

# **Managing Costs in the ASC**

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## **OVERVIEW**

Cost management is a top priority in all of healthcare, specifically the ambulatory surgical setting. With care reimbursement continuing to diminish, awareness of and the ability to take action to minimize cost is imperative. ASC administrators and clinical leaders need be conscious of the different types of cost and how to operationalize best practices in this arena.

## **OBJECTIVES**

1. Identify fixed costs associated with an ASC.
2. Distinguish the variable supply and workforce costs within an ASC.
3. Discuss operational efficiencies in an ASC.

## **INTRODUCTION**

Every day presents a new set of challenges to ambulatory surgery centers (ASCs). Cost management is one of those challenges, one that requires constant review to ensure an ASC achieves optimal profit margins. The administrators running ASCs must ensure everything from reliable technology infrastructure to dependable information streams, from well-stocked supply rooms to cost management and the consistent flow of revenue, and all these require precise execution and planning.<sup>1</sup>

### ***ASC Cost and Revenue***

An essential metric for measuring an ASCs cost-effectiveness and financial performance is its contribution margin, its revenue minus variable expenses. In a study based on 2016 and 2017 data from over 275 ASCs, the breakdown of operating expenses as a percentage of net revenue are as follows:

- employee salaries and wages 21.9%;
- taxes and benefits 5%;
- occupancy costs 6.1%;
- drugs and medical supplies 24.4%;
- other medical costs 0.4%;
- insurance 6%;
- general and administrative 16.6%; and
- total operating expense 77.8%.<sup>2</sup>

Financial, operational, and clinical data can all be leveraged to maximize the performance of an ASC, and cost management is an important part of that process.

### **EBITDA Overview and Impact**

Calculations of earnings before interest, taxes, depreciation, and amortization (EBITDA) are used to analyze a facility's operating profitability before non-operating expenses (ie, interest and other non-core expenses) and non-cash charges (ie, depreciation and amortization). EBITDA is calculated by taking operating income and adding depreciation and amortization back to it. EBITDA can impact the valuation of an ASC valuation, however, given that a center's EBITDA can fluctuate from year to year, it may not be the best tool to determine a facility's current value. Projecting a future of growth is one of the best ways to increase the value of an ASC. Strategies to increase the value of an ASC include recruiting cases that can be done quickly (eg, ophthalmology, pain, gastrointestinal (GI)), eliminating unprofitable long cases (eg, plastic surgery), and recruiting commercial and private-pay cases and those that generate high facility fees (eg, bariatric, spine surgery),<sup>3</sup> all of which affect the bottom line.

## **Reimbursement in the ASC Setting**

Ambulatory surgery centers have been in a progressive profit margin squeeze over the past decade due to the lack of reimbursement increases and increasing costs. The more procedures an ASC can complete in a day, the more profitable they will be. However, not all insurance plans contract with ASCs, and some geographic regions may have reimbursement rates below national standards. When planning an ASC, contracting should be discussed with payers to determine if contracts will be available and what the pricing structure will be.<sup>4</sup>

## **FIXED COSTS**

Development of a new, stand-alone ASC typically requires a cost of approximately \$220 to \$250 or more per square foot to become operational, with a total cost of approximately \$1 million per operating room (OR) to be operational. For an ASC to be successful, it needs to meet its specialty group volume, needs, and financial parameters.<sup>4</sup>

## ***Infrastructure***

Ancillary ventures such as ASCs are becoming increasingly popular to physician groups and hospital systems in this environment of constrained revenues/income and increased costs. Ambulatory surgery center ownership is appealing because it provides new sources of income. According to a Medical Group Management Association (MGMA) cost report, orthopedic practices that owned surgery centers offset higher associated costs with higher overall net profits when compared to those without surgery centers.<sup>5</sup> They also reported higher total medical revenue per physician. Surgery centers provide additional income from surgical cases that physicians are already performing while at the same time providing efficient, cost-effective, high-quality patient care.<sup>5</sup>

For physicians, developing and managing ASCs on their own requires a significant investment of research, time, and capital from each of the physician-owners. ASC owners run the risk of project delays, design problems, and cost overruns, and partnering with a local hospital may provide access to capital and payor relationships that can benefit a new ASC. Equity/corporate partners are also options for physicians looking to open an ASC. These partners not only have extensive surgery center experience, but also significant financial resources. Both parties can benefit from these types of partnership and have an equal voice in the development, management, and governance decisions. This type of relationship often allows physicians time to concentrate on providing patient care while the corporation oversees the business aspects of the ASC.<sup>5</sup>

## **Purchase vs Lease**

### **Property**

Ambulatory surgery centers can be built from the ground up, purchased, or leased from a third party. Facility costs for ASCs are typically about 10% of their revenue, and it is often less expensive to operate as a tenant and lease a space instead of purchase.<sup>4</sup>

### **Medical Equipment**

Overequipping a center can quickly hinder a budget and decrease the financial viability of an ASC. Instead of overbuying, a plan to phase equipment in over time may be a better option as procedure volume increases.<sup>5</sup> If it fits within an ASC's financial plan, equipment that is expected to last 10 to 15 years should be purchased instead of leased.<sup>6</sup> However, medical equipment leases have become a popular method of acquiring equipment. The average lifespan of high-cost medical equipment is roughly five years, and new technologies often drive the need for new equipment,<sup>6</sup> so leasing may be a better option in those cases.

Medical equipment leasing provides ASCs with additional financing options, including finance and operating leases. Finance leases for medical equipment allow an organization to record the liability on a balance sheet and deduct the depreciation of equipment from profits. Like other leases, there is an option to purchase the equipment at a discount

at the end of the lease. However, with a capital lease the facility treats the equipment as if it were owned, including taking responsibility for any maintenance costs, insurance, and taxes.<sup>6</sup>

Operating leases treat payments as operating expenses. These leases have a low cost of use and can help ASCs maximize cash flow as compared to a cash purchase. Monthly payments are deducted, and the equipment is returned to the lessor at the end of the lease term when the organization can lease or purchase new equipment. Maintenance and insurance are typically provided by the lessor with these types of leases and these lease payments are tax deductible.<sup>6</sup>

Leases can also be a strategic option for ASCs. Leases can help preserve cash and lines of credit, maximize cash flow, avoid ownership of obsolete equipment and standardize equipment for operational efficiency. Some vendors provide payment programs that allow capital equipment to be funded through the purchase of implantable and disposable products. They also may allow for equipment upgrades as new technology becomes available. Leases also allow for predictable budgeting and align well with value-based payment models.

Determining the return on investment (ROI) is key. If a piece of equipment is necessary, the business office of an ASC should be able to obtain the average reimbursement rate per case using that equipment by running a report of CPT codes associated with the equipment. They then must decide if the cost of purchasing will easily be covered within one year of performing cases using the equipment.<sup>7</sup>

### **Service Line Needs**

A MGMA poll from 2019 asked healthcare leaders if they used external resources to develop their service line strategies. Thirty-three percent responded “yes” and stated that they used either consultation services, benchmarking services, or assessed community needs to decide which service lines they should offer. Developing a service line strategy requires organizational buy-in, frequent reporting, and budgeting. Service line budgets should be designed as separate cost centers or business units where all expenses and revenues are attributed to that service line. The budget should be managed by the service line manager, who should be given the flexibility to reallocate resources as needed to manage costs. The budget process should allow the service line manager to participate in possible risk sharing arrangements with payers.<sup>8</sup>

### **Capital Equipment Planning**

Significant issues can be created if an organization does not properly budget for their capital equipment needs. Not only is there the cost of the equipment itself, but the potential costs of training and educating staff members and any potential mechanical or electrical support costs should be considered.<sup>9</sup>

It is important for ASCs to maintain continuous vendor contracts to review equipment operation and learn more effective utilization and maintenance opportunities. Highly utilized equipment should have regularly scheduled preventative maintenance to ensure optimal performance and longest life span to aid in cost management. Some vendors offer specialized on-site ASC-focused equipment care. In some instances, when the equipment is financed through the vendor, the service could also be financed.

### **Capital Budgeting**

Evaluating the current budget is the first step in designing a baseline budget for the following year. Specific points from the previous year must be assessed such as which figures were off, which projections aligned, if any numbers were inaccurate and why, and what the figures should be going into the new year.<sup>9</sup>

The addition of new specialties can greatly impact a budget. Money should be allocated for marketing and recruitment as well as devices, supplies, necessary capital equipment, potential additional staff, training, education, and any necessary physician credentialing. Expanding or converting existing space to serve a new purpose (ie, a new specialty) should be carefully evaluated from a financial standpoint. There are numerous costs associated with

construction, and the way a large project can affect existing operations must be considered. Specific events, such as an ASC needing to close on days it is typically open or scaling back working hours, have an impact on revenue. Operational costs should be considered when discussing any potential construction needs.<sup>9</sup>

Budgeting season is also a good time to reevaluate any outsourced services and determine if other companies may be able to better provide the services at a reduced cost more efficiently, effectively, and with a better ROI.<sup>9</sup>

Whether you are building a new surgery center, growing or renovating an existing center, or evaluating an annual budget, it is important to consider bringing in a vendor partner early in the planning process. They will have expertise in project scope, best practices across the industry, and flexible financing options that align with clinical, financial, and operational goals.

### ***Sterile Processing***

Surgical site infections (SSIs) are a major financial burden and patient safety issue. SSIs are the third most expensive type of healthcare-acquired infection. Therefore, similar to the hospital setting, sterile processing of reusable instruments is a key to the optimal patient outcomes. In addition to the training and staffing of competent sterile processing technicians, it is imperative that sterile processing be equipped with necessary equipment (e.g. sinks, washers, sterilizers) to perform the job.

### **Capital**

Fixed and movable equipment (eg, sterilizers, hospital beds, surgical equipment, imaging equipment) were found to be between 41% and 57% of hospital spending costs. Purchases of sterile processing equipment are significant capital expenses and should be researched thoroughly. Research and planning should include all foreseeable costs related to the processing equipment (ie, technology, warranties, training, education, maintenance, lost productivity from any potential equipment failures, etc.). Prior to purchase, the ROI of sterile processing equipment should be determined based on its benefits to the facility in both dollar amounts and quality improvement. Capital equipment investments come with both planned and unplanned costs, and both must be weighed to determine if purchasing certain equipment is economical given the types of instrumentation being processed.

Although there are many vendors who may be consulted to build a comprehensive project scope, there could be value in partnering with a vendor that has best-in-class technology across multiple categories. The chances of finding economies of scale with a single-vendor are far greater than an a-la-carte approach.

### **Outsource**

Some ASCs find it more efficient to outsource several support services, depending on the volume of business.<sup>1</sup> An emerging topic of conversation in both hospital SPDs and some ASCs is the concept of cleaning and sterilizing instrumentation at an off-site facility. However, this is a complex decision which must be carefully strategized with multiple stakeholders. Outsourcing sterile processing may keep an ASC ahead of compliance and reimbursement trends while also managing costs and increasing efficiency, all of which could solve some value-based care challenges. With the continuous changes in regulatory and industry standards for sterile processing, outsourcing SPDs could free ASCs up to focus more on core competencies and focus less on the complexities of sterile processing training, productivity, and certifications.<sup>12</sup> From a quality and safety perspective, considerations must be made during outsourcing discussions such as: instrument tray inventory, case scheduling, and managing the delivery logistics for planned and unplanned scenarios. As a result of these challenges, some ASCs leverage a mixed model, whereby a certain percentage of daily inventory is processed on location, necessitating some SPD capacity in the ASC.

One of the competitive advantages of ASCs when compared to hospitals has been infection control. By outsourcing an SPD, an ASC can take that advantage one step further. Growing ASCs benefit from a focus on specialties.

Outsourcing SPDs may help an ASC simplify things and give them the ability to better focus on their specialties while also benefitting from significant operating cost savings.<sup>12</sup>

## **VARIABLE COSTS**

While some costs in ASCs are predictable and consistent, other costs are variable year to year. These costs include staffing numbers, administrative and non-clinical support.

### ***Manpower***

Staffing costs for an ASC are typically about 20% to 30% of their revenue. Staffing is one of the largest expenses for an ASC, and benchmarking hours per case at similar centers is critical. Staff members should be used efficiently, be open only as many hours as cases require, cross-trained where appropriate, and sent home when not needed to control costs.<sup>4</sup>

### **Administrative and Non-clinical Support**

There are many non-clinical roles in an ASC, including medical billers, coders, transcriptionists, receptionists, human resources, information technology, and administrative assistants. Some ASCs which are associated with a larger hospital system have the ability to leverage the Human Resource (HR) department framework to assist leaders with the many demands. However, much of this important function still resides with ASC leaders in both the system level ASC and especially in the freestanding, locally owned ASC. Benefit functions, overtime calculations, and payroll tasks are time-consuming and of the utmost importance to operating an ASC. HR and Payroll department services are available from multiple outside vendors, often at a lesser cost than would be required to sustain an in-house team.<sup>1</sup>

The technology demands of an ASC also require effective attention, planning, and management. Initial costs of installation and equipment should be considered, as well as training, ease of use, ongoing maintenance, integration capabilities, backup, and customization options.<sup>1</sup> Hardware and software systems make up the technology infrastructure of an ASC. This integral infrastructure affects everything from basic operational functions to scheduling, billing, and electronic health records (EHR). Software pricing for EHRs varies, but an ideal EHR system should be faster, easier, and less expensive than paper records. ASCs should research several vendors to determine which benefits, features, and costs would best suit their facility.<sup>1</sup>

Financial considerations for technology management should factor in not only required equipment and technological functions like server management and connectivity, but also the availability and responsiveness of tech support during and outside an ASC's normal operating hours. Purchasing the right systems and equipment is important, but so is finding the right people to manage it.<sup>1</sup>

### **Clinical Staff**

The most successful ASCs are built around a core group of physicians,<sup>4</sup> and behind every good physician is a good registered nurse, licensed practical nurse, nurse anesthetist, patient care technician, surgical assistant, OR Tech, scrub tech, nursing assistant, and allied health professional. Recruitment of new staff members by high-performing current employees may save an ASC costs when compared to more traditional staff recruitment methods (ie, newspaper ads, websites listings, etc.). Most OR personnel come from a hospital environment and could recommend OR techs and nurses qualified to work in an ASC. Referring employees may also assist with training and orientation of new employees,<sup>1</sup> which adds to operational efficiency and potential cost savings.

Budget decisions can result in staffing changes. Many decisions require additional staffing (ie, adding specialties, new procedures), while others (ie, outsourcing certain services, adding certain new technologies) may help an ASC maintain their current staffing level or even reduce it. All ASC budgets should account for such projected changes.<sup>9</sup>

### **Benchmarking Staff Ratios**

Benchmarking can help ASCs determine if the number of staff members per case is higher than the median when compared to other ASCs. Benchmarking can be done formally by using programs from ASC associations and private companies or informally by contacting peers in the industry to get an idea of how your facility compares. Benchmarking is not a rigid measure of what a facilities numbers should be, but rather a place to start when determining what changes might be beneficial.<sup>13</sup>

### **Scheduling to Demand**

Using staff members properly is an important part of ASC efficiency and cost management. Every surgery center has a different patient volume and case mix; therefore, no exact staffing equation is possible. Staffing needs are generally based on the number and type of cases on a given day. Typical staffing plans consist of one scrub technician and one circulator per operating room. Preoperative care and Post-anesthesia care unit staff members are typically scheduled based on the number of operating surgeons. Scheduling templates are generally built around individual surgeon's typical incision start and end times. Cross-training employees helps fill various roles when needed and decreases the need to overstaff. This flexibility encourages teamwork, increases productivity, efficiency, and potentially adds to costs savings. To get the most out of staff member costs, it may be necessary to ask staff members to perform additional tasks (ie, make preoperative or postoperative patient calls, chart audits, prepare for upcoming cases, restock inventory) if there is downtime between procedures. Using staff member time wisely is the best way to manage staff costs.<sup>14</sup>

### **Anesthesia**

One of the costliest elements in healthcare delivery is anesthesia. One report notes that anesthesia care had the highest average price per service for a professional procedure in 2011. Anesthesia billing is unique because services bill based on a time component, which is different from other healthcare services that bill based on visits and procedures.<sup>15</sup>

Time-driven activity-based costing (TDABC), a cost-accounting tool which uses estimates of resource consumption to measure costs of services, can be used in healthcare to estimate the costs of anesthesia care and identify the primary drivers of those costs. Staffing ratios between certified registered nurse anesthetists (CRNAs) and anesthesiologists profoundly influence the cost of care. In a study of a Head and Neck Center, TDABC estimated the cost of the 11 most performed outpatient oncologic surgical procedures. The objective of the study was to determine anesthesia costs for each outpatient oncologic procedure, define the distribution of those costs, and identify costs drivers. Personnel was defined as the predominant cost driver, and different staffing ratios were then used to determine which scenarios most affected anesthesia costs. As expected, the ability to leverage nurse anesthetists, while spreading the anesthesiologist's costs across more operating rooms proved to be most cost effective.

### **Employed Anesthesia Providers**

Employing anesthesia staff members may be practical if an ASC uses anesthesia often. Facility employment would allow an ASC to have qualified anesthesia staff members readily available without worrying about independent contractor schedules. ASCs who employ anesthesia care providers have an advantage in that they can avoid ongoing competition for what could be a scarce resource. However, employing anesthesia care providers also has its drawbacks including negotiating contracts, finding vacation coverage, and managing billing services. Overestimating how often anesthesia services are needed may lead to costly downtime of a salaried employee during periods of low volume.<sup>16</sup>

### **Outside Anesthesia Groups**

Outside anesthesia groups allow ASCs to have access to multiple providers and scheduling flexibility. However, this can present a challenge if an ASC handles emergent or urgent procedures that would need an on-site or on-call anesthesia team. Also, compensation agreements with outside groups generally do not offer compensation to the

ASC itself, the anesthesia group would receive all professional fees for anesthesia services, and this could lower a potential revenue stream for an ASC. Contracting with an outside group can also make an ASC more vulnerable to price increases if a region is experiencing anesthesia provider shortages.

### ***Supplies and Implants***

Supply and implant costs for ASCs are typically about 20% of their revenue. Use of a purchasing organization, standardizing internal use of common surgical supplies, and reducing nonessential supply use may help reduce supply costs.<sup>4</sup> Medical supply costs continue to increase and purchasing personnel should keep current on competitive OR product pricing by using multiple supply vendors to ensure they extract the best prices in this competitive market. Before being evaluated in the OR, new products should be priced. Staff members should be open to trying new products to contribute to efficiency and potentially help the bottom line.<sup>1</sup>

### **Materials Contracts**

Material management programs are responsible for procuring products with the expectation of distribution mediums, cost control, and inventory management. Supply and drug expenses at a typical ASC are approximately 25 to 28% of the facility's net revenue, and options such as group purchasing organizations and value analysis committees may influence the outcomes.<sup>17</sup>

### **Group Purchasing Organizations (GPO)**

A group purchasing organization has extensive networks of suppliers and serves to support high-volume purchasing power. These organizations can offer lower contract pricing and provide an ASC with many more contracts than they could obtain independently. Robust GPOs leverage the member facility spend at the highest aggregated level to vendors. Once a member, an ASC should develop strong communication with their GPO to discuss the expectation of lower pricing that may come from the volume tiers they may be able to achieve. GPOs may also help an ASC reduce some of their administrative labor costs with their ability to execute vendor contracts with a high level of efficiency and monitor contract loads monthly to ensure high performance.<sup>17</sup>

### **Inventory Management**

#### **Software**

To ensure valuable capital is not wasted, there should be a process in place to manage inventory levels. Unused drugs can expire, and slow-moving inventory items can take up valuable storage space.<sup>1</sup> Warehouse management software systems can be effective tools to precisely manage inventory levels and trigger reorder of necessary items. Although these solutions have gained momentum in hospital systems, this technology is not utilized in a large segment of the ASC market. ASCs that do not use these systems may be expending many staff hours to maintain data records and supply flow, and these hours could be freed up to do other things. Establishing efficient, internal processes for inventory management and centralized ordering can help contain costs.<sup>1</sup>

### **Materials Manager**

Materials management is a major source of variability in an ASC. The physician preference list contains all supplies particular surgeons need to perform particular procedures. Preference lists drive both billing and clinical documentation, and therefore an accurate procedure file is of the utmost importance to ensure the correct materials and human resources are provided for each procedure. Preference list processes should be standardized. It is also helpful to provide a quarterly review of high-volume procedures to each surgeon for the procedures they perform to identify opportunities for standardization and consolidation. The report should include benchmarking information to compare other surgeons performing the same procedures, reimbursement information, and cost information so they can see how they compare with others in terms of cost. Preference list variability reduction not only helps with cost management, but it also lessens the risk for errors because staff members develop expertise when using the same equipment, supplies, and instrumentation.<sup>19</sup>

## **OPERATIONAL EFFICIENCY**



### ***Throughput***

New technologies have improved patient throughput, which in turn has improved ASC efficiencies. Information management technologies can be used to integrate patient information and automate anesthesia record keeping, order entry systems, and drug supply management. Technologies such as radiofrequency identification tags allow for real-time information on patient throughput by acting as automated triggers of patient transition through stages of surgery. Data generated from this electronic process can be used to evaluate current practices and optimize ASC efficiency as well as the quality of patient care.<sup>20</sup>

### **OR Efficiency**

Operating room use optimization is critical to perioperative cost reduction. Case cancellation rates, OR underutilization, OR overrunning, complication rates, and overall costs all contribute to operating room efficiency. Efficiency in the OR has been defined as  $[(\text{fraction of scheduled time utilized}) - (\text{fraction of scheduled time overrunning})] \times (\text{fraction of scheduled operation completed})$ , meaning if all scheduled procedures are completed within the allotted operating room time, 100% efficiency would be obtained.<sup>20</sup> However, it is unlikely to achieve 100% OR efficiency, even with it as the goal. A realistic goal would be 85-90% efficiency, as higher goals may lead to staff overtime/dissatisfaction and patient delays from overrunning ORs.<sup>20</sup>

### **First Case Starts**

On-time starts are critical to ensure surgeries proceed as scheduled. If the first procedure of the day does not start on time, all other procedures will likely be late causing staff and patient frustration and potential increased overtime. Start times should be well understood by all staff members involved in a procedure. If start time is determined to be when the patient enters the room, then all staff members should be available to start the procedure at that time. Delays from when the patient enters the room until the incision can unnecessarily increase the duration of the procedure, and result in an inaccurate procedure duration and scheduling.<sup>19</sup>

Researchers collected three years of data from an outpatient surgery facility with six operating rooms to determine the cost reduction from reducing tardiness of first case starts in ORs with at least 8 hours of cases and turnovers. Each one-minute reduction in first cases tardies resulted overall in 1.1 +/- 0.1-minute reduction in regularly scheduled labor costs, which could greatly reduce costs, depending on the amount of ORs and the number of procedures performed.<sup>21</sup>

### **Turnaround Time**

Equipment needs, staff members and competencies, and procedure mix all add to the variability of turnaround time. Efficiencies can be gained by scheduling similar procedures back-to-back as often as possible. Preference list standardization within each specialty to streamline what is picked for procedures and what needs to be kept in the OR can also add to turnaround time efficiencies and cost reductions over time.

### **Case Costing**

For an ASC to ensure their success they must be sure they are getting paid enough for their cases. This includes covering things like anesthesia supplies, implants, and OR time. Effective case costing can help an ASC identify exact expenses attached to each procedure and use that information to determine where adjustments might be needed to maximize revenue.<sup>22</sup>

Inventory audits are critical to accurate case costing and a good place to start. Physician preference card updates should also be included. This due diligence will help an ASC determine correct case costing and perhaps sort out other potential inventory issues that may affect their overall revenue cycle. Once an inventory database is loaded and

preference cards are updated, the ASC can cross-reference the information to determine accurate case supply costs. Overhead can then be calculated by determining the cost of an OR per minute. Medical records should reflect detailed case times to allow a facility to determine how long ORs are in use. This information, combined with the profit and loss (P&L) statement, can calculate overhead for a given month. Supply costs should be subtracted from the P&L and the remainder of the operating expenses divided by the total OR minutes for the same month. This will be the average OR cost per minute and that average, once multiplied by the number of minutes for an individual case, will determine that case's overhead cost. Once supply and overhead data is determined, they can be added together to determine the total cost for each ASC case. This number should then be compared to the amount of payer reimbursements for each case to determine if the ASC is making or losing money. It may turn out that some specialties are more profitable than others and trying to increase the number of those specialty procedures will add to an ASCs revenue. Good case costing helps ASCs reduce costs and maximize efficiencies.<sup>22</sup>

### ***Benchmarking***

Benchmarking is an important part of managing costs in an ASC. Internal benchmarking compares data collected recently with past performance within the same facility. External benchmarking compares performance and data with other established professional organizations or with other ASCs. External benchmarking may also include participation in a collaborative study by a third party like a vendor.<sup>23</sup>

Financial results should be benchmarked by month or season against the previous year's performance. Managers can determine how well their ASC is performing by benchmarking their results against the performance of other like-procedure ASCs. National organizations can provide valuable tools for administrative, business, and clinical benchmarking.<sup>1</sup>

### **Financials**

The efficiency to which a billing and revenue services department collects insurance claims determines the fate of an ASC. Having a qualified firm under contract or the right people in collections roles is crucial to ASC management.<sup>1</sup> Billing is not a mechanical process. Revenue streams will be faster and greater with billing specialists who understand the procedures that are being performed and the use of modifiers.-Claims should be filed as quickly as possible after a procedure and patient record has been completed.<sup>1</sup>

Having budgeting processes that produce regular financial reports is also important. ASC managers with access to timely financial reports can see where they are and compare that to their annual plan, see where market conditions require changes, consider seasonal variations, and track expenses and revenue throughout the year. Whether in-house or outsourced, budgeting and reporting must be completed and updated frequently — frequent reporting is effective reporting.<sup>1</sup>

### **Payroll**

The financial life of an ASC includes handling of payroll, payables, cash management, tax preparation, banking relations, and more. Good ASC management ensures that these activities are taken care of properly and expediently.<sup>1</sup> Labor costs are typically a multispecialty ASC's biggest single line-item expense. A typical ASC spends 29 percent of its net revenue on personnel expenses (when including benefits and taxes), higher than its medical and surgical occupancy and administrative costs. Case volume, procedure type, facility size, geography, and other variables all have an impact on an ASCs payroll. It's important for an ASC to benchmark their staffing model to determine if they are achieving workforce optimization to ensure good cost management.<sup>24</sup>

### ***Case Scheduling***

Organizing and managing an OR schedule is critical to ensure appropriate procedure time for surgeons and ready access for patients. It is also critical to ensure the success of the OR in an ASC. An OR schedule is an important tool that ensures not only patient access, but also organizational efficiency. The OR schedule is the tool that helps with the flow of resources (ie, instrumentation, equipment, staffing) and patient flow.<sup>25</sup>

Data-driven schedule management allows for improved resource use. The daily flow of patients is impacted by case booking time and case order and should be considered during schedule preparation. Coordinated leadership and governance can use the OR schedule as a platform to ensure smooth comprehensive management from the strategic block schedule through daily OR management and beyond.<sup>25</sup>

Allocating OR time such that it would keep prevent underutilization but minimize overrunning is the most important step in optimizing OR efficiency. Operating room allocation (ie, granting block time to a surgical service) may be based on historical utilization data or financial criteria. However, to be profitable it may be necessary to base OR allocation on contribution margin rather than utilization data. Allocations should be reevaluated and adjusted quarterly.<sup>20</sup>

### **By Procedure Type**

Optimizing OR use requires scheduling cases to the allocated OR time in a way that the available time is filled every day using surgical duration estimates based on historical data to schedule cases into available blocks. Scheduling based on duration has its controversy wherein some recommend the longest case of the day be scheduled first and others say it should be scheduled last. If the longest case is scheduled first, shorter cases should be moved to a different OR to ensure a higher chance of completion within the allocated time. This method would also allow patients adequate recovery time and avoid discharge delays.<sup>20</sup> Appropriate nursing, anesthesia, and support staffing plans can be generated once a block schedule is determined. Staffing patterns may be affected if an OR doesn't run the same total number of ORs each day of the week, but a variable OR volume may provide more predictable, timely care for patients and help smooth out the use of other resources.<sup>25</sup>

### **SUMMARY**

Even as healthcare costs continue to rise, ambulatory surgery centers have demonstrated an ability to offer safe, efficient patient care while controlling costs and saving money. With their smaller footprint, ASCs already have a lower overhead when compared to hospital facilities, and flexible staffing options offer them another way to decrease overhead costs. Smart business decisions, schedule optimization, inventory management, accurate case costs, and other savvy leadership decisions all allow ASCs to better manage costs and pass those savings along to payers and patients.

**NOTE: This content has been created for Stryker by an independent, third-party medical writer. This is evidence-based research and is not intended to be legal or consulting advice.**

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