

ASC Development and Operations



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History of Free Standing Ambulatory Surgery Centers



- In 1970 all Orthopedic surgical procedures were performed in hospitals as inpatients
- 1970 - Phoenix, Arizona first ASC opened
- 48 years later 75% of all Orthopedic procedures performed as outpatients.

History of Free Standing Ambulatory Surgery Centers



- In 1988 there were 1,000 ASCs in the United States
- In 2017 there were 5,480 Free Standing Ambulatory Surgery Centers
- The Western PA Surgery Center (WPASC) opened on October 25, 2000

Why Build / Invest / Operate In An ASC?



- A Surgery Center creates an efficient, safe environment for both patients and surgeons
- A Surgery Center has the ability to improve quality convenience and service while simultaneously reducing costs.

Goals



- Improve patient care
- Improve efficiencies in the delivery of care
 - This benefits both the patient and surgeon
- Improve educational opportunities for fellows and residents
- Financial – Return on Investment

Surgeon Ownership



- We understand what patients need more than anyone else
- Control of the management
- Control over how money is spent
- Efficient scheduling/turnover of cases

Advantages of Surgeon Ownership



- Reduces time between cases
- Dedicated personnel including anesthesia
- Up to date equipment
- Preferred management
- Safer and cleaner environment

Surgeon Ownership Pitfalls



- Financial risk
- Time necessary to put the structure together
- Time and skill necessary to run the business

Planning a Surgery Center



- Corporate Structure
- Recruitment of investors
- Financing
- Amount of Individual Investment
- Management of the business
- Compliance with Stark regulations

Corporate Structure



- **Option A:**
 - Surgeons exclusively own and manage the Surgery Center
- **Option B:**
 - Surgeons partner with a hospital and/or a management company

Corporate Structure



- The choice of surgeons partnering with the hospital or business may be dependent upon
 - Local politics
 - Physician tolerance of risk
 - Physician interest in running a business

Corporate Structure



- Advantages to Partnering with Hospital
 - Financial backing / lower risk exposure for physicians
 - Insurance contracting
 - “Politically” correct
 - Management experience

Corporate Structure



- Disadvantages to Partnering with Hospital
 - Less flexibility
 - Decision making process prolonged
 - Conflicts of interest
 - Stark regulations concern: Hospital or employed physicians referring patients

Corporate Structure



- Advantages of Partnering with a Management Company
 - “Know-How” from conceptual stage to profitable operations
 - Ensures long term involvement
 - Developer, contractor, lender relationships
 - Potential risk sharing

Corporate Structure



- Disadvantages of Partnering with a Management Company
 - “Know – How” stays within management company
 - Management Fees + % of equity

Corporate Structure



- Physician owned partnership
 - General Partners
 - ✦ One or more investors who jointly own an ASC and assume the day to day role in its management.
 - Limited Partners
 - ✦ One or more investors who have ownership in an ASC and do not pay a role in its day to day management.

Establish & Foster Relationships



Services

Surgeons



Business
World



Establish & Foster Relationships



- Admit What you don't know
- Combine Strengths with contacts who do know
- One contact can double the chances of knowing someone who has news, information, or necessary resources.

Practical Approach



- Line up developer, architect and general contractor
- Recruit potential investors
- Align financing
- Sign investor agreements/operating agreements
- Start construction

Feasibility Study & Planning



- Formulate sound financial projections
- Analysis of amount of income necessary to break even
- Once an estimate of potential income is made, then the size of the project is determined

Feasibility Study



- Create and Foster relationships with Major Contract Insurance Carriers.
 - Attempt to obtain commitments from insurers prior to making large financial investment
 - Evaluate the center's payer mix

Estimating Potential Income



- Align physician investors
- Estimate the number of procedures the investors will perform
- Use CPT-4 codes to determine reimbursement
- Add up the potential income from all the physician investors

Planning – Location / Structure



- Once an estimate of potential income is available a decision is made on location.
- A structure can be created by:
 - Refitting an existing structure
 - Building a new facility
 - Purchasing an established facility

Planning -What Else Can Affect the Center?



- Stark Regulations
- Safe Harbor
- Government & State Regulations
- Licensure
- Accreditation

Stark Law



- August 2008 - Stark Law is a set of United States federal laws that prohibit physician self-referral, specifically a referral by a physician of a Medicare or Medicaid patient to an entity providing designated health services ("DHS") if the physician (or an immediate family member) has a financial relationship with that entity.

Stark Regulations



- **Safe Harbor**

- All physician investors must be active users of the facility
- At least 1/3 of annual practice income is from ASC procedures
- At least 1/3 of the cases have to be performed in an outpatient setting
- At least 1/3 of those have to be performed at the physician owned Surgery Center

Safe Harbor



- Effectively eliminates PCPs or other referring, non-surgeon, owners
- Highly recommendable to incorporate in Operating Agreement (protects the interests of the surgeons that comply)
- Non-compliance does not automatically mean infringement on Stark regulations

Government / State Regulations



- Certificate of need (CON)?
 - Not all states require a Certificate of Need
 - State of PA does not, however 37 states still require CON

Certification / Licensure



- Certified by CMS
- Licensed by State Department of Health
 - Inspects the facility
 - Issues Certificate of Licensure
 - Licensure allows you to apply for Medicare Provider Number
 - No managed care contracts without Medicare Provider Number

Accreditation



- Accreditation Bodies
 - The Joint Commission
 - JCAHO
 - AAAHC
- Not essential to open the Center
- Required by many insurance carriers today

What Factors



- Contribute to the success of the Western PA Surgery Center?
- What is our approach to Quality and the Business?
- What Statistics were measured and what were their results?

Factors Contributing to Success -WPASC



- Small Facility
- No Class IV patients
- No patients with active infections
- Exclusively elective cases

Factors Contributing to Success



- Hand picked surgeons and staff
- Teaching facility
 - Students challenge surgeons
- Focused health care

Our Approach



Quality of Care

+

Quality Approach to Business Practices



Profitability

Quality of Care - System Factors



- Easy access to management and administration
- Maintain formal and informal staff education system
- Perform root cause analysis instead of scratching the surface of a problem
- Be prepared for a state inspection everyday

Quality of Care – System Factors



- Patient Safety
 - Adequate staffing
 - Equipment maintenance
 - Technology: Most Up-to-Date Software Platform / Equipment
- Responsible employees, proud of their contributions / accomplishments

Quality Approach to Business Practices



- Apply Total Quality Management principles to facility setting
- Define, implement, evaluate and improve consistently
- Facilitate communications
- Cross train employees
- Set goals, not quotas
- Do it once, do it right, be done

Quality Approach to Business Practices



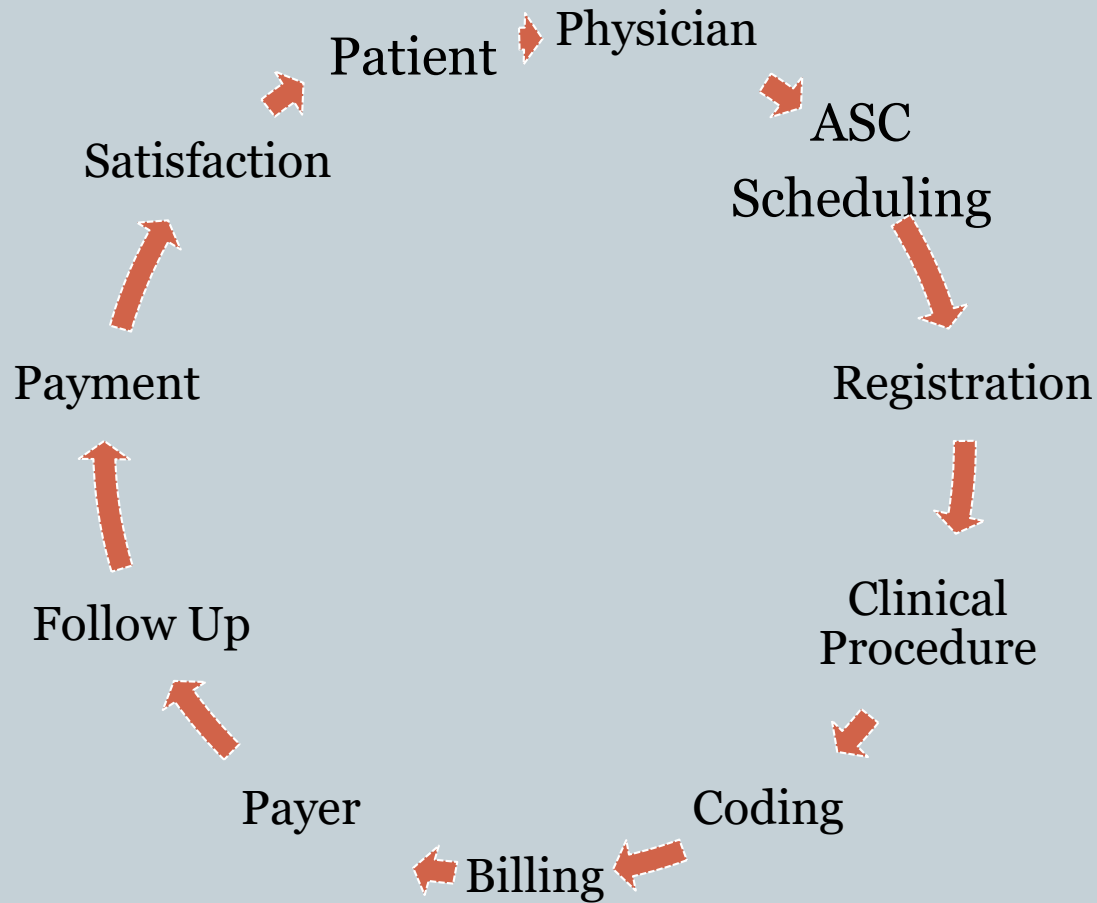
- Clinical Staff + Physicians
 - Conserve supplies
 - Maintain inventory control (w/o technology)
 - Take care of the equipment

Quality Approach to Business Practices



- Revenue Cycle Management
 - Internal Components
 - ✦ Fee Schedule Development
 - Set by CPT code and charge for procedure
 - Financial Policies
 - ✦ Enforce Compliance consistently
 - External Components
 - ✦ Payer Contracts
 - ✦ Patients

Revenue Cycle Management



Revenue Cycle Management



- Never Underestimate any step in the system
- Start with scheduling and monitor functions through Final Collections
- Recognize the need for full organizational support

Strategies for Expense Control



- Educate physicians and staff
- Standardize equipment and supplies/implants
- Obtain implants on consignment
- Join group purchasing organizations, but be aware that the cost for certain items may not be the best but overall will be a cost savings initiative.

Employees



- Salaries: Adjust proactively not reactively as personnel leave your employment
 - Participate in regional salary survey
- Health Insurance: Employees contribute a percentage to health insurance cost

Results



- Quality of Care + Quality Approach to Business Practices Fosters:
 - Efficiency for staff, surgeons and patients
 - Increased Overall Satisfaction
 - Enables the ease of change in the business environment

Data Collection – Tracking ASC's Health Metrics



- Comparison of FTE's (clinical and non-clinical with national averages)
- Breakeven – Analysis
- Number of cases
- Gross charges
- Net revenue
 - by physician
 - by specialty
 - entire facility

Data Collection – Tracking ASC's Health Metrics



- Average charge per case
- Average reimbursement per case
 - per physician / per specialty
- Average cost per case / per physician
- A/R over 61 days

Surgery Center Statistics 2017



- Cases mix 6550

Ortho	2,804	43%
Ophthalmology	2,417	37%
Pain Management	1,331	20%

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28, 737 Surgical Cases



700

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THE ORTHOPAEDIC FORUM

The Safety of Hand and Upper-Extremity Surgical Procedures at a Freestanding Ambulatory Surgery Center

A Review of 28,737 Cases

Kanu S. Goyal, MD, Sameer Jain, MD, Glenn A. Butlerbaugh, MD, and Joseph E. Imbriglia, MD

Investigation performed at the Hand & UpperExt Center, Wexford, Pennsylvania

Background: More procedures are being completed on an outpatient basis at freestanding ambulatory surgery centers. The purpose of our study was to determine the safety and rate of adverse events in outpatient hand and upper-extremity surgical procedures.

Methods: A retrospective review of cases at a single, freestanding ambulatory surgery center over an eleven-year period was performed. In our analysis, 28,737 cases were performed and were included. Adverse events were defined as serious complications causing harm to a patient or leading to additional treatment. Using state-reportable adverse events criteria as a guideline, we divided the adverse events into seven categories: infection requiring intravenous antibiotics or return to the operating room, postoperative transfer to a hospital, wrong-site surgical procedure, retention of a foreign object, postoperative symptomatic thromboembolism, medication error, and bleeding complications. These adverse events were then analyzed to determine if they led to additional laboratory testing, hospital admission, return to the operating room, emergency department visits, or physical or mental permanent disability.

Results: There were fifty-eight reported adverse events, for an overall rate of 0.20%. There were no deaths. There were fourteen infections, eighteen postoperative transfers to a hospital, twenty-one hospital admissions after discharge, one medication error, and four postoperative hematomas. There were no cases of wrong-site surgical procedures or retained foreign bodies.

Conclusions: Our study shows that, with a selected patient population, a very low adverse event rate (0.20%) can be achieved. Our review showing few adverse events, no deaths, and no wrong-site surgical procedures supports our view

continued

Peer Review: This article was reviewed by the Editor-in-Chief and one Deputy Editor, and it underwent blinded review by two or more outside experts. The Deputy Editor reviewed each revision of the article, and it underwent a final review by the Editor-in-Chief prior to publication. Final corrections and clarifications occurred during one or more exchanges between the author(s) and coeditor(s).

Disclosure: There was no external funding source. The **Disclosure of Potential Conflicts of Interest** forms are provided with the online version of the article.

Objectives / Interrogation



- More procedures are being completed on an outpatient basis at Freestanding Ambulatory Surgery Centers
- To provide statistics supporting the safety and rate of adverse events in outpatient hand and upper-extremity surgical procedures
- Analyze hand and upper-extremity cases performed at the WPASC over a period of time and the occurrence of adverse events

Update



- In 2018 we added to the data that was originally assembled for the publication.
- The additional data increased the procedure volume from 28, 737 to 41,751

Adverse Events Reporting Classifications



- Infection requiring intravenous antibiotics or return to the operating
- Bleeding Complications
- Post-operative transfer to a hospital
- Post-operative Admissions
- Wrong-site surgical procedure
- Retention of a foreign object
- Medication errors
- Post operative symptomatic thromboembolism
- Deaths

Adverse Event - Infection



- Infection requiring intravenous antibiotics or return to the operating room.
- Total Infections 25
- As a percentage of 41, 751 cases 0.06%

Adverse Event – Bleeding Complications



- Bleeding Complications resulting in a return to the Operating Room
- Total Bleeding Complications 4
- As a percentage of 41,751 cases .009%

Adverse Event – Post Operative Transfer



- Patient is transferred to a hospital from the post operative care unit of the Freestanding Standing Ambulatory Surgery Center.
- Total Postoperative Transfers 24
- As a percentage of 41, 751 cases 0.05%

Adverse Event – Post Operative Admissions



- Admissions as a result of hospital transfer or within a twenty four hour period of discharge.
- Total Post – operative Admissions 32
- As a percentage of 41, 751 0.07%

Adverse Event – Wrong Site



- Wrong site surgical procedure – procedure performed on incorrect site, incorrect procedure or appendage.
- Total Wrong Site surgical procedures 0
- As a percentage of 41, 751 cases 0%

Adverse Event – Retention Foreign Object



- Retention of a foreign object refers to needles, sponges and/or instrumentation retained in a patient postoperatively.
- Total Retentions of a foreign object 0
- As a percentage of 41,751 cases 0

Adverse Event - Medication Errors



- Medication errors refer to the incorrect medication being given pre-operatively, intra-operatively or post-operatively.
- Total Medication Errors 1
- As a percentage of 41, 751 cases 0.002%

Adverse Events –Symptomatic Thromboembolism



- Post Operative Symptomatic Thromboembolism
- Total Post Operative Symptomatic Thromboembolism Adverse Events 1
- As a percentage of 41, 751 cases 0.002%

Adverse Event - Death



- Death that occurs within the Freestanding Ambulatory Surgery Center
- Total Deaths 0
- As a percentage of 41,751 cases 0%

CQI 18 Years of ASC Data

41,751 Procedures



• Infections	25	.06%
• Bleeding Complications	4	.009%
• Post Operative Transfer to a Hospital	24	.06%
• Post Operative Admissions	32	.07%

CQI 18 Years of ASC Data

41,751 Procedures



• Wrong Site Surgery	0	0%
• Retention Foreign Object	0	0%
• Medication Error	1	.002%
• Post Operative Symptomatic Thromboembolism	1	.002%
• Deaths	0	0%

Results



- There were eighty- four reported adverse events reported over a sixteen – year period.
- Overall rate as a percentage of 41, 751 cases 0.21%

Conclusion



- Our study shows that, with a selected population, a very low adverse event rate can be achieved
- Our review showing few adverse events, no deaths and no wrong site surgical procedures supports our view that hand and upper-extremity surgical procedures can be completed safely in the outpatient setting at a Freestanding Ambulatory Surgery Center.

Questions?

