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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

January/February 2013 • Vol. 2013 No. 1

10 Ways to Improve ASC Finances & Operations in 2013

By Rachel Fields

Stuart Katz, director of TMC Orthopaedic Outpatient Surgery, Chris Bockelman, administrator of Foundation Surgery Center of Oklahoma, Greg DeConcilis, administrator of Boston Outpatient Surgical Suites, and Joe Zasa, co-founder of ASD Management, discuss 10 ways to achieve success at your surgery center in 2013.

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6 Ways to Dig Deeper Into ASC Financial Metrics

By Rachel Fields

Benchmarking operational data is nothing new for surgery centers — at this point, most successful ASCs are looking at their performance with a critical eye to plan for the future. But there may be benchmarking areas you haven't considered, or results that seem to point one direction but actually indicate something different.

Matt Lau, corporate controller for Regent Surgical Health, discusses six benchmarking tips that will clarify your understanding of your center's performance and could help improve operations.

1. Analyze payor mix and payor reimbursements by specialty rather than just overall. Many surgery centers look at their payor mix to determine where their reimbursement is coming from. Mr. Lau says "We go one step further and ask, 'What is our payor mix

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ASC Roundtable: What to Do in Markets With Heavy Hospital Employment

By Laura Miller

Hospitals are employing surgeons at a higher rate than ever before, and many surgery centers are competing with these hospitals for physician as well as patient volume. Here, Cliff Deveny, MD, vice president for physician practice management at Catholic Health Initiatives; Jim Schafer, managing principal at Rehmann; and Kathy Tayon of Fowler White Boggs, discuss this trend and how surgery centers can position themselves for success in the future.

Q: What are the biggest challenges for ambulatory surgery centers in markets where hospitals are employing physicians?

Dr. Cliff Deveny: Surgery centers in these types of markets tend to be very

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Publisher's Letter

In this issue of *Becker's ASC Review*, we explore strategies for improving surgery center finances and operations in 2013. We also look into pressing trends for the next year, namely the impact of President Obama's re-election and hospital employment of physicians. This issue includes two lists — 70 of the ASCs Opened in 2012 and 50 of the Most Powerful People in Healthcare.

Please save the date for the 11th Annual Orthopedic, Spine & Pain Management-Driven ASC Conference on June 13-15, 2013, in Chicago. The conference will feature sessions led by surgeons, industry CEOs and other key players in the ASC industry, covering key business and legal issues for orthopedic, spine and pain management surgeons and facilities.

Key note speakers at the conference will include:

1. Mike Krzyzewski (Coach K), former basketball player and head coach at Duke University.
2. Brad Gilbert, former professional tennis player, TV tennis commentator, author and tennis coach.
3. Geoff Colvin, senior editor-at-large for Fortune Magazine and author of 'Talent is Overrated.'

4. Forrest Sawyer, TV journalist and entrepreneur in innovative health-care and founder of FreeFall Productions, an award-winning documentary production company.

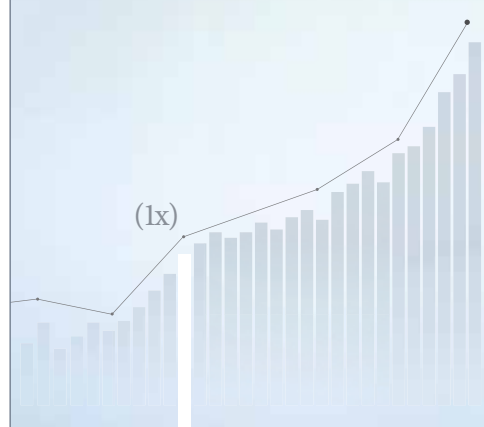
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10 Ways to Improve ASC Finances & Operations in 2013 (continued from page 1)

1. Create a generic preference card. Mr. Katz says his surgery center updated physician preference cards in 2012, creating a "generic preference card" that gets pulled for every case. For example, when physicians perform knee arthroscopies, every physician receives the same items, in addition to any "extras" requested by each individual physician. For knee arthroscopies, Mr. Katz says out of approximately 25 supplies needed for the case, 20 are standardized and five are physician-by-physician. One of the differences is always glove size, because physicians have different sized hands and must be supplied accordingly.

Mr. Katz says the initiative has been extremely successful in improving efficiency and cutting costs. "We started with 2,000 preference cards," he says. "We looked at the supplies used for each case, and all the things that were the same across the board automatically made the generic preference card." He says the physicians signed off on the initiative because they understood it would improve efficiency; staff are able to equip rooms much more quickly, and they don't open supplies that the physician won't use.

2. Prepare for ICD-10. ICD-10 will kick off on Oct. 1, 2014, according to a recent change by the Department of Health and Human Services. Starting on that date, anyone filing a claim with an insurer or government health program must use a new diagnostic coding system that increases the number of codes from 14,000 (under ICD-9-CM) to 68,000 (under ICD-10-CM). Under ICD-10, HHS believes providers will be able to document procedures with greater specificity, improving insights into the landscape of healthcare and making diagnoses clearer for payors. At the same time, the implementation of ICD-10 will likely not be easy.

Mr. Zasa says surgery centers should be preparing for the transition to ICD-10 now, even though it's not due for another two years. A transition to ICD-10 will require training for physicians, coders and business office personnel, probable upgrades to surgery center software and discussions with payors about any changes that will occur under the new system.

"You have to be budgeting for your people to attend seminars and classes," Mr. Zasa says. He also recommends setting aside money in case of payment delays, while payors adjust to the new system. "I think payors are going to struggle due to the voluminous nature of the change for them," he says. "It may be a real challenge."

3. Eliminate supplies you no longer use. Mr. Katz says his surgery center has also cut costs by eliminating supplies that are no longer used in the facility. "We've eliminated some stuff that we haven't used in two or three years," he says. He says the surgery center has traded in older trays that were used once or twice a year and received appropriate trays in exchange.

"We got the values back in trays we use constantly, so we have them available all the time, instead of waiting for a tray to get re-sterilized," he says. He recommends looking at your trays and determining whether you could eliminate some of them: If you have discontinued a procedure or only perform it once a year, you could probably dedicate those funds to another product.

4. Complete quality reporting requirements. Mandatory quality reporting for ambulatory surgery centers began on Oct. 1, requiring all Medicare-certified ASCs to start reporting quality data G-codes or face future Medicare payment reductions. As of Oct. 1, ASCs must report data on the following five quality measures: patient burn, patient fall, wrong side/site/patient/procedure/implant, hospital admission/transfer and prophylactic IV antibiotic timing.

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Starting in 2013, surgery centers will be required to report an additional two measures: safe surgery checklist use in 2012 and 2012 volume of certain procedures. This means surgery centers must start collecting quality data immediately if they are not already. Because 2013 requires surgery centers to report data based on activities conducted in 2012, surgery centers should make sure they are using safe surgery checklists and have some kind of system to capture surgical volume data.

ASCs that do not successfully report data to the Medicare program by the specified 2012 deadlines will see their payments reduced by 2 percent in 2014. Mr. Zasa says this potential payment reduction — and the importance of proving quality care in the outpatient setting — means a focus on quality reporting is absolutely necessary for ASCs in the coming year. “We [at ASD Management] have been preparing for this for two and a half years, so it’s going smoothly for us,” he says. “But we’re hearing that not all ASCs are seeing it go so well.”

5. Educate per-diems on cost-cutting initiatives. Mr. DeConcilis says surgery center leaders often fail to educate per-diem staff about the ways they can contribute to the center. “You really have to have a monthly staff meeting where you’re constantly talking about supply costs and physician recruitment,” he says. “Make sure you invite all the per-diems, and pay them to come to the meeting.” If the per-diems can’t come to the meeting, print off detailed minutes and ask each staff member to sign off on them.

He says his surgery center actually audio-tapes the meeting and asks staff to sign off. “That can save you time, because the staff can listen to the tape on a slower day at the center,” he says. While he says the surgery center tries to staff mostly full-time workers, per-diems are sometimes necessary, and it’s important to keep them educated so that you don’t drop efficiency and cost-cutting initiatives when they’re working.

6. Invest in a third-party inventory management system. Mr. Zasa says surgery centers can cut costs significantly by focusing their attention on medical supplies, drugs and implants. He recommends investing in a third-party inventory management system that will help the ASC cut down on inventory on-hand and make sure the ASC is achieving the best pricing possible.

The system should also ensure that the surgery center is paying the prices listed in its vendor contracts. “These systems will pay for themselves, just by not keeping excess inventory on hand,” he says. He adds that surgery center personnel should be trained in how to use the system to make sure the investment does not go to waste.

7. Improve pre-op education. Mr. DeConcilis says his surgery center has undertaken a project in the last year to improve patient pre-op education. He says it can be difficult for PACU staff to address patient questions and education about post-operative care after surgery, since they’re often stressed and busy. He says instead, the surgery center started talking about those issues prior to surgery. The patient comes to the surgery center prior to surgery and answers a series of questions regarding their medical history, signs documents and undergoes a DVT risk assessment. The patient also has a phone conversation with a pre-operative nurse who goes over what to expect during the surgery. When the patient registers, they are also given an iPad, which they can learn to use about the upcoming surgery and what to expect afterwards.

“It keeps things moving in the post-op area because the staff doesn’t have to spend as much time educating the patients,” he says. He says patients are also more able to digest information when they’re coherent and not recovering from anesthesia.

8. Make sure your supply storage is easily accessible. Mr. Bockelman says his surgery center completed a quality improvement study in 2012, focused on the facility’s materials management process. “We created a living, working document on the total revamping of central supply and

materials management, and we decided to create a lean environment for our inventory,” he says. He says the surgery center had a large room for storing medical supplies, but the room wasn’t organized efficiently and it was hard to set par levels. “We ultimately transitioned the room into a sterile environment, instead of using the long hallway down the backside of the OR,” he says. Now, he says, the staff can view all the supplies when they walk into the room and easily ascertain order points and complete accurate counts.

He says the surgery center has also concentrated on managing the most-used items — the 20 percent of supplies that are used 80 percent of the time. He says the ASC has been vigilant about implant logs as well. “Make sure you capture every one of your implants and compare it to what you bill the insurance company,” he says. If you track your implants properly, one that isn’t covered by reimbursement will “stick out like a sore thumb,” he says.

9. Assess equipment needs and future capital expenditures. As 2013 nears, surgery centers should be looking at their equipment needs for the next year, Mr. Zasa says. These considerations are essential to accurately budget for the next 12 months. For example, if your multi-specialty surgery center plans to add ophthalmology over the next year, do you have the money to invest in new equipment for your center? The femtosecond laser, used to automate the principle steps of cataract surgery traditionally performed by hand, costs around \$400,000.

Some specialties, such as spine, have equipment that requires a good amount of space in a surgery center, meaning you may need to make modifications to your physical plant prior to implementation.

Even if you’re not considering the addition of a new specialty, you should assess the state of your current equipment to determine what you may need to replace in the next year. “Stuff wears out, and it’s not atypical for a center to have to purchase a \$100,000-\$125,000 piece of equipment every year,” Mr. Zasa says. “You’re going to have capital expenditures coming down the pike, and you need to be prepared for that.”

10. Recruit new physicians. Physician recruitment is an ongoing challenge for most surgery centers, especially as hospitals continue the march towards physician employment and markets become more saturated with centers. Mr. Bockelman says his market is particularly challenging because, though it isn’t large, it hosts three major health systems and numerous surgery centers. He says he has utilized the reputation of his current physicians in order to attract new providers to the surgery center. “You have to continue to have meetings focusing on quality patient care and take advantage of those opportunities,” he says. ■

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6 Ways to Dig Deeper Into ASC Financial Metrics (continued from page 1)

within each specialty?" For example, he would look at the surgery center's total pain volume and determine what percentage of those cases are billed to Medicare, Blue Cross, workers' comp and other payors. He says he also drills down even further to determine reimbursement on a per-case basis by payor within each specialty.

Once you have an idea of your payor mix and payor reimbursements by specialty, take your last year of data and look at how your payor mix and reimbursements per case have changed for that specialty. "You might be able to tell that within orthopedic cases, you've really been pushing workers' comp because you're in a state that pays decent workers' comp rates," Mr. Lau says. "You'll see that your overall net collection for orthopedics is higher because you implemented the initiative to increase the proportion of higher-paying workers' comp cases."

He says you need that extra level of detail to determine when initiatives are working and when action is needed. For example, you might notice that your percentage of Medicare in a certain specialty has increased over the last year. Because Medicare reimbursement cannot be swayed — and is generally lower than commercial reimbursement — it may be important to push for higher-paying commercial cases to make up for the jump in Medicare volume. "Without that extra level of detail, you may not be able to head off a disturbing trend," Mr. Lau says.

2. Analyze every line in your income statement on a per-case basis. Mr. Lau says most centers analyze their overall net revenue on a per case basis to determine how reimbursement has changed over the last year. But he says the buck shouldn't stop there: Administrators should keep doing that for every single line item on the income statement. "Your medical supply costs per case, implant costs per case, labor costs per case — all the way down to the bottom line," Mr. Lau says.

He says it's important to look at these statistics over longer periods of time, because looking at data from the previous month may not show the complete picture. "Most centers have seasonality in their volumes; you may see lower numbers in January and February, and higher numbers at the end of the year," Mr. Lau says. "What we like to look at is not only how these revenues and expenses move on a month-to-month basis, but how they compare in this calendar quarter versus the same calendar quarter of the prior year."

When you analyze your income statement this specifically, you can generally get a better idea of operational changes. For example, if you recruited a new physician in one specialty, that could explain a jump in total revenues. If you undertook an initiative to reduce implant costs, you could see a sig-

nificant difference in those numbers. Furthermore, if there haven't been any significant operational changes, but you are still seeing per case costs increasing, these comparisons can act as a "red flag" and alert you to inefficiencies and cost savings opportunities.

3. Look at income statements on a per-business day basis. Mr. Lau says this may seem silly, but you should look at your income statement on a per-business day basis. He says "What I mean by that is that most places aren't open Saturday or Sunday, and so some months have 18 or 19 weekdays and others have 22 or 23." If you just look at your total monthly numbers, you may think you did better — or worse — than you actually did compared to other months.

For example, in September you might have net revenues of \$550,000 over 19 workdays, compared to \$580,000 over 23 workdays in October. You would think, from looking at the total revenue, that October was a more productive month than September. But in fact when the revenue is divided by the number of workdays in the month, September is shown to be more efficient. Once you understand this, you can look at "what worked" in the good months — did you do something different with scheduling, or were you booking more high-reimbursement cases?

4. Consider the number of collection days each month. The same goes for the number of collection days in a month. Most surgery centers have collection goals for each month, often based on the collection record and case volumes from the previous month. But months with more workdays are significantly more likely to show higher collections than months with fewer workdays. Make sure you're dividing your total collections by the number of business days, and adjust your monthly goals accordingly. "If you're proactive and setting goals for your business office, you will want to adjust the goal based on the number of collection days for the next month," he says.

5. Compare to your own record — not to other centers. Mr. Lau says many surgery centers benchmark against national, regional or local data, essentially comparing their operational data to that of other surgery centers. He says while this can be useful, it's generally much more telling to compare your current data to your past data.

This is because surgery centers vary tremendously based on a variety of factors. For example, if your surgery center is heavily orthopedics, you will have higher net revenue per case than a center that performs primarily GI or pain management. You will also have longer case times and turnover times, making it difficult to compare with a more naturally efficient surgery center.

Even if you're comparing to another center with a similar case mix, you may be comparing to a center that depends on out-of-network reimbursement rather than negotiating contracts with payors. "Rarely are you going to find a center that's doing exactly what you do and operating with the same cost structures," Mr. Lau says. "The only way you can really, truly track what's going on with the center is to compare your current numbers against what you've done in the past." He says every center should go back as far as they can in comparing their numbers — previous month, previous quarter, previous year, previous five years, etc.

6. Track expenses in further detail. Mr. Lau recommends tracking a few expenses you may not have thought of — sales tax and freight charges. These expenses, which normally are listed separately within vendor invoices, should be tracked separately; in addition to medical supply and implant costs.

"You should do this because your center may have deals with your purchasing agents or GPOs that freight should be a certain percent per shipment," Mr. Lau says. "Sometimes vendors have a glitch in the system and you're charged for freight when it's not in your contract." He says you should be able to track those costs to make sure sales tax and freight costs match up with your expectation from the vendor. ■

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ASC Roundtable: What to Do in Markets With Heavy Hospital Employment
(continued from page 1)

dependent upon their owners driving volume, or being good at performance on customer service, costs and turnaround time. They are keeping surgeons happy. There are 6,000 ASCs in the country, driven by the motivation of physicians to have a space they can control.

Hospitals are also creating their own surgery centers with the same mindset. Sometimes they are giving surgeons the ability to joint venture with them. When this happens, ASCs now have to think about new payment systems going forward and how they will show value in the future on costs, outcomes and patient satisfaction. They need to figure out how to stay in-network as provider groups stick together.

Jim Schafer: Some states have a certificate of need requirement, and right now the ability to justify additional freestanding surgery centers has been a real challenge. In Michigan, because of the CON requirements and because hospitals have a pretty good lock on the OR situation at this point, we are having a hard time. Five years ago, there was really rapid expansion of surgery centers, but now that has slowed.

Kathy Tayon: One of the challenges is understanding the independent surgeon's practice and showing him what it could mean from a professional experience standpoint to be part of a successful ambulatory surgery center. There can also be financial benefits if the surgeon is interested in becoming an investor. From a business and operational perspective, the surgeon should be happy.

Q: Are there steps ASCs can take to overcome these challenges?

CD: Just being a place where physicians come to perform surgery isn't sustainable anymore. Older surgeons are going to retire and there is an issue with younger physicians being in the position to buy in. We are interested in how to partner with ASCs where there is community need as access points and lower the cost of care. We are challenged to provide care at a lower cost. Maybe now it's time for owners of the ASC to find out how they can partner with hospitals instead of competing.

Additionally, ACOs are forming everywhere across the country; typically ASCs aren't the conveners, so they have to be at the table as a participant.

JS: Even though surgery center expansion is slow, ASCs are an attractive recruitment tool for physicians who already have ownership. It's beneficial to have an ASC because the practice is more profitable and bringing on new physicians gives them the opportunity to drive more revenue.

KT: From a business perspective, demonstrate

the benefits of being an owner versus being an employee in the hospital to surgeons and physicians. It can be appealing from a financial and psychological perspective. On the financial side, if the surgery center is well-run and successful the surgeon can share in that success whereas they can't with the hospital. From the psychological perspective, surgery centers in some scenarios may be more responsive than hospitals at addressing the needs of the surgeon.

Q: Some surgery centers are seeking partnerships with hospitals that are former competitors. How can they make these relationships positive?

CD: Typically ASC philosophies are a skill set hospitals can benefit from — having a dialogue on turnaround, supply costs, efficiency and labor can pave the way for a nice model of clinical co-management. They may be able to evolve into a services company that will help the hospital with those kinds of issues. They typically compete, but if there is a way to rationalize services the relationship can be mutually beneficial.

Nationally, a specialty like ophthalmology is moving out of the inpatient operating room and into more efficient care settings. The economic model is no longer efficient or appropriate from the inpatient side, so rather than building an ASC that has the same reimbursement model as one that already exists, some hospitals are willing to give this business to the surgery center with the caveat that they can't be selective about who they take. This means taking Medicare and Medicaid patients along with others who need their services.

JS: One of the things surgery centers have to keep in mind is they can demonstrate they are more cost efficient. They get paid less by insurance companies and Medicare because that's recognized. Keeping that in mind, they are attractive for hospitals that are involved in accountable care organizations. Insurers and ACOs are going to seek out the most cost-efficient solution, so the future can be very bright.

KT: The key for ASCs making a positive relationship with the hospital is demonstrating to the hospitals that the ASCs know what they are doing. They understand how to control costs and run a successful ASC. They know how to produce positive outcomes and manage data.

Q: Where should ASCs in these markets focus their attention going forward?

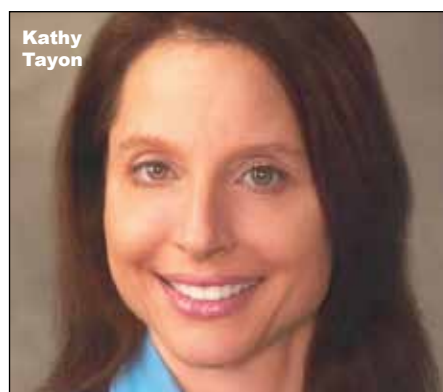
CD: ASCs must get away from a through-put model and move toward a care management philosophy. This might mean ASCs will be doing bundled payment in the future. We are seeing bundled payments with health systems offering packages and companies signing agreements with places like Walmart to provide care for their employees. In the future, there could be packages for professional and ambulatory services that include ASCs.



Cliff Deveny



Jim Schafer



Kathy Tayon

JS: ASCs should consider becoming a one-stop shop for care. If they are part of a group practice, they might want to think about adding a pharmacy. You can build a lot of activities around the surgery center. I think it's attractive to the physician because it's another investment that will drive revenue. It also makes the center a more convenient destination for the patients. It becomes a marketing tool for the physicians as they compete for patients.

KT: If you are able to develop a facility that controls costs and provides a terrific experience to the professionals that use it, and the patients have good outcomes, that is really appealing. Have a positive environment where the staff enjoys working and patients are satisfied with their care. Strive for positive patient outcomes and to hold down costs; if you are able to accomplish that and get the word out, that's a big selling point. ■

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How Will Obama's Re-Election Impact Healthcare? ASC Industry Leaders Respond

By Rachel Fields

President Barack Obama has been re-elected as the 44th president of the United States. Despite a strong showing against Republican candidate Mitt Romney, gathering a total 303 electoral votes compared to Mr. Romney's 206, the president still faces an incredibly divided electorate and the challenges of a second term. Here four ASC industry leaders discuss the impact of President Obama's re-election on the healthcare industry and ASCs specifically.

Michael Lipomi, CEO of Surgical Management Professionals:

The election is over, President Obama has won, the House is Republican and the Senate is Democrat. If this sounds familiar, it is; we will relive the last four years again. There will be one very positive change coming out of California, where incumbent Pete Stark has lost his seat. ObamaCare will move forward, and there will be partisan pressure to tax the wealthy and to get rid of capital gains tax treatment.

Nothing new, and certainly not unexpected given the outcome of the election. It's not all bad news, and in fact there is some silver lining in some areas for healthcare providers. Under the Obama health plan, there will be more insured who are able to access doctors and have insurance pay for procedures in surgery centers and hospitals. This should, over time, increase volumes at our facilities. The challenge is to find a way to continue to prosper under lower reimbursement, to continue to grow despite an unfavorable tax environment and to continue to be profitable through efficiencies. Good business knows that they can overcome almost any adversity, given they know the rules they are playing by.

We all know the new rules and the new tax environment, and now it is our turn, as educated business men and women, to find a way to make our business thrive under the rules we before us.

One of the greatest lessons from this election is the dramatic move to social media. I remember back when presidential debates were first televised and that changed campaigning and the entire elec-

tion process. The same is true for war when CNN was broadcasting as we bombed the Middle East. Now, we have all witnessed an election won using social media, and we must study and understand the business implications of this shift. We must study, adapt and move forward with changes that move us into the future in order to compete and prosper over the next four years. Change is upon us, and we cannot sit back and complain that the election didn't go our way — but rather embrace the opportunities of the future and once again become the innovative leaders Dr. Reed and Dr. Ford were in 1970, when they opened the first surgery center in Phoenix Arizona.

Chris McMenemy, Ortmann Healthcare Consultants:

The simplistic view would be that under Obama, the Affordable Care Act would stand and more people would be insured, which should be good for ASCs. But nothing is ever that simple. What will be the long-term effects of the Act as far as changes in how people are insured? Will the public option become more popular than the current

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private insurance plans, and how will that affect reimbursement to ASCs? It's difficult to know. What I think is really important is that just getting this election over will help with the uncertainty of the past year. Even if we don't like the outcome, at least we know something concrete and that allows us to plan for the future.

Matt Searles, CEO of Merritt Healthcare:

Before addressing healthcare I will state I believe Obama's goal should be to address the single greatest threat to our nation, which is the rapidly expanding federal deficit, now growing by a trillion dollars every year. The deficit is a result of years of spending more than we take in, and the current voting populace, which is responsible for the debt, should be the ones to implement austerity measures to reduce it. Foisting the debt on future generations is unethical and immoral. We all caused it, now let's solve it.

Regarding healthcare costs, the industry should work to maintain its position as the low-cost, high-quality provider. As important, we need to make sure we educate the public, lawmakers and payers on how we are part of the solution, not the problem.

John Seitz, CEO of MMX Holdings:

If Obama wins, ObamaCare (the Affordable

Care Act) will be accelerated and on target for January 2014. Surgical centers will need to adjust for a market that includes accountable care organizations and a higher emphasis on "pay for performance." The spotlight will most likely get much brighter on inefficient or expensive providers of care.

James St. Louis, CEO of Advanced Healthcare Partners:

The election results are in, and now our uncertainty and pause can go back into motion. With the recent news, it is stated that new policy will provide healthcare coverage to more than 30 million uninsured consumers, will expand Medicare by up to 17 million, and will guarantee coverage for children and young adults. What does this mean to all of us as employers and operators? With mixed feelings by all, it still provides each of us the opportunity to continue to focus on first-class customer care, true differentiation in our level of service, and always making sure that our commitment is to our patients.

From a planning perspective, healthcare organizations should be prepared to deal with a different patient population mix, who previously may have faced barriers in obtaining healthcare, and have resources in place to support a more diverse population of patient needs.

While the Affordable Care Act could cause a shortage of primary care physicians and increased wait times, making it difficult for patients to receive essential follow-up treatment at local primary care facilities, it also very well could provide an opportunity for us to assess what is really important, which is making sure that our patients are adequately cared for. New strategies on efficiencies, treating the patients as the true customers, and the balance of quality of care will be the future of successful healthcare operations. In addition, with a supply and demand shift toward greater demand for healthcare, it is key that we focus attention toward the quality of our providers, starting with our medical school foundation and focusing on fostering motivated providers.

Joe Zasa, co-founder and managing partner of ASD Management:

The election should be neutral to the industry because the Obama health act is in place but the Republicans still control Congress so we won't see further funding. We will wait two more years for the next election to see what occurs, but in the meantime funding the ASC lobbying efforts should be the priority. ■

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10 Key Trends in Spine Surgery in 2013

By Laura Miller

Several leaders in the spine surgery field discuss the key trends to watch for 2013.

1. Coverage denials will continue among many payors. This year more than ever, spine surgeons are reporting coverage denials from insurance companies for surgery as well as other procedures and tests.

"The last two years have been extremely challenging," says Neel Anand, MD, director of spine trauma, minimally invasive spine surgery at Cedars-Sinai Spine Center in Los Angeles. "Seemingly, everything is being denied, including MRIs and CT scans. We spend at least 50 percent of our time, compared to two years ago, getting approval for patients and talking to non-medical personnel. Sometimes even then, we aren't able to get clearance for the surgery."

The inability to treat patients quickly and efficiently could lead to health problems in the future, especially for patients with degenerative conditions.

"It really has become a vicious and ineffective cycle that I think will adversely affect patient care," says Dr. Anand. "It is delaying patient care and it's really sending them backwards. There is a very finite window for treatment, and that's become apparent now. If we are able to tackle the problem right away, patients can go back to work and their regular life. On the flip side, if the back pain digresses and they are unable to work for a year or more, patients don't tend to do as well."

Professional societies are responding to payors and advocating in Washington, DC, so patients can receive the care they need without bankrupting the healthcare system.

"I know the North American Spine Society is trying to start a registry to gather evidence," says Jeffrey C. Wang, MD, vice chair of clinical operations in the UCLA department of orthopedic surgery and chief of the orthopedic spine service at the UCLA Comprehensive Spine Center. "Whenever there is a new code or issue, NASS is there to respond and have an evidence-based approach. When payors announce an inappropriate coverage decision, NASS responds."

2. All surgeons must gather data and practice evidence-based medicine. Insurance companies are increasingly implementing coverage guidelines that exclude patients and services from coverage that traditionally would have been approved in the past. The most glaring example in spine surgery is the Milliman guidelines, which have been adopted by insurance companies across the country.

"It's becoming harder and harder to take care of our patients and deal with the payors," says Dr. Wang. "Because of the Milliman guidelines, when we try to authorize surgery for our patients we are getting push back from our payors. We need to advocate on the behalf of the patients and say these guidelines aren't accepted by the medical community."

The Milliman guidelines recommend continued conservative treatment for patients who were considered candidates for spinal fusion in the past, particularly those presenting with just degenerative disc disease. The guidelines are based on hand-picked, outdated studies that many surgeons reject in favor of new, higher quality studies.

"Payors are adding these guidelines and there is very little evidence that they are appropriate," says Dr. Wang. "We as spine surgeons have to collect evidence and outcomes — whether it is from registries or good prospective studies, to show what works and what doesn't. There are some things we can work on and it's incumbent upon the surgeons themselves to gather the evidence for these things and show what will be successful for our patients."

The implementation of EMR and other healthcare IT may make this process easier in the future. "The one good thing coming out of EMR is that it will gather our data and show our treatments work," says Dr. Wang. "I think that's going to result in better outcomes. I think gathering outcomes and doing the surgeries that work is important. It may be harder for people in private practice to do it, but it's more important because private practices are dwindling and more surgeons are becoming hospital employees."

3. Hospital employment will likely increase. Today's tight regulatory environment, coupled with low reimbursements and rising costs for practice management, mean fewer physicians coming out of medical school are choosing to strike out on their own. Instead, they are becoming hospital employees. Established physicians are also selling their practices to hospitals at an alarming rate in search of more flexible hours and high salaries hospitals are willing to pay.

"The trend of hospital employment of spine surgeons is growing and will continue to grow," says Robert Watkins Jr., MD, co-director of the Marina Spine Center at Marina Del Rey (Calif.) Hospital. "The larger hospital networks are gaining control of masses of patients which will make it more difficult for private practice surgeons. The private practice surgeons need to be able to spend adequate time with their patients and provide outstanding service."



Jeffrey Wang



Matt Chong

When hospitals begin employing specialists it becomes more difficult for private practice surgeons to drive referrals.

"The opportunities are going to become more constricted as more hospitals hire people to be staff members instead of independent contractors," said Donald Corenman, MD, a spine surgeon with The Steadman Clinic in Vail, Colo. "I think it's going to negatively impact care because doctors will become shift workers and that's going to diminish their quality and continuity of care."

Even when surgeons are not employed by hospitals, hospital executives and leaders are dictating clinical measures, such as which types of implants surgeons can use.

4. Care will need to become more cost-effective. All providers will be pushed further toward delivering the most cost-effective care possible as the government and payors pursue ways to lower healthcare spending and cut costs. Additionally, more patients with high deductible plans will shop for the best value and expect spine surgeons to deliver.

"Reimbursements are declining and they will continue to decline," says Dr. Watkins. "Patients expect better care and more time with doctors, but most people don't want to pay for it."

This trend also holds true for spine innovations. "One of the biggest challenges in the medical profession is dealing with the decreased reimbursement and moving toward more cost-effective measures," says Matt Chong, MD, a spine specialist at White Memorial Medical Center in Los Angeles. "How do we make safer, more reliable implants and keep innovation going while minimizing the cost of developing and using this new technology?"

Striking that equilibrium for better products with fewer complications while meeting lower reimbursement needs will make it more difficult to innovate. However, some innovations we are likely to see in the future include robotic guidance for spine surgery because it delivers higher quality of care.

"Technology will continue to make spine surgery safer and more effective," says Dr. Watkins. "Robotic computer navigation will continue to evolve."

5. Spine care is becoming more interdisciplinary. Spine care providers are now integrating more than in the past to provide patients with a one-stop location for all their spine and back pain needs. Spine surgeons are partnering with all types of non-surgical specialists,

including physical therapists, pain management, physicians, massage therapists, chiropractors and acupuncturists to bridge the gap in care.

"Spine surgery can be an isolating profession but at its core, our patients require a multidisciplinary approach," says Dr. Chong. "We need to reconnect with primary care physicians and pain management specialists on a multi-modal approach to care."

Practices are also incorporating MRI, behavioral specialists and other ancillary services into their practice for convenience; patients can have multiple services in the same visit and specialists are able to coordinate care better.

"I think the model that a lot of people are interested in is the 'one-stop shop' approach, where through a single practice site you can see a non-operative specialist or a spine surgeon, as well as a physical therapist, and have access to advanced imaging facilities," says Dr. Chong. "Consolidating all of that is an advantage from a financial perspective and enhances good communication."

It will take considerable skill to lead these practices of the future. "To be a leader at a major institution, a spine surgeon needs to become flu-

ent in the politics of the field," says Dr. Watkins. "To be a leader in private practice, the surgeon needs a marketable trait and [needs] to provide outstanding service to patients."

6. Regulations and lower reimbursement threaten the patient/physician relationship. As more regulations are passed, and healthcare providers struggle to implement electronic medical records, surgeons are spending more time doing administrative and paper work than ever before. While they are still spending time with patients, it has become more difficult for them to carve time out of busy schedules.

"It's a challenge for surgeons comply with the rules, institute EMRs and improve patient satisfaction scores," says Dr. Wang. "A lot of the reimbursement in the future will be based on patient satisfaction. We need to figure out how to maintain our practices and profitability while having good relationships with patients and complying with more rules and regulations."

According to a Medscape 2012 report, around one quarter of orthopedists spend 30 to 40 hours per week seeing patients, slightly higher than last year. However, 20 percent of orthopedists reported spending 10 to 14 hours per week

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on paperwork and administrative activity; another 29 percent reported spending five to nine hours weekly on non-patient visit work. With the uncertainty surrounding healthcare reform implementation, more regulations are possible in the future.

"Right now, we know what we have to do and we think we know what will be required next year, but they could change the rules at any time," says Dr. Wang. "They could have new rules and regulations in a few years, so it's almost like a moving target."

Another threat to the patient/physician relationship is lower reimbursements, which prompt some surgeons to see more patients per day and spend less time with each patient.

"One of the biggest challenges facing spine surgeons over the next five years is being able to afford to spend enough time with patients to make a proper diagnosis and to properly inform patients of their conditions and potential treatments," says Dr. Watkins. "Patients desire to know more information than in the past, and they want their doctor to answer many questions. These are reasonable expectations from the patient with spinal disability, but with decreasing reimbursement the doctor will less be able to afford to do this."

7. More surgeons will jump on the minimally invasive bandwagon. Over the past five to 10 years, the biggest trend in spine surgery technological development has been

less invasive surgical technique. "Minimally invasive approaches are really revolutionizing the field," says Dr. Chong. "At times in the past, we were often limited to offering a patient a more invasive procedure. The advancements and increased adoption of minimally invasive techniques are resulting in shorter hospital stays, less post-operative pain and a reduction in traditional complications."

While most surgeons were initially skeptical of these developments, solid evidence have shown certain techniques and procedures — performed with the same goal as open surgery — have good outcomes while minimizing comorbidities such as pain and blood loss.

"Minimally invasive spine surgery should play a role in the practice of every spine surgeon," says Dr. Watkins. "Surgeons should perform less invasive surgery when they feel confident that it will treat patients' conditions as safely as more invasive surgery. Surgery may be performed as an outpatient [procedure] if the safety is not compromised."

In time, the procedures that don't show clinical and cost improvements will fall out of favor and those with clear, proven benefits will continue to grow.

"There are some procedures that are good and we know work well, but even among these procedures there will be innovation," says Dr. Chong. "We'll want to reduce the rate of revision surgery and maximize long term patient

satisfaction. We're also looking for new technology that will make us more accurate and expose surgeons to less radiation."

New developments in minimally invasive procedures for more complex surgeries, such as spinal deformities, are on the horizon and pioneers in the field are already using them.

"I think the minimally invasive correction of spinal deformity is a massive move forward," says Dr. Anand. "It represents a huge paradigm shift in performing major spine surgery. I see that continuing in the future because many centers are adopting it, societies are accepting it and courses are teaching it. A big operation being done through minimally invasive techniques is showing equivalent to better outcomes; we have five and seven year outcomes data proving it works."

8. Artificial discs and lateral fusion research is coming due. For years, spine surgeons and medical device companies have collaborated on artificial disc replacements and lateral fusions with mixed results for coverage. Lateral procedures, initially developed by NuVasive with the eXtreme Lateral Interbody Fusion, are now becoming a standard approach from device companies across the board.

"Compared to many other spine procedures, direct lateral interbodies are relatively new," says Dr. Chong, "but within the next decade we will have long-term feedback to help us determine what techniques work and where we need further development."

Insurance companies are covering these procedures more readily than artificial disc replacements, which still have some room for development.

"There are trends right now that are going in the direction that will try to maintain mobility but they haven't been completely successful yet," said Dr. Corenman. "The problem with current artificial discs — and it may be resolved in the next generation — is impact absorption. There are a few discs out of Europe that may show some promise in fixing this problem."

One of the road blocks facing many artificial discs is payor coverage. A few discs have gained 510(k) clearance, but even after that insurance companies often continue to deny coverage, citing lack of evidence for clinical efficacy.

"There are new technologies out there that are being hampered by coding and regulations in that they are put forward as experimental and insurance companies won't pay for it," says Dr. Anand. "These issues will determine whether new technology moves forward and whether it will become more ubiquitous."

Current research in these fields is promising and coverage could be expanded in the future, if cost- and quality-effectiveness are shown.

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"One way to influence the decision by insurance companies on whether to provide coverage for this procedure," says Dr. Chong, "is to conduct studies designed for superiority to determine if artificial disc replacements are better than traditional fusion in long term follow up."

9. Online marketing and patient education becomes a must. There is a huge opportunity for spine surgeons to market themselves and their practice to patients online. Beyond the standard practice website, spine surgeons must engage the online community with patient education platforms, videos and blogs related to spine conditions.

"I think the internet is going to be the next wave for spine care," says Dr. Corenman. "Patients are coming into the office having significant fear and not understanding anything about spine surgery, and they are hungry for knowledge. Unfortunately, there is not a lot of education in typical spine offices, and that's where I think the internet is really going to shine."

Dr. Corenman has a website that includes a forum where anyone can ask general questions about spinal conditions and he answers to the best of his ability. One common problem is patients receiving different diagnoses and treatment recommendations from multiple spine surgeons and specialists; he tries to help patients sort through this information and find the right pathway to care.

"There is a significant lack of continuity for different problems," says Dr. Corenman. "When I'm interacting with them online, I'm not practicing medicine, it's purely education. When you can gain accurate and succinct education, it makes patients more confident and empowers them in their own decisions."

Dr. Corenman receives two to seven questions per day on his forum and spends around an hour answer the questions daily. He also writes articles for the website and uploads videos of procedures. He has nearly 40 videos on his YouTube site, which receives about 100,000 hits per month. While the website has gained traction, it takes significant time and effort to maintain.

"It's still uncommon for surgeons to have a vast online presence," says Dr. Corenman. "The problem is that it takes a tremendous amount of time to write these things and an understanding of how patients think so you can write in a way they will understand. Even though there are a lot of plug in sites where you can purchase information and publish it on your webpage, it might not be accurate or accessible to patients. It behooves you to write that information yourself."

10. Physician ratings and online reputation management won't go away. Over the past five years, several physician rating websites have sprung up from various organizations,

allowing patients to "rate" their physician and leave comments.

"The most difficult part of the internet will be how to rate doctors," says Dr. Corenman. "Now a patient can go on the internet and there are a number of different rating sites. They can express their opinions and you don't know how accurate it is. That's one of the dangers of the internet, and it's relatively new territory."

While a vast majority of these websites are underutilized, they are gaining traction as patients are continuously encouraged to take more responsibility for their care. Unfortunately, the most avid contributors to these pages are often those with negative experiences.

"It's a double-edged sword," says Dr. Anand. "You can have one disgruntled patient for any reason who could post a very negative review that is an inaccurate misrepresentation of the physician and his clinical skills. On the flip side, you can also have patients posting extremely positive results. At the end of the day, I advise people to look at these comments very carefully, conduct extensive research about the surgeon they are considering, and assess their decision based on more than just one review whether it is positive or negative."

If someone publishes false damaging information, physicians may be able to take action based on libel or slander. However, wrongdoing may be difficult to prove and removing the information could be a time-consuming process. Instead, physicians should work on getting ahead of a negative reputation by creating a positive one.

"The internet is going to make decisions for us," says Dr. Corenman. "If physicians don't take part in the discussions regarding the internet, you are going to have the decisions made for you by the general public."

Beyond using the internet, Dr. Anand suggests connecting patients via phone. With permission, connect a previous patient with a future surgical candidate so they can discuss the process and what to expect in the future. "I think that's the most effective way for patients to be comfortable about who the surgeon is and what the surgeon is capable of clinically and surgically," he says. ■

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5 Key Items for 2013 ASC Strategic Plans

By Laura Miller

H. Thomas Scott, director of operations for Surgical Management Professionals, discusses five key concepts for strategic planning for surgery centers in 2013.

1. Market opportunities. Every market has different opportunities for surgery centers to grow and become more successful next year. Whether you are a single or multispecialty ASC, understand your physicians' capabilities and whether they will be able to expand their services in the future.

"Know your market and whether there are additional patients and physicians that can be recruited," says Mr. Scott. "Can your surgeons do more procedures within their specialty? Know what your physicians are capable of and what opportunities are available in your market."

The biggest opportunity right now is in orthopedics. Surgery centers are looking to capture high acuity cases, such as total joint replacements and spine surgery. However, performing these cases often means having 23-hour stay capabilities. Another opportunity to drive additional cases and revenue would be extending operating hours during the week or adding cases on the weekends.

2. Education on regulations. There will be several new regulations for ambulatory surgery centers over the next few years, and strategic plans should include employee education and training in the budget. Two key changes for next year will be quality reporting and the transition to ICD-10.

"I think the biggest challenge we are going to face this next year is educating physicians and staff for the new rules under ObamaCare," says Mr. Scott. "There has been a lot of uncertainty within the physician community about what is going to happen, and now that the election is over some of the fear has been alleviated and we can now move forward with quality reporting and ICD-10 requirements."

Surgery centers that have already begun planning for these changes have a head start, but it's not too late to successfully integrate quality reporting and ICD-10 into next year's strategic plan. ASCs can bring in experts to discuss the changes or send leaders from the team out for training.

"I would encourage facilities to educate themselves on these changes now," says Mr. Scott. "If you wait until the last minute, you will be overwhelmed and it could be devastating to the business office staff and your bottom line."

3. Surgeon communication. Surgery center administrators can take a more proactive approach to driving patient volume at their surgery center next year by improving communication with the surgeons and making sure they are part of the strategic planning process.

"We need to know what the physician is thinking and what they are experiencing so we can improve their experience at our facility and increase patient satisfaction," says Mr. Scott. "Have the physicians and staff involved in developing and implementing your strategic plan. Without them, it won't be successful."

Look at both short term and long term goals with the physicians so they know what's on the table for 2013 and beyond.

"The most important elements to your plan will include upgrading equipment, acquiring new equipment and implementing new technology," says Mr. Scott. "Information technology will be a big part of the plan in the future, so look at where new technology can be implemented to improve efficiency. Tablets for the clinical staff or radio-frequency identification chips (RFID) for inventory control are just a few examples."

4. Increased community presence. There are several reasons for surgery centers to explore ways to increase their community presence. A bigger presence could drive more patients to the center as well as build a strong reputation for future collaborative opportunities.

"I think you are going to see a need for physicians and surgery centers to increase their presence in the community," says Mr. Scott. "You are going to see accountable care organizations (ACOs) starting to pick up some bandwidth in the market and you have to be a leader in the community so you can help direct those conversations."

Also consider ways your surgery center can build a stronger relationship with local hospitals, physician groups and other providers in the community. This could be just a working relationship or exploring the potential for a joint venture in the future.

"Have a good working relationship with primary care physicians as well," says Mr. Scott. "Moving forward, there will be a demand for cooperation with everyone in the community versus standing alone on your own island."

5. Expand revenue. Most businesses frame their strategic plan around expanding their revenue base. Surgery centers can do this by bringing in new procedures to the facility—like spine or bariatric. These types of initiative require intense time and planning.

"In both instances, you have to work with your staff to make sure they feel comfortable providing good quality care for those cases," says Mr. Scott. "Encourage physicians to become more involved with the facility and evaluate whether any new equipment will help them perform more cases there." ■

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How Does Revenue Compare for 10 Surgery Center Specialties? 40 Statistics

By Rachel Fields

Here are 40 statistics on revenue for 10 surgery center specialties, according to VMG Health's Multi-Specialty Intel-limarker 2011. **Note:** All numbers are averages.

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Percent of total cases: 8 percent
Gross charges per case: \$8,783
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Discount to charges: 73.4 percent

GI/endoscopy

Percent of total cases: 29 percent
Gross charges per case: \$3,583
Net revenue per case: \$867
Discount to charges: 72.1 percent

General surgery

Percent of total cases: 7 percent
Gross charges per case: \$6,558
Net revenue per case: \$1,934
Discount to charges: 67.8 percent

OB/GYN

Percent of total cases: 4 percent
Gross charges per case: \$7,061
Net revenue per case: \$2,155
Discount to charges: 68.1 percent

Ophthalmology

Percent of total cases: 17 percent
Gross charges per case: \$5,964
Net revenue per case: \$1,335
Discount to charges: 74.5 percent

Oral surgery

Percent of total cases: 1 percent
Gross charges per case: \$4,515
Net revenue per case: \$1,235
Discount to charges: 67.7 percent

Orthopedics

Percent of total cases: 17 percent
Gross charges per case: \$9,886
Net revenue per case: \$2,766
Discount to charges: 69.5 percent

Pain management

Percent of total cases: 14 percent
Gross charges per case: \$5,541
Net revenue per case: \$1,362
Discount to charges: 71.9 percent

Podiatry

Percent of total cases: 3 percent
Gross charges per case: \$8,139
Net revenue per case: \$2,052
Discount to charges: 72.8 percent

Urology

Percent of total cases: 3 percent
Gross charges per case: \$7,193
Net revenue per case: \$2,011
Discount to charges: 68.6 percent ■

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5 Key Trends for ASC Financing Opportunities

By Laura Miller

There are several key trends making an impact on the financing market today with a specific focus on healthcare and ambulatory surgery centers.

“Healthcare is a very specialized niche,” says Jim Irwin, President of MC Healthcare Finance. “In the world of generalist asset-based lending, healthcare is often perceived as an orphaned asset class. Banks appreciate the size and favorable demographics of the healthcare industry but also realize that financing this industry is not for dilettantes. However, with the upheaval in the real estate market, banks have a need to add consumer and industrial (C&I) loans and in many cases are trying to figure out how to prudently loan to this industry. We have built MC Healthcare Finance to be not only a direct lender to healthcare providers but to also provide a robust servicing and lending platform to partner with banks.”

Mr. Irwin discusses five big trends and why they are important for ASCs going forward.

1. Banks aren't lending. Banks' appetite to lend to small business is not nearly as great as it was five or 10 years ago. Healthcare providers face an even greater uphill battle because many banks aren't set up to lend to the healthcare world.

“Even in the best of times, healthcare isn't well understood by traditional lenders,” says Mr. Irwin. “There are many aspects of healthcare lending that frankly scare non-specialized lenders. For example, banks are often unfamiliar with the third-party payment stream, HIPAA provisions, significant receivables dilution and government anti-assignment requirements associated with lending to the healthcare industry. Most lenders are much more comfortable funding assets or receivables in which they can more easily evaluate contractual economic transactions between buyers and sellers in which the lender knows with reasonable certainty how much will be paid, and when, and in which they can straightforwardly perfect their security interest. In healthcare, you don't know when or how much you will be paid, for example.”

Today's regulatory environment is also prohibitive for banks, particularly in smaller communities. These banks in particular are keeping their capital tight. “Community banks know enough about healthcare to realize that they lack the expertise to effectively fund healthcare loans as a matter of course,” says Mr. Irwin. “They appreciate the size of the healthcare industry and the immutable demographic changes occurring but they also realize they lack the expertise and infrastructure to be able to prudently lend to it.”

2. Immense consolidation among lend-

ers. Ten years ago, it was not uncommon for businessmen and financiers to strike a deal with a handshake over an evening dinner. Today, that isn't really happening. Immense consolidation within the industry makes intimate relationships difficult with most lenders. Historically the primary lenders to the majority of the healthcare industry have been community banks which often enjoyed close personal relationships with their healthcare clients.

“The ranks of community banks, which traditionally have been the primary lenders to the healthcare industry, have been dramatically winnowed,” says Mr. Irwin. “Surviving small community banks typically lack the infrastructure to effectively value, track and monitor healthcare receivables, resulting in restricted loan advances which throttle healthcare providers.”

Furthermore, with FDIC regulations today, any bank with under \$1 billion of assets is in danger of being acquired, which will further limit most ASC's borrowing options.

3. Increasing demand for med tech financing. Ambulatory surgery centers are seeking financing at higher levels today particularly for medical technology. They are purchasing new instrumentation and electronic medical records programs to stay ahead of the curve while at the same time facing the likelihood of lower reimbursements.

“Now that President Barack Obama has been re-elected, you will see increased pressure to dramatically decrease reimbursements,” says Mr. Irwin. “For ASCs, if they can successfully navigate these waters, this is growth opportunity because they provide about 40 percent of all surgeries in the United States. Their expansion is seen as a vehicle capable of decreasing the cost of performing surgery.”

If surgery centers are able to successfully bring EMRs to enhance workflow and quality reporting, while also purchasing the equipment necessary for new higher acuity cases, they may see an increase in direct case volume for stakeholders.

“There aren't a lot of financing options, which is why we formed our company,” says Mr. Irwin. “In some markets, you see a longstanding relationship between the surgery center and community bank, but if that bank is bought or restricts loan advances it can significantly impact an ASC's ability to accommodate growth. They are also dealing with regulatory requirements for capital acquisitions and in some cases equipment.”

4. ACO formation. Accountable care organizations, or similar risk sharing ventures, are springing

up across the country and making an impact on the ASC market. ACOs could function as clearing houses that provide contracts to the lowest bidder and ASCs are poised to take that position.

“If you bid too high you won't get the contract and if you bid too low and win the contract you'll lose money,” says Mr. Irwin. Surgery centers must focus on profitable markets such as out-of-network spine surgery to be able to boost profit margins in this environment. They will also have to co-exist with, if not participate in, an ACO. “It's a difficult environment.”

For seasoned physician groups, there is a different dynamic because they are often viewed favorably by the banks and are seen as good credit risks. However, physician groups will have the same accountability as other providers in the future as the ACO dominated paradigm is implemented.

“ASCs will need to know their cost structures very well,” says Mr. Irwin. “They need to figure out that balance to maintain profitability in an environment of decreasing reimbursements. As a result of ObamaCare, 30 million more Americans will be eligible for insurance and patient volume will increase dramatically. Healthcare providers will have a hard time accommodating those patients while keeping their costs down.”

5. New opportunities for financing. Where some of the traditional capital opportunities have dried up, there are new opportunities for healthcare providers. Some are looking into private equity while others are working with financing companies, few of which are focused on healthcare.

“Given the changing landscape of healthcare, a prudent CFO should have a line of credit in place to accommodate growth, uncertainty and a rainy day. They should put together a strong financial package,” says Mr. Irwin. “If I were running an ASC, I would have a robust business plan supported by clear eyed financial projections and proof of in-depth industry knowledge. You need to show that you understand the landscape, or at least have developed contingency plans, as well as appreciate what a lender looks for in a potential borrower.”

Surgery centers should have a critical mass, such as a minimum amount of receivables, and transparency. They must have a strong though not necessarily deep management bench, decent infrastructure and clear financial reporting. “Get your house in order, have cohesive financials and intelligent projections,” says Mr. Irwin. “Have a clear, well thought out and articulated plan for why you need the money.” ■

Contact Laura Miller at lmiller@beckershealthcare.com.

8 Strategies for Surgery Centers to Stay Profitable & Accept Medicare

By Laura Miller

Medarva at Stony Point Surgery Center in Richmond, Va., has a policy of accepting every patient, regardless of their payor, and is able to maintain profitability despite treating a considerable number of Medicare and Medicaid cases. In some markets, surgery centers are considering dropping government payor cases, but CEO Bruce Kupper doesn't see that in the future for Medarva.

"I think if we are going to be a full service ASC we have no choice but to take Medicare patients," he says. "The population is growing too fast and they have too many needs for us not to take Medicare anymore. In our particular situation, we believe strongly in providing charitable care and we take those patients on willingly."

Here, Mr. Kupper discusses how his surgery center is able to maintain profitability while also accepting government payors.

1. Don't turn cases away (even if they are Medicare). Medarva's policy is to treat every patient, which means never turning a Medicare or Medicaid case away. Commercial payor cases can make up the difference between government payor rates and ASC expenses, and in some cases vice versa.

"We look at every patient as a reduction in overhead so we don't refuse anything," says Mr. Kupper. "We see it as pure volume and even if it's a Medicare or Medicaid patient, we see it as a way of reducing our overhead so we are happy to see that patient."

There are some Medicaid procedures Mr. Kupper has found to reimburse better than commercial payor rates, which is unusual for a government payor. These aren't necessarily typical ASC procedures, but they can be brought into the outpatient surgical setting if surgeons are willing to perform them.

"Medicaid pediatric dentistry in this market has done well," says Mr. Kupper. "Sometimes we seek out unusual types of cases other surgery centers tend to stay away from. We keep track of the different reimbursements to see where we can have success next."

2. Recruit new surgeons with non-Medicare payors. Mr. Kupper is constantly trying to recruit new physicians who will be able to bring commercial payor cases to the center. While physicians are often excited about the opportunity to work in the outpatient environment, it can be challenging to change scheduling habits.

"The hardest thing we face is changing the surgeons' habits and their scheduler's habits," says Mr. Kupper. "Physicians are excited because they could have ownership in the center and will see faster turnaround times than at the hospital. It's harder to change the habits of the schedulers because they are familiar with the process for the hospitals already. Adding a new entity is challenging."

Mr. Kupper sends his scheduler out to meet the physician's office staff and invites the physician's scheduler to the ASC to tour the facility. They also invite the physician's scheduler to call any time, even if it's an urgent case, and ensure that the physician will have a slot in the OR.

"Our scheduler can't turn cases away, so that's helpful for last minute changes," says Mr. Kupper. "We tell them that we'll figure out a way to get them on the schedule at a time that's convenient for the physician, patient and for us."

3. Present cost comparisons to commercial payors. In contract negotiations with commercial payors make sure they understand the cost differential between surgeries performed in the surgery center versus hospital setting, as well as the strong quality and patient satisfaction from your ASC. Negotiating strong contracts with commercial payors will offset the burden of government payor rates.

"The best thing we can do is make our case with commercial payors," says Mr. Kupper. "We are a great alternative to the hospital and we are willing to partner with insurance companies on cases that hospitals aren't. We don't want a fight with the payors; our approach is to make it work for everyone."

Medarva does a high volume of ophthalmology cases and they partner with insurance companies on corneal transplants, as an example. Mr. Kupper showed the insurance company the center's costs and compared them to hospital costs for corneal transplants, and the insurance companies were supportive of reimbursing for the tissue and the procedure. The surgery center has also partnered with commercial payors on pediatric urology cases.

"Urinary reflux leads to bladder and kidney infections. To treat this problem the surgeons use a product called DeFlux which is injected into the patient to keep the urine from flowing back up," says Mr. Kupper. "One of our insurance companies didn't want to reimburse for DeFlux, but we showed them that if the patient didn't receive

Bruce Kupper



the injection they would have to have a surgical procedure in the hospital. We showed them the costs for DeFlux versus the costs for that procedure as well as the clinical data to support it. They quickly approved the addition of DeFlux for our patients."

4. Pay attention to expense management. Managing expenses at the surgery center can close the gaps of unnecessary and wasteful spending. Tightening in these areas allows the surgery center to perform more lower-reimbursing cases when necessary. One of the best ways to keep supply costs low is by managing vendor relationships within the ASC.

"We make sure our vendors know what our reimbursement structure is like and where it's going," says Mr. Kupper. "If we don't see rate increases from our carriers, we make it clear that we aren't going to be the only ones feeling pain in this process."

Surgeons are also informed of supply costs and they partner with the ASC to make sure vendors receive a consistent message about what the center can afford and what it can't.

"If surgeons come to us with a new item — an inserter or a widget — we show them our reimbursement and what it's costing us," says Mr. Kupper. "We work with the physician and vendor to see what can be eliminated or modified to reduce our costs so we can afford that item. In working with the physicians, they have been incredibly responsive and supportive."

5. Partner with vendors on materials management. Surgery centers can partner with their vendors on lowering cost and improving quality at the ASC. When vendors show they are willing to work with you on your terms, remain loyal to them.

"We try to build long term relationships with the sales folks," says Mr. Kupper. "They know where we are and where we stand so they don't try to sneak something in or play a game. In exchange for that, we become fiercely loyal to them."

Make sure surgeons are aware of your vendor relationship policy as well. When vendors approach surgeons about a new item, the surgeon should redirect the vendors to ASC administration. "When the sales reps try to go to the physicians first, our physicians send them back to us or give them the same cost information we would," says Mr. Kupper. "They hear the same tune from the physicians and the center."

6. Accommodate all surgeons. Whether the surgeons are investing partners or just bringing cases into the ASC, administrators and staff must accommodate for them to keep their volume. This might mean putting in extra time to work with a scheduler, shifting around OR blocks or going the extra step to coordinate patient services.

"Our goal is to make it as easy as possible for our surgeons and their schedulers," says Mr. Kupper. "We don't get into whether there is a private or government payor; we will schedule everything and deal with the financial consequences as they happen. We want it to be as easy as possible for everyone who practices here."

One of the general surgeons bringing cases to Medarva requests a home health nurse visit the patient one day after surgery and remove the drain. The office staff members at Medarva have a process where they schedule the home health nurse at the same time the surgery is scheduled to make it easy for this surgeon and his scheduler.

"We focus on quality, interaction with patients, surgeons and schedulers," says Mr. Kupper. "My staff does a great job of making surgeons feel comfortable and welcome here."

7. Keep an open mind. There are plenty of non-traditional opportunities to partner with other healthcare entities and providers in the community to strengthen the ASC's reputation and success for the future. Mr. Kupper is always open to these opportunities and has found a mutually beneficial partnership with an academic medical center training program to include residents at their center.

"We take on some things that the average ASC wouldn't take on, such as allowing residents to operate and medical students to observe here," says Mr. Kupper. "We have affiliations with five different residencies at the medical school and it has a couple of benefits: it's a whole different population of surgeons we can recruit from."

The program allows residents to perform their cases at the ASC, and even though the training surgeon is a little bit slower, the case volume and recruitment potential is strong. If the case drags too long, the attending surgeon and circulating nurse can help move it along.

"A lot of the residents stay in Richmond, so they are familiar with us and our staff," says Mr. Kupper. "Familiarity breeds relationships and a high comfort level. We've seen a lot of residents say this is where they want to operate and we have a chance to recruit them."

8. Support advocacy initiatives. Surgery centers are currently reimbursed at lower rates than hospitals and hospital outpatient departments. Government payors reimburse a fraction of private payors, and even less when they reimburse to ASCs. National organizations such as ASCA are advocating for better rates in the future and surgery centers can support these efforts.

"Obviously the payment structure that Medicare comes up with is an issue because we keep falling farther behind the hospitals," says Mr. Kupper. "ASCA has done a good job of keeping Congress and CMS aware of the issue. A more telling story would be actually showing comparisons of what hospitals and ASCs receive for the same procedure."

Surgery centers sometimes use these comparisons as leverage during commercial payor contract negotiations to drive patient volume or increase rates. These same tactics could apply to government payors. "We should ask them why they are sending patients to the hospital when it costs more and see if they can increase our rates so the ASC is a viable option," says Mr. Kupper. ■



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50 of the Most Powerful People in Healthcare

By Rachel Fields

50 of the Most Powerful People in Healthcare

The re-election of President Obama in November 2012 means the solidification of change for the healthcare industry; since the polls closed, support for the repeal of the Affordable Care Act has dropped to its lowest level since the law was passed, according to a Kaiser Family Foundation poll. Republican Speaker of the House John Boehner recently called PPACA “the law of the land” — a statement that, while he backtracked several days later, suggests that measures proposed by the law will be implemented nationwide regardless of party lines.

The next year holds many changes for the healthcare industry: the implementation of higher spending caps and flexible spending account limits, preparation for ICD-10 and health insurance exchanges, and further consolidation from health systems and insurance companies. Here are 50 people with considerable sway over healthcare policy, operations and opinion in 2013.

Joel Allison. Mr. Allison is president and CEO of Baylor Health Care System in Dallas, which operates a network of 27 owned, joint-ventured or affiliated hospitals; 26 ambulatory surgery centers; and the Baylor Research Institute. Mr. Allison has led the non-profit system since 2000. In the last year, the system has undertaken under \$1.2 billion in projects, joining a Dallas-area push by local health systems to grow market share. The system's plans include a joint venture with for-profit Emerus for several free-standing emergency departments, each of which could cost at least \$12 million. Mr. Allison, who joined Baylor in 1993, has been in healthcare for three decades. He serves on the Healthcare Leadership Council, the Joint Commission Board of Commissioners and is a member of the United Surgical Partners International board.

Mark T. Bertolini. Mr. Bertolini is the chairman, CEO and president of Aetna, a health insurance company with more than \$33.7 billion in 2011 revenue. Aetna posted a third quarter increase of 11 percent over the third quarter of 2011, driven by growth in healthcare premiums. The company's membership is expected to grow significantly in mid-2013, when the company completes its \$1.5 billion acquisition of Coventry Health Care. The acquisition will increase Aetna's member base by more than 20 percent. Responding to the re-election of President Barack Obama in an interview with the Wall Street Journal, Mr. Bertolini said the shape of health insurance exchange is still unclear. “There are still a lot of regulations to be proffered,” he said. “We'll see a flood of those coming out in the next three months.” Mr. Bertolini has held executive positions at Cigna, NYLCare Health Plans and SelectCare. He was named CEO of Aetna in November 2010.

John Boehner. Mr. Boehner is the 61st and current Speaker of the United States House of Representa-

tives and a member of the Republican Party. He assumed office in 2011, taking over for Nancy Pelosi. Mr. Boehner has come into conflict with President Barack Obama over the Patient Protection and Affordable Care Act, which he said in June he “respects” but will work to repeal. Despite calling healthcare reform the “law of the land” in a recent interview, Mr. Boehner remains committed to the law's repeal. “It is costing us jobs and threatening healthcare,” said Kevin Smith, the Speaker's communications director, to NBC News. “Speaker Boehner and House Republicans remain committed to repealing the law.” Prior to his position as Speaker of the House, Mr. Boehner served as House Minority Leader for four years and House Majority Leader for one.

Richard M. Bracken. Mr. Bracken is chairman and CEO of HCA, the largest private operator of healthcare facilities in the world. Based in Nashville, Tenn., the system currently manages 162 hospitals and 112 freestanding surgery centers in the United States and United Kingdom. The health system has frequently been listed among the leading providers in the nation, with the Joint Commission naming 96 HCA hospitals to its list of 620 Top Performers in 2012. HCA posted a profit in the third quarter of 2012 that rose almost 500 percent and reported an increase in same-facility equivalent admissions.

William F. Carpenter. Mr. Carpenter has served as CEO of Brentwood, Tenn.-based LifePoint Hospitals since June 2006 and assumed the additional position of chairman of the board in 2010. He currently serves as chair of the Federation of American Hospitals, the national representative of investor-owned or managed hospitals and health systems. LifePoint's third quarter earnings fell 51 percent in 2012, after what Mr. Carpenter called a “challenging quarter.” Acquisition expenses, higher operating costs, lost revenue from Hurricane Isaac and experiences with Medicare Recovery Auditors all took their toll on the health system, causing net income to plunge from \$38.8 million in the third quarter of 2011 to \$19.2 million this year.

Benjamin K. Chu, MD. Dr. Chu is president of Kaiser Permanente Southern California Region and chairman-elect of the American Hospital Association, an organization representing hospital and health system interests in the United States. He will take over for current chair Teri Fontenot, president and CEO of Louisiana's Woman's Hospital, at the end of 2012. In his role at Kaiser, Dr. Chu directs hospital and health plan operations for 14 hospitals and 168 medical offices, serving more than 3.6 million members in both locations. Prior to joining Kaiser, he served for three years as president of New York City's Health and Hospitals Corp. Dr. Chu is a primary care internist by training.

Carolyn M. Clancy, MD. Dr. Clancy was appointed director of the Agency for Healthcare Research and Quality in February 2003 and reappointed in October 2009. A general internist and health services researcher, Dr. Clancy focuses on improving healthcare quality and patient safety and reducing care disparities based on race, ethnicity, gender, income and education. As director of AHRQ, she launched the first annual report to Congress on healthcare disparities and quality. In September, AHRQ announced a 40 percent reduction in central line-associated bloodstream infections, saying that the improvement has saved more than 500 lives and \$34 million in healthcare costs. "Until recently, these infections were thought to be an unfortunate consequence of care," Dr. Clancy said at a news conference. "Our work ... demonstrates definitively that they are not."

Francis Collins, MD, PhD. Dr. Collins was sworn in on Aug. 27, 2009, as the 16th director of the National Institutes of Health, nominated by President Barack Obama and unanimously confirmed by the U.S. Senate. In this role, he actively shapes the agency's activities and outlook, seeks advice from experts on the Institutes' policies and activities, and communicates with HHS and Congress. He is also responsible for advising the President on his annual budget request

to Congress. Since 2011, Dr. Collins has led an effort to open the National Center for Advancing Translational Services, a project inspired by his frustration with the declining productivity of the pharmaceutical industry. In its first few months, NCATS has launched research initiatives on therapeutic uses for existing molecules and the use of tissue chip for drug screening. Dr. Collins recently started a blog on the NIH website, where he comments on health issues and government policy.

David Cordani. Mr. Cordani is president and CEO of Cigna, a role he has held since December 2009. He was named to the helm of the company at a pivotal time, as Cigna transitions from a traditional health insurance company into a global health service company. The company continues to look for growth by acquiring healthcare companies in the U.S. and abroad and maintains that India and Turkey are ripe for growth. According to Mr. Cordani in an interview with The Courant, Cigna is pursuing three "strategic categories" of mergers and acquisitions: furthering the company's global footprint, entering the U.S. seniors' market and expanding retail capabilities. Cigna announced November 1 that the company will cut 1,300 jobs worldwide now through June 2013, mostly in Europe.

Delos "Toby" Cosgrove, MD. Dr. Cosgrove is president and CEO of the Cleveland Clinic, a multi-specialty academic medical center currently regarded as one of the top four hospitals in the United States, as rated by U.S. News & World Report. As CEO, Dr. Cosgrove presides over a \$4.6 billion healthcare system, comprised of the Clinic, nine community hospitals, 14 family health and ambulatory surgery centers, and several extensions of the Clinic in Florida, Toronto and Abu Dhabi. The Clinic recently released a list of the "best medical innovations" for next year, including a hand-held scanner that detects skin cancer, a device to relieve severe headaches and new drugs to treat advanced prostate cancer. Dr. Cosgrove is among several big names in healthcare who will appear in a new HBO documentary, "The Big Picture: Rethinking Dyslexia."

Lloyd H. Dean. Mr. Dean is president and CEO of Dignity Health, formerly Catholic Healthcare West, a California-based non-profit company that operates hospitals and ancillary care facilities in California, Arizona and Nevada. Dignity Health is the fifth-largest hospital system in the nation. In 2012, the company changed its name to better reflect its ministry as a non-profit organization. Officials said in a

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statement that Dignity Health was not immune to fluctuating volumes and a poor economy in 2012. "The majority of the drop in income [from \$917 million to \$132.5 million] was a decrease in investment earnings, which is directly related to the poor performance in the stock market overall," said Michael Blaszy, senior executive vice president and CFO for Dignity. Towards the end of the year, the health system broke off acquisition talks with Ashland (Ore.) Community Hospital, the first hospital with which Dignity talked about partnership after its re-branding.

Ralph de la Torre, MD. Dr. de la Torre is the president and CEO of Boston-based Steward Health Care System, a two-year-old hospital system formed by the sale of Caritas Christi Health Care to Steward in 2010. Since its inception, the 10-hospital system has attracted providers from Massachusetts-based Tufts Medical Center, Partners HealthCare and Beth Israel Deaconess, and was named a participant in the Medicare Pioneer Accountable Care Organization Program in late 2011. The system also recently established a health plan called Steward Community Choice. Dr. de la Torre, who was the youngest chief in cardiac surgery in the history of any Harvard teaching hospital prior to joining Steward, established the hospital's cardiovascular institute. Dr. de la Torre has made a name for himself as an outspoken leader; in August 2012, the CEO lambasted Rhode Island Attorney General Peter Kilmartin for an "unwelcome attitude to Steward" and disappointing behavior in mediating an agreement with Blue Cross Blue Shield of Rhode Island.

Nancy-Ann DeParle. Ms. DeParle is the current deputy chief of staff for policy in the administration of President Obama, a position she assumed in January 2011. Prior to that, she served as director of the White House Office of Health Reform, leading the administration's efforts on

healthcare issues. She has also served as the director of the Health Care Financing Administration, administering the Medicare program for the Clinton administration. She has been suggested as a replacement for HHS secretary Kathleen Sebelius, should Ms. Sebelius choose to step down from her current position.

Thomas C. Dolan, PhD, FACHE, CAE. Dr. Dolan is the president and CEO of the American College of Healthcare Executives, an international professional society of more than 40,000 healthcare executives who lead hospitals, healthcare systems and other healthcare organizations. ACHE's goal is to be the premier professional society for healthcare executives dedicated to improving healthcare delivery and endeavors to keep its finger on the pulse of hospital leaders' concerns. Dr. Dolan served as ACHE's executive vice president prior to being named president and CEO and has also held a variety of teaching, research and administrative positions at St. Louis University, the University of Missouri-Columbia, the University of Washington and the University of Iowa.

Trevor Fetter. Mr. Fetter is the president and CEO of Tenet Healthcare Corp., an investor-owned healthcare system based in Dallas. Tenet owns and operates 49 acute-care hospitals in 11 states and 90 outpatient centers in 12 states, with a majority of these hospitals in California, Florida and Texas. Tenet has had a tumultuous year; eighteen months ago, the health system rejected a \$3.5 billion, all-cash offer from Community Health Systems, and has since experienced a stock decline of \$1 billion. According to a statement released by Mr. Fetter on Oct. 1, the company has a new plan to raise money, acquire hospitals and buy back more shares to raise the system's stock price. Mr. Fetter also said, post-election, that the healthcare reform law should be a "material positive driver" to the company's earnings over the next few years.

Teri Fontenot, FACHE. Ms. Fontenot is chair of the American Hospital Association and the president and CEO of Woman's Hospital, a 350-bed regional referral hospital for obstetrics, newborn and women's care. In August 2012, the hospital completed its \$340 million replacement campus, which increases the capacity for current services and new growth opportunities. Ms. Fontenot will step down from her position as the chair of the AHA Board of Trustees at the end of 2012. She has also chaired the Chief Executive Officers Committee of the American College of Healthcare Executives and has served on its board and Office Nominating Committee. Ms. Fontenot recently spoke at a Becker's Hospital Review event on the future of healthcare, saying, "We already are working very hard to be held more accountable ... We know that the current cost structure for care in our country is completely unsustainable."

Thomas Frieden, MD. Dr. Frieden is director of the U.S. Centers for Disease Control and Prevention, a position he has held since May 2009. Prior to his current position, he served as the New York City Health Commissioner, a position in which he introduced the city's first comprehensive health policy targeting ten leading causes of preventable illness and death. He was also an active proponent of electronic health records, launching the nation's largest community-based EHR project. Dr. Frieden has worked to control both communicable and non-communicable diseases in the United States and internationally and regularly comments on health issues affecting the American people, such as obesity, end-of-life issues, vaccines and food quality.

Atul Gawande, MD. Dr. Gawande is a surgeon, writer and public health researcher who practices general and endocrine surgery at Brigham and Women's Hospital in Boston. He is also a professor of surgery at Harvard Medical School and a professor in the Department of Health Policy and Management at the Harvard School for Public Health. Dr. Gawande has written three New York Times bestselling books on healthcare: "Complications," "Better" and "The Checklist Manifesto," and has been a staff writer for New York Magazine since 1998. His research work currently focuses on systems innovations to transform safety and performance in surgery, childbirth and care of the terminally ill. Dr. Gawande recently spoke on

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coaching, success and failure at the Harvard Graduate School of Education's Askwith Forum, saying that proper mentorship is the key to replicating excellence.

Alex Gorsky. Mr. Gorsky, CEO of pharmaceutical giant Johnson & Johnson, was named to the helm of the company in February 2012, succeeding William Weldon. His current tenure with the company is Mr. Gorsky's second stint with Johnson & Johnson; he originally served as company group chairman of J&J's pharma business in Europe, the Middle East and Africa before leaving to join Novartis in 2004. He returned to J&J in 2008 to become company group chairman of Ethicon. The company recently rejected a call by a Goldman Sachs analyst to break up into smaller companies, as some of its competitors have done. The comments came after the release of J&J's first quarterly earnings report of 2012, which one analyst called its best in five years. Mr. Gorsky said in July 2012 that the company was better equipped to serve its customers as a large, diversified company.

Glenn Hackbarth, JD. Mr. Hackbarth is chairman of the Medicare Payment Advisory Commission, more commonly known as MedPAC, which recommends reimbursement rates to Congress. He previously served as CEO and one of the founders of Harvard Vanguard Medical Associates, a multi-specialty group practice in Boston that serves as a major teaching affiliate of Harvard Medical School. Mr. Hackbarth recently commented on Medicare Advantage, which costs the government approximately 14 percent more than standard Medicare. A proposed program would provide bonuses to health insurers who beef up Medicare Advantage plans by limiting hospital re-admissions, increasing preventive care and achieving high patient satisfaction ratings. Mr. Hackbarth told HHS officials that the program does exactly the opposite of its intention, amounting to a "mechanism to increase payments" that "lessens the incentive to achieve the highest level of performance."

George C. Halvorson. Mr. Halvorson is the chairman and CEO of Kaiser Permanente, a role he will hold through the end of 2013. Kaiser Permanente announced on Nov. 5 that Mr. Halvorson will be succeeded by Bernard J. Tyson. With more than nine million members and nearly \$50 billion in annual revenue, Oakland, Calif.-based Kaiser is the biggest system that combines insurance plans and healthcare providers under a single umbrella. The model is becoming more popular nationwide as health systems look to take on risk and blur the lines between the two businesses.

Margaret Ann Hamburg, MD. Dr. Hamburg serves as commissioner of the U.S. Food and Drug Administration, the agency of HHS responsible for regulating and supervising food safety, tobacco products, dietary supplements,

drugs and other products. She was one of the youngest people ever elected to the Institute of Medicine and is a highly-regarded expert in community health and bio-defense, including preparedness for nuclear, biological and chemical threats. U.S. and state health regulators have recently called on Congress to strengthen federal oversight of compounding pharmacies, following a deadly fungal meningitis outbreak linked to a compounded steroid. The FDA faces legal restrictions in regulating drug compounders such as the facility where the outbreak started.

Stephen J. Hemsley. Mr. Hemsley has been CEO of UnitedHealth Group since 2006 and joined the company in 1997, prior to which he served as managing partner and CFO at Arthur Andersen. UnitedHealth Group serves approximately 70 million individuals nationwide and is the parent of UnitedHealthcare, the largest single health carrier in the country. In 2011, he was named by Forbes Magazine as the country's highest-paid CEO, bringing in an estimated \$48.8 million in total compensation that year. UnitedHealth recently reported a jump in third-quarter earnings, coming in at 23 percent higher than last year, thanks in part to Medicare and Medicaid business growth. In July, the Obama administration announced an innovative partnership with UnitedHealth Group, as well as Humana and WellPoint, to track medical claims in real time and better identify suspicious billing patterns.

Charles "Chip" Kahn III. Mr. Kahn is the president and CEO of the Federation of American Hospitals, whose member companies own nearly 20 percent of all American hospital beds. Mr. Kahn and the FAH represent their members on issues such as healthcare reform and hospital care quality improvement. Mr. Kahn also serves as a member of the governing board of the National Quality Forum, helping to build consensus on national priorities for quality reform and reporting. Despite lobbying Congress on behalf of Republican-leaning for-profit hospital businesses, Mr. Kahn recently stated that Democratic healthcare policies may be more beneficial for the country's bottom line. In an industry panel for the Nashville Health Care Council, he said the Affordable Care Act should prove "good for business" by creating opportunities for entrepreneurs.

Sister Carol Keehan, DC. Sister Keehan is the ninth president and CEO of the Catholic Health Association of the United States, a ministry of the Roman Catholic Church that comprises more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states. The association is the largest group of non-profit healthcare providers in the nation. Sister Keehan has openly supported President Obama's healthcare reform act, which the United States Council of Catholic Bishops opposed. Sister Keehan has said the continued roll-

out of the Affordable Care Act is critical due to the spread of insurance coverage to 30 million more people. Despite this support, she has spoken out against PPACA's mandate that all private employers provide co-pay-free contraception, sterilization and abortion-inducing drugs in their employee health plans — with a narrow religious exemption for houses of worship and institutions that employ and serve people of the same religion.

John Kitzhaver, MD. Dr. Kitzhaver is the 37th and current governor of Oregon and the first person to be elected to the office three times. Prior to becoming a politician in Oregon, he was a practicing emergency room physician. During his tenure in the Oregon State Senate, to which he was elected in 1980, Dr. Kitzhaver was the chief author of the state's government-funded healthcare plan, the Oregon Health Plan. In 2006, he launched the Archimedes Movement, an organization that seeks to maximize the health of the population by creating a sustainable system that uses public resources spent on healthcare to ensure that everyone has access to a defined set of health services. Dr. Kitzhaver has also garnered \$1.9 billion in federal funding to implement coordinated care organizations across Oregon. The push towards single-payor healthcare is alive and well in the state, led by Rep. Michael Dembrow (D-Portland), who plans to re-introduce single payor legislation in February.

Jeremy Lazarus, MD. Dr. Lazarus, a Denver psychiatrist in private practice, was inaugurated as the 167th president of the American Medical Association, the nation's largest and most influential physician organization, in June. Dr. Lazarus was first elected to the AMA Board of Trustees in 2003 and has served as speaker and vice speaker of the House of Delegates, the association's primary policy-making body. In a speech at the House of Delegates on Nov. 10, Dr. Lazarus outlined the AMA's plans following President Obama's re-election, saying the AMA will continue working with Congress to implement health system reform and protect the interests of physicians and patients. In October, the association, along with 110 other societies, wrote to Congress outlining principles to transition to a new Medicare delivery system. He also outlined three areas of focus for the next five years: improving health outcomes, accelerating change in medical education and helping physicians to navigate delivery and payment models.

Daniel Levinson. Mr. Levinson has headed the Office of Inspector General for HHS since 2004. As Inspector General, he is the senior official responsible for audits, evaluations, investigations and law enforcement efforts related to HHS programs. Prior to his appointment at HHS, he served for four years as Inspector General of the U.S. General Services Administration. According to a recent video presentation posted

to the agency's website, Mr. Levinson plans to focus on Medicare overbilling and fraud in 2013. The work plan, released in October 2012, may be a reaction to a letter written by HHS Secretary Kathleen Sebelius and U.S. Attorney General Eric Holder in September, in which the officials warned healthcare provider associations to crack down on fraud. The OIG will focus much of its attention next year on the role that EHRs play in Medicare overbilling.

H. Stephen Lieber, CAE. Mr. Lieber has served as president and CEO of Healthcare Information and Management Systems Society, since 2000. Founded in 1961, HIMSS is a non-profit organization dedicating to improving healthcare quality and access through the best use of healthcare IT and management systems. The society includes more than 35,000 individual members. During his tenure, Mr. Lieber has more than quadrupled the organization's size and expanded its scope to encompass ambulatory IT issues and healthcare business information systems, in addition to HIMSS' historical leadership in the acute-care clinical information systems area. Mr. Lieber has recently launched HIMSS conferences and exhibitions in Europe, Asia and the Mideast; the U.S. educational conference and trade show is the world's largest in health IT, attracting over 32,000 healthcare professionals annually. In 2013, HIMSS plans to assist the healthcare industry in reaching ICD-10 compliance.

Steven H. Lipstein. Mr. Lipstein is president and CEO of BJC Healthcare, based in St. Louis, a health system with annual revenues of \$3.5 billion and more than 26,000 employees. Its teaching hospitals, Barnes-Jewish Hospital and St. Louis Children's Hospital, are consistently ranked among the nation's best medical schools and research institutions. Mr. Lipstein has served as president of the health system since 1999, in addition to his work with the St. Louis Regional Health Commission and the Missouri Hospital Association. The boards of BJC HealthCare recently approved a new partnership, BJC Collab-

orative, made up of St. Luke's Health System, Memorial Health System and BJC. The partnership aims to rein in healthcare costs by combining negotiating power and was initiated by Mr. Lipstein this year in response to the Affordable Care Act.

Kevin E. Lofton. Mr. Lofton has been president and CEO of Englewood, Colo.-based Catholic Health Initiatives since 2003, having previously served as the system's COO and in other executive positions. Active with the American Hospital Association, he served as the 2007 chair of the AHA Board of Directors and currently serves as chair of the Committee on Nominations. In October 2012, he led the system in its largest bond issue in CHI's history, which he called "an essential investment in our future." The bonds will finance a wide array of strategic initiatives in 2013 and beyond, including virtual technologies, physician integration and partnerships and alliances in key areas across the country. CHI merged with Jewish Hospital, Saint Mary's Healthcare and Saint Joseph Health System in January to create KentuckyOne Health.

Charles N. Martin, Jr. Mr. Martin has served as Vanguard Health Systems' chairman and chief executive officer since the company's inception in 1997. Prior to forming Vanguard, he served as chairman, president and CEO of OrNda HealthCorp. Under his leadership, OrNda grew from revenues of \$450 million to \$3 billion in three years, becoming the nation's third-largest investor-owned hospital management company. Vanguard Health Systems, based in Nashville, owns 28 hospitals in five states and recently merged with Connecticut-based Waterbury Hospital. While the hospital system got off to a rough start in its first quarter of 2012, posting a \$21 million loss, Vanguard had bounced back by the same quarter of 2013, reporting a profit of \$13.9 million.

Farzad Mostashari, MD, ScM. Dr. Mostashari serves as National Coordinator for Health Information Technology within the Office of the National Coordinator for Health Informa-

tion Technology at HHS. He joined ONC in July 2009, having previously served at the New York City Department of Health and Mental Hygiene. Dr. Mostashari, a vocal proponent of data and analytics in the improvement of healthcare, recently commented on the role that data played in the campaign and re-election of President Barack Obama. "It was something of a relief that data matters, that science matters, that predictions can be based on evidence," he said in the Nov. 7 meeting of the federal advisory Health IT Policy Committee. He added that the re-election gives the Obama administration more time to finish the job of implementing health IT initiatives. Dr. Mostashari also plans to launch an internal review to determine whether EHR systems prompt some providers to overbill Medicare or "upcode" for procedures.

Gary D. Newsome. Mr. Newsome became president and CEO of Health Management Associates, based in Naples, Fla., in 2008. Prior to that, he was employed by Community Health Systems. Health Management Associates is a for-profit corporation that operates or provides services to 66 hospitals in 15 states, including the former Wuesthoff Healthcare hospitals, which were purchased by the company in 2010. Mr. Newsome said in a recent statement that the company will continue in 2013 to focus on patients, managing costs and investing resources, as well as building partnerships with other facilities. "This culture and track record of solid operating performance is ... attracting a significant number of hospitals and health systems that are seeking a strategic partner," he said. HMA recently entered a new corporate partnership with St. Petersburg, Fla.-based Bayfront Medical Center.

John H. Noseworthy, MD. Dr. Noseworthy is president and CEO of Mayo Clinic, a Rochester, Minn.-based health system routinely recognized as one of the top providers in the country. Dr. Noseworthy began his career as a neurologist and holds the title of editor-in-chief of Neurology, the journal of the American



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Academy of Neurology. Last year, Mayo Clinic initiated the Mayo Clinic Care Network, which aims to extend the hospital's expertise to outside physicians and providers. So far, the network has added a number of members, including the Dartmouth-Hitchcock healthcare system, St. Alexius Medical Center and St. Elizabeth Hospital. To help the network be as effective as possible, Mayo has developed electronic consulting tools such as the Ask-MayoExpert database, which help outside providers connect with Mayo Clinic specialists on questions of patient care.

President Barack Obama. President Obama is the 44th and current President of the United States and the first African American to hold the office. In 2010, President Obama passed the sweeping Patient Protection and Affordable Care Act, which expands healthcare coverage to 35 million individuals and sets up health insurance exchanges to lower the price of health insurance, among other measures. In November 2012, President Obama was re-elected to his position, beating Republican candidate Mitt Romney by a wide margin — 332 electoral votes to 206. Following President Obama's re-election, polls have found that support for repealing the Obama healthcare law has dropped to a record low, at just 33 percent. In the wake of the election, states that previously adopted a "wait and see" approach to implementing health reform measures have started scrambling to make plans. Many states must decide whether to establish their own programs for residents and businesses to buy insurance, through programs that will begin in 2014.

Thomas M. Priselac. Mr. Priselac has been president and CEO of Cedars-Sinai Health System in Los Angeles since January 1994, with an association to the health system going back to 1979. The health system is among the nation's leading providers of healthcare services, medical education and research, and Cedars-Sinai is the largest private hospital in the western United States, with revenues over \$1.7 billion. Mr. Priselac has also served the healthcare industry in other roles, as past-chair of the American Hospital Association Board of Trustees and past-chair of the Association of American Medical Colleges. In March 2012, the system completed a seven-phase, five-year effort to buy and roll out a commercial EHR system with a hospital-wide implementation of computerized physician order entry, 10 years after an infamous failure to implement CPOE through a "big bang" strategy.

Kenneth Raske. Mr. Raske has been president of the Greater New York Hospital Association since 1984 and is a recognized expert on healthcare policy and finance. He has been instrumental in growing GNYHA to the nearly 250 hospitals and continuing care facilities in the New York metro area and throughout the state. On the federal front, GNYHA has been a leading advocate in the fight for relief from deep Medicare and Medicaid cuts that threaten healthcare communities every year. Mr. Raske also created The Health Economics and Outcomes Research Institute, which analyzes and interprets fiscal data and economic trends affecting healthcare providers. Mr. Raske sought federal financial aid on behalf of New York's hospitals following Hurricane Sandy, saying hospitals that evacuated lost revenue and others were burdened with additional patients due to closures.

Ian Read. Mr. Read is chairman of the board and CEO of Pfizer, one of the world's leading biopharmaceutical companies. Prior to his current position, Mr. Read served as senior vice president for Pfizer and group president of the worldwide pharmaceutical businesses. He joined the company in 1978 as an operational auditor and has taken on roles of increasing responsibility since then. Pfizer experienced a boost in late 2012 after the approval of its drug Xeljanz for rheumatoid arthritis, which followed a string of setbacks with drug approvals that raised concerns in the industry. The company also wrapped up 2012 by resolving several government and civil lawsuits involving numerous medicines, for which Pfizer expected to pay approximately \$825 million.

John Roberts. Chief Justice Roberts is the 17th and current Chief Justice of the United States, a position he has held since 2005, having being nominated by President George W. Bush. In June 2012, he delivered the

majority opinion in the Supreme Court case that upheld the Patient Protection and Affordable Care Act by a 5-4 vote. The Court ruled that although the law's "individual mandate" component of the act was unconstitutional according to the Commerce Clause, it could be construed as a tax and therefore valid under Congress' authority to "lay and collect taxes." President Obama commented on the decision, saying, "I think Justice Roberts made a decision that allowed him to preserve the law but allowed him to keep in reserve the desire, maybe, to scale back Congress' power under the Commerce Clause in future cases." Although the Supreme Court upheld the Act in June, some of its core provisions still face challenges in courts at the state level.

Nancy Schlichting. Ms. Schlichting is CEO of Henry Ford Health System in Detroit, Mich., a \$4 billion healthcare organization with 23,000 employees. She is credited with leading the health system through a dramatic financial turnaround and for implementing award-winning patient safety, customer service and diversity initiatives. She joined the system in 1998 as senior vice president and has accepted roles of increasing responsibility ever since. Henry Ford Health System is currently planning a "mega-merger" with Detroit's Beaumont Health System, touting better and more convenient care for metro Detroit residents as a key selling point. The systems would also share electronic medical records to offer a safer and more efficient way to look at patient history. The merger should not result in any changes to Health Alliance Plan, the state's second-largest health insurance company, which is owned by Henry Ford. Ms. Schlichting called the merger a partial response to the "tsunami coming with Medicare."

Kathleen Sebelius. Ms. Sebelius currently serves as the 21st Secretary of Health and Human Services. She also served as the second female governor of Kansas from 2003 to 2008 and the chair-emerita of the Democratic Governors Association. Sec. Sebelius has been responsible for implementing



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many reforms under the Patient Protection and Affordable Care Act, including policies that place emphasis on wellness and prevention, support adoption of EMR and train more primary healthcare providers. At the end of 2012, Sec. Sebelius and HHS decided to extend the deadline for states to submit plans for state-based health insurance exchanges, an issue that has been contentious as many Republican-led states chose to "wait and see" the results of the presidential election before taking action. Sec. Sebelius emphasized in the deadline extension that the Obama administration "is committed to providing significant flexibility for building a marketplace that best meets your state's needs."

Gov. Peter Shumlin. Gov. Shumlin is the 81st and current governor of Vermont, having previously represented his Vermont Senate District for eight non-consecutive two-year terms. He was re-elected as governor of his state in November 2012. In 2011, Gov. Shumlin led the state in passing legislation that would establish a single-payor healthcare system, making Vermont the first state in the nation to make healthcare "a right and not a privilege," said Gov. Shumlin. The Vermont legislature and his administration are currently working on setting up a state health insurance exchange under the healthcare law, building a potential platform for a state-based single-payor system in the future. "This Vermont boy wants to implement that single-payor healthcare system tomorrow, and I don't know why you guys want to stop me from doing that," Gov. Shumlin said at a recent Politico health policy panel. "It's the right thing to do. The rest of the world has figured it out. Let's grow up and join them."

Wayne Smith. Mr. Smith joined Community Health Systems in 1997 and has since become the system's chairman of the board, president and CEO. He worked for insurance company Humana for 23 years before joining CHS. CHS, based in Franklin, Tenn., is the largest non-urban provider of general hospital healthcare services in the United States, in terms of acute-care facilities. In the third quarter of 2012, the system reported \$3.2 billion in revenue. Commenting on the potential outcomes of the presidential election on an investor conference call in late October 2012, Mr. Smith said, "If it's a Romney win, you're going to test our ability to continue productivity and develop new strategies around reductions in cost and how we can better deliver our care at a lower cost. If President Obama is re-elected, then we'll continue to work on the revenue side."

Glenn D. Steele Jr., MD, PhD. Dr. Steele is president and CEO of Geisinger Health System, a position he accepted in 2001 after a tenure at the University of Chicago. He is past chairman of the American Board of Surgery and is widely recognized for his investigations into the treatment of primary and metastatic liver cancer and colorectal cancer surgery. More recently, he has concentrated on innovations in healthcare delivery and financing. In late 2012, he led Geisinger in a bid for Altoona Regional Health System, a 380-bed non-profit hospital operator, competing against

UPMC and Highmark. The system was also recently chosen as one of six nationwide to provide heart surgery services for Walmart associates and their dependents enrolled in the company's medical plans.

Joseph R. Swedish. Mr. Swedish became president and CEO of Novi, Mich.-based Trinity Health in December 2004 and has since led the organization through many initiatives to improve clinical and business processes. Under his direction, Trinity Health has improved financial and operational performance while focusing on seven imperatives: community benefit ministry, excellence in care, financial stewardship, accelerated integration, physician alignment, best people and accountable health networks. He is currently leading the Catholic hospital system through two major changes: the move of its headquarters from Novi to Livonia, Mich., and a potential merger with Pennsylvania-based Catholic Health East. Together, the two hospital systems would form one of the nation's largest Catholic health systems and the 10th-largest U.S.-based hospital chain overall.

Marilyn Tavenner. Ms. Tavenner is the current acting administrator for CMS, succeeding Donald M. Berwick, MD, who resigned in December 2011. Ms. Tavenner has nearly 35 years of experience working with healthcare providers, previously serving as principal deputy administrator for the Medicare program and HCA's president of outpatient services. She has stated her opposition to converting Medicaid to a block grant program, saying "the only way to stabilize costs without cutting benefits or provider fees is to improve care to those with the highest health costs," according to a Washington Post interview. In October, 60 members of Congress wrote to Ms. Tavenner urging CMS to table a proposal expanding multiple procedure recommendations, which apply when the same physician performs multiple services to the same patient in the same session on the same day. CMS plans to expand MPPR and propose a 25 percent reduction on the technical component for the less expensive service.

Anthony Tersigni, EdD, FACHE. Dr. Tersigni serves as president and CEO of Ascension Health Alliance, whose subsidiaries include Ascension Health, the nation's largest Catholic and non-profit health system. Dr. Tersigni is the first president and CEO of the Alliance, which began operations on Jan. 1, 2012, as part of an organizational redesign to increase clarity and accountability in the changing healthcare environment. He previously served as interim CEO for the system, starting in January 2004. In November 2012, he led the St. Louis-based system in signing a memorandum of understanding with Oklahoma-based Marian Health System to acquire the three regional health systems that comprise the Marian system.

Richard Umbdenstock, FACHE. Mr. Umbdenstock is president and CEO of the American Hospital Association, the nation's primary organization for promoting policy that supports hospitals and health systems. Prior to joining the AHA, Mr. Umbdenstock was executive vice president of Providence Health & Services in Spokane, Wash. Mr. Umbdenstock has said Medicaid expansion in the states is a top concern for the American Hospital Association in 2013, especially the issue of undecided states that may require individual conversations with HHS officials. He said that while implementation of the national health reform law is a top priority, the AHA is willing to work on tweaking parts of the 2010 law on Capitol Hill, including repeal of IPAB. He also recently led the AHA in suing HHS over Medicare payment denials for audited outpatient procedures.

Chris Van Gorder. Mr. Van Gorder is president and CEO of Scripps Health in San Diego. He was integral to the system's turnaround in 2000 and is currently leading the system through an expansion plan for the San Diego region. In October 2010, Mr. Van Gorder announced a new direction for the system, turning "the organization on its side" to create a horizontally matrixed management structure. This change was intended to identify and significantly reduce unnecessary variation in patient care and healthcare operations. The new "One Scripps" approach led to more than \$70 million in performance improvements in the first year. ■

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70 of the Ambulatory Surgery Centers That Opened in the U.S. in 2012

70 of the Ambulatory Surgery Centers That Opened in the U.S. in 2012

Here are 70 of the many ambulatory surgery centers that opened in the United States in 2012, according to *Becker's ASC Review* reports. The list is certainly not comprehensive, and we welcome additions. Please contact Rachel Fields at rfields@beckershealthcare.com with additions.

Arkansas

- Sparks Regional Medical Center in Fort Smith opened a new ASC on March 2.
- The Tri-State Advanced Surgery Center in Marion, Ark., opened in early September.

California

- La Jolla Women's Surgery Center opened in California in late January.
- Sutter Health opened a new surgery center in Elk Grove in May.
- Corona (Calif.) Summit Surgical Center opened its doors on Oct. 4, 2012.
- Dignity Health opened the Weight Loss Surgery Institute of the Central Coast in Santa Maria, Calif.
- Blue Chip Surgical Center Partners announced the opening of Archibald Surgery Center in Rancho Cucamonga, Calif., in mid-October.

Colorado

- Vail Valley Surgery Center opened in Glenwood Springs, Colo., in fall 2012.
- Grand Junction (Colo.) VA Medical Center opened a new ASC in March.

Florida

- Stevens Construction completed construction on the Cape Health Surgery Center in Cape Coral in Nov. 2012.
- Tallahassee Memorial Healthcare and 30 physicians opened a joint venture, multi-specialty ASC in Sept. 2012.
- Foundation Surgery Affiliates opened a joint venture ASC with physicians in Jacksonville in fall 2012.
- The Digestive and Liver Center of Florida opened Endo-Surgical Center of Florida in Orlando in May.

Georgia

- Northside Hospital in Cumming opened Northside-Forsyth Outpatient Surgery Center in July.

Hawaii

- The Endoscopy Institute of Hawaii opened in Honolulu in Oct. 2012.

Idaho

- Treasure Valley Surgery Center opened as a joint venture between physicians, Surgical Care Affiliates and Saint Alphonsus Health System on July 16.

Illinois

- Hart Road and Spine Institute opened in Barrington, Ill., and saw its first patient on Oct. 2, 2012.
- Loyola University Health System opened a bariatric ASC in Melrose Park in July.
- Gailey Eye Clinic opened a retina surgery center in Bloomington in June.

Indiana

- Indiana University Health Saxony in Indianapolis opened a new ASC in March.
- Johnson Memorial Health opened a new surgery center in Franklin in April.
- Franciscan St. Anthony Health – Crown Point opened a new ASC in May.

Iowa

- Greater Regional Medical Center in Creston opened a new ASC in April.

Kansas

- Kansas Gastroenterology and Kansas Endoscopy opened a new ASC in Wichita in 2012.

Kentucky

- Kentucky Oral and Maxillofacial Surgery Associates opened an ASC in Louisville in April.

Louisiana

- The Advanced Surgery Center of Metairie, partnered with SurgCenter Development, was planned to open by the end of 2012.

Maryland

- A new hospital and ASC opened out of a former Wal-Mart in Elkton in early 2012.
- Sinai Hospital of Baltimore opened a surgery center, the Sinai Center for Geriatric Surgery, targeted at the elderly population, in Dec. 2012.

- Anne Arundel Medical Center in Annapolis opened a new ASC in August.
- Kimbrough Ambulatory Care Center in Fort Meade opened a new ASC in May.

Massachusetts

- Newton-Wellesley (Mass.) Hospital opened a new ASC in fall 2012.
- Massachusetts Eye and Ear opened a new outpatient surgery center in the Longwood/Mission Hill area of Boston.
- Winchester (Mass.) Hospital opened a new ASC in late April.

Michigan

- Detroit Medical Center's Harper University Hospital opened a bariatric surgery center in May.

Missouri

- Scotland County Hospital opened a new surgery center in Memphis (Mo.) in January.

New Jersey

- Princeton HealthCare System opened a new ASC in Plainsboro in May.
- The Malo Health Clinic and Wellness Center in Rutherford opened the doors to its new four-OR ambulatory surgery center in Nov. 2012.
- The Paul Phillips Eye & Surgery Center opened in Flemington in Dec. 2012.

- Virtua opened a new surgery center in Voorhees in March.

New York

- Manhattan Endoscopy Center opened in the New York borough in January.
- Olean (N.Y.) General Hospital opened a new ASC in May.
- Tom Bersani, MD, opened a new ASC in Salina in May.
- Vassar Brothers Medical Center dedicated its new ambulatory surgery center, the Daniel Z. Aronson, MD Center for Ambulatory Surgery, in mid-Sept. 2012.

- Hudson Valley Center for Digestive Health opened as a joint venture between Hudson Valley Hospital Center, GI physicians and Physicians Endoscopy in July.

- Thompson Health opened an ASC at F.F. Thompson Hospital in Canandaigua in April.

North Carolina

- Piedmont (N.C.) Ear Nose and Throat Associates opened an ASC in February.
- Presbyterian Healthcare in Charlotte opened a new ASC in March.
- 24 physicians and WakeMed Health & Hospitals opened the Capital City Surgery Center in Raleigh in August.
- A new ASC opened at Midwest-Haywood Hospital in Clyde in August 2012.
- Gastroenterologist Eric Ibegdu, MD, opened a GI-driven ASC in Kingston in April.

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North Dakota

- Doctors Hospital opened a surgery center in Grand Forks in early January.
- Williston, N.D.-based Mercy Medical Center opened an outpatient surgery center on its hospital campus in Sept. 2012.

Ohio

- The Specialty Surgery Center of Columbus opened in February.
- Cleveland Clinic opened an ASC at Marymount Hospital in Garfield Heights in March.
- The Urology Group opened a new HQ and surgery center in Norwood in September.
- The Hand Center in Columbus opened and received accreditation in Sept. 2012.
- Humility of Mary Health Partners in Youngstown unveiled the St. Elizabeth Robotic Surgery Center in June.
- Nationwide Children's Hospital in Westerville opened its first suburban ASC in April.

Oklahoma

- Physicians Surgical Center in Norman opened a new ASC in Moore in May.

Pennsylvania

- Coordinated Health opened a new ASC in Hazle Township in March.
- A group of local physicians in Susquehanna Township opened an ASC in Nov. 2012.
- The Advanced Center for Surgery opened in Altoona in June.
- WellSpan Health opened a \$71 million ASC in York Township in April.

South Dakota

- Avera Sacred Heart Hospital in Yankton opened a new surgery center in June.

Tennessee

- Maury Regional Medical Center completed a \$7.9 million surgery center in Nov. 2012.

Texas

- AOK Spine and Pain Surgery Center opened in Houston in August 2012.

Washington

- Evergreen Eye Center opened a new ASC location in Auburn in May.
- Eastside Endoscopy Center in Bellevue opened a new ASC in Issaquah in March.

West Virginia

- Mon General Hospital in Morgantown opened a new orthopedic ASC in January.

Wisconsin

- David Paustian, MD, opened Paustian Medical & Surgical Center in rural Neillsville in August.

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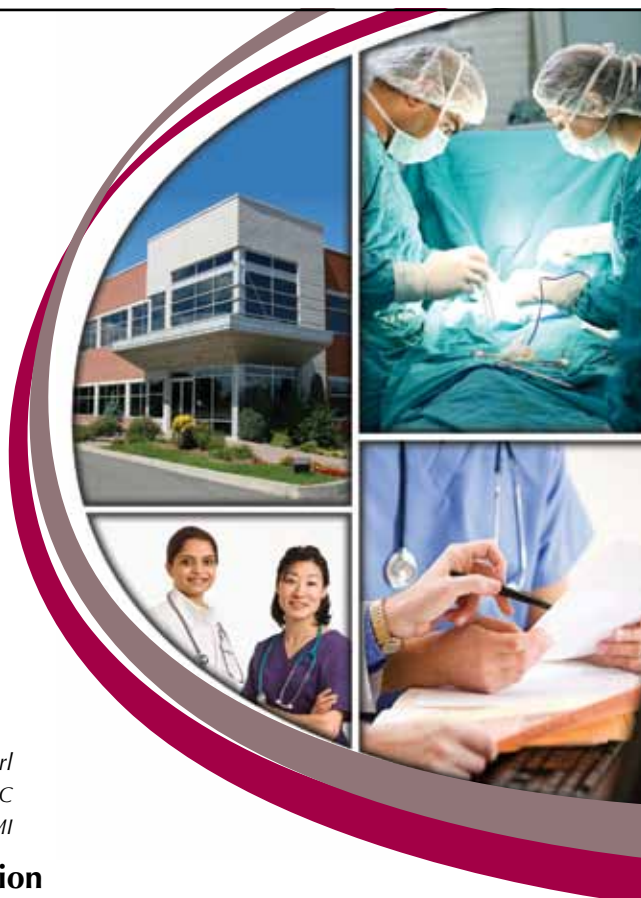
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4 Factors Affecting ASC Valuation and Sales

By Heather Linder

Surgery center owners looking to sell should be aware of several factors influencing valuation and profitability.

Colin McDermott, CFA, CPA, is a senior manager with VMG Health in Dallas. He specializes in providing financial, valuation and transaction advisory services to healthcare clients, including ambulatory surgery centers and hospital systems.

Here are Mr. McDermott's four main factors affecting ASC valuation and sales.

1. Loyal and diverse physician base. One of the most important factors — and potentially the biggest risk — to a surgery center valuation is the physician base. An ASC with a sizeable number of physicians equally sharing the case load will have less risk than an ASC with only one or two key physicians, Mr. McDermott says.

If your ASC has a handful of physicians performing most of the cases, encourage those

physicians to motivate their colleagues to increase the work load and better diversify the number of physicians using the facility.

“Really get your physician base to work together as a cohesive unit,” he says.

When all physicians are on the same page and understand the importance of being loyal to their center, then the center's valuation will increase through the physicians bringing more cases to their center. The physician loyalty will bring about stronger operating metrics due to higher case volume, which is a crucial indicator of a center's monetary value.

2. Physician recruitment. ASCs must be constantly recruiting new physicians to keep the center's physician base fresh and enthusiastic in supporting their center.

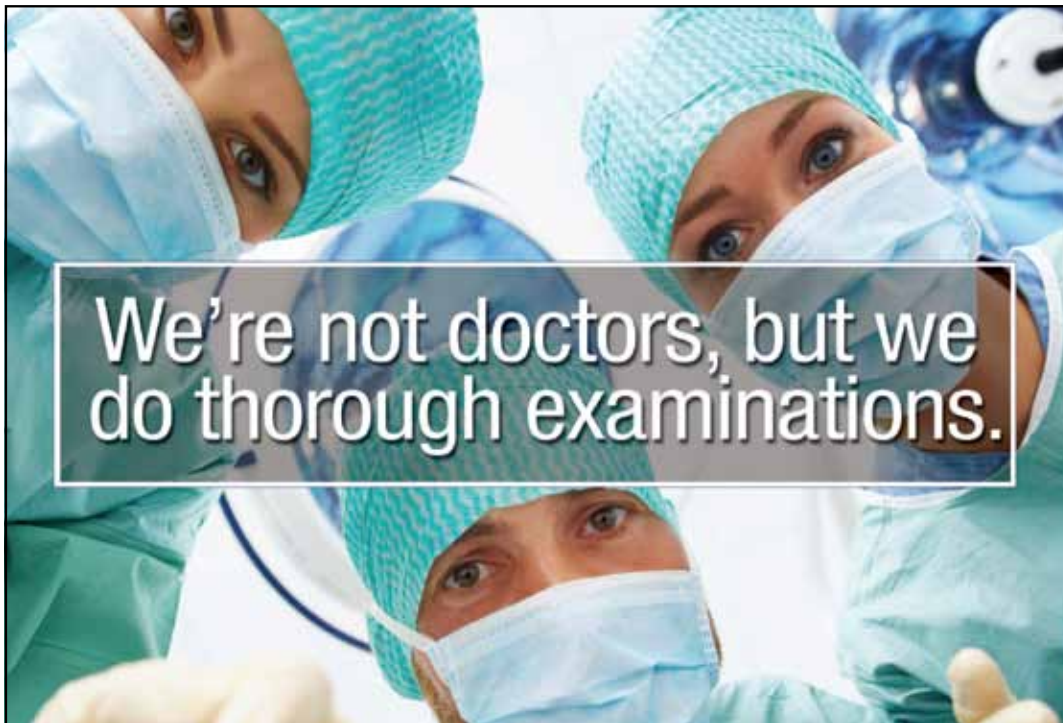
“You get physicians approaching retirement, and their case volume slows down,” Mr. McDermott

says. “It's a volume game. If volume goes down, but you haven't recruited new physicians, then the ASC's performance may start to slide.”

New physician recruitment can decrease the future risk to a center and increase its value, but it becomes more difficult to do as many surgeons are already aligned with a competing center and these competing centers are trying to recruit from the same limited pool of available physicians.

“With the current ASC industry, there is a strong demand for these free-agent physicians,” he says. “Hospitals are also seeking to employ physicians, which can limit [physicians'] ability to take ownership in an ASC, which further decreases this pool of available physicians.”

Despite the increased competition, it's necessary for ASCs to be mindful of the age and activity level of their physicians so to keep their center attractive to future investors.



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3. Expense management. After physician diversity and volume, potential buyers will be cognizant of an ASC's expense management. Even centers with a diverse group of physicians and cases may have mismanaged expenses or overspending.

"Always be thinking about what you can do to control expenses and the bottom line," Mr. McDermott says.

Staffing efficiencies and cost-effective supply management drive stronger values for ASCs, he says. Financially struggling centers should look to cut costs wherever possible. For instance, an ASC with a strong orthopedic focus could work with its distributor to access a single implant manufacturer and leverage this volume to achieve cost savings.

4. Market strength. The ASC market will always have a bearing on surgery center sales, and the current market should remain strong for the foreseeable future, Mr. McDermott says.

"There are plenty of active buyers," he says, "particularly management company buyers and hospital buyers looking to align with local ASCs."

Buyers see how active the market is for outpatient surgical procedures, particularly in local hospitals, from which ASCs have historically drawn business. ASCs are also less susceptible to the negative effects of healthcare reform than other healthcare business. Also the ASC industry has matured, ASCs are generally viewed as a long term, stable investment for buyers, and

these buyers continue to seek well-run and highly-valued surgery centers.

The ASC industry is still the "low-cost" provider for surgical services and, although reimbursement has been generally flat for the industry, it is not much of a deterrent for buyers, Mr. McDermott says.

"In this environment we've had some economic struggles, some flat reimbursement is not a bad thing," he says. "That's much better than what some other healthcare businesses have experienced." ■

Contact Heather Linder at hlinder@beckershealthcare.com.

10 Characteristics That Increase Surgery Center Risk

By Rachel Fields

As merger and acquisition trends continue to ramp up in the ASC industry, many surgery center owners are asking themselves the critical question: "What is my ASC worth?" According to VMG Health's Value Driver 2011 Survey, surgery center value is impacted by a laundry list of factors, including physician ownership, managed care contracts, market characteristics, legal structures and physical plant. Here are 10 characteristics that increase surgery center risk, according to the survey.

1. High level of ownership by physicians in competing centers. According to VMG Health's Value Driver 2011 Survey, physicians with ownership in competing centers pose a "very high" risk to the center's EBITDA multiple, defined as an impact on EBITDA of > 1.0X. Many ASC experts recommend asking physicians to sign a non-compete that prevents ownership in other surgery centers; this ensures that a higher percentage of the physician's ASC-appropriate cases will come to your ASC. A physician with interest in two centers must think about how to keep his distributions robust in both facilities, rather than concentrating on yours.

2. Significant number of active physicians nearing retirement age. A high percentage of older physicians was also thought to be a "very high" risk for ASCs, according to VMG Health's survey. If a physician is a major driver of volume in your surgery center, his or her retirement could pose a threat to profitability. If you have a significant number of physicians nearing retirement, it's a good strategy to also bring in younger physicians to prepare for their departure. In many cases, older physicians will look within their own practice to find younger physicians to purchase their shares.

3. High reliance on out-of-network payors. Out-of-network was one of the biggest risk factors cited in the VMG Health survey, with 93 percent of respondents calling it a "very high" risk. Out-of-network used to be a very lucrative strategy for surgery centers, as they could generally receive much higher reimbursement rates than those contracted with payors. However, as payors attempt to push surgery centers to negotiate contracts, the strategy is becoming less viable in many areas of the country. If you do pursue out-of-network, make sure you have a qualified staff member who understands the appeals process and when to push the payor for a more money on a case.

4. High concentration of revenue from a single payor. This factor was rated either "high" or "very high" risk by 33 percent and 40 percent of respondents, respectively. If a high percentage of your revenue comes from one payor, you are at the mercy of their reimbursement changes. If the payor decides to cut rates on a certain specialty that dominates your facility, you may see your revenue decline significantly. Payor diversity is a good way to ensure that your money is coming from several strong sources, rather than one that could weaken at a moment's notice.

5. Aging facility/poor layout of facility. This risk factor was rated "high" by 42 percent of respondents. An aging facility will generally require significant capital investment to attract new physicians and patients and excite the community, making it a riskier investment. A facility with a poor layout may pose an even greater problem: If a facility is built without the capacity to expand, the surgery center may find that it can't add specialties or additional case volume because the building is simply too small. In designing an ASC, owners should always think about whether the building is capable of adding extra operating rooms, which may be necessary in the future.

6. Facility location (patient/physician convenience). Facility location posed medium risk to most respondents, with the most popular answer weighing in at 40 percent. A facility in an inconvenient location may stymie additional case volume, as new physicians will hesitate to drive to a surgery center miles away from their practice location. Patients may also be put off by an inconvenient location.

7. Expected growth in future periods. Expected growth was rated a "very high" risk factor by 47 percent of respondents, and it's a key factor that valuation companies examine in determining the price of an ASC. Expected growth may involve factors such as physicians available for recruitment in the community; new procedures that could be added with limited capital expenditure; patient volumes that have not been accessed yet; and possible increases in managed care contracts.

8. Rate of growth of prior two to three year period. Prior growth rate poses a "high" risk to ASC value; in looking to the future, ASC investors often evaluate the past several years to determine if growth has steadily inclined. If growth has plummeted over the last several years, they don't have as much reason to believe it will suddenly shoot up (barring a significant change in the

market or the ASC's operations or strategic plan).

9. Lack of consistent, reliable financial & operational data reporting. Data is becoming critical to surgery center success, and all surgery centers are wondering how and what they should be benchmarking. In payor contract negotiations, vendor discussions, valuation conversations, partnership opportunities and day-to-day operations, data is key to determining how the center is doing and where it could go. Because of this, most respondents rated lack of data as a medium, high or very high risk to value.

10. Active hospital employment in the local area. Hospital employment was divided in its impact; 40 percent called it a high risk, while 27 percent said medium and 20 percent said very high. The level of hospital employment varies by region, but most experts agree that markets saturated with aggressively-employing hospitals are dangerous for ASCs. Physicians employed by hospitals generally are not allowed to hold investments in outside facilities, limiting their engagement in an ASC. If your ASC is in an area with hospitals that employ physicians, you also run the risk of losing your current physicians to the hospital for good. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

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Marcia Patrick, RN, MSN, CIC, member of the board of directors for the Association of Professionals in Infection Control and Epidemiology, and Marsha Wallander, RN, associate director of accreditation services at the Accreditation Association for Ambulatory Health Care, will present.

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Building a Spine Center: 5 Points From Dr. Richard Kube

By Laura Miller

Richard Kube, MD, is the CEO, founder and owner of Prairie Spine & Pain Institute in Peoria, Ill. Dr. Kube built his new surgical facility, Prairie SurgiCare, and worked to streamline the project. Prairie SurgiCare went from demolition to occupancy permit in about six weeks with accreditation six weeks later. Countless considerations go into building a new spine surgery center, and here Dr. Kube gives his five points on what major factors contribute to building a successful center from the start.

1. Adhere to accreditation guidelines. Dr. Kube's spine center is classified as an ambulatory surgical treatment facility certified by The Accreditation Association for Ambulatory Health Care. When preparing for his build out, he had to follow all AAAHC guidelines for physical site requirements.

Know the site requirements for your accrediting body, including stipulations from The Centers for Medicare and Medicaid Services. Nearly all accrediting agencies print physical environment checklists to consider during the construction phase of a surgery center.

It can also be a good idea to hire an architect who is certified by The American Institute of Architects, and use an AIA contract, because it holds the architect accountable for making sure everything done during the process meets a high standard of quality and adheres to the spec in the site plan, Dr. Kube says.

"A lot of contractors won't be familiar with building healthcare facilities," he says. "It's important that they follow your [guidelines] specifically. You don't want them cutting any corners that may adversely affect accreditation."

He recommends checking every week that all standards are being met. Potential issues could be firewalls, ceilings and the building's grid. Hold the architect accountable for being on site and surveying the area so future accreditation guidelines are precisely adhered to.

2. Hire a job foreman. Hiring a job foreman to be on site every day can keep construction problems from happening and speed up the finished product, Dr. Kube says.

Find a foreman to work for your surgery center who is familiar with the accreditation and surgery center guidelines. The right foreman can save you weeks on the construction timeline.

"That person is able to make sure they are following the physical environment guidelines, that the work is getting done on site and the [construction] guys are efficient," he says. "It's another check and balance."

Most contractors are not at the work site every day, closely monitoring the work to make sure deviations from the plan do not occur. If mistakes are made, change orders have to be filed, costing time and money. An onsite foreman also minimizes the amount of change orders that a project requires, and is well worth the price of his or her salary, he says.

3. Determine proper financing. One of the main steps before construction begins is to determine the cost of the project and budget for any potential overages. The salaries for a contractor or foreman should be included in your cost estimate, as well as future equipment costs, Dr. Kube says.

One element of proper financing is to know what type of cases your surgery center will predominantly handle, including Medicare, commercial payors, worker's compensation or a combination. A high volume of worker's compensation cases means an additional three to four months or more before cases get paid.

"It's important to think about [the case mix] with financing," he says. "You

need to pay the bills and meet payroll. You need to analyze and assess what kinds of cases you will be doing in order to anticipate the age of receivables and what financing is appropriate to those cases."

Surgery centers using injections or scopes typically have equipment costs incorporated into the lease, whereas minimally invasive spine procedures with high case costs can require carve outs or specific contract negotiations. Know what you will need your cash flow to look like to be successful.

4. Create vendor incentives. Surgery center owners should also work with ASC vendors and create incentives to get the necessary supplies delivered prior to the center's opening. Dr. Kube recommends setting clear penalties for vendors who do not make delivery deadlines.

Though the price is important, having the equipment in time for opening is paramount, so agreed upon discounts create an incentive to meet the deadline.

"The time is of the essence," he says. "If you can't meet the timeline, we start stipulating a percent off of the product for every day over. Sometimes they have to concede 5 or 10 percent in cost for every day or two over."

5. Recruit a dedicated management team. One of the most important pieces of opening a successful spine surgery center is the management team. Recruit a top-notch director of nursing, chief operating officer or administrator and medical director prior to construction to be prepared once the center is ready to open.

Dr. Kube's director of nursing, Nicole Dentino, and administrator, Scott Anderson, were crucial to making sure all accreditation guidelines were fulfilled so when the inspection day came, his center, Prairie SurgiCare, passed with a perfect score, he says.

All management members need to be unified and working together or the division will hamper your spine center's projects, cash flow and overall performance. All of my staff members were equally motivated to get this project done, he says.

"There are a considerable number of moving parts," he says. "You need experienced, dedicated people involved. You can expect and plan that it will be a cost and endeavor, but it will be well worth it with the right pieces in place." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

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10 Revenue Cycle Mistakes ASCs Make — and How to Fix Them

By Rachel Fields

If your ASC is making mistakes in coding, collecting and billing, you probably aren't receiving as much money as you could be. Here, John Bartos of Collect Rx and Adrian Epps of abeo discuss 10 mistakes surgery centers make in the revenue cycle process, as well as solutions for ASC leadership to implement in the coming year.

1. Failing to get proper authorization for performing services and procedures. Mr. Epps says many surgery centers make the mistake of not getting proper authorization for the procedures they perform. "When they receive referrals from physicians not tied to the ASC, they're not getting authorization for the services rendered," he says.

This means contacting the payor about the member's benefit plan and going over financial obligations, including co-payment, deductibles, which services are covered and how the surgery center will receive payment. The surgery center also needs to notify the patient about payment options, including what payment is expected from the health insurance company and how the patient's deductible factors in.

Mr. Epps says it should be relatively easy to find this information online. "Most of the top health insurance companies give you the ability to go online, check member benefits and plug in procedure codes to find out what the insurance plan covers," he says. It's important that your staff members understand how to use these systems; if you plug in the incorrect parameters, the information will be useless and even damaging.

2. Failing to staff a certified coder and qualified business office staff. A certified coder is critical to making sure you send out the right codes and receive the right reimbursement, Mr. Epps says. He says the other areas of the business office are just as critical — without the right people to manage medical records, transcribe, understand the billing and collections process and collect payment up-front, your ASC could lose money.

"I often see staff members either without healthcare experience or without training," Mr. Epps says. "Many ASCs don't have the management team in place to hire and train these individuals, let alone hold organizational meetings to discuss performance, perform audits and implement quality initiatives."

He says in some cases, surgery center leaders or physicians hire their friends or family members to run the business office, assuming it's not a

critical task. He says this is a huge mistake, and the business office should in fact be audited regularly to ensure top performance. The medical record manager should regularly check to make sure coders are accurately coding procedures, and leadership should track the collection of co-insurance and co-payments upfront.

3. Failing to proactively manage commercial payor contracts. Make sure to start re-negotiating payor contracts six to nine months prior to the auto-renew date, Mr. Epps says. If you let the deadline lapse, you will receive the same rates for another year, regardless of changes to your business.

Look at the contract as a whole and compare reimbursement and costs for your top 30 procedure codes. Also look at the payor's multiple procedure discount policy — you may be getting a 150-25-25 rate when you could be receiving substantially more. "If you do implants, carve out your implants and make sure that's addressed in the contract," Mr. Epps says.

4. Failing to effectively work A/R. Mr. Epps says it's common for A/R to fall by the wayside in a business office. "You need to have a system," he says. "Without oversight, A/R can escalate beyond a level that's financially sustainable. You've got to know how many days out you are — 45, 90, 120."

He says the ASC should know where it stands with all unpaid bills, and should have a system for contacting patients when bills have not been paid. For example, does the surgery center write off collections that are under \$100, or does it go after every single penny? Are you sending out multiple letters and emails to increase the probability of payment?

Mr. Epps says it can help to send out a letter before surgery, explaining your expectation for collecting as much up-front as possible, as well as the potential cost of the service. You can also call the patient prior to the procedure to discuss his or her financial responsibility and talk about setting up a payment plan, if necessary.

If a patient is not keeping up with payments after the procedure, send out four or five letters with increasingly aggressive language, Mr. Epps says. Make sure to follow up with phone calls, especially during the evening when patients are more likely to be home. When you send a fifth letter, he recommends changing the layout and typeface and mentioning that the patient's credit could be hurt. If the patient sees a new format, they may be jarred into paying the bill.



5. "Defaulting" to a strategy of 100 percent in-network participation. Mr. Bartos says he commonly sees providers "defaulting" to a strategy of 100 percent in-network participation, and thus failing to take advantage of the opportunities to obtain higher out-of-network reimbursements. True, out-of-network does not work in every market — but Mr. Bartos says "the reality is that in most geographies, providers can increase revenue by having a portion of their revenue come from out-of-network patients."

He says this requires an analysis of each of the surgery center's payors. Compare in-network and out-of-network reimbursement levels for your most common procedures on a payor-by-payor basis, and determine which contracts should be cancelled to reap a higher return.

"In addition, providers need to understand both the local payor and employer mix, as well as their relative market share compared to other providers." He says if providers are prudent in picking the payors with which they pursue out-of-network, they should be able to maximize total revenue and profits.

6. Failing to follow payor claims submission policies. The parameters for submitting a "clean claim" to a commercial payor should be clearly spelled out in the contract, Mr. Epps says. If you receive a denial, you need to call the payor and follow the appeals process as outlined in the agreement or the provider reference manual. You should also look into what caused the denial in the first place and keep a spreadsheet of common reasons for denial at your ASC.

“The more you understand about what the payor requires, the more you can prevent having to appeal,” Mr. Epps says. “If you do your due diligence on the front end, you’ll likely have fewer issues.” He says payors often update their provider reference manuals on an annual basis, so it’s important to stay on top of any changes in submission policies.

7. Failing to maximize reimbursement with an out-of-network strategy. Mr. Bartos says when providers do decide to pursue an out-of-network strategy, they often fail to take the necessary steps to maximize their out-of-network reimbursement. “We see providers accept reimbursement levels that are perhaps only slightly above their in-network or Medicare or Medicaid rates,” he says. “The payors, knowing that providers won’t push for more, will often under-pay those claims.”

He says this strategy requires staff members who are dedicated to negotiating out-of-network settlements on individual bills and effectively appealing claims. If your surgery center does not have staff members experienced with out-of-network bills, you might consider hiring a third party to handle this side of your reimbursement. “The provider [also] needs to have supporting data to be effective in negotiating individual bills,” Mr. Bartos says. “For example, the provider must have the ability to identify the inconsistencies between the EOB and the remittance advice and be able to decipher the actual language.”

Providers must also follow a rigorous appeals process if reimbursement is unsatisfactory. The process includes, for example, elements like:

- Creating a well-drafted assignment of benefits that – (1) assigns the surgery center all rights under the insurance policy (including the right to appeal and the right to receive relevant documentation); (2) refers to the provider as the patient’s authorized representative, and (3) references ERISA and a full and fair review of claims.
- Documenting all calls with the payor (benefits, pre-authorization, etc.). “Make sure that both parties understand what was said and that the surgery center has a record of what was said,” Mr. Bartos says. He says in many cases, surgery centers never call the payor to inquire about insufficient reimbursement.
- Recording the reference numbers of all payor calls. Mr. Bartos says when a surgery center calls a payor, the payor assigns a reference number to that call. The staff member should document the reference number, in case there is a dispute later over what was said. “If the provider can’t give the reference number, the payor can say, ‘We never had that call,’” he says.

8. Failing to meet regularly as a practice or surgery center. Mr. Epps says when he managed a practice, he met with the business office staff every two weeks or every month to discuss any problems in the department. He went over what the staff was doing on a daily basis, and how effective they were being. “I asked what we could do to improve the process, based on patient and physician feedback surveys,” he says. “How could we improve those relationships?”

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For example, the practice made a note when a patient went back to the primary care physician and asked to go to a different surgery center next time. “The patient might say, ‘They were more interested in playing [computer games] than talking to me about my insurance benefits,’” Mr. Epps says.

9. Failing to listen to business office staff and disseminate goals. Mr. Epps says many surgery centers assume that business office staff don’t need to be part of center-wide discussions and growth. “You need to explain the doctors’ goals and the center’s plan for future growth, so that everyone can have a voice in the planning process,” Mr. Epps says.

He says leadership should hold regular meetings to discuss what’s working and what isn’t. How many hours are dedicated to each activity, and which are taking too long? If the center recognizes inefficiencies, what’s the plan to fix those issues? Business office leaders will understand where the ASC is losing money and may be able to recommend solutions.

10. Failing to plan for narrow and tiered networks. Starting in Jan. 2014, the federal government will mandate the implementation of “health insurance exchanges,” or online marketplaces where consumers can comparison-shop for health insurance. Many states have already made moves to set up their own state-run exchanges; those that have not made progress by 2013 will have exchanges set up for them by the federal government. The exchanges are designed in part to increase competition among health insurers and prevent large payors from increasing rates without experiencing a drop in business. This means that as payors prepare for 2014, providers can expect to see their reimbursement rates drop, so that payors can offer discounts to patients and hold onto their market share.

Mr. Epps says many large insurance companies are creating ‘narrow networks’ that exclude certain providers. By creating narrow networks, the payors can ensure a steady stream of patients to their in-network providers and, in return, ask that those providers accept discounted rates for their procedures. The benefit is a smaller network of providers with reduced rates resulting in greater cost savings to the health plan and Employer groups.

He says another approach is to create “tiered networks,” which include a variety of different plans with various discounts. “For example, there may be a PPO 1, 2 and 3, and those would correspond to a 10 percent, 15 percent and 40 percent discount,” he says. This means that ASCs must be very careful when signing contracts with payors who are using tiered networks, since a 40 percent discount could cut into profits significantly. He says the upside of opting into every single plan/product with a payor — regardless of discount — is that you provide accessibility to as many members as possible which may lead to increased case volume. The concern is that a 10-40 percent discount — on top of the discount you’re already offering the payor by joining the network — may not be financially sustainable for an ASC or physician practice. Mr. Epps says surgery centers need to be fully aware of their financials before signing this kind of contract. ■

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4 Considerations for Ambulatory Anesthesia From SAMBA's Dr. Peter Glass

By Heather Linder

Ambulatory anesthesia can create a new set of challenges for anesthesiologists accustomed to working at inpatient settings. Anesthesia in ambulatory surgery centers must be approached from a different perspective.

Peter Glass is the immediate past president of the Society for Ambulatory Anesthesia. He is also an ex-officio member of the ambulatory anesthesia division of Anesthesia & Analgesia. Dr. Glass is the chair of the department of anesthesiology at Stony Brook Medicine in New York.

Here are Dr. Glass' four considerations for ambulatory anesthesia:

1. Patient experience matters. The patient experience is always a priority in ASCs. In a hospital, operating rooms are tucked far away from where patients are admitted and the layout is not designed to maximize efficiency.

However, freestanding ASCs are usually compact facilities, where patients are processed and walked a few yards away to a changing room and operating room, Dr. Glass says. "The whole experience for patients is more efficient and pleasant," he says.

Anesthesiologists are also working with generally healthy patients, rather than critically ill patients in a hospital. Since ASC patients tend to have fewer co-morbidities, the emphasis is more on a quick recovery and how to make the experience pleasant with the least impact to the patient.

2. Techniques are the same, but mentality is different. Techniques for administering anesthesia do not vary much from hospitals to surgery centers, Dr. Glass says, but considerations are different for each environment.

In ASCs, anesthesiologists can speak to their patients and reassure them about the minor nature of the procedure and anesthesia. "We like to walk our patients into the OR," he says. "That way, you don't feel like you're sick."

Anesthesia for outpatient procedures must also be quick to subside, so patients can wake up shortly after the procedure is finished. ASC anesthesiologists are also very aggressive with pain management and managing post-operative vomiting and nausea.

"We are geared toward getting the patient out in a positive way as soon as possible," he says. "This is not the same modus operandi in hospitals, which have different objectives."

ASC anesthesiologists, more than hospital-based providers, opt for propofol as an anesthetic because it is short lasting and an effective antiemetic.

3. Technology will bring new procedures. As surgical techniques and technology improve, procedures will continue to move from inpatient to outpatient settings, including to ambulatory surgery centers.

"What previously we were forced to do in the main hospital can, in many instances, now be done in the ASC environment," Dr. Glass says. "We will continue to see new technology moving patients toward an ambulatory environment."

It's difficult to predict which procedures are likely to receive approval for the outpatient setting, but Dr. Glass expects to see total joints being performed in ASCs in the near future. "The thing that is keeping them inpatient is the pain and the rehabilitation," he says. Once incision sizes can be reduced, the pain can be more easily managed and allow for ambulatory rehabilitation.

4. Not all patients are a good fit. Sleep apnea is becoming a more common condition for patients and requires a risk assessment prior to administering anesthesia.

Not all patients with the condition are good candidates for outpatient surgery. It depends on several factors, including the severity of the sleep apnea, the procedure being done and how long a center is willing to keep a patient in the recovery room.

"Each ASC needs to determine what level of risk they are willing to take from any given patient," Dr. Glass says.

Sleep apnea can be problematic during the procedure, but it also poses a risk to patients the day after surgery while they are recovering at home.

When performing anesthesia on a patient with sleep apnea, anesthesiologists could consider using regional anesthesia, rather than general, if the procedure permits. They could also opt for non-opioid narcotics for pain management and short-lasting sedatives. ■

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10 Ideas for Boosting Surgery Center Staff Morale — Without Giving Raises

By Rachel Fields

Lori Martin, administrator of Summit Surgery Center at St. Mary's Galena, says her facility has been unable to grant raises since the ASC started operations in 2009. In a down economy, it can be tough to boost employee morale while communicating the financial reality of your center. Here, she gives 10 tips for keeping employees satisfied while working on a tight budget.

1. Make the decision to be positive every day. Ms. Martin bases part of her leadership strategy on "Taking the Stairs: 7 Steps to Achieving True Success," by Rory Vaden. Mr. Vaden tells his readers, "Happiness is not a mood. It is a decision." Ms. Martin tries to live by that philosophy every day; she says that if a leader chooses to be positive, they inevitably spread a culture of positivity throughout the organization.

She says she greets her staff at the beginning of every work day, making sure to smile and say everyone's name. "We're all going to be here for eight or 10 hours, so let's make it good," she says. "I walk in every day and smile, because when you're at work, you've got to put your game face on." She says rather than walking into the ASC and "taking the temperature" of the staff, the administrator should set the temperature upfront.

2. Take on responsibilities outside the administrator role. Staff members will respect the administrator if he or she is willing to pick up extra tasks, Ms. Martin says. For example, if the administrator takes out the trash regularly, staff members will see that everyone is committed to the facility's success — no matter how menial the task at hand. "Leaders should think about what they actually do as a leader," she says. "Do you come in and help the staff? As long as they see you doing what they do — and doing it with a smile — they will keep up that morale."

3. Ask staff to speak to each other about interpersonal concerns first. Surgery centers are small facilities, and staff members can easily get into conflicts about someone's tone of voice or a misunderstanding about a job responsibility. Ms. Martin says when staff members come to her with interpersonal problems, she generally asks the complaining team member to talk to their colleague first.

"If they're comfortable talking to the person, I want them to handle the situation with respect for each other," she says. "Once people get over that first hurdle of confrontation, it can be a great team-building experience to bring up an

issue." She says this also helps morale, because employees don't feel that their colleagues are "telling on them" to Ms. Martin. "Let the two of them deal with it if possible," she says. "At the end of the day, we're all here for the common goal of patient care and don't want anything to interfere."

4. Choose an "employee of the month." If you can't afford to give raises, it helps to reward employees in other ways. Ms. Martin's ASC has an "employee of the month" program that rewards a team member nominated by the other staff members. The peer nomination process builds morale, because everyone wants to be respected by their peers and doesn't feel that leadership is "picking favorites." The winner receives a gift card from the center — a nice way to reward someone financially without giving a bonus or a raise.

5. Hold regular gatherings. If you want your employees to get along, give them a chance to socialize outside the operating room. Ms. Martin says her surgery center holds monthly potlucks, where every staff member brings a dish. They also host an annual Christmas party. "Sometimes, if we have a really busy month and hit a volume record, we'll have a pizza day so that everybody doesn't have to bring something," she says. The center also holds an optional "secret Santa" gift exchange during the holiday season.

6. Give every staff member additional responsibilities and job titles. To help every staff member feel involved in the center, Ms. Martin recommends giving everyone some added responsibility outside their regular roles. For example, at her ASC, one person is in charge of the CTQ patient satisfaction process, while another heads up medication management for the center.

"Everybody has a full-time responsibility other than their day-to-day job," she says. "When they have downtime, they can work on their project." She says this means every staff member is fully invested in the center and can see their part in the facility's progress. She adds that every staff member enjoys having an additional title, such as "infection control officer" in addition to "pre-op nurse."

7. Build relationships between physicians and staff. Sometimes barriers exist between physicians and staff members, who may find physicians intimidating or aloof. Ms. Martin says her center has built a healthy rapport between physicians and staff by inviting physicians

to the center's social gatherings. "The potlucks are a huge mixer, and the physicians also come to the Christmas party and any of those receptions," she says. She also has a front-office staff member who works closely with the physician offices. Every time a patient visits the facility, they have a point of contact from their experience with the referring physician.

8. Ask, "How are you?" When Ms. Martin conducts her rounds at the center, she asks her employees for feedback on their day. "I say, 'How are you? Do you have everything you need? Is there anything going on?'" she says. If the staff member does need something, she makes sure to get it done as soon as possible. She says it's important to instill a sense of trust with your employees.

Follow-up is a major factor even if the answer is not what they want to hear. "If I can't get it for them, I follow up on that conversation and explain why," she says. "I'll say, 'This is a great idea, the cost is X amount of dollars. Does this item have a major impact on your ability to do your job?' If not, I explain why we can't put it in the budget right now." This closes the loop of communication.

9. Don't overlook the simple things. Ms. Martin says her employees frequently mention problems that she would never have noticed. For example, a staff member might say they lost their name tag, or that the facility's soap irritates their hands. Encourage staff members to speak up about these small things, since they may feel that they're inconveniencing you. Most of the time, the changes will be easy and cheap to implement and will cause a significant boost in staff satisfaction. "They come in and they're so excited and happy that you cared enough to handle it," Ms. Martin says.

10. Be honest about your inability to give raises. If you can't give raises, give a reason, Ms. Martin says. If you don't explain why you can't give raises, staff members may think that they're the only ones being left out — or that leadership is keeping the money.

Ms. Martin has a meeting every year where she gives a presentation about the center's budget and explains why raises are infeasible. "I'm very honest, and I tell them, 'Look at what we've created, and look where we're going,'" she says. "We have this great place to come to every day. I focus on that." ■

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5 Steps for ASCs to Make Big Equipment Purchases

By Laura Miller

Equipment purchases can be a difficult process for many freestanding ambulatory surgery centers, but it's necessary for attracting new surgeons and staying competitive in the market. Now, ASCs are seeing cases that were previously done as inpatient procedures ushered into the outpatient setting and they must make capital purchases to capture a portion of that market share.

"We are seeing a lot of capital purchasing at our centers as cases that have been dedicated to the hospital environment move toward surgery centers," says Daren Smith, director of clinical services at Surgical Management Professionals. "Some of those cases coming into ASCs require power equipment — like total joint replacement — or other tools for procedures like spine surgery."

Surgery centers are also seeking to propel themselves ahead of the curve by purchasing electronic health record systems. Here, Mr. Smith discusses five steps for acquiring new equipment with ease in today's healthcare environment.

1. Know when the time is right to make a purchase. There are two main reasons why ambulatory surgery centers purchase new equipment: to stay updated with new services coming into the surgery center or to attract a new specialty with the best equipment available. This equipment should improve patient care and enhance the surgeon's experience.

"If the local hospital and other ASCs in town have high definition technology and you're still on standard definition, you're not going to attract the market share you would want because you don't have the equipment to support what the market wants," says Mr. Smith.

ASCs must stay attractive in today's competitive healthcare environment.

2. Look at capital expenditures over the next five years. Before purchasing new equipment, surgery center administrators should complete a capital budget analysis that considers all capital acquisitions that will be made over the next five years. Research how those acquisitions will impact your capital budget and set the appropriate benchmarks for payment.

"On each of the items you plan to put into a capital budget, do research to create a return-on-investment report," says Mr. Smith. "Show your board how the investment in new equipment will yield new cases and how long it will take before the equipment will pay for itself."

Once you've finished that process and presented it for board approval, focus on scheduling the purchases to respect the cash you have on-hand or make time to obtain financing on individual items.

3. Collect quotes from different vendors. Once you've determined which projects you want to move forward, gather quotes from different vendors and compare products. Mr. Smith directs surgery centers to distribute a standard terms document when requesting a quote for capital equipment that outlines terms for delivery, payment and warranty.

"That information is written in a single document and we ask companies to quote equipment using those terms," says Mr. Smith. "We also ask the center's group purchasing organization to review the quotes and make sure the fine print is acceptable and congruent with the GPO's pricing and contract."

Most GPOs have a quote review product which can really assist surgery centers when making their final decisions.

4. Access available capital. You may need to seek additional financing for big ticket items. This process can take several months from initial conversations to closing negotiations and will likely include back-and-forth between parties. Traditionally, surgeons sought financing from banks, but other opportunities now exist to access capital, such as private equity or other healthcare-specific lenders.

"There are many different ways to finance capital acquisitions, whether you are leasing or purchasing the equipment," says Mr. Smith. "However, working through these options takes time and research."

Make sure you know how long it will take to pay off the equipment and realize a return on investment. Timeframes depend on the type of equipment, but generally Mr. Smith likes to see an ROI in less than 24 months.

5. Coordinate installation and training. Surgery centers can order equipment and have it delivered onsite within a few weeks, but surgeons must wait for the company to install it and train their employees. Sometimes it takes a while before the company is able to send a representative onsite, which spells trouble if the surgeons have speedier expectations.

"Highly anticipated items coming to the market often means you'll have to wait longer for someone to install it and train your staff," says Mr. Smith. "Sometimes these smaller companies only have a couple of installers for the United States, so you want to make sure you get on their calendar. Managing physician expectations is important because surgeons usually want the ability to use the device right away."

Discuss this process with physicians so they know everyone must be trained and checked off before the equipment is put into service. ■

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Get Paid More for Ophthalmology Cases: 4 Tips for Surgery Centers

By Laura Miller

Here are four tips for ambulatory surgery centers to maximize reimbursement on ophthalmology cases.

1. Renegotiate your contracts regularly.

The more often you renegotiate payor contracts, the better your contracts will be. The constant back-and-forth allows you to more frequently update reimbursement based on the market and regular interaction leads to the formation of a closer bond with the insurance company.

“Go back as often as possible and look at the contracts so you can seek reimbursement increases whenever and wherever possible,” says Dan Connolly, vice president of payor contracting for Pinnacle III. “In the contracting world, if you go back to the payor after letting the contract lapse and roll over under the evergreen clause for several years, it’s extremely difficult to make up that lost yardage.”

You can renegotiate increased rates and tie them to a 12-month fixed term. Begin the conversation again after eight or nine months to make sure you have time before the contract rolls over.

2. Leverage your relationships with payors.

If you negotiate with the same people at the insurance company every year, you can leverage that relationship for better rates. If possible, meet the person you negotiate with in person instead of over the phone. You’ll have the benefit of reading their body language and they’ll be able to see yours.

“There’s a night and day difference of how you pick up on things and responses in person versus over the phone,” says Mr. Connolly. “If you watch the presidential debates on TV, you’ll have a different experience than listening to them on the radio. If you’re just listening, you lose the non-verbal communication and all you can do is take what people say at face value.”

Once you have their attention, be prepared to describe your case mix, cost per case and other aspects of your business that depend on fair reimbursement rates.

“In a recent negotiation for a multispecialty center, we successfully secured a carve out on ophthalmology codes as a deal closer,” Mr. Connolly states. “We were able to increase reimbursement by leveraging other aspects of the center — orthopedic cases — that would remain in the hospital at a much higher cost to the payor if we could not close the deal. If the payor wouldn’t step up on reimbursing for cataract procedures, we wouldn’t move forward. There was more savings on the overall package, so the payor agreed to better reimbursement for cataract procedures, resulting in a 40 percent gain on the carve-out.”

3. Collect and leverage data on average payor rates.

In some cases, commercial payors will try to negotiate a rate well below the average reimbursement for a particular procedure. You can use general reimbursement data from other commercial payors in the region and, in some situations, even Medicare to support your case for higher rates.

“Show them the comparison on top volume ophthalmology procedures,” suggests Mr. Connolly. “Over the last five years Medicare reimbursement changes have occurred with many of those procedures. Some may reflect moderate to significant increases on Medicare’s end. If a commercial payor’s reimbursement to the facility was previously based on a multiple of Medicare’s reimbursement and the payor’s rates haven’t increased over the past few years, use Medicare rates to demonstrate credibility for rate increases.”

You can also use blind data to illustrate the average reimbursement of other payors and work with the insurance company to shore up that gap.

“You really have to lay out your evidence-based negotiation and show the payor where their reimbursement is deficient and what the facility is comparing them to,” says Mr. Connolly. “For example, a glaucoma laser procedure didn’t pay well at ASCs, but Medicare increased reimbursement by 35 percent. That’s a potential case that could be brought to the center since there is adequate reimbursement from Medicare. If the commercial payor can’t increase reimbursement to provide the facility with a reasonable margin, that procedure will have to stay in the hospital at a higher cost to the payor.”

4. Be aware of new groupers. Insurance companies are enhancing their own methodology to move more unlisted codes into groupers. There have been significant changes to procedures and codes that were initially considered unlisted moving to groupers.

“They’ll tell you they just want to assign more procedures to groupers and will give you a 5 percent increase in those groupers, but more often than not there have been other changes that impact the bottom line,” Mr. Connolly notes. “In a recent situation, we performed a thorough grouper cross-walk by procedure. Had we simply accepted what we were being told by the payor, the facility would have ended up with a 32 percent deficit overall after adjusting for utilization.”

In this case, know what you can save the payor and show them what cases historically went to the hospital that you are now doing in the ASC. Let them know that if the reimbursement isn’t high enough, the cases won’t be performed in the ASC and the insurance company will have to cover the full hospital rates. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

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5 Core Concepts to Drive Revenue at Ophthalmology ASCs

By Laura Miller

Kim White, a consultant with Numerof & Associates, discusses five core concepts for driving revenue at ophthalmology surgery centers.

1. Stay updated with quality data reporting.

As of October 1, Medicare-certified ASCs must submit CMS outcomes and quality data; if they don't, they could see a 2 percent annual payment reduction, which is significant for surgery centers serving Medicare patients.

"For surgery centers, this is new territory," says Ms. White. "They need to know what to submit, when and what format so they can protect reimbursement because that's important. Protecting reimbursement is a key part of the broader strategy for the center."

For some ophthalmology cases, Medicare is actually reimbursing at a higher rate than in the past. You want to show them, as well as other payors, the value of higher reimbursement for these procedures.

"With added benefits comes added responsibility," says Ms. White. "If CMS sees more dollars flowing from them, they are going to want to see the impact of their investment. Surgery centers should meet and exceed quality baselines."

2. Demonstrate the value of additional services at the center.

Many patients covered by Medicare will need cataract surgery, or other typical degenerative procedures, and patients may be willing to pay additional out-of-pocket costs for services that Medicare doesn't cover if the center can show them why it's worth it.

"Having data showing why they should select these extra services and pay that premium will help surgery centers capture additional out-of-pocket revenue," says Ms. White. "Medicare will pay for some basic procedures, but it doesn't necessarily cover all technologies."

Extra services to enhance care could also be a valuable marketing tool for the surgery center, especially if you can feature your own outcomes improvement relative to the current standard of care.

3. Know your audience when touting outcomes.

Surgery centers must market directly to patients, local surgeons, referring physicians and payors to drive a steady stream of patients into the ASC. All groups are looking for positive outcomes data, but not all presentations should be the same.

"If there are no outcomes, there will be no income," says Ms. White. "Present information in a way that the audience will understand. A consumer may not understand the relative importance of a seemingly small statistical difference. A clinician is another story; they understand it could make a significant difference."

Take time to develop different presentations for the different audiences and help them understand the significance of your data for their situation.

4. Invest in new technology. Even though new technology might not be covered by Medicare, having it available for patients who want the added value could enhance your surgery center's revenue. Eventually, these technologies may show a broader clinical and economic benefit and could be covered in the future.

"The traditional methodology may still give good results, but if the new technology is better, some people are willing to pay for that," says Ms. White. "You want to show the clinical and economic benefits of the additional dollar."

Clinical benefits could include better precision and reproducible outcomes. Economic benefits could include faster functional improvements or quicker return-to-work times.

"A surgery like LASIK was initially very expensive for patients, but as more evidence was developed to support it as a viable solution, more people sought the procedure and prices went down," says Ms. White. "As additional advances are made to medical devices in other areas, they can leverage those for better outcomes and revenue."

5. Differentiate your surgery center from other providers.

A key aspect of

Kim White



driving case volume and reimbursement is demonstrating why you are better than other providers in the area, which could include other surgery centers or hospitals. Market your good outcomes, positive patient satisfaction and high quality to patients and other referral sources.

"Your outcomes should demonstrate how you differentiate yourself from others," says Ms. White. "You want to demonstrate to the consumer and the payor how you are different and why you should receive the compensation that you ask for."

Another way surgery centers can differentiate themselves is with new technology, as long as it is proven to produce better quality. This is especially important in competitive markets where an ASC's survival depends on demonstrating its success. ■

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How to Fully Comply With Medicare Quality Reporting: 7 Points for ASCs

By Carla Daley Shehata

The following article was written by Carla Daley Shehata, vice president of operations for Regent Surgical Health.

According to the Centers for Disease Control and Prevention, surgical site infections pose significant risks to patients and are the third most commonly reported healthcare associated infections. Surgical site infections increase the cost of healthcare from \$3,000 to \$29,000 per surgical site infection, depending on the procedure or pathogen. This is a cost of up to 10 billion dollars annually.

The CDC defines a surgical site infection as an infection within 30 days after the operation. It can be a superficial infection, a deep incisional infection or an infection involving organ/space. In regards to implant use with deep incisional and organ/space, it is an infection within a one year period. The National Patient Safety Goal 07.05.01 for ambulatory health care gives the best practice guidelines for timelines in tracking SSIs that include implants.

A more detailed definition of each of these types of infections can be found in CDC Definitions of Nosocomial Surgical Site Infections; 1992, which can be accessed at www.cdc.gov.

Now that we have had an overview of the definition and the significant cost that SSIs impose, let's look at some best practices for monitoring SSIs.

1. Infection control program. There must be a solid infection control program in place that follows federal and state regulations along with CDC, APIC and accrediting bodies' recommendations and standards. Benchmarking with national standards should be an important piece of your program. The Ambulatory Surgical Center Association's benchmark for SSIs in the first quarter of 2012 was 0.9 out of 1,000 patients reporting a surgical site infection.

So much has been written on what is involved in setting up an infection control program that I won't get into all the details. Here is a link with CDC references (http://www.cdc.gov/ncidod/hip/SSI/SSI_guideline.htm) that have been very helpful in establishing best practices within Regent centers.

2. Tracking instrument sterilization. The sterile processing department personnel must keep excellent documentation of everything that is

sterilized within the center, as well as the preventative maintenance of all of the equipment required for the sterilization process. These records must be kept in a manner so that any person trying to find information may do so easily.

A best practice that Regent has implemented has been the use of piggyback stickers on all instrumentation packaging when going through the sterilization process. These stickers have the date and load information on them and easily peel off the packaging to then go into the patient's medical record. This makes it easy to track whatever instrument(s) were used back to the specific load without digging through paperwork. This process is also vital when sterilizing implants.

Instruments should never be used in patient care until the biological results have been read. In many of our centers there is a shelf with a large sign that states "Biological Results Pending." These instruments are not used until they have been cleared and are taken off the shelf.

When there is rapid turnover of specific instrument trays the one-hour biological is used. The centers using this method do not have to worry about having to go through their entire sterile storage when a biological reads positive and they know that no contaminated instrumentation was used on a patient.

3. Physician reporting. Having an infection control program established with a means for physicians to easily report infections and complications on their patients is imperative. Within the Regent Surgical Health centers, we institute a monthly reporting process. A form is generated using our IT system. This form is created per physician and has a list of all the patients that had an invasive procedure performed by that specific physician. Making sure that there is 100 percent physician compliance in returning the survey form is not always an easy task and takes a great deal of vigilance.

Having a well-established medical executive committee is definitely essential in helping to achieve and maintain the 100 percent return goal. The members of the MEC can improve physician compliance through peer review and, when necessary, peer pressure. If your facility is not achieving the high standard of physician compliance a good performance improve-

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ment project idea is right in front of you. Once your project is complete review your policies and make sure that they reflect what needs to be done. Take your findings and your reviewed policies to the MEC and the governing board. This process is part of the Centers for Medicare and Medicaid Services 2009 Conditions for Coverage.

4. Following up on reported infections. Once a physician has reported that a patient has an infection, the designated infection control nurse has to become a sleuth. Your infection control program should have a systematic way of researching the patient visit in order to determine if this infection is an HAI or caused from circumstances outside the center. One of the problems that make it difficult to determine the origin of an infection is that many physicians do not culture the wound prior to prescribing antibiotic therapy. Encourage your physicians to culture any surgical sites showing signs of infection.

The patient's medical record is the first place to investigate. Here are a few questions to ask yourself as you review the medical record.

- Did the physician document that there was an infection prior to the procedure?
- Does the history and physical reflect any previous or ongoing issues regarding infection?
- Does the patient have a history of Multi-Drug Resistant Organism?
- Who were the members of the surgical team? Is there a pattern of infections with any of the team?
- Is there documentation that there were signs of an infection once the procedure was initiated?
- Was there an implant? Remember that implant patients are tracked for infections for one year.

- Were there any instruments that were sterilized using the Immediate Use method?
- On the post-operative phone call, were there any significant concerns that the patient may have verbalized?

Once you have answered these questions, it is time to look at instrumentation used. If you used the piggyback stickers that were previously discussed you will be able to go right to the documentation of when and how the instrumentation was sterilized. Was there any chance that the instrument was used prior to attaining a passed biological? Pull and copy all of the sterilization records and attach to your other findings.

If there has been an increase in reported infections it is imperative that the commonalities be found. If it is with one specific procedure with different physicians, then check for damaged instrumentation. If the increase in infections is with one physician and that physician cannot self-identify the problem, have a peer that does the same case review the technique used. In the case where this is the only physician that does the procedure in your facility, contact an outside like physician to review the technique of the physician whose patient infection rates have risen.

The last step is to review the findings and discuss in the infection control or quality assurance committees. Then this information must go to the MEC and the governing board. Be sure that this is well documented in all of the meeting minutes.

The end result of following all of these best practices should be a lower than national average of SSIs within your facility. ■

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