points to consider when selling interest in an ambulatory surgery or endoscopy center.

1. First, do the spadework. When physicians are contemplating selling interest in their center, the first step should be to undergo an operational and financial review. Before talking to any would-be buyer, thoroughly review finances and operations of the facility. Although purchasers usually focus on trailing 12-month earnings as a basis for their valuation, there is still a chance to identify and remove items from the operational side. These changes can affect the valuation. Look for one-time, non-recurring expenses not related to operations.

2. Pare down potential buyers. Develop a list of buyers and then eliminate the unlikely candidates. The selling physicians will be giving potential buyers inside information about the facility, which should not get into the hands of competitors. To mitigate that threat, focus on entities that would truly have an interest. "Get a good handle on who is buying," Mr. Searles says. "Don't send your information to someone who will not be interested." Keep in mind that while there are many ASC companies, relatively few are the really desirable candidates: those who are prepared to offer high multiples. This group is shrinking with recent consolidations in the industry.

3. Consider each offer's strategy. When evaluating potential offers, it is useful to understand each buyer's motivations. A buyer's strategic focus might be a hospital partnership, accumulating geographic locations or an interest in single specialty or multispecialty centers.

4. See hospitals as potential buyers. The local hospital that was once the foe of the surgery center might now be a potential friendly buyer. Hospital deals can be quite lucrative. While national ASC companies buy no more than 60-65 percent of a center and often less than that, a hospital may offer to buy 100 percent, convert the center into an HOPD and enter into a co-management agreement with the selling physicians. However, depending on the size of the market, there may be only one or two viable hospital purchasers to choose from.

5. Decide how much interest to sell. Physician-owners have a choice between selling all of their interest in the ASC or only part of it. This is an important decision because purchases of majority interest offer much higher multiples. For example, if 51 percent or more is sold, the multiple is 6-8 times, but if less than 51 percent is sold, the multiple is only about 4 times.

6. Consider selling a majority interest. Physicians often resist selling a majority interest because they are worried about losing control of the center. However, giving up a majority interest does not necessarily mean ceding control. "The buyer views the physicians as the revenue-generators, so he is going to want to cooperate closely with them," Mr. Searle says. Drawing on his experience negotiating sales of majority interest, he adds: "I have not found that physicians were told what to do. The buyers are very collaborative."

Physicians also often think they will benefit more from earnings on retained shares than from the proceeds of selling those shares, but this may not be the case. As already stated, multiples are much higher when a majority interest is sold, and the income from such sales can exceed potential earnings for many years to come. Furthermore, capital gains taxes for the seller, at as little as 15 percent, are lower than ordinary income taxes on earnings from shares, which amount to as much as 35 percent for the tax bracket applicable to many physicians.

7. Compile a comprehensive report. The seller should prepare an "information memorandum" that is typically 40-60 pages long. Since it will be the purchaser's introduction to the facility, it should be comprehensive and carefully written. The information memorandum should cover financial and operational performance, the background of the facility and the competitive landscape. The document should describe its owners and — this is key for attracting buyers — the future growth potential of the facility.

8. Don't hide the center's weaknesses. Make sure the comprehensive information memorandum represents a fair view of the facility, warts and all. "Include the good, the bad and the ugly," Mr. Searles says. "In addition to all the great aspects of your ASC, mention the ones that are not so good." For example, if a key physician is retiring, and that would reduce the center's volume and perhaps its value, it's important to reveal this early in the process. "You can lose some credibility with the buyer if you send limited information in the memorandum," he says. "The purchasing community is sophisticated."

9. Know how far to push. While there is some room for negotiation with the buyer, the seller's expectations of potential buyers need to be realistic. "You can only push them so far in terms of valuation and governance issues," Mr. Searles says. "They may back off. I've seen it happen where a buyer just bows out." The selling physician may think he is just pushing the envelope a little with an added demand, while the buyer may see it as evidence that the physician would be a difficult future partner. "By all means seek the best possible terms," Mr. Searles says, "but pushing beyond reasonable limits will cause purchasers to back away from your deal."

10. Be patient. In addition to properly preparing for negotiations and understanding what to expect, the seller has to be patient. "Don't rush it," Mr. Searles says. "Purchasers aren't going away tomorrow, so don't be in a hurry." The large ASC companies need time to evaluate a facility. It can take 6-12 weeks for them to decide on a purchase. In this period, "there is a constant back and forth between the buyer and the seller," he says. For example, the buyer will ask for follow-ups, arrange visits and collect references. ■

Learn more about Merritt Healthcare at www.merritthealthcareasc.com.

The Quiet Takeover: Insurers Buying Physicians and Hospitals

By Molly Gamble

Payors might provide more than reimbursement in the next few years — they may be signing the checks to buy hospitals or the physicians that drive referrals.

Payors buying physicians

Two related but distinct trends are emerging, and quietly: insurers buying physician groups and insurers buying hospitals. The first development has been subtle. Four of the five largest health insurers have increased physician holdings in the past year, according to a *Kaiser Health News* report. Recently, UnitedHealth Group has been buying medical groups and launching physician management companies. The same report said the strategy has stirred little controversy largely because few people know about it. One physician group mentioned in the report learned of United's new strategy only when it received a phone call from company with an offer.

So far, UnitedHealth is the payor with the largest revenue to buy physicians, but it is not the first. CIGNA Medical Group launched its CareToday clinics in 2006, providing "an alternative to traditional [physicians'] offices" in Arizona. Last December, Louisville-based Humana purchased Concentra, an urgent-care system based in Addison, Texas. In early June, Indianapolis-based WellPoint acquired CareMore Health Group, a health plan operator based in Cerritos, Calif., that owns 26 clinics.

"There is definitely a national landgrab over primary care physicians," says Ted Schwab, partner at the Health and Life Sciences practice of Oliver Wyman, an international management consulting firm. This creates a clash between the insurance industry and hospital industry as both fight to control primary care, the epicenter of care management. "We work with insurance companies all over the country, and every single one of them is discussing this in their board rooms. Some are very aggressive, some have decided not to do it," says Mr. Schwab.

The model poses a natural threat to providers, particularly hospitals. OptumHealth, UnitedHealth's subsidiary, has said its physician networks serve all players in a health system, including rival health plans with policyholders who use the same physicians. Still, the CMO of a physician group in Nevada declined UnitedHealth's offer, saying it would compete directly with the group's business model, according the same *Kaiser Health News* report. Primary care physicians are already in high-demand, and by acquiring them in certain markets, insurers could potentially wrest control of entire health systems by influencing referrals — whether that is an explicit intention or not.

Payors buying hospitals

A proposed deal in Pittsburgh has proven insurers can take their acquisitions one step further

and buy entire hospital systems. While the concept may be making headlines, the unorthodox model is leaving many players in the healthcare industry with cold feet. "Everybody is looking at one another, saying 'I don't mind being second, but someone should go first,'" says Mr. Schwab. "This is a huge chance to take." So far, only a handful of payors and providers have made a move and a transaction has yet to involve a major hospital system, making the proposed merger between Pittsburgh-based West Penn Allegheny Health and Highmark highly significant.

Insurance companies experimented with buying hospitals in the 1990s, a trial-run Mr. Schwab calls "an unbelievable failure." For instance, Louisville-based Humana had to abandon its strategy of jointly operating healthcare plans and 76 hospitals across the country. Industry experts suggested the dual structure would likely lead to internal conflicts and weakened profits. Bond raters said it alienated physicians, who would not refer patients to Humana hospitals if they objected to certain managed-care practices. Humana ended up dividing the hospital operations into a spinoff company called Galen Health Care in 1993.

Nearly 20 years later, a national deficit and skyrocketing healthcare costs may now play in payors' favor. Providers are already collaborating with payors through care coordination initiatives and accountable care organizations, but acquiring hospitals involves a different set of political, economic and cultural factors. "Every politician and big employer is pointing to healthcare as one of the major reasons the country is going bankrupt," says Mr. Schwab. "Insurance companies believe they can bring efficiencies to the table, and the integration of insurer and delivery system can bring a 20-30 percent reduction to the cost structure."

Keeping an eye on Pittsburgh

Five-hospital West Penn Allegheny, which is the region's second-largest chain, has faced bleak finances for the past five years and reported a $26.8 million operating loss for the first half of fiscal year 2011. Under the proposed transaction, Highmark would buy the system for nearly $500 million and assume approximately $1 billion in liabilities. Rating services are closely watching to see how the deal unfolds — Standard & Poor's quickly revised West Penn Allegheny's credit rating from negative to "developing," indicating the game-changing nature of the deal.

The proposed deal in Pittsburgh involves unique circumstances, such as Highmark's contentious relationship with West Penn's rival, University of Pittsburgh Medical Center. Disagreement over contracts led to a payor-provider standoff, with frustrated employers in the area asking the regional giants to stop bickering and playing games. UPMC finally put an end to negotiations, announcing the cancellation of Highmark contracts by the end of June 2012. After learning of Highmark's plan, UPMC announced it would not sign a new contract after the acquisition in refusal to subsidize competition.

Changes in payor-provider relationships

Unique elements of provider-payor relations combined with regional market conditions make it difficult to predict transactions on a national scale. Short of mergers or acquisitions, some hospitals may form an honest spirit of collaboration with payors through medical homes and bundled payments. Others may remain isolated.

If payors and hospitals are remote enough, though, the latter risks being considered a means to an end in their marketplace. "There are really separate worlds between payors and providers in some markets," says Bill Woodson, senior vice president of Sg2, a healthcare intelligence and information services company based in Skokie, Ill. He names

San Francisco as a city with mature physician organizations and IPAs that have been around since the 1990s. "They're sophisticated and able to manage patients and risk. The dynamics between these groups and payors are interesting. If I were a health system, I'd be worried I'd be seen as a commodity over time," says Mr. Woodson.

Payors are acting aggressively to control costs in some marketplaces, calling hospitals out for high-cost care, devising new methods to reduce spending and leaving consumers in the crossfire. In January, Blue Cross Blue Shield of Massachusetts launched its Blue Cross Hospital Choice plan, which limits the use of 15 higher-cost hospitals. Employers that sign up for the plan receive a reduced premium increase, but BCBS members face extra charges if they go to high-cost hospitals, which include prestigious organizations such as Brigham and Women's Hospital, Massachusetts General Hospital and Dana Farber Cancer Institute. "So consumers are being told, 'You can still go wherever you want, but if you go to this particular hospital, your out-of-pocket costs will be much higher,'" says Mr. Woodson. "Some consumers will be caught between brand perception, quality and marketplace power."

A game of finger-pointing

Insurers are not only holding providers more accountable, but are also beginning to tout their management skills and low-costs — a dig to hospitals and physicians. Many insurers point the finger at physicians as the culprits in rising healthcare costs, saying they order too many tests, name-brand prescriptions and implants.

Samir Qamar, MD, stands on the other end of the spectrum. In 2009, he cut insurers out of the equation when he founded MedLion, a direct primary care physician network based in Monterey, Calif. Patients pay $59 a month for discounts on primary care, such as $10 physician visits, up to 50 percent discounts on labs and imaging services, and subsidized medication plans. Patients are referred to non-affiliated health insurance agents that provide plans for catastrophes. Cutting the insurer out of primary care has led to big cost-savings, according to Dr. Qamar.

"For instance, we refer to a GI physician that cuts a $2,000 colonoscopy down to $700. There are a lot of inflated costs because of insurance. If you can promise a physician you'll pay cash upfront, then physicians can give big discounts. It's estimated that up to 35-40 percent of overhead costs in a private practice come from insurance-centric systems," says Dr. Qamar. The MedLion model is friendly with hospitals, acting as a "gatekeeper" and treating patients before they become preventable hospital admissions. "We help hospitals save money by reducing uncompensated care," says Dr. Qamar. "We receive a ton of patients from hospitals."

A conundrum for consumers

Consumer reaction may be one of the most fascinating developments in payor-provider mergers, as the model is likely to create dissonance in attitudes towards quality and price. Historically, consumers have resented limitations on which physicians they can see or where they can receive an operation. "Now, they're looking at their paycheck and thinking, 'Wow, if you tell me you'll give me a break and reduce my cost for limiting my choices, I'm all in,'" says Mr. Schwab.

But, when it comes down to it, how would patients feel knowing the hospital delivering their care is owned by an insurance company? "It would scare the daylights out of me," says Mr. Schwab. "I don't think insurance companies are full of bad people who want to skimp on care, but I think the management competencies are different for what it takes to deliver care." ■

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Current Trends in ASC Management Company Consolidation

By Leigh Page

Brent W. Lambert, MD, founder and CEO of Ambulatory Surgical Centers of America, has been noticing a new trend in recent years. Several small ambulatory surgery center companies with an equity stake in multiple ASCs have approached ASCOA, asking to be bought out.

"That would never have happened five years ago," says Dr. Lambert, whose larger ASC company has not taken up any of these offers, but is still interested. As of the beginning of the year, ASCOA had developed or turned around more than 60 ambulatory surgery centers.

"The smaller companies are looking to a bleak future," Dr. Lambert says. "The ASC industry is changing very rapidly and many of the smaller companies, even when they have an equity stake in their ASCs, see the handwriting on the wall."

Why small companies are selling

Dr. Lambert says smaller ASC companies, basically those with fewer than 12-15 ASCs, are beset with a number of challenges:

- **Inadequate reimbursements**. "CMS is unlikely to pay enough money to ASCs so that they can make a profit on Medicare," Dr. Lambert says. "ASC profit margins have been declining year after year. People are saying we want out of this environment." He says larger companies like ASCOA can weather the storm, but smaller ones feel the pain very deeply.
- **Less access to financing.** "Small companies have not been able to get financing to grow their portfolio of centers," Dr. Lambert says. "The tend to be viewed as a risk by the banks. The banks are asking, 'What are the prospects that they would be profitable if they did have the money?'"
- **Declining interest from private equity funds.** Although private equity funds have made some high-profile acquisitions of ASC companies, Dr. Lambert thinks the funds are losing interest because they are not seeing the kind of high returns they were used to in the past. "Virtually no equity funds are entering the ASC market for the first time and some funds are getting out of the ASC market," he says.
- **Lack of economies of scale.** "When you get to be a certain size in the market, you can become more efficient," Dr. Lambert says. For example, large companies like ASCOA have teams to help with key tasks like physician recruiting and contract negotiations that smaller companies cannot organize. ASCOA itself has a team of six analysts who work full time to gather data for contracting. And when ASCOA recently acquired a center, it assigned one person to do nothing but recruit more physicians over several months. This person brought in 13 new physicians who will be adding $7 million to the ASC's bottom line.

A string of recent ASC company acquisitions

As small companies yearn for a white knight, some of the larger ASC companies and equity funds are still willing to play the role — picking through the small companies for great opportunities to make money in turnarounds, says Jon Vick, president of ASCs Inc. in Valley Center, Calif.

"Over the past decade, there has been a constant movement of small ASC companies into larger ASC companies," Mr. Vick says. "Private equity funds and other capital partners have had lots of money. As the market matures, there are opportunities to buy up failing centers."

This has been going on for some time, he says. But in the past nine months, several high-profile mergers have taken place:

- AmSurg Corp., which has 202 ASCs, is acquiring 18-center National Surgical Care for $173.5 million.
- United Surgical Partners International, with 165 ASCs, is purchasing 14-center HealthMark Partners for $32 million.
- H.I.G. Capital, a private equity fund working through 12-ASC Surgery Partners, is acquiring NovaMed for $109 million. NovaMed, with 40 ASCs, is much larger than Surgery Partners. But like the smaller companies, NovaMed is looking for capital and the opportunity for growth, Mr. Vick says.
- Irving Place Capital, another private equity fund, acquired 14-ASC National Surgical Hospitals. Irving Place is replacing National Surgical's previous owners, led by Ferrer Freeman & Company, Charlesbank Capital Partners and JPMorgan Asset Management.

Big players build on ready-made networks

The big players often seek out small companies rather than acquire individual centers one by one, Mr. Vick says. It's easier to buy a ready-made network, he says. The buyer doesn't have multiple closing costs and the acquisitions move faster. While it takes one year to acquire a center and two years to build a center from scratch, it takes six months or less to acquire a network or company that owns 10-20 centers, he says.

Mr. Vick thinks demand for small ASC companies has heated up. "There is a lot of competition these days to acquire smaller companies," he says. "It's a lot harder to acquire a company today because there are a dozen or so other companies who also want multi-center networks."

As larger companies search for good deals, some smaller companies intentionally develop strategies to make themselves more attractive for acquisition, Mr. Vick says. "Some companies offer stock options to physician partners so that when the company gets acquired, the stock options will be worth several times their face value and the physicians will benefit," he says.

Mr. Vick still sees a lot of activity in the private equity market. "Selling to private equity firms is a real opportunity for the founders of the company who put in sweat equity," he says. Private equity funds, he adds, are typically seeking an ASC management company with a minimum EBIDTA of $5 million-$10 million. That rules out many of the newly emerging ASC companies that have just a few centers. He says the private equity funds also want proven earnings on the books and are looking for an internal rate of return on their investment of at least 25 percent.

Warning: Mergers may erode physician-control

Mergers of ASC holdings may not always be a good thing for the original physician-investors. Mr. Vick cautions that one outcome of mergers is loss of physician control as the acquired ASC moves up the food chain of buyers. "When small companies are sold to larger owners, the physician-partners end up with less clout in many cases," he says. When the physicians sell off majority interest in their ASC to a small management company, they often have little control over the sale of that small company later on.

"The physicians may end up with a new partner that they're not happy with," Mr. Vick warns. To avert this, he advises physicians to always retain a majority interest in their center and insist on participating in governance of the ASC company. "They should have seats on the board and require a super-majority approval for certain critical issues, such as a sale to a larger company," he says. ■

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Outsourcing Key Areas of Your Business Office: Q&A With Pinnacle III Executives

By Rob Kurtz

Rob Carrera is president, Kim Woodruff is VP of corporate finance & compliance, Kelli McMahan is VP of operations and Carol Ciluffo is VP of revenue cycle management for Pinnacle III.

Q: What are you seeing as some of the driving factors pushing organizations to consider outsourcing parts of their business operations?

A: The continued economic downturn and declines in provider and facility reimbursement are forcing organizations to do more with less, says Ms. Woodruff. "There's also a lack of qualified personnel and the inability to absorb/understand and sustain compliance with the overwhelming number of regulatory changes," she says.

Other challenges facing ASCs which are driving them to consider outsourcing include finding the right personnel; identifying the right number of staff members with the knowledge, experience and expertise required to successfully perform business office functions; retaining qualified personnel and maintaining uninterrupted work flow when in-house employees are ill or on vacation.

"Some geographic locations also have an applicant pool that is small or non-existent," says Mr. Carrera.

Q: What's coming down the pike that may encourage more organizations to look to outsourcing as a feasible option?

A: ASCs can expect to see continual changes in coding, billing and collections regulations, says Mr. Carrera. Changes resulting from healthcare reform, the continued increase in the cost of benefits leading to a desire to limit the number of in-house employees and the need to reduce the organization's liability exposure are all factors which may encourage surgery centers to consider outsourcing.

"As regulatory demands continue to rise and internal business office staff are either ill-equipped or aren't allotted the time necessary to deal with the myriad of issues that face them, they end up having to be a jack of all trades but master of none," says Ms. Woodruff. "Administrators need access to expertise — an outsourcing company they can trust to become an extension of their existing team and look out for the best interests of their organization. Economies of scale have to be employed to sustain a viable business model in today's challenging environment."

Q: How would an organization know if outsourcing is worth considering?

A: "They would need to know the true costs related to the operations they are considering outsourcing," Ms. McMahan says. "The organization would most likely need to undergo an audit to determine if money is being left on the table and how they perform in comparison to similar organizations."

Such an audit would assess current practices, policies, procedures and processes against industry benchmarks to determine areas where the organization excels and where it requires assistance in order to more efficiently and/or effectively manage components of the organization's revenue cycle. An analysis might also look at the cost of current operations compared to the cost of outsourcing and weigh those costs against the benefits of same.

"Cost versus value needs to be considered," Mr. Carrera says. "We never say outsourcing will necessarily be cheaper in dollars spent - the value and quality of the services is where the comparison should take place."

Q: When is outsourcing not worth considering? Would an efficiently run organization want to consider outsourcing?

A: Outsourcing is not right for everyone, says Ms. Ciluffo. It may not be a good fit for organizations that are well-run with clean A/R and low overhead, or when an operation is very small (i.e., one practitioner, one specialty, low volume, few third-party payors), she adds. It might also not make sense when an organization is large enough to sustain an expansive internal business office staff specializing in defined components of the revenue cycle process (i.e., multiple departments), says Ms. Woodruff.

However, even an efficiently run surgery center may want to explore the potential benefits of outsourcing. "An efficiently run organization may be very insular, not receiving new ideas or information from the outside, and, therefore, not growing in knowledge," says Mr. Carrera. "After all, standing still is going backward." Ms. Ciluffo says organizations facing a potential staff issue may want to consider outsourcing as a means to maintain efficiency.

If an organization is going to outsource, the surgery center will want to do its due diligence and perform a thorough review of any company it is considering partnering with, says Ms. Woodruff. "If you outsource to a company that doesn't understand or honor your organization's values, you are risking loss of valued clientele," she cautions. "Patients need compassionate human contact as part of their overall treatment experience. They want to feel cared for throughout the entire process — from initial appointment setting, registration and financial obligation discussions to final payment of their bill."

Q: Is outsourcing a viable option if an organization loses a critical member of its business staff and is looking for a temporary stop-gap while a search for a replacement team member is performed?

A: This approach will not typically work because, from the outsourcing companies' perspective, there is too much time and energy involved to set up work flows on a temporary basis, says Ms. Ciluffo. With the costs that a high-quality outsourcing group would incur bringing on a new client, most would opt not to take on such a short-term project, Mr. Carrera adds, and many outsourcing companies are hesitant to sign contracts for less than 1-2 years because of these upfront transitional costs.

If a surgery center is considering operational changes as a result of the employee's departure, then outsourcing would become a viable option, says Ms. Woodruff. "Loss of a critical business office member, such as someone responsible for performing only one component of the process (i.e., coding) — can present an opportunity to rework the organization's existing model — moving it forward in positive ways especially, when a 'we've always done it that way' mentality is firmly entrenched."

Q: If an organization wanted to outsource as much of its business operation as possible, what's the minimum amount of staffing it would need to maintain in-house? What work would this staffing still need to tackle in-house?

A: The number of in-house business operations FTEs will vary based on the volume and type of services being performed; however, Ms. Ciluffo

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Thursday, October 27, 2011
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Evaluating the Return on Investment: Outsourcing Key Business Office Operations

Kim Woodruff
Vice President of Corporate Finance & Compliance

As costs of providing care climb while reimbursements decline, providers continue to seek viable options for streamlining business office operations. Effectively evaluating which areas of your business office to outsource and aligning with the right partner are keys to a prosperous future.

notes essential in-house staffing would need to include a dedicated contact person and competent front desk personnel responsible for accurate data entry, upfront collections, communicating changes in insurance information, providing medical records assistance and documenting deposits. "An established workflow for communication is essential for effective in-house/outsourcing collaboration," she adds.

Q: What are some best practices outsourcing company's follow to provide effective outsourcing services that organizations can learn from and emulate?

A: "Establish a continuous improvement program for business office operations similar to what is in place on the clinical side of the business equation," recommends Ms. Carrera. "Obtain an external view of operations on a regular basis to avoid developing inefficient ruts."

Ms. Woodruff suggests ASCs also focus on processes and performance improvement, ensure staff skill sets match up well with task assignments, cross-train and encourage open discussion and collaboration between staff members.

Q: What are some steps an organization can take to help maximize the benefits of outsourcing and improve the outsourcing process?

A: Here are some of the key steps suggested by the Pinnacle III team:

- Document goals for the outsourcing company.
- Institute regular communication with the outsourcing company to assess progress on established goals. Ensure the flow of information to the outsourcing company is consistent, timely (daily), and smooth.
- Determine what types of workflow technology works best for each individual member of the team (i.e., is e-mail or phone contact the preferred method of communication).
- Employ the use of web meetings and conference calls to work through troubling issues and provide ongoing educational opportunities for in-house and outsourcing personnel.
- Don't pass the buck. The work performed in-house combined with the work performed by the outsourcing group reflects on the organization as a whole. The organization cannot afford to adopt an "us versus them" stance.
- Assess what portions of the process already in place in-house can be accessed/utilized by the outsourcing company to create seamless hand-offs of essential information.
- Understand that a provider of excellent service is entitled to earn a profit from providing that service; it should be a win-win proposition for both organizations. ■

Learn more about Pinnacle III at www.pinnacleiii.com.

6 Things to Know About Pharmaceuticals and Outsourcing Pharmaceutical Solutions

By Rob Kurtz

Brian Williamson, PharmD, president & CEO of JCB Laboratories, a compounding pharmacy that serves ambulatory surgery centers, hospitals and clinics, discusses six things ASC should know about pharmaceuticals and outsourcing pharmaceutical solutions.

1. Regulatory problems and other challenges are going to continue to create shortages for critical drugs. "In 2010, there were over 170 drugs unavailable," Mr. Williamson says. "During the first quarter of 2011, there were over 80 unavailable, with over 50 percent of those being injectables that are critical drugs for chemotherapy, anesthesia and surgery."

There are three primary reasons for today's drug shortages: raw material shortage (powder is not available), regulatory issues (manufacturing plant has an FDA compliance issue) or financial/economic reasons (a company decides to discontinue producing a drug). While there are a few legislators trying to enact laws requiring manufacturers to give advanced notice of drug cancellation, there's currently no such law, he says.

2. When drugs become scarce, outsourcing is an option worth exploring. Most healthcare facilities have primary wholesalers from whom they order the majority of their drugs. In cases where drugs are unavailable or in short supply from primary vendors, secondary or tertiary wholesalers are often contacted. Alternative sources should be qualified and they should be able to provide pedigree information for the products, Mr. Williamson says. When no other option is available, compounded drugs may be a reasonable option. It is very important that proper due diligence is performed on compounding suppliers before procuring drugs from them.

3. Alternative drugs can carry significant costs. While purchasing a non-formulary alternative drug is one means of overcoming the lack of availability of a commonly used formulary drug, ASCs may see a noticeable increase in cost of the alternative over the formulary.

"Markups as high as 3,000-4,000 percent are not uncommon from alternative sources says Mr. Williamson. "Something that used to cost $1 or $2 is now $12-$15 a vial, and sometimes even higher than that. It's a pretty significant issue when it comes to dollars. They have everybody held hostage: Do you want to cancel cases or do you want the drug?"

4. Dosing and concentration differences can create safety problems. The need to switch from a familiar drug to an alternative can do more than just raise costs — it can also create safety problems.

"If you have to use an alternative drug that has different dosing and concentration [from the traditional drug used in your ASC], that can create safety problems," says Mr. Williamson. "There have been instances of overdoses when morphine was unavailable and providers had to switch to hydromorphone instead and the dosing was different."

5. Lack of drug availability can hinder efficiency. "At many ASCs, a staff nurse, clinical nurse manager or director of nursing will do the ordering [of drugs]," says Mr. Williamson. "When they have all of these other things to do, the last thing they want to do at the end of the day is spend 2-3 hours trying to find a drug that's unavailable."

When an alternative drug is found, it often requires retraining of staff to ensure proper dosing and administration. This can create inefficiencies during patient cases, which will inevitably decrease throughput.

6. Outsourcing not always an appropriate option. Outsourcing should not be considered when patient safety is questioned. If forced to look at alternative options for securing drug products, patient safety should be the first priority. "There are a lot of 'gray market' drug providers whose only interest is to make a quick buck," says Mr. Williamson. "If there is any question about the credibility of drug suppliers then the choice should be made to not use them. Partnering with a company that can help locate credible alternatives is important." ■

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5 Things to Know About Outsourcing Cataract Surgery in an ASC

By Rachel Fields

Ann Deters, founder and CEO of cataract outsourcing company Vantage Outsourcing, discusses five essential facts surgery centers should know about outsourcing cataract services.

1. Proper case scheduling maximizes efficiency. Convenience is oftentimes the enemy of efficiency. For example, a physician whose office is located next to the surgery center may schedule one or two cases daily versus 5-10 once a week. Cataracts are a non-emergent type of procedure. Therefore, by scheduling as many cases as possible on one day, a center will lower costs, as well as free up available OR time for other surgical specialties.

"If you can work with your surgeons to schedule their cases consecutively, you can truly maximize your facility and staff efficiencies. We recommend a minimum of five cases per surgical day," Ms. Deters says. Her company often assists its clients by providing cataract outsourcing services to one facility in the morning and then servicing a second facility in the afternoon.

2. Even low volume facilities can save money on supplies. Outsourced cataract surgery does not only benefit high-volume ophthalmic centers, Ms. Deters says. Both high- and low-volume centers can reduce their equipment and medical supply costs by utilizing cataract outsourcing services. Smaller centers in particular can benefit by not having to purchase, store and manage cumbersome equipment, procedure packs and large IOL consignments associated with cataract cases.

"For facilities performing eye cases only once or twice a month, it really doesn't pay to have all this equipment and inventory sitting idle and taking up valuable floor/shelf space," Ms. Deters says.

3. All equipment, "just in time" supplies and trained staff are provided. Outsourcing provides surgery centers with equipment, disposables and IOLS, as needed, for each scheduled surgery day. Cataract outsourcing companies assist with cataract procedures by delivering all the necessary ophthalmic equipment and supplies. This includes phacoemulsification equipment, microscopes, IOLs, procedure packs and all other ophthalmic supplies that are required. Equipment is packaged according to each particular surgeon's specifications.

Cataract outsourcing companies can also assist the ASC by providing a trained surgical technician. Outsourcing companies provide trained staff to coordinate and ensure the surgeon's day will run as smoothly as possible. The company's technician becomes part of the ASC's surgical team and creates a sense of additional ophthalmic expertise, utilized by both surgeon and staff. "[Our team] will arrive the day before schedule cases to setup equipment, coordinate inventory and do a final check to ensure a successful eye day," says Ms. Deters.

4. Need to open a second OR? Some surgery centers own their own equipment but use outsourcing services to equip a second OR. This increases the center's efficiency and profitability by allowing the surgeon to move from room to room quickly, thus providing efficient patient care without having the capital outlay.

5. Outsourcing can offer valuable insight into established ASC processes. Since outsourcing companies service a variety of facilities and witness a multitude of processes and policies, they have the unique ability of sharing "best practices" with client facilities. For example, an outsourcing company can point out staffing inefficiencies that lose the center money. "Many times centers make the expensive mistake of overstaffing," Ms. Deters says. "If you are using an outsourcing company to monitor equipment and facilitate room turnover, it is more than likely that you don't need more than three other staff to assist the surgeon, whether you're doing five or 50 case in a given day."

Another area of improvement an ASC might experience with outsourcing its cataract surgery is in room turnover. Ms. Deters says her team begins turnover as soon as the physician leaves the room and doesn't stop until everything is in proper order for the next case. ■

Learn more about Vantage Outsourcing at www.vantageoutsourcing.com.

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The company's leadership team includes Rick DeHart, CEO; Rob Carrera, president; and Scott Thomas, executive vice president. Its vice presidents are Kim Woodruff (corporate finance & compliance), Carol Ciluffo (revenue cycle management), Lisa Austin (operations), Kelli McMahan (operations) and Dan Connolly (payor contracting). Simon Schwartz is the director of marketing and sales.

PINNACLE III offers ASC development, management and billing along with consulting services in the area of facility auditing, payor relations and contract work. While PINNACLE III offers equity models, non-equity models are accessible as well. PINNACLE III also provides auditing and billing services to physician practices.

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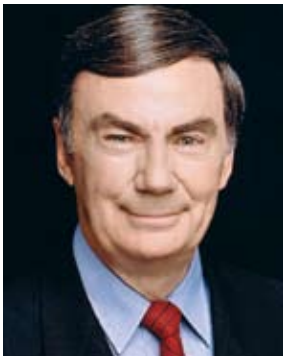

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Physicians Partnering With Hospitals on GI Centers: Q&A With Barry Tanner of Physicians Endoscopy

Barry Tanner is president and CEO of Physicians Endoscopy.

Q: To what extent are GI physicians working with hospitals on joint ventures for ambulatory centers?

Barry Tanner: There has been a lot of activity here, as there has been in several other specialties. Hospitals seem to be positioning themselves to function under an accountable care model or some kind of bundled-payment that would require greater collaboration among providers. Gastroenterologists who own ASCs that do not have a relationship with a hospital or some other large entity are increasingly concerned that if that entity took charge of some bundled-payment arrangement, the ASC would be left out in the cold. No one wants to be left out in the cold.

Q: Are concerns about being left out in the cold justified?

BT: I believe they are justified. No one knows exactly what the future holds, but I believe physician-owners need to work toward identifying the most likely options and then position their ASC so that it can connect with the greatest number of those options. Any sort of bundled payment scenario would require more collaboration, coordination and cooperation.

Q: How could aligning with a hospital help gastroenterologists?

BT: Internists and other primary care physicians, traditionally important referral sources for GI physicians, are increasingly employed by hospitals. This realignment could cause a basic change in GI referral patterns, making the GI center's relationship with the hospital all the more important. This does not mean giving up independence, though. Quite often, GI physicians retain their independence in these arrangements, even as they align their incentives with those of the hospital.

Q: How do these arrangements help the hospital?

BT: The hospital can recapture a portion of the facility fees that it lost to the physician-owned ASC. Moreover, hospitals are increasingly aware that GI physicians generate a great deal of in-bound healthcare services for the hospital. For example, colonoscopies unfortunately detect cancer, requiring surgery or other forms of treatment and follow-up care at the hospital. In addition, GI practices generate a lot of services for the hospital, such as CT scans and tests at the hospital lab.

Q: Are more GI physicians being employed by hospitals?

BT: Yes, but it's not a big trend. On a chart showing the amount of physician employment in each specialty, you'd go from ophthalmologists on the left, who are rarely employed, to cardiologists on the right, who are flocking to employment. Gastroenterologists are somewhere in the middle. Younger GIs, fresh out of fellowships, have been leaning toward hospital employment. These young GI physicians are thinking of quality-of-life issues. They seem to want more control over their professional lives. Some older gastroenterologists may also be exploring hospital employment, too. But anyone who considers hospital employment has to understand that it reduces their other options to zero.

Q: Are hospitals interested in GI-only centers?

BT: Hospitals are increasingly looking for GI-only centers. There has been a trend in recent years toward single-specialty centers because they are highly focused, efficient and cost-effective. However, hospitals with limited financial resources may opt for multi-specialty surgery centers. These centers tend to be more profitable for the hospital, and by catering to a broader group of specialists, they can spread the risks inherent in any one specialty. This may come down to the hospital asking, "Where am I going to get the biggest bang for the buck?"

Q: How would gastroenterologists fit into hospital-run multi-specialty centers?

BT: GI physicians working in multispecialty ASCs can have some of highest volumes but they get relatively low reimbursement. They'll sometimes notice that they are responsible for most of the case volume and feel their great volume is subsidizing the smaller volume of, say, orthopedics or spine. It's not uncommon for GI physicians to say — to themselves at least — that "we're doing 65 percent of the volume, so we should get 65 percent of the ASC ownership." Since orthopedic and spine cases typically get much higher reimbursements, that attitude may simply not be realistic.

Q: How are ASC arrangements between hospitals and GI physicians put together?

BT: Many of these arrangements are structured as three-way joint ventures, between the hospital, the physician-owners and an ASC management company like Physicians Endoscopy. We are participating in quite a few of these arrangements. Each partner has an ownership share in the facility, with the management company typically having the smallest share and no one having an absolute majority. In the arrangements we are involved in, the physicians often own something like 40 percent or more, while the hospital and Physicians Endoscopy cooperate to own something like 51 percent, but no one entity owns a majority.

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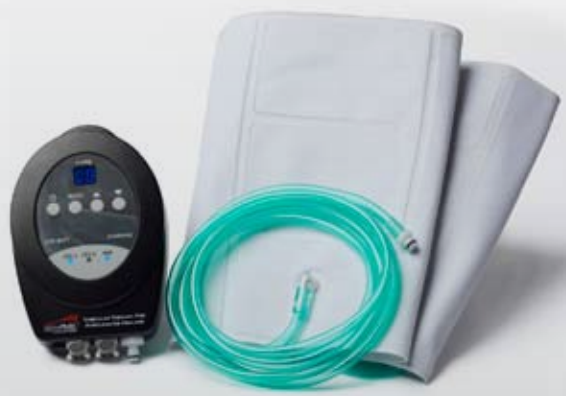

* Orthopedics 1996, Aug. 19 Suppl: 15-8. Fitzgerald, RH Jr.

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

surgeons at RVSC perform around 4,500 cases annually. The multi-specialty ASC focuses on orthopedics, general surgery, ENT, podiatry, pain management, ophthalmology, gynecology and dentistry. Ms. Allard has been with RVSC since early in its construction phase.

W. Jan Allison, RN, CHSP. Ms. Allison manages accreditation and survey readiness for Surgical Care Affiliates by supporting corporate-wide initiatives for quality improvement and assistance for approximately 130 ASCs with accreditation participation. In 2002, Ms. Allison authored the book "Assessment and Care of Patients: Your Guide to JCAHO Compliance." Since then, she has served as a speaker on numerous nationwide audio-conferences and seminars about quality, regulatory and accreditation issues. Ms. Allison is certified as a healthcare safety professional and has served on two advisory panels at the National Quality Forum to provide technical review of quality measures for ASCs. She currently sits on the NQF Steering Committee for Patient Safety Measures.

Lisa A. Austin, RN, CASC. Ms. Austin serves as vice president of ASC operations for Pinnacle III. She has acted as a board member of the Colorado Ambulatory Surgery Center Association and currently serves as president of the organization. Ms. Austin also serves on the surgery center advisory board of MedAssets. Ms. Austin has been a registered nurse for over 29 years and has served in the ambulatory care arena for the majority of those years. Her extensive experience with operational development, management and consulting provides clients with expertise in facility administration, budget development, regulatory compliance, staff recruitment and retention and other ASC processes.

Glenda Beasley, RN. Ms. Beasley is the administrative director of the Kentucky Surgery Center in Lexington, a multi-specialty surgery center opened in 1986. Ms. Beasley joined the center in 1990 and celebrated her 20-year anniversary with KSC in July 2010. She started at the center as an OR circulator and was promoted to OR/PACU/pre-operative supervisor and then clinical director before becoming the administrative director. She currently oversees 90 employees and an average of 1,000 cases per month. Ms. Beasley attributes much of her success to the people she works with on a daily basis. She takes great pride in her center and has watched it grow from a two-OR center to a seven-OR, three-procedure room center that saw close to 11,000 patients in 2010. Staying abreast of current issues affecting the ASC industry is a constant challenge, but she believes educating oneself, staff and physicians keeps the center on top. Ms. Beasley is certified in BLS, ACLS and PALS and is a member of AORN and the ASC Association.

Linda Beaver, RN, MSN, MHA. Ms. Beaver serves as administrator of Gateway Endoscopy Center in St. Louis. She started as a her career as a critical care nurse who specialized in cardiovascular recovery before moving into the management sector as a nursing supervisor, nurse manager and clinical director of multiple unit specialties in an acute-care hospital. While at her hospital, she developed and implemented a multidisciplinary "value analysis team" to standardize hospital clinical inventory. Ms. Beaver has been in the outpatient setting for three years and has over 16 years of management experience.

Cristina Bentin, CCS-P, CPC-H, CMA. Ms. Bentin is the founder and president of Coding Compliance Management, a healthcare consulting

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company specializing in coding support, training, reimbursement audits and business office assessments. She is nationally recognized as a leading freestanding ASC coding educator, speaker and writer, with more than 21 years of experience in the ASC industry.

Sandy Berreth, RN, MS, CASC. Ms. Berreth is the administrator of Brainerd Lakes Surgery Center in Baxter, Minn., a multi-specialty ASC that performs approximately 4,500 cases a year. She has been in the ambulatory surgery management arena for 12 years and has been with the center in Baxter since 2004. She is also currently working as an AAAHC surveyor. Ms. Berreth believes that her staff is what makes the center what it is today. "Hard work, compassion and dedication are shared visions by everyone," she says.

Lee Anne Blackwell, RN, BSN, EMBA, CNOR. Ms. Blackwell is a director of clinical services, quality and safety for Surgical Care Affiliates. In this position, she is responsible for developing and coordinating clinical-quality strategies, accreditation and regulatory survey readiness, clinical and quality best practice programs and patient safety initiatives for approximately 50 facilities, including surgery centers and surgical hospitals. Ms. Blackwell's accomplishments include patient care and surgical services in the hospital and surgery center arenas, as well as the development of several formal and self-paced nursing clinical education programs.

Dotty Bollinger, RN, JD, LHCRM, CASC. In just three years with Laser Spine Institute, Ms. Bollinger, senior vice president of medical operations, has established processes and procedures that improved efficiency of care at the facilities. Ms. Bollinger was instrumental in implementing electronic medical records at all Laser Spine Institute surgical centers, and she has been tasked with leading the company's accreditation readiness efforts as well. Under her leadership, Laser Spine Institute has successfully acquired AAAHC accreditation status for three of its clinic and ambulatory surgery facilities. Ms. Bollinger is a frequently sought-after speaker on topics such as infection control, accreditation and patient safety.

Regina Boore, RN, BSN, MS. Ms. Boore is the principal and CEO of Progressive Surgical Solutions. She has more than 25 years of clinical, administrative, teaching and consulting experience in ambulatory surgery. She has held every nursing position in a surgery center throughout her career and currently serves as the administrator of Newport Bay (Calif.) Surgery Center. As the CEO of Progressive Surgical Solutions, Ms. Boore's goal is to equip clients with functional tools and strategies to increase efficiency, improve outcomes and enhance the quality of life in the work environment. She is a frequent presenter on ambulatory surgery topics at national meetings and has published numerous articles in industry publications. Prior to coming to Progressive Surgical Solutions, Ms. Boore worked as a perioperative nurse, OR supervisor and ASC director.

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

Bonnie Brady, RN. Ms. Brady is the administrator of Specialty Surgical Center, a multi-specialty, two-OR ASC in Sparta, N.J. Ms. Brady has served as administrator of SSC since May 2008. Her ASC was recently featured in a New Jersey physician magazine as a notable surgery center. Ms. Brady is the co-chair of the New Jersey Association of Ambulatory Surgery Centers mem-

bership committee; the organization recently held its first annual conference in June.

Colleen Bridge, BSN. Ms. Bridge serves as an assistant administrator at Providence Health & Services Alaska. Ms. Bridge started her career in healthcare with Providence Alaska Medical Center straight after receiving her bachelor's of nursing in 1976. Over the last 37 years, she has held a variety of positions within the health system, beginning as a staff nurse in orthopedics and moving into a position as the assistant administrator for affiliations and partnerships.

Pamela Bronson. Ms. Bronson has been the administrator of Northeast Surgical Care since the center opened in 2000. The freestanding ASC features a single OR that regularly functions at maximum capacity and handles 1,800 cases each year. The ASC recently celebrated its 10th anniversary with an open house celebration for physicians and staff. According to Eric Simon of Access Sports Medicine and Orthopaedics, Ms. Bronson played an integral role in the opening of Northeast Surgical Care. "The project was met with a significant amount of resistance in the Seacoast communities," he says. "The hospital system that was in place was very strong, and they did not want to allow a freestanding ASC in their market." Following lengthy legal battles, Northeast Surgical Care was built and served as a foundation for other ASCs in New Hampshire. "There are now more than 20 ASCs throughout the state," Mr. Cimon says. "By accommodating patients more quickly and efficiently, Northeast Surgical Care can offer services at a significant discount compared to what patients would face at many other facilities."

Mary Beth Brust. As senior vice president of shared services for Health Inventures, Ms. Brust is responsible for operational performance and same-store growth throughout the company's network of ASCs. She joined Health Inventures in 2000 as an administrator for one of the company's surgery centers and has since held several positions within the company, ranging from regional manager to regional vice president. She has more than 20 years of progressive experience in healthcare administrative positions and has been involved in outpatient service delivery for 15 years.

T. Taylor Burnett. Ms. Burnett is CEO of Plastic and Hand Surgery Associates, a large plastic surgery practice that is the parent company of The Plastic Surgical Center of Mississippi, a physician-owned, multi-specialty surgery center in Flowood, Miss. Ms. Burnett is the administrator for The Plastic Surgical Center and lead the turn-key operation that opened in August 2003. She is the current president of the Mississippi Ambulatory Surgery Center Association and occasionally consults for other ASCs and their particular concerns.

Sue Dill Calloway, RN, MSN, JD. Ms. Calloway is a nurse attorney and president of Patient Safety and Healthcare Consulting. She was the past vice president of legal services at a community hospital in addition to being the privacy officer and the compliance officer. She worked for over eight years as the director of risk management and health policy for the Ohio Hospital Association. She was also the immediate past director of hospital patient safety and risk management for The Doctors Insurance Company in Columbus area for five years. She does frequent lectures on legal and risk management issues and writes numerous publications.

Monica Cintado. Ms. Cintado is the senior vice president of development for United Surgical Partners International, and she has been with USPI since 1998. Prior to joining USPI, Ms. Cintado provided development and operations support with the international group at HCA.

Kelli Collins, RN. Ms. Collins is regional vice president for Surgical Care Affiliates, which man-

ages more than 125 ambulatory surgical facilities and surgical hospitals. With 30 years of experience in the medical field and an operating room nurse by trade, Ms. Collins currently oversees the development, operations and management of a network of surgery centers in North and South Carolina. She has extensive experience in creating and nurturing physician partnerships and developing joint ventures with health systems such as the Wake Med Health System in Raleigh, N.C.

Mary Ann Cooney, RN, CASC. Ms. Cooney is the administrator of Riverside Outpatient Surgery Center, a multi-specialty facility in central Ohio with six ORs and one minor procedure room. ROSC performs over 6,000 cases per year. The specialties at the facility, which is currently managed by Health Inventures, include general surgery, gynecology, hand orthopedics, ophthalmology, orthopedics, pain management, plastic surgery and urology. The evolution of the center began with its building and opening in 1972 by a small group of innovative physicians and in 1977 was acquired by Riverside Methodist Hospital in Columbus, Ohio as a freestanding outpatient surgery department. The surgery center became a joint venture with OhioHealth and physicians in 1997.

Rebecca Craig, RN, BA, CNOR, CASC, CPC-H. Ms. Craig is CEO of Harmony Surgery Center, a multi-specialty ASC in Fort Collins, Colo. Ms. Craig has been with the center since it opened 11 years ago. She began her career as a registered nurse, working at a rural hospital in the OR, PACU, gastroenterology and pain management areas. She held several management roles in perioperative services before moving into outpatient and ambulatory surgery. Ms. Craig was recently elected and will serve on the national Ambulatory Surgery Center Association Board of Directors.

Deborah Lee Crook, RN, CASC. Ms. Crook is the administrator of Valley Ambulatory Surgery Center & Valley Medical Inn in St. Charles, Ill., a seven-OR, multi-specialty surgery center with adjacent inpatient facility. Mrs. Crook has been with Valley ASC since 1993 starting as a pre-op nurse before serving as director of nursing at Valley's post-surgical recovery care center and then assuming the role of administrator of both facilities in 2006.

Vicki Dekker. Ms Dekker is the director of business development at Blue Chip Surgical Center Partners. Prior to joining Blue Chip, she was responsible for the business office supporting the ENT, neurosurgery and neurology departments at the University of Minnesota. Ms. Dekker also managed an ENT group in Atlanta, where she developed and managed a single-specialty ENT surgery center that included facial plastic surgeries.

Pamela Dembski Hart, CHSP, MT. Ms. Hart serves as principal and founder for Healthcare Accreditation Resources in Boston. In her role at Healthcare Accreditation Resources, Ms. Hart assists ASCs, dental practices and medical practices in successfully meeting federal, state and accreditation requirements. She also serves as an active member of the safe injections policy task force and as a scientific advisor for the Hepatitis Outbreak National Organization for Reform. Ms. Hart has met with the Commonwealth of Massachusetts, Division of Healthcare Quality to present objective data and concerns regarding the standard of healthcare in ambulatory clinics, office-based surgical practices and other ambulatory surgical facilities.

Joan Dentler, MBA. Ms. Dentler has spent the past 15 years consulting for, developing and operating successful ASCs in 26 states. She has worked with clients providing direct services such as feasibility analysis, project design, partnership development, day-to-day management, physician recruitment and multi-disciplinary ASC troubleshooting. Through these activities, she has personally conducted hundreds of interviews with surgeons to determine physician preferences in the structure and operations of

ASCs and hospital surgical service delivery. Ms. Dentler has worked as a hospital liaison for hospital/physician joint ventured surgery centers and an administrator of women's health and pediatric primary care facilities. She holds an MBA from the University of Texas.

Meena Desai, MD. Dr. Desai serves as the founder, president and CEO of Nova Anesthesia Professionals. Established in 2001, Nova Anesthesia provides physician and CRNA anesthesia services to endoscopy centers and ambulatory surgery centers, and the company's more than 40 physicians and CRNAs provide anesthesia services for over 40,000 cases per year in three states. A board-certified anesthesiologist who has practiced since 1991, Dr. Desai also serves in numerous leadership positions for the Society of Ambulatory Anesthesia and the AAAHC. "Dr. Desai is truly one of the outstanding leaders in the field of ambulatory surgery and anesthesiology," said Michael Rose, practice administrator with Nova Anesthesia.

Ann S. Deters, MBA, CPA. Ms. Deters is CEO and co-founder of Vantage Outsourcing (formerly Vantage Technology), which provides complete cataract outsourcing services to hospitals and ASCs. Ms. Deters also serves as founder of 7D, a consulting and management service company for ASCs across the United States. With Ms. Deters' leadership, her businesses saved the healthcare industry more than $70 million in capital costs and more than $20 million in disposable cost savings. Vantage Outsourcing is also a certified "women-owned small business."

Michelle Dickinson, RN, CASC. Ms. Dickinson is the administrator of Baptist Plaza Surgicare in Nashville, Tenn., an ASC managed by United Surgical Partners International. Since starting her career with USPI in 2002, Ms. Dickinson has served in various roles — clinical manager, chief nursing officer and administrator among them. She has also had the opportunity to open several multi-specialty facilities with USPI, including a specialty hospital. Ms. Dickinson has concentrated the majority of her 15 years as an RN on the surgical environment, during which time she has worked with several health systems and physicians as partners.

Jill Dowe. Ms. Dowe was recently appointed director of business office operations for Blue Chip Surgical Partners, joining the company from a position as business office manager of Surgery Center Cedar Rapids (Iowa). In her role at SCCR, Ms. Dowe supervised office teams and worked with other members of the management team to ensure interdepartmental continuity and efficient operations in key areas, including scheduling, registration, admissions, coding and billing, accounts receivable and medical records. She has also worked as a consultant for Health Inventures, where she trained new business office managers in daily and monthly tasks. Ms. Dowe obtained her MHA from the University of Iowa.

Renee Duff. Ms. Duff has more than 14 years experience managing physician practices owned by a large integrated health system. During that tenure, she was responsible for the general office functions (including coding, billing, and collections) for a number of primary care physicians and surgical specialists. Ms. Duff oversees MCG Billing Services, a Medical Consulting Group affiliate that provides billing and collection services to ASC clients.

Vicki Edelman, RN. Ms. Edelman is the administrator of Blue Bell (Pa.) Surgery Center, a four-room, multi-specialty ASC managed by ASCOA that opened in Sept. 2008. Ms. Edelman has been with Blue Bell since May 2008, during the center's construction phase. She has been a nurse for 33 years and began her career in medical surgical nursing and high-risk obstetrics. As she continued her career, she pursued ambulatory surgical settings, initially as an assistant man-

ager of the short procedure unit at Albert Einstein Medical Center in Philadelphia and then as staff RN in multiple other ambulatory settings. She worked for 13 years in an ASC dedicated to outpatient endoscopy, first as a staff RN and then as the administrator for the facility.

Rose Eickelberger. Ms. Eickelberger is the director of surgical services at Summit Surgical Center and Beacon West Surgical Center, both part of Beacon Orthopaedics in Sharonville, Ohio. Ms. Eickelberger began at Beacon in May 2006. Previously, she was the director of nursing at the Cincinnati Eye Institute for eight years, after having served as its assistant director for six years.

Stephanie Ellis, RN, CPC. Ms. Ellis is the president of Ellis Medical Consulting and has worked with most surgical specialties, assisting ASCs, physician practices, hospitals and outpatient clinics around the country in her consulting work. Prior to starting the company, she worked as a fraud investigator for the Medicaid program in Tennessee and served as a case manager and utilization review nurse. Ellis Medical Consulting has been in business for 19 years, and Ms. Ellis is a regular contributor of articles on ASC topics for many national publications, including *Becker's ASC Review* and *Becker's Orthopedic & Spine Review*, AORN, AAPC and the ASC Association *Focus* magazine.

Carolyn Evec, RN, CNOR. Ms. Evec opened a surgery center in Mississippi and served as its nurse manager prior to joining The Surgery Center at Beaufort (S.C.). She has 30 years of nursing experience and 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."

Terri Gatton, RN, CASC, CNOR. Ms. Gatton is the administrator of the Andrews Institute Ambulatory Surgery Center in Gulf Breeze, Fla., a joint venture between Baptist Health Care and area surgeons. Ms. Gatton was instrumental in setting the foundation for AIASC, which opened in 2007. According to Barbara J. Holder, RN, QA coordinator for the center, Ms. Gatton's experience as an administrator has guided the center through several successful surveys, including AAAHC, CMS and the state of Florida. "Under Ms. Gatton's leadership, healthcare professionals from throughout the world travel to AIASC to learn the art of regional blocks, infection control practices and improved patient safety standards through an automated medication delivery system," she says. Under her leadership and guidance, more than eight employees have returned to higher education via the AIASC tuition reimbursement program.

Ann Geier, RN, MS, CNOR, CASC. Ms. Geier serves as senior vice president of operations for ASCOA. She has over 20 years of experience in all aspects of ASC operations, including perioperative services, clinical coordinator, administrator and chief operating officer of a multispecialty ASC. She also serves on the board of directors for the ASC Association and lectures for AORN.

Judy Graham. Ms. Graham is administrator of Cypress Surgery Center, a freestanding, multi-specialty ASC that opened in Dec. 2000. Ms. Graham has been with Cypress for more than 10 years, since construction began. She has a strong clinical background in the operating room and ambulatory surgery and previously served as an OR manager and a clinical director in ASCs before becoming an administrator. Ms. Graham has over 35 years of clinical, managerial and administrative experience in the ASC industry and was named "operating room director of the year" in 1997 while employed by HCA.

Amanda Gunthel. Ms. Gunthel is the administrator of Wilton (Conn.) Surgery Center, a two-OR, two-procedure room ASC that specializes in ophthalmology and pain management. Ms. Gunthel has been with Wilton since its inception, and before taking on the role of administrator, she worked for four years as director of practice management and development for the healthcare management firm that first opened the center.

Marilyn Hanchett, RN. Ms. Hanchett is the senior director of clinical innovation at the Association for Professionals in Infection Control and Epidemiology. She is dual-certified in infection control and healthcare quality and has spoken and written on the topic of infection control on numerous occasions. Before joining APIC in 2010, Ms. Hanchett served at CMS as infection control technical lead for the ambulatory surgery center program.

Anne Hargrave-Thomas. Ms. Hargrave-Thomas, CEO of West Bloomfield (Mich.) Surgery Center, is "definitely someone to know in the ASC industry," according to her colleagues. When Ms. Hargrave-Thomas joined West Bloomfield Surgery Center as CEO, she encountered a facility that was struggling to survive in a challenging economy. She took a facility in disarray and turned it into a competitive, highly-functioning surgery center, earning her praise and recognition from the center's manag-

ing partner, National Surgical Hospitals. Under her leadership, the facility has received several awards from National Surgical Hospitals and was named to the *Becker's ASC Review* list of the "100 Best Places to Work in Healthcare" in 2010 and 2011. Ms. Hargrave-Thomas also serves as president of the Michigan Ambulatory Surgical Center Association.

Dare Hartsell, RN, MSN. Ms. Hartsell serves as vice president of clinical services for Practice Partners in Healthcare. She has over 15 years of healthcare experience including direct patient care experience in CVICU, PACU and PRE-OP. She has experience in capital equipment planning, accreditation support, state licensure, clinical policy and procedure development and staff education, physician credentialing, infection control, risk management, compliance and development in the ASC industry, which enables her to offer a broad scope of services to meet the clinical and regulatory support needs of ASCs.

Colleen Heeter. As senior vice president of operations design for Nueterra Healthcare, Ms. Heeter provides leadership for a broad range of clinical and operational services, including project development, business office services, policies and procedures, clinical services, risk management, compliance, imaging services and supply chain management. Before assuming her current role, Ms. Heeter served as a group vice president for Nueterra. She brings more than 20 years of diverse healthcare experience to the company, including service as an ASC administrator, where she was responsible for financial administration, operations, human resources and planning and development. Ms. Heeter is a published author as well as a nationally requested speaker.

Tracy Hoeft-Hoffman, RN, MSN, MBA. Ms. Hoeft-Hoffman is the administrator at Hastings Surgery Center, a Nueterra Healthcare facility. She has 27 years of experience as a registered nurse and more than 20 years of experience in nursing management and administration. Ms. Hoeft-Hoffman is involved with the Nebraska Association of Independent Ambulatory Centers and Nebraska Medical Group Management Association.

Carolyn R. Hollowood, RN, CASC. Ms. Hollowood is the administrator of City Place Surgery Center in Creve Coeur, Mo., which is located in West County of St. Louis. The center is housed in a medical office building and has four ORs. The physician-owned, multi-specialty facility focuses on orthopedics and pain management. City Place opened in Dec. 2000 and moved to its current location in April 2006. Ms. Hollowood 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.

Tracey Hood, RN. Ms. Hood is the administrator of Ohio Valley Ambulatory Surgery Center and Mid Ohio Valley Medical Center in Belpre, Ohio. She previously worked as an ASC charge nurse, OR circulating registered nurse, PACU nurse, certified emergency RN, cardiac catheterization lab nurse and a critical care nurse. Ms. Hood currently serves as an executive board member for the Ohio Association of Ambulatory Surgery Centers and is active in the government affairs committee.

Georganna Howell, RNFA, CNOR, CEN, LNC. Ms. Howell serves as the administrator of Greenspring Surgery Center in Baltimore, bringing 32 years of nursing experience to her role at the facility. She has achieved several meaningful accomplishments with Greenspring, including increasing case volumes, decreasing center operational costs, negotiating vendor agreements, improving throughput, unearthing hidden equipment and supplies and improving staff morale. She has achieved numerous certifications, including the Trauma Nurse Core Curriculum, Emergency Pediatric Nurse Core Curriculum, Certified Nurse Operating Room and Certified Fixed Wing Helicopter Transport.

Lauren Jensen, RN. Ms. Jensen is the nursing director of endoscopy centers for Digestive Health Management, which manages the Digestive Health Associates of Texas. The centers were developed over the last seven to eight years, and include Endoscopy at Redbird Square, Old Town Endoscopy Center, Central Park Endoscopy Center, Park Ventura Endoscopy Center and North Richland Hills Endoscopy Center. In addition to helping develop new centers, Ms. Jensen serves as a CPR instructor for her employers and for staff at the physician offices.

Beth Ann Johnson, RN. In 2005, Ms. Johnson joined Blue Chip Surgical from LCA Vision, where she served as vice president of operations, responsible for the growth of the ophthalmic surgery center business. Previously, Ms. Johnson was with Aetna as director of provider relations, recruitment and contracting for the tri-state region. She has extensive experience in the development and ongoing management of hospital-owned, minimally invasive surgery centers. She began her career as an RN in the operating room, rapidly advancing to director of surgical services, supervising 13 ORs and the PACU of a major tertiary care medical center in Cincinnati.

Ellen Johnson. Ms. Johnson is COO of Facility Development & Management and has more than 20 years experience within the healthcare arena. She has been with FDM since 2001

and previously held management positions within a physician management firm and in various departments of a 370-bed suburban regional medical center. She also served as nursing director for a home care agency and a staff nurse in a medical surgical unit and newborn nursery of a community hospital. Prior to joining FDM, Ms. Johnson was director of clinical services and executive director of an emerging group purchasing organization for a physician management company.

Jen Johnson, CFA. Ms. Johnson is the managing director of professional service agreements with VMG Health. Her expertise is related to the in-depth knowledge required to understand fair market value challenges, market data and regulatory guidelines associated with valuing professional service arrangements for healthcare systems and life sciences companies. She has been published and presented over a dozen times on determining fair market value for physician compensation arrangements. She previously worked with a national consulting practice in their forensic and litigation services department and at University of North Texas as a finance professor. She earned her MBA in finance and her CFA designation while working for several companies as a consultant.

Milla Jones. Ms. Jones serves as vice president of government relations for United Surgical Partners International. She has 40 years of healthcare experience and has been politically active at the state and federal level for over 20 years. Prior to USPI she worked for Baylor Health Care System in Dallas. Her current responsibilities include coordinating and managing state and federal advocacy efforts for USPI and its partners. She is also active on the board of the Texas ASC Society and with many other state ASC associations.

Sandra J. Jones, BA, MSM, MBA. Ms. Jones is executive vice president of ASD Management, a board member of the ASC Association and Ambulatory Surgery Foundation, and member of the ASC Advocacy Committee. She also owns Ambulatory Strategies. She has 30 years of experience in healthcare and has overseen or contributed to the successful establishment and development of more than 80 ASCs nationwide.

Kelly Kapp, RN. Ms. Kapp is the administrator of Specialty Surgery Center in Westlake Village, Calif. Ms. Kapp began her nursing career as an OR nurse at L.A. County Hospital. She then was an assistant at Southern California Orthopedic Institute and served as orthopedic coordinator at St. John's Regional Medical Center in Oxnard, Calif., for 13 years before accepting a director of nursing position at SSC.

I. Naya Kehayes, MPH. Ms. Kehayes is the founder, managing member and CEO of Eveia Health Consulting & Management. She is a nationally recognized for her expertise in reimbursement systems, managed care and insurance contract negotiations for ASCs and surgical practices. Ms. Kehayes is a former president of the Washington Ambulatory Surgery Center Association.

Cindy King, RN. Ms. King serves as Health Inventures' associate vice president of clinical, quality and compliance. In this role, she works closely with and provides consultation and education to corporate and client members on licensure, regulatory and accreditation compliance, oversight of risk management issues and managerial direction of facility operations within the clinical practice setting. These services promote positive physician, staff and patient relations while upholding high quality standards of patient care. The services also utilize the most efficient and cost-effective methodology available.

Beverly Kirchner, RN, BSN, CNOR, CASC. Ms. Kirchner is the owner and CEO

of Genesee Associates. She has served on the Association of Perioperative Registered Nurses board of directors, has authored many AORN manuals and leads research in collaboration with the organization on violence in the nursing workplace. Ms. Kirchner also sat on the Joint Commission Task Force that assisted in developing the 2009 standards format and content, as well as a task force to revise the National Patient Safety goal on medication reconciliation. "I have found that helping others win the CMS survey battle is the best reward anyone could have," she says. She has been a member of the ASC Quality Collaboration group since it was founded.

Susan Kizirian, BSN, RN, MBA. Ms. Kizirian is the COO of ASCOA and has more than 27 years of experience in all aspects of ASC operations. Ms. Kizirian has served as an administrative executive and a consultant for ASC management and development, physician practice management and clinical site research. She is one of the founders and lifetime president emeritus of the Florida Society of Ambulatory Surgical Centers and past president of the Ambulatory Surgery Management Society of the Medical Group Management Association.

Catherine W. Kowalski, RN. Ms. Kowalski brings more than 20 years of healthcare experience to her position as executive vice president and COO for Meridian Surgical Partners. Prior to joining Meridian, Ms. Kowalski served as the executive vice president of operations and co-founder of Surgical Alliance Corp., a specialty surgical hospital company founded in 2001. Prior to Surgical Alliance, Ms. Kowalski served as co-founder and vice president, operations and hospital/ancillary services of OrthoExcel, a hospital management company focused on contractual management of orthopedic hospital business lines. She is an excellent source on topics related to ASC and surgical hospital development and operations, orthopedic-driven ASCs, managed care contracting and optimizing reimbursements.

Kris Kroeger. Ms. Kroeger is the administrator of Windward Surgery Center in Kailua, Hawaii, a multi-specialty ASC that opened in late 2009 as a partnership between local physicians and Castle Medical Center. Ms. Kroeger began her management career in Columbus, Ohio, as the administrator of a freestanding, joint-venture imaging center. She joined Health Inventures in 2005 to provide oversight to a number of ASCs in the Ohio, New Jersey and Colorado areas. When the opportunity to start a surgery center in Hawaii presented itself, Ms. Kroeger moved to Hawaii, established the new center and forged relationships in the healthcare community.

Beth LaBouyer, RN, BSN, CNOR. Ms. LaBouyer is the executive director of the California Ambulatory Surgery Association, for which she has served as a board member since 2000. CASA currently has over 340 members and is an extremely active association, advocating on behalf of ASCs with the legislature, CMS and the major health plans. Most recently, through a partnership with the Ohio Association of Ambulatory Surgery Centers, CASA launched a California specific benchmarking program that allows CASA members to compare their operations to other ASCs in their particular regions from a management and clinical perspective. Ms. LaBouyer previously served as director of Feather River Surgery Center in Yuba City, Calif., and as a surgical nurse and manager at Rideout Hospital in Marysville, Calif.

Linda M. Lansing. Ms. Lansing is the senior vice president of operations and clinical services at Surgical Care Affiliates. She is a nurse with 38 years of healthcare experience in hospital

and outpatient services, physician practice management, intensive care, pediatrics, dialysis and ambulatory surgery centers. She also serves as part of the Expert Group for the ASC Quality Collaboration.

Marian Lowe. Ms. Lowe serves as a partner at Strategic Health Care in Washington, D.C., where she advises clients on Medicare policy and strategy. Through her work at SHC, she has represented the ASC industry in various capacities, including as a consultant to the AAASC and then the ASC Association. She currently serves as executive director of the ASC Advocacy Committee, where she directs political, policy and public relations work on behalf of the industry. She has worked to improve Medicare payments to ASCs, expand the list of Medicare-covered services and maintain equitable policies for participation in Medicare. Prior to joining SHC, Ms. Lowe worked in a number of capacities at MedPAC, most recently as special assistant to the executive director.

Sue D. Majewski, CASC. Ms. Majewski currently serves as COO of Bedford Ambulatory Surgical Center, which she joined in 1994. Her expertise includes overall management of facility and staff operations, oversight of compliance with state and federal regulations and development and implementation of marketing and strategic planning ventures. Additionally, her primary responsibilities include payor relations, negotiation/maintenance of contractual agreements and oversight of all aspects of the accounts receivable process. Ms. Majewski currently serves at the ASC executive member on the board of directors of the New Hampshire Health Care Quality Assurance Commission, and is vice president of the New Hampshire Ambulatory Surgical Association.

Becky Mann. Ms. Mann is the director of Houston Orthopedic Surgery Center. She came to Houston Orthopedic in May 2007 and was involved in the development of the center. Ms. Mann has been working in the medical industry for 37 years in surgery or in post-surgical care. According to Ms. Mann, one of the most important things to know as an ASC administrator is the difference between reimbursement and cost per procedure. "To know this, it is key to keep preference cards and supply costs current and to know your payors' reimbursements," she says.

Marianne Maravich. Ms. Maravich is an account executive-clinical specialist at Kimberly Clark. With more than 30 years in the medical sales industry, Ms. Maravich is responsible for the launch and development of new pain management technologies for Kimberly Clark. She works with neurosurgeons, orthopedic and pain management physicians to sell new devices for spine pain relief. Prior to her career in pain management, she worked in sales and market development for several product and procedure lines for Ballard Medical and Kimberly Clark. The lines included a patented brand of suction catheters, which prevent hospital acquired infections in ventilator-dependent patients and a low-profile feeding tube for children.

Lori Martin. Ms. Martin, administrator and director of nursing at SUMMIT Surgery Center since 2009, is responsible for the day-to-day operations of one of the newest surgery centers in Reno. She was an integral part of opening the center and is now focused on recruiting physicians, hiring quality staff and achieving financial success. During her brief tenure with the center, she has helped to double case volume and take the center from a negative cash flow position to a positive cash flow position in just five months. She has also negotiated managed care contracts and implemented new purchasing and software programs. The center achieved a successful three-day unannounced CMS survey in March 2010, and the center's first AAAHC survey will occur before the end of the year.

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Sarah Martin, RN, BS. Ms. Martin serves as regional vice president of operations for Meridian Surgical Partners, where she excels in directing financial and clinical operations of surgery centers, understanding accreditation best practices and recruiting and retaining physicians. Ms. Martin has close to 30 years of healthcare experience and has concentrated her efforts in the ambulatory surgery arena for the past decade. Prior to joining Meridian, Ms. Martin served as regional director of ASCs for Universal Health Services, where she managed both ASCs and specialty hospitals. She also worked as a regional vice president for Symbion Healthcare, covering the Midwest region that included ASCs, surgical hospitals and an imaging center.

Sara McCallum, CASC. Ms. McCallum, administrative director of Sheboygan (Wis.) Surgery Center, has been actively been involved in the ambulatory surgery center industry for many years. She had worked all phases of perioperative nursing prior to obtaining her MBA from Nova Southeastern University in Ft. Lauderdale, Florida. She has opened seven surgery centers from construction to operation and has served as an administrator at five of those centers. She has served in many professional organizations and helped to form the Florida Society of Ambulatory Surgery Centers. Ms. McCallum moved from Florida to Wisconsin five years ago and presently serves on the WISCA Board of Directors and is the legislative chairperson.

Angela McComb. One of the founders of Austin, Texas-based Innovative Health Resources, Ms. McComb has extensive experience in management, strategic planning and negotiations of insurance contracts. Prior to forming Innovative Health Resources in 1999, Ms. McComb worked for three insurance companies in Texas and Arkansas, including three start-up locations. She was also the director of managed care for a start-up, full-service outpatient radiology facility in Austin. She completed her MBA in 1999.

Dawn Q. McLane, RN, MSA, CASC, CNOR. Ms. McLane has worked in the ASC industry since 1995 and currently serves as the regional vice president of operations for Health Inventures in Broomfield, Colo. She joined Health Inventures in 2010 and is responsible for pre-operations and operational accountability for joint venture ASCs at multiple surgery center sites. Prior to joining Health Inventures, Ms. McLane worked as chief development officer for Nikitis Resource Group and vice president of operations for Aspen Healthcare.

Kelly McMahan, RN, CASC. Ms. McMahan has worked with Pinnacle III from 2006 to present. She serves as the vice president of operations, working with the development phase of ambulatory surgery centers. In this role, Ms. McMahan meets with partners, architects and contractors on space planning and blueprint completion. She also gathers equipment quotes, purchases equipment, obtains payor contracts, sets up software and manages the facility after development, among other tasks. Prior to joining Pinnacle III, Ms. McMahan worked at the Fort Wayne (Ind.) Orthopaedics Surgicenter and Lutheran Hospital of Indiana in Fort Wayne.

Cathy Meredith, RN, BS, CASC. Ms. Meredith serves as vice president of finance for ASCOA. She has been managing surgery departments since 1979 and has extensive experience in all phases and aspects of inpatient and outpatient surgery management and development. Her ambulatory systems expertise extends to physician offices, where she has set up office-based operation rooms, endoscopy suites and pulmonary function and cardiac testing labs. Prior to joining ASCOA, Ms. Meredith worked primarily in the development of ASCs with Woodrum/ASD Management.

Beth Miller, RN, CASC. Ms. Miller is the administrator of the Eastside Endoscopy Center in St. Clair Shores, Mich., which opened in 1996 as the first freestanding endoscopy center in lower Michigan. The center opened a second location in 2007. Prior to joining EEC, Ms. Miller worked at a local hospital for 16 years, spending nine years in endoscopy as assistant manager. She started with EEC as the nurse manager and moved her way up to become the business manager and later the administrator. Ms. Miller was the first ASC administrator in Michigan to receive CASC certification. Under Ms. Miller's leadership, EEC has developed a staff incentive plan based on center profits and implemented a comprehensive quality assessment program.

Evelyn S. Miller, CPA. Ms. Miller is the vice president of development for United Surgical Partners International and is responsible for the strategic direction of USPI's mergers and acquisitions efforts. Before joining USPI, she was executive vice president of Medway Health Systems, overseeing the financial operations of its medical clinics.

Krystal Mims. Ms. Mims is president of Texas Health Partners. She is responsible for the overall management of five managed facilities. These facilities are Texas Health Center for Diagnostics & Surgery Plano, Texas Health Surgery Center Denton, Texas Health Presbyterian Hospital Flower Mound, Texas Health Harris Methodist Hospital Southlake and Texas Health Presbyterian Hospital Rockwall. Ms. Mims was instrumental in the successful development and management of each of these facilities and has been with Texas Health Partners since its inception. Her background in healthcare began in physician practice management. She was CFO of Texas Back Institute in Plano and also administrator of Steadman Hawkins Denver Clinic.

Joy Moore. Ms. Moore has served as executive director of Oak Surgical Institute in Bradley, Ill., since May 18, 2009 — the first day the CMS Interpretive Guidelines went into effect. OSI is an orthopedic practice that also focuses on pain. Ms. Moore has more than 20 years of healthcare experience, having served as a nurse, nursing director and administrator. She has worked on the design and development of surgery centers, including all phases of start-up, and has served as ca consultant on regulatory and accreditation activities. At OSI, Ms. Moore is responsible for overseeing accreditation, budget, contracting, policy and procedure development and personnel management, among other duties.

Yvonda Moore, MBA, CHFP. Ms. Moore is the director of implementation at GENASCIS, a Los Angeles-based company that provides billing, coding and transcription services to ambulatory surgery centers. She has more than 20 years of experience in healthcare accounting/finance and business office operations.

Amy Mowles. Ms. Mowles is president and CEO of Mowles Medical Management. As a fee-based regulatory consultant, she not only provides rare and valuable expertise, but also educates, prepares and assists her clients with putting into practice all policies and procedures, provisions and standards; resulting in a facility that meets the highest standards for regulatory conformance and third part accreditation, without need to surrender exclusive ownership in an effort to secure outsourced management. She has successfully guided hundreds of single and multi-specialty centers in 20 states across the United States and fully developed 30 ASCs, most concentrating solely on pain.

Miriam Odermann, RN, MPH. Ms. Odermann serves as the chief executive for ambulatory services at Providence Health and Services, Oregon region. In her role, she is responsible for strategic planning, development and implementation of the system's ambulatory strategy, including all clinical joint ventures and surgery centers in the greater Portland, Ore., metro area. Ms. Odermann is also responsible for inpatient and outpatient rehabilitation services, diagnostic imaging, health education services, wellness and fitness services and occupational health and retail pharmacies. Ms. Odermann received her master's of public health in health administration and policy from Portland State University.

Rebecca Overton. Ms. Overton brings more than 15 years of healthcare receivables and revenue cycle experience to her role as director of revenue cycle management for Surgical Management Professionals. Prior to joining the company, she served as director of A/R and materials management for SurgCenter Development, where she provided overall direction in her respective areas for more than 20 multi-specialty surgery centers. Before joining SurgCenter Development, she worked as the business director for two successful, freestanding, multi-specialty surgery centers in Florida and worked as an A/R coordinator for an ASC in Little Rock, Ark. With SMP, Ms. Overton has improved EOM processes internally and with clients; reviewed adjustment history to identify opportunities for appeals and increased collections; and implemented contract management.

Linda Kelley Peterson, MBA. Ms. Peterson is founder and CEO of Executive Solutions for Healthcare, providing consulting in mergers and acquisitions, development, management, compliance and operational reviews of surgery and imaging centers, as well as new product line consulting for physicians and hospital systems. Ms. Peterson has more than 35 years of experience in development and operational management of ambulatory healthcare organizations. Her previous experience includes corporate director of development/registered representative for HealthSouth, development consultant for national ASC management and consulting companies and executive director for ambulatory care at The Joint Commission.

Terry Rajendran, MHA. Ms. Rajendran is cofounder and CEO of Johnstown, Colo.-based LaClaro, a revenue cycle software company that specializes in the ASC market. The company's flagship product, Lighthouse, is a web-based tool to improve workflow management, analytics and reporting for ASCs. In addition to her work with LaClaro, Ms. Rajendran serves as revenue cycle director at Surgical Center at Premier in Colorado Springs. The five-OR center treats approximately 450 patients per month, about half of which receive orthopedic surgery services. In her role at Surgical Center at Premier, Ms. Rajendran is responsible for managing workflow, collector oversight, management reporting and negotiating payor contacts.

Holly Ramey. As group vice president for Surgical Care Affiliates, Ms. Ramey currently leads acquisition, integration and physician relations for SCA. She has more than 10 years of ASC industry experience and previously served as a surgery center administrator, director of financial operations and regional vice president of operations, with responsibility for 12 surgery centers in Georgia, Mississippi and Alabama. She received SCA's President Award in 2009, given to two SCA leaders every year for outstanding leadership and exceptional contribution to the organization.

Lori Ramirez. Ms. Ramirez founded Elite Surgical Affiliates in 2008 and now leads the company as its president and CEO. Ms. Ramirez launched her business in the middle of the recession and, despite countless obstacles, forged ahead to build a company that provides management and development services for surgical facilities with a special emphasis on orthopedics, spine and pain. Ms. Ramirez drew inspiration for the firm from her 12 years of prior experience in surgical development, operations and management. Before founding Elite Surgical Affiliates, Ms. Ramirez served as senior vice president at United Surgical Partners International. In this role, she was directly responsible for developing the second-largest network of surgical facilities for USPI in Houston and supervising more than 600 employees.

Rosalind Richmond. Ms. Richmond is the chief coding compliance officer for GENASCIS, a company that provides billing, coding and transcription services to ASCs. She has more than 30 years of experience as a coding and HIM consultant. During her career, Ms. Richmond also served as the data quality committee chair for Colorado Health Information Association for four years.

Anne Roberts, RN. Ms. Roberts is the administrator at the Surgery Center at Reno, 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 came to the Surgery Center at Reno in Feb. 2006 when it opened and became administrator in Oct. 2006. She 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 emergency department seeing 55,000 patients annually.

Lisa Rock. For the past nine years, Ms. Rock has served as president of National Medical Billing Services, one of the largest ASC billing companies in the country. Ms. Rock is a seasoned healthcare management veteran with more than 25 years experience in the industry. Her wide-ranging background consists of director of training and education for Mid-Atlantic Medical Services and vice president of business office operations for an ASC development and management company. She has also managed private practices in the specialties of orthopedics, retina surgery, cardiology and anesthesia.

Suzanne Rogers. Ms. Rogers brings 19 years of human resources experience to her position as senior vice president of human resources for Employment Management Solutions, an employee staff leasing company owned by Health Inventures. In this role, she assumes responsibility for all facets of human resources services provided to Health Inventures ASCs. Ms. Rogers has been employed by Health Inventures since 2000 in a variety of HR roles of increasing responsibility. Prior to joining the company, she worked for the family of CH2M Hill Companies and The Washington Group (formerly Morrison Knudsen) in human resources.

Cathy Rudisill, RN, MHA, CNOR, CASC, BSN. Ms. Rudisill brings extensive experience in the perioperative setting to her role as senior vice president of operations for ASCOA. Ms. Rudisill worked as a market manager for HealthSouth and as the executive director for the Bon Secours St. Francis Health System Surgery Center in Greenville, S.C., prior to joining ASCOA. Ms. Rudisill is a registered nurse with certification in OR nursing and completed her MHA at Seton Hall University.

Mary Ryan, RN, CASC, MBA. Ms. Ryan is the administrator of Tri-State Surgery Center, a multi-specialty facility in eastern Iowa with three ORs and two procedure rooms. Tri State performs over 5,000 cases annually. The specialties at the facility include ENT, gastroenterology, general surgery, gynecology, ophthalmology, orthopedics, pain management, plastic surgery, podiatry and urology. The evolution of the center began with its building and opening in 1998 by Medical Associates Clinics and Health Plans and Mercy Hospital. The center is managed by Health Inventures. Ms. Ryan is a past AORN chapter president, a founding member of the Iowa ASC Association and is currently serving her second term as its president.

Karen Sablyak. Ms. Sablyak, CFO at Physicians Endoscopy, has been with the company since 1999. She has more than 20 years of experience in healthcare finance, billing and business operations. Prior to joining PE, Ms. Sablyak worked as a vice president of practice management for Allegheny University Hospitals in Philadelphia, where she had oversight responsibility for nearly 150 primary care physician practices. In her role at PE, Ms. Sablyak has directed a transition to a paperless A/R billing system and strives to enhance performance through PE's payor contracting services, group purchasing discounts and performance benchmarking.

Phenelle Segal, RN, CIC. Ms. Segal is the president of Infection Control Consulting Services. She has more than 28 years of infection prevention and control experience, and has led the State of Pennsylvania's mandatory Healthcare-Associated Infections Advisory panel. She also provides consulting services to ASCs, acute care hospitals and nursing home facilities.

Donna St. Louis. Ms. St. Louis currently serves as a vice president for ambulatory services at BayCare Health System. Before joining BayCare, she was a group president for Symbion and responsible for more than 45 ASCs. Prior to joining Symbion, she served as group president for HealthSouth, where she was responsible for more than 60 surgery centers. She has extensive knowledge in ambulatory surgery and the Tampa Bay market.

Marcy Sasso. Ms. Sasso serves as administrator of Raritan Valley Surgical Center, which is managed by ASCOA. Although she has been with the center less than one year, she has made a significant impact: Employees cite her open-door policy, commitment to staff satisfaction and policy of encouraging ideas from all ASC personnel. Ms. Sasso is also the co-founder of the Surgery Center Coalition, which was founded nearly six years ago and is now one of the largest free networking groups in the state of New Jersey. In addition to her work with ASCs, Ms. Sasso has hosted numerous charitable events to benefit those devastated by Hurricane Katrina and the Haiti earthquake, for which she raised over $3 million in medical supplies.

Tona Savoie, RN. Ms. Savoie is administrative director of Bayou Region Surgical Center, a multi-specialty surgery center that opened in July 2007. Bayou Region Surgical Center has four ORs and one procedure room. Surgeons at Bayou Region specialize in orthopedics, ENT, neurology, general surgery, plastic surgery, GI, ophthalmology and pain management. The ASC operates as a 50-50 partnership between physician-investors and a subsidiary of the local community hospital, Thibodaux Regional Medical Center. It is managed by ASD Management.

Tara Sellers, RN, BSN. Tara Sellers, administrator of Surgery Center of Key West (Fla.), assisted in starting her facility in July 2008. Prior to her position with the surgery center, Ms. Sellers served as the OR charge nurse at a local hospital and also owned and managed a physician billing company. While in nursing school, she was voted "Most Likely to Become an Administrator" and received an "Excellence in Nursing" award from the local hospital in 2007. Surgery Center of Key West is also financially successful and received a three-year accreditation from AAAHC in 2009.

Caryl Serbin, RN, BSN, LHRM. Ms. Serbin is executive vice president and chief strategy officer for SourceMedical, which provides clinical and business software solutions for ambulatory surgery centers. She was founder and CEO of Serbin Surgery Center Billing, which was recently acquired by SourceMedical as the core of their new billing division, Revenue Cycle Solutions. Ms. Serbin has more than 25 years experience in healthcare industry, with the last 18 years spent in ambulatory surgery administration and consulting.

Lynda Dowman Simon. Ms. Simon is the administrator at St. John's Clinic: Head & Neck Surgery in Springfield, Mo., the only ASC in Missouri dedicated solely to ENT procedures. The center has a patient satisfaction rating of 97.2 percent. Ms. Simon has been at her center since 1994. Prior to joining St. John's Clinic, she worked for 13 years in surgery at St John's Hospital, specializing in open heart and urology. Ms. Simon is proud to say her coworkers stay at the center once hired, and she has not hired a new staff member in over four years.

Susan Simons, RN, BSN, CASC. Ms. Simons serves as administrator of Pacific Surgery Center in Poulsbo, Wash., a multi-specialty, physician-owned

surgery center that opened in 1984. Ms. Simons has been with the center, which performs over 6,000 cases annually, since 1985. She also currently serves as vice president of the Washington Ambulatory Surgery Center Association.

Donna Slosburg, RN, BSN, LHRM, CASC. As executive director of the ASC Quality Collaboration, Ms. Slosburg helps ASCs improve healthcare quality and safety by developing standardized quality measures, publically reporting quality data and assembling tools for infection prevention. Ms. Slosburg has worked in the healthcare industry for over 30 years and joined the ASC industry in 1987. As a leader in the ASC industry, her positions have included nurse manager, administrator and regional operations manager. She was a senior vice president of surgery operations and national surgery specialist for HealthSouth, one of the nation's largest healthcare services providers. Ms. Slosburg is a licensed healthcare risk manager and was one of the first to receive her CASC certification.

Brooke Smith. In her two years with Maryland Surgery Center for Women, Ms. Smith has successfully taken a struggling ASC and turned it into a safe, profitable, professional facility. She has worked to increase collections from an average of $70K per month to an average of $240K per month, all while decreasing the center's days in A/R significantly to an average of 25 days. She also led a pilot program for online pre-surgical admission, trialing the program for presentation to the center's management company, ASCOA, for consideration among 30 other ASCs. Her cost savings in 2010 alone added up to $110,000.

Christina Smith, RN, MSN. As vice president, Ms. Smith leads the Amerinet Clinical Advantage consulting team on developing and implementing a process driven, evidence-based program which delivers improved margins and reduced supply costs for physician preference products. Ms. Smith joined Amerinet in 1998 with more than 18 years of progressive clinical leadership experience in perioperative services including staff member, nurse manager and administrative director of surgical services. Her varied healthcare background includes knowledge of both large urban teaching hospitals and small community-based facilities.

Christy Stafford. As the director of information technology for Borland-Groover Clinic, P.A., Ms. Stafford is responsible for ensuring IT drives the organization toward aggressive goals. She facilitates the direction, implementation, support and maintenance of software, hardware and telecommunications for a 15-node, 400-end use base throughout the state of Florida. Ms. Stafford brings 17 years of healthcare experience to her current position, 15 of which have been spent focusing on and directing IT for a multi-specialty private clinic in Florida.

Kim Stevens. Ms. Stevens brings more than 15 years of healthcare experience to her role as one of the founders of Innovative Health Resources, an affiliate of ASD Management. Her expertise lies in management, human resources, operations, marketing, HIPAA, OSHA, coordination of health and vendor fairs and managed care contracting, among other areas. She has extensive experience with large and small physician groups as well as solo practitioners and has held positions with one of the largest cardiovascular groups in Texas, an international insurance company and an allergy and asthma clinic.

Joyce M. Stiles. Ms. Stiles serves as Health Inventures' controller, overseeing all corporate

and client accounting functions, including financial reporting, budgeting, accounts payable, treasury, forecasting and ad-hoc analysis. Ms. Stiles joined the company in 2009 as an outside consultant and was soon offered an internal position as the director of client accounting.

Debra Saxton Stinchcomb, RN, BSN, CASC. Ms. Stinchcomb a consultant at Progressive Surgical Solutions and has more than 30 years of experience in the healthcare industry, including positions in administration, operations, sales and clinical areas. She previously served as director of operations preparation and transition management for Health Inventures. She has also held positions as an ASC administrator, assistant regional vice president and regional vice president.

Stephanie Stinson, RN, BSN, CASC. Ms. Stinson is the administrative director of Strictly Pediatrics Surgery Center in Austin, Texas, a multi-specialty facility that performs more than 5,000 procedures annually. Ms. Stinson has been an administrative director in the ASC industry for seven years and has been at Strictly Pediatrics since its inception in 2006. She served in the Mississippi Army National Guard as a surgical technologist for eight years and has been a nurse for 18 years, during which time she fulfilled staffing roles in neurosurgical ICU, surgery, recovery room and home health. She currently serves as a board member of Strictly Pediatrics Land Company, a position she's held since Dec. 2010.

Stacey Taylor. Ms. Taylor is a senior vice president of operations with ASCOA and holds over 15 years of experience in healthcare. Prior to joining ASCOA, Ms. Taylor served as the regional administrator of four multi-specialty surgery centers and was recognized for her resourceful management skills and the exceptional ability to lead projects. She has been involved in the ambulatory surgery industry in various management roles since 1997 and has worked in all areas of freestanding ASCs, including pre-assessment, pre-op, OR and PACU. She currently oversees projects in Maryland, Michigan and Florida.

Joyce (Deno) Thomas. Ms. Thomas is senior vice president for Regent Surgical Health. Before joining Regent, she served as the executive director of Loveland (Colo.) Surgery Center and worked for HealthSouth as a regional director of quality improvement and as an administrator. Ms. Thomas also opened a new facility in Mount Dora, Fla., coordinated the quality, risk and values program for Regent and was involved in the development of two new facilities.

Kimberly L. Tude Thuot, MAOM, CMPE. Ms. Tude Thuot has been in healthcare administration since 1997 and joined the physician-owned Yakima Ambulatory Surgical Center in Aug. 2009. She holds a master's degree in organizational management and is currently working on her PhD in organizational change and leadership. She is also currently board-certified in the ACMPE and is actively pursuing fellowship, as well as her CASC and CPC. Since she joined Yakima ASC, the center has been through a re-accreditation survey with AAAHC, moved billing back in-house and is in the process of adding neurosurgery and spine to the multi-specialty facility.

LoAnn Vande Leest, RN. Ms. Vande Leest is clinical director and acting CEO of The Surgery Center in Franklin, Wis., a joint venture between Associated Surgical & Medical Specialists and Aurora Health Care Ventures. The Surgery Center has five operating suites, four procedure rooms, two endoscopy GI suites, areas for pre- and post-surgery observation, and a recovery area.

Kara Vittetoe, CASC. Ms. Vittetoe is the administrator of a one-OR, two-procedure room, multi-specialty surgery center in a growing rural area. Thomas Johnson Surgery Center in Frederick, Md., which is managed by ASCOA, features surgeons specializing in general surgery, gynecology, neuro-spine, podiatry and urology. Ms. Vittetoe has been with the center since it opened in 2008. Prior to joining Thomas Johnson, she spent the majority of her career in the private sector of healthcare management.

Diane Wallace, RN, BSM, MBA. Ms. Wallace has been executive director and CEO of the Menomonee Falls Ambulatory Surgery Center for more than 12 years. She has previously held clinical and administrative positions in hospitals, home health and medical group practices. Ms. Wallace has served as past president of the Wisconsin Surgery Center Association and is currently a board member for that organization. She was instrumental in the development of an orientation and mentoring program for new members of the state association and serves on the association's legislative committee, which is working diligently to try to remove a new tax imposed on surgery centers in the state.

Michelle Warren, RN, BBA. Ms. Warren is the executive director of Powder River Surgery Center in Gillette, Wyo. She began her career in healthcare as a surgical tech and soon pursed her nursing license and a bachelor's in business administration. She spent many years as an operating room traveling nurse, working mostly in trauma, orthopedic, spine and open heart specialties. She also serves as a surveyor for AAAHC.

Chris Washick, RN, CASC. Ms. Washick serves as director of the Orthopedic & Sports Surgery Center in Appleton, Wis. During her time as director, the center has added total joint replacements, which the ASC has performed since 2009, and has developed an on-site rehab facility for joint replacement patients. According to Aaron Bleier, finance manager at Orthopedic & Sports Surgery Center, Ms. Washick has "aggressively pursued growth in her career" and passed the CASC exam in Oct. 2010. Ms. Washick began her work at Orthopedic & Sports Surgery Center as a recovery nurse when the ASC opened in June 2006.

Suzanne Webb. As owner of ASC Billing Specialists, Ms. Webb has used her 25 years of experience in the healthcare finance industry to help clients increase reimbursements by an average of 50 percent, bringing the total collected to over $70 million over the last five years. Before starting her own business, Ms. Webb served as CFO for three large hospital chains: Universal Health Services, Behavioral Healthcare in Nashville, Tenn., and Iasis Healthcare in Nashville. In each of these roles, Ms. Webb used her understanding of payor collections to increase revenue by at least 30 percent.

Michelle J. Weidner-Jordan, RN, BSN. Ms. Weidner-Jordan serves as the administrator for Lewis & Clark Specialty Hospital. She has worked as a registered nurse in Norfolk, Neb., before joining the nursing staff of Lewis & Clark when the facility opened in 2002. Since then, Ms. Weidner-Jordan has been promoted to the position of director of nursing in 2003, and most recently was promoted to the position of administrator in 2006. She oversees the daily operation and management of the hospital, while promoting the values of the hospital's mission and vision statements.

Suzanne Wienbarg, RN, CASC. Ms. Wienbarg is a senior vice president of operations at ASCOA, with more than 25 years of experience in healthcare management and operations. Prior to joining ASCOA, Ms. Wienbarg was a vice president of operations for the ambulatory surgery division of HealthSouth. During her time with HealthSouth, she worked extensively in development, operations and physician recruitment. She has been active as a member and officer in healthcare professional organizations.

Kathleen Whitlow, RN, BS, CASC. Ms. Whitlow is the COO for Blue Chip Surgical Center Partners. She has more than 25 years of experience in the medical/healthcare industry and has worked as an ASC administrator and consultant with expertise in development, marketing, operations and strategic planning in support of facilities across the country. As director of surgical services for a large national hospital system, she developed and directed the outpatient and ambulatory surgery programs, clinics, case management and endoscopy department. She has served as an advisor/consultant to a group of attorneys representing physicians.

Kim Woodruff. During Ms. Woodruff's tenure with Pinnacle III, her role has evolved from vice president of business office operations to her current role as vice president of corporate finance and compliance. In 2003, Ms. Woodruff provided oversight of in-house business office functions for Pinnacle III's clients in a multi-state region. One year later, Kim launched Pinnacle's centralized billing office providing coding, billing and collection services to single and multi-specialty ASCs who desired increased efficiencies via qualified personnel in a constantly changing reimbursement environment. She assumed her current position in 2008.

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Lexa L. Woodyard. Ms. Woodyard has been the administrator of Cabell Huntington Surgery Center in Huntington, W. Va., for four years. In that time, she has decreased expenses by $200,000 for a calendar year, increased net revenue per case by introducing cases with better payor mixes, increased over-the-counter patient collections and formulated a plan to decrease days in A/R. "Many ASCs have made the hard decision to close their doors as decreasing reimbursement rates and increasing costs have eaten away their bottom line and financial stability," she says. "Every day is a struggle for ASCs in today's economy; cooperative staff and surgeons can make or break an ASC."

Cindy Young, RN, CASC. Ms. Young has been with The Surgery Center of Farmington (Mich.) for the past 12 years. The center has shown profits quarter-over-quarter consistently for the past eight years, and Ms. Young has maintained tight staff hours per patient while producing high patient, staff and physician satisfaction scores. She led the ASC through a three-year AAAHC accreditation in 2002, 2005 and 2008 and currently manages 28 employees that staff two ORs and two procedure rooms. Prior to joining her current center, Ms. Young served as a staff nurse at Arcadia Valley Hospital in Pilot Knob, Mo., where she was responsible for supervising the night shift, handling emergency transfers and maintaining central supply and central sterilization.

Monica M. Ziegler, MSN, CASC. Ms. Ziegler is the administrator for the Physicians Surgical Center in Lebanon, Pa., a position she's held since April 2005. Physicians Surgical Center — a multi-specialty center with three ORs and one procedure room — surpassed all established benchmarks and continues to lead in operating incomes, cost containment, staff utilization and profitability after 1.5 years of operation. Ms. Ziegler's administrative approach is to focus on "efficacy and efficiency" — doing the right things in a timely and cost effective manner and serving as a leader organizational change.

Becky Ziegler-Otis, RHIA, CPHQ, CHC. Ms. Ziegler-Otis has served in her current role as administrator of the Ambulatory Surgical Center of Stevens Point (Wis.) since Jan. 2008. In this position, Ms. Ziegler-Otis has worked to keep days in A/R at benchmark levels. When she took over as administrator, the center was at almost 100 days in A/R. Through her continued efforts and her work with an outsourced vendor, the center has stayed at 39-40 days in A/R for the past year. Ms. Ziegler-Otis' goals for 2011 include becoming more involved in the state ASC association. Prior to joining Stevens Point, she worked on implementing an electronic medical record at Klasinski Clinic in Stevens Point and oversaw facility-wide compliance at Bay Area Medical Center in Marinette, Wis. ■

Contact Rachel Fields at rachel@beckersasc.com.

10 Ways to Increase Surgery Center Patient Collections Immediately

By Rachel Fields

Rob Morris, vice president of marketing and new business development for GE Capital's CareCredit, discusses 10 simple ways surgery centers can start collecting more money from patients.

1. Be persistent with pre-op phone calls. Mr. Morris says ASCs often fail to collect because a front desk staff member calls the patient at home, leaves a message and never hears back before the day of surgery. Mr. Morris says it is essential that staff members talk to patients about their financial responsibilities prior to surgery, meaning several phone calls may be necessary.

"It can be hard to reach the patient, so the patient shows up and says I don't have the money," he says. "Usually the ASC will still accept the patient because the doctor is coming in half an hour, so they're stuck with that case and they don't collect." During the pre-op phone call, staff members should be clear that the ASC expects to receive payment on the day of surgery — or, failing that, needs the patient to commit to a payment plan while at the surgery center.

2. Get patient contact information from the physician's office. Home phone numbers are useful, but busy patients may be more likely to answer their cell phones or office phones during the day. Similarly, some patients will ignore a call from a phone number they don't recognize but will quickly respond to an email. Mr. Morris recommends contacting the referring physician's office and asking for patient contact information, including a cell phone number, work phone number, email address and home number.

3. Don't let patents ignore your bills. ASC bills may fall lower on a patient's priority list than hospital bills, so ASCs should be especially persistent with collection efforts. "There's always been a struggle because ASCs typically have smaller charges then hospitals," Mr. Morris says. "ASCs get ignored a lot when it comes to payment by patients." Make sure patients understand the importance of paying their bill in full; introduce the expected payment during the pre-op phone call and establish the ASC's policy of collecting within 30 days.

4. Try to collect within 30 days. Once 30 days have passed, Mr. Morris says the likelihood of collecting drops off considerably. "If it goes beyond 30 days, the ASC is going to have a really big problem," he says. He says ASC collection staff should keep a calendar that marks the 30 day deadline for each patient; otherwise, collections can be forgotten until payment is much more unlikely.

5. Set up a payment plan if the patient can't pay. If the patient arrives at the surgery center without a check or credit card to pay their bill, ask if the patient would like to set up a payment plan. Many payment plans can offer patients interest-free financing for six to 12 months, and eligible patients can generally be approved in 10 minutes prior to surgery. Third-party payment plans are almost always preferable to billing the patient, Mr. Morris says.

6. Eliminate other options. If you tell the patient that he can choose to be billed after surgery, he may agree to that option because it seems easier than paying on the spot. Mr. Morris recommends that instead, ASCs talk to patients as if day-of-surgery payment is the only option. "The ASC staff member can say, 'We have to collect today, and since you don't have any means of paying, let's set you up with a payment plan,'" he says. Some patients may still push for post-surgery billing, but it helps if the surgery center does not highlight that option.

7. Ask patients to repeat their financial commitment back to you. Mr. Morris says surgery centers can use a subtle persuasion technique by asking patients to repeat their payment responsibilities back to the staff member. "Get the patient to repeat back to you that they will be putting a check in the mail today," he says. "It's a subtle technique that causes people to follow through with that behavior."

8. Ask for a check the next day. If the patient absolutely cannot pay on the day of service, ask him to bring a check to the surgery center the next day, Mr. Morris says. "You might not even want to suggest billing at that point," he says. "Instead, you can ask them to bring in a check tomorrow or this week, and that sometimes works."

9. Track A/R days by period. Mr. Morris says ASCs should constantly monitor A/R days based on period — that is, 0-30 days, 30-60 days, 60-90 days and 90-120 days. The ASC should prioritize these periods from lowest to highest. In other words, because patients are most likely to pay the ASC if they pay within 30 days, the ASC should concentrate the most effort on this period. The 30-60 day period might warrant a little less attention, and so on until the 90-120 period, at which point collections are unlikely.

10. Decide whether aggressive collections will hurt patient relationships. Physician offices, like other businesses, may be hesitant to pursue patients aggressively if they want to maintain a longstanding relationship with the patient. If the patient feels the office is being too pushy, they may decide to go elsewhere for treatment. However, patient collections in ASCs are slightly different; because many patients are one-time customers at the ASC, surgery centers can be more aggressive with non-paying patients without losing their customer base. Without being rude, surgery center staff members should call patients consistently and consider submitting them to a collections agency once phone calls have proven unsuccessful. ■

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6 Tactics to Prepare for ICD-10

By Rachel Fields

Rosalind Richmond, CCS, interim coding compliance officer for Genascis, Raemerie Jimenez, director of education for AAPC, and Cyndee Weston, CPC, CMC, CMRS, executive director of the American Medical Billing Association, discuss six ways facilities can start preparing for ICD-10 implementation.

1. Start looking at ICD-10 equivalency mapping. While the 2013 implementation date for ICD-10 is still a couple of years away, Ms. Jimenez says coders should start looking at the expectations involved in ICD-10 coding and documentation. "It would be good for coders to see the ICD-9 codes that they're typically coding now and see what the ICD-10 equivalents are going to be," she says.

Ms. Richmond says while coders should not depend on general equivalency mappings to code ICD-10 going forward, GEMs will be useful as coders prepare for training in 2012 and 2013. She says the huge increase in the number of codes through ICD-10 means that GEMs are complicated. "Trying to [explain ICD-10 with ICD-9 codes] is like trying to fit New York into Rhode Island," she says.

2. Go through a "day in the life" of an ICD-9 code. Ms. Jimenez recommends that IT personnel and coders work together to analyze a "day in the life" of an ICD-9 code. She believes many practices and facilities will underestimate the number of systems and programs that are affected by ICD-10 and need to transition to the new system. "If you just did a day in the life of an ICD-0 code and walked through every system that's affected, you'd see the systems that need to keep working correctly with the new codes," she says.

She says hospitals and ASCs may underestimate the impact of ICD-10 because they buy electronic systems piece-by-piece instead of all at once. "They don't get everything, so when they need another function, they look for a different program and apply all these band-aids to help the programs communicate with one another," she says.

3. Find a "coder champion" to lead your implementation efforts. Ms. Richmond says facilities with limited budgets — those that can't necessarily afford to send every coder away for training or bring in an expensive consultant to lead training — should ask an experienced coder to lead the implementation effort. That coder can go to conferences and workshops to become very familiar with ICD-10 and then teach the rest of the staff the essential information.

4. Talk to coders about their plans for the future. Older coders may be considering retirement as the ICD-10 implementation deadline looms, Ms. Richmond says. "Older coders don't want to learn a new classification system, especially one that is alpha-numeric," she says. These coders may have experienced the switch from ICD-8 to ICD-9 in the early 1970s and know the transition will be a significant undertaking, she says. She expects the move to ICD-10 to be even more complicated because of the numerous software applications affected by the change in each facility.

She says facility leaders should speak with coders to determine whether they plan to slog through training and implementation of ICD-10 — or whether they are planning to move to different positions or retire prior to Oct. 1, 2013. Getting a sense of coders' plans will help facilities prepare for coder shortages.

5. Expect a three-month "fog" after implementation. Ms. Richmond says she anticipates the coding industry will suffer for a few months after ICD-10 implementation. "Coders should expect a three-month fog," she says. "That didn't happen when the industry moved from ICD-8 to ICD-9 because we used the same categories, but for this transition, I anticipate it's going to be awhile [before productivity recovers]." She says American coders can learn from other countries — Canada, for example — that have already implemented ICD-10 and have seen productivity lag during the initial months.

Ms. Weston agrees that the learning curve for ICD-10 will be steep. "It's going to take more time because not only are people going to have to learn it, it's also going to take more time to code claims," she says. "This might mean a couple of minutes versus a few seconds." She says eventually some practices may be able to save time with ICD-10, especially if they code the same diagnoses very frequently, but initially the change will cut into productivity.

6. Help specialty coders expand their knowledge base. Ms. Richmond says specialty coders, or coders who concentrate on a particular specialty such as GI, may face unique challenges in the transition to ICD-10. "It will be a challenge because you won't just have to learn the GI portion of ICD-10 — you'll have to learn the whole thing in order to assign the co-morbidities," she says. "A lot of facilities assign work based on specialty to get the work out faster, so you have a lot of specialized coders." She says these coders may need to re-train in other areas as they prepare for ICD-10 implementation. ■

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5 Things Surgery Centers Need to Know About Meaningful Use and the 50% Rule

By Sean Benson, Cofounder and Vice President of Consulting, ProVation Medical

The march towards meaningful use (MU) has created a sense of urgency within the physician community to adopt EHRs for their offices — as it should. Hospitals and eligible professionals (EPs), which include physicians, began attestation for MU incentive payments on April 18, and the first payments were issued in May.

Central to physicians qualifying for stimulus payments is the use of certified EHR technology. Vendors began applying for certification in July of 2010, and physicians have begun the process of either choosing appropriate technology or making needed changes to existing systems in order to qualify.

With $27 billion in incentives up for grabs over the next five years and the potential for penalties hanging in the balance for providers who do not meet criteria, the stakes are high. But like any rush to a deadline, it's important that providers and ambulatory surgery centers understand the full picture and take a careful, thoughtful approach to choosing systems that align with both workflow needs and future expectations to avoid the potential for costly mistakes.

ASCs are becoming increasingly aware of the MU provisions — specifically as they relate to the perceived need to deploy a certified EHR as opposed to a system that may be more appropriately aligned to their environment. Since ASCs are not eligible for stimulus payments, and MU certification criteria for ASCs were never developed, there has been no real incentive or benefit for them to invest in certified systems. However, some ASCs are now feeling pressure to purchase a certified EHR and make costly technology decisions in order to satisfy the needs of their physician base.

This pressure is the result of a little-known clause in the meaningful use regulations, referred to as the 50 percent rule. A clear understanding of the 50 percent rule and four other aspects of MU is imperative for ASCs and EPs as they weigh their responses to the mounting external pressures to deploy certified EHR technology.

1. 50 percent rule. According to CMS, "any eligible professional demonstrating meaningful use must have at least 50 percent of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting *all* of the meaningful use objectives."

The latest guidance from CMS is that, when they refer to a "practice/location," ASCs are included in that definition. Additionally, CMS has commented that "equipped" means that the technology needs to be available in such a way that the EP can use a certified EHR to accomplish all of their MU objectives.

This clause can potentially have the unintended consequence of leading ASCs to believe that they need to adopt certified technology that is not designed for their environment, and for which they receive no stimulus payments, unlike EPs and hospitals.

2. Potential solutions. ASCs under pressure to adopt a certified EHR product should first have their physicians determine where their encounters occur. If at least half occur at an office or offices equipped with certified EHR technology, then there is no need for that physician to be concerned about the 50 percent rule.

In cases where a physician does have more than 50 percent of patient encounters occurring at an ASC, there are two options that exist for the center: 1) significantly change the workflow within the ASC and the physician's office to capture data associated with MU objectives, or 2) encourage physicians to carefully review the CMS definition of an encounter and potentially change the way in which they schedule their patient activity to avoid falling short of the 50 percent rule.

According to CMS, for the purpose of calculating this 50 percent threshold, any encounter where medical treatment and/or evaluation and management services are provided should be considered a "patient encounter."

3. Workflow challenges. MU criteria were designed to address longitudinal patient care and a move towards the efficient electronic capture of patient data over time. To meet this need, EHR vendors have designed products to capture patient information over the course of many encounters.

It is a workflow that fits well in a physician office environment. But an ASC is much different. To efficiently address the workflow needs of an ASC, products need to be designed around procedures. That is, data capture needs to address the specific needs of a particular procedure being performed. This will not typically require the extensive evaluation that may occur in a physician office.

There are numerous examples of MU objectives that do not fit well within an ASC's workflow. For example, a meaningful user must use a certified system for the following types of workflows, many of which do not translate well into the ASC environment:

- Computerized provider order entry
- Drug/drug interaction checking
- Drug formulary checking
- Prescribing electronically
- Reconciling medications
- Incorporating clinical lab results into the EHR
- Calculating and reporting clinical quality measures to CMS
- Providing clinical summaries to patients
- Submitting data to immunization registries and public health agencies
- Keeping problem lists, medication lists and medication allergy lists updated

To be a meaningful user, either the ASC or the physician's office will have to significantly change their workflows to meet these types of requirements.

4. What's in it for ASCs and EPs? Simply put, the answer to this question is "very little," at least for ASCs. For physicians, working with an ASC that utilizes certified technology can eliminate concerns over running afoul of the 50 percent rule. This, in turn, can potentially benefit the ASC through higher satisfaction rates. However, that is where the benefits to the ASC end.

Indeed, ASCs that choose to significantly change their workflows and use certified EHR technology, as it is currently defined, will face costly uphill challenges related to administrative needs and productivity, with no stimulus dollars to back the effort and no guarantees of ROI.

It is also important to reiterate that it's not enough to make the investment in a certified EHR. In order for physicians to meet MU criteria, *they have to demonstrate appropriate use of that product.*

There is no getting around the workflow challenges. Not only will ASCs have to make the initial infrastructure investment, they, or the physician's office, will also have to address the workflow challenges in order for their physician base to qualify for MU stimulus funds.

5. What else can be done? ASCs need a voice in this issue going forward. There is much at stake if the expectation becomes that ASCs invest in a certified EHR, and there is little to gain without the ability to qualify for incentive payments.

ASCs should become more actively involved in the MU dialog via associations and direct communication with CMS. They should request that the 50 percent rule be clarified and that ASC certification criteria be developed and stimulus funding be made available if ASCs are going to be required to be a part of the MU discussion.

Physicians and physician associations should become more vocal on this topic as well, particularly for specialties in which a large percentage of encounters occur outside of an office-based environment. Having ASCs modify their workflows in order to demonstrate MU, as it is currently defined, will lead to both duplication of effort and decreased productivity. ■

Sean Benson (sean.benson@provationmedical.com) is cofounder and vice president of consulting with ProVation Medical (www.provationmedical.com), part of Wolters Kluwer Health.

6 Key Ways to Save on ASC Supplies

By Leigh Page

Todd Borst, managing partner of Smithfield Surgical Partners in Northern California, recommends six ways save on supplies in ambulatory surgery centers.

1. Don't get comfortable with pricing. An ASC has to be ready to switch GPOs and vendors when prices become less favorable. "You can't be loyal to any one vendor," Mr. Borst says. While it can be difficult to switch suppliers, it would be worthwhile if a great deal of money were being lost to a high-priced vendor.

2. Compare prices with competitors. Scrutinizing supplier pricing is essential. "The idea is to get these guys to work against each other all the time," Mr. Borst says. Check prices for the key items the surgery center buys from its current GPOs and vendors and compare them to prices of competitors. If an item costs less at a competitor, point this out to the supplier. This is not a great deal of work. Even when a lot of specialties are involved, no more than 30 key suppliers would have to be monitored.

3. Check GPO prices monthly. GPO prices have to be checked monthly because they are constantly changing. "You've got to be vigilant," Mr. Borst says. "GPOs change their pricing all the time." Perform a contribution margin analysis on GPO prices to understand if you are getting the best prices. "You may get a low price for a wide range of goods, but the savings may be offset by higher prices for some key items," he says.

4. Check vendor prices monthly. "You've got to look at every line item," he says. "They'll be giving you a discount in some areas but then they'll be whacking you in other areas."

5. Go outside the GPO as needed. Even with the GPO discount, prices can sometimes be lower at vendors outside the GPO. For example, Mr. Borst found that a vendor outside the GPO was selling lead aprons for X-rays at a price that was 60 percent lower than the next lowest-priced vendor. "That was a substantial savings on an item that normally costs $1,600-$1,700," he says.

6. Check high-dollar implants daily. Implant prices can vary daily by as much as 10 percent. Each time the center has an upcoming implant, contact the representatives of key competing implant makers to check their prices. If the implant maker you usually use has a higher price, you may still decide to stay with that company if it offers other valuable services. ■

Learn more about Smithfield Surgical Partners at www.smithfieldmd.com.

6 Traits Anesthesiologists Look for in a Surgery Center

By Rachel Fields

Charles J. Militana, MD, director of ambulatory surgery centers for North American Partners in Anesthesia and director of anesthesia for Dorothy and Alvin Schwartz Ambulatory Surgical Center, North Shore University Hospital, Manhasset, N.Y., discusses six priorities for anesthesiologists practicing in ambulatory surgery centers.

1. Tools to provide appropriate ambulatory anesthesia care. Dr. Militana says to provide excellent anesthesia care in a surgery center, anesthesiologists must be equipped with the necessary tools. "Taking care of ambulatory patients is quite different than taking care of patients who will have a prolonged recovery room stay or who are expected to stay overnight," he says. "This requires unique skills and unique tools."

For example, ASC anesthesiologists often perform regional techniques using ultrasound guidance for shoulder arthroscopies and anterior cruciate ligament repairs. The ASC would therefore need an ultrasound machine to perform regional blocks to provide the highest standard of care for those patients.

2. Freedom for anesthesiologists to act as 'perioperative providers.' Anesthesiologists can play a crucial role in the perioperative process by leading pre-surgical testing and overseeing post-anesthesia care, Dr. Militana says. For example, anesthesiologists can help identify which patients are at risk for nausea and vomiting or have cardiac or pulmonary issues prior to surgery. They can also improve PACU care by planning for effective pain management after surgery through the use of regional anesthetics and using preemptive analgesia protocols and appropriate analgesics postoperatively.

He says anesthesiologists are important to the perioperative process because they can tailor the surgical experience to each individual patient. "Throughout the whole process, from pre-surgical testing through the intra-op and post-op period patients should be getting individualized patient care," he says. "They should feel like they're the only one you're taking care of on that particular day, even though they know that may not necessarily be the case."

3. Ability to cancel cases if medically necessary. When asked if anesthesiologists should have the ability to cancel cases when patients are inappropriate candidates for ambulatory surgery, Dr. Militana says, "Without a doubt." He says his surgery center has always given anesthesiologists the authority to cancel surgery if necessary.

"We approach it with the belief that we are the patient's advocate," he says. "Sometimes we have to take heat for it, but it's in the best interest of the patient." ASC administrators should explain to physicians and staff that anesthesiologists have the authority to cancel cases and review case cancellations after the fact to determine whether they could have been prevented.

4. Efficient, effective pre-surgical testing process. Dr. Militana says anesthesiologists should be placed in charge of developing pre-surgical testing policies to ensure an effective, efficient overview of patient conditions. "You want to minimize the same-day cancellation rate," he says. "The last thing you want is a patient to go through the process and have the surgeon and ambulatory staff members there, and then have the case canceled because something fell through the cracks during the pre-surgical testing process." He says same-day cancellations eat into profits and damage patient and provider satisfaction.

Pre-surgical testing processes should identify patients at higher risk for specific conditions such as nausea and vomiting, cardiac or pulmonary complications, as well as those patients that would most benefit from a preemptive analgesia protocol. "Pre-emptive analgesia is very important with respect to controlling patient pain post-operatively," Dr. Militana says. "It also increases patient satisfaction." He says staff members should understand how to "zero in" on certain risk factors to keep pre-surgical testing efficient. "You don't want patients spending an inordinate amount of time during the presurgical testing process," he says.

5. Involved anesthesia director. The anesthesia director at a surgery center should be heavily involved in policy decisions and problem-solving, Dr. Militana says. This person should work at the surgery center on a regular basis and take the lead in policy and procedural decisions for the anesthesia department. "The director needs to take an active leadership role in meetings and on a day-to-day basis," he says. "That means providing anesthesia on a daily basis, getting your hands dirty each and every day." He says this consistency will give anesthesia leaders credibility when problems come up at leadership meetings. "You don't want to be at a meeting hearing about the problems," he says. "You want to be able to say, 'I've been there and I've seen them.'"

The anesthesia director should also take charge of disciplinary issues involving anesthesia providers. "The leader needs to hold his staff responsible for their actions with respect to, [for example], not showing up on time," he says. "There have to be some consequences for these actions." He says the anesthesia director should be able to approach every member of the anesthesia team and address problems without causing ill feelings among staff members.

6. Respect among surgeons, nurses and anesthesia providers. Dr. Militana says most importantly, anesthesiologists need to feel appreciated by the surgery center and respected by their colleagues. "Once the department of anesthesiology is appreciated for what they do, that will make things run more smoothly," he says.

However, he cautions anesthesia providers that it may take time to build respect in a new surgery center. "If you're hired by a surgery center where there's a different attitude than you'd hoped for, you can't come in like a bull in a china shop," he says. "Stick to your principles and apply the high quality standard of care that you are there to provide, and, over time, attitudes will begin to change." ■

Learn more about North American Partners in Anesthesia at www.napaanesthesia.com.

Rising Stars: 30 ASC Industry Leaders Under Age 40

Here are 30 ambulatory surgery center leaders and industry representatives under the age of 40. *Note:* Leaders are listed in alphabetical order by last name, with their age provided in parentheses.

Chris Bishop, Blue Chip Surgical Partners (38). Mr. Bishop is a partner and senior vice president of acquisitions & business development for Blue Chip Surgical Center Partners. His responsibilities include optimizing performance at ASCs within the Blue Chip network and acquiring and "turning around" underperforming surgery centers. Prior to joining Blue Chip in 2010, Mr. Bishop served as vice president with ASCOA. In his five years with the company, he succeeded in developing or acquiring 11 surgery centers, leading to substantial revenue and profit increases. He was also instrumental in refocusing the firm's core strategy on acquisitions and turnarounds. In addition to his work with Blue Chip and ASCOA, Mr. Bishop has extensive leadership experience and a proven track record in developing surgeon partnerships within the medical device industry.

Craig Bryan, Gateway Surgery Center in Concord, N.C. (31). Mr. Bryan serves as the administrator for Gateway Surgery Center, a facility that has seen massive growth in volume and revenue since he began as its leader. According to Kyle Goldammer, CEO of Partners Medical Consulting, when Mr. Bryan started with Gateway Surgery Center, "he walked into a situation where the physicians and management company were at odds. He showed maturity and experience beyond his years in negotiating the buy-out of the management company while keeping his stakeholders satisfied with the settlement." Since Mr. Bryan joined Gateway, case volumes have grown at an annual rate of 26 percent, revenues have increased 56 percent and profitability has increased 314 percent. Mr. Bryan earned his MHA from the University of Minnesota and currently serves as an advisor on North Carolina CON matters.

Dan Beuerlein, Symbion (36). Mr. Beuerlein has spent the last four years as regional vice president of operations for Symbion Healthcare, where his role encompasses full operational and profit and loss responsibility for seven facilities. Together, the facilities represent $45 million in revenue and 300 employees. His primary focus is continued organic growth of same-store revenues in existing facilities, while finding opportunities in new and existing markets for potential acquisitions and joint ventures. He has extensive knowledge and experience with the dynamics of physician partnerships and stresses the importance of aligning incentives to create and maintain a successful venture. Prior to his current role, Mr. Beuerlein served as assistant vice president of acquisitions and development, where he led merger, acquisition and de novo development activities for five facilities within a two-year period.

Aric Burke, CPA, Health Inventures (33). Mr. Burke leads the Health Inventures development and consulting department, with responsibility for directing consulting engagements and developing new projects from inception through opening. With more than eight years of healthcare consulting experience, Mr. Burke understands how to guide clients through all phases of business development, including financial feasibility assessments, preparation of detailed business plans, formation of joint ventures and facility development. He also has significant experience working with hospitals and physicians to negotiate partnership terms and prepare organizational documents, and has managed numerous multi-million dollar private investment offerings to successful formation of new businesses. He began his career working for Deloitte, providing consulting and accounting services to private and public companies.

Jill Dowe, Blue Chip Surgical Partners (34). Ms. Dowe was recently appointed director of business office operations for Blue Chip Surgical Partners, joining the company from a position as business office manager of Surgery Center Cedar Rapids (Iowa). In her role at SCCR, Ms. Dowe supervised office teams and worked with other members of the management team to ensure interdepartmental continuity and efficient operations in key areas, including scheduling, registration, admissions, coding and billing, accounts receivable and medical records. She has also worked as a consultant for Health Inventures, where she trained new business office managers in daily and monthly tasks. Ms. Dowe obtained her MHA from the University of Iowa.

Michael Doyle, Surgery Partners (38). As CEO of Surgery Partners, Mr. Doyle is responsible for overseeing the firm's day-to-day operation and expansion through partnerships. He brings to the company many years of experience developing and managing hospitals, surgery centers and imaging centers. Throughout his career, Mr. Doyle has been a hands-on manager, and he currently applies practical experience of managing and developing healthcare services to his position with Surgery Partners. Prior to joining the company, he spent 10 years in a large, corporate healthcare organization, where he became senior vice president of operations. He earned his MBA from Troy (Ala.) State University.

Viva Elia, Surgical Care Affiliates (34). Ms. Elia is the southern California vice president of operations with Surgical Care Affili-

ates, where she manages and serves on the board of six ambulatory surgery centers. Ms. Elia has been in the ASC industry for nine years and has been invited to speak at California Ambulatory Surgery Association meetings on topics ranging from marketing to diversifying specialty mix. Her breadth of experience includes single-site, multi-specialty and health system partnerships, and she has a passion for turnaround centers. Ms. Elia is accomplished in identifying opportunities to improve earnings in even the most profitable centers and has formulated health system partnerships with University of California San Diego and Tri City Medical Center in her market.

Andrea Fann, Orthopaedic South Surgical Center in Morrow, Ga. (38). Ms. Fann serves as the administrator of Orthopaedic South Surgical Center, a United Surgical Partners International facility. She has served in the position since 2005, before which she worked as business office manager for Buckhead (Ga.) Ambulatory Surgery Center and as director of front office operations for Atlanta Outpatient Surgery Center in Sandy Springs, Ga. Ms. Fann believes that a manager does not automatically become a leader and that installing the right team is essential for ASC success. In 2010, Orthopaedic South Surgical Center was recognized as a Clayton County Chamber of Commerce Small Business of the Year Finalist.

John Gol, Borland-Groover Clinic in Jacksonville, Fla. (38). Mr. Gol is the CFO for Borland-Groover Clinic, which owns two endoscopy ASCs. He also serves as executive administrator for the Fleming Island Surgery Center in Orange Park, Fla., and is Borland-Groover Clinic's representative for ownership interest in St. Augustine (Fla.) Surgery Center. His background in applying financial knowledge to real-world situations has helped BGC's surgery centers run efficiently and turned around Fleming Island Surgery Center from near bankruptcy.

Heidi Gwynn, Laser Spine Institute in Scottsdale, Ariz. (31). Ms. Gwynn is the executive director for Laser Spine Institute in Scottsdale, Ariz., a surgery center that recently celebrated its two-year anniversary. In its first two years, the surgery center has experienced tremendous growth and success, achieving accreditation from the AAAHC in July 2009. Ms. Gwynn shares leadership of the center with chairman of surgery Michael Weiss, MD, and director of medical operations Stacy Danahy. She joined Laser Spine Institute in 2008 as a seminar patient coordinator and transitioned into the role of consult specialist, where she worked side-by-side with the Laser Spine Institute Arizona clinical team to facilitate the patient process. Under Ms. Gwynn's leadership, the center maintains a patient satisfaction rate of more than 90 percent and cares for more than 100 surgical patients each month.

Bill Heath, Practice Partners in Healthcare (36). Mr. Heath is the chief development officer at Practice Partners in Healthcare in Birmingham, Ala., an ASC management and development company. He has had more than eight years of experience in the healthcare field, previously serving as the director of development for a large provider of ASC services where he assisted in acquisitions, de novo projects and syndications. His background includes treasury and finance experience. He began his career in the financial arena with a Fortune 500 company. He earned his master's degree from the University of Alabama.

Steve Henry, CASC, Fremont Surgical Center in Fremont, Neb. (34) Mr. Henry joined Fremont Surgical Center as administrator in July 2010. During the past year, he has enjoyed a 4 percent case volume growth and 9 percent increase in net revenues. He recently earned CASC certification at ASCs 2011 in Orlando. He began his career in market research for a well-known ASC management and development company before earning his MBA in healthcare administration. His background includes experience as a financial analyst, business office director and administrator of a start-up surgery center.

Jeremy Hogue, Sovereign Healthcare (38). Mr. Hogue is the president and CEO of Sovereign Healthcare, as well as the founder and chairman of MedMedia and an investor and consultant to numerous other healthcare ventures. Prior to joining Sovereign, he served as the vice president of Audax Group, a Boston-based private equity firm with over $1 billion under management. With Audax, Mr. Hogue headed the firm's west coast office and served on the boards of six companies in various high-growth sectors. He earned his JD from Harvard Law School and his MBA from the University of Southern California, where he was also an academic all-American football player and a three-year starter on the USC football team. Mr. Hogue continues to work with Fox Sports Net as an analyst for pre- and post-game USC football coverage.

Jennifer Hunara, MHA, MBA, Surgery Center of Allentown in Allentown, Pa. (33). Ms. Hunara has managed the Surgery Center of Allentown, a large multi-specialty ASC, for the last four years. She began her healthcare career at the age of 24 as a business manager of perioperative services at Lehigh Valley Health Network, headquartered in Allentown, Pa., and then moved on to the role of executive director of surgical services for Robert Wood Johnson University Hospital Hamilton (N.J.). Her background includes experience in financial and IT management of perioperative services, oversight of surgical processes and management of a profitable surgery center. She maintains her success has been due hard work and great mentors. "I firmly believe mentoring in our field is extremely important to developing the next set of leaders," she says.

Brian Jackson, Surgical Care Affiliates (30). Mr. Jackson serves as vice president of finance for Surgical Care Affiliates, taking responsibility for corporate finance, operational finance and treasury groups. He joined SCA in 2008 as director of financial operations and transitioned into the leadership role for the finance team in 2010. According to his colleagues, Mr. Jackson leads with a servant heart and demonstrates a passion for developing leaders of tomorrow. Recently, Mr. Jackson helped lead SCA through a $100 million capital raise to fund a large multi-site acquisition. He graduated from the University of Central Florida and is a CPA in the state of Alabama.

Emilie Keene, Parkridge Surgery Center in Columbia, S.C. (31). Ms. Keene is the administrator of Parkridge Surgery Center, and president-elect of the South Carolina Ambulatory Surgery Center Association. She earned her MHA at the University of South Carolina in Columbia and was promoted to administrator just eight months after joining Parkridge as an assistant to the vice president and administrator. During her time with the surgery center, she successfully recruited eight surgeons, increased net revenues by $1 million, increased employee satisfaction scores

by 30 percent and patient satisfaction scores by 4 percent. She also led the ASC through the accreditation process and identified cost savings of nearly $200,000 per year.

Angela Laux, Bellin Orthopedic Surgery Center in Green Bay, Wis. (37). Ms. Laux started as the administrator of Bellin Orthopedic Surgery Center in June 2010. The center opened in March 2010. Prior to joining Bellin Orthopedic, Ms. Laux served as director of quality and outpatient joint program coordinator at The Orthopedics and Sports Institute in Appleton, Wis. In this role, she assured the institute followed all AAAHC/CMS requirements and served as staff educator for the facility. Ms. Laux graduated from Marian University with a master's degree in organizational leadership and quality in 2009.

Brian Mathis, Surgical Care Affiliates (31). Mr. Mathis joined Surgical Care Affiliates in Feb. 2009 as the vice president of strategy. The strategy group at SCA focuses on providing insight to each SCA partnership regarding opportunities to grow, based on SCA's "every case optimized" system. The group also structures the company's overall strategic plan for growth. Prior to SCA, Mr. Mathis worked for Blue Ridge Partners, a strategy-consulting firm, where he worked with numerous private equity companies in developing revenue growth strategies. He also spent several years analyzing the U.S. automotive market as well as performing macroeconomic forecasts for the Congressional Budget Office. Mr. Mathis holds an MBA from the Darden Graduate School of Business at the University of Virginia.

Angela McComb, Innovative Health Resources (39). One of the founders of Austin, Texas-based Innovative Health Resources, Ms. McComb has extensive experience in management, strategic planning and negotiations of insurance contracts. Prior to forming Innovative Health Resources in 1999, Ms. McComb worked for three insurance companies in Texas and Arkansas, including three start-up locations. She was also the director of managed care for a start-up, full-service outpatient radiology facility in Austin. She completed her MBA in 19999.

Kevin McDonough, VMG Health (31). Mr. McDonough is a senior manager with VMG Health, a leading provider of valuation services to the surgery center industry. Mr. McDonough began his career with VMG in 2003 and now leads the firm's ASC business valuation department. He has had the privilege of working with industry leaders in helping them navigate today's market challenges and the experience of providing valuation services to over 100 ASCs each year. He is a frequent speaker at national and regional surgery center conferences and has authored a number of articles for Becker's ASC Review and other publications over the years. Mr. McDonough holds a CFA designation and is a graduate of the University of Texas at Austin.

Amy McKiernan, Louisville Surgery Center in Kentucky (35). Ms. McKiernan joined Louisville Surgery Center, an ASD Management facility, in Jan. 2005, three months after the center opened. She says the center has grown tremendously since her first day; in the first year, the ASC performed 814 cases, and in 2010, the number had jumped to 3,431 cases. The center currently performs plastics, orthopedics, ENT and pain management in two ORs and seven pre-op/recovery bays. She says the center has benefitted from ASD Management's bonus program. Since the implementation of the program, the staff has looked to every area of the center for cost savings.

Amber Patterson, Westside Surgery Center in Douglas, Ga. (26). "I'm young, but I'm working extremely hard to become an excellent administrator," says Ms. Patterson, practice administrator of Ear Nose & Throat Clinic and Westside Surgery Center. She came to Westside Surgery Center in Dec. 2008, when she inherited the administrator position of the freestanding, physician-owned ASC. In her first three years with the center, she has researched the best deals on ASC equipment, worked with a consultant to ensure the facility was built according to state guidelines, hired and trained new staff, completed the state survey and Joint Commission accreditation and maintained compliance with federal regulations. In constant pursuit of professional development, Ms. Patterson is currently pursuing a degree in business administration.

Rebecca Overton, Surgical Management Professionals (35). Ms. Overton brings more than 15 years of healthcare receivables and revenue cycle experience to her role as director of revenue cycle management for Surgical Management Professionals. Prior to joining the company, she served as director of A/R and materials management for SurgCenter Development, where she provided overall direction in her respective areas for more than 20 multi-specialty surgery centers. Before joining SurgCenter Development, she worked as the business director for two successful, freestanding, multi-specialty surgery centers in Florida and worked as an A/R coordinator for an ASC in Little Rock, Ark. With SMP, Ms. Overton has improved EOM processes internally and with clients; reviewed adjustment history to identify opportunities for appeals and increased collections; and implemented contract management.

Stephen Rosenbaum, Interventional Management Services (39). Mr. Rosenbaum is the CEO of Interventional Management Services, where he is responsible for the day-to-day operations of 10 healthcare companies and more than $60 million in annual revenues. He has more than 18 years of experience in the healthcare industry, beginning his career at Ernst & Young's healthcare consulting practice. The majority of his work has been for physician-owned hospitals, surgery centers and physician practices, and he was a leading factor in the development of MedCath's heart hospitals throughout the country. Before joining IMS, he founded SourceRevenue, an independent healthcare consulting company, which provided syndication, development, management and transaction advisory services to physician-owned hospitals and ambulatory surgery centers throughout the country.

Tara Sellers, RN, BSN, Surgery Center of Key West, Fla. (39). Tara Sellers, administrator of Surgery Center of Key West, assisted in starting her facility in July 2008. Prior to her position with the surgery center, Ms. Sellers served as the OR charge nurse at a local hospital and also owned and managed a physician billing company. While in nursing school, she was voted "Most Likely to Become an Administrator" and received an "Excellence in Nursing" award from the local hospital in 2007. Surgery Center of Key West is also financially successful and received a three-year certification from AAAHC in 2009.

Brooke Smith, Maryland Surgery Center for Women in Rockville, Md. (35). In her two years with Maryland Surgery Center for Women, Ms. Smith has successfully taken a struggling ASC and turned it into a safe, profitable, professional facility. She has worked to increase collections from an average of $70K per month to an average of $240K per month, all while decreasing the center's days in A/R significantly to an average of 25 days. She also led a pilot program for online pre-surgical

admission, trialing the program for presentation to the center's management company, Ambulatory Surgery Centers of America, for consideration among 30 other ASCs. Her cost savings in 2010 alone added up to $110,000.

Kim Stevens, Innovative Health Resources (39). Ms. Stevens brings more than 15 years of healthcare experience to her role as one of the founders of Innovative Health Resources, an affiliate of ASD Management. Her expertise lies in management, human resources, operations, marketing, HIPAA, OSHA, coordination of health and vendor fairs and managed care contracting, among other areas. She has extensive experience with large and small physician groups as well as solo practitioners and has held positions with one of the largest cardiovascular groups in Texas, an international insurance company and an allergy and asthma clinic.

Jason Strauss, Surgical Care Affiliates (31). As a vice president of operations for Surgical Care Affiliates, Mr. Strauss currently oversees 13 ASCs representing close to $80 million in annual net revenues in the greater Los Angeles area. Mr. Strauss joined SCA in April 2008 as a consultant for special projects at the company's Birmingham, Ala., office. His talents were quickly recognized, and within three months, he was brought on board as director of financial operations. One year later, he was promoted into the operational role and entrusted with a highly competitive Los Angeles market. Applying his value-based servant leadership philosophy, he was effective in engendering deep relationships based on trust with his physicians and developing a strong, unified team with the staff. This combination of analytical and interpersonal skills helped Mr. Strauss achieve the highest improvements in physician satisfaction scores across the entire enterprise while delivering bottom line growth of 10-12 percent over three years.

Stacey Taylor, ASCOA (39). Ms. Taylor is a senior vice president of operations with Ambulatory Surgical Centers of America and holds over 15 years of experience in healthcare. Prior to joining ASCOA, Ms. Taylor served as the regional administrator of four multi-specialty surgery centers and was recognized for her resourceful management skills and the exceptional ability to lead projects. She has been involved in the ambulatory surgery industry in various management roles since 1997 and has worked in all areas of freestanding ASCs, including pre-assessment, pre-op, OR and PACU. She currently oversees projects in Maryland, Michigan and Florida.

Parth A. Zaveri, MHA, MBA, The Endoscopy Center of St. Louis (32). Mr. Zaveri is the administrator of The Endoscopy Center of St. Louis, located in St. Louis and St. Charles, Mo. The two Endoscopy Center locations are independently-owned, single-specialty and have six procedure rooms between them. He joined the Endoscopy Centers of St. Louis in 2007 as the practice administrator. During his time as administrator, Mr. Zaveri's team has been able to undertake several successful initiatives: the ASC has a capsule endoscopy program that was started last year, as well as a new in-house pathology department for patients. Prior to coming to the Endoscopy Center of St. Louis, he worked with a large multi-specialty physician practice in St. Louis as a business analyst. He has also worked for several large hospital systems in the St. Louis and Columbia, Mo., region. ■

Changing the Culture of an ASC: Q&A With Mike Lipomi of Surgical Management Professionals

By Leigh Page

Mike Lipomi is president and CEO of Surgical Management Professionals.

Q: How does the culture of an organization affect operations?

Mike Lipomi: Culture is critical part of any organization. Look at any association of people and you will see a culture that has built up around them. It will have an impact on just about everything those people do. For example, the deeply embedded cultures of the Mideast influence how women are treated and a host of other attitudes and concerns. In business, each organization will have its own unique culture. Compare Ben & Jerry's to something like IBM.

Turning to healthcare, you have the culture of hospitals and the culture of ambulatory surgery centers or physician-owned hospitals. They are dramatically different. In the hospital, you see a tremendous distrust of the administration and an animosity toward physicians. There is a nine-to-five attitude: "I want to get my job done and get out of here." No one speaks up. The attitude is, "They don't care what I think, so I won't even talk to them."

In sharp contrast, ASCs and physician-owned hospitals thrive on mutual trust and the focus is taking care of the patient with less regard to "That is not my job." Physicians work closely with nursing staff. When staff members make improvements, they know that they will be rewarded for the success of the whole enterprise.

Q: How do you develop the right kind of culture?

ML: This is an interesting challenge because, traditionally, ASCs and physician-owned hospitals get their employees from the hospital, so you are always up against a certain mentality that is bred by the hospital culture. When you are hiring, you have to be very aware of cultures. They don't just change overnight.

This challenge became quite apparent when we converted an ASC into a much larger physician-owned hospital. We took 40 employees form the ASC, who knew the ASC culture, and we added more than 100 employees from traditional hospital settings. Outnumbering former ASC staff by more than two to one, the new hires from traditional hospitals almost overwhelmed the ASC culture. These newcomers questioned how the ASC employees did things whenever it was different from what was done in their old hospital. That was stressful. However, many of these new hires came to embrace the new culture because they appreciated being rewarded for what they did.

I liken the process of changing an employee culture to herding cattle, which you see a lot of here in South Dakota. To a city-dweller, herding cattle might be all about cracking the whip. But ranchers actually deal with their cattle in a more subtle way: you can't push them too hard, too fast or too much. You have to go with the flow. The rancher rides alongside the cattle, and after awhile he gets to understand what they are doing and how he can incentivize them, based on what they do.

This approach worked well for us in the conversion of the ASC into a physician-owned hospital. My managers would meet with each of the new employees. And every month I would do annual visits with all the employees hired in that month. We talked about three things that are most important for an employee:

1. Have fun. To be a valuable long-term employee, you have to be having fun with what you do. You're spending more time at work than anywhere else — more time than with your wife, children or other activities such as a sport or a hobby. If you're not happy at work, your whole life is going to be miserable.

2. Build relationships. Relationships at work should replicate your relationships in private life. First there are your relationships with your immediate family, then with your friends, then with your neighbors and so on. Your relationships radiate outward. The same applies to the workplace. Let's say you work in pre-op in an ASC. The other pre-op people are like your family. You have to support them and they have to support you. But you also need to have relationships with people in other departments that you deal with every day, such as the reception area and the surgery area. Having strong relationships with those folks helps you be better at your job.

3. Face financial reality. The operation is trying to make the best use of a limited resource. Do we spend it on productive or on non-productive ways? The money you make for the organization should be used in the best, most productive and most rewarding way, for the sake the investors, the employees and the organization as a whole. Waste is something that is bad for all organizations but often it's easy way to go. Having the right culture reduces waste and increases profitability. ■

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

Current State of Physician Recruitment: 6 Thoughts From USPI's Phil Spencer

By Rachel Fields

ASC leaders are finding physician recruitment more difficult as hospital employment increases, markets become saturated with recruiting facilities and the uncertainties of healthcare reform loom on the horizon. Phil Spencer, senior vice president with United Surgical Partners International, shares six thoughts on the trends impacting physician recruitment.

1. Employment is making physician recruitment difficult. Mr. Spencer echoed the woes of many ASC administrators when he said physician employment is trimming the pool of physicians in many areas of the country. "If you talk to almost anybody in the industry, physician employment is the greatest challenge," he says. "It's going to vary by location and by specialty across the country, but the net outcome is that surgeons who might previously have joined an ASC are out of the marketplace now."

He says the trend is particularly pronounced in groups of younger physicians, who are increasingly seeking hospital employment as a way to ensure job security and decrease administrative burdens. As ASCs plan for the future, they must be able to target younger physicians for recruitment to replace older physicians looking to retire.

2. Certain specialties are faring worse than others. Mr. Spencer says several specialties are in shorter supply than others for surgery centers, including orthopedics and gastroenterology. These two specialties have been "picked over" thoroughly in the last 20 years, and many markets have recruited all the eligible physicians to the existing ASCs. He says while orthopedics has been recruited heavily in the past, there may still be an opportunity for surgery centers to enlist orthopedic surgeons who shy away from hospital employment. "Many of these guys are entrepreneurs by nature, but they are still highly sought after by hospitals," he says.

Data from Medscape's *Physician Compensation Report 2011* showed that 40 percent of surveyed gastroenterologists are already ASC investors, and 10 percent would consider the investment opportunity in the future. Around 30 percent of orthopedic surgeons are currently ASC investors, compared to 27 percent of ophthalmologists, 19 percent of general surgeons and 11 percent of anesthesiologists.

3. Employment may slow down — but not for a few years. Mr. Spencer predicts physician employment by hospitals will continue to accelerate over the next few years, but the trend may not last. "You have to wonder if over the long term, hospitals will lose money on employment arrangements," he says. "Physician employment goes in cycles. AS in the past, some physicians who become employed decide it is not for them and become independent again. And some health systems who employ physicians find they can't afford it and they unwind the relationships."

4. Physician involvement is essential to recruiting. Mr. Spencer says physician recruit-

ment is still possible if surgery centers involve their physician owners in the process. "Physicians really validate someone's decision to join the center," he says. If your physician owners can talk to potential investors and explain the financial and operational benefits of surgery center investment, providers may be more likely to consider the opportunity seriously. "This can be done through a phone call or a collegial physician discussion after they've been through the decision process," he says.

5. ASC leaders should explain the place of surgery centers in healthcare reform. Physicians considering ASCs may be hesitant because the future of healthcare is uncertain. As providers struggle to handle new regulations from healthcare reform and predict their place in changing payment models, ASCs may seem risky because they lack the clout of a major hospital system. However, Mr. Spencer points out that as a high-quality, cost-effective surgery setting, ASCs are actually well-situated to take advantage of healthcare reform. "ASCs are very cost-efficient, and they're really part of the solution," he says. "I find it difficult to believe they'll be left out of the process."

If your ASC can present a strategic plan to your investors, they will feel more confident in your position in the marketplace. Present your plans for physician recruitment, specialty development and hospital or payor relationships to physicians considering a long-term relationship with your center.

6. New specialties can open up opportunities for recruitment. Surgery centers may have more luck with physician recruitment if they add specialties that have only recently moved into the outpatient setting, Mr. Spencer says. The most commonly referenced of these specialties is spine, which is moving into surgery centers as managed care groups become more comfortable negotiating contracts with ASCs. "If a surgery center is doing a lot of orthopedics, adding a line like spine is attractive," Mr. Spencer says. "Surgery centers that are doing general surgery — or anything minimally invasive — can bring laparascopic surgery or bariatrics into the center."

Of course, surgery centers considering adding a specialty should first look to the marketplace to ensure they can add case volume before investing in equipment and staffing changes. ■

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Turning the Medicaid Crisis Into an Opportunity for ASCs: Q&A With Rob Schwartz of the Colorado ASC Association

By Leigh Page

Rob Schwartz, executive director of the Colorado Ambulatory Surgery Center Association, discusses Colorado Medicaid's plan to save money by shifting Medicaid patients to ambulatory surgery centers.

Q: A lot of states are trying to cut Medicaid spending to help balance their budgets. How can ASCs help?

Rob Schwartz: The goal for states needs to be making Medicaid dollars do more for less. As the ASC industry has been saying for years, surgery centers are the low-cost, high-quality alternative to hospitals. Medicaid patients tend to go to hospitals for many procedures that could be done in outpatient facilities. If they used ASCs instead of hospitals, states could cut Medicaid funding without cutting services.

Q: What is Colorado Medicaid doing in this regard?

RS: Starting later this month, Colorado Medicaid plans to offer ASCs higher reimbursements for 11 selected procedures. The exact amount has not been announced yet and this is part of phase one of a program, which could be expanded to cover more outpatient procedures. Physicians will be asked to send patients to surgery centers for these specified procedures, but they will not be required to do so.

Q: What are the procedures that will be initially covered?

RS: The four procedures that can be discussed at this point are treatment for metacarpal fracture, repair (primary, open or percutaneous) of ruptured Achilles tendon, arthroscopy rotator cuff repair and arthroscopy knee surgery with menisectomy.

Q: What sort of savings would the state realize from this?

RS: We calculate that if Medicaid patients went to ASCs for a set of 50 outpatient procedures, the state would save millions of dollars. It is hard to put an exact number on it because there are so many variables. In addition to lower reimbursement rates, the state could also realize savings from fewer readmissions due to infections.

Q: How was this program created?

RS: About two years ago, the Colorado Ambulatory Surgery Center Association began having talks with the Colorado Department of Health Care Policy and Financing, which runs the Medicaid program. The department took the lead on this and has made it a high priority.

Q: Did this require any legislation?

RS: No legislation was involved. It was totally a regulatory change. It involved shifting budget dollars mainly to pay for the higher reimbursements. But legislators are interested in this program. The house majority leader, for example, is about to tour an ASC and then get briefed by the association. ASCs are getting a higher profile in the legislature.

Q: How will Medicaid patients be directed to ASCs?

RS: The state Medicaid office will send out a bulletin to providers alerting them of the opportunity to send Medicaid patients to ASCs. However, redirecting appropriate Medicaid patients to surgery centers is going to take a while. It will require new referral patterns.

Q: How are hospitals responding to the program?

RS: Colorado hospitals were not opposed to the plan. Two hospital representatives sit on CASCA's board, including a representative from HCA, which owns several surgery centers in the state. In addition to physician-led ASCs, hospital-led ASCs and HOPDs will be eligible for the program.

Q: What do ASC administrators and physicians think of this?

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RS: We have been preparing them for this. CASCA has sent out notices to members over the past year, explaining what we are doing. For valid reasons, many ASC administrators and physicians were skeptical. Medicaid payments have not been great. But now they have heard more about the state's plans, they are intrigued.

Q: How many ASCs do you think are going to participate?

RS: I try not to predict. A potential sticking point is the reimbursement rate. ASCs are going to ask themselves, "Can we do this and be financially viable?" ASCs would have to measure appropriateness of patients.

The larger issue is the state's fiscal health. Everybody is going to have to sacrifice a little and collaborate. If not, we're going to see an implosion. Then there would be a lot of pain for taxpayers and for Medicaid patients. For this work, it's going to require a partnership among all the players.

Q: What is the next step?

RS: The state will be evaluating what kinds of patients are using this channel, how many physicians and ASCs are involved and how much money is being saved. If the program is successful, it will broadened to include other procedures, perhaps starting next year.

Q: Do you know of other states that are doing this?

RS: The Washington Ambulatory Surgery Center Association, where I am also executive director, has been exploring this approach with senior leadership in the Washington State Health Department, which oversees the state Medicaid program. They recognize that this would produce serious savings for the state. They are working on a preliminary list of procedures to include. Hospitals are not as collaborative as in Colorado because WASCA does not have as close a relationship with hospitals in the state.

My impression is that this is not happening in other states yet. We have not talked about our plans with other ASC associations, because we did want to upset the apple cart with Colorado Medicaid. But I have kept my ear to the ground and I have not heard of anything like this in other states. ■

Learn more about the Colorado Ambulatory Surgery Center Association at www.cascacolorado.com.

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