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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

January/February 2011 • Vol. 2011 No. 1

10 Current Issues Affecting ASCs Nationwide

By Rachel Fields

As ASCs enter a period of declining reimbursement, regulatory changes and new ownership models, state ASC associations are attempting to guide their members through budgetary crises and confusing legislation. Leaders and members from six state ASC associations discuss 10 issues affecting ASCs nationwide.

1. Declining reimbursement rates. Across the country, ASCs are struggling because of rapidly declining reimbursement rates — a problem that many facilities unfortunately lack the negotiating clout to reverse. While most ASCs are struggling with the general trend of

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Outlook for ASCs in 2011

By Andrew Hayek, Chair, Ambulatory Surgery Center Advocacy Committee, and President and CEO, Surgical Care Affiliates

While we are optimistic regarding our industry over the long-term, from a near-term perspective, 2011 will be as challenging as 2010. Starting from a very broad economic perspective, we believe the nation will continue a very slow recovery in 2011. Interest rates, inflation and GDP growth will remain low, and unemployment will improve only marginally.

Politically, 2011 will be a year of gridlock. House Republicans will introduce various legislation intended to fulfill campaign promises that will not get through the Senate or survive a presidential veto. There will be even more finger-pointing. Republicans will blame Democrats for a lack of cooperation in fulfilling the mandate they believe they re-

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75 of the Best Gastroenterologists in America

By Leigh Page

The following gastroenterologists were selected based on awards they received from major organizations in the field, leadership in those organizations, work on GI journals and other publications or distinguished service in a GI ASC.

Specialists are listed in alphabetical order by last name. All physicians who are placed on the list undergo a substantial review with other peers and through our own research. Physicians do not pay and cannot pay to be selected as a best physician. This list is not an endorsement of any individual's or organization's clinical abilities. *Editor's note:* Complete profiles are available at www.BeckersASC.com

Edgar Achkar, MD (Cleveland Clinic). Dr. Achkar is vice chairman of the Digestive Disease Institute at the Cleveland Clinic and director of the American College of Gastroenterology Institute. He earned his MD from Saint Joseph University Faculty of Medicine in Beirut, Lebanon, and completed his

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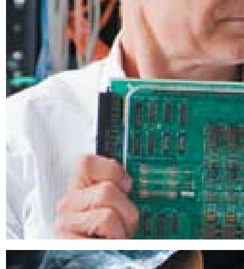

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Publisher's Letter

Healthcare in 2010; ASC Consolidation; 9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

2010 was an interesting year in the healthcare area. The industry saw serious headwinds. These included (1) pressure on case volumes that came principally from the acquisition of practices by hospitals, and (2) pressures on reimbursement. Notwithstanding these headwinds, a great deal of surgery centers and many of the best managed chains survived the year intact and in fact prospered. As the dust clears, it appears certain of the worst headwinds did not place as direct a hit on surgery centers as feared. In fact, in some regards the industry is looking up as people evaluate the future and start to conclude that the independent practice of medicine will survive and that everything will not move towards a national healthcare plan and complete hospital employment.

There was substantial consolidation last year amongst both individual centers and investor-owned chains. Some of the acquisitions involved hospital acquiring surgery centers 100 percent and then turning them into HOPDs. Other consolidation occurred at the chain levels. Finally, the chains themselves acquired individual surgery centers.

We have planned an exciting June 9-11 Orthopedic, Spine and Pain Management Driven ASC Conference. We have the best business speakers in the orthopedic, spine and pain management driven ASC area, some great orthopedic, spine and pain management speakers, plus great keynote speakers. Two confirmed keynotes include Mike Ditka, the famous coach of the Chicago Bears, and Joe Flower, a well known and very smart healthcare futurist. We also have joining us Bill Prentice from the ASC Association.

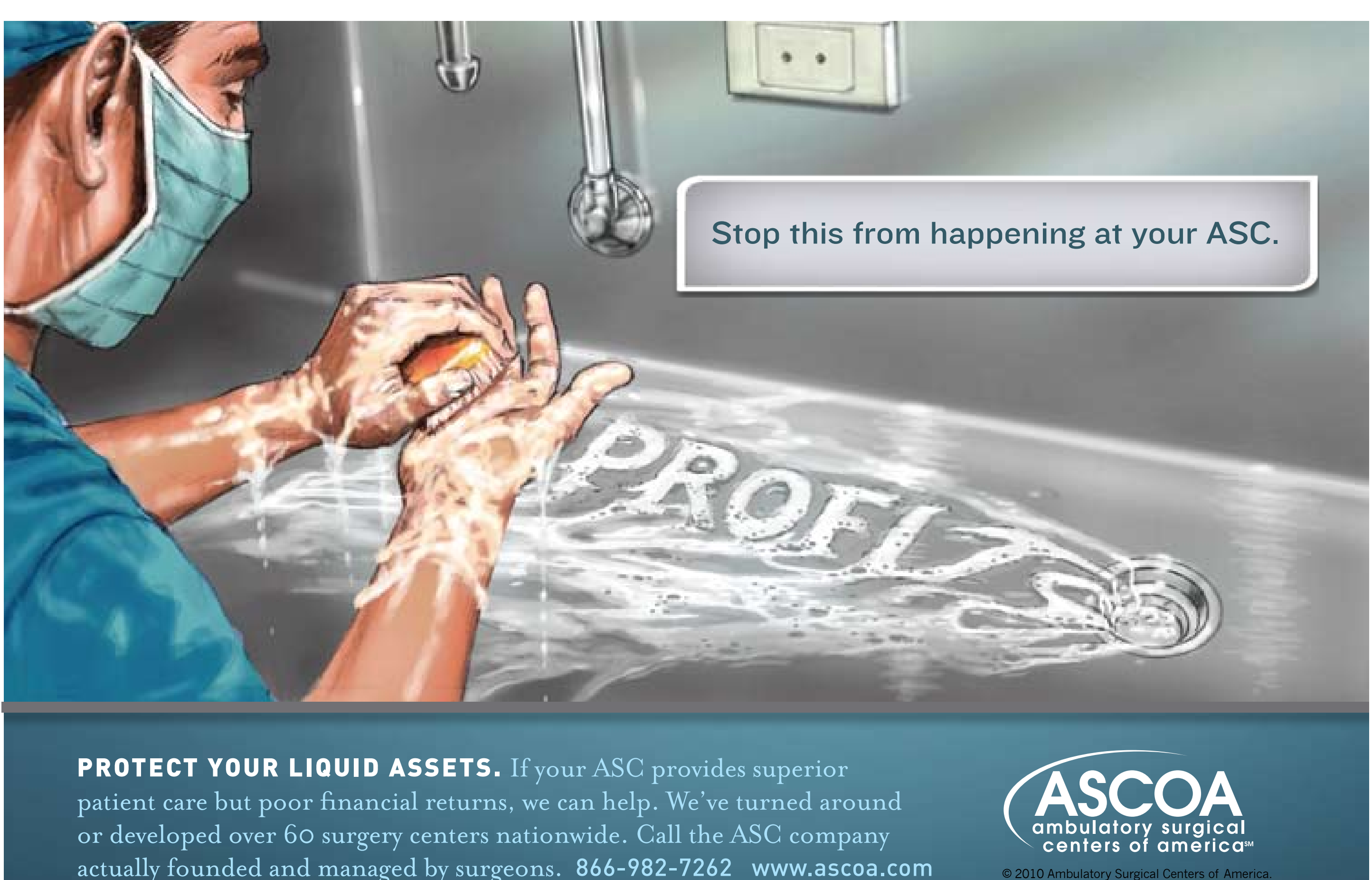
Should you have any questions, please contact me at (312) 750-6016 or at sbecker@mcguirewoods.com.

We are looking forward to a great year in 2011.

Very truly yours.

Scott Becker

P.S. For advertising and business related inquiries, please contact Jessica Cole, president and CEO of ASC Communications, at (800) 417-2035 or at jessica@beckersasc.com.



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Letter to the Publisher: Hospital Power to Fire a Doctor At-Will

Dear Mr. Becker,

As a surgeon and director of a physician group-owned surgery center, I enjoy your newsletter. In an article published in November, "Trend of Hospital-Employed Physicians Causing Concerns About Market Leverage," (*www.beckersasc.com/news-analysis/wall-street-journal-trend-of-hospital-employed-physicians-causing-concerns-about-market-leverage.html*) you referred to the *Wall Street Journal Article* entitled "When the Doctor Has a Boss." This is a particular area of interest of mine, but not for the reasons noted in the article. The problem is that your doctor now has a boss that can fire him at will. As a result, your doctor no longer works for you, he works for the guy that can fire him.

We literally have congressional committees looking at how drug and equipment representatives can have "undue influence" on the practices of physicians, yet no one seems at all concerned that the majority of doctors now are "at will" employees who can be leaned on by some administrator to change their practice so as to maximize revenue. Who is more likely make me do something that might not be in the best interest of my patient — some drug representative with pizza and a logo pen or some suit who can fire me, make me walk away from my practice, pull my kids out of school, sell my house and relocate?

The power to fire a doctor at-will is the power to practice medicine through him. In some states like California, there are laws specifically against the Corporate Practice of Medicine, but I really don't know that they address this issue, which is largely under the radar screen.

I wrote a short blog a couple of years ago about this at *www.whoownsyourdoctor.blogspot.com*, mostly just to organize my thoughts. You may find it interesting. I never really went anywhere with it, but I go back and read it every now and then, especially when my 80-partner multispecialty group practice, where I have been for the last 19 years, gets into it with the local hospital megasystem that has swallowed up every other practice for 50 miles in any direction. Then I smile to myself knowing that I am doing the right thing by not selling out. I only wish I had a mechanism for letting the public know how important it is that their doctor works for them. Those relationships should be reportable, and easily available to the public by law, but they are not. That fact alone should raise suspicion.

Best Regards,

Nick C. Benton, MD
Otolaryngologist, Head and Neck Surgery and Maxillofacial Trauma
Corvallis Clinic P.C.
Corvallis Clinic Ambulatory Surgery Center
Corvallis, Ore.

10 Current Issues Affecting ASCs Nationwide (continued from page 1)

declining reimbursements, some states are currently seeing legislative changes that could lower reimbursement rates even further.

In Alabama, children who are ineligible for Medicaid but cannot afford private health insurance are covered under the ALL Kids program, a health insurance program for children under the age of 19. According to Donna Smith, president of the Alabama Association of Ambulatory Surgery Centers and administrator of The Surgery Center in Oxford, Ala., the program has been "phenomenal" in the past because it has historically reimbursed ASCs at Blue Cross Blue Shield rates.

"But we understand that because of Medicaid eligibility requirements being expanded, some of those kinds [that weren't previously covered] will fall under Medicaid and increase our Medicaid numbers," she says. Since Medicaid reimbursement rates are significantly lower than the current ALL Kids/Blue Cross reimbursement rates, she predicts ASCs will be forced to reject Medicaid cases for children — or accept reimbursement rates that force the ASC to absorb a loss.

2. Lack of reimbursement for implants. Many state associations have seen their state's multi-specialty and orthopedic-driven ASCs struggling due to failure on the part of insurers to reimburse for implants. According to Ms. Smith, the cost of implants in Alabama is significantly higher than the reimbursement rate. "It means that either those cases have to be done at a huge loss, or they have to be sent to the hospital." In a state like Alabama, where the majority of licensed ASCs are multi-specialty facilities, this trend is a major problem for those facilities traditionally replying on orthopedics for revenue.

The same problem faces ASCs in Arizona and Minnesota. According to Stuart Katz, executive director of Tucson Orthopedic Surgery Center and an Arizona Ambulatory Surgery Center Association member, Arizona's Medicaid agency, AHCCCS, recently implemented legislative changes that curtailed coverage of operations that implant insulin pumps. "That change means people will have to go back to needles and insulin, and I don't think [AHCCCS] understands the long-term effects when patients are left to use [needles and insulin rather than implanted pumps]," he says. "They wind up in the hospital, which means the cost benefit isn't there in the long run."

Chris Squire, board member of the Minnesota Ambulatory Surgery Center Association, says the value of ASCs is wasted when payors fail to reimburse for implants. "Our hospital partners are great facilities, but for the more elective cases that can be done in an outpatient environment, we provide quality care and high patient satisfaction, and we can move cases in and out in a much more cost-effective way," he says. "To not get reimbursed seems counter-productive."

3. Low patient volume. As a result of competition between ASCs and hospitals, as well as patient financial woes, many ASCs are experiencing decreased patient volume. According to Mr. Katz, Arizona ASCs — like many facilities nationwide — are suffering from the state's unemployment. He says around 20 percent of Arizona residents use AHCCCS, and many centers are struggling because residents lack the discretionary spending necessary to undergo ASC procedures.

Ms. Smith says while Alabama is "neck-and-neck" with the national unemployment rate overall, rural areas of the state have been af-

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fected at a rate higher than the national average. As patients struggle to pay their medical bills, Alabama ASCs are forced to consider options they might not have accepted in the past, such as long-term payment plans. "ASCs have to do more to compensate for the patient not having out-of-pocket money," she says. "They have to make sure they offer options that allow the patient to pay over time."

4. Impending infection control standards. For many ASCs, the impending expansion of infection control standards poses a problem for financially strapped facilities. Unlike hospitals, ASCs often lack the financial resources to invest in technology necessary for quality reporting and staff members to oversee compliance. Mr. Katz says while Arizona ASCs are currently in a good position to meet upcoming infection control standards, the real issue lies with the people responsible for developing those standards. "If you have a bunch of bureaucrats back in Washington with no practice experience [developing the standards], some of [the standards] may be doable and some may be outrageous." He says ASCs are concerned CMS may publish a zero-tolerance policy for infections that ASCs would find impossible to meet.

Mr. Squire says before ASCs worry about following infection control regulations, associations should work with the state to interpret the guidelines. MNASCA is currently working with Minnesota's department of health to "get on the same page as to the expectations for current regulatory guidelines," he says. "If we have to report infection data within 30 days, [the state needs to understand] we're very dependent on physicians to report back data when we request it."

Mark Mayo, executive director of the ASC Association of Illinois, says his association is working with the Illinois Department of Health to create an adverse reporting mechanism that would let ASCs benchmark their quality control data against other facilities. "Rather than just look at what centers were doing, we felt [the department of health] needed to be more of a resource [to help centers improve]," he said.

5. Moratoriums on ASC development. The New Jersey Association of ASCs is especially concerned with the moratorium on ASC development put forth by an amendment to the Codey Law, says Larry Trenk, president of the N.J. Association of ASCs. The amendment, which was issued in March 2009 and includes revisions to the N.J. anti-self-referral statute, also placed a moratorium on the issuance of new licenses to ASCs by the N.J. Department of Health and Senior Services. Some exceptions include changes of ownership of an existing center, relocation of an ASC to within 20 miles or, with DHSS approval, entities owned in whole or in part by a New Jersey hospital or medical school.

But for most ASCs, the moratorium means no new development. "The moratorium and reimbursement issues are going to have a major impact on the future development of ASCs," Mr. Trenk says. "You may see some centers purchased by outside companies or a hospital that will present them with better leverage in terms of managed care contracts."

6. Increased need for hospital/ASC partnerships. Increased competition between hospitals and ASCs, in addition to declining reimbursement rates, is pushing ASCs in many states to consider joint ventures with hospitals. Mr. Squire says in Minnesota, "it's becoming increasingly difficult to survive without a system or hospital affiliation," which can give an ASC better access to managed care contracts and better GPO leverage.

Ms. Mims says the Texas ASC industry may start to notice a move toward partnerships with hospitals because of the increased emphasis on integrated care models and ACOs. "Most people believe that standalone entities, including ASCs, hospitals and even physician practices, are not going to be able to survive healthcare reform without integration of healthcare models," she says. She adds physicians and ASCS that are aligned with hospitals will be in a better position to implement EMR going forward as well.

Mark Mayo, executive director of the ASC Association of Illinois, says that as more hospitals merge and partner with each other, independent surgery centers may be excluded from physician referrals and see drops in patient volume. But he says a hospital joint venture does not have to be the answer. As 32 million Americans receive coverage for the first time in 2011, presumably individuals will seek treatment for conditions they were not able to get coverage for in the past. He says in order to take advantage of this patient influx, ASCs must work to build relationships with primary care physicians. "We need to provide information to those PCPs who feed cases into surgical practices," he says. "I see that as a way to grow interest in surgery centers, and I think it's an excellent opportunity to partner with physicians."

7. Challenges to out-of-network facility reimbursements. In some states, out-of-network facilities are facing new laws that reduce OON reimbursements or place caps on OON reimbursement rates. In New Jersey, OON ASCs have historically benefited from very lucrative reimbursement rates, receiving on average three times the reimbursement for being OON than in-network. But that trend may be about to change: New Jersey insurance carriers have recently announced plans to tie OON network reimbursement of ASCs to Medicare. Mr. Trenk says if insurance companies are successful in curtailing or controlling the OON insurance level, the power will shift dramatically from ASCs to payors. If insurance companies gain extreme leverage over OON ASCs, he predicts in-network ASCs will also be adversely impacted. "If the most they're going to pay you is a certain percentage of Medicare if you're OON, who's to say they're not going to pay the same thing for in-network?" he says.

According to Ms. Mims, Texas insurance companies are pursuing similar plans. At a recent ASC conference, Ms. Mims heard discussion about Blue Cross Blue Shield announcing OON rates will be tied to Medicare rates. "If these changes occur, that could affect all the facilities that have historically been OON," she says.

8. Cuts to ASC supply budgets. In states across the country, tight ASC budgets mean administrators must look to staffing and supplies — the two most expensive items on a center's budget — to cut costs. Ms. Smith says Alabama ASCs have responded to the economic downturn and tighter budgets by going through distributors to achieve savings on janitorial and office supplies as well as medical supplies. "Those are supplies we [traditionally] didn't purchase with a medical distributor," she says. She says working with a distributor for those supplies can save ASCs money at a time when keeping supply costs low is essential for a center's financial stability.

9. Inconsistency between federal and state rules. In Arizona, the state association is attempting to change an Arizona rule requiring ASCs to document the patient's history and physical on the chart the day before the procedure. "Medicare allows the H&P to be on the chart prior to admission, and Arizona says it has to be on the chart the day before, so there is an inconsistency there," says Mr. Katz. Unfortunately, Arizona Gov. Jan Brewer instituted a moratorium on all new rule-making by state agencies in Jan. 2009 in order to avoid costly, burdensome and unnecessary rules — a decision that prevents the Department of Health Services from changing the H&P rule.

Mr. Katz says the rule should be changed to ensure ASCs do not have to cancel surgeries unnecessarily. "[Physicians] have to assess the patient prior to surgery anyway," he says. "It's not as if it's the first time they're seeing the patient." He says the AASCA would like Gov. Brewer to temporarily lift the moratorium on rulemaking to allow the rule change.

10. Attempts to grow association membership and influence. In order to tackle the changes coming through healthcare reform, many state associations recognize the importance of growing their membership to more accurately and effectively represent the state's facilities. In New Jersey, where membership sits at around 30 percent of all ASCs, the NJAASC would like to increase membership to 50 percent over the next year through an extensive membership drive.

Mr. Katz says the Arizona association has increased membership by lowering dues, a strategy that associations with available finances might consider. "If you lessen dues, you'll create more members," he says. "When we say we want everybody involved, we mean it."

For states with an already-high percentage of ASC membership, the next task may be to connect with other state associations on common issues. The Alabama Association, which boasts a membership rate of 80 percent of freestanding ASCs in the state, holds an annual ASC conference that brings together ASCs from Alabama, Mississippi, Louisiana and northern Florida — states that share similar issues facing ASCs.

MNASCA is working with state legislators to grow awareness of the value of ASCs in state government, according to Mr. Squire. "A lot of it's about education and getting legislators to understand how the healthcare delivery system works," he says. "We're letting them know what our challenges are and how regulatory burdens can add cost without bringing many substantive changes." ■

Contact Rachel Fields at rachel@beckersasc.com.

Outlook for ASCs in 2011
(continued from page 1)

ceived in the mid-term elections. Democrats will argue that Republicans have done nothing with their new power to address the most pressing issues we face, including the economy and deficit.

Expect modest improvement in 2011

From a healthcare industry standpoint, we expect modest improvement in overall consumption for 2011, compared to a weak 2010. Modest improvements in unemployment, personal wealth and consumer confidence will overcome the continued dampening effect of rising deductibles. This will result in flat to very slight growth in overall consumption compared to the decreases we saw in 2010.

We expect the current uncertainty regarding the implications of healthcare reform to continue in 2011. Concepts like bundled payments and accountable care organizations will continue to create fear, uncertainty and very few specifics for hospitals, physicians and most other categories of providers.

We expect the trend of physician employment to continue. It will be driven on the physician side by decreasing reimbursement, increasing complexity, the prospective costs of EMR and greater clinical surveying activity, and the threat of rising taxes. It will be driven on the hospital side by an interest to create greater physician alignment as a prerequisite to creating an ACO or preparing for bundled payments. Physician employment will continue to be concentrated in general practitioners and cardiology, with expansion into other specialties on a market-by-market basis.

Fissures between hospitals, employed physicians

That said, in markets where physician employment has been most active over the past few years, we expect to see the beginning of fissures in employment arrangements, especially as initial contracts coming to term in markets where the hospital is under financial pressure. Original contracts may be amended to the physicians' disadvantage or not renewed altogether.

We expect to see a continuing divergence in the hospital space between the "haves" and "have-nots." Independent community hospitals, which are struggling to maintain break-even economics, will face even greater pressure with lower Medicare and commercial reimbursement increases, and with rising input and technology costs. Larger health systems, both not-for-profit and for-profit, will continue to grow and reap the benefits of contracting power for revenue and cost and will continue to deploy capital by adding new facilities and physicians.

We believe the moratorium on surgical hospitals will remain unchanged in 2011, and the heightened transaction volume for surgical hospital consolidation will continue in 2011, as legislative clarity opens up the market to a range of buyers.

Prospects for ASCs in 2011

In the ASC space, we expect a modest improvement in volume trends, compared to 2010, and continued pressure on reimbursement.

Turning to case volumes, we estimate they declined approximately 5 percent across the industry in 2010. We expect this trend to improve modestly next year, although case volume growth for the industry will likely remain negative.

We expect reimbursement rates across the industry to increase at a similar rate next year, by roughly 2 percent. In the final year of the phase-in of new rates, GI and eye centers will face more Medicare reimbursement reductions. Overall, Medicare rates will increase 0.2 percent in 2011. We expect the final rule next year to reflect an update of zero to 1 percent for 2012.

Although the average Medicare reimbursement change will be roughly flat, there continues to be disproportionate opportunity in certain specialties, due to shifts in RVUs in certain CPT codes and specialties.

The pressure on out-of-network reimbursement will continue. Buyers of surgery centers will discount virtually all profit value of out-of-network reimbursement. This pressure will be particularly acute in states like New Jersey, and many ASCs will face significant changes in their economics.

We expect continued pricing pressure from implants and other medical-surgical supplies, the average price of which continues to grow, despite flatter reimbursement and continued volume pressure. Surgery centers will continue to increase the sophistication with which they address supply purchasing. This is something we are highly engaged on and have seen significant positive impact on our implant, medical, and surgical supply costs as an organization.

Net number of ASCs won't grow much

We expect another year of little to no growth in the total number of ASCs. This year will be the first year on record in which there was almost zero growth in the total number of Medicare-licensed ASCs. New ASCs continue to be built in select markets with committed groups of physicians. However, there is now a roughly equal number of ASCs that are closing or converting to hospital licenses. We expect this general trend to continue in 2011.

Clinically, we expect continued negative press regarding infection control. The results of Medicare surveys will likely reflect modest improvement in adherence to the new infection control practices outlined in the expanded Conditions for Coverage. However, the portion of ASCs with one or more deficiencies will draw significant negative press coverage and significant attention on Capitol Hill. This coverage is particularly disappointing, given that it implies the risk of infection is higher in ASCs than in other settings. This is an implication that we believe to be false and misleading to healthcare consumers.

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Greater use of quality measures

From a positive standpoint clinically, we expect greater utilization of the NQF endorsed quality measures by ASCs, allowing the industry to better articulate the outstanding clinical outcomes we provide. We hope there will be material progress in towards reaching the point where there is a valid measure of actual infection rates, such that the safety of ASCs can be compared to hospital outpatient departments. When such data becomes available, we believe the results will be favorable for ASCs and shift the discussion regarding infection control.

We expect to see consolidation to continue in 2011 at a similar rate as this year, mainly through individual centers continuing to join larger organizations, as has been occurring for many years. The largest ASC companies will continue to add ten or more ASCs each in 2011, and we expect the uncertainty around healthcare reform and volume trends to cause EBITDA multiples to decline. The average trading multiple of the publicly traded ASC companies has declined to six to seven times EBITDA, and hospitals and skilled nursing facilities are trading at six times EBITDA. When you adjust for the lack of liquidity in a single-site transaction, this implies a range of high fours to mid fives for individual surgery centers in the foreseeable future.

Looking forward to strong federal advocacy

In terms of federal advocacy, we are very optimistic regarding the leadership of Bill Prentice, ASCA's new executive director. We are hopeful more ASCs will join ASCA and begin to participate in the political process — engaging with lawmakers, making political contributions, and staying connected to the industry's work. We firmly believe a higher level of political engagement is critical for the industry, given that our aggregate spending on lobbying and political contributions is a small fraction of other healthcare provider groups. The American Hospital Association, for example, outspends ASCs by 30 to 1 in lobbying and 50 to 1 in political fundraising.

We continue to view the industry as shifting to a very new phase – that of a mature market, similar to dialysis, radiation therapy, and home health. The era of rapid growth in case volumes and in the number of ASCs has ended, and the new era will be defined by slow case volume growth and consolidation.

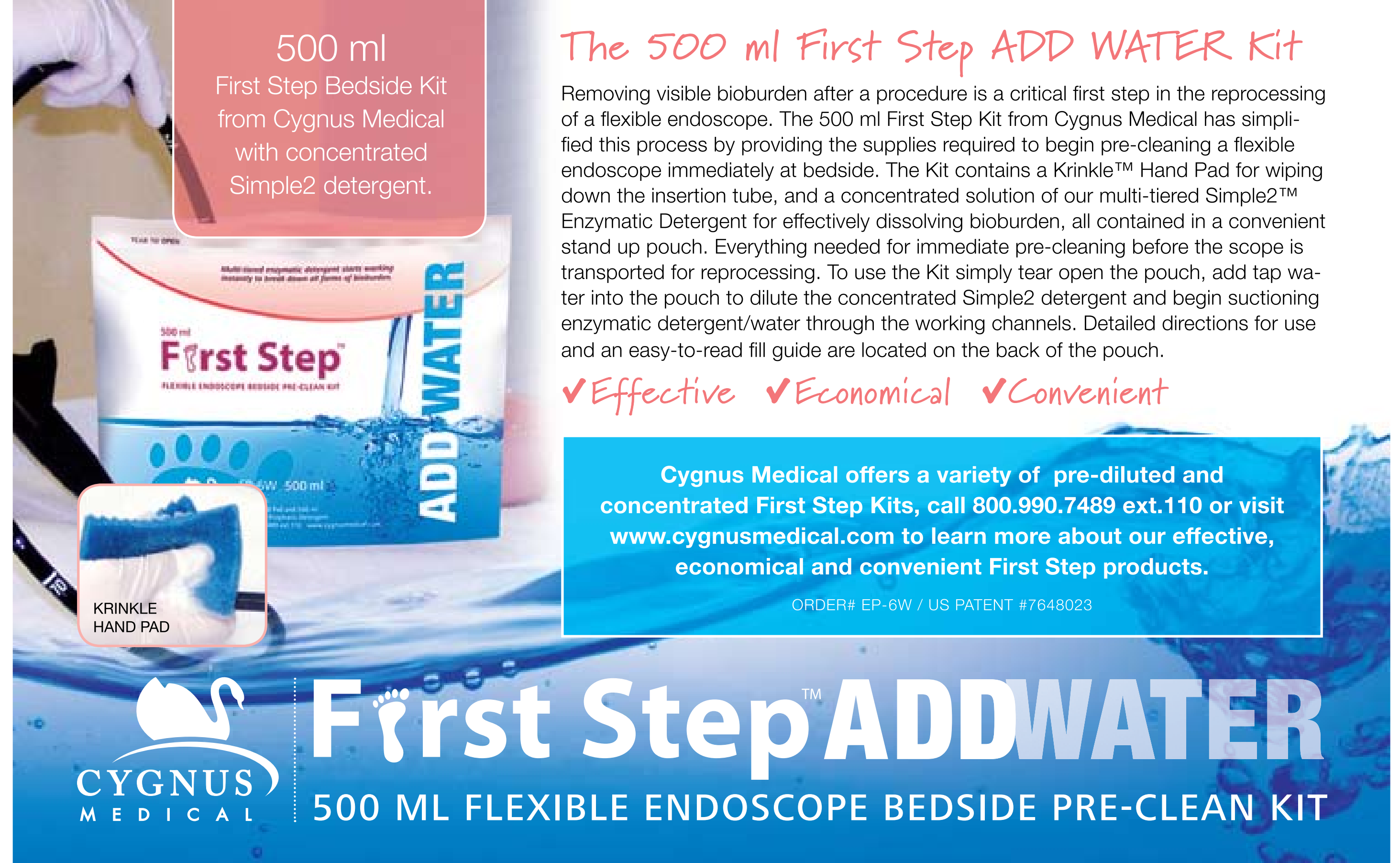
Consolidation will continue. Organizations that can provide differentiated levels of support and efficiency to individual centers in areas like clinical services, supply costs, training, and informatics will be in increasing demand. Physician owners of stand-alone centers will continue to explore options to maintain their independence and their economics in the face of volume, rate, cost and regulatory pressures.

ASCs have bright long-term future

Over the long term, we are highly optimistic about the role ASCs will play in the healthcare delivery system. With increasing focus and urgency regarding quality, cost, and access, we believe consumers and payers will continue to seek out the ASC setting, especially with greater transparency of cost and quality.

Ultimately, we are passionate about this space for the same reason we believe greater transparency will benefit the industry. We know ASCs deliver outstanding value to patients and the healthcare system. ASCs are the high-quality, low-cost setting for routine outpatient surgery, and we are proud of the role they will continue to play in improving U.S. healthcare. ■

Learn more about the Ambulatory Surgery Center Advocacy Committee at www.advancingsurgicalcare.com.



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6 Things to Know About ASC Reprocessing

By Rob Kurtz

With supply costs as one of the top two expenses for surgery centers (staffing is the other), more and more ASCs are purchasing reprocessed devices, which help to reduce costs, among other benefits.

Scott McDade, vice president, surgery center sales, with McKesson Medical-Surgical, discusses six things ASCs should know about using reprocessed devices and establishing reprocessing programs in their facilities.

1. Reprocessed devices are safe and effective. Reprocessed devices go through an extensive decontamination, inspection and sterilization process that ensures they meet or exceed federal requirements for original manufacture of new devices. To learn about the required steps a common ASC device goes through when it is reprocessed, you can read "5 Critical Steps in the Reprocessing of Single-Use Devices" on **P. 14.**

2. Amount of work for the ASC is minimal. For an ASC to establish a reprocessing program, it first needs to partner with a reprocessor. The reprocessor then supplies the ASC with a designated bin for reprocessable devices and instructions for preparing devices to be placed in the bin, which may include a simple decontamination of the devices. Then the ASC either mails the devices to the reprocessor or the reprocessor may retrieve the bin.

"Quite often it's as simple as educating staff on which devices need to go in the reprocessing bin — building the habit of throwing a device in the reprocessing bin rather than throwing it in red bag waste," says Mr. McDade. "Some facilities actually create incentive programs for their techs to reprocess in order to maximize the savings."

You can learn about one successful ASC program by reading "Developing a Successful ASC Reprocessing Program" on **P. 18.**

3. Savings opportunities are significant. While there are a number of different pricing formulas to determine the true cost of a reprocessed device, it is, on average, around 50 percent of the cost of a new device, says Mr. McDade.

"That is significant money and every one of our customers is looking for savings opportunities," he says. Additional savings are achieved by reducing the amount of red-bag waste.

4. Thousands of reprocessable devices. Thousands of devices used by ASCs can be reprocessed. Devices that can be reprocessed, according to reprocessor SterilMed, include the following categories:

- Trocars
- Arthroscopic shavers
- Laparoscopic instruments
- Compression sleeves
- Imaging and EP catheters
- Biopsy forceps
- Drill bits
- Saw blades
- Pulse oxisensors

Orthopedic blades are commonly used in ASCs and are reprocessable, says Mr. McDade. "A lot of people think you can't reprocess a blade because it has been leaned on, pushed on or bent, but the reality is they're brought back to the exact manufacturer's standards that were required for a new blade."

5. One-hundred percent reclamation rate is an option and turnaround time is fast. Many devices sent to reprocessors are disposed of if they fail to pass the required, stringent tests. But ASCs can still receive an equal number of devices back from reprocessors as the number they send for reprocessing, says Mr. McDade.

"Customers have two options; they can just get back what was reprocessable of the devices they send in, and that's roughly around a 75 percent reclamation rate, or they can choose to get 100 percent back," he says. "If the customer chooses to receive the same number of devices as what they sent, they will receive 25 percent of devices accumulated by the reprocessor from other facilities."

Reprocessors have developed efficient processes that allow them to turn around stock in roughly 3-4 weeks, Mr. McDade says. "Once you get up and going, you're getting product back on a weekly or bi-weekly basis. It works like a continuous replenishment program," he says.

6. Reprocessing is environmentally friendly. While cost saving is the primary driver for facilities, many also find the environmentally-friendly component appealing. "You're re-utilizing instruments rather than putting them into landfills," says Mr. McDade. Reprocessors divert millions of pounds of waste from landfills annually, he says.

This is a significant reason why McKesson encourages its clients to consider reprocessing programs.

"It's very important to our customers that we provide safe, environmentally friendly solutions that also save money," says Mr. McDade. "With reprocessing, we can meet all three of these challenges with one solution." ■

Learn more about McKesson at www.mckesson.com.

5 Critical Steps in the Reprocessing of Single-Use Devices

By Rob Kurtz

In 2000, the FDA began to view and regulate all companies reprocessing single-use medical devices in the same way it viewed and regulated original equipment manufacturers (OEMs). Before returning reprocessed devices to providers for use, these reprocessors must conduct studies and submit all required 510(k) documentation to the FDA as if they were seeking to market a new device. The 510(k) documentation indicates the reprocessed device is as safe and effective as the original version of the device.

"Essentially what we are obliged to do when we submit our 510(k) documentation is specify a device's design characteristics," says Bruce Lester, PhD, vice president of R&D for reprocessor SterilMed. "We do that by

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spending time disassembling these devices, finding out how they are put together, what they are made of, the identity of the polymers and lubricants, how they're constructed and then we begin to test for functionality, cleanliness and for sterility to ensure our processes will result in clean, sterile and functional devices."

In some respects, reprocessors must meet even stricter requirements than the OEMs. Since reprocessors will reprocess some devices several times, the companies must demonstrate that the device does not degrade during repeat reprocessing.

"If we say a device can be reprocessed four or five times, we must test this device repeatedly and run it through simulated use," Dr. Lester says. "The simulated uses are worst-case situations and then we show validation for these scenarios. The idea is if you can clean or bring the device back to function or sterilize it from the worst cases then you can certainly do it for the intermediate stages."

The reprocessing processes vary amongst the reprocessing companies but all must meet these requirements as well as other regulations and periodic inspection audits. If physicians at your ASC are hesitant to consider using reprocessed devices, it is helpful to learn more about the process from reprocessing company representatives and, if possible, visit a reprocessor for a tour and demonstration. These experiences will help alleviate concerns over the safety of using reprocessed equipment.

To provide you with an initial understanding of some of the extensive tests reprocessed devices might go through before returning to an ASC for additional uses, Dr. Lester highlights five of the critical steps in SterilMed's reprocessing of a harmonic scalpel, an instrument commonly used by ASCs for minimally invasive and open surgery.

1. Onsite preliminary decontamination. One of the first steps in the reprocessing process might occur in your ASC. SterilMed suggests that ASCs put the devices through their on-site decontamination process. "Our notion is that the way you can clean these things most easily is you have to do some preliminary decontamination on-site," Dr. Lester says. "It doesn't need to be an extensive process. For the harmonic scalpel, it might be as simple as a rinse or short soak in a detergent solution that digests protein or lipids, or simply wiping it off with an antiseptic wipe before putting it in the retrieval bin. That really increases the number of devices that can effectively be reprocessed."

2. Decontamination. Once collected at your ASC, the device is shipped to the reprocessing facility. SterilMed then conducts its own extensive cleaning and decontamination process. Devices are cleaned and decontaminated using various, stringent and proprietary procedures, Dr. Lester says.

In the case of a device like the harmonic scalpel, the team at SterilMed takes great care in examining each individual device during the process. For example, they are particularly concerned with a potential contaminant finding its way past the first bushing that holds the scalpel shaft. "The harmonic scalpel shaft is a titanium shaft that vibrates at very high rates and there are little bushings that center the blade and hold the inside of the shaft so that you get proper frequency," he says. "Sometimes tissue or blood might get by that first grommet so we're very concerned with making sure we evacuate that chamber, clean it and check the jaw pad," which presses the tissue up against the scalpel blade itself.

During this process, the scalpel will go through several different processes to not only ensure the device is decontaminated but also to remove all fluid that was used in the cleaning of the device. "It's very important to remove that fluid because it can act as a shield against ethylene oxide," a gaseous sterilant used by many OEMs, Dr. Lester says.

3. Individual visual inspection. Every device is visually inspected by trained professionals, Dr. Lester says. These individuals are looking for a number of problems that could lead to SterilMed rejecting the device for reprocessing. These include any nicks, scratches, discoloration, physical abnormalities and other damage — anything out of the ordinary from a brand new device. If any flaws are present, the device is recycled and not sent back for re-use.

"The people inspecting these devices might have seen hundreds each day allowing them to note visual flaws more readily," he says. In addition, the inspectors have pictures in front of them which show exactly what disqualifies the device from being accepted. It is at this point that we make a decision as to whether or not the device has passed and is something that can be returned to an end-user."

4. Generator tests. Many of the devices SterilMed reprocesses, including the harmonic scalpel, are plugged into generators or power supplies when they are used by physicians for procedures. These generators often have their own set of internal self-tests to ensure the device is in working condition. For example, the harmonic scalpel would be plugged into the Ethicon Harmonic Scalpel Generator 300 to test the scalpel, and this generator is extremely sensitive in picking up the frequency of the device. Dr. Lester says. SterilMed will plug the scalpel it is reprocessing into this generator and run the internal tests.

"The diagnostic self-test used by the generator produces an ultrasonic signal at a frequency near the device's own resonance frequency," he says. "When internal phase and impedance detectors in the generator indicate that the resonance matches a specific and known range characteristic of the blade it indicates the physical status of the blade. If there's any sort of discrepancy whatsoever, it will reject the blade — for example, if there's a flaw in the blade, if there's a nick, if there's debris or even water — we've actually seen this generator pick up any sort of moisture left on the device."

5. Sterilization. One of the final steps in the reprocessing process is sterilization of the device. To confirm the success of its sterilization process, SterilMed will validate it by spiking test devices with microorganisms and then re-testing them after sterilization to ensure the process kills all microorganisms, Dr. Lester says.

"Particularly we want to make sure it kills these microorganisms much better than the biological indicator which goes along with these devices as they are sterilized," he says. "That biological indicator tells the quality inspector that the ethylene oxide sterilization process has been successful. This is accomplished by doing what is called a 'zero time' or chamber filling incubation with ethylene oxide. The chamber is then evacuated and we compare the number of killed spiked spores with the biological indicator spores killed to insure that the BIs are more resistant to ethylene oxide sterilization." SterilMed utilizes an industry leader in sterilization, Steris Corp., for all sterilization activities. Steris is a major provider of sterilization programs for many of the OEMs.

After completion and validation of the sterilization process, the scalpel is then shipped out to ASCs for re-use. ■

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Developing a Successful ASC Reprocessing Program

By Rob Kurtz

Dominica Pelshaw is materials manager for Bone and Joint Surgery Center of Novi (Mich.), a four-OR ASC with about 16 physician-users.

Q: When did your ASC establish its reprocessing program and what type of program do you have in place?

Dominica Pelshaw: Our center has had a reprocessing program for approximately a year and a half. We started with arthroscopic shavers and burrs and added ablation wands shortly thereafter. Our surgeons decided they wanted limited use reprocessing and our items are disposed of after the second use. The typical life span is 4-5 times.

Q: Why did you start a reprocessing program?

DP: Our operation is a joint venture with hospital and surgeon-investors. There were many suggestions of where to cut costs and this was an easy transition as most of the surgeons had used reprocessed items at other facilities.

Q: What type of savings has your ASC seen since starting the program?

DP: Our center has saved approximately $30,000.00 over the last year and a half.

Q: What do you reprocess?

DP: We reprocess shavers, burrs and ablation wands. It's important to note that you cannot sharpen burrs. All items are tolerance tested, cleaned and reprocessed accordingly.

Q: Did you face any challenges bringing your physicians on-board with establishing a reprocessing program?

DP: The transition was somewhat uneventful. Most of the surgeons had used reprocessed items. It is important to note that all the reprocessing companies I've worked with have stood behind all their products. We have had only incident of failure due to performance with our last company, which is similar to new items that have had performance failure.

Q: What are some of the best practices you use to maximize the benefits of reprocessing?

DP: In each of our operating rooms there is a list which indicates what can be reprocessed. All items are returned to our central processing department and visually inspected. Anything that is damaged is disposed of and all other items are decontaminated per reprocessing guidelines.

My feeling is that all items should be returned to your reprocessing facility. All the companies we have used don't charge for damaged items returned; they simply dispose of them.

Q: For ASCs that do not have a reprocessing program, why would you suggest they seriously consider one?

DP: Financially it just makes good sense. The company we presently use will backfill your order with identical product if our product cannot be returned. That means if I send them 50 and 10 do not pass their quality control, they still send me 50.

It's not going to hurt you to implement the program. You're not going to lose anything except half the cost of the product, which isn't losing anything at all. The most important thing is to "get on board" with sending everything to central processing that can be reused. You [allocate] very little manpower to reprocessing other than the cleaning of your disposables. ■

Learn more about Bone and Joint Surgery Center of Novi at www.ascnovi.com.

ASC Quality Collaboration Issues Free Single-Use Device Reprocessing Toolkit

By Rob Kurtz

The ASC Association has announced that a free toolkit on single-use device reprocessing is now available from the Ambulatory Surgery Center Quality Collaboration.

There are two toolkits available: a basic and expanded version. The basic version includes information about what CMS surveyors are looking for and a policy template for reprocessing of single-use medical devices.

The expanded version includes the resources found in the basic version as well as assessment tools, training materials, guidelines from authorities and other resources.

View the single-use device reprocessing toolkit at www.ascquality.org/SingleUseDeviceReprocessingToolkit.cfm. ■

McKesson Medical-Surgical, based in Richmond, Va., is a leading distributor of medical-surgical supplies and equipment to physician practices, surgery centers, home care and extended care facilities. McKesson Medical-Surgical helps manage the business of healthcare through advanced supply chain models, technology and software, and by offering comprehensive solutions to healthcare providers across the country.

Benchmarking Ambulatory Businesses

By Robert J. Zasa, MSHHA, FACMPE, Founder and Managing Partner, ASD Management

How do I measure up? Against what criteria? Who is the judge to say that we meet or not meet standards? Who establishes the standards? These are common questions when the topic of benchmarking is raised within the health services management community. It sounds good in principle, but how many managers really want to be measured? And if they do, how good are the measurements of the standards of practice?

The purpose of this article is to describe a method that is an objective, yet practical method to use quantitative data to compare a healthcare organization's performance against a set of standards that will ultimately result in better financial and management performance for the healthcare organizations.

Benchmarking is a phrase used to describe the activity of measuring one's performance against standards of performance. Many times it is hard to find such legitimate standards for similar businesses. If such standards exist, such as the MGMA's *Cost Survey Report* for group practices, these standards can be of great benefit to improve the organization. However, many times there are not standards for the operations of ancillary businesses such as surgery center, pain management, diagnostic, comprehensive women and men's health centers, complimentary and alternative care centers, or other new programs, or, as I like to call them, ambulatory businesses. It is therefore important to first establish one's own benchmarks of performance and try to improve on them. If a similar database is available, this is can be of great value; however, setting ones own standards are extremely important.

Each ambulatory care program should be developed and run like a freestanding business. At the Sloan School of Management at MIT in Cambridge, Mass., research was done on how businesses were run successfully. Being a business school based at an institution strong in engineering, many of the factors were quantified. What resulted in the studies was a remarkably simple, yet powerful tool called "Critical Success Factors" (CSF). CSF should be measured in each business. The premise is that in any given endeavor, including a business, there are no more than a dozen factors that are critical to the success of that endeavor. In examining managers and businesses that had been very successful, those managers identified and focused their and their management team's efforts on the basic principles of the business. It is like the Vince Lombardi school of football: He was a great coach, motivator and manager. The key to the Green Bay Packers success under Vince Lombardi was that Lombardi took very complicated things and he simplified them (not over-simplified them). He stressed performing basic tasks extraordinarily well. He said, "You know whoever runs the fastest, catches the most balls, makes the most tackles, monopolizes the time in the field with the ball usually wins the game." He practiced the fundamental skill sets and concepts of the game, and won a lot.

Dr. Warren Bennis, a past professor at MIT and the time who is now at the USC Marshall School of Business, looked at various businesses, and it seems to him that there were no more than maybe 10-12 critical factors for a business to succeed. He called them the Critical Success Factors. He proposed that, "If one does a very good job of those 10 basic things, and executes those tasks well, and measures them routinely, the businesses usually succeed. It is significant to inculcate that thought process into all the people that are on the team. Those in an organization should share those same 10 common denominators, and make them part of that organization's corporate culture."

Applying CSF to ambulatory businesses

I have applied CSF in five companies I have run, a 500-bed hospital with 95 different departments and eight satellite ambulatory centers, a division of public company, a separate public company and two private firms representing over 150 different ambulatory care businesses in 40 U.S. states. The process really does work. It is a very inclusive process. There are educational pieces to it, and these factors do change based on the business. I have 10 factors for occupational medicine businesses that I have run which are different ones than for the surgery centers we operate. There is another 10 for diagnostic and breast center ambulatory businesses. As you are measuring different aspects of the business, and every business it's a little bit different than the other, there are different critical factors for success. Each business has it own nuances. It is the manager's role to identify those critical to the success of that particular business. One must build consensus around those factors by educating the staff and physician partners as to why those factors were selected, and then finalize those factors and make them part of the every day priorities of that ambulatory business.

If you have similar types of businesses like satellite ambulatory centers, urgent care centers or surgery centers, you can establish your own benchmarks.

In our case, we took a look at all of our surgery centers, and defined what 12 factors were critical financially to the success of a surgery center. I first did this in 1979. Over the years, most of the factors have not changed except for managed care. We use the CSF at each center, explaining them in detail to the staff and the physicians that use the ASC. We emphasize that if we implement and focus on these factors to the best of our collective abilities, the smaller issues will take care of themselves and we will succeed. This has been a very successful tool for any ambulatory business where it has been applied.

The best part of the CSF system is it focuses all of the key players of the business on the important things. We stay on point. We all share in the joy of "exquisite execution" of those key factors. It simplifies work in a creative and productive way. It allows employees to measure their success objectively each month. We can jointly look at the factors at the end of the month and know how well we did or what areas in which we can do better. You cannot hit the bull's eye of a target unless you can see the rings clearly. CSF focuses all the team on the bull's eye.

Each year we ask ourselves what would be the things in this practice (ambulatory business) that would contribute most to its success. That is what we basically do each year. We then measure those factors. Many times the financial ones are very similar, such as productive hours per patient, net revenue per patient, cost of medical supplies and drugs per patient, inventory levels and revenue per square foot.

One needs to established measurable, critical success factors. I will discuss the ones that we came up with for surgery center business.

Measuring ASC financial results

Every month, we review our financial results, and every month, we measure these by applying CSF. The critical success factors reflect staffing issues, quality issues, supply and contracting issues — all the variable costs one needs to control in a very volume sensitive business. We take the total number of patients, not procedures, as our base quantified number for an ASC. Procedures are how many CPT codes click on the computer, but the number of patients is really the variable that matters the most in an ASC. Patients or cases represent the number of people seen. We want to use patient count because it is the basis for determining space and equipment needs, which impacts our business, supplies and staffing of our ASC business. Multiple procedures are performed at the same time on a patient, but the patient is the common denominator.

When we examined our ASC business, there really was less of a correlation to the success factors related to procedures than patients. We measure procedures, because they are important as you will see later in this article, but they are not our base factor by which all factors are measured. In developing CSF, you have to dissect the business in this way to get the really critical factors.

In the ASC, we calculate the average number of patients per day. We want

to measure that because most of my nurses think in days and staffing, and it helped for staffing purposes, so we broke it down to days. We want to know the number of procedures because it is an intensity factor. It also helps us measure specialty mix. The more procedures per patient we had, the more acute and intense the treatment of our patients.

Financially, we measure both gross revenue and net revenue in our financial statements. We want to know what we are billing and the net revenue after discounts. Net revenue per case is calculated from our contractual allowance and bad debt. We want to know how much we are writing off and if we need to raise prices or reduce managed care contracts. It allows us to identify a problem, and then go deeper into the business to find the solution. CSF serves as flags to tell you where to focus for solutions to problems in the business.

We want to know the net revenue per patient; it is an important number and it also tells us about our specialty and patient mix. We are able to compare that number with our costs to make sure our profit margin stays intact. This is obviously important. Since net revenue per patient is a critical number for our budget, we really focus on it as a CSF. It is critical that we track it.

Analyze staffing

We look at total *worked* (or productive, not paid) full-time equivalent (FTEs) employees for staffing. Staffing hours per patient, and FTEs per patient (staff hours per patient.) are both important measures. If it is too low, we know our patients are not getting the attention necessary. If it is too high, we are either overstaffed, we had a heavy mix of acute patients or we incurred too much overtime. We balance this CSF with number of procedures to measure intensity and acuity of patients so we can see the whole picture of the business.

CSF support one another. Key elements of an endeavor are interlocked. To start, we began looking at our own measures of staffing. We discussed this measure with the physicians and asked patients (via surveys) if they felt they had adequate attention and care. We then found a few other ASCs that were similar to us and asked them to measure the same staffing factor to gain an idea of their performance. You find that there is a pretty narrow range of staffing per patient given a standard, multi-specialty ASC. There are different ranges for different specialties and different caseloads, but for similar caseload (number of patients) and similar specialty centers, the staffing CSF ranges from the 11 man-hours per patient down to 8.5. It is not uncommon for a new center to experience 12-14 man-hours per patient because they just are not as efficient with staffing and the physicians are not settled into their block times yet.

The point is the staffing CSF helps you understand multiple, critical parameters of the business and what to focus upon when it is too high. As an aside, productive work-hours per patient run 8-8.5 for some of the large patient volume surgery centers that are at the 5,000 caseload and above. Normally, a surgery center experiencing 2,500 cases is usually in the 11-12 range, 11 if it is well run. This includes a full business office. If the ASC is group-practice based and the group has integrated the business office of the ASC into the group's business office (which is common), you take account for the FTE's in the business office when making your calculation.

Payroll, supply costs, patient costs and A/R

Payroll expense as a percentage of net revenue is usually at 25-27 percent range on average. We do experience ASCs in the 18-19 percent range due to the low pay rate or with extraordinarily high case volume. This CSF is also a function of the revenue. So, if you have very high revenue, your

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expenses over-revenue is going to lower the CSF. The lower percentage of staffing ranges for staff as a percentage of net revenue may also occur with ASCs that are mostly out-of-network with payprs since their net revenue is usually much higher than contracted ASCs.

We also measure medical supply and drug (including anesthesia drugs) costs per patient, total expenses per patient and accounts receivable days outstanding. We always try to be no greater than 50 days, with a goal of 45 days. This is an achievable CSF due to electronic billing, especially with Medicare. Operating income, operating income per patient, operating margin and inventory are all CSF.

We want to keep the inventory down, and at all of our centers below 3,000 cases we try to keep the inventory below $100,000. Now with just-in-time inventory, we can actually do better than that. We make sure the nurse doesn't buy 15 boxes this month and then nothing the next month. Critical to our success is cash flow management. Inventory is key to this. I tell our nurses to think of the supplies in sterile storage as cash on the shelf. If it is on the shelf, neither the partners nor them can access it for bonuses, nor can I use it to invest in the business or buy more equipment for them. If you are only seeing 10-15 patients a day, and you have $50,000 on the shelf, you are using up the group's cash. Remember, "cash is king".

The CSF are used for performance review on all employees. We tell the director of nursing that she is paid for the making certain critical success factors happen, and the CSF is our tracking system.

Critical ASC benchmarks

To summarize, here are the critical factors we track monthly in a spreadsheet at our ASCs:

Volume
- Total number of Cases

Revenue
- Net patient revenue
- Net patient revenue per patient

Staffing/payroll
- PTO hours paid
- Productive staff hours worked
- Total paid FTEs based on hours worked
- Productive staff hours per patient
- Payroll expense
- Total payroll as a percentage of net revenue
- Payroll $ per case

Other expenses
- Medical supply cost
- Medical supply cost per patient
- Total supply costs as a percentage of net revenue
- Total operating expenses
- Total operating expenses per patient

Profit
- Total A/R
- A/R days outstanding
- Net income
- Collections

Maximizing benefits of CSF

The clinical analogy of CSF is lab test ranges. A male between 25 and 35 should have a normal white count of a certain range. In a surgery center, running 2,500 cases with a standard mix of specialties should have a staffing in a certain range. If you're outside of that range, the CSF doesn't tell you that you're wrong — it says you have to look at it. It is a way of measuring on a consistent basis and flagging those areas where your best practices may not be best. You want to go back and look so you can stay on your best practice target ranges as defined first your own CSF and then against others if such pertinent standards exist. First you define the CSF, and then you quantify them.

It is ideal if the group or ambulatory business owners will share the profit with the employees if the budgeted profit is met or exceeded. This reinforces CSF as a management tool even more. In this way, all involved with achieving the profit gets to share in that profit. It's the American way. I've done that almost in every center, group practice or hospital in which I have worked and in both for-profit and non-profit organizations. It is good to take some portion of the profit and share the wealth with those who helped you make it. It could be only 1-2 percent; it doesn't have to be a large amount of money. Even a $300-$400 check at the end of the year if it's earned is meaningful, more obviously the better. One of the best parts about using CSF is the employees and the doctors only make money if they did the right things.

Using CSF to assist managing your ambulatory business is a valuable tool. It takes great thought to identify the truly critical factors for the success of your business. In this article, I have concentrated upon the business aspects that are critical to an ambulatory business, but that is the domain of the manager. We are charged to create good value by making sure the business is on sound financial footing and motivating the employees and the medical staff to focus on issues that will ensure the success of that business. CSF help us all focus on a few key points, allow us to measure our progress, and allow us to savor the effort which results in success of our joint efforts. ■

Robert Zasa is a founder and principal of ASD Management. Contact him at rzasa@asdmanagement.com and learn more about ASD Management at www.asdmanagement.com.

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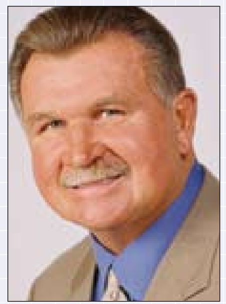
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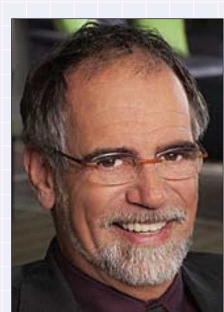
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75 of the Best Gastroenterologists in America (continued from page 1)

residency and fellowship at the Lahey Clinic in Burlington, Mass.

John I. Allen, MD, MBA (Minnesota Gastroenterology, Minneapolis). Dr. Allen is medical director for quality at Minnesota Gastroenterology and chair of the board of Institute for Clinical Systems Improvement, a Minnesota-based health care improvement collaborative. His clinical focus is gastrointestinal cancer, colon cancer and cancer genetics.Dr. Allen earned his MD from the University of New Mexico and completed his residency and fellowship at the University of Minnesota.

Paul K. Anderson, MD (Dallas Diagnostic Association). Dr. Anderson is a member of Dallas Diagnostic Association, a multispecialty group, and is on the medical staff of the Ambulatory Endoscopy Clinic of Dallas, the first licensed freestanding surgery center exclusively for GI procedures in North Texas. He earned his MD from Tulane University, New Orleans and completed his residency at Duke University in Durham, N.C., and his fellowship at University of Texas Southwestern in Dallas.

Damian Augustyn, MD (Pacific Internal Medicine Associates, San Francisco). Dr. Augustyn is managing partner of Pacific Internal Medicine Associates as well as chief of the medical staff and chair of the medical executive committee of California Pacific Medical Center in San Francisco. In addition to serving as a board member of the San Francisco Endoscopy Center and Anthem-Wellpoint-Blue Cross, he is CFO and treasurer of PRF Medical Malpractice Insurance Companies. Dr. Augustyn earned his MD at Harvard Medical School, undertook his residency at University of Colorado Health Sciences Center and UCSF Medical Center and completed his fellowship at UCSF Medical Center in San Francisco.

J. Sumner Bell III, MD (Gastroenterology Ltd., Norfolk, Va.). Dr. Bell is a member of Gastroenterology Ltd., a group practice, and professor of clinical internal medicine at Eastern Virginia Medical School. Dr. Bell earned his MD from Medical College of Virginia, completed his residency at Thomas Jefferson University Hospital of Philadelphia and his fellowship at Mayo Clinic in Rochester, Minn. He is secretary/treasurer of the American Gastroenterological Association and was president of the Eastern Virginia Medical School from 2000-2005.

Fernando Bermudez, MD (Eastside Endoscopy Center, St. Clair Shores, Mich.). Dr. Bermudez is medical director and board member of Eastside Endoscopy Center and a member of G.I. Medicine Associates. He specializes in diseases of the gastrointestinal tract, the liver and pancreas and has a special interest in inflammatory bowel disease and motility disorders of the esophagus. Dr. Bermudez earned his MD from Javeriana University in Bogota, Colombia, completed his residency at St. John Hospital in Detroit and his fellowship in gastroenterology at Michael Reese Medical Center in Chicago.

Henry J. Binder, MD (Yale School of Medicine, New Haven, Conn.). Dr. Binder is senior research scientist in medicine and professor of medicine and cellular & molecular physiology at Yale University School of Medicine. He is winner of the 2005 Distinguished Achievement Award from the American Gastroenterological Association for his work on colonic ion transport and diarrhea. Dr. Binder earned his MD at New York University and completed his residency at Bellevue Hospital in New York and his fellowship in gastroenterology at Yale University School of Medicine.

C. Richard Boland, MD (Baylor University Medical Center, Dallas). Dr. Boland is chief of the Division of Gastroenterology at Baylor University Medical Center. Because many in his family had colon cancer, he focused on this entity and has identified the unique mutation in the gene that allows this cancer to occur in multiple family members. Dr. Boland earned his MD from Yale University School of Medicine and completed his residency at Public Health Service hospital in San Francisco and his fellowship at the University of California at San Francisco School of Medicine. He is president-elect of the American Gastroenterological Association.

Geoffrey Braden, MD (Gastrointestinal Specialists, Philadelphia). Dr. Braden is a member of Gastrointestinal Specialists, a group practice with 11 gastroenterologists. He is on staff at Aria Health Hospital System and Roxborough Hospital, with faculty privileges at Drexel University College of Medicine. Dr. Braden earned his MD from Ohio State University Medical School and completed a residency at the University of Chicago Hospitals and Clinics and a fellowship at Brigham and Women's Hospital.

Carol A. Burke, MD (Cleveland Clinic). Dr. Burke is director of the Center for Colon Polyp and Cancer Prevention and head of the Section of Polyposis in the Sanford R. Weiss Center for Hereditary Colorectal Neoplasia at the Cleveland Clinic. Her focus is on inherited colon cancer syndromes and the prevention of colorectal neoplasia. Dr. Burke earned her MD at Ohio State University College of Medicine and Public Health, completed her residency at Riverside Methodist Hospital in Columbus, Ohio, and completed her fellowship at the Cleveland Clinic.

Robert "Bruce" Cameron, MD (Endoscopy Center at Bainbridge, Chagrin Falls, Ohio). Dr. Cameron is the medical director of the Endoscopy Center at Bainbridge. His areas of special interest are colonic neoplasia, esophageal diseases, gastroenterology and general gastroenterology. Dr. Cameron earned his MD from Case Western Reserve University and completed his internship in internal medicine and his residency in gastroenterology at the University Hospitals of Cleveland. He is a clinical professor of medicine at Case Western Reserve University in Cleveland.

Donald O. Castell, MD (Medical University of South Carolina, Charleston, S.C.). Dr. Castell is director of the esophageal disorders program at the Medical University of South Carolina. He is considered one of the foremost experts in esophagology and is the 2010 recipient of Julius Friedenwald medal from the American Gastroenterological Association. He served in the Navy from 1959-1979. Dr. Castell earned his MD from George Washington University; internship and residency at the National Naval Medical Center; fellowship at Tufts University.

Lin Chang, MD (University of California, Los Angeles). Dr. Chang is director of the Women's Digestive Health Center at David Geffen School of Medicine at the University of California. Her main area of research is the pathophysiology of irritable bowel syndrome with particular interests in the overlap of IBS with fibromyalgia and gender differences and neuroendocrine alterations. She is principal investigator on two NIH grants studying the central and peripheral mechanisms underlying IBS. Dr. Chang earned her MD at UCLA School of Medicine and performed her residency and fellowship at Harbor-UCLA Medical Center.

William D. Chey, MD (University of Michigan, Ann Arbor). Dr. Chey is director of the GI Physiology Laboratory and the Michigan Bowel Control Program at the University of Michigan. Research interests focus on the diagnosis and treatment of the functional bowel disorders, acid-related disorders, and Helicobacter pylori infection. He is past chair of the Clinical Practice Section of the American Gastroenterology Association and is a board member of the American College of Gastroenterology. Dr. Chey earned his MD and completed his residency at Emory University School of Medicine and completed his fellowship at the University of Michigan in Ann Arbor.

Delbert L. Chumley, MD (Gastroenterology Consultants, San Antonio). Dr. Chumley is a member of Gastroenterology Consultants. He is 2010-2011 president of the American College of Gastroenterology and co-chaired the college's National GI Carrier Advisory Committee, which oversees federal Medicare payment issues. He is a past president of the Texas Society of Gastroenterology and Endoscopy. His interests include therapeutic endoscopy for hepatobiliary, pancreatic and sphincter of Oddi disorders, Crohn's disease, ulcerative colitis and refractory gastroesophageal reflux disease. Dr. Chumley earned his MD and completed his residency and fellowship at the University of Texas Medical Branch at Galveston.

Sheila E. Crowe, MD (University of Virginia, Charlottesville, Va.). Dr. Crowe is professor of medicine, gastroenterology and hepatology at the University of Virginia. Her clinical interests are inflammatory bowel disease, celiac disease, GI food allergy, acid-peptic diseases, Helicobacter pylori infection and colon cancer screening. Research interests include immune-epithelial interactions in mucosal inflammation. Dr. Crowe earned her MD and completed her residency and fellowship at McMaster University in Canada.

Stephen Deal, MD (Carolina Digestive Health Associates, Charlotte, N.C.). Dr. Deal is a member of Carolina Digestive Health Associates, which operates five endoscopy centers in the Charlotte area. He specializes in gastroenterology with a subspecialty in pancreatic biliary tract diseases. He served on the Quality in Endoscopy Task Force of the American Society of Gastrointestinal Endoscopy and the American College of Gastroenterology. Dr. Deal earned his MD at the University of North Carolina at Chapel Hill School of Medicine and completed his residency and fellowship at Medical College of Virginia Hospital.

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Thomas Deas Jr., MD (Fort Worth Endoscopy Center, Fort Worth, Texas). Dr. Deas is the medical director of the Fort Worth Endoscopy Center and the Southwest Fort Worth Endoscopy Center, which are both operated by Surgical Care Affiliates. He has focused on achieving efficient, high-quality gastroenterology practices and endoscopy centers. Dr. Deas earned his MD from Louisiana State University School of Medicine in Shreveport, La., while serving in the U.S. Air Force, and completed his residency in internal medicine and his fellowship in gastroenterology at Wilford Hall USAF Medical Center in San Antonio, Texas.

Anthony J. DiMarino Jr., MD (Thomas Jefferson University, Philadelphia). Dr. DiMarino is chief of the division of gastroenterology and hepatology at Thomas Jefferson University. His clinical interests are consultative gastroenterology, celiac disease, swallowing disorders and problems of gastrointestinal motility and inflammable bowel disease, including ulcerative colitis & Crohn's disease. His research interests are new drug development in treatment of celiac disease, esophageal reflux and gastrointestinal endoscopic disinfection. Dr. DiMarino earned his MD from Hahnemann Medical College in Philadelphia and completed his internship at Hahnemann Medical College and Hospital and his residency and fellowship at the Hospital of the University of Pennsylvania in Philadelphia.

Steven A. Edmundowicz, MD (Washington University School of Medicine, St. Louis). Dr. Edmundowicz is chief of endoscopy and director of the Interventional Endoscopy at Washington University School of Medicine. He is a councilor of the American Society of Gastrointestinal Endoscopy and senior associate editor of *Gastrointestinal Endoscopy*. Dr. Edmundowicz earned his MD from Jefferson Medical College and completed his residency and fellowship at Washington University School of Medicine.

Glenn M. Eisen, MD (Oregon Clinic, Portland). Dr. Eisen is a member of Oregon Clinic, a multispecialty practice with more than 120 physicians, and is clinical professor of medicine at Oregon Health and Science University. His special interests lie in esophageal disease, Barrett's esophagus, colorectal cancer screening, therapeutic pancreaticobiliary endoscopy, capsule endoscopy and inflammatory bowel disease. Dr. Eisen earned his MD from Albert Einstein College of Medicine, completed his residency at Mount Sinai Medical Center in New York and completed his fellowship from Duke University Medical Center. He is editor of *Gastrointestinal Endoscopy*.

Douglas O. Faigel, MD (Oregon Health and Sciences University, Portland). Dr. Faigel is a member of the OHSU University Medical Group and is involved in the endoscopic ultrasound program at the university. His interests are primarily in therapeutic endoscopy and endoscopic ultrasound. Dr. Faigel earned his MD from University of Pennsylvania, Philadelphia, completed his residency at University of California, San Francisco, and completed his fellowship at University of Pennsylvania Medical Center.

Francis A. Farraye, MD (Boston Medical Center). Dr. Farraye is clinical director in the gastroenterology section at Boston Medical Center. His clinical interests are inflammatory bowel disease and management of colon polyps and colorectal cancer. He is studying Vitamin D absorption in patients with Crohn's disease. Dr. Farraye earned his MD at Albert Einstein College of Medicine, New York, and completed his residency and fellowship at Beth Israel Hospital, Boston.

M. Brian Fennerty, MD (Oregon Health & Science University, Portland, Ore.). Dr. Fennerty is section chief of gastroenterology at Oregon Health & Science University. He is the current president of the American Society of Gastrointestinal Endoscopy. Dr. Fennerty is an authority on gastroesophageal reflux disease,

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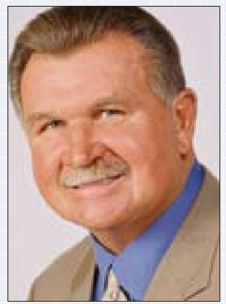

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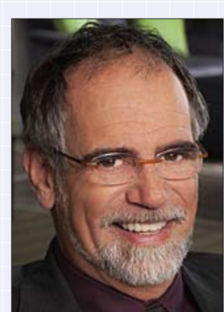

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Barrett's esophagus and Helicobacter pylori. He is editor of *Journal Watch Gastroenterology* and *Reviews in Gastroenterological Disorders* and the past associate editor of *American Journal of Gastroenterology* and *Clinical Perspectives in Gastroenterology*. Dr. Fennerty earned his MD from Creighton University in Omaha, Neb., and completed his residency in internal medicine at the Naval Medical Center in San Diego and his fellowship in gastroenterology at the University of Arizona Health Sciences Center in Tucson, Ariz.

Ira L. Flax, MD (Digestive and Liver Specialists, Houston). Dr. Flax is a managing partner of Digestive and Liver Specialists, a six-physician specialty practice in Houston. He has been board member of Memorial Hermann Healthcare System in Houston, chaired its gastroenterology section and was chief of staff of his hospital. Dr. Flax earned his MD from the Medical College of Virginia, completed his residency at Baylor College of Medicine in Houston and completed his fellowship at the Medical College of Virginia. He co-founded and served as chairman of the Texas Alliance for Digestive Diseases, a regional gastroenterology IPA.

David Fleischer, MD (Mayo Clinic Arizona, Phoenix). Dr. Fleischer is chair of the department of gastroenterology and hepatology at the Mayo Clinic Arizona. His research interests include endoscopy, esophageal cancer, GI bleeding, capsule endoscopy and endoscopic therapy for Barrett's esophagus. Dr. Fleischer earned his MD from Vanderbilt University in Nashville and completed his residency at Cleveland Metropolitan General Hospital and his fellowship at Harbor-UCLA Medical Center in Los Angeles.

Amy E. Foxx-Orenstein, DO (Mayo Clinic, Rochester, Minn.). Dr. Foxx-Orenstein is a member of the motility section, Enteric Neuroscience Program, and Gastroenterology and Hepatology Division at Mayo. Her research and clinical interests include obesity, motility disorders, functional bowel, pelvic floor disorders, eosinophilic esophagitis and pharmacodynamics. Dr. Foxx-Orenstein earned her MD from Des Moines University and completed her residency at Geisinger Medical Center and fellowships at the Medical College of Virginia.

James T. Frakes, MD (Rockford Gastroenterology Associates, Rockford, Ill.). Dr. Frakes is a member of Rockford Gastroenterology Associates. An expert in therapeutic pancreaticobiliary endoscopy, he is the 2007 recipient of the Distinguished Service Award from the ASGE for long-term contributions to the field and was designated a Master of the American College of Gastroenterology for stature and achievement in clinical gastroenterology and teaching and contributions. Dr. Frakes earned his MD from the University of Illinois College of Medicine and completed his residency at the University of Missouri Medical Center in Columbia and his fellowship in gastroenterology at the University of North Carolina at Chapel Hill.

Robert A. Ganz, MD (Abbott-Northwestern Hospital, Minneapolis). Dr. Ganz is chief of gastroenterology at Abbott-Northwestern Hospital and associate professor of medicine at the University of Minnesota. He earned his MD and completed his residency at University of Illinois College of Medicine. He is foundation chair of the American Society of Gastrointestinal Endoscopy.

Ralph A. Giannella, MD (University of Cincinnati). Dr. Giannella is professor in the digestive diseases division at University of Cincinnati and co-supervises the University Hospital gastroenterology clinic. His focus is on intestinal infections and diarrheal disorders. He has been using a new breath test to determine problems in the GI tract. Dr. Giannella earned his MD from Albany Medical College and completed his residency at Boston City Hospital.

Gregory G. Ginsberg, MD (University of Pennsylvania School of Medicine, Philadelphia). Dr. Ginsberg is executive director of the Endoscopic Service at University of Pennsylvania School of Medicine. His clinical interests include Barrett's esophagus, esophageal cancer, especially endosonographic staging and palliation, colorectal cancer screening and surveillance, resection of large polyps, ERCP for pancreaticobiliary cancer diagnosis and palliation, EUS staging and fine-needle-aspiration for diagnosis. Dr. Ginsberg earned his MD from Thomas Jefferson Medical College and completed his residency and fellowship at Georgetown University Hospital.

Gary Gitnick, MD (University of California, Los Angeles). Dr. Gitnick is a professor of medicine and chief of the division of digestive diseases at UCLA School of Medicine. He leads the largest gastroenterology division in the world, with 80 full-time faculty members, 99 employees and a multi-million dollar budget. Dr. Gitnick earned his MD from the University of Chicago and completed an internship at Johns Hopkins University Hospital in Baltimore and a residency and fellowship at the Mayo Clinic in Rochester, Minn.

David A. Greenwald, MD (Montefiore Medical Center, Bronx, N.Y.). Dr. Greenwald is in the division of gastroenterology at Montefiore Medical Center, associate professor of clinical medicine at Albert Einstein College of Medicine and director of the gastroenterology fellowship program at Montefiore Medical Center. He studies the risks of infection and issues of safety concerning GI endoscopy. He is chair of the board of the American College of Gastroenterology. Dr. Greenwald earned his MD from Albert Einstein College of Medicine and completed his residency fellowship at Columbia Presbyterian Medical Center in New York.

Stephen B. Hanauer, MD (University of Chicago). Dr. Hanauer is chief of gastroenterology at the University of Chicago. His clinical research has been related to epidemiology and therapeutics for IBD. Dr. Hanauer earned his MD from the University of Illinois and completed his residency and fellowship at the University of Chicago. He chairs the FDA Gastrointestinal Drugs Advisory Committee and is a member of the Subspecialty Board of Gastroenterology for the American Board of Internal Medicine.

Gail A. Hecht, MD (University of Illinois at Chicago). Dr. Hecht is section head of the Section of Digestive Diseases and Nutrition at the University of Illinois at Chicago and is past president of the American Gastroenterological Association. Her current research interests include the interaction of enteric bacterial pathogens with host intestinal epithelial cells and the mechanisms. Dr. Hecht earned her MD from Loyola University in Maywood, Ill., and completed her residency at the University of Minnesota in Minneapolis and her fellowship at Brigham & Women's Hospital and Harvard Medical School.

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

Dr. Hogan earned his MD from the University of Mississippi School of Medicine and completed his residency and internship in internal medicine at University of Mississippi Medical Center and his fellowship in gastroenterology at Baylor University Medical Center.

David A. Johnson, MD (Eastern Virginia Medical School, Norfolk, Va.). Dr. Johnson is chief of gastroenterology at Eastern Virginia Medical School. His primary research interests are esophageal and colon disease, and he is a past president of the American College of Gastroenterology. Dr. Johnson worked to enact the historic first legislation to mandate colon cancer screening with colonoscopy as the preferred standard. He has served as a primary advisor for national Medicare GI issues on endoscopy, a CMS advisory committee, and has co-chaired the national Gastroenterology Medicare advisors. Dr. Johnson earned his MD from Virginia Commonwealth University School of Medicine.

Nicholas F. LaRusso, MD (Mayo Clinic College of Medicine, Rochester, Minn.). Dr. LaRusso is a member of the Department of Gastroenterology and Hepatology and Transplant Center at the Mayo Clinic and he chairs the Foundation for Digestive Health and Nutrition at the American Gastroenterological Association. Dr. LaRusso earned his MD from New York Medical College, completed a residency at Mayo Graduate School of Medicine and Metropolitan Hospital Medical Center in New York and completed a fellowship at the National Institutes of Health, where he was a Mayo Foundation scholar and guest investigator.

Anthony Kalloo, MD (John Hopkins University, Baltimore). Dr. Kalloo is chief of the division of gastroenterology and hepatology at Johns Hopkins University. His interests include therapeutic endoscopy, sphincter of Oddi dysfunction and natural orifice translumenal endoscopic surgery, where he is considered a pioneer. Dr. Kalloo earned his MD from the University of West Indies Medical School, performed his residency at Howard University Hospital in Washington, D.C. and completed his fellowship training at the combined Georgetown University, VA Medical Center and NIH program.

Philip O. Katz, MD (Albert Einstein Medical Center, Philadelphia). Dr. Katz is chair of the division of gastroenterology and associate program director for the internal medicine residency at Albert Einstein Medical Center. An authority on esophageal disease, Dr. Katz focuses on gastroesophageal reflux disease, including nocturnal recovery of gastric acid secretion during proton pump inhibitor therapy and esophageal pain perception. Dr. Katz earned his MD from Bowman Gray School of Medicine at Wake Forest University in Winston-Salem, N.C., and served his residency and his fellowship at the Bowman Gray School of Medicine. He is clinical professor of medicine at Thomas Jefferson University in Philadelphia and the immediate past president of the American College of Gastroenterology.

David A. Katzka, MD (Mayo Clinic, Rochester, Minn.). Dr. Katzka is head of the esophageal interest group in the Miles and Shirley Fitterman Division of Gastroenterology and Hepatology at the Mayo Clinic. A consultative esophagologist, he created the Center for Swallowing Disorders, bringing together surgeons, radiologists, neurologists, internal medicine and sleep therapy experts. He won the 2010 Distinguished Clinician Award from the American Gastroenterological Association and the Simon B. Komarov prize for excellence in gastroenterology from the Penn Measey Foundation Award, the NIH Clinical Investigator Award and the Louis Duhring Award for Excellence in Clinical Specialty Medicine from

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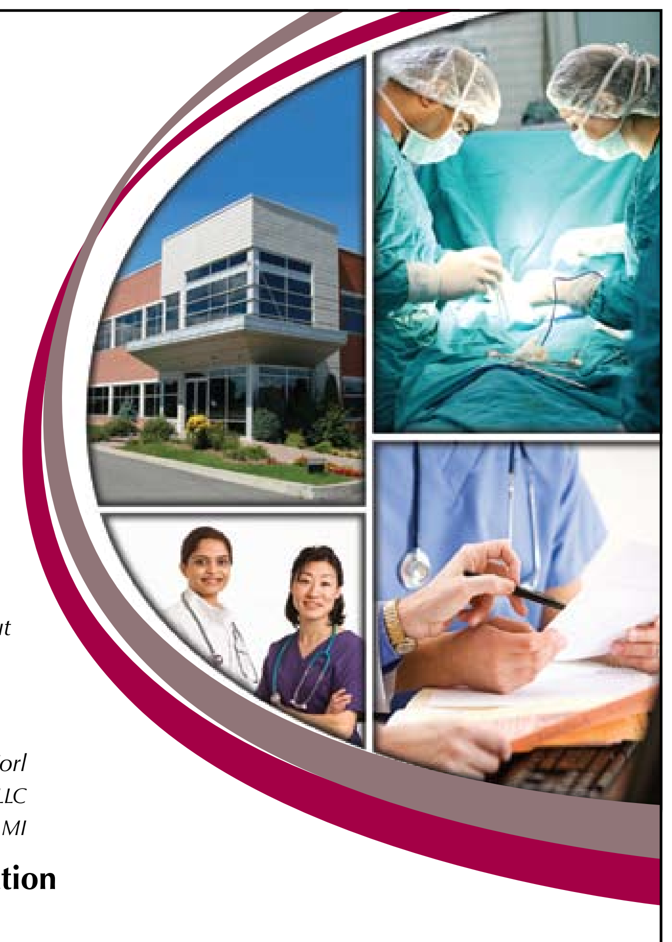

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the University of Pennsylvania School of Medicine. Dr. Katzka earned his MD and completed his residency at Mount Sinai School of Medicine in New York and completed his fellowship at the Hospital of the University of Pennsylvania in Philadelphia. He is a professor of medicine at the Mayo Clinic College of Medicine.

Michael L. Kochman, MD (Hospital of the University of Pennsylvania, Philadelphia). Dr. Kochman is the endoscopy training director and co-director of the Gastrointestinal Oncology Program at the Hospital of the University of Pennsylvania. He is chairman of the editorial board of *GIE: Gastrointestinal Endoscopy* and editor for techniques for that journal and for the *Year Book of Gastroenterology*. Dr. Kochman earned his MD from University of Illinois College of Medicine, residency at University of Illinois and fellowships at Indiana University School of Medicine University of Michigan Hospitals.

Loren A. Laine, MD (USC School of Medicine, Los Angeles). Dr. Laine is director of endoscopy and the associate director of the Division of Gastrointestinal and Liver Diseases. Areas of interest include gastrointestinal bleeding and upper gastrointestinal tract injury due to helicobacter pylori and anti-inflammatory medications. Dr. Laine earned his MD from UCLA School of Medicine and completed his residency at University of California at Los Angeles and his fellowship at University of California at San Diego.

Bret A. Lashner, MD (Cleveland Clinic). Dr. Lashner is co-chair of the Cleveland Clinic Clinical and Translational Science Collaborative Advisory Committee. He is the chair of the Research Committee of the American College of Gastroenterology. He is an associate editor of *The American Journal of Gastroenterology* and *Inflammatory Bowel Diseases*. Dr. Lashner earned his MD from New York University School of Medicine, and completed a residency at Temple University Hospital and his fellowship at the University of Chicago.

James S. Leavitt, MD (Miami Endoscopy Center, Miami). Dr. Leavitt is an assistant clinical professor at the University of Miami School of Medicine Department of Gastroenterology and a physician at the Miami Endoscopy Center and the Gastroenterology Care Center. He has served as a member of the American College of Gastroenterology's practice management committee. Dr. Leavitt earned his MD from the State University of New York Downstate Medical School and completed his medical internship and residency and his gastroenterology fellowship at Jackson Memorial Hospital in Miami.

Blair Lewis, MD (Mount Sinai Hospital, N.Y.). Dr. Lewis is clinical professor of medicine at the Mount Sinai School of Medicine. He was the primary investigator for the first clinical trial of capsule endoscopy for the small intestine and for the first clinical trial for the colon capsule. He chairs the International Conference of Capsule Endoscopy annually and coordinated the Consensus Conference statements to guide capsule usage throughout the world. Dr. Lewis earned his MD from Albert Einstein College of Medicine in the Bronx, N.Y., completed his residency at Montefiore Medical Center in the Bronx and completed his fellowship at Mount Sinai Medical Center. He is past president of the New York Society for Gastrointestinal Endoscopy.

James F. Martin, MD (Kaiser Permanente San Rafael, Calif., Medical Center). Dr. Martin is chief of the department of medicine at Kaiser Permanente San Rafael Medical Center. He won the American Gastroenterological Association's 2010 Distinguished Clinician Award, cited as "the consummate private practice clinician who combines wisdom with a breadth of knowledge in the practice of gastroenterology and internal medicine." Dr. Martin earned his MD from Ohio State University, completed his residency at Johns Hopkins University and completed his gastroenterology fellowship at the University of California, San Francisco.

Arthur McCullough, MD (Cleveland Clinic). Dr. McCullough is the chair of the department of gastroenterology and hepatology at the Cleveland Clinic and is vice-chairman of research and education at Cleveland Clinic's Digestive Disease Institute. Dr. McCullough earned his MD from SUNY Health Science Center at University Hospital of Syracuse, N.Y., and completed residency at Cleveland Clinic and a fellowship at Mayo Clinic in Rochester, Minn. He was president of the American Association for the Study of Liver Diseases and helped develop a non-invasive test for liver disease without needing a liver biopsy.

Kenneth R. McQuaid, MD (VA Medical Center, San Francisco). Dr. McQuaid is director of GI Endoscopy at the VA Medical Center. He is the primary clinician for luminal gastrointestinal disorders at the VA Medical Center, responsible for clinical and administrative oversight of the inpatient GI consult service, the outpatient GI clinics, the GI motility laboratory and the GI endoscopy unit. Dr. McQuaid earned his MD from University of California San Francisco and completed his residency at Hennepin County Medical Center in Minneapolis and his fellowship at University of California San Francisco.

Steven J. Morris, MD, JD (Atlanta Gastroenterology Associates). Dr. Morris is CEO and co-founder of Atlanta Gastroenterology Associates, a 47-physician GI group practice. A clinical associate professor at Emory University School of Medicine, he is past president of the Georgia Gastrointestinal Society and served as chief of staff at Emory University Hospital Midtown Hospital. Dr. Morris earned his MD from the University at Buffalo and completed his residency at Emory University Affiliated Hospitals in Atlanta and a fellowship in digestive diseases at the University of Miami. He also holds a law degree from Georgia State University College of Law.

Daniel J. Pambianco, MD (Martha Jefferson Hospital, Charlottesville, Va.). Dr. Pambianco is chairman of the endoscopy/ motility lab at Martha Jefferson Hospital in Charlottesville, Virginia. He is also medical director of Charlottesville Medical Research, a local network of community-based physicians in private practice who conduct clinical research studies in the central Virginia area. Dr. Pambianco earned his MD at the American University of the Caribbean School of Medicine in Montserrat, British West Indies, completed his residency at Robert Packer Hospital in Sayre, Pa., and undertook his fellowship at the University of Virginia Health Services Center at Charlottesville.

John L. Petrini, MD (Sansum Clinic, Santa Barbara, Calif.). Dr. Petrini is a former board member of Sansum Clinic and is a past president of the American Society of Gastrointestinal Endoscopy. He earned his MD from University of California San Francisco and completed his residency at Emory University Affiliated Hospitals and his fellowship at University of California Los Angeles Medical Center.

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Irving Pike, MD (Gastroenterology Consultants, Virginia Beach, Va.). Dr. Pike is president of Gastroenterology Consultants. His special interests are endoscopic management of biliary and pancreatic disease, inflammatory bowel disease and the prevention of colon cancer. He is on the board of the American College of Gastroenterology and chairman of the American Society for Gastrointestinal Endoscopy's Ambulatory Endoscopy Special Interest group. Dr. Pike earned his MD from Medical College of Georgia School of Medicine and completed his residency at Parkland Memorial Hospital in Dallas and his fellowship at University of Texas Southwestern Medical Center.

Daniel K. Podolsky, MD (Massachusetts General Hospital, Boston). Dr. Podolsky is chief of the gastrointestinal unit at Massachusetts General Hospital, the Mallinckrodt Professor of Medicine and faculty dean for academic programs at Partners for Harvard Medical School and chief academic officer at Partners HealthCare System. He is the 2009 recipient of Julius Friedenwald medal from the American Gastroenterological Association. Dr. Podolsky earned his MD from Harvard Medical School and completed his internship and residency at Massachusetts General Hospital.

John W. Popp Jr., MD (Centocor Ortho Biotech, Horsham, Pa.). Dr. Popp is medical director for Centocor Ortho Biotech. He has served as chief of the Division of Digestive Diseases and Nutrition at the University of South Carolina School of Medicine and director of the Endoscopy Laboratory at Richland Memorial Hospital in Columbia. He was a founder of the South Carolina Gastroenterology Association and has served as president of the American College of Gastroenterology. Dr. Popp earned his MD and completed his residency at Yale University School of Medicine and completed his fellowship at Massachusetts General Hospital.

Daniel H. Present, MD (Mount Sinai Medical Center, New York). Dr. Present is a founder of the Foundation for Clinical Research in Inflammatory Bowel Disease at Mount Sinai Medical Center. He is co-founder of the Foundation for Clinical Research in inflammatory bowel disease. Dr. Present earned his MD from State University of New York Downstate in Brooklyn and completed his residency at Mount Sinai Medical Center.

Douglas K. Rex, MD (Indiana University, Bloomington, Ind.). Dr. Rex is a professor of gastroenterology and medicine at Indiana University and serves as director of endoscopy at the Indiana University Hospital in Indianapolis. Research areas include colorectal disease and colorectal cancer screening and the technical performance of colonoscopy. He has been chairman of the board and president of the American College of Gastroenterologists. Dr. Rex earned his MD at Indiana University School of Medicine and completed his residency and fellowship at Indiana University Medical Center in Indianapolis.

Moshe Rubin, MD (New York Hospital, Queens, N.Y.). Dr. Rubin is director of gastroenterology at New York Hospital Queens. His research shows real-time capsule endoscopy when given in the ED can rapidly identify patients with upper gastrointestinal bleeding who require urgent treatment. Dr. Rubin earned his MD from Yale University and completed his residency and fellowship at New York Presbyterian Hospital.

Michael A. Safdi, MD (Ohio Gastroenterology and Liver Institute, Cincinnati.). Dr. Safdi is a member of Ohio Gastroenterology and Liver Institute, a group practice with 20 physicians, and built the Consultants for Clinical Research arm of the practice, involving the group in more than 220 clinical research trials. He has been a surveyor for the

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Accreditation Association for Ambulatory Health Care since 1996 and is ACG representative on AAAHC's board. Dr. Safdi earned his MD from University of Cincinnati Medical School and completed residency and fellowship at the University of California at San Diego.

William J. Sandborn, MD (Mayo Clinic, Rochester, Minn.). Dr. Sandborn is vice chair of the Division of Gastroenterology and Hepatology at Mayo Clinic. He is involved in clinical trials and clinical pharmacology in inflammatory bowel disease and is the principal investigator on several clinical studies on the management of Crohn's disease and ulcerative colitis. Dr. Sandborn earned his MD and completed his residency at Loma Linda University and completed his fellowship at Mayo Clinic.

Robert S. Sandler, MD (University of North Carolina, Chapel Hill, N.C.). Dr. Sandler is a professor of medicine and epidemiology and chief of the division of gastroenterology and hepatology at the University of North Carolina. He is also longstanding director of the Center for Gastrointestinal Biology and Disease, an NIH-funded Digestive Disease Research Core Center based at UNC and North Carolina State University. Dr. Sandler earned his MD from Yale University and completed his residency at George Washington Hospital and his fellowship at University of North Carolina, Chapel Hill. He has served as president of the American Gastroenterological Association.

Harry Sarles Jr., MD (Digestive Health Associates of Texas, Garland, Texas). Dr. Sarles is a gastroenterologist with the Digestive Health Associates of Texas. Areas of interest include colon cancer screening, pancreato-biliary problems of the GI tract, gastrointestinal bleeding problems and gastroesophageal reflux disease. Dr. Sarles earned his MD and completed his residency at the University of Texas Medical Branch at Galveston and completed his fellowship at the VA Hospital in Phoenix through the University of Arizona.

Mark A. Schattner, MD (Memorial Sloan-Kettering Cancer Center, New York). Dr. Schattner practices at Memorial Sloan-Kettering Cancer Center. He has a special interest in therapeutic endoscopy and specialized nutrition support for cancer patients. He perform endoscopic procedures including colonoscopy, polypectomy, upper gastrointestinal endoscopy, endoscopic ultrasound, fine needle aspiration, capsule endoscopy and endoscopic placement of feeding tubes and stents. Dr. Schattner earned his MD for the University of Pennsylvania School of Medicine and completed his residency at New York Hospital/Cornell Medical Center and his fellowship at Memorial Sloan-Kettering Cancer Center. He is president of the New York Society for Gastrointestinal Endoscopy.

Lawrence R. Schiller, MD (Digestive Health Associates of Texas, Dallas). Dr. Schiller is a member of the board of Digestive Health Associates of Texas, clinical professor at University of Texas Southwestern, Dallas and program director of the gastroenterology fellowship at Baylor University Medical Center. His clinical interests include colon cancer screening gastroesophageal reflux disease, irritable bowel syndrome and Crohn's Disease. Dr. Schiller earned his MD from Thomas Jefferson University and completed his residency at Temple University Hospital in Philadelphia and his fellowship at University of Texas Southwestern in Dallas. He is president-elect of the American College of Gastroenterology.

Helen M. Shields, MD (Beth Israel Deaconess Medical Center, Boston). Dr. Shields is a gastroenterologist at Beth Israel Deaconess Medical Center and an associate professor at the department of medicine at Harvard Medical School. She has served as chair of the Colorectal Cancer Screening Advisory Committee at Beth Israel Deaconess Medical Center and is education and training councilor at the American Gastroenterological Association. Dr. Shields earned her MD from Tufts University School of Medicine and completed her residency at New York Hospital-Cornell Medical Center and her fellowship at University of Pennsylvania Health System.

Leonard B. Stein, MD (Long Island Center for Digestive Health, Garden City, N.Y.). Dr. Stein is medical director at the Long Island Center for Digestive Health, an endoscopy center performing 6,000 procedures a year, and a member of Gastroenterology Associates, a single-specialty group also in Garden City. Dr. Stein earned his MD from Sackler School of Medicine, completed his internal medicine at residency Long Island Jewish Hospital and gastroenterology fellowship at Temple University Hospital. He is clinical assistant professor of medicine at State University of New York at Stony Brook.

Ian L. Taylor, MD (SUNY Downstate Medical Center, Brooklyn, N.Y.). Dr. Taylor is senior vice president for biomedical education and research and dean of the College of Medicine at SUNY Downstate Medical Center. He is president of the American Gastroenterological Association. A native of Liverpool, England, Dr. Taylor earned the equivalent of an MD there and performed his fellowship in gastroenterology at UCLA/Wadsworth VA Medical Center. He was dean of the School of Medicine at Tulane University in New Orleans.

Kalpesh H. Thakkar, MD (Baylor College of Medicine, Houston). Dr. Thakkar is assistant professor for pediatrics in the section of gastroenterology, hepatology and nutrition at Baylor College of Medicine. His research interests include abdominal pain, gastrointestinal endoscopy and clinical outcome and epidemiology. He earned his MD from Texas Tech University College of Medicine, completed his residency at University of Texas Medical Branch and completed his fellowship at Baylor College of Medicine.

Jacques Van Dam, MD, PhD (USC University Hospital, Los Angeles). Dr. Van Dam, formerly at Stanford University, joined the gastroenterology department at University of Southern California in Aug. 2010. An NIH-funded investigator, Dr. Van Dam's research efforts include developing methods for the endoscopic diagnosis and treatment of gastrointestinal cancer. Dr. Van Dam earned his MD from Georgetown University School of Medicine, completed his residency at New England Deaconess Hospital and undertook fellowships at Massachusetts General Hospital, Cleveland Clinic and Beth Israel Deaconess Medical Center and Harvard Medical School. He has been president of both the American Society of Gastrointestinal Endoscopy and the Bockus International Society of Gastroenterology.

John J. Vargo II, MD (Cleveland Clinic Foundation). Dr. Vargo is a member of the Section of Therapeutic Endoscopy in the Department of Gastroenterology and Hepatology at the Cleveland Clinic Foundation and is program director of the advanced endoscopy fellowship there. Interests include biliary tract disease, capsule endoscopy, deep enteroscopy, deep enteroscopy and interventional endoscopy, upper endoscopy,

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double balloon enteroscopy, endoscopic mucosal ablative and resection techniques, endoscopic ultrasonography, endoscopic cancer therapy and stenting. Dr. Vargo earned his MD at the University of Rochester School of Medicine and Dentistry, completed his residency at Montefiore Hospital University Health Center, Pittsburgh and completed his fellowship at the Cleveland Clinic.

Ronald J. Vender, MD (Yale Medical Group, New Haven, Conn.). Dr. Vender is chief medical officer of Yale Medical Group, the physician practice of Yale University faculty. He is vice president of the American College of Gastroenterology. Dr. Vender earned his MD from Yale School of Medicine and completed his residency and fellowships at Yale-New Haven Hospital. He won the Distinguished Clinician Award from the American Gastroenterological Association.

Kenneth K. Wang, MD (Mayo Clinic, Rochester, Minn.). Dr. Wang is director of the Advanced Endoscopy Group and Esophageal Neoplasia Clinic and consultant in the division of gastroenterology and hepatology at Mayo Clinic. His interests include laser therapy, Barrett's esophagus Esophageal cancer, photodynamic therapy, endoscopic ultrasonography, gastrointestinal bleeding, optical biopsy, laser confocal microscopy, radiofrequency ablation and endoscopic mucosal resection/dissection. Dr. Wang earned his MD from Wayne State University and completed his residency and fellowship at the Mayo Clinic.

James J. Weber, MD (Texas Digestive Disease Consultants, Dallas). Dr. Weber is president of Texas Digestive Disease Consultants, which has 17 offices. He specializes in colorectal cancer prevention and irritable bowel disease. Dr. Weber earned his MD from the University of Texas Southwestern Medical School in Dallas and completed his residency at Parkland Memorial Hospital and his gastroenterology fellowship at Baylor University in Dallas.

David C. Whitcomb, MD, PhD (University of Pittsburgh). Dr. Whitcomb is chief of the division of gastroenterology, hepatology and nutrition at the University of Pittsburgh. He co-founded and directed the Center for Genomic Sciences, which formed the foundation for the current Genomic and Proteomic Core Laboratories at the University of Pittsburgh. Dr. Whitcomb earned his MD and a PhD in physiology at Ohio State University and completed his residency and fellowship at Duke University. His laboratory group discovered the gene causing hereditary pancreatitis and other causes of pancreatic disease.

F. Taylor Wootton III, MD (Digestive & Liver Disease Specialists, Norfolk, Va.). Dr. Wooten is a member of Digestive & Liver Disease Specialists, a seven-physician practice. He is a community private practice councilor of the American Gastroenterological Association. He earned his MD from Eastern Virginia Medical School and completed his residency and fellowship at Medical University of South Carolina. ■

5 Physician Statistics ASCs Should Track and Benchmark

By Rob Kurtz

Brian Brown, regional vice president of operations of Meridian Surgical Partners, identifies five ASC physician statistics to track and benchmark and shares some insight into what surgery centers should do with the data.

1. Case volume by physician. Mr. Brown says this should be examined monthly, and ASCs should also have 12 months of trailing case volume data when gathering and examining monthly financials. "What we're looking for is practice trends within the individual physicians," Mr. Brown says. "Are their practices growing? Are they losing referrals? Where are their case trends growing?"

By studying this data, you will more likely identify if you have physicians that want to reduce their caseload, perhaps in preparation for retirement; identify if physicians are sending more of their cases to the hospital; and identify the young physicians who are most likely to drive the success of the ASC in the future. "These are the guys we can put our stock in and bank on," Mr. Brown says. "They're the ones you can put your focus into as to what is going to be their needs in the future of their practice and ASC."

2. Total net revenue by physician. Like case volume, Mr. Brown says you should track this monthly and also examine the previous year's worth of data. "With this figure, we'll look at revenue by physician … and if one physician is doing the same case number as another but one surgeon's revenue is way ahead of the other, we're looking at that and working to identify what it is that physician is doing that the other is not."

This is a great way to examine the types of cases each physician performs in the same specialty, he says. "Just because you have orthopedics as specialty, it doesn't necessarily guarantee you high reimbursements. If your physicians are performing a majority of hand cases or simple knee arthroscopies, your total revenue may be lower than you would initially expect just looking at case volumes with 'orthopedics' as the specialty next to it, he says. You can also evaluate the payor mix of each physician by analyzing total net revenue.

3. Revenue per case by physician. By comparing revenue per case by physician by specialty, you will most likely observe significant practice patterns causing differences in reimbursement per case. "In pain management, for example, if you have one physician that's receiving $500 per case reimbursement and then you have another pain physician who is getting $750 per case, then you're going to want to look at those cases," Mr. Brown says. "In pain, you can do one level injections, two levels of injections, three levels. All of a sudden you're going to start to find that one surgeon is more advanced in techniques than another surgeon." Also, in some pain cases, surgeons will use fluoroscopy while others will not, he says. Those that use the C-arm typically receive higher reimbursement than those that do not use fluoroscopy, and examining and comparing revenue per case will help reveal such differences.

After identifying what is causing the differences in revenue, you can visit with your physicians and talk to them about their techniques, Mr. Brown says. "If you present the numbers to physicians, sometimes they'll be interested … to know they can get more money on the physician side as well, and that may change their technique."

4. Supplies per case by physician. Mr. Brown says ASC should look at supplies per case for physicians by like procedures. He suggests ASCs case cost these procedures and compare costs between physicians. One of the better ways to bring about change is to share this data with physicians, but he says you should not identify the physicians by name when doing so. Mr. Brown suggests ASC "blind the case cost," which means identifying physicians by letter or number (e.g., Dr. A, Dr. B, Dr. C).

"For example, let's say you have three ophthalmologists in your ASC," he says. "You have one that's running about $400 in supplies per case, one that's $300 and one that's $550. If you put those figures in front of [the surgeons], they're going to figure out who is who very quickly. When they do that, they never want to be the highest cost physician; they don't want to be the one that's costing the partnership money unless it's a valid reason.

"For example, when it comes to cataracts, you're talking about a fairly straightforward procedure that can be compared very easily," he says. "If you have a physician using a lot of high dollar supplies like your viscoelastics, there are different ones that cost more than the others; or maybe the lens they're using costs more than the others; it stands out fairly quickly."

By sharing the data and what's driving the cost differences, physicians will be more likely to make similar supply choices as their partners. "That really produces some healthy discussion," Mr. Brown says. "Whenever they're talking peer-to-peer, they can usually convince each other about the quality of products and they'll often switch (to a lower cost supply)."

5. Contribution margin by physician. This figure takes into account the other four statistics discussed. It's the collectible revenue from the case, the variable supplies and variable costs for the case which would include your direct labor as well, Mr. Brown says. "Then you come up to what is the contribution of that case to the partnership (before you apply any overhead)," he says. "That's what that case is contributing to the profitability of the center. We can really hone it down and see if there's a physician that's break-even or less; then we can get into those numbers and figure out why those cases not being profitable to the center. Is it supplies? Is it that cases take too long? Is it the reimbursement of the case?"

One example Mr. Brown has seen this work well is for GYN physicians performing ablations. Thermal ablation has a disposable supply that costs around $1,000, he says. That case has a Medicare reimbursement rate of around $1,100-$1,200, depending upon where in the country you are located. Once you included other supplies used on top of disposable supply and add in the direct labor costs associated with the case, you're more than likely losing money and that's even before overhead.

"While we may not be able to do those Medicare cases in our center but we'll try to work with our commercial payors and see if we can get a carve out for that supply item or for that CPT code," Mr. Brown says. "We ask if they will pay us $2,500 instead of $1,100-$1,200. That takes into account the $1,000 supply item and now you have a very nice, substantial contribution margin. The doctor didn't have to change anything, we just worked to obtain a carve out and then that case becomes a very profitable case."

This can also help to identify physicians who are performing many highly profitable cases the ASC should work to ensure those cases remain in the ASC. "What you want to be able to achieve is a certain contribution margin at the end of the day from these physicians," Mr. Brown says. "Let's say they have one of those Medicare cases they were going to lose money on but they had four other commercial cases. Why inconvenience our partner and make them go to the hospital to do one case versus coming to the ASC" and performing all five of the cases as their book of business, a book of business that is highly profitable for the ASC and convenient for the physicians and their patients." ■

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

5 Achievable Goals for ASCs in 2011

By Leigh Page

Michael Lipomi recently became president and CEO of Surgical Management Professionals in Sioux Falls, S.D., which runs 16 facilities. Eleven of them are ASCs and five are physician-owned hospitals. With a 32-year career in healthcare and facility management, he served most recently as president of RMC MedStone Capital. In addition, Mr. Lipomi will continue to manage three centers run by RMC, as part of a consulting agreement with SMP.

Mr. Lipomi describes five achievable financial goals for ASCs in 2011.

1. Renegotiate payor contracts. "We're always out renegotiating contracts," Mr. Lipomi says, but he sees a lot of the smaller ASCs simply extending their current payor contracts without renegotiating. Renegotiating might involve bringing in an outside contractor for the work, but it is well worth it, he says.

2. Expand services. Look for more procedures within your current specialties, such as moving to total joints, more neurosurgery and implanting pacemakers. "Talk to your physicians to gain an understanding of the additional services you could provide," Mr. Lipomi says.

3. Consider strategic arrangements with hospitals. One option for ASCs is to create a joint venture with a hospital or even converting the ASC into an HOPD. "Some hospitals are very willing partners and can offer mutually beneficial arrangements," Mr. Lipomi says.

4. Recruit new physicians. Although there is a higher saturation level of ASCs today than five years ago, not every suitable surgeon is aligned with a surgery center yet, Mr. Lipomi says. Ask physicians and staff to name potential recruits.

5. Possibly ACOs, but you'll need to wait. There may be opportunities for ASCs to expand their case volume by joining an ACO as the lowest-cost, high-quality choice for surgery. However, "it's too early to determine the effects of healthcare reform and the jury is still out on ACOs," Mr. Lipomi says. "There is a lot of confusion and not much in the way of information." ■

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6 Common Complaints Physicians Have When Acquired by Hospitals

By Leigh Page

Robert C. Bohlmann, principal of MGMA Health Care Consulting Group, advises hospitals on integrating group practices. Here he lists six common complaints physicians have when their practices are acquired by a hospital.

1. Unfair compensation. To avoid bad feelings, new hospital-based physicians need to know from the get-go that their compensation is being figured differently than in private practice. Hospitals are limited as to how much they can pay by anti-kickback laws. The hospital needs to base payments on national benchmark data, such as those generated by MGMA. Also, physicians who are used to being paid for in-house imaging will not see imaging income in the hospital setting.

2. Look like money-losers. Practices that were breaking even when they were acquired by hospitals may suddenly be swimming in red ink after joining the hospital. According to the hospital's ledgers, these practices may lose $50,000-$100,000 per physician, per year because the hospital is deducting hospital-wide costs onto the cost side and removing ancillary income, such as imaging services, from the revenue side.

Mr. Bohlmann calls this "red-ink syndrome." Even though the group may be no less productive than before, "it creates a real rhubarb," he says, not just for physicians, but as for the hospital. He was working with a hospital board that was all set to dump its doctors until he prepared a report showing the physicians were actually very valuable to the hospital in such areas as the value of their admissions. The board then decided to keep the practices.

3. Not involved in decision-making. Physicians can get unhappy when they have no say over their working hours, patient load or support staff. Physicians should be included when such policy changes are being discussed so that they can point out potential problems. For example, the system cannot simultaneously expect more physician productivity and cut their support staff. "Hospital executives think they know everything about medical practices, but they don't," Mr. Bohlmann says. "It's a different animal from a hospital."

4. Falling patient demand. Physicians get uneasy when appointments fall off, which can happen for various unanticipated reasons. For example, the hospital may decide to relocate a newly acquired practice but its patients don't follow. Similarly, it recruited 25 family physicians but the service area can only support 18. Or the hospital failed to effectively market the practices.

5. Inadequate disclosure. In the rush to sign them up, the hospital may forget to adequately inform physicians about the fine print of the agreement. For example, the physicians — not the hospital — may be on the hook for collecting the old practice's accounts receivable. Or the physicians may not be allowed to bring over anyone from their old staff.

6. No exit. If some physicians do not like the new arrangement, is there a way for them to politely part company without having to move 100 miles away due to a non-compete clause? Mr. Bohlmann says non-compete clauses were appropriate in the 1990s when hospitals bought the physicians' "goodwill," their patient lists, but hospitals today buy only the building and equipment from the practice, which is considerably less valuable than the goodwill. For this reason, he believes non-compete clauses should not be used and physicians should be allowed to walk away with few strings attached. ■

Contact Leigh Page at leigh@beckersasc.com.

56 ASC Management and Development Companies to Watch in 2011

By Rachel Fields

Here is a list of 56 companies involving in ASC management and development. *Note: This list is not an endorsement of any company.*

Ambulatory Healthcare Strategies. Ambulatory Healthcare Strategies was founded in 2009 by John J. Goehle, MBA, and Vito Quatela, MD. Most of AHS' surgery centers are located in the northeast United States. Mr. Goehle, who serves as the company's COO, has written four books about ASCs and says, "AHS focuses on providing an alternative to traditional management companies by focusing on surgery centers that don't need all the resources of a management company, but would like to receive some of the same services that they usually offer." Dr. Quatela is a board-certified facial plastic and reconstructive surgeon and the immediate past president of the American Academy of Facial Plastic and Reconstructive Surgeons. He has developed and owns two surgery centers in Rochester, N.Y. The company provides administrative, oversight and consulting services for surgery centers,

Ambulatory Surgical Centers of America. Led by CEO Luke Lambert, CFO Robert Westergard and founders Brent Lambert, MD and Tom Bombardier, MD, ASCOA is one of the most renowned privately-held ASC chains in the country. ASCOA currently operates 34 facilities across the country with others in development. ASCOA is a physician-owned ASC development and management company that offers years of experience in real estate, staffing, training, equipping, licensure, accreditation and compliance from a group of all-surgeon principals. The company was formed by Dr. Lambert, Dr. Bombardier and George Violin, MD and has a record of successful ASC turnarounds, correcting major problems such as poor management, inefficiencies caused by overbuilding and loose scheduling, lack of surgeon recruitment and lower-than-optimal reimbursement per case.

Ambulatory Surgical Group. ASG was founded in 2008 by long-term ASC veterans John Seitz and Stuart Bruck, who currently serve as CEO and director of financial and strategic planning, respectively. Mr. Seitz came to Ambulatory Surgical Group from Surgem According to the ASG website, Mr. Seitz believes that a higher percentage of physician ownership means better participation by physicians in ASC operation. ASG currently works in New Jersey and several cities in California.

AmSurg. AmSurg, one of the few publicly-traded ASC companies, partners with over 1,200 physicians at more than 200 ASCs across the United States and strives to help its ASCs provide high-quality, low-cost surgical services coupled with great patient satisfaction. AmSurg is led by CEO and president Christopher Holden, a highly skilled leader who joined the company in 2007 from Triad Hospitals, where he served as senior vice president and division president. AmSurg has centers in 33 states.

Ascent Partners. Ascent Partners is run by partners H. Thomas Scott and W. Scott Riegle. Prior to owning Ascent, Mr. Scott, a certified public accountant, was a co-founder and senior vice president of a physician practice and ancillary management company, while Mr. Riegle served as director of operations for HealthSouth Corporation. Ascent Partners has developed and operated 18 ASCs throughout the United States.

Artisan Medical. Founded in 2003, Artisan Medical has grown by building relationships with key ASC industry leaders and focusing on cost-saving strategies for its facilities. The company is run by managing partner Jesse Chamberlain, who specializes in organizing strategic ASC partnership teams and recruiting surgeons. Mr. Chamberlain previously worked for Johnson & Johnson, Chiron Vision, Bausch&Lomb and managed Proctor & Gamble's co-op merchandising agreements compliance program. The company operates five surgery centers in Maryland and Virginia.

ASD Management. ASD Management (formerly Woodrum/Ambulatory Systems Development) is one of the largest and oldest privately-funded ASC companies in the United States. ASD is noted throughout the ASC industry for being a truly hands-on, high-integrity company. The company is run by Robert and Joe Zasa, both of whom are nationally recognized for ASC development and management and have led the company to develop and manage over 125 surgery centers since 1986. ASD focuses on hospital/physician joint ventures and is known in the industry for hands-on, business-focused leadership. The company also specializes in turnaround strategies for existing ASCs and de novo development.

Blue Chip Surgical Center Partners. Run by the highly-regarded CEO Jeff Leland, Blue Chip focuses on spine, multi-specialty and physician/hospital joint-venture ASCs and takes care of financial, payor, legal and operational matters so that its surgeon-partners can focus on their clinical practices. Blue Chip is a true leader in spine and in minority ownership interest. The company continues to partner with surgery centers across the country, announcing a partnership with Crane Creek Surgery Center in Melbourne, Fla., in early Nov. 2010. In 2010, Blue Chip has also announced several new key staff members, including Chris Bishop, who joined the company as partner and senior vice president of acquisitions and business development in March, and Kathleen Whitlow, who joined the company as COO in January.

Cirrus Health. Cirrus Health, which is led by CEO Donald C. Wilson, specializes in the management and development ASCs, as well as of multi-specialty and single-specialty surgical hospitals. The company was founded in 1999 and adapted its business model in 2005 to encompass development and management of physician-owned ASCs and short-stay hospitals, rather than simply development. Cirrus Health works to align with local physicians and community healthcare providers to provide the best patient care in its ASCs.

The C/N Group. Founded in 1980, The C/N Group began offering consulting and management expertise to the healthcare industry. The company is owned and managed by the Chopra family — Ravi, Raman and Rajiv. During its initial decade of operation, the firm's primary focus was physician practice management and consulting, after which it expanded its services to include the development and day-to-day operation of healthcare facilities. In the last 10 years, the C/N Group has completed projects totaling more than $75 million in cost. The family-owned company employs approximately 230 people at its New York, Indiana and Texas regional markets.

Constitution Surgery Centers. CSC has provided patients with surgical care for more than a decade. Based in Newington, Conn., CSC operates more than 10 single- and multi-specialty ASCs in Connecticut, Rhode Island and Massachusetts. Founded in 1997, the company is led by co-founder, president and CEO Kris Mineau. Mr. Mineau was also the founding president of the Connecticut Association of Ambulatory Surgery Centers. In 2009, the company opened the Greater Springfield (Mass.) Surgery Center, a single-specialty ASC focused on urology.

Covenant Surgical Partners. Nashville, Tenn.-based Covenant Surgical Partners is led by Michael Koban, Jr., chairman of the board of directors, Richard Jacques, president and CEO, and Marnix E. Heersink, MD, vice chairman of the board of directors and chief medical officer. Mr. Koban has more than 25 years of experience as

a senior executive in hospital management, while Mr. Jacques has held positions at Surgical Health Group and AmSurg. Covenant acquires and operates single- and limited-specialty surgery centers in partnership with physicians.

Ethos Partners. Ethos Partners offers turnkey ASC development and management solutions from a group of professionals who have worked with more than 150 ASCs across the country. The company's ambulatory surgery center solutions team includes Carolyn Axley, RN, Mark Dunlap and Andrew and Tina King. Mr. Dunlap has managed and/or developed over 100 ASCs and previously served as founder and principal of management and development firm Acumen Healthcare. He also served as vice president of HCA's ambulatory surgery division. Mr. Dunlap and Ms. King also worked for Acumen Healthcare prior to joining Ethos.

Elite Surgical Affiliates. Based in Houston, Elite Surgical Affiliates manages and has an interest in ASCs with surgeons. The company was founded by respected CEO Lori Ramirez, who has more than 12 years of experience in surgical development, operations and management and has successfully partnered with more than 350 surgeons. She has also played a critical role in recruiting more than 100 new surgeons and has successfully restructured and turned around failing partnerships. Elite Surgical Affiliates' management team specializes in operations, development, sales and marketing, financial management, syndications and clinical excellence programs.

Facility Development & Management. FDM is a for-profit limited liability corporation that provides consultative, developmental and managerial services for ASCs through the country. The company was founded in 1992 and currently helps ASCs provide quality surgical services to physicians and consumers. FDM partners in de novo centers with physicians and hospitals, as well as re-syndicating existing ASCs. According to its website, the company has partnered with its clients to open and operate more than 45 profitable centers, including gastroenterology, urology, pain management and orthopedic centers, among others. The company is headed by Edward P. Hetrick, president, who has over 30 years of experience in healthcare and has held management positions in major teaching institutions in the New York metropolitan area. He has been involved in the development of over 50 ASCs.

Foundation Surgery Affiliates. FSA was founded in 1996 by Thomas A. Michaud, a pioneer in the ASC industry, who continues to oversee the company's significant growth as chairman of the board. FSA offers turnkey management and development solutions for physician partners. FSA partners with physicians through investment in a minority ownership position, usually between 10-40 percent, and currently operates 14 ASCs in five states. All of the ASCs the company operates are multi-specialty facilities.

Global Surgical Partners. GSP focuses exclusively on the development and management of physician/hospital and physician-owned joint-venture ASCs. The company acquires minority interests in its center and currently manages eight surgery centers. Under the GSP model, each centers' activities are decentralized, but administrators are employed by GSP. The company is led by J. A. Ziskind, president and CEO, who has served in that position since the company's inception, and Ken Arvin, Esq., CFO and general counsel.

Hospital Corporation of America. HCA is the largest for-profit operator of hospitals in the country and currently operates approximately 105 freestanding surgery centers as well as its 163 hospitals in the United States and England. The company was one of the first hospital companies when it was founded in Nashville in 1968. HCA is led by chairman and CEO Richard M. Bracken, who has been with the company since 1981 and has held various executive positions within the company, including CEO of Green Hospital of Scripps Clinic and Research Foundation in San Diego, Calif. The company's its outpatient services group is led by A. Bruce Moore, Jr.

Health Inventures. Health Inventures, founded by Richard Hanley, was one of the original non-equity management and development companies focused in the ASC industry. It is now often an equity partner in joint ventures as well as a manager and developer. Mr. Hanley and the rest of the company's management team have launched more than 100 surgery centers, surgical hospitals, imaging centers and medical office buildings, and managed more than $1 billion in revenues during their careers. The team includes industry experts Christian Ellison, vice president of business development, Dennis Martin, senior vice president of health systems and Thomas Wherry, MD, consulting medical director. Mr. Ellison has formed numerous physician-hospital joint ventures throughout his career and has helped build Health Inventures domestically and internationally during his 12 years with the company. Health Inventures currently manages more than 25 ASCs across the country.

Healthcare Venture Professionals. HVP is an ASC management company that specializes in multi-specialty, orthopedic, pain management, endoscopy, GI and hospital-owned surgery centers. The founders and principles of HVP are John Smalley and Chuck Owen, seasoned healthcare

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executives with more than 60 years of combined healthcare leadership experience. The company manages ASCs across the United States, with most facilities located in Michigan, Alabama, Mississippi and North Carolina.

Innovative Surgical Solutions Management. Innovative Surgical Solutions Management partners with physicians and health systems to develop and operate ASCs, making surgery operations its sole business. The company is run by D. Jeffrey Sapp, former vice president of development for USPI, and Nancy Kastner, who each have years of healthcare management experience and have successfully turned around numerous failing centers. Founded in 2001, the company's senior leadership has developed or managed more than 100 ASCs across the country.

Interventional Management Services. IMS is a physician-owned ASC management and development company that focuses on pain management physicians. Centers managed by IMS range from one-room, single-specialty centers to large multi-specialty physician/hospital joint ventures. The company has corporate offices in Atlanta and affiliate ASCs in Georgia, Texas and New Mexico, and it continues to expand throughout the country. The company is led by CEO Stephen Rosenbaum, who created the company with Robin Fowler, MD, in 2008 and is responsible for the day-to-day operations of 10 healthcare companies and over $35 million in annual revenues. Dr. Fowler, who serves as the company's medical director, has been one of the leading pain practitioners in the east Atlanta area since 2005 and has performed more than 5,000 epidurals and pain procedures.

Medical Consulting Group. Established in 1998, MCG has grown from a small start-up consulting firm with one employee to more than 40 employees in Springfield, Mo., and Fayetteville, Ariz. The firm specializes in medical consulting, both at the surgical practice and corporate levels, and provides ASC development and management solutions for single, multi-specialty and hospital joint-venture facilities. MCG offers a variety of services to its facilities, including IT set-up and support, employee benefits services, billing, coding and accounting, among others. Its team includes Stephen C. Sheppard, CPA, and Rob McCarville, MPA. MCG has completed over 20 centers and currently has more than 10 ASCs under various stages of development.

Medical Facilities Corp. MFC owns majority interest in two ASCs and four specialty surgical hospitals in South Dakota, Oklahoma and California. The company is run by CEO Donald Schellpfeffer, MD, who co-founded the company, and brilliant, focused leader Larry Teuber, MD, a board-certified neurological surgeon and physician executive of Black Hills Surgical Hospital. MFC is noted in the hospital industry for very focused leadership and critical thinking. MFC, which was developed by the physicians of Black Hills Surgery Center and Sioux Falls Surgical Center in South Dakota, is considered Canadian property and is publicly on the Toronto stock exchange. MFC's management philosophy focuses on efficiency and productivity of its facilities and strives to maintain competitive rates in order to generate superior margins relative to its competitors.

Medical Surgical Partners. MSP offers turnkey development and consulting services to ASCs that remain 100-percent locally owned and managed. MSP does not require any ownership equity in a facility. The company is led by David Thoene, who has 27 years of experience consulting for and developing ASCs throughout the United States. Before founding MSP, Mr. Thoene was the vice president of development for FSC Health and Titan Health Corp. and founded the development arm of Randlett Associates. Since 1982, Mr. Thoene has developed and consulted for more than 40 physician-owned ASCs and surgical hospitals and hospital/physician joint-venture surgery centers.

Meridian Surgical Partners. Meridian Surgical Partners specializes in ASC acquisition, development, management and turnaround in partnership with its physicians. The company was founded by three healthcare industry veterans and is currently led by renowned CEO David "Buddy" F. Bacon, Jr., who previously served as CEO and CFO for Medifax-EDI, Inc., a healthcare IT company in Tennessee. Meridian's management team also features the really smart president and chief development officer Kenneth Hancock, former CDO and co-founder of Surgical Alliance Corporation, a specialty surgical hospital company. Meridian has greatly reduced the industry standard ratio of facilities to operations, giving its physicians access to senior management and ensuring that facility relationships are founded on communication rather than a standard formula. In Oct. 2010, Meridian acquired the single-specialty ASC City Place Surgery Center in Creve Coeur, Mo. Mr. Bacon said about the acquisition, "We are extremely excited about this new partnership and the growth opportunities it presents … We look forward to partnering with the physicians and staff for continued success."

Mowles Medical Practice Management. Founded in 1996, MMPM has spent the last 15 years dedicated to assisting pain management and other specialists develop efficient and productive ASCs. MMPM CEO Amy Mowles has an expertise in pain management almost unequaled in the ASC industry, and her experience with CMS policy analysts as well as ASC and pain management societies have cemented her reputation as a leading expert in the ASC field. To date, MMPM has successfully developed more than 35 ASCs, the majority of them pain management-focused, and is currently developing five more.

Murphy Healthcare. Under the leadership of founder and CEO Robert Murphy, Murphy Healthcare has developed over 30 ASCs. Murphy Healthcare's ASC Turnaround Group rehabilitates failing or ailing ASCs throughout the country, the first being a success story in Seminole, Fla., where a failing surgery center achieved a 75 percent increase in case volume and a 20 percent reduction in cost. Murphy Healthcare is renowned for its smart, creative leadership. In addition to development and management, Mr. Murphy runs Murphy Healthcare's central data processing center in Montvale, N.J., which provides billing services to dozens of independently owned and operated ASCs. Mr. Murphy is assisted in the management of Murphy Healthcare by president Bill Mena and COO John Murphy.

National Surgical Care. NSC operates 18 centers around the country in partnership with physicians and hospitals. By the end of 2010, centers managed by NSC will perform over 115,000 cases, support 300 physician partners and include four hospital partners. The company is headed by chairman and CEO Sami S. Abbasi, who previously served as president and CEO of Radiologix, a leading national provider of diagnostic imaging services. National Surgical Care's surgery center development and management is led by company president Richard D. Pence, who previously served as COO for MAGELLA Healthcare and COO of National Surgery Centers.

Nikitis Resource Group. NRG provides a full range of ambulatory surgery center services, including ASC development and management, AAACH accreditation and operations analysis. The company was founded by Tom Galouzis. MD, and its leadership includes industry veterans such as Bob Scheller, CPA, CASC, and Gregory Nowak, MD.

NovaMed. NovaMed acquires, develops and manages surgery centers in partnership with physicians. The company is publicly traded on the Nasdaq exchange. Founded in 1995, the company went public in 1999 and is currently run by chairman and CEO Thomas S. Hall, executive vice president and CFO Scott T. Macomber and executive vice president of operations

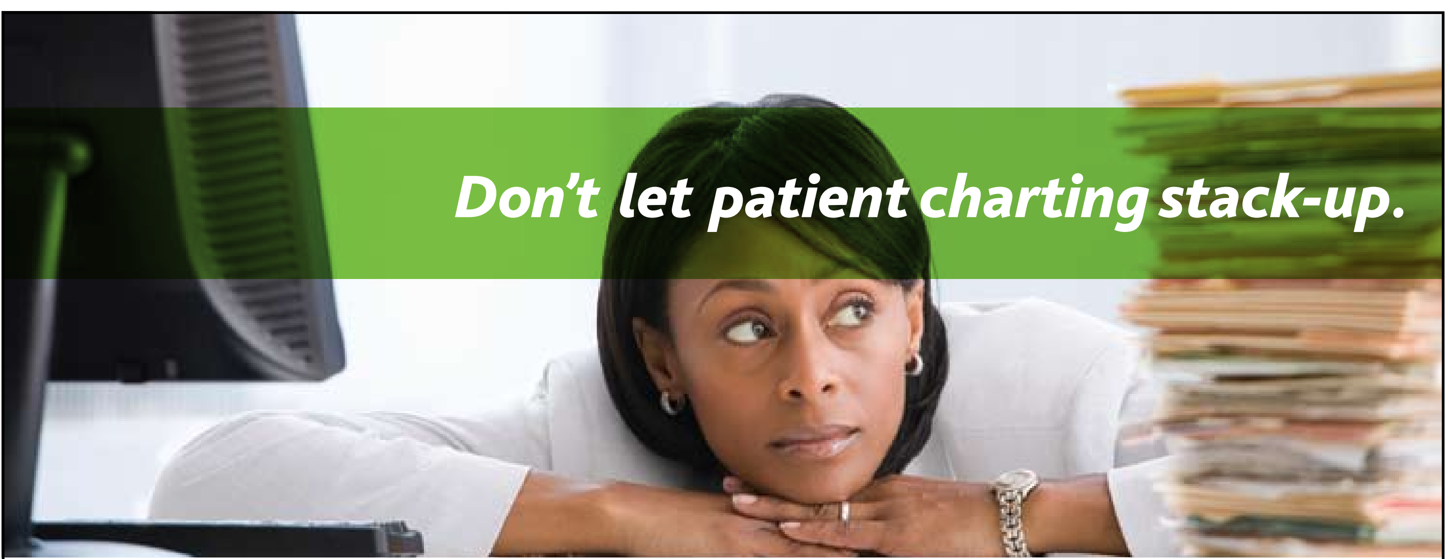
Graham B. Cherrington. NovaMed is known for having a great and disciplined management team, which includes smart, motivated leaders William Kennedy, senior vice president of business development, Thomas Chirillo, senior vice president of corporate development, and John Lawrence, Jr., senior vice president and general counsel. The company has ASCs all over the United States and currently operates more than 35 centers.

Nueterra Healthcare. Nueterra Healthcare partners with physicians and hospitals to develop and manage community hospitals, surgical hospitals, ASCs and physical therapy centers including new development, joint ventures, acquisitions and turnarounds. The company's executive leadership includes CEO David Ayers, who has extensive experience working with physicians and health systems to develop successful partnerships, and CFO Kevin Standefer, who has a strong financial background and served as senior internal auditor for one of the largest publicly-traded healthcare companies in the country prior to joining Nueterra. Since 1997, Nueterra has worked with more than 1,200 physicians and established more than 85 surgical and outpatient facilities across the country.

Orion Medical Services. Orion Medical Services specializes in developing and managing ASCs and medical office buildings and lets physicians retain a majority interest in the center's business. The company is led by outstanding leader James H. Cobb, who founded the company in 1997 and currently serves as president and CEO. In the past 12 years, Mr. Cobb has developed, constructed and managed seven high-volume ASCs, and he has been a member of the Medical Group Management Association for 20 years. Orion Medical Services currently has a number of centers in Oregon, Colorado and Texas and lends its specialized experience and expertise to neurospine surgery centers in particular. In 2010, Orion Medical Services announced the launching of several websites for its surgery centers, including the Littleton (Colo.) Day Surgery Center, Kerryville (Texas) Surgery Center and Columbia Gorge Surgery Center in The Dalles, Ore.

Ortmann Healthcare Consultants. Based in Columbia, S.C., with offices in Chelan, Wash., Ortmann Healthcare Consultants specializes in the development of both single-specialty and multi-specialty ASCs. Founder and CEO Fred W. Ortmann III has over 30 years of experience in various aspects of healthcare, including 25 years as a hospital administrator and 10 years as the vice president of center development for a premier developer and operator of surgery centers. Ortmann currently operates nine surgery centers in various states, including North and South Carolina, Texas, Colorado and Florida.

Physicians Endoscopy. As the country's premier GI/endoscopy-driven ASC company, PE is focused exclusively on developing and managing single-specialty endoscopy centers. PE has an outstanding core management team and typically owns a minority interest in the centers it manages. Founded in 1998, the company currently manages 17 endoscopy centers and is led by Barry Tanner, CPA, president and CEO. Mr. Tanner joined PE in July 1999 after serving as CFO and co-founder of Navix Radiology Systems, a physician practice management company based in Miami. Physicians Endoscopy's management team includes clear-thinking industry leaders Karen Sablyak and John Poisson, who serve as CFO and executive vice president of new business development, respectively. Ms. Sablyak has worked as vice president of practice management for Allegheny University Hospitals, while Mr. Poisson came to PE from Transcend Services. In Jan. 2010, Physicians Endoscopy announced the commencement of operations at East Side Endoscopy in Manhattan, a collaboration between PE and Beth Israel Medical Center. The company also appointed a new COO during 2010, hiring Frank Principati to take responsibility for strategic and operational leadership of the company's operations.



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Pinnacle III. Pinnacle III is a leading provider of development and management services to physician-driven ASCs as well as hospital joint ventures. Pinnacle III's leadership team includes Rick DeHart, CEO, Rob Carrera, president, and Scott Thomas, executive vice president. Lisa Austin, vice president of ASC operations for Pinnacle III, has exntesive experience in ASC operation and development and serves on the board of CASCA, the Colorado Ambulatory Surgery Center Association. The company also recently added director of marketing and sales Simon Schwartz to the team, who joined Pinnacle III from the ASC Association, where he spent five years planning, managing and executing medical conferences and trade shows. The company offers both equity and non-equity models, though it is focusing on the expansion of its surgical network through equity ownership. Since 1999, the company has delivered a comprehensive range of services and solutions to 35 ASCs — from single-specialty physician-owned ASCs, to multi-specialty joint ventures with hospital partners.

Practice Partners in Healthcare. PPH is a developer, manager and minor equity share holder in ASCs, a privately held company dedicated to the management and operation of its ASCs. The company is headquartered in Birmingham, Ala., and was founded by respected industry veteran Larry Taylor in 2005. PPH currently has seven surgery centers in operation and six additional centers in the development and construction phase. Practice Partners is led by president and CEO Larry Taylor and COO Mike Rickman, who tout a physician-focused model. The company is noted for its hands-on approach to management and high-integrity leaders. PPH's management team has ASC operational experience in 34 states, including both CON and non-CON states, with success in obtaining CONs in difficult environments.

Regent Surgical Health. Founded in 2001, Regent Surgical Health has grown to develop, manage and own 15 ASCs and two specialty hospitals across the United States. Regent is a privately held company. Headquartered in suburban Chicago, Regent is led by Harvard Business School graduates Thomas Mallon and W. Michael Karnes, who founded the company together and currently serve as CEO and CFO, respectively. Regent's management team also includes COO Nap Gary, who previously served as senior vice president and assistant corporate counsel for HealthSouth Corporation, and CDO Jeff Simmons, who has led two specialty hospitals and one full-service acute-care hospital and oversees Regent's acquisition and development efforts. Bo Hjorth, vice president of business development, also makes valuable contributions to the Regent team.

RMC MedStone Capital. RMC Medstone Capital was founded when RM Crowe, leading real estate developer and property manager in Dallas, purchased TruMedical Partners. MedStone is led by CEO R. Maurice Crowe, Jr., who formerly served as a senior financial officer with Criswell Development Company and focuses on new business and acquisitions for RMC. The RMC MedStone model is to acquire an appropriate percentage of each facility and to manage the operations and growth of the facility's caseload and profitability through its affiliated entity, RMC MedStone Management. RMC MedStone Capital's plan for growth includes the addition of surgery centers and hospitals throughout the country, including both existing facilities and de novo projects.

Solara Surgical Partners. Started in 2008, Solara Surgical Partners develops and manages ASCs and other surgical facilities across the United States. The company's principals, Ken Ross, Bill Murphy and Andrea Kingsley, have a successful track record of over 75 surgical facility projects. Mr. Ross serves as the company's CEO, while Mr. Murphy serves as COO. The leadership team also includes Matt Parra, who serves as vice president of acquisitions and development and previously served as senior vice president with ASCOA.

Smithfield Medical Development. Together with its physician partners, Smithfield Medical Development creates and manages medical developments that merge high caliber patient care with real estate development trends. The company focuses on the enhancement of physician profitability and has experience in the development of medical office buildings, surgical facilities and medical malls. Smithfield maintains minority ownership in its surgical facilities.

Sovereign Healthcare. Sovereign Healthcare is a privately held company based in Orange County, Calif., that partners with physicians for the ownership and management of ASCs. The company was founded in 2002 by a group of healthcare industry veterans who had been involved in the development and management of major acute-care hospitals, specialty hospitals, surgery centers and other healthcare ventures. The company is headed by Jeremy Hogue, president and CEO, who co-founded Sovereign Healthcare and previously served as vice president of $1 billion private equity investment firm Audax Group.

Specialty Surgery Centers of America. Specialty Surgery Centers of America, based in Texas, was formed to assist physicians and man-

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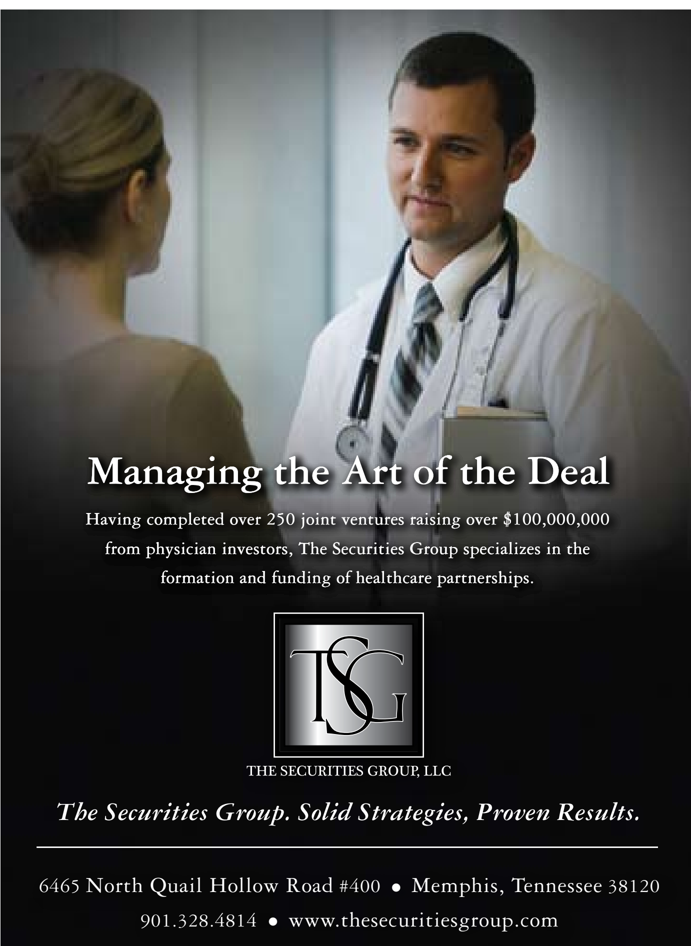
agement companies in developing and operating ASCs. SSCA currently operates two surgery centers and is in the process of opening a third in Lebanon, Texas. SSCA is run by president Keith Bolton, who previously worked for Humana, served as CEO of a California hospital and ran the Texas division of Heritage Surgical Corp.

Surgem. The principals of development and management company Surgem have been successfully managing ASCs since 1992. The company currently oversees surgery centers in New Jersey, Florida, New York and various other states. The company is led by John Hajjar, MD, chairman, CEO and chief medical officer, who developed one of the first ASCs in New Jersey and has been managing facilities profitably since 1992.

SurgCenter Development. Run by founding principals Gregory George, MD, and Sean O'Neal, among others, SurgCenter Development specializes in developing multi-specialty surgery centers averaging around 5,000 square feet. The company has developed ASCs across the United States, with the highest concentration in Missouri, California and Maryland. SurgCenter has developed over 60 profitable, physician-owned ASCs under the leadership of Dr. George and Mr. O'Neal. Dr. George is a practicing ophthalmologist with insight into surgeon needs, while Mr. O'Neal served as a hospital CEO for 20 years and developed his first physician joint venture ASC with Dr. George before founding SurgCenter Development.

Surgery Center Partners. Founded by Samuel Marcus, MD, PhD, and George Tinawi, MD, Surgery Center Partners has a physician-centered approach that provides physician partners with majority control of their surgery centers. With a motivated and insightful leadership team, Surgery Center Partnership focuses on GI-driven ASCs and has more than 16 affiliated ASCs, a majority of which are single-specialty endoscopy centers.



Surgery Partners. Surgery Partners acquires, develops and manages free-standing ASCs in partnership with leading physicians and currently owns and operates 11 ASCs in the southeast. In Jan. 2010, H.I.G. Capital, a leading global private equity firm, announced the completion of a majority investment in the Tampa-based company. Surgery Partners is led by CEO Michael Doyle, who most recently spent 10 years in a large, corporate healthcare organization, and vice president of operations Jeff Park, who joined the company in June 2006 after spending 10 years managing diagnostic, surgery and rehabilitation centers in the southeast.

Surgery One. Surgery One manages four multi-specialty ASCs in the San Diego, Calif. area. The four centers offer orthopedic, sports medicine, pain management and bariatric services. The four locations include a network of physicians and offer cutting-edge technology to perform surgical services. The centers specialize in various procedures, including arthritis/minimally invasive hip and knee solutions, weight loss, back and neck pain treatment, hand/carpal tunnel and upper extremities, hernia treatment, sports medicine and chronic pain management.

Surgical Care Affiliates. SCA currently operates more than 125 ASCs and three surgical hospitals across the country and now has more than 2,000 physician partners. A growing force is the important market segment of physician/hospital joint ventures, the company is led by president and CEO Andrew Hayek, who joined SCA after serving as president of a division of DaVita Inc., a $6 billion publicly traded renal dialysis company. Mr. Hayek also served as chair of the ASC Advocacy Committee, launched in Aug. 2009 to advocate for ASCs on topics of health reform. Joe Clark, SCA's executive vice president and CDO, previously served as president and CEO for HealthMark Partners and as CEO of Response Oncology, a publicly traded cancer management company. Oct. 2010, the company announced the appointment of a new executive vice president and CFO, Gregory Cunniff, who has more than 20 years of healthcare experience and worked at surgery center development and management company Medical Care America. Mr. Cunniff has served as board member and treasurer of the ASC Association since 2007 and previously served as western CFO of HCA's ambulatory surgery division.

Surgical Development Partners. Surgical Development Partners is a privately held company that develops and manages surgical facilities including ASCs and surgical hospitals. The company has completed surgery center development projects in a number of states, including Ohio, New Mexico and Tennessee. The company is led by president and CEO G. Edward Alexander, who previously served as CEO of Surgical Alliance Corporation, a company focused on musculoskeletal hospital development and management. SDP's current projects include Park West Surgical Center in Akron, Ohio and Summit-Medina Ambulatory Surgery Center in Medina, Ohio.

Surgical Health Group. During the last 17 years, the leadership team at Surgical Health Group has helped start over 150 surgery centers, offering turnkey solutions to physicians to develop quality physician-owned centers. SHG's services include human resources management, financial analysis, accreditation, design and construction, compliance issues and many others. The company is run by Rodney H. Lunn.

Surgical Management Professionals. SMP specializes in the management and development of ASCs and surgical specialty hospitals. In Oct. 2010, SMP announced Michael Lipomi as the company's new president and CEO. Mr. Lipomi most recently served as president of RMC MedStone Capital and has served on the board of directors of the ASC Association, California Ambulatory Surgery Association and Physician Hospitals of America, of which he is a co-founder. SMP is also led by Kyle Goldammer, MBA, senior vice president of financial services. The company provides comprehensive management and development services to more than 10 ASCs throughout the Midwest and Canada and has recently been involved in a number of hospital joint-venture ASCs in CON states

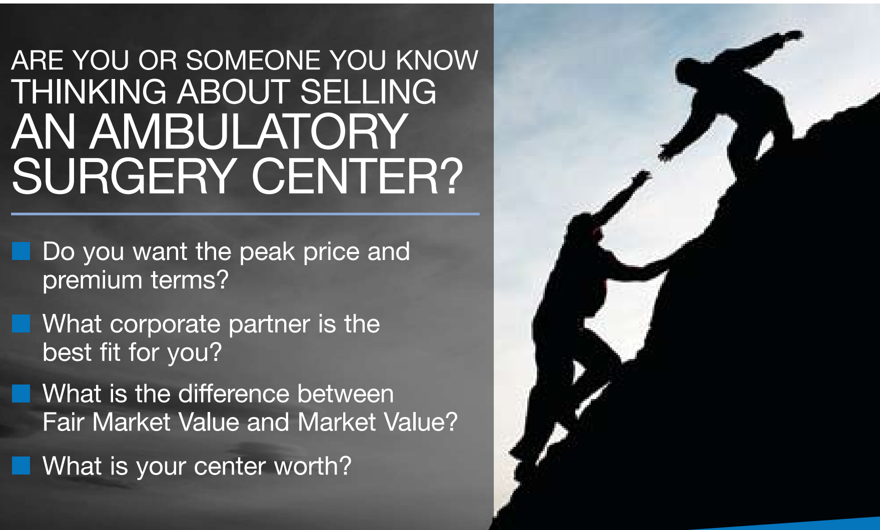
Symbion Healthcare. Symbion Healthcare was founded in 1999 to acquire, develop and operate short-stay surgical facilities in partnership with physicians, hospitals and health systems. Through continued capital investment and flexible partnership arrangements, the company's network has grown to include more than 70 short-stay surgical facilities across 27 states. Symbion has 3,000 employees and more than 1,100 physician partners and is headquartered in Nashville, Tenn. The company is led by president Clifford G. Adlerz, who has served in the role since May 2002 and as COO and a Symbion director since the company's inception, and CEO Richard E. Francis. Mr. Francis has served as CEO of Symbion since the company's inception in 1999 and previously served as president and CEO of UniPhy, an operator of multi-specialty clinics, independent practice associations and related outpatient services. Vice president of acquisitions and development Michael Weaver has worked to develop long-term partnerships and joint ventures opportunities for Symbion for more than a decade.

Titan Health Corp. Titan, established in 1999, manages and develops specialty-focused surgery centers with an emphasis on orthopedics, spine and neurosurgery and pain management, on a national basis. Titan's leadership includes such industry leaders as Chairman David Hall, president and CEO Marc Jang, and CFO Boyd Faust, CPA. Titan typically maintains a minority interest position and has a solid reputation as a smart and trustworthy partner. The company currently manages 16 ASCs across the United States.

TRY Healthcare Solutions. TRY Healthcare Solutions was founded by Tom Yerden, an ASC veteran and who previously founded Aspen Healthcare, which was sold under his leadership to TLC Vision Corporation and then to National Surgical Care. The company provides consulting services for de novo hospital/physician partnership models, expanding existing outpatient surgery enterprises, resyndications and operational improvement and profitability strategies. Mr. Yerden has helped establish more than 35 ASC joint ventures since 1992.

United Surgical Partners International. USPI develops and manages more than 150 different facilities, principally surgery centers, and serves as a true leader in ventures involving ASCs, hospitals and physicians. Most of its centers have a non-profit health system joint-venture partner, and more than 6,500 physicians will use USPI's facilities this year. The company has also partnered with more than 2,800 individual surgeons in the ownership of its surgical facilities. USPI's leadership team includes talented veterans such as chairman Don Steen and CEO Bill Wilcox, as well as CDO Brett Brodnax, who worked for Baylor Health Care System for 10 years before joining the company in 1999, and vice president and general counsel Jason Cagle. USPI was founded in 1998 by Mr. Steen and major stockholder Welsh, Carson, Anderson & Stowe. The company went public in 2001 and was taken private again in April 2007. In the third quarter of 2010, USPI acquired Nashville, Tenn.-based ASC operator HealthMark, which is led by Bill Southwick. ■

Contact Rachel Fields at rachel@beckersasc.com.



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Blayne Rush is the President of Ambulatory Alliances, LLC and is a SEC/FINRA Registered Investment Banker and Texas real estate broker. He specializes in acquisitions, alliances and access to capital markets for surgery centers and radiation oncology centers. Rush holds a masters degree in Health Promotions and a MBA, and has over 15 years of experience in the health care industry; he's worked with over 250 different healthcare organizations. Ambulatory Alliances uses a two stage negotiated bid process to help obtain the premium price for your center.

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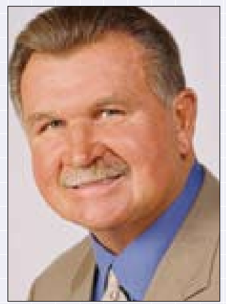
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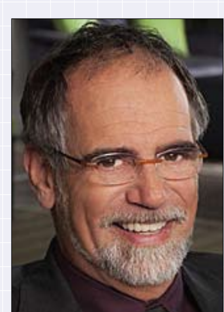
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12 Anesthesia Processes to Track and Benchmark

By Rachel Fields

Thomas Wherry, MD, principal of Total Anesthesia Solutions and medical director for Health Inventures, discusses 12 anesthesia processes to consider benchmarking in your ASC. He recommends choosing five or six of these processes and creating a neat, easy-to-understand report card for your anesthesia providers, rather than trying to benchmark too much.

1. Same-day cancellation rate. According to Dr. Wherry, same-day cancellation rates should be close to zero. Once you know your same-day cancellation rate compared to other centers, you can work with surgeons and anesthesiologist to determine the cause of cancellations. The pre-op phone call screening process is often the root cause.

2. Average phone call length. "Benchmarking the average phone call length is important because phone calls made by nurses should be short and succinct," Dr. Wherry says. While this may not be a direct anesthesia benchmark, he says anesthesiologists can work with nurses to go over necessary information for the call. If the anesthesiologist explains what anesthesia needs to know prior to the case, the nurses should be able to cut the pre-op phone call down to 10 minutes or less.

3. Supply costs per case. Benchmark supply costs per case against other facilities to determine where you waste money on supplies, Dr. Wherry says. He identifies top supply money-wasters as expensive IV tubing and breathing circuits and inhalation agents that are allowed to flow into the atmosphere.

4. Late arrivals. "A lot of centers complain about the anesthesiologist showing up late," Dr. Wherry says. He says tracking arrival times can give you leverage when speaking to your anesthesia providers about lateness problems, as well as give you an idea of where time is wasted during the pre-op process. He says as a general rule, anesthesiologists or CRNAs working in an ASC should be at the center 15-30 minutes before the first schedule case.

5. Time in the procedure room before and after surgery. According to Dr. Wherry, your ASC should benchmark the time the anesthesia provider spends in the room before surgical prep and after surgery ends. These are typically referred to as induction time and emergence time. "Both those times should be under five minutes," he says.

6. Narcotic documentation and compliance. Dr. Wherry says your ASC should ensure anesthesiologists are recording narcotic documentation according to CMS and accreditation regulations. Compare what was recorded on the anesthesia record to what was signed out.

7. ASA physical class of patients. Dr. Wherry recommends benchmarking American Society of Anesthesiologists Physical Status of patients, which (for an ASC) will typically fall on a scale of 1 (normal, healthy patient) through 3 (patient with severe systemic disease). This will give you an idea of how healthy your patient population is and could alter the precautions you take with anesthesia or surgery.

8. Recovery time. Be careful about tasking your anesthesiologists with lowering recovery times, as they are not the only people responsible for the process. However, ASCs can still benchmark recovery times to involve anesthesiologists in promoting efficiency. "If they're benchmarked for [recovery time] and they see that, they may take some ownership to decrease that benchmark," he says. "It's not necessarily fair because they don't have 100 percent impact on recovery times, but you can certainly get them to participate."

9. Type of anesthesia provided. Dr. Wherry recommends benchmarking how much regional and general anesthesia your surgery center performs. "It's an easy benchmark, and most scheduling modules can track it without any extra effort," he says.

10. Patient satisfaction. While patients might not always feel well after anesthesia — no matter how well the anesthesiologist performed — centers can track patient satisfaction based on other factors, such as the level of comfort going into surgery. "You can ask, 'Did the anesthesiologist address your concerns in the pre-op area? Were you satisfied with your care? Did you have concerns for your recovery?'" Dr. Wherry says. "Things aren't going to be 100 percent perfect, but patients will mostly be satisfied if the anesthesiologist listened to their concerns and took them seriously."

11. Post-operative nausea and vomiting rates. Dr. Wherry says your ASC should track nausea and vomiting separately, as in feeling sick versus actual vomiting. "With today's anesthetic techniques, those rates should be low," he says. "It's worth measuring and comparing if you're in a network of 10 centers because you know there's a problem if you're the highest."

12. Surgeon satisfaction. Dr. Wherry says surgeon satisfaction with anesthesia can be measured when the ASC distributes surveys on surgeon satisfaction with the overall ASC. Because surgeons and anesthesiologists sometimes butt heads over patient eligibility for surgery and other issues, benchmarking surgeon satisfaction on a regular basis will help you understand when you need to step in and talk to both parties about regular disputes. ■

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9 Key Considerations Regarding Healthcare Internal Investigations

By Scott Becker, David Pivnick and Elaine Gilmer, McGuireWoods

Healthcare providers face a climate of increased investigation coupled with a quickly changing business environment. The Department of Justice has requested increases in its budget, including substantial increases in the DOJ's 2011 budget for investigating and litigating healthcare fraud cases. There has also been a very substantial increase in False Claims and other whistleblower litigation aimed at hospitals and health systems. These developments create a recipe for serious legal challenges. Moreover, a quickly changing business environment has led to a variety of new and creative ways for hospitals, surgery centers and physicians to interact. The existence of these new and aggressive relationships combined with an ever-increasing investigative climate creates substantial risk of regulatory and legal exposure.

When a hospital or health system becomes aware of potential improper conduct either through an employee, an independent contractor or otherwise, the standard response is to commence an internal investigation. In conducting such investigations, there are several different issues and factors that come into play. This article briefly describes nine such considerations.

1. Plan and subject matter expertise. The internal investigation should start with a core work plan. This may include the scope of the investigation, what documents are going to be reviewed, who is going to be interviewed, and what is expected in terms of a final product. Generally, it is helpful to identify a list of questions that the company wants answered and often some of these questions will be open ended. Additionally, it is helpful to include in the plan the timing and sequencing of the activities that will be conducted. For example, before starting with interviews, it is helpful to review a substantial number of relevant documents to provide information that can be used in conducting the interviews. The interviews may start with an outline of 10-15 basic questions and then include additional questions as the interview evolves. Furthermore, it is helpful to interview the party on the opposite end of the relationship and not just the hospital official or other party who supervised or engineered the relationship for the hospital. For example, in certain situations a hospital supervisor may have an understanding of their risk and be very cautious in answering questions, such as "how did you decide on that person for providing funds to?" but the recipient of the funds may provide a clearer or more frank answer as to how they believe they were selected.

The investigative team should include lawyers or consultants with specific and deep knowledge of the areas under investigation, each by industry niche (e.g., hospital business practices, physician referral relationships, surgery centers, pharmaceutical or device marketing practices, etc.) and by legal statute (Anti Kickback, Stark, exempt organizations, FDA, etc). This is critical both from assuring the right questions are asked and the right focus is taken to the effort. It is also critical to help bring a level of efficiency to the investigation.

2. Who to report to? An internal investigation is typically conducted for the chief legal officer or general counsel if the company has such

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an officer. In companies without such an officer, internal investigations are often conducted for the president, chief executive officer or board. The persons responsible for conducting the internal investigation will generally provide his or her findings to the person that has requested and is responsible for the internal investigation. However, an exception arises where the person who has requested the investigation has a conflict or does not appear responsive to the findings of the internal investigation. In such situations, the general advice is that those persons responsible for the investigation should take their findings further up the corporate ladder until the investigation is properly responded to. This scenario presents a very interesting judgment call and will often require an analysis of the severity of the conduct under review and of the significance of any conflict that exists. It is critical to understand the chain of authority for internal investigations.

3. Constituents. In most internal investigations, there will be a mix of different perspectives on what the individual parties involved in the investigation are attempting to accomplish. The chief compliance officer or general counsel may have a perspective that the business people have acted too aggressively, improperly or simply not heeded their advice. In contrast, an executive may be looking for a report that provides them with a confirmation that they have performed properly. The persons responsible for conducting the internal investigation must have an understanding of each of these different constituents with a comprehensive view of what each expects, while at the same time being prepared and willing to record their true findings and to conduct an unbiased investigation. In essence, one party might want a report that essentially approves the conduct in question, whereas another party might be seeking a report identifying wrongdoers and suggesting appropriate redress. These divergent views can also affect the manner in which these constituents respond to and participate in the investigation. From an investigator's standpoint, the goal is to provide the company with the most accurate and useful report possible without being persuaded by other persons' objectives and agenda. Rather, the internal investigator must be willing to diligently investigate, to provide prophylactic guidance and advice on how to improve things on a going forward basis, and must consider whether affirmative next steps are required with respect to past conduct. For example, the investigator may need to evaluate whether there should be a self disclosure of the conduct to the government, whether current relationships should be terminated and whether other steps are necessary.

4. Independence. The internal investigation should almost always be handled by outside counsel that is independent of the company and the conduct in question. For example, to the extent that high-ranking officers were heavily involved in the conduct to begin with, such persons should not handle the investigation and it is imperative that the findings of the investigation go beyond the general counsel or such officers. Further, where outside counsel has been involved in or in any way provided advice relating to the conduct in question, serious consideration should be given as to that counsel not conducting or otherwise being involved in the investigation. Separating persons who are subjects of the investigation from the conduct of the investigation is imperative in ensuring a careful, reasoned investigation without interference by persons with a personal stake in the outcome. Moreover, independent investigators are more likely to consider each of the issues and to be unaffected by preconceived opinions regarding the subjects of the investigation.

5. Hold notices. At the start of an internal investigation, it is often helpful and important to send out a memorandum warning all persons who may have relevant information not to destroy any documents, emails or other correspondence relating to the facts at issue. A hold notice is particularly important if there has been any sort of government or litigation inquiry. A hold notice helps to ensure that the investigators are able to obtain and review all relevant documents and helps to avoid potential liability associated with the destruction of documents. Additionally, prior to the inception of an internal investigation it is also helpful for companies to have established document retention policies, which should be implemented and enforced.

6. Email records and discovery. Depending on the scope of the internal investigation, it can be very helpful to review email records and other documents related to the parties involved. In a government investigation, all emails will almost certainly be subpoenaed and they often contain the types of information that can be particularly challenging in defending a company. It should be noted, however, that conducting such a comprehensive investigation of emails can become extremely expensive. For example, in one internal investigation there were approximately one million emails that were reviewed over the course of three weeks by lawyers working 24/7. This is an expensive undertaking. It will however ensure a thorough investigation and a complete understanding of the documentary evidence that exists and the challenges presented by such evidence.

7. Conducting Interviews. When conducting interviews, it is helpful and advisable to have two persons present in addition to the interviewee. One of the individuals is then able to conduct the interview, while the other individual takes notes. This allows the person conducting the interview to really focus on the interview and on the responses being given, in order to ensure that appropriate and necessary follow-up questions are asked. The interviewer can also then focus on the body language and conduct of the interviewee. Additionally, the person who is actually taking notes is better able to focus on accurately recording the questions and responses without having to formulate follow-up questions or determine the course of the interview. It is often helpful to have the person responsible for note-taking provide a short, written memorandum after the interview articulating the issues that have been discovered and discussed through the interview. Having multiple persons present during an interview provides an additional and significant benefit by encouraging the interviewee to be accurate and by deterring interviewees from altering or amending their answers after the interview has concluded.

8. The Upjohn Warning. When conducting an internal investigation, a witness will often state that he or she does not want the investigator to repeat the witness's statements. However, as the internal investigation is often intended to identify and remedy wrongdoing, it is often critical that the witness's statements are included in the final investigative report. Moreover, the company may consider it beneficial to disclose those statements. Therefore, it is often not possible to fully protect the confidentiality of each witness and his or her statements. In this regard, each person should be warned that the attorney represents the company rather than the individual employee and, therefore, the attorney-client privilege on the communications belongs to the company and not the employee. This is called an Upjohn Warning after the seminal case of *Upjohn Company v. United States*. In Upjohn, the United States Supreme Court held that the attorney-client privilege is between the attorney and the company even where the attorney is communicating with employees of the company. Accordingly, the Upjohn opinion is very relevant in the context of internal investigations because it sets forth the ownership of the privilege and ensures that the employee cannot invoke the attorney-client privilege to prevent a disclosure that benefits the company or that the company intends to make. Accordingly, the investigator should be careful to provide an Upjohn Warning.

9. A written policy. Companies ideally should implement a written policy setting forth with specificity the guidelines and parameters of their internal investigative process. The existence of a written policy governing internal investigations helps to ensure that any such investigations are conducted in an orderly fashion and also serves to deter any employees from engaging in improper conduct during an investigation, as the policy will set forth what is expected and required. This written policy should be communicated to employees to ensure that they are aware of the existence of the policy and of its provisions. ■

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6 Things GI/Endoscopy-Driven ASCs Should Benchmark

By Jaimie Oh

Bunny Twiford, RN, president of Twiford Consulting in Warminster, Pa., shares six things GI-driven ASCs should benchmark.

1. Length of the procedure vs. scheduling allotments. Ms. Twiford says ASCs should benchmark the actual length of GI/endoscopy-related procedures, such as EGDs and colonoscopies, and compare those time frames to physicians' scheduled allotments or block scheduling. Benchmarking this will allow GI/endoscopy-driven ASCs to better schedule procedures for improved room utilization and patient throughput or zero in on re-educating specific physicians and staff members on the importance of starting on time.

"A physician might say he can do an EGD in 10 minutes, but when you go back through your ASC's records you find that this physician's average EGD is more in the 15-20 minute range," Ms. Twiford says. "This causes the front desk to deliver the news to some patients that their procedure will be delayed, and this is not what the patient wants to hear upon arriving for a procedure."

2. Reasons for cancellation on the day of the procedure. GI/endoscopy-driven ASCs should also benchmark reasons patients are cancelled on the day of the scheduled procedure. This would allow ASCs to categorize the reasons so that solutions could be found. Ms. Twiford says poor bowel prep is one of the causes of sudden GI procedure cancellations. Non-adherence to "nothing by mouth" or NPO instructions or a patient with cold or flu symptoms might be other reasons for a cancellation.

"For example, ASCs don't want to find out at 7 a.m. that the patient stopped their bowel prep," Ms. Twiford says. "Let's say my GI/endoscopy-driven ASC had 14 cancellations in November, and I go back to find 10 of those were bowel prep-related. I have to go back and find out what difficulties or challenges around bowel prep caused the cancellations. Maybe patients aren't understanding the bowel prep procedure or they encountered problems with the bowel prep in the evening when the ASC was closed."

3. Method of pre-op assessment. Benchmarking the method of pre-op assessment of patients is another target for GI/endoscopy-driven ASCs. For example, ASCs may want to benchmark how cost- or time-effective it is to conduct pre-op assessments over the phone versus doing it on the day of surgery with the patient.

"This would be more of an external benchmarking exercise. How many ASCs in Indiana do pre-procedural calls versus in-person nursing assessments with patients, and how much time does it really save them?" Ms. Twiford says.

4. Expected capital equipment expenditures for the next year. GI/endoscopy-driven ASCs typically manage their capital equipment and disposable supplies somewhat differently from most other specialties. For capital equipment, such as scopes and stretchers, GI/endoscopy-driven ASCs should diligently benchmark costs tied to such equipment to project expenditures for the next year.

"ASCs, after being open for 4-6 years, may want to benchmark very specific equipment, such as scopes and stretchers. In a GI center, the patient typically goes through the entire ambulatory experience on a stretcher and isn't moving to an OR table as frequently as some other specialties," Ms. Twiford says. "This means stretchers may be wearing out more quickly because patients are using those stretchers more frequently and for longer periods of time. ASCs have to get some kind of idea of how long of a lifespan each piece of equipment has."

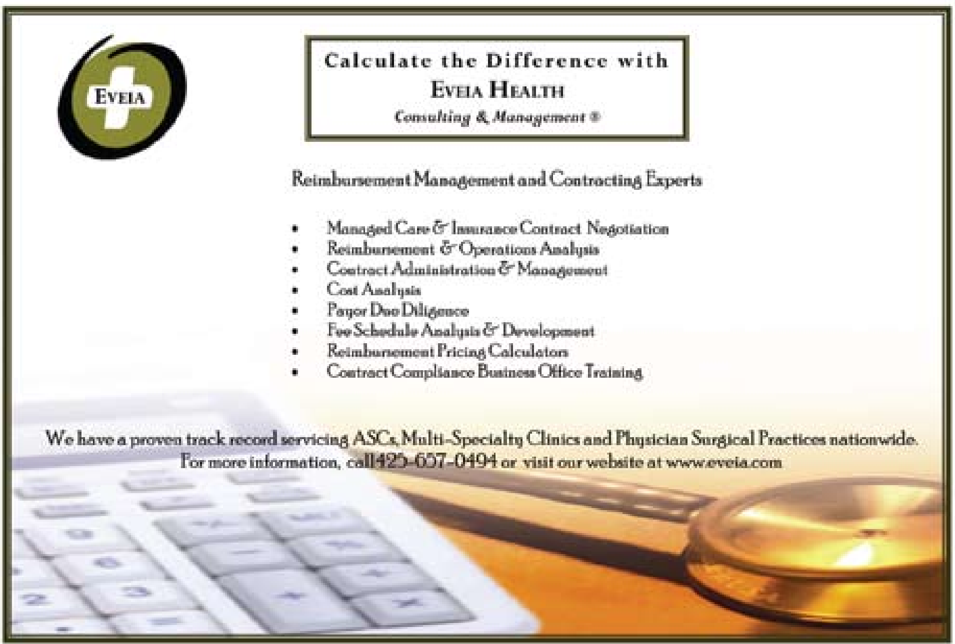
5. Marketing due to increased competition. For more mature GI/endoscopy-driven ASCs, another factor to benchmark regularly is local competition — if it's increasing or decreasing — and marketing methods for increased staff and physician retention.

"There appears to be a movement of physicians in and out of some ASCs. Some who might have been with a group for a number of years may decide to open their own GI center," Ms. Twiford says. "Physicians are also retiring and younger physicians are moving around much more frequently than was traditionally done. All these factors have to be considered, so the ASC has to really know where the competition is and how to keep itself marketable in face of that."

6. Educational benefits for the GI staff. Educational benefits for GI staff members are a crucial part of ensuring top-notch competency in their respective roles. Investing in ongoing education also gives staff members a reason to stay loyal to your GI/endoscopy-driven ASC, thereby retaining a higher percentage of staff members over time. As such, GI/endoscopy-driven ASCs should externally benchmark educational benefits it gives staff members.

"GI centers will want to look at other center to see what would be a great set of educational benefits for its staff. Perhaps it's that every year the center sets aside x amount of money for every single member's continuing education or send two individuals to the ASGE conference," Ms. Twiford says. ■

Bunny Twiford, RN, is a member of SGNA, AORN and APIC. She is currently president of the Bux-Mont Chapter 3912 of AORN in Pennsylvania. Learn more about Twiford Consulting at www.twifordconsulting.com or you can contact Ms. Twiford at twifordconsulting@gmail.com.



35 Statistics About GI/Endoscopy

By Rachel Fields

1. Mean gross charges per GI/endoscopy case in ASCs is $3,305.

2. Mean gross net revenue per GI/endoscopy case in ASCs is $816.

3. GI/endoscopy cases make up 24 percent of total ASC cases.

4. Nine percent of surgery center rooms are designated for endoscopy.

5. Twenty-seven percent of single-specialty surgery centers are driven by gastroenterology procedures.

6. Gastroenterology is the most common surgical specialty in both single- and multi-specialty ASCs. It is present in 34 percent of all ASCs and and 3,744 GI procedures are performed annually in each ASC.

7. Between 2000 and 2009, the percentage of surgery centers offering gastroenterology procedures increased from 11 percent to 34 percent.

Compensation

8. Gastroenterologists earned a mean annual salary of $496,139 in 2009.

9. Gastroenterologists employed by a hospital earned a mean salary of $484,275 in 2009.

10. Gastroenterologists not employed by a hospital earned a mean salary of $461,640 in 2009.

11. Gastroenterologists in the Eastern United States earned a mean salary of $440,584 in 2009.

12. Gastroenterologists in the Midwest United States earned a mean salary of $507,717 in 2009.

13. Gastroenterologists in the Southern United States earned a mean salary of $482,700 in 2009.

14. Gastroenterologists in the Western United States earned a mean salary of $432,371 in 2009.

Medicare charges

Here is the average 2008 Medicare sub charge (submitted charges divided by allowed services), average allow charge (Medicare-allowed charges divided by allowed services, including co-pays and deductibles paid by patient), and average payment (Medicare payments divided by allowed services, not including co-pays and deductibles paid by patient) for 16 GI procedures commonly performed in ASCs.

15. Upper stomach-intestine scope, simple (CPT 43234)
- average sub charge: $1,025
- average allow charge: $329
- average payment: $259

16. Upper stomach-intestine scope for diagnosis (CPT 43235)
- average sub charge: $1,117
- average allow charge $325
- average payment: $255

17. Stomach-intestine scope, inject intestine wall (CPT 43236)
- average sub charge: $1,359
- average allow charge $338
- average payment: $267

18. Upper stomach-intestine scope for biopsy (CPT 43239)
- average sub charge: $1,451
- average allow charge $408
- average payment: $321

19. Stomach-intestine scope ultrasound guided biopsy (CPT 43242)
- average sub charge: $2,116
- average allow charge $404
- average payment: $320

20. Stomach-intestine scope for foreign body removal (CPT 43247)
- average sub charge: $1,458
- average allow charge $408
- average payment: $322

21. Stomach-intestine scope with ultrasound exam (CPT 43259)
- average sub charge: $2,232
- average allow charge $452
- average payment: $359

22. Scope of upper small intestine (CPT 44360)
- average sub charge: $1,419
- average allow charge $416
- average payment: $328

23. Scope of upper small intestine with biopsy (CPT 44361)
- average sub charge: $1,344
- average allow charge $425
- average payment: $336

24. Scope of colon thru ostomy for diagnosis (CPT 44388)
- average sub charge: $1,325
- average allow charge $334
- average payment: $262

25. Scope of colon with biopsy thru ostomy (CPT 44389)
- average sub charge: $1,354
- average allow charge $325
- average payment: $255

26. Scope of sigmoid colon only with biopsy (CPT 45331)
- average sub charge: $967
- average allow charge $267
- average payment: $208

27. Scope of colon for diagnosis (CPT 45378)
- average sub charge: $1,502
- average allow charge $422
- average payment: $330

28. Scope of colon with biopsy (CPT 45380)
- average sub charge: $1,549
- average allow charge $406
- average payment: $318

29. Cancer screen colon scope, high risk patient (HCPCS G0105)
- average sub charge: $1,308
- average allow charge $409
- average payment: $306

30. Cancer screen colon scope, not high risk patient (HCPCS G0121)
- average sub charge: $1,415
- average allow charge $412
- average payment: $308

U.S. GI/endoscopic device market

31. In 2009, the U.S. market for GI endoscopic devices was valued at over $1.8 billion, an increase of more than 8 percent from 2008.

32. More than 55 million procedures were performed with GI endoscopic devices in 2009, nearly 50 percent of them colonoscopies.

33. GI endoscopes represented the largest segment for GI endoscopic devices in 2009, but capsule endoscopic devices are expected to grow to the second-largest market segment by 2016, thanks to advances in camera capsule technology.

34. The fastest-growing segment in the U.S. market for GI endoscopy in 2009 was anti-reflux devices; the market for them increased by more than 300 percent over 2008. This market growth is expected to increase at a compound annual growth rate of 67 percent by 2016.

35. Virtual colonoscopy procedures, less invasive than conventional colonoscopy, grew by 2.9 percent in 2009 from 2008 and are expected to show moderate to strong growth by 2016 as the population ages and trial results show their effectiveness. ■

Sources:
Items 1-3: VMG Health *Multi-Specialty ASC Intellimarker 2010*
Items 4-7: SDI's *Outpatient Surgery Center Profiling Solution*
Items 8-14: MGMA 2010 *Physician Compensation and Production Survey*
Items 15-30: CMS
Items 31-35: iData Research's *U.S. Market for Gastrointestinal Endoscopic Devices*

Contact Rachel Fields at rachel@beckersasc.com.

21 GI/Endoscopy-Driven ASCs to Know

By Rachel Fields

Ambulatory Endoscopy Clinic of Dallas (Dallas, Texas). The Ambulatory Endoscopy Clinic of Dallas opened in April 1993 as the first licensed free-standing surgery center exclusively for GI procedures in North Texas. According to the center's site, the facility was opened by a group of physicians who wanted to create a facility that provided efficient, easily accessible care for patients and featured a staff dedicated exclusively to GI health. In Jan. 1995, Healthcare Corporation of America joined the center as its general partner, and the facility is currently operated under Ambulatory Surgery Division of HCA. AECD has been accredited by AAAHC since 1995 and named a "substantially compliant" facility every year since its initial accreditation. Featuring one OR and two procedure rooms as well as nine practicing physicians, the center states its mission is "[providing] economical, high-quality ambulatory care in a manner consistent with the needs of the community we serve."

Amarillo Endoscopy Center (Amarillo, Texas). Amarillo Endoscopy Center is a Medicare-approved, GI-driven center that performs a variety of procedures, including colonoscopy, upper endoscopy, capsule endoscopy and remicade treatments. The ASC features two GI physicians —Amit K. Trehan, MD, and Srinivas Pathapati, MD. According to Freida Toler, administrator of Amarillo Endoscopy Center, physicians have input about every staff member hired at the center, effectively building cohesion between physicians, nurses and other staff members. She says she also cross-trains employees and moves them through different departments in order to encourage collaboration and break down walls between physicians and employees. "Periodically staff members move through different areas of the ASC they haven't been in for a while to maintain competency in all areas, as well as to ensure they aren't working with the same people all the time," she says. "Surgical teams tend to form cliques, so we try to make sure everyone gets a chance to work with different people."

Berks Center for Digestive Health (Wyomissing, Pa.). Berks Center for Digestive Health was founded in Dec. 2001 through a partnership between Digestive Disease Associates' physicians and Physicians Endoscopy. The center is currently owned by 10 GI physicians and features 13 GI physician users and is accredited by the AAAHC. The center, which is 100-percent focused on GI procedures, houses three procedure rooms and schedules 17 patients per day in each room. According to Berks Center for Digestive Health executive director John Gleason, the ASC has plans to move to a new facility within the next year and a half, as well as to expand to four procedure rooms. "We are extremely efficient and customer service-oriented," he says. "Despite handling so many patients, we consistently get very positive feedback on patient satisfaction surveys about the kind and service-oriented staff."

Eastside Endoscopy Center (Bellevue, Wash.). Eastside Endoscopy Center opened in 1995 and specializes in upper endoscopies and colonoscopies, which are performed in three procedure rooms. The center, which is managed by Physicians Endoscopy, has been accredited by the AAAHC since 1996 and was the first endoscopy center in Washington to achieve AAAHC accreditation. According to Michelle Steele, administrator of Eastside Endoscopy, the ASC recently implement an electronic medical record, allowing staff to track times and easily identify areas of delays and target them for improvement. She said the center also successfully implemented anesthesia services, contracting with a local anesthesia group to administer propofol in the facility. "One of the reasons I believe patient satisfaction is high is because our patients are now awake and alert after the procedure and are able to remember discussing their procedure results with the gastroenterologist," she says. She calls the center "a family" and credits its success to the combination of great physicians, RNs, medical assistants, techs and its corporate partner, Physicians Endoscopy.

Endoscopy Center of St. Louis (St. Louis, Mo.). The Endoscopy Center of St. Louis currently has two facilities in the St. Louis and St. Charles, Mo., metropolitan areas, both of which provide upper and lower endoscopic gastrointestinal procedures with state-of-the-art equipment. Both facilities are accredited by AAAHC and staffed by board-certified endoscopists, anesthesiologists and registered nurses specifically trained in endoscopy. The center features 11 practicing physicians, including David Cort, MD, and David Walden, MD, who have been featured on local news stations speaking about gastrointestinal procedures. In an interview with Becker's ASC Review, Susan Rahn, clinical manager of the Endoscopy Center of St. Louis, shared the centers' secrets for maintaining accreditation — both have been accredited since their openings in 2005 and 2007. She said her ASCs take advantage of the various seminars, conferences and learning materials available for ASCs, as well as use accreditation surveys as a learning experience for future growth.

Fleming Island Surgery Center (Orange Park, Fla.). Fleming Island Surgery Center was founded in Jan. 2007 and currently performs approximately 8,000 cases per year, 65 percent of which are GI. The center features five GI specialists who routinely use the ASC and between four and five general surgeons who perform GI cases at the center. The center is accredited by the AAAHC and is affiliated with Borland-Groover Clinic, the largest gastroenterology clinic in the Southeastern United States. According to Lindsay Allen, special services coordinator for Borland-Groover Clinic, the center's success can be traced back to the staff's commitment to patient satisfaction. "Our physicians and staff have adopted a culture that embraces excellence in patient care and satisfaction," she says. "Our credo states that customer satisfaction is our top priority, and it is everyone's job. Our administrative team continuously does a great job promoting this culture within our facility."

GastroIntestinal Associates Endoscopy Center (Wasau, Wis.). GI Associates Endoscopy Center was opened in 2008. Accredited by the AAAHC and certified by Medicare, GI Associates Endoscopy Center was designed "to create a calm, caring environment" for patients and family members, according to the ASC's website. Since its opening, the center has participated in ASGE Quality and Safety in Endoscopy Center's continuing education programs, according to COO Cathleen Rohling. The center also applied for and was awarded ASGE Unit Recognition Certification, one of only several hundred in the country — and the first provider in Wisconsin — to earn the distinction. In a release following the center's recognition, medical director Raymond L. Hartke, MD, said, "Our patients deserve the highest standard of care. At GI Associates, we work daily to provide the highest quality outcomes and experience for our patients. We are honored to be recognized by ASGE for our efforts to enhance patient safety and quality." Ms. Rohling added that the GI Associates Endoscopy Center's practices are undergoing review currently, and the staff is working on developing audit tools to continually improve the ASC's processes.

Gwinnett Endoscopy Center (Lawrenceville, Ga.). Gwinnett Endoscopy Center is affiliated with Atlanta Gastroenterology Associates and specializes exclusively in gastroenterology. The center, which opened in 2000 and is accredited by AAAHC, expanded its services in 2008 to include hemorrhoid banding. The center is owned by 36 physician owners and used by an additional eight physicians and features three procedure rooms. According to Atlanta Gastroenterology Associates managing partner Steven Morris, MD, the center's success can be credited to a combination of skilled and experienced physicians and staff and "attention to individual patient needs."

Jacksonville Center for Endoscopy (Jacksonville, Fla.). The Jacksonville Center for Endoscopy was established in 1998 and is currently a state-licensed, Joint Commission-accredited, AHCA-certified ASC owned and operated by the physicians of Borland-Groover clinic. The center, which has two locations in Jacksonville, performs colonoscopies, upper endoscopy and sigmoidoscopy and staffs only nurses trained specifically in endoscopy. The center performs more than 32,000 procedures annually. Since its inception, JCE has been determined to implement health information technology to improve quality and safety, as well as streamline workflow, increase patient throughput and maximize revenues. JCE administrator Cindy Hall says the center aimed to "ensure that our physicians had access to patient information that was up-to-date to the minute." Since the implementation of an EMR, JCE has saved more than $26,000 and is now completely paperless, according to Ms. Hall.

Lincoln Endoscopy Center (Lincoln, Neb.). Lincoln Endoscopy Center opened in July 1998 and features three suites equipped with state-of-the-art Olympus equipment. The ASC was the first free-standing endoscopy center in Nebraska and is accredited by the state, Medicare and AAAHC. The center performs a variety of GI and endoscopic procedures, including colonoscopies, upper endoscopies, flexible sigmoidoscopies, capsule video endoscopies and many others. The center recently added HALO ablation technology, which removes the diseased layer of cells from the esophagus and treats Barrett's esophagus, a precancerous condition, without incisions. The ASC is deeply involved with the Lincoln community and participates in various charity events every year, including the Crohn's and Colitis Foundation of America Walk in Lincoln in 2010 and the Chubby Bubby Benefit, a bake sale that raised funds for spinal muscular atrophy. Becky Johnson, clinical director of Lincoln Endoscopy Center, credited the center's financial success to careful planning for purchasing equipment. She said she attends at least one large ASC conference every year to network with others in the industry and glean better practices about keeping up with advancing technology and saving money.

Memorial Mission Surgery Center (Chattanooga, Tenn.). Memorial Mission Surgery Center was one of 48 endoscopy units in the country recognized by the American Society for Gastrointestinal Endoscopy Unit Recognition Program in June 2010. The program honors endoscopy units that follow ASGE guidelines on privileging, quality assurance, endoscopy reprocessing and CDC infection control and guidelines. In an interview with Becker's ASC Review, Sharon Rosser, RN, endoscopy manager, and Brent A. McLean, ASC administrator, credited teamwork, patient feedback and quality ancillary departments as reasons for the center's success. "Everyone works together to make sure the patients are cared for in a safe and efficient way," they said. "In addition to credentials, all new hires are assessed to see whether or not they "will fit" with the culture. This emphasis, in combination with the perks of working in an ASC, allows us to hire only the best of the best, which translates directly to better patient outcomes."

Michigan Endoscopy Center (Farmington Hills, Mich.). Michigan Endoscopy Center is a physician-owned joint venture with Physicians Endoscopy. The center was founded in Jan. 2003 by senior physician leadership and has since earned AAAHC accreditation. Sixteen physician owners have majority ownership of the center, and three physician non-owners also use the ASC, which focuses primarily on digestive health and GI procedures. Michigan Endoscopy Center has three licensed ORs and three procedure rooms and continues to look for opportunities to expand services by recruiting new physicians and establishing partnerships with group practices and physician organizations, according to administrator Brien Fausone. He credits Michigan Endoscopy's success to its "all star team of care givers [and] clinicians" — all of the center's GI nurses have more than 15 years experience, and its endoscopy technicians are all certified and have worked side-by-side with the center's physicians prior to joining Michigan Endoscopy Center.

Midtown Endoscopy Center (Atlanta, Ga.). Midtown Endoscopy Center features four procedure rooms and performs only gastroenterology procedures. The center, which is affiliated with Atlanta Gastroenterology Associates, is owned by 36 physician owners and utilized by 17 physician users. The center opened in 2001 and is certified by the AAAHC. According to Atlanta Gastroenterology Associates, the center recently expanded its serves to include hemorrhoid banding (2008), liver biopsy (2009) and Bravo pH (2010). The center, like all of AGA's endoscopy centers, provides patients easy access to quality care and offers procedures that are otherwise only provided in hospitals.

MNH Surgical Center (Maitland, Fla.). MNH Surgical Center, which is partnered with Covenant Surgical Partners in Nashville, Tenn., was established in 1998 and has since earned AAAHC and Medicare accreditation, as well as ACLS certification for all its physicians and nursing staff. The center's five physicians perform a variety of procedures, including upper endoscopy, colonoscopy, hemorrhoid banding and desiccation, liver biopsy, abdominal paracentesis and esophageal manometry. According to the center's site, the center was "designed with high quality of care, safety, patient privacy and convenience in mind." MNH Surgical Center specializes in the examination of the upper and lower gastrointestinal tract.

New York GI Center (Bronx, N.Y.). New York GI Center is a single-specialty GI ASC in Bronx, N.Y. The center opened in 2007 and has since earned AAAHC accreditation. Over the last three years, the center has cared for more than 21,000 patients, opened its fifth OR and expects to perform around 10,500 cases in 2010. A joint venture between private practice physicians and a major academic medical center, NYGI contains "safety-based technology," such as 100 percent disposable endoscopic accessories, end tidal CO2 monitoring and a video laryngoscope for emergency intubations, according to NYGI president James C. DiLorezo, MD. "We have strived to create a culture of quality by instituting measures such as single-dose, single-use vials and a comprehensive infection control program long before they were required," he said. The ASC also employs rigorous employee re-training in-services for endoscope reprocessing, use of argon plasma coagulation and cautery devices. Staff members are supported financially for pursuing additional certification.

Old Town Endoscopy Center (Dallas, Texas). Old Town Endoscopy Center is staffed by Digestive Health Associates physicians and contains multiple GI endoscopy procedure rooms with state-of-the-art safety and diagnostic equipment. The center is certified by Medicare and licensed by the state of Texas, and its physicians are all board-certified gastroenterologists who specialize in endoscopic procedures such as colonoscopies, upper endoscopies and flexible sigmoidoscopies. The center's patient satisfaction surveys repeatedly earn high marks, and the center's staff credits Old Town's high patient satisfaction, low infection rates and patient focus as reasons for its success.

Pacific Endoscopy Center (Pearl City, Hawaii). Pacific Endoscopy Center is a free-standing single-specialty center specializing in endoscopy. The center opened in May 2008, aiming to bring down the high rate of colon cancer deaths in Hawaii. In an interview with Hawaii News Now upon the ASC's opening, CEO Yousif A-Rahim, MD, stressed the importance of colonoscopies to catch cancer early, saying, "We get about 765 cases of colon cancer per year, and about a third of these patients will actually die within one year." The center cost $3 million to develop and offers high-definition technology, which "allows [Hawaii] doctors for the first time to detect hard-to-find flat or depressed polyps which actually carry a higher risk of cancer," according to the report. Pacific Endoscopy Center staffs three physicians ¬— Dr. A-Rahim, Darrell Lee, MD, and Robert Wong, MD.

Physicians Endoscopy Center (Houston, Texas). A joint venture with HCA Ambulatory Surgery Division, Physicians Endoscopy Center has 18 physician owners and eight procedure rooms and performs around 1,200 cases every month. The ASC was founded by several physicians who wanted "a centralized, convenient and patient-focused center to perform procedures at lower cost than hospitals," says PEC administrator Nancy Le Nikolovski. The AAAHC-accredited center opened in Dec. 2002 and performs GI procedures exclusively. Going forward, PEC is looking to launch a hemorrhoid ligation clinic to complement colonoscopies and is considering the addition of colorectal surgeons to offer more comprehensive services to patients. The center may also offer propofol anesthesia to increase patient comfort and satisfaction in the future. As to why the center continues to enjoy success, Ms. Le Nikolovski credits its "very specialized care," saying the center is "staffed with highly-trained endoscopy nurses and technicians." She adds that PEC uses the latest high-definition endoscopes from Olympus to improve patient care.

Southern Crescent Endoscopy Suite (Stockbridge, Ga.). Southern Crescent Endoscopy Suite is affiliated with Atlanta Gastroenterology Associates and opened in 1994. The ASC performs exclusively gastroenterology procedures and contains seven procedure rooms that are used by seven physician users. The center is AAAHC-accredited and owned by a group of 36 physicians. The center expanded its services by adding hemorrhoid banding in 2008 and Bravo pH in 2010. Steven Morris, MD, managing partner of AGA, credits the center's success to a combination of technology ¬— Southern Crescent features "high definition scopes and full-function EMR" as well as supervised propofol administration — with individual attention to patient needs and a skilled staff.

Surgery Center at Tanasbourne (Hillsboro, Ore.). Surgery Center at Tanasbourne, which was opened in March 2009 by Providence Health and Services, is a free-standing, multi-specialty facility with four ORs and two procedure rooms. The center is managed through a joint venture with Blue Chip Surgical Partners and stands at around 17,000 square feet. The center features state-of-the-art medical technology and performs, in addition to GI, general surgery, orthopedics, gynecology, plastic surgery, pain management, spine and ear, nose and throat procedures. According to ASC administrator Cindy Givens, the Surgery Center at Tanasbourne recently underwent efforts to grow case volume for colonoscopies by contacting its hospital partner's primary care group, meeting with community physicians and marketing directly to consumers. She said the center drives referrals by following up with physicians about the patient's experience — an aspect of the relationship that ASCs might sometimes overlook. "I make sure the loop is closed," she says. "When they send a referral over, we follow up with them to let them know the patient was scheduled on this date, or that we were not able to contact the patient, or that the patient was referred on to another provider."

Surgery Center of Joliet (Joliet, Ill.). The Surgery Center of Joliet opened in 2008 and specializes in colonoscopy, EGD and upper and lower GI diagnostics and screenings. The center houses two procedure rooms, two endoscopy rooms and three operations rooms and contains a portable endoscopy machine that allows patients to undergo endoscopic procedures in one of its ORs. According to Marge Schillaci, administrator of the Surgery Center of Joliet, the ASC keeps costs low by decreasing inventory of high-cost items. "We looked at what we were keeping on the shelf and also specifically how long it took us to get the item," she said in an interview with Becker's ASC Review. "Based on what our volumes were and actually looking at our usage, we no longer kept more on the shelf than we actually needed." She said this strategy improved cash flow to the center and decreased holding costs. In addition to GI procedures, Surgery Center of Joliet also performs ENT, general surgery, pain management, plastics, podiatry and orthopedic procedures. ■

Contact Rachel Fields at rachel@beckersasc.com.

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ASC Managed Care Contracting Best Practices by Specialty

By Lindsey Dunn

ASC managed care contracting best practices are largely dependent on an ASC's specialty mix. While single-specialty centers can rely on best practices for their specific specialty, multi-specialty facilities must take into account the volume of each of their service lines to negotiate the most favorable contracts, says Naya Kehayes, managing principal & CEO of Eveia Health Consulting & Management, a managed care contracting consulting firm. For example, centers with large GI and pain management volumes benefit by staying on Medicare grouper methodology, while orthopedic- and ENT-dominated centers benefit from moving to Ambulatory Payment Classification methodology when negotiating rates.

Here are several tips, by specialty, from Ms. Kehayes to improve the profitability and success of your managed care contracting negotiations.

Orthopedics

Consider introducing the APC payment system to payors as an alternative methodology to the old grouper system or fee schedule. "APC methodology does a better job of weighting payments for orthopedics with respect to costs," says Ms. Kehayes.

If moving to the APC system, ensure allowances are high enough to cover high-cost implants. "Procedures with high-cost implants may still require carve-outs," Ms. Kehayes says. For example, a shoulder arthroscopy with three anchors might exceed the cost threshold in an allowed rate, while a two-anchor procedure may not, dependent upon the unit cost and implant type. In this instance, the ASC should carve out the procedure when it involves more than two anchors, she says.

Spine

ASCs should perform payor due diligence to ensure the payor has spine codes on its approved ASC procedures list before adding the service line. If a payor does not have these codes approved in the ASC setting, centers may need a spine surgeon to get involved. This may require meetings with the insurer's medical director and/or providing literature to educate the insurer on the appropriateness of spine cases in the ASC setting, Ms. Kehayes says.

Highlight the cost savings of moving spine cases from the hospital to the ASC. "Demonstrate the cost savings that is created for the payor by moving these cases from the hospital to the ASC" says Ms. Kehayes. "Often this savings is significant and will be attractive." To quantify the value of the cost savings to the payor, the ASC must work with physician offices to capture EOBs from patients who have had spine surgery in the hospital or ask the surgeons to provide information to the payor regarding payor members that have been taken to the hospital. It is beneficial to provide the payor with the Member ID number, physician name, date of service, CPT codes the physician billed, name of the hospital where the case was per-

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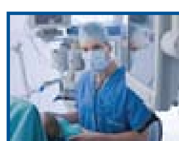
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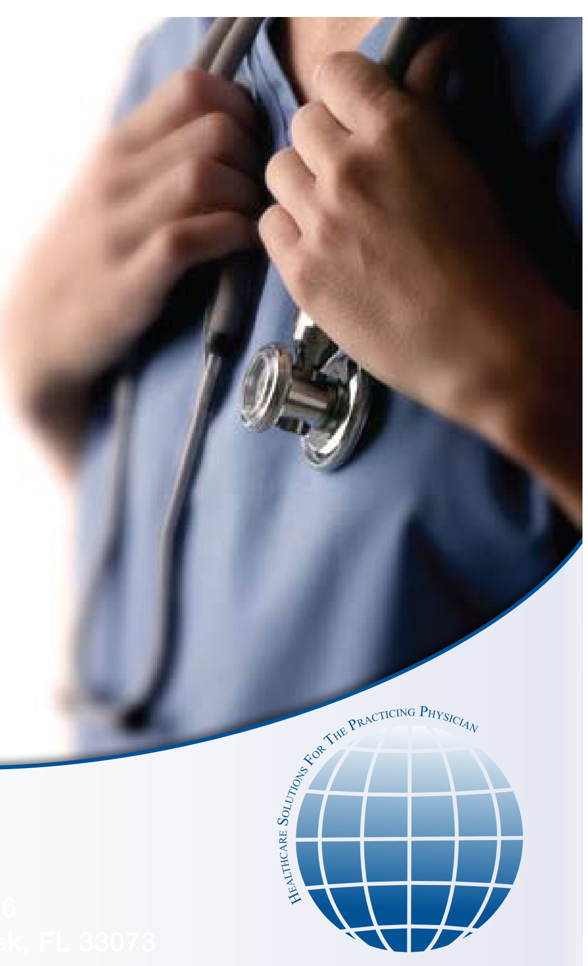

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formed and the potential volume of cases the surgeon can move from the hospital to the ASC.

Include capital expenditure costs in evaluating reimbursement rates. Adding spine includes significant start-up costs — sometimes up to $300,000 — for centers, so it is important that administrators include these costs in addition to supply and labor costs when evaluating spine rates, Ms. Kehayes notes. "When determining volume and rates needed to break even, capital costs must be considered," she says. "If an administrator determines case costs without the capital expenditure expense, the contracted rate might not be high enough to ensure the center breaks even."

Don't assume every payor is interested in moving spine cases out of the hospital. "Moving these well-reimbursed cases out of the hospital could be detrimental to that hospital," says Ms. Kehayes. "If the loss to the hospital is enough that it puts the payor's contract with the hospital at risk, then the savings might not be worth it the payor. This is especially true in a one-hospital market." Consider the following scenarios: 1) A payor saves $1 million dollars by moving spine cases to an ASC, but, as a result, the hospital drops its contract with the payor. The payor must then pay out-of-network rates to the hospital, and it is the only option in the market for patients. In this situation, the payor might experience increased costs in the millions of dollars, even when accounting for its savings on spine cases. 2) A payor saves $1 million dollars by moving cases to an ASC, but as a result, the hospital demands a 10 percent increase in its contract in order to stay in network with the payor. In a one hospital market, the payor cannot sell insurance to employer groups without the hospital in network. The hospitals contract is valued at $30 million, so the cost to the payor to keep the hospital in network is $3 million. In these scenarios, the payor is clearly not motivated to move the volume because the cost to maintain the hospital as an in network provider outweighs the cost saving benefit that is presented by the ASC.

Gastroenterology

Stay on a grouper payor methodology. "Be on the lookout for payors that want to put you on the 'current Medicare payor methodology,'" says Ms. Kehayes. "APC methodology — which is the current Medicare methodology for ASCs — is less favorable than the grouper methodology for GI."

If moving to the APC system, understand what percentage increase on the new Medicare methodology equates to the center's current payment rates. For example, 130 percent of a grouper rate is going to be higher than 130 percent of an APC rate for GI cases. Centers, therefore, must know what percent of APC rates will be equivalent to their current reimbursement rate. In addition, if the payor is moving with transitional weights on APCs, the reduction in 2011 will be even greater. Thus, the APC weight year should be locked in when negotiating with the payor. Further challenging GI ASCs, HOPD APC rates for GI cases may actually be lower than ASC rates based on old grouper methodology. This could make ASC negotiations much more challenging in markets where hospitals have switched to the APC system, says Ms. Kehayes.

Pain management

Stay on a grouper methodology. "Pain management is very similar to GI in that centers with high pain management volumes will benefit from staying on the grouper methodology," says Ms. Kehayes. As with GI, if centers do switch to APC rates it is critical they translate their current grouper rates into a percentage of APC rates, she says.

Understand how site-of-service differentials impact rates payors are willing to pay. This holds true for GI as well, says Ms. Kehayes. Injections and certain GI procedures can be performed as office-based procedures, which are often less costly to payors than procedures performed at an ASC. As a result, most pain management and GI codes include site-of-service adjustments in physician fees. If a physician performs an injection at the office, the physician fee is higher, based upon a non facility value unit of compensation to account for the costs for the "facility" component of the fee. Payors often will not pay a higher reimbursement rate to the ASC than the "facility" component paid to the physician when the procedure is performed in an office, which restricts the level of compensation an ASC may get for procedures that are approved in the office setting. "If physicians have the ability to do the same procedures at the ASC in their office, this creates a stumbling block for the ASC," says Ms. Kehayes. "If the physicians do not have the ability to perform the procedure in-office, they need to let the payor know so the ASC's reimbursements won't be impacted." For example, if a C-Arm is required to do the procedure, and the physician does not have a C-Arm available in the office.

ENT

Consider introducing the APC payment system. With ENT, like orthopedics, reimbursement should increase from a switch to current Medicare methodology. Centers with high volumes of ENT should consider transitioning to this new methodology.

Ensure contracts contain language allowing for reimbursement of unlimited multiple procedures. "If your ASC provides a high volume of ENT procedures, make sure your contracts do not limit reimbursement on multiple procedures," says Ms. Kehayes. "If your contract has limitations on multiple procedures and your center does have significant volume of ENT cases, use this as leverage for higher reimbursements on primary and secondary procedures." For example, if an ASC is only reimbursed for the first two codes rather than for all codes, centers should ensure reimbursement on the first two codes will cover cases that involve three or more procedures.

Consider adding BAHA and cochlear implant procedures. BAHA and cochlear implants (CPT 69714, CPT 69715 and CPT 69930) are now approved by Medicare for reimbursement when performed in the ASC. "These cases are expensive in the hospital setting and present an opportunity to move volume out of the hospital and into the ASC, which can be very attractive to payors," says Ms. Kehayes. ■

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Guidance for Benchmarking Your ASC as Part of a Quality Improvement Program

By Jaimie Oh

Dianne Wallace, executive director of Menomonee Falls (Wis.) Ambulatory Surgery Center, explains how the surgery center has implemented benchmarking processes as part of its larger quality improvement program to meet the standards set by the Accreditation Association of Ambulatory Health Care.

Q: What processes does Menomonee Falls ASC use to benchmark quality measures?

Dianne Wallace: On a quarterly basis, we have a number of quality indicators that our organization looks at. The four quality indicators we measure are cost, service, clinical outcomes and functional, which measures documentation and productivity. For example, in terms of performance measures for service, we have a set number of formal complaints per patient, percentage of patients that are satisfied with our quality of care and so on. For our outcome indicators, we measure the number of incidents or number of post-operative wounds or infections that a patient may experience. For functional measurements, we see if the facility is meeting national standards for operating cost-effectively. We also look at percent of cases that start on time and amount of total hours per case.

Q: Once the center has measured those aspects, what does it do with that information?

DW: We put together a profile and submit our data to the Ambulatory Surgery Center Association and compare our data to other ASCs that submit information. We also use the MGMA cost survey and compare our data with them. These profiles are also presented to our surgery center's finance committee, quality committee and governing body to show them how we fare in those benchmarks. We do this to compare our quality with local and national standards and ensure that we are trending in a positive direction. For us, benchmarking is used as a basis for identifying areas of improving and that feeds into our QI program. It helps us identify if there are studies we should be doing to see how we trend in various areas.

Q: What changes needed to take place in order to accommodate the extra work put toward benchmarking?

DW: We have a staff member dedicated to completing the quarterly ASCA quality survey. I also have a business office manager that completes data and other national and local surveys related to cost, such as the MGMA survey which comes out once a year. Along the way, we benchmark with local organizations such as the local human resources organization and the American Society of Gastroenterologists. ■

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4 Target Areas for ASC Supply Chain Savings

By Jaimie Oh

Here are four areas ASC administrators, owners or materials managers should target for greater savings at their facilities.

1. Generic brands of ASC supplies. Shawn Lunney, vice president of sales and marketing for Gig Harbor, Wash.-based GMD, a company that develops generic medical device products, says ASCs can yield enormous savings just by considering alternative, generic brand supplies. Although the last 20-30 years have been marked by tremendous advancements in medical technology, much of that has been tied to high costs. However, the healthcare industry is now coming into an age where medical supplies may be coming out in generic forms, which will give ASCs the opportunity to consider alternatives at a lower cost, says Mr. Lunney.

"What has happened in the pharmaceutical market is now being carried out in the medical devices market," he says. "In the pharmaceutical market, it used to be all about the new expensive blockbuster drug, but now 70-80 percent of prescriptions have some generic variation."

For example, companies, such as GMD and Gold Standard Orthopaedics in Louisville, Ky., respectively offer devices such as slings for female urinary incontinence and orthopedic screws for approximately half the price of brand-name versions of similar medical devices.

Approximately 250,000 slings are performed each year, most of which were performed in hospital outpatient departments due to economic reasons. "Reimbursement was too low and cost of slings too high for surgery centers to do these procedures. With the much lower price of the generic sling and rising Medicare reimbursement, it now makes economic sense for surgery centers add this service," Mr. Lunney says.

2. Free trials of equipment/supplies. Jaime Wilber, who is the director of nursing at Ashtabula (Ohio) Surgery Center, encourages surgery centers to more actively pursue free trials of equipment and supplies before committing to a big purchase.

"We're always open to hearing what new product a vendor may have, especially if it's at a lower cost than one we're already using," Ms. Wilber says. "One time, we had a vendor come in with a new product for rotator cuff repair, and we asked to try [it] for free. After one of our orthopedic physicians tried [it] out, we agreed to purchase the implant from that vendor."

In aggressively pursuing better deals with different vendors, Ms. Wilber says there may at times be an added incentive in the form of free accompanying equipment to go with the purchase. "There's equipment a physician needs to drill holes to put the shoulder cuff implant into place," she says. "After we purchased the new implants for rotator cuff repair, [the vendors] gave us the accompanying equipment for free."

3. Cheaper or generic alternatives for medications. Using generic versions of medication can help cut supply costs, which can make a huge difference to ASC supply expenditures and eventually profit margins. However, Charles Friedman, MD, an anesthesiologist at West Park Surgery Center in Pinellas County, Fla., says ASCs should also consider compounding pharmacies when purchasing pharmaceutical drugs. Although West Park works with vendors to purchase some of the drugs the ASC needs, it also visits compounding shops to find better deals on certain pharmaceutical drugs.

"To decrease the cost of pharmacy items, we may go to a compounding pharmacy," Dr. Friedman says. "The benefit of buying from a compounding pharmacy is that some of the drugs may be cheaper to purchase, but not all of their items will be. This way, we can get a few items from a compounding pharmacy that are cheaper, and some drugs that are not cheaper we'll get from our vendor."

4. Refurbished equipment. When considering used equipment, it is important to note that refurbished equipment is not simply *used* equipment, which is resold without being inspected and warrantied for performance. Rather, it is equipment that has been remanufactured and reconditioned by the manufacturer. "It is a process of converting it into like-new condition," says Russ Ede, vice president of non-acute contracting for Amerinet, a national group purchasing organization.

In addition, refurbished equipment can carry with it a warranty and certification that used equipment may not. "It's like a certified pre-owned car," Mr. Ede says. "You are paying less money, but someone guarantees the equipment."

After bringing on the new spine physician in late 2009, Midlands Orthopaedics in Columbia, S.C., faced the challenge of researching and buying new equipment and supplies the new physician would need in order to perform spine procedures. Belinda Rutledge, administrator of Midlands Orthopaedics, says she worked closely with the physician for several months before he officially joined the surgery center so they could jointly agree on the least expensive options without compromising on the quality of the instruments.

"We didn't want to spend a lot of money on a spine table, and it took about eight months just to find a quality used spine table because a brand new one will cost you around $160,000," she says. "We finally purchased a used spine table for half that price after working with three vendors and working out the best deal. The key is that we worked with that surgeon to develop and bring in all the equipment he would need to build his practice." ■

Contact Jaimie Oh at jaimie@beckersasc.com.

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10 Proven Strategies to Successfully Reduce ASC Supply Costs

By Jaimie Oh

As the economy struggles to stabilize and ASCs deal with declining reimbursements, it is critical for surgery centers to take more proactive approaches to saving money and helping their bottom line when ordering supplies. Here are 10 proven strategies ASCs can adopt to cut down supply costs at their facilities.

1. Cross-examine different vendors for new supplies. When evaluating new supplies, Freida Toler, administrator at Amarillo (Texas) Endoscopy Center, says the surgery center makes it a goal to evaluate as many different options as possible before settling on a final purchase. Ordering from multiple vendors, instead of just one, may be a way to reduce costs if different vendors are able to offer better prices.

"We don't order disposable items, such as snares and forceps, from just one company. We cross-evaluate the costs and quality of as many companies as possible," she says. "Working with a GPO works when we're ordering IV supplies, start kits and catheters because you can't beat their prices. But there are other things, like chemical disinfectants, we'll order directly from the manufacturer instead of through a vendor."

2. Elect a staff member to monitor supply levels and costs. Keeping par levels low to help contain supply costs first requires formally electing a staff member who is in charge of monitoring inventory, ordering supplies and equipment and keeping a close watch on prices of each item. Ideally, an ASC hires a materials manager who is tasked with supervising this critical financial aspect of the ASC. Lorreine Borrayo, director of nursing at Carillo Surgery Center in Santa Barbara, Calif., says electing a scrub technician, not a licensed staff member, to fill the materials manager position is the most cost-efficient way to carry out supply cost duties.

"Cesar, who is our materials management staff member, is in charge of ordering everything, keeping a close eye on costs and our supply need," Ms. Borrayo says. "Of course, he keeps an eye on the quantity but also the quality of everything he orders. He's the most qualified because he's the one pulling the supplies from our inventory and making packs for our physicians to use during surgeries. So really, I think he's the best person for the job."

Steve Smith, director of Surgery Center of Wisconsin Rapids, who has also charged one staff member with regularly monitoring prices on inventory, adds that having a materials manager who controls inventory is a good way to maintain a better relationship with representatives working through your contracted GPO. "Our [inventory control] staff member and GPO representative stay in good contact with each other and look at costs of each of our supplies every month," Mr. Smith says. "They look at what we're paying right now for anything, like sterile gloves, and our GPO representative may be able to find sterile gloves that are similar to the ones we have but for less money."

3. Create custom packs to cut supply costs. At Carillo, surgery packs and trays underwent some revision to cut out supplies that weren't being used. Ms. Borrayo says by creating custom packs for physicians, the ASC was able to save money by not ordering unnecessary supplies such as non-reusable items, additional basins, blue towels and syringes. Mr. Smith agrees, saying that by creating customized packs for surgeons, his ASC was able to see drastic savings that helped the facility's bottom line tremendously.

"We just customized pre-package trays for knee arthroscopies," Mr. Smith says. "In these pre-packages, there should be everything you would need in order to perform a knee scope. By going through the packs and customizing it, we're able to lower cost by 10-15 percent without affecting patient safety or patient outcome. You always have to see if changing supply will affect either of those in any way."

4. Make surgeons and staff members aware of what everything costs. Ms. Borrayo regularly talks to Carillo's surgeons about pricing on supplies to keep them apprised of how much the facility is spending and to level with them about proposals for new equipment and supplies they may want to start using.

"They have preferences with certain supplies, so I really try to educate our surgeons and employees and point out that a cheaper alternative — such as certain sutures for shoulder rotator cuffs — from a different company is just as good as the model they want but it costs us this much less," she says. "So we really include our staff with pricing. Cesar is able to go through different companies and do price comparisons."

Staff members at Amarillo also have their own set of responsibilities that help keep them aware of the costs of supplies. Ms. Toler says staff members in each department of the facility are responsible for turning in supply orders for their department each week. On the supply orders, staff members can see the required quota needed for each item and the cost of each item.

"That supply order is updated frequently, and we also talk about supply costs in our monthly staff meetings," she says. "Through doing these things, they know they shouldn't open sterile supplies that aren't going to be used during a GI procedure, they shouldn't be using a half bottle of lubricant before a colonoscopy when they only need a tablespoon and so on. They learn that things do cost money, and the more we save the better off the facility is."

5. Take advantage of free trials. Jaime Wilber, who is the director of nursing at Ashtabula (Ohio) Surgery Center, encourages surgery centers to more actively pursue free trials of equipment and supplies before committing to a big purchase.

"We're always open to hearing what new product a vendor may have, especially if it's at a lower cost than one we're already using," Ms. Wilber says. "One time, we had a vendor come in with a new product for rotator cuff repair, and we asked to try them for free. After one of our orthopedic physicians tried them out, we agreed to purchase the implants from that vendor."

In aggressively pursuing better deals with different vendors, Ms. Wilber says there may at times be an added incentive in the form of free accompanying equipment to go with the purchase. "There's equipment a physician needs to drill holes to put the shoulder cuff implant into place," she says. "After we purchased the new implants for rotator cuff repair, they gave us the accompanying equipment for free."

6. Seek cheaper options for medications whenever possible. Using generic versions of medication can help cut supply costs, which Ms. Borrayo says has made a huge difference to its supply expenditures and eventually its profit margins.

Charles Friedman, MD, an anesthesiologist at West Park Surgery Center in Pinellas County, Fla., says ASCs should also consider compounding pharmacies when purchasing pharmaceutical drugs. Although West Park works with vendors to purchase some of the drugs the ASC needs, it also visits compounding shops to find better deals on certain pharmaceutical drugs.

"To decrease the cost of pharmacy items, we may go to a compounding pharmacy," Dr. Friedman says. "The benefit of buying from a compounding pharmacy is that some of the drugs

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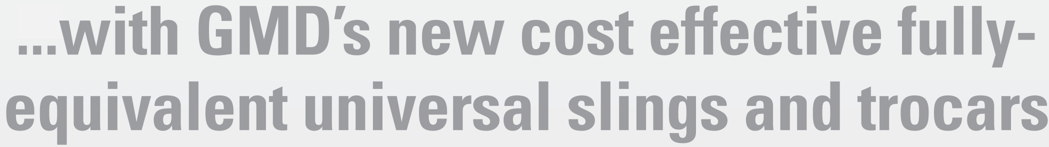

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may be cheaper to purchase, but not all of their items will be. This way, we can get a few items from a compounding pharmacy that are cheaper, and some drugs that are not cheaper we'll get from our vendor."

7. Outsource billing services to save on overhead costs. Outsourcing is becoming a more popular option for cutting costs as ASCs seek different ways to save dollars spend on staffing hours and supplies. Billing is just one example of a service that ASCs can outsource as a way to cut work hours and supplies such as paper or even medical equipment.

"We use companies that supply implants and they actually do the billing directly with insurance companies, so instead of us absorbing the price of the implant — which is substantial — they do the billing and take care of all that," Ms. Borrayo says. "We get the prior authorization to make sure insurance companies can cover the costs, and it's a substantial savings because now our own staff doesn't have to do the billing."

8. Partner with a GPO aligned with your specific specialty. Laxmaiah Manchikanti, MD, medical director of the Pain Management Center of Paducah (Ky.) and Ambulatory Surgery Center in Paducah and Chairman of the Board and CEO of the American Society of Interventional Pain Physicians, says partnering with a GPO that is in-tune with the specific needs of a single-specialty ASC is a great cost-saving measure when ordering supplies. "We go through a GPO, which assures that we get very good prices, but it is best to have a GPO specific for interventional pain management surgery centers and pain management practices," he says. "Such a GPO was started by Lora Brown, an ASIPP board member, which may be helpful for many centers, including the smaller ones."

9. Use credit cards to accumulate awards. Administrator Linda Phillips, RN, of Southgate (Mich.) Surgery Center, says the ASC has started using a credit card to pay for supply orders because the center is able to accumulate points to exchange for rewards each time the credit card is used.

"We earn those points through the bank to get thing such as iPods and docking stations, for our physicians and staff because they like listening to music, and a mini-fridge," Ms. Phillips says. "By paying our supply bills by credit card, we are able to save money by buying things through these points. We immediately pay off the credit card with our checking account because you don't want to fall into the trap of paying interest. We really try hard to be creative in this economy."

10. Streamline supply or equipment costs. Mike Kintner, service contracts manager at TriMedx, says there are various strategies ASCs can adopt to streamline supply costs, including consolidating equipment purchases, working to negotiate a warranty tailored to your advantage, standardizing equipment and more.

Mr. Kintner adds that most organizations don't look how much it costs over a piece of equipment's life span to support it and only look at the capital acquisition. "They have to actively manage service costs to understand that maybe an investment in equipment with higher capital would be better because its service costs over its life span will be lower than cheaper equipment," he says. ■

Contact Jaimie Oh at jaimie@beckersasc.com.

Section 179 Deduction for Businesses Increased to $500,000

By Marion K. Jenkins, PhD, FHIMSS

Now here's something that doesn't happen very often, especially lately: The Feds recently passed legislation that actually benefits small and medium businesses. H.R. 5297, known as the "Small Business Jobs and Credit Act of 2010," creates significant benefits for businesses who invest in capital equipment.

The main impact is a significant increase in the Section 179 deduction to $500,000 for 2010. Any company that purchases or leases any capital equipment and puts it into service prior to Dec. 31 of this year can deduct 100 percent of the entire purchase price, up to $500K, in this tax year, rather than depreciating it over multiple years.

This could have a substantial impact. For example, based on a 35 percent tax bracket, a capital purchase or lease of $250,000 could result in a tax savings of $87,500.

The regulation stipulates the type of capital equipment that qualifies, and computer equipment, including servers, network systems, data storage devices, laptops, desktops and related equipment all qualifies under the guidelines. The new regulation is retroactive, meaning any equipment already purchased since Jan. 1, 2010, is included.

Marion K. Jenkins, PhD, FHIMSS, is founder and CEO of QSE Technologies, which provides IT consulting and implementation services for ASCs and other medical facilities nationwide. Learn more about QSE Technologies at www.qsetech.com.

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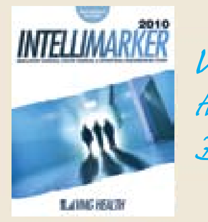

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