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SPRING/SUMMER 2017 ISSUE

EndoEconomics
by Physicians Endoscopy

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Message from the President

BARRY TANNER
President and CEO,
Physicians Endoscopy

A few short weeks ago I attended one of my favorite conferences – GI Roundtable (GIRT) in Fort Worth, Texas. The meeting was well attended by many of the thought-leaders from the GI community, and the assembly of speakers was once again consistently phenomenal. In the weeks leading up to GIRT, I attended two private equity conferences that were predominantly healthcare focused. Both concentrated on an emerging topic—the physician practice management space.

As most of our readers know, I am a huge proponent of physician independence. That said, it has become apparent over the years, most notably since enactment of the ACA, that for most gastroenterologists the option of continuing to operate as a small independent practice is increasingly threatened. I am not going to spend time reviewing all of the threats, as most of you know them all too well, but what I'd like to do is focus on the alternatives. I am seeing, and perhaps share, some encouragement, some reassurance and even some caution as more of you grapple with the future.

I see the alternatives as being divided into three broad categories: a) Do nothing and see what happens; b) Sell to and effectively become employed by a health system; or c) Band together into a larger regional, sub-regional or even a national practice(s). By pulling together, you have the capability to raise needed investment capital, add human resources and business expertise, garner the efficiencies that typically accompany scale and access capabilities that may allow the independent practice of gastroenterology to continue to thrive in a dynamic new practice model.

For many, the do-nothing option is an obvious pick. It doesn't require making a choice, which is why it may well prove to be the most common. Joining a hospital or health system in an employment model or even quasi-employment model may be the second easiest alternative. Most hospitals seem at least willing to entertain GI employment, and in many cases, it could prove to be the path of least resistance. On the other hand, it also represents a near total loss of autonomy for some gastroenterologists, and in some markets, it may represent the most viable and secure option for the future. Then, of course, we have the third alternative of banding together as a specialty. This particular option can be characterized as the most challenging to execute because it requires a significant level of change, cooperation, collaboration (e.g. give and take), and insightful, strong leadership. It is also, however, a model/alternative that is increasingly being embraced.

At the conferences, I was a bit surprised by the level and breadth of interest both from physicians and from the private equity sector in physician consolidation/aggregation and practice management. While the movement in GI is still in its infancy, the activity in other practice specialties (e.g. anesthesia, dermatology, oncology, ENT, dental, ophthalmology, primary care, etc.) is well known and documented. In the GI specialty, the Gastro Health initiative sponsored by Audax is, I believe, the first entry into this space. There will be more, and I want to go on record as generally being a strong supporter of this new initiative.

Here at Physicians Endoscopy, we have been privileged and fortunate to work with four different private equity firms over the past fifteen years. Each firm in their own way added tremendous resources and value to our enterprise. All parties benefited from the experience. Since inception, Physicians Endoscopy has always had a clear vision of what we wanted to accomplish and how we wanted to be known among GI physicians, which can be attributed to our continued success. As we have grown, our commitment to that vision has only strengthened. As a team, we developed that shared vision/commitment over nineteen years, and our private equity partners have always recognized our strength and dedication to that vision. They have worked toward helping build upon our strengths, continue to develop our team and to think outside the box. I can say from first-hand experience that our journey in working with private equity professionals has been everything that we could have hoped for.

So what then is my reason for caution? At the conferences, I witnessed a near feeding frenzy with respect to the physician practice management space. Whenever a market segment attracts that much attention from professional investors and financial architects, you can rest assured that there are large sums of money at stake. For me, at least, the yellow caution light begins flashing. I firmly believe that the convergence of clinical and business expertise is critical toward building a platform for the survival of the independent practice of medicine. My caution is that physicians must choose their partners carefully. They must actively participate in and share the responsibility of designing a practice model that will not only create stability (and yes, financial winners in the short-term), but also be a model that is attractive to all physicians. Thoughtful consideration must be given to doctors who are entering into or completing their GI fellowship programs, and those who will follow in their footsteps in the years ahead. The partner selected and the practice models created must be built on a platform of shared vision, shared contribution, shared governance, shared risk, and financial commitment and responsibility to the specialty of gastroenterology.

When there is a lot of money at stake, regardless of the industry, proceed with caution, but keep moving forward for the preservation and advancement of the independent practice of gastroenterology.

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Maintaining Independence

Through Hospital and Health System Alignment

By Robert Kurtz

Physician independence is being threatened.

BARRY TANNER

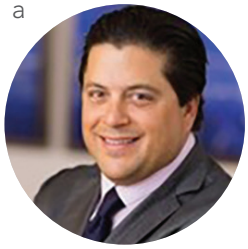
"If you go back just ten years, a majority of physicians were independent," says Barry Tanner, chief executive officer of Physicians Endoscopy (PE). "Now that's reversed, with a majority of physicians employed by a hospital or health system. That development alone — with hospitals increasingly controlling referral sources — has created pressure on physician independence."

When you also take into account other developments, such as reimbursement pressures, changing reimbursement architecture (e.g., value-based and bundled payments) and the ever-growing need and ability to monitor and measure metrics, it's becoming increasingly difficult for independent physicians to survive and thrive.

As independent physicians go, so go independent ASCs, Tanner says. "ASCs, to a large degree, are dependent upon independent, entrepreneurial-type physicians for success. Maintaining that independence is difficult, especially for physicians in smaller practices that lack the time, financial resources and access to non-clinical expertise that will prove vital to survival. At Physicians Endoscopy, we work with physicians to help them remain independent and to protect the independence, quality and cost structure of our joint-ventured ASCs."

Such collaboration, he says, is taking on greater importance with the changing healthcare landscape. But that's not only collaboration between physicians, their ASCs and management and development companies like PE, but also collaboration with hospitals and health systems as well as payers.

"In order to really get involved in value-based care, we need to work more closely with hospitals and third-party payers," Tanner says. "The next step becomes determining how we can play in the same sandbox and work with hospitals and payers to make sure we are delivering the right care at the right location at the best possible price."



MARK MANIGAN

Mark Manigan, a healthcare attorney with Brach Eichler, agrees. "While no one in the system is better positioned than physicians to drive quality and price, strategic alignment with other market participants can be very effective."

Alignment between physicians, ASCs and hospitals can take many forms and help accomplish these objectives, Manigan adds. "It is smart for physicians to consider health system alignment in some form. It's a sound business practice to partner with the big players in your market. As many folks in the outpatient space appreciate, it's often difficult to negotiate effectively with health plans as a one-off surgery center or medical practice."

Hospital and health systems also benefit from alignment with physicians and their ASC, says Barry Graf, senior vice president of partnerships and business

development at Virtua Health, a nonprofit healthcare system in southern New Jersey.

BARRY GRAF

"We see physicians as critical to the future of healthcare delivery," Graf says. "They are a key part of the interaction with the patients and ultimately driving the key quality outcomes that will be necessary in the healthcare model of the future. We know that there will be declining and at-risk reimbursement for all providers within the healthcare delivery system as we move forward toward the future state healthcare delivery model. ASC sites are a low-cost means to provide surgical procedures in a high-quality manner."

Joint Venture Model

ASC joint ventures with hospitals, if executed effectively, can be a formula for success in today's healthcare environment, Tanner says.

"When hospitals, ASCs and physicians have chosen to joint venture, there can be a strong alignment of incentives," he says. "When everyone is vested in a joint venture designed specifically to deliver high-quality care at the best possible price, that gets everyone focused on a strategy and a value-based equation that is precisely where I think the industry needs to be going."

Alignment with independent physicians, including those with ASCs, has been a tried-and-true strategy of Virtua.

"We have aggressively pursued the concept of alignment with physicians, particularly the non-employed physicians that want to remain independent," Graf says. "They have a fierce independent streak in them. They want to continue to have a lot of say in and control of their destiny, what they do in their daily lives, and how they provide patient care. Those are the physicians we seek out for relationships. We believe that passion will drive improved quality outcomes when you work together with them."

While many health systems still view independent physicians as competition, Virtua has long-believed the opposite. More than 30 years ago, Virtua established its first freestanding ASC.

"It was an acknowledgement for us organizationally that cases were going to move out of the hospital to a lower cost site of care," Graf says. "About 11 years ago, we made a conscious decision that instead of competing with our physicians in the marketplace, we wanted to partner with them. We took this very mature, freestanding ASC and syndicated it, allowing our physician partners who were doing a large number of cases at this center to become investors and owners with us."

Virtua has leveraged this model and turned it into a family of ASCs across New Jersey, he says. "Virtua uses an unusual governance model. Our partnership model is predicated around equal and shared governance. We can't do anything without the physicians and they can't do anything without us. This impacts the clinical outcomes, how care is delivered, the efficiency of the center and all of the financial results."

Sometimes joint ventures will come together more out of necessity than desire, Manigan says. That's okay, as long as the organizations involved still embrace the partnership.

"I have large GI center clients that actively track the amount of referrals they get from the captive medical practice in their market," he says. "In one instance, as a result of that percentage of their business increasing over time, the center partnered with the health system controlling those referrals. While there was a rate play there, it was also a defensive measure to protect those referrals."

Co-Management Agreements

In addition to comprehensive alignment strategies such as joint ventures, ASC physicians may want to explore more strategic forms of alignment, Manigan says. "While more procedures are moving toward the outpatient setting, hospitals are still the sites for big, complicated cases. Physicians can look to co-management deals where private practice physicians are retained by and partner with health systems on the management of their inpatient operating room service line."

Tanner says he is seeing more progressive hospitals/health systems considering such partnerships with ASC physicians. "They are looking at how they can incorporate some of the efficiencies that are inherent to the ASC environment into the inpatient setting. It's like disease management, just with the incorporating of best practices from both sides to help increase efficiency and reduce costs of care for a particular service line."

He continues, "Hospitals are still going to be dependent upon specialists for service line management and referrals. GI physicians, unfortunately, deal with a high incidence of cancer. As a result, GI physicians tend to generate a lot of inbound referrals to hospitals, whether that be lab, X-ray, oncology and sometimes surgery. That codependency which already exists between GI physicians and the local hospital sets the stage; it's then just a matter of developing an appropriate co-management

agreement wherein each party can contribute their expertise toward achieving a shared goal."

These arrangements can be structured to provide for fair market value reimbursement and include measures and bonuses tied to cost savings, quality and outcomes, Manigan says.

Virtua has embraced and used co-management agreements, Graf says. More recently, the system has pursued the "clinically integrated network" concept.

"It's really one that links health providers together," he says. "That can be health systems and independent physicians looking at the care delivery model and working together to determine how to improve efficiencies and quality outcomes. The clinically integrated network entity agrees on what areas they are going to target for improvement. As cost savings are derived from improvement efforts achieved through collaboration, there can be a collective sharing in some of the resulting savings."

There are about 1,400 physicians in the Virtua Physician Partners physician-led clinically integrated network. About 1,100 of these physicians are independent.

"These are physicians who said they want to be part of this network because they want to have a say in the delivery model and help drive efficiency, reduce cost and achieve the highest quality results but remain independent," Graf says. "That's a high-level way we try to create alignment. These can be purely business arrangements or based around clinical and care delivery models."

Value-Based Reimbursement

Another alignment option ASCs may want to consider centers around value-based reimbursement structures, Manigan says. "On the inpatient side, whether it's case rates or bundles, for example, there is room for entrepreneurial physicians along with their ASC management partners to increase quality, reduce price, share in the savings and potentially grab market share."

Such a model can also be pursued on an outpatient basis, he says. "In GI, we have seen transactions where the ASC facility fee, anesthesia fee and, in some cases, pathology fee are bundled. These are often most successful when the ASC has a strong health system partner in the market. That partner helps facilitate discussions about more aggressive, creative ways to contract and do alternative reimbursement deals. If the procedural volume is there, it's easier to make those alternative reimbursement strategies work."

Just Doing Some Good

Not all alignment strategies need to be in the form of an official agreement, Manigan says. ASCs looking to build stronger relationships with their local hospitals/health systems can explore joint marketing opportunities around education.

"I've seen an ASC aligned with a local hospital put on a big colon cancer screening event," he says. "Now you have the center, associated medical practices and health system doing some good community outreach through preventative medicine while building their brands collectively and, in some sense, individually."

Fight to Be Free

Tanner is a firm believer in physician independence. While he acknowledges that not all ASC physicians need to align to preserve that independence, a partnership with companies like PE and hospitals/health systems may be a worthwhile consideration for many physician-owned surgery centers.

"One of the reasons I fight so aggressively for physician independence is I believe strongly that physicians have the capability of changing the way we deliver healthcare," he says. "I think healthcare should be a physician-led, physician-driven effort, but for physicians to be able to deliver that change, they will need access to financial, business and analytical expertise and support in order to be able to affect the right outcome."

Graf says ASCs are well-positioned for growth, and there are some health systems eager to help physician achieve that success.

"We see community-based GI as being the solution for primary diagnostic procedural studies," he says. "If you need tertiary-level GI care, that can go inside the walls of the hospital, but there is no reason with the efficiencies of ASCs that most of these procedures shouldn't be performed in community-based ASC locations."

Graf continues, "We see an opportunity to drive cases out of hospitals, including our own, to lower costs sites of care. I think we will see even more eligible cases moved outside the walls of the hospital. Health systems are increasingly acknowledging this is the approach they need to take. Frankly, it's the responsible thing to do, and I think that's what payers and patients want as well."

When physicians work to keep their autonomy and their voice in the process of change and innovation, healthcare as a whole benefits, Tanner says. "I've always felt that physicians lose their entrepreneurial edge by becoming employees. Even if the hospital sincerely wants them to have a voice, they are still basically getting paid to show up and do a job. The entrepreneurial spirit, that motivation to go out and find a better way, really dissipates in my opinion when physicians surrender their independence."

***Barry Tanner**, who joined the company in July 1999, is considered to be a founder of Physicians Endoscopy, co-writing the business plan with CFO, Karen Sablyak, for the company that has evolved and grown into what exists as Physicians Endoscopy today. Today, Barry shares responsibility for the company's partnership development activities, as well as being primarily responsible for the company's strategic direction, and services development while also sharing in the day-to-day management and governance of several of the company's partnered facilities.*

***Mark Manigan** is a member of Brach Eichler's Health Law Practice Group focusing on the representation of health care industry participants on transactional and regulatory matters. Mark serves a wide spectrum of health care clients, including health systems, ambulatory care facilities, physician groups and healthcare entrepreneurs.*

***Barry Graf** has forty years healthcare leadership experience in hospital operations and partnership development. He was a leader in the development and delivery of a new 1 M sq. ft. health care campus and has led the development of various forms of physician and provider partnerships including Virtua's 17 partnered ASCs.*

Adding a Partner, Adding a Procedure Room:

A Case Study

By Robert Kurtz

Ramon Fernandez-Ledon, MD, felt it was time for a major change at Garden State Endoscopy Center (GSE). In fact, he felt it was time for two major changes.

Garden State Endoscopy & Surgery Center

The two-procedure room facility in Kenilworth, N.J, which opened for operations in 2000, was performing more than 10,000 procedures annually, but Fernandez-Ledon was concerned about what he considered to be the ASC's stagnation.

"I've always tried to be dynamic and keep adding doctors to my practice," he says. "When it comes to gastroenterologists, one of the incentives of the specialty is that some day you will have ownership in an ASC, which provides another revenue stream. That was a big sales point to attract quality candidates to our practice."

But over the years, as the number of physicians performing procedures at GSE grew, the amount of available time shrunk.

"With only the two rooms and so many hours to go around, we needed to operate on Saturdays and even some Sundays," Fernandez-Ledon says. "Any young physician coming in would essentially have to give up his weekends to do cases because the week was taken. I was finding it increasingly difficult to attract physicians with these circumstances."

The solution, he said, was to grow. But that was easier said than done.

"What I have learned from operating an ASC for 10 years is that people become entrenched in their ways and are sometimes very hesitant to change," he says. "Older physicians become increasingly afraid of big moves, especially those that require a significant financial investment. But I thought it would be a disservice to both my practice and the ASC if we did not grow. At some point, people retire. If you do not have a succession plan, what happens to the center?"

Fernandez-Ledon said he was also becoming concerned with the state of the healthcare industry and what he felt was a cloud of uncertainty about its future.

"There are so many changes occurring in healthcare and more coming," he says. "We realized that taking on a corporate partner was necessary if we were going to grow and do so appropriately. We needed a partner that would keep us on the cutting edge and help ease some of my partners' financial fears. We also realized we had become comfortable

with our finances and had maybe taken our eye off the ball a bit."

The decision to bring in outside expertise was embraced by the ASC, says its medical director, Ricardo Rodriguez, MD.

"It came to a point 15 years after the inception of our center when we realized that we needed support if we wanted to grow," he says. "We thought it would be wise to welcome expertise in management, support and billing."

GSE's leaders went in search of a partner that would help improve the ASC's operations and work with them on the significant decision they had made: It was time to add a third procedure room.

The Search

GSE interviewed a number of possible partners, including Physicians Endoscopy (PE).

"PE was brought to us by our accountant, who is intimately involved in New Jersey ASCs," Rodriguez says. "He's a very savvy person who has been with us since we opened and provided plenty of advice throughout our years of operations, so his recommendation of PE gave us confidence."

PE was different from other the partners GSE had considered, says Fernandez-Ledon. "They didn't insist on having majority ownership, which was very important to us. We didn't want to give up control. We wanted to continue to be the owners and the guiding hand in the center but do so along with help. PE seemed very amenable to that arrangement. It also helped that their references from other physicians who have worked with them were great."

GSE was a natural fit as a partner for PE, says Ann Sariego, vice president of operations for PE.

"GSE's owners' drive to service their community and provide quality, safe and effective care aligned with our goals," she says. "They knew that with the way healthcare landscape is rapidly changing, it would be most productive to align with an ASC management company that would share those common goals and guide and assist them with navigating the complicated process of partnering and expanding the ASC."

Rodriguez says, "Once we met PE's people, we were enthusiastic in forming a relationship with them."

In May 2015, GSE and PE finalized a joint-venture relationship.

Getting to Work

Not long after the partnership was finalized, the work began on adding the third room, says Mary Ann Gellenbeck, vice president of implementation services for PE.

"Part of the reason they aligned with us was to assist them with this very complicated, intensive construction product to expand their facility," she says. "We wasted no time in getting started."

The decision was made to undertake the expansion in GSE's existing building, in which the ASC rented space. But there was concern that this approach could harm the existing center operations.

"One of the daunting potential problems we thought we would encounter with opening a third room was having to close the center for a long period of time for the construction," Rodriguez says.

Understanding that concern, PE set out to formulate a plan with GSE that would limit downtime as much as possible. GSE's operations were spread out over two floors in a four-story building. On the first floor were the clinical space, part of the business office and administrative operations and other non-clinical components, such as the waiting room, kitchen, staff lounge and lockers. On the fourth floor was the rest of the business and administrative offices.

GSE's original architect was brought in to design the third procedure room to share the space with the other procedure rooms. GSE leased additional space on the first floor, located across the lobby from its existing space. This newly leased space was designed for the entire business and administrative offices and the other non-clinical components.

The plan was to move these components from the first floor into the new space while the fourth floor offices continued to operate. Once this transition was complete, the third room would be built into the now available space and the fourth floor offices would move down to the new first floor space. On top of all of this was the goal of maintaining operations as close to normal as possible.

The project was as complicated as it sounds, Gellenbeck says. "It was probably the most difficult phased project I have been involved in. It required de-

tailed coordination between the architectural and construction side, and also the facility operations side so patient flow and infection control would not be impacted during construction."

It also required a flexible construction company, which PE found.

"They engaged a company they had used in the past at another center that was able to work evenings, Saturdays and Sundays," Rodriguez says. "For awhile we had to stop performing procedures on Saturdays, but that was about the only major disruption we experienced."

Fernandez-Ledon adds, "When you are able to have construction performed on weekends and after 5:00 pm on weekdays, that's how you can avoid having to shut down for two months to get this type of project completed."

The third room received final approval in the first week of November 2016 and opened one month later.

"They essentially maintained operations throughout the entire project with the exception of two days they needed to completely shut down," Gellenbeck says. "The project was planned well, coordinated well and everyone was very flexible. The whole team worked closely together, and the physicians and staff were fantastic to work with."

"It was an incredible feat," Fernandez-Ledon says.

Reaping the Rewards

It didn't take long for the third room to deliver on its promise. Only one month after the room opened, GSE had gone from averaging 40 cases to 60 cases a day, Fernandez-Ledon says. He's been able to grow his practice as well, adding three physicians over the past two years.

"Now I have a place to put them to do procedures, which benefits all of the partners," he says.

As the third room project progressed, PE worked with GSE to improve other aspects of its operations.

"From a billing and collections perspective, we worked to ensure billing was performed and reconciled immediately," Sariego says. "From a payor contracting perspective, we looked at all of their contracts and renegotiated them at rates that were more favorable. From a medical supply and services perspective, we were able to leverage PE's contracts to make a significant impact on all of their prices. In addition, we ensured that GSE's clinical services were meeting regulatory requirements."

"Thanks to PE, our billing and collections have improved tremendously," Fernandez-Ledon says, "and PE's purchasing power saved us at least $250,000 in the first year."

Rodriquez adds, "They came to us with a number of skills that we welcomed, especially support in the financial aspect of our center and operations. PE has also continually provided support in other activities, such as human resources, credentialing and leadership support."

What may be most rewarding is the close partnership that has been formed between PE and GSE, Sariego says. "I think the physicians view PE as a true partner. Everything is done collaboratively. We share the same goals, quality focus and vision to drive the business forward in a way that will truly benefit patients. That is what ultimately matters most in the end."

Remote Video Auditing Supports Scope Cleaning Compliance Efforts

Infection prevention is a top priority at East Side Endoscopy & Pain Management Center (ESE), a Physician's Endoscopy partnered facility in Manhattan, New York. So when ESE was presented with the opportunity to serve as a beta site for a new technology designed to support its efforts in this area, the ASC leadership team jumped at the offer.

The technology is called "remote video auditing" (RVA). With RVA, activities are captured on video and then analyzed off-site by independent auditors. The analysis looks at whether the activities were performed appropriately.

"RVA has been used in the food industry for infection prevention for many years," says Brett Bernstein, MD, AGAF, FASGE, medical director for ESE. "We know infection control is very high on the radar of all ambulatory centers, and all of the governmental and accrediting bodies are looking to ensure that centers are adherent to the most up-to-date guidelines. At ESE, we have always strived to be ahead of the curve on infection control. We believed the use of RVA could potentially identify any gaps that might exist in our scope cleaning and infection control processes and drive improvements."

How It Works

ESE purchased and installed the RVA system in May 2016. The system consists of software, a camera that was installed in the ASC's ceiling over the scope decontamination sink and a high-speed internet connection linking ESE and the off-site auditing company.

The ESE clinical leadership team and company representatives collaborated to develop a scope cleaning observation tool, Bernstein says. "We worked off of the scope manufacturers' instructions for use and recommended factory cleaning protocols to craft a written script that broke down the decontamination process. We also filmed our lead technician (Bellanira Cruz, CFER) going through the process of cleaning the scopes we use."

A great deal of work went into preparing the script, says Helen Lowenwirth, MBA, CASC, ESE administrator.

"It was a very collaborative and iterative process," she says. "When you break it down, there's about 100 detailed steps the techs are supposed to follow, from leak testing (wet and dry), manual cleaning, brushing the channels, noting all the supplies and chemicals used at each step and the duration of each step, and the use and changing of proper personal protective equipment."

The script is followed by auditors who monitor the scope decontamination process. At the beginning of the process, an "identifying card" is held up to the camera for identification of the device about to be decontaminated. When a step is

missed or not performed according to the script, an e-mail notification is sent to the clinical leadership team.

No Punitive Ramifications

The decontamination process is recorded in its entirety, but the team member performing the process is never identified. This is an intentional — and important — aspect of the program.

"This is not designed to focus on any individuals in particular," Bernstein says. "The camera that's used is a zoom, pan and tilt camera, but it's not pointed in a way that could be used to identify an individual technician. There's no 'big brother is watching' element."

That was very important for ESE in initiating this program, he adds. "The goal is to drive improvements in process, not use what we learn in a punitive way. That has to be a key element when you are implementing such a program. There may be the tendency among some to believe that it will threaten their job or serve to target them. That should never be considered part of the reasoning behind doing it."

Staff is provided with reports sent by the auditing company. Cleaning techniques are reviewed and protocols are reinforced, Lowenwirth says.

Results

When ESE initiated the program, the ASC had an initial compliance rate with the steps outlined in the audit trail of 67%, Bernstein says. "There were specific elements in the cleaning process that were not consistent. For example, at a very basic level, we occasionally saw that people were not using their personal protective equipment."

Through diligent, repeated review of the decontamination process, performance quickly improved, he says. "We performed the review in a very iterative way through our lead technician, nurse manager and myself as medical director overseeing the program. Over a 6-8 week period, we were able to achieve over 90% compliance."

After about nine months of using the system, ESE is at a sustainable rate of 98%. Through January, ESE had audited more than 3,000 standard colonoscopes and about 75 scopes with an elevator mechanism.

"We expected this to potentially impact the amount of time it would take to process a scope," Bernstein says. "As it turns out, there was no significant increase in the time needed to perform these tests."

Benefits

The primary benefit of the program has been the increased patient safety resulting from the added measure of infection prevention, Lowenwirth says. "Staff has really embraced the process. There is the improved awareness of how important each and every step of the process is to ensure adherence to proper protocol. The project provided the team with an opportunity to reevaluate long-established protocols and standardize techniques based on best practices."

Investment in such system sends a message to an ASC's team, says Ann Sariego, vice president of operations for Physicians Endoscopy.

"It speaks to the center's and medical staff leadership's level of expectation about the quality of the services they want to provide to every patient," she says. "It places the emphasis on those technicians who are performing the cleaning that anything less than perfect is not acceptable."

It also helps leadership better support team members, Sariego says. "It is not possible to monitor everyone all of the time. A program like RVA takes this human factor and examines it on an ongoing basis to identify opportunities for improvement. When people know they are being watched, they are naturally going to do things differently. Before adding RVA, ESE did an excellent job in the scope cleaning processes. This brought them to a new level and helped get their people to pay even closer attention to everything they did during the decontamination process."

Bernstein says what was critical to the program's success is ESE's and its staff's commitment to a culture of improvement and safety. "When staff feel competent and are confident in their leadership doing what is best, they know the initiation of a program like this is happening purely for the right reasons. As good as you think you are, you can always get better."

ASC Valuation

Trends and Developments

By Hunter M. Outcalt, MTX, CPA, Director, and
John J. Hakanson, Senior Associate, HealthCare Appraisers

Earlier this year, HealthCare Appraisers released its 2017 ASC Valuation Survey. It's the 15th edition of our survey, which examines trends in the value and characteristics of ASC ownership interests and management fees charged to ASCs.

For this year's survey, we had 24 respondents (including Physicians Endoscopy), representing more than 700 ASCs. Here are some of the bigger takeaways from this year's survey that may be of particular interest to GI physician owners of ASCs.

High Level of Acquisition Activity and Interest

Survey results revealed a high level of acquisition activity in 2016 and potentially even higher in 2017.

About 59% of respondents said they purchased a majority or minority ASC interest in 2016. This means a majority of respondents were not only looking to get into deals, but were closing deals. We anticipate seeing that figure rise this year as 78% of respondents indicated plans to acquire a majority or minority interest in 2017.

These statistics tell a few stories. First, organizations believe they can get into ownership of ASCs for a reasonable price and still make a return on their investment. Many of our respondents are health systems and management and development companies, and while certain acquisitions are made for strategic purposes, these organizations are often looking to make sound investments. The survey results seem to indicate the market is generally reasonably priced, at least for the moment.

We also know that ASCs remain attractive acquisition opportunities. Insurers, both Medicare and commercial, are continuing to push surgeries away from the higher-cost hospital outpatient department settings toward lower-cost settings such as ASCs. Their continued support of ASCs as a lower-cost option and, in many cases, a more convenient option for a lot of patients is helping to support that ongoing demand.

Valuation Multiples Remaining Steady

Part of the survey looks at what organizations are paying for ASCs, examining valuation multiples from year to year. We ask respondents to identify multiple ranges.

For 2017, the results were fairly consistent with what we saw in 2016. For purchasing a majority interest in multi-specialty ASCs, 75% of respondents reported valuation multiples in the 7.0 to 7.9 times EBITDA range; about 72% were in the same range for 2016.

For single-specialty ASCs, it was about 78% in the 6.0 to 7.9 EBITDA range in 2017 compared to 73% in that range for 2016.

What this tells us is that prices are remaining consistent; however, additional deals are occurring in this higher-level range. This further supports what we discussed earlier: ASCs still represent a reasonable venture for organizations to earn a good return on investment.

Management Fees

Another area of focus for the survey is the amounts paid for providing management services to ASCs. Management fees typically vary dependent upon the level of service provided. Based on the survey results, 67% respondents reported their typical management fee ranges from 5% to 6%. Billing/collections services is an additional 4% to 5.9%, based on 57% of respondents. The combined market rate would be 9% to 11.9%.

In addition, 20% of respondents report their typical management fees range between 3% to 4%, which decreased from 28% in the prior year. This indicates an increase in the services provided by these managers, which is not surprising given the wealth of knowledge many ASC management companies can provide. These results would also indicate ASCs are willing to let these managers provide additional services as opposed to performing them in-house.

Note: To learn more about and download the 2017 ASC Valuation Survey, visit **www.healthcareappraisers.com/insights/valuation-surveys/**.

Complying with the

CMS Emergency Preparedness Rule

By Mary Ann Gellenbeck, VP Implementation Services, Physicians Endoscopy

MARY ANN GELLENBECK

In September 2016, the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* was published in the Federal Register, the federal government's publication for rules, proposed rules and notices. The rule applies to 17 provider and supplier types, which includes ASCs.

Here are eight things to know about the rule and emergency preparedness that may help you begin or continue your efforts to bring your ASC into compliance.

1. Rationale. The Federal Register describes the purpose of the rule as follows:

"This final rule establishes national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to plan adequately for both natural and man-made disasters, and coordinate with federal, state, tribal, regional and local emergency preparedness systems.

"It will also assist providers and suppliers to adequately prepare to meet the needs of patients, residents, clients and participants during disasters and emergency situations.

"Despite some variations, our regulations will provide consistent emergency preparedness requirements, enhance patient safety during emergencies for persons served by Medicare- and Medicaid-participating facilities, and establish a more coordinated and defined response to natural and man-made disasters."

2. Does it apply to you? If your ASC is one of the roughly 5,500 Medicare-certified ASCs in the United States, it does.

Within the CMS Conditions for Coverage (CfC) is 42 CFR § 416.54, the CfC for emergency preparedness. It begins with the following: "The ASC must comply with all applicable federal, state and local emergency preparedness requirements. The ASC must establish and maintain an emergency preparedness program that meets the requirements of this section."

3. Implementation date. While the regulation went into effect on November 16, 2016, ASCs have until November 16, 2017, to comply and implement all regulations.

That may seem like a lot of time, but preparing your ASC for the changes is not a quick process. You will want to take advantage of the time to work on preparation and not wait until the last minute.

4. Requirements overview. CMS identified four core elements central to an effective emergency preparedness program. They are summarized as following:

i) **Risk assessment and emergency planning.** Facilities are required to perform a risk assessment that uses an "all-hazards" approach prior to establishing an emergency plan. The risk assessment will identify the essential components for integration into the emergency plan. An all-hazards approach focuses on capacities and capabilities critical to preparedness for the full spectrum of emergencies or disasters. It is specific to the location of the provider and considers the particular types of hazards most likely to occur in their areas (e.g., care-related emergencies; equipment and power failures; communications interruptions, including cyberattacks; loss of part or all of a facility; and, interruptions in the normal supply of essentials, such as water and food).

ii) **Policies and procedures.** Facilities are required to develop and implement policies and procedures supporting the successful execution of the emergency plan and risks identified during the risk assessment.

iii) **Communication plan.** Facilities are required to develop and maintain a compliant emergency preparedness communication plan. Patient care must be well-coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems. During an emergency, providers must have a system to contact appropriate staff, patients' treating physicians, and others in a timely manner to ensure continuation of patient care functions and that these functions are carried out in a safe and effective manner.

iv) **Training and testing.** Facilities are required to develop and maintain an emergency preparedness training and testing program. This must include initial training for new and existing staff in emergency preparedness policies and procedures and annual refresher trainings. Facilities must also conduct drills and exercises to test the emergency plan to identify gaps and areas for improvement.

5. Possible requirements if you're part of a healthcare system. If your ASC is part of a healthcare system with a unified and integrated emergency preparedness program, you may participate in the program along with the healthcare system. Doing so adds some requirements, which may include the following:

- Your ASC must actively participate in the development of the emergency preparedness program.
- Development and maintenance of the program should take into account your ASC's unique circumstances, patient populations, and services.
- Your ASC must be capable of actively using the emergency preparedness program and is in compliance.

6. Team involvement. Emergency preparedness is not a one-individual responsibility. Responsibilities should be divvied up amongst various members of your team.

The administrator will likely wear multiple hats, possibly filling multiple roles. Then it will be necessary to engage other members of the staff to fill additional positions and responsibilities.

While you may need to assign some roles, first see if members of your team are interested in taking on the emergency preparedness leadership positions you need to fill. That will help with buy-in.

7. Check state requirements and accreditation standards. Depending upon what state your ASC is located in and which accreditation organization your ASC uses, you may have requirements your ASC must meet in addition to CMS regulations.

For example, your state or accreditation organization may not allow tabletop drills. While a tabletop drill technically simulates the event, since it does not require physical simulation or use of equipment, it may not be viewed as an acceptable substitute for an emergency exercise.

If CMS regulations, state regulations and accreditation standards all address the same issue, you must follow the rules which are most stringent in order to be in compliance.

8. Keep current. An emergency preparedness plan and program should be treated as living documents, receiving regular reviews and updates, when necessary.

If members of your emergency preparedness team leave the ASC, you will need to replace them and update your documentation to reflect the new positions and these team members' contact information.

If you add a new specialty, your documentation will need to reflect how you will maintain care of those patients in the event of an emergency.

If you expand your facility, you will need to take into account how the new space affects your response plan.

Also, make sure to keep an eye out for Life Safety Code changes and other industry updates that could affect emergency preparedness. If your ASC is a joint venture with a management and development company and/or hospital, make sure emergency preparedness is a regular topic of discussion.

Get to Work

Depending upon how far along you are with meeting the emergency preparedness rule, you may still have a lot of work to do. There are a few steps you can take to help move you forward and closer to compliance. They are:

- Review any forms, policies, disaster supplies and other documentation concerning your emergency preparedness to assess your current state of preparation.
- Assign a few staff members to help. As stated earlier, emergency preparedness requires teamwork.
- Develop a plan for bringing your preparedness up to par, and have it approved at the committee and governing board level.
- Complete an exercise. By running a drill and analyzing your ASC's performance, you may identify areas and opportunities for improvement.
- Seek out resources. If you have a management company or hospital partner, find out how they can help. There are ample resources available from national and state associations, federal and state agencies, publications and even other providers. At a minimum, you may be able to use such resources as guides or templates to fill in plan gaps.

While the mid-November deadline may seem a ways away, it will be here fast. The sooner you can get to work on meeting requirements, the better; you don't want to be caught unprepared.

***Mary Ann Gellenbeck, RN, CNOR, RNFA, CASC**, joined the Company in August 2011, bringing with her many years of healthcare leadership and operations experience. Prior to joining PE, Mary Ann worked as a member of the senior management team with operational oversight of multiple multispecialty centers including hospitals, ambulatory surgery centers, and other ancillary services.*

Mary Ann has extensive experience in facility design, education and training, Joint Commission, AAAHC, CMS and State accreditation standards and compliance. In her role at PE, Mary Ann oversees all aspects of implementation, facility construction, design and development, clinical and operations support. She also serves as a PE Board Member for Ohio centers.

Legal Corner:

FAQs About Supergroups

Michael F. Schaff, chair of the corporate and healthcare departments and shareholder of law firm Wilentz, Goldman & Spitzer in Woodbridge, N.J., answers some of the most common questions he receives concerning gastroenterologists joining and working successfully with supergroups.

Q: When joining a supergroup, will this affect my ownership in an ASC?

Michael Schaff (MS): Typically, it shouldn't. However, that is not always the case, which is why it is important to ask that question upfront.

How your ownership in an ASC will be affected depends on the goals of the supergroup. If one of the goals of the supergroup is to include and capture different types of ancillary revenue, it is possible that, over a period of time, the supergroup may require joining gastroenterologists to eventually participate in their new center. This may require joining gastroenterologists to transition out of their existing centers.

If that is the case, joining gastroenterologists need to be aware of and review their operating agreement for their existing surgery center and whether there is a restrictive covenant which might limit their participation in the new center for a period of time. The gastroenterologist should carefully review the ASC agreement prior to joining the supergroup to understand its impact.

MICHAEL F. SCHAFF

Based on my experience, many gastroenterology supergroups permit the ownership of ASCs outside of the group. The rationale is that most established gastroenterologists currently have interests in surgery centers or endoscopy suites. If supergroups required joining gastroenterologists to transition out of existing centers, it would add another level of complexity in setting up the supergroup, which could lead to its downfall.

Q: How will joining a supergroup affect my retirement buyout?

MS: The first thing you need to do if you are a gastroenterologist joining a supergroup is determine your goals and whether they match many of the goals of the supergroup. Much of this may depend on how much longer you plan to work and when you see yourself retiring. If you see retirement on the five-year horizon, you may have already worked out some type of buyout in your current agreements.

In many cases, when you join a supergroup, existing buyout arrangements may be affected, especially if the

new supergroup requires significant upfront capital. You may need to invest significant money for long-term planning purposes, which may be utilized during the first few years you are an owner. If your retirement horizon is limited, you might never be able to recapture that investment under your buyout formula since it's being used for initial startup costs and may not translate into tangible assets, which may be the only assets that get valued at the time of your retirement.

For someone who is thinking about retirement within a five-year horizon, I would recommend assessing what the buy-in is, any requirement for you to make significant capital contributions up front or guaranty borrowed money, and the buyout formula for the supergroup, then compare it to your current scenario. In some cases, it may be more beneficial economically not to go in as partner or owner in the supergroup but to coordinate a non-ownership track with your buyout being addressed now or committed to in the future from your practice. However, that is not always the case. You typically will need to do an analysis.

Keep in mind that even if you don't go in as an equity owner of the supergroup, you can still be involved in decisions and voting. Ownership has three basic components: 1) the ability to share in the profits (and hopefully not the losses); 2) the ability to be involved in decision making; and 3) equity and/or some amount of money if the company is sold or if you leave for another reason. Each one of those issues can be dealt with separately, outside of the commitment of capital and investment.

Q: What is one of the biggest obstacles to new supergroup success?

MS: When a supergroup is formed, it can bring about significant cultural changes. You may be in a group of a few gastroenterologists and are combining with groups that are of similar size, smaller or larger. Each group has an internal culture within its practice that might differ from the others. You need to understand what's going to happen when these cultures start to mesh and how that is likely going to affect you.

Oftentimes, personalities get into the mix. Keep in mind that the people coming together to form a new supergroup are typically competitors. Over the course of a career, they likely formed some biases. Sometimes they like their competitors, but many times they do not, often for reasons they may not even be aware of: the competitive nature, spouses, or some of them are former partners that disbanded years ago and they just don't like them.

If you're going to go into one of these arrangements, you need to go in with a healthy attitude. Put these prior experiences on a shelf. Don't forget about them, because they may impact what you do and decisions you make, but you cannot focus on them. Rather, you need to focus on going forward and not looking backward.

Q: What are some important financial considerations I should be aware of before joining a supergroup?

MS: When you join a supergroup, you will likely be starting from scratch on some financial issues, such as bank financing. In today's economy, many banks require the doctors to personally guarantee the entire loan. Sometimes the funds borrowed will not be utilized for your group but may be used to enhance one of the other practices joining. Even though it's part of the supergroup, and may be a company obligation, you may think that you are not a beneficiary of the loan and don't understand why you would need to guaranty it since it may have no real financial impact on your practice.

Besides having appropriate indemnification if you end up having to pay more than your fair share, what you may want to do in this scenario is negotiate upfront that if the money is being used just for a specific division, the sole guarantors would be members of that division. You may want to have separate loans for each division, even if it's with the same bank. That way you can properly isolate the guarantees and obligations of the specific doctors in the group.

If the supergroup's bank is unwilling to take this approach, I would suggest that you have some type of limitation on the guarantees. If a bank asks for the guaranty to be joint and several, you may be able to limit it to 110% to 120% of your pro rata ownership of the company. So, if there are 10 doctors and each is owning 10% of the company, instead of each doctor being responsible for 100% of the debt, each doctor in that instance would be responsible for 110% or 120% of their pro rata share of their ownership. In this example, you would each be responsible for your 10% + 10% (or 20%) of that, which would be 11% (or 12% depending on what the bank requires) total. The bank would have guarantees totaling 110% (or 120%) of the loans if you add them all together. This will limit your exposure.

Q: When I combine my practice with others, what will happen to our human resources and other operations services?

MS: When you form a supergroup, there are a number of items that will be re-

quired by law to be integrated. Among them are employee benefits, pension plans and billing. You need to plan and understand that process in advance so you are not hit with surprises along the way.

For example, each group most likely will have a different pension plan. Under the supergroup plan, you will need to deal with one pension plan eventually. You need to get on the same page because people tend to have different opinions on how to approach pension plans.

It's really a coordination effort. There's not necessarily a right and wrong way. In each group, there is typically one or two dominant physician leaders. You just need to make sure all of the dominant leaders play in the sandbox well together.

Q: How does governance in a supergroup work?

MS: A supergroup will often have several levels of governance. There's governance on the division level. Assuming your existing practice is staying as a separate profit center and division, you would be able to make certain decisions there.

There is going to be a "superboard," which would be responsible for the entire company. Most significant decisions for the supergroup will be made at the superboard, while many site-specific decisions will be permitted to be made at the division level. You should understand what is proposed regarding your voting on each level and make sure you or your group has appropriate representation.

For example, there may be four groups forming a supergroup. One group has 20 gastroenterologists, the second five, the third may be a solo practitioner and the fourth a group of six. Do they all have the same voting on the superboard level? Usually not. Is the voting based on the number of doctors in each group? If every doctor has one vote, then the group of 20 has control of every decision. You should anticipate and set up a plan to appropriately give the group of 20 more than one vote but not give them the dominant ability to make all of the decisions.

As an attorney, I strongly recommend that if you decide to pursue the joining of a supergroup that you speak with experienced counsel.

Website Compliance:

7 Areas of Focus

By Michael Sacopulos, JD

MICHAEL SACOPULOS, JD

Healthcare provider websites are in the spotlight. An increasing percentage of patients are turning to the Internet for help with their healthcare, whether it be to research possible solutions for ailments, options for where and from whom to receive care or as a means to communicate with providers.

As the importance of the Internet in patients' lives has grown, so has the scrutiny of website content and methods of interaction from various regulatory agencies.

"Websites for a practice or ASC serve several functions. They provide marketing. They offer educational materials. They also act as a platform for communicating with patients," says Michael Sacopulos, JD, founder and president at Medical Risk Institute in Terre Haute, Ind. "Due to websites' many functions, numerous laws and regulations govern them. Federal statutes, governmental agencies and even boards of medicine have some authority over a website's content. Unfortunately, many people don't find this out until it is too late."

A non-compliant website can create problems in many different regards. Boards of medicine have taken an interest in electronic communications, which Sacopulos says should be eye-opening for providers.

"All of those rules of professional conduct and responsibility that you may have thought just applied to print advertisements now apply to your website," he says. "The Federation of State Medical Boards have been active in this area as well, coming up with electronic guidelines. There are governmental entities that have authority over you as well that have the potential to cause problems."

He adds that there is also the potential for significant financial implications. "A non-compliant website could result in an individual patient or class-action claim. Now you are looking at potential monetary penalties in addition to licensing issues."

Even if you do not believe a non-compliant website will ever create any legal problems for you, there are other compelling reasons why Sacopulos says organizations should take compliance into account. By following the rules and laws, you may improve a website visitor's experience and potentially their first direct interaction with your organization.

"We know statistically that the Internet is a major source of information for patients and helps drive new patient acquisition, which is the lifeblood of a practice and ASC," he says.

"In addition, you should feel obligated to follow the law, whether you think it is a good idea or not. That's part of our job as professionals and our professional responsibility."

Here are seven areas of focus identified by Sacopulos to help improve your website's compliance.

1. Contact forms. Most websites offer an electronic means for visitors to provide information to the organization. This is usually performed through a contact form. While the use of a contact form can be an effective way for prospective and current patients to communicate with the organization, Sacopulos says it is important to consider how the form is similar to other ways in which patients communicate with their providers.

"For example, if patients were to call their physician at 7:00 PM, they would likely get a voicemail advising them to call 9-1-1 in the event of an emergency or answering service that could provide some information," he says. "But if we pull up the contact form on a website, there may not be a note about calling 9-1-1 or information about when visitors should expect to hear from the organization."

Sacopulos notes that there are generations of people who feel more comfortable communicating through computers than picking up the phone. Organizations need to consider their responsibility to serve this portion of the population.

"Online disclosures help set proper expectations and establish necessary and appropriate safety levels," he says. "It could be a disclosure about the information patients are providing. You may want to inform patients that submitting a form does not create a physician/patient relationship, and they should not expect to be treated based upon what they submit. Another disclosure could state that if they are in a crisis, they should not expect an immediate response from a form submission."

Another important consideration concerning contact forms is the sharing of medical information. If people are submitting personal information or photographs, it is not likely to be considered a secured transmission under the Health Information Technology for Economic and Clinical Health (HITECH) Act, Sacopulos says.

"It's fine if patients want to send the information and the organization wants to receive it, but people need to know that it is not a secure transmission, it is not encrypted and it is, therefore, subject to exposure," he says. "This is a worthwhile notice — essentially a warning — to people who want to interact with you through your website."

2. Americans with Disabilities Act (ADA). The federal government describes the ADA as prohibiting "discrimination against people with disabilities in employment, transportation, public accommodation, communications and governmental activities. The ADA also establishes requirements for telecommunications relay services."

Compliance with ADA is becoming a bigger issue, and practices and ASCs should pay closer attention to when it comes to their websites, Sacopulos says.

"This can be particularly important if you are treating older patients with vision and hearing problems," he says. "There are software programs that can run in the background of a website that allows content to be conveyed in audio form for those with vision problems. If your website displays videos, you will want to make sure the option to display text in closed captions is available for those with hearing problems."

3. Patient portals. In an attempt to improve the patient experience, Sacopulos says he is seeing an increase in the number of websites including a portal component that provides a pathway for patients to access their medical records within the organization's electronic medical records system. But if these portals are not configured appropriately, any goodwill they may bring could be lost.

"There are plenty of reports about portals with vulnerabilities that were exploited by cybercriminals," he says. "Hundreds of thousands of patients have had their information exposed or stolen, and records have been ransomed back to providers. These are legitimate and growing concerns if you are going to add such functionality to your website."

4. Images. Images are an integral part of any website, but there are several ways that their use can raise legal concerns. If your website uses stock photos, such as images that represent healthcare services, your specialty(s) or perhaps the city in which you're based, in most cases you need to pay for their use through a service like Getty Images or Adobe Stock.

"If you do not pay for use of the images, you could receive a demand letter stating you may have committed copyright infringement," Sacopulos says. "Get with your web designer and make sure you have rights to use all images on your website."

A related problem concerns the use of "scraping," which is when images are taken from one website and used on another. This is common with the use of "before" and "after" images associated with plastic and cosmetic surgery,

Sacopulos says, but can extend to other specialties.

"This can happen when a web designer is looking for some good representations of what a procedure should look like," he says. "Sometimes these types of images aren't available through stock photos or can be very expensive, but neither is a legitimate reason to scrape."

A way to work around copyright and cost concerns is to take your own images, but there are potential legal risks with these as well if the images include patients, Sacopulos says. "You can't put any patient information up on your site without a proper patient release. There is a wild misconception that just because the patient's face isn't present in the image, a release isn't needed."

5. Testimonials. If you want to include patient testimonials, there are a few important considerations.

Like the use of images of patients, you should secure a proper release to use any patient's words on your website, Sacopulos says. This is true whether you are using a patient's full name, initials or some variation of the two. Make sure patients approve the words you are attributing to them.

But even before you seek approval, learn your state's laws concerning the use of testimonials, Sacopulos says. "Some states allow for testimonials; some do not. This goes back to the old rules of professional advertising. If you promote a result, people may think that's the result they should expect. But we know results vary based upon the patient. Even if your state allows testimonials including this disclaimer is worthwhile."

Note: He adds that another area where state laws vary is the use of the term "board certified" to describe clinicians. "If you say you are board certified, certain state boards require you to indicate through which board you are certified."

6. Language. An issue gaining more attention concerns the provision of care for individuals with limited English proficiency (LEP). In May 2016, the HHS Office for Civil Rights issued a final rule that noted: "the prohibition on national origin discrimination requires covered entities to take reasonable steps to provide meaningful access to LEP individuals who are eligible to be served or likely to be encountered within the entities health programs and activities."

Sacopulos says, "You need to inform your patient population that language assistance services in the form of interpreters or written translations can be made available upon request. This disclosure should be on your website."

7. Keeping current. It is not unusual for an organization to launch its website and then make few changes to it over time. This can be a problem if some of the content on the website becomes outdated.

"Privacy policies are typically posted on a website when it is created," Sacopulos says. "I know of more than one occasion where the policies were later changed, with the new version posted in the organization, but no one thought to update it on the website. Claims were brought against the organization for misleading people because the policies were inconsistent."

What You Can Do

If you are feeling overwhelmed by all of these areas in need of your attention, Sacopulos says that's understandable.

"There are so many different sources that can regulate or impact your website," he says. "It is difficult to state exactly what you need to do to be compliant. Unfortunately, the rules and laws are changing fast and becoming more complex. There have been several developments within the last 12 months, and I'm sure there will be more coming."

Sacopulos says it is likely unrealistic for a practice or ASC to keep up with the rules on its own, but there are a few steps organizations can take to help achieve and maintain compliance. Consider speaking to your legal counsel about ways they can assist. Another option is to solicit the assistance of the individual or vendor that performs your risk analysis.

"Everyone is supposed to have a routine risk assessment for HIPAA purposes and other requirements," Sacopulos says. "Websites are often left out of this assessment, but they should be included. Doing so will keep website compliance on your radar."

He continues, "It's common to see an organization put extensive effort and money into getting a great website designed and launched. But six months later, no one is thinking about it. That's how problems develop. Your website's content and use need to be routinely revisited to make sure you are not falling out of compliance. Just by reviewing your website, it shows you are making an effort to keep it compliant. Distinguish yourself in the eyes of the law by having a game plan."

Michael J. Sacopulos *is the CEO of Medical Risk Institute (MRI). Medical Risk Institute provides proactive counsel to the healthcare community to identify where liability risks originate, and to reduce or remove these risks. Michael won the 2012 Edward B. Stevens Article of the Year Award for MGMA. He has written for Wall Street Journal, Forbes, Bloomberg and many publications for the medical profession. He is a frequent national speaker. He attended Harvard College, London School of Economics and Indiana University/Purdue University School of Law. He may be reached at* ***msacopulos@medriskinstitute.com****.*

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Chinook Acoustics, Inc., the maker of a noise reducing medical curtain called HUSH Curtain®, is currently used in over 150 facilities nationwide. Using patented acoustical privacy panels that can be installed on existing cubicle tracks, the HUSH Curtain® dramatically reduces noise and has been shown to reduce stress, enhance the quality of sleep and promote overall healing.

"Throughout the nation, hospitals have seen significant improvements in reducing noise and enhancing quality of care with their use of HUSH Curtain®," said Ben Forrest, CEO of Chinook Acoustics, Inc. "We're excited to be a part of a movement that will promote healing and provide patients with a better hospital experience."

Developed by an acoustics expert with a background in noise reduction, the design of HUSH Curtain® absorbs and blocks sound in ways that reduce ambient noise. Countless studies have shown the impact of noise on patient healing, staff effectiveness and even a patient's confidence in the medical staff.

Danielle Gabele, nurse manager at Cedars Sinai Medical Center in Los Angeles, has HUSH Curtains® in her Medical Observation Unit. "The HUSH Curtains® we purchased made a world of difference in my hospital unit. The unit where they were placed is a department with patients who stay overnight in curtained areas. Prior to the HUSH Curtains®, we had daily complaints about the background noise all day and all night. Once the HUSH Curtains® were in place, not only did we hear fewer complaints from the patients, but also my staff benefitted from a quieter, more peaceful space. I would recommend these curtains to anyone looking to add more privacy and sound reduction to any space. I also appreciated that they come in many different styles so we could find one that matched with our existing color scheme."

Terri Halverson, assistant nurse manager at Providence Holy Cross in Mission Hills CA, has HUSH Curtains® in her Emergency Department. "Providence Holy Cross Medical Center Emergency Department is very busy, seeing on average 300 patients a day in a 36 bed Emergency Department. The layout of our Emergency Department presents a huge challenge in terms of privacy and noise disturbance for our patients. We have several rooms that accommodate multiple patients, up to four. Privacy and noise levels in the ED drove our search to find a product that would improve privacy and decrease noise for our patients at a minimal cost. HUSH Curtains® have been the answer. They are attractive, move with ease and do not come off the track or tangle as our previous curtains did and they are easily cleaned. They come in different sizes to accommodate a range of spaces and are especially nice in our single patient bays where they act as doorways. We have been very happy with this product and it has helped immensely with decreasing noise levels and providing privacy in our spacially challenged ED."

In addition to improving patient experience, hospitals are utilizing HUSH Curtain® to advance a hospital's HIPAA compliance through better privacy controls and it can be used as a tool to improve HCAHPS scores – and Medicare reimbursements – by reducing the noise patients are exposed to at night. Excess noise is the most common patient complaint on HCAHPS surveys.

For more information on HUSH Curtain®, visit ***www.hushcurtain.com***.

Front and Center

Awards

Becker's ASC Review honored the top 45 gastroenterology practices in the US according to the highest ratings on Angie's List. Gastroenterology Consultants of Hollywood, FL, the practice associated with **South Broward Endoscopy Center**, came in at number 9 on the list. Barry Migicovsky, MD, was this practice's top review earner with five "A" reviews. Complimented extensively on his bedside manner, reviewers were stricken by Dr. Migicovsky's approach at dealing directly with them, and not using a physician's assistant. Gastroenterology Consultants features nine providers in total.

DHA Endoscopy Center's Eric Libby, MD, and Robert Muggia, MD, were named Boston's Top Doctors for 2016. For their annual look at Boston's best physicians, Boston magazine partnered with healthcare researcher Castle Connolly Medical Ltd. to bring this year's guide to hundreds of Boston's Top Doctors.

Endoscopy Center at Bainbridge (ECB) has been selected for the 2017 Best of Chagrin Falls Awards for Medical Services. Each year, in and around the Chagrin Falls, OH area, the Chagrin Falls Award Program chooses only the best local businesses. The selection focuses on companies that have demonstrated their ability to use various marketing methods to grow their business in spite of difficult economic times. The companies chosen exemplify the best of small business, often leading through customer service and community involvement. Congratulations ECB!

Endoscopy Center of Niagara (Niagara Falls, NY) and **South Broward Endoscopy Center** (Hollywood, FL) were among 78 healthcare organizations honored by SPH Analytics for the 2015/2016 National APEX Quality Award. The national distinction recognizes outstanding healthcare organizations and care teams who have demonstrated the highest level of excellence in patient satisfaction and overall care in the 12-month evaluation period. Winners include ambulatory surgery centers, orthopedic centers, pain management centers, physician practices, and urgent care centers.

The **NYC Community Cares Recognition Ceremony** honored multiple organizations on March 21, 2017. Carnegie Hill Endoscopy and East Side Endoscopy & Pain Management Center were two of the recipients of the NYC Department of Health Community Cares Project Award. The NYC Department of Health (DOH) Commissioner of Health cited that the project has provided approximately 2,200 screening colonoscopies to uninsured residents of NYC since 2012.

Carnegie Hill Endoscopy (CHE)

- CHE provided over 50% of these screenings.
- Dr. Blair Lewis, medical director for CHE, was recognized as one of the two people who generated the concept for the community cares project in NY.

East Side Endoscopy & Pain Management Center (ESNY)

- ESNY performed 40% of the screenings.
- ESNY received an award which distinguishes them as the only center in NYC to hire a dedicated patient navigator to liaison with the federally qualified health clinics in NYC, which is a key component to removing the barriers to screening for patients. The patient navigator program at ESNY serves as the model for other GI centers state-wide.

Richard Chessler, MD, of Northern New Jersey Center for Advanced Endoscopy, was honored with the Herbert Dardik, MD, Leadership, Research, and Education Award at the Annual Englewood Hospital and Medical Center Medical Staff Recognition Dinner. The event

acknowledged physicians and other members of the medical staff for their commitment to patient care and their contributions to the success of the medical center.

Congratulations to **Sarah Malaniak, CASC**, administrator at Ambulatory Center for Endoscopy (North Bergen, NJ). She was named one of Becker's ASC Review's "84 ASC Leaders under 40" for 2017. Those chosen were awarded for having already made an impact on the ASC industry.

Anniversaries

July 2017 will mark twenty-five years for **Sante Bologna, MD, FACP** providing GI care to patients. Dr. Bologna is American Board of Internal Medicine certified in Gastroenterology and Internal Medicine. He is the senior partner and was instrumental in forming Troy Gastroenterology PC in 1992. Dr. Bologna is the medical director of Macomb Endoscopy Center and also performs cases at Surgical Center of Michigan.

"Dr. Sante Bologna, first and foremost, is an excellent physician who cares for his patients as if they were family. He carries that passion over to the business aspects of his group's practice constantly striving to examine and then build the best delivery system for their care. 'What if" and "why not" are consistent aspects of his patient-centered hands on approach to high quality yet cost conscious patient care."

"I have known Dr. Sante Bologna for many years. He delivers the highest level of quality care and compassion to his patients but does so in our neighborhood to create a family feel with trust and confidence. He has been a role model for me over the past 20 years. During that time I have watched him develop centers of excellence to deliver the best possible care to his patients."

Congratulations to the following Physicians Endoscopy partnered centers who have hit or surpassed their 5-year and 10-year anniversary mark as a PE partner!

- Advanced Endoscopy Center (May 2007)
- Central Arizona Endoscopy Center (Dec. 2006)
- Kalamazoo Endoscopy Center (March 2006)
- Lone Star Endoscopy (April 2006)
- Long Island Center for Digestive Health (June 2006)

- Carnegie Hill Endoscopy (March 2012)
- Eastside Endoscopy Center Issaquah (Feb. 2012)

Awareness

Physicians Endoscopy and nearly all of its affiliated partnered centers have signed the "80% by 2018" pledge—joining forces with over 500 local and national organizations to increase colorectal cancer screening rates across the country. The initiative, led by the American Cancer Society, the Centers for Disease Control and Prevention, and the National Colorectal Cancer Roundtable, is a shared goal to have 80% of adults aged 50 and older regularly screened for colorectal cancer by 2018. For more information on the campaign, visit *http://nccrt.org/tools/80-percent-by-2018/*.

Current GI Opportunities

Submit your CV online at **www.endocenters.com/recruiting**

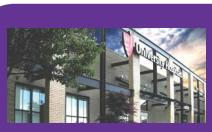
Laredo, TX

Gastroenterology Consultants of Laredo – Laredo Digestive Health Center

The physicians of Gastroenterology Consultants of Laredo, a private gastroenterology group, are seeking a gastroenterologist to expand the practice. This candidate will have ownership opportunity in the affiliated endoscopic ambulatory surgery center.

This two-room facility is located in Laredo, Texas in the Northtown Professional Plaza on McPherson Avenue.

- Physician-owned and controlled center
- State-of-the-art endoscopic equipment
- Medicare licensed and AAAHC accredited
- Anesthesia services for patient comfort
- Physician efficiency and optimal patient quality of care
- Nursing staff has extensive experience in GI endoscopy
- An outstanding benefits package is offered
- Professionally operated and managed
- Group participates in research
- High population to GI Doctor ratio 60,000:1



Cleveland, OH

UHMP Gastroenterology Associates

The physicians of UHMP Gastroenterology Associates, a private gastroenterology group affiliated with University Hospitals of Cleveland and CWRU School of Medicine, are seeking a gastroenterologist to expand the practice. This candidate will have ownership opportunity in their two thriving endoscopic ambulatory surgery centers. These freestanding, state-of-the-art ambulatory procedure centers are located in Chagrin Falls and South Euclid, Ohio (suburban Cleveland).

This Opportunity Offers:

- Physician owned and controlled centers.
- State-of-the-art endoscopic equipment.
- Medicare licensed and AAAHC approved.
- Physician efficiency and optimal patient quality of care.
- Nursing staff has extensive experience in GI endoscopy.
- All physicians and nurses are advanced cardiac care life support certified.
- An outstanding benefit package is offered.
- Professionally operated and managed.

Mesa, AZ

Central Arizona Medical Associates

The physicians of Central Arizona Medical Associates (CAMA) are seeking a full time Gastroenterologist to join their practice. Physician can expect to step into a busy practice while replacing a retiring partner. Anticipate a short track to practice partnership and ASC ownership. Practice operates out a single office and covers one hospital. Outpatient endoscopy is performed at a 2 room ASC with maximum efficiency and quality of care. Enjoy sunshine and a great lifestyle in the metro Phoenix area.

Central New Jersey

Garden State Digestive Disease Specialists, LLC

Garden State Digestive Disease Specialists, LLC is seeing a BC/BE Gastroenterologist to join our three physician practice in Central Jersey for a full-time position. The job offers an excellent salary, competitive benefits package, a reasonable call schedule (which includes other gastroenterology colleagues in the rotation), and an opportunity for full partnership track in 2- 3 years. EUS/ERCP training is preferred.

We serve culturally rich and diverse communities; our patients reside primarily in the Union and Middlesex counties of Central Jersey. Our Surgi-Center is a state-of-the art Endo Center presently being expanded into a 3 room facility. We are affiliated with 4 local hospitals, 2 of which are teaching hospitals with residency programs. We are in the NYC metropolitan area, 45 minutes from Manhattan, conveniently located near an international airport, and in close proximity to many cultural centers and the Jersey Shore.

Lima, OH

Gastro-Intestinal Associates, Inc.

The physicians of Gastro-Intestinal Associates are seeking a BE/BC gastroenterologist to join our six physician, four CNP single-specialty practice.

Established in 1977, the practice has an outstanding reputation with the local Lima community. This is an opportunity to join a GI physician-owned 18,000 square foot combined office and three-room endoscopy center. The center, built in 2008, is AAAHC and ASGE certified. In the area are two local hospitals with state-of-the-art facilities.

This opportunity offers:

- 1:7 call rotation
- First year salary guarantee
- Outstanding earning potential
- Professionally operated and managed

Consider submitting your CV even if you do not see a desired location currently listed and indicate where you would be interested in practicing.

For more information visit:
www.endocenters.com/recruiting

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Rochester Hills, MI

Troy Gastroenterology

The Center for Digestive Health (Troy Gastroenterology) is a well-established, highly respected private practice looking for two Gastroenterologists to join our growing practice. We have several offices across Metro Detroit with two state-of-the-art AAAHC accredited ambulatory surgery centers. We're looking for an enthusiastic physician skilled in general endoscopy, ERCP.

- Competitive base salary with productivity incentive
- Incentive bonus
- Retirement plan
- Discretionary allowance
- Eligibility for member status, after two years
- Insurance (malpractice, health, dental, vision, life, supplemental & dependent life, short & long-term disability)

North Bergen, NJ

An outstanding opportunity for a gastroenterologist!

Advanced Center for Endoscopy (ACE) has an immediate opportunity available for GI physicians looking for an outstanding ASC in which to perform procedures. Our single specialty, nine physician GI center is the perfect environment for you and your patients.

Our center can help drive additional patient volume to you through the ASC, allowing you to increase your procedure volume in the environment that is more convenient. Our center can provide your patients a better outcome, and you will have satisfied and loyal patients.

ACE is ideally located in North Bergen along the banks of the Hudson River—the "gold coast" of Northern NJ, with a spectacular view of the NYC skyline. This is an excellent opportunity for a motivated physician.

Bellingham, WA

NW Gastroenterology & Endoscopy

Exciting opportunity to join a nine person single specialty GI practice in Bellingham, Washington. This progressive coastal community offers ocean and lake recreation, skiing, and miles of hiking and biking trails. Small college town atmosphere with proximity to Seattle and Vancouver, Canada. Great place to raise a family! This collegial group has a freestanding AEC and pathology lab. EUS optional, ERCP strongly preferred. Outstanding benefit package.

Lumberton, NJ

Gastroenterology Consultants of South Jersey

Gastroenterology Consultants of South Jersey is a privately owned, seven physician practice located in Lumberton, NJ. We are a well-established practice of 25 years that is located among several growing communities in Southern NJ.

- Located within 30 minutes of Philadelphia and within 1 hour of New York City
- Affiliated with Burlington County Endoscopy Center, a three room ASC which is physician owned and operated
- We are seeking to add a full or part time gastroenterologist
- We offer a 1:7 call schedule and an opportunity to perform ERCP/EUS (not required)
- Partnership will be offered in both the practice and ASC

Northern CA
Central CA

GI physicians: are you looking for flexibility and supplemental income?

Our mobile endoscopy practice is seeking board-certified gastroenterologists in **Northern CA** (Sacramento/Stockton/Tracy) and **Central CA** (Fresno/Tulare/San Luis Obispo)!

Flexible schedules allow you to work as many as 1-2 days per week or as few as 1-2 days per month. Position offers competitive pay.

Gastonia, NC

Carolina Digestive Diseases

Four established gastroenterologists located in central North Carolina, are seeking a BE / BC gastroenterologist to join our physicians to expand the coverage in our community of Gastonia, NC.

The physician candidate can expect to step into a busy practice while replacing a retiring partner. Anticipate a short track to practice partnership and ASC ownership. Practice currently operates out of a single office and covers one hospital. Outpatient endoscopy is performed at a 2 room ASC with maximum efficiency and quality of care.

Located 2 hours to the Smoky Mountains and 4 hours to the Atlantic beaches. Enjoy sunshine and a great lifestyle in the metro Charlotte area.

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(Almost as easy as the procedure itself.)

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The CRH O'Regan System® is a non-surgical solution that is simple, fast, and 99% effective.
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Your patients will thank you.

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