

The Physician's Perspective — Planning and Building an Ambulatory Surgery Center



By Paul N. Arnold, M.D., FACS
Arnold Vision, Springfield, Missouri, USA

Having been through the planning, building, and equipping of two ASCs (ambulatory surgery centers) in 15 years, I have given lots of thought to this process. Writing and editing a book

on the fundamentals of owning and operating an ophthalmic ASC, *The ABCs of ASCs* (published by ASOA), has given me the opportunity to learn from many of the experts in the field. This experience leads to the conclusion that any surgeon contemplating ownership in an ASC must begin by asking many questions.

1. Why are so many ophthalmologists interested in building (or owning some part of) an ASC?

The number of ophthalmologists operating in ASCs continues to grow every year. The most frequent Medicare-covered operation performed in ASCs is cataract surgery. Even vitreo-retinal surgeons are learning how to take their posterior segment operations into the ASC. I believe there are three factors driving this movement — the ability to deliver a more patient-centered, higher quality of care; far greater control over the operating environment; and finally, economics.

The economics of Medicare, in the United States, for the ophthalmologist are compelling for ASC ownership. The Medicare allowable for cataract surgery with intraocular lens implantation has gone down 72% in constant (inflation adjusted) dollars in the past 15 years. The allowable reimbursement in the U.S. for the ASC for CPT Code 66984 has gone down only 15% in the same time-frame. Put another way, in 1990 only 30% of my take home pay came from my ASC; in 2005, assuming the same surgical volume, 70% of my income would have derived from my ASC. I think that illustrates the economic transformation of ASC ownership.

2. Why should I be interested in owning an ASC?

Begin by performing a practice examination, just like you might examine a patient — using the helpful acronym SOAP.

S: What are the **subjective** practice complaints or problems? Is the volume of surgical patients stagnant? Are they complaining about going to the hospital for surgery?

O: What are the **objective** findings? Is your net income dropping year after year in spite of constant volume? Do you frequently face different, non-ophthalmic staff in the hospital OR? Are your eye cases bumped to handle other “emergencies”?

A: What is your **assessment** of this situation? “My practice is ill and needs treatment.” Or it might be, “my practice is OK, but I’d like to improve it.” You conclude that an ASC would help the practice and your bottom line.

P: What is your **plan**? Build or buy-in to an ASC!

This is a major project and you must be absolutely convinced of the rationale for undertaking this effort. Are your medical and spousal partners in agreement with your plan? Must you build a new facility, or is there an existing ASC that you could buy-in to? Are you psychologically equipped to be an investor? Remember that investors must be prepared to lose money, although we all hope to avoid this calamity.

3. Can I afford to buy-in or build an ASC?

Are you financially prepared for the years it may take to build a new facility and have it grow beyond the “break even” stage? You will need sufficient savings and ongoing earnings to fund this new venture. As an owner, you and your practice income will need to feed this machine until it matures and is able to feed you.

When we have arrived at the proper question, the answer is already near. — Ralph Waldo Emerson, 1852

Surgical Insights

It usually takes about a year to build and equip a new ASC and perhaps more than a year to plan and design the facility. A flourishing practice with more than 500 surgical cases and 200 laser cases per year should begin to see a profit after one or two years — if the ASC is prudently managed.

4. How should I go about building an ASC?

Before lifting a hammer to commence building, do your homework! I recommend joining OOSS (the Outpatient Ophthalmic Surgery Society) and attending their meetings. Obtain and read your State and Federal ASC regulations. Ask colleagues about some of the more knowledgeable and experienced ASC consultants and get references on several of them. *The ABCs of ASCs* is a wonderful compendium of many of these experts.

Our ASC was featured on the *Video Journal of Ophthalmology*, Volume 21 #1, in 2005. The producers did a great job of filming our facility while I was able to explain why we did what we did regarding design and equipment. One of the most valuable experiences is to visit different ASC facilities in your area. Take advantage of your colleagues' expertise; learn from what they did right and what they would do differently.

Try to have a very good idea of what you want in your facility before engaging the services of the professional members of your team. This may come as a shock, but you will be managing at least

10 different professionals during the course of this project! Unless you decide to delegate everything — and this is not recommended (see #6).

5. What do I really need in my ASC?

Will your facility be eye only, or multi-specialty? How many surgeons will be working there? Most important, what is the estimated case volume? How many days a week will it be open for operation? Is there any need for general anesthesia? Do you want to incorporate excimer laser refractive surgery in the ASC? The answers to these questions will help determine how large a facility you need to design.

How many ORs will you need? One OR can be very efficient if fewer than 20 anterior segment cases per day are planned. It is quite possible to do four cataracts/hour out of one OR — and utilize one OR crew, personnel being the biggest operational expense. If more cases than that are anticipated, or if more than one surgeon per day is expected, another OR will be necessary.

Consider the additional cost of equipping and staffing more than one OR.

How many staff are needed? All of these numbers are dependent on surgical volume. At a minimum, two receptionist/patient and family liaison people will be required for front office duties; one



RN (registered nurse) in pre-op/post-op, as long as there are no more than four patients in the room (another assistant to the RN is recommended if there are routinely 3-4 patients); a surgical assistant and circulating RN are necessary in the OR; finally, an anesthesiologist (CRNA - Certified Registered Nurse Anesthetist) is invaluable in attending the patient during surgery. That's a total of six as a bare minimum.

An additional person to help with sterilization and room turnover can cut the turnover time in half. Two surgical scrubs who alternate cases would be ideal. This is highly recommended if there are more than 8-10 cases per day planned.

6. Can I manage all the moving parts?

While it is imprudent to delegate everything, beware of the opposite mistake — don't try to attempt this project as a complete do-it-yourselfer. You are the responsible party, so your role becomes one of managing your team of experts. With so many moving parts, occasionally, the left hand doesn't know what the right hand is doing. It is your job to be the central processing unit, keeping each expert moving in the direction you determine.

Here's a list of the consultants you may want to bring on board to help achieve your goal:

a. ASC Consultant — these folks are usually quite knowledgeable about the regulations, requirements, and essentials of a successful ASC. They also have a pool of experts capable of filling some of the roles noted below. Be sure to get several physician references on an experienced ASC consultant.

b. Accountant — your practice accountant will help supply the necessary financial information for a feasibility study. They should also be able to construct a pro forma for the first several years of operation. This type of forecast is essential.

c. Real Estate Agent — a commercial agent is best at helping you find land that will meet the unique needs of a successful ASC.

d. Lawyer — in addition to the federal regulations regarding certification of an ASC, there are state and local issues that must be reviewed and addressed.

e. Architect — this may be the most important individual on your team. The design and construction will be orchestrated by your architect. They must be aware of all the state and Medicare rules so that your facility will get approval. An ASC consultant can help direct the design, but the architect will need to assemble the pieces.

f. Banker — you will need a financial partner to construct a million dollar (or much more) facility. The terms of the loan are as important as the interest rate. Communication with your banker over the course of the loan period is very important.

g. General Contractor — these are the folks who actually build your facility. Your architect and ASC consultant can help you determine the best medical facility builder in your area.

h. Equipment Purchasing Agent — this individual can help find the necessary equipment, drugs, and devices at the best prices, according to your desires.

i. ASC Director/Administrator — as construction nears completion, you will need this person to assemble your ASC team: RNs, surgical assistants, receptionists, etc. You will also need to negotiate purchasing agreements with IOL and surgical supply companies. This individual should be responsible for these necessities.

The bottom line is, confront yourself with all of these questions before embarking on this journey. "The question of a wise man is half the answer." And the answers will provide the guideposts along the way to a successful ASC.

