

## **AVOIDING PITFALLS WHEN DEVELOPING AMBULATORY SURGERY FACILITIES**

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The process of developing a surgery center is a complicated one; there are many obstacles to avoid. This article highlights some of the pitfalls that have been experienced in developing multiple centers throughout the United States. Most importantly, its purpose is to share information on the timing and decisions that should be made, which will result in a more successful center. This article should answer the questions of where to start, how to proceed, and when to bring in the proper consulting expertise to assist in successfully developing an ambulatory center.

It is often the case that a physician group or a hospital wishing to do a joint venture with its local physicians will first contact an attorney or an architect (or even worse, buy a piece of property) as the very first step. This is one of the most common mistakes in developing a center because these professionals cannot offer great assistance in this phase of the project. Indeed, they will ultimately be critical to the success of the project. But, the issue of when to use certain types of expertise is critical and they must be used in a cost-effective way. There have been enormous sums of money paid to professionals prior to the time that they are needed, when they must be carried by the ensuing surgery center.

In short, there are preconstruction issues that need to be resolved. First, there should be a critical attitude taken toward whether or not the project should even be initiated. Before deciding to build, the project's financial feasibility should be determined by someone who is familiar with the development and operation of such facilities. This should be done in conjunction with a physicians group with specific data for that specific area, such as land costs, rent costs, actual case mix of the services to be provided in the center, local areas fees, and numerous other critical data.

A variety of financial scenarios should be run, based on a multiple volumes of projected caseloads, rather than a typical five-year projection. In other words, the group should see the various levels of the patient volume and the economic effect that each of these patient volumes will bring upon the group. It's very easy to see if the project will economically pencil-out if case volumes and case mix is present. It is also easy to see and determine if the project is a stretch project, or one that should be deferred until further volumes are gained by the committee group.

Population demographics often have nothing to do with the success or failure of a surgery center. A center's success relies more heavily on those individuals committed to making the center prosper. It is assumed that someone competent to do such projections would be hired by the group to

guide it in an objective way. When selecting that individual, the hospital or physician group should ask how many projects the candidate has previously found unfeasible and has advised against. Objectivity is important, particularly at this critical phase of the project.

Second, the organizational structure will be critical to the project's success and the achievement of its goals. Though this sounds elementary, the point is often overlooked by groups developing centers. Specifically, it must be decided whether the main purpose of the center is to reap economic benefit for the group or physicians putting the center together. Or, whether its main function is to provide surgeons with the opportunity to be more productive in the way they schedule their cases and allow more office time to see new patients, or even to have more leisure time. Is the purpose of the center to have only the physicians in the group use the facility, or to have it attractive to outside physicians?

All of these issues have enormous ramifications on the physical design, the capital needs of the facility, particularly in regard to equipment and space, and staffing. They also have a critical impact on financial projections. The medical politics of the situation are very important when considering whether or not shares should be given to all on an equal basis, or if a paid board should be instituted in addition to equal shares, or if shares should be given in percentages of current volume of practice.

In short, before contacting attorneys or architects, or purchasing land or equipment, these issues need to be addressed and discussed thoroughly by the group with an outside third-party objective individual. There must be consensus on these issues in order to proceed in a logical and efficient way.

Finally, assuming that all of these issues can be resolved, a team should be assembled made up of an architect who has had experience doing such projects; a corporate attorney who has experience in health law, health regulation, and setting up structures and syndications; a business developer who will guide the project, make sure it gets built on time, and ensure that all operational considerations are performed, and that the facility is licensed and certified within a set period of time; and an accountant who is familiar with the group's financial status, financial strength, and can work as a critical part of the team on an ongoing basis.

Once the critical questions are addressed and the team is assembled, location requirements regarding the facility should then be addressed. Again, it is a waste of time to line up a piece of land, or even put opinion money down if the group does not know the direction in which it is going. The land must be totally responsive to the structure of the group and questions about it will be answered when the critical questions above are addressed. Location requirements will include a physical location in a medical office building if the center is to be located there.

Should the center provide access to all of the physicians in the building, or will the center be located in a particular physician's suite? It is now common to have the center open onto a common corridor since there are a great number of facilities that were once single-specialty facilities, now being converted for multispecialty use. The alter-market for such centers is great, and a physician who has set one up for his own office can now often times sell out some of his shares to others and gain financial appreciation for such an investment.

The location of the facility is therefore critical if used by others is being considered. Just as critical to a medical group or group of physicians putting together a surgical center is the location of a freestanding center. Traffic count, the proper side of the road, access from traffic lights, are all critical factors in selecting a location.

The facility's accessibility to women patients is also critical importance since women account for the largest share of patient volume, particularly in outpatient services. Extensive market research throughout the health care field has shown that women themselves are heavy users, as are their children in their early years. Many times they will help select physicians for their husbands. Therefore, access to this important referral group is critical.

Access to a hospital is also critical, particularly for a freestanding center. The proper amount of land and the way it is laid out, the grading of the land, and the zoning of the land are also critical factors. In other words, this is a major decision to be reviewed carefully, usually in conjunction with the architect and business developer. A common pitfall is that a surgeon who is integral to the group owns a piece of land, and the group tries to fit the project on this piece of land. It should, however, be an objective decision for the benefit of all.

Once the project is deemed feasible, the goals are set, the purpose is determined, and the team is assembled, there needs to be agreement on the floor plan, as well as the specialties that will be house in the center. The structure of the deal and the investment will be critical, and issues concerning whether physicians will just be able to buy into the facility, need to be resolved. It must be decided which specialties will be included, based on their impact on the architectural design.

Second, it must be determined whether or not the facility will be built only for Medicare specifications, or to the state's licensure standards. There are advantages and disadvantages to each side of this decision. In California and Florida, there are extensive architectural and construction cost consequences of deciding to be licensed. Costs for state licensure can run between \$50,000 and \$150,000 more for the construction costs than for a facility that is merely Medicare licensed. This greatly depends on the type of building in which the center is located, and/or if the facility is a free-standing facility.

On the other side, the positive aspects of licensing is that the facility is able to serve PPOs and HMOs, which now often require the facility to be licensed. Furthermore, the facility can be syndicated and sold at some later point. Generally, it is worthwhile to go through the trouble of licensing the facility. If the architect is one who has past experience in these facilities, many efficiencies can be achieved from the original plans. This will keep the additional costs to a minimum, yet meet all the standards required.

There are also equipment concerns to be considered when deciding whether to license or just build to Medicare standards. Empirically, it is well worth the effort to seek licensure for the above-mentioned reasons. However, this point needs to be decided by the group and will be dictated by the scope and purpose of the project.

Third, the decision of what to include in fixed equipment in designing the center for multispecialty groups will be critical. It is obviously much more complicated to buy a variety of equipment for various specialties. There are numerous purchasing sources. In addition, it should be determined if economies of scale can be made in utilizing the same type of microscopes, for example, for ENT and OB-GYN. These equipment considerations are critical because they will represent a large fixed cost for the facility.

As most operators of facilities are aware, the two largest variable costs are staffing and supplies. They are also among the top four total costs of the center. The two largest fixed costs will be the rent and, typically, the equipment lease, or loan to service the start-up costs, which sometimes includes the equipment. The equipment is critical in a surgery center and again, will be dictated by the scope of the project. For instance, fixed equipment, such as sterilizers, will be dependent on the specialties using the facility. In addition, the type of lights and other critical items regarding equipment that will actually be installed in the center, not the movable equipment, will be factors for consideration.

It is critical that these issues be addressed early on. The process is much like a game of dominos. When one falls, all the others should fall behind it. If something gets out of sequence, it can have negative consequences for the project. Others will touch on architectural considerations. However, it is important, again, for the purpose and specialties to be decided, in order to determine, for example, if the facility will have piped nitrogen for orthopedic surgeons, or if the caseload will be small enough to use portable tanks.

Recovery room bed ratios will be determined on the basis of whether heavy ENT or children's use of the facility is anticipated. Many times facilities have co-utilized their preoperative area when space is restricted, and when there will be a significant amount of ENT volume in the facility. Also scheduling becomes a major critical factor in anticipating patient volumes so that staffing can be properly organized prior to opening.

In other words, two ENT physicians should not be coming in at 7:30 on the same day and totally absorbing all recovery room space in the facility. It is better if they can be scheduled for different days and the caseload can be mixed. This is commonly done in well-organized and managed facilities to assist in ensuring that the physical facility lends itself to high-touch and high-quality patient care, rather than just doing a volume of cases every month. The architectural ramifications of such decisions are significant. Further examples are plumbing for Yag lasers for ophthalmologists, and special recovery areas for children as necessary.

These issues emphasize the importance of contracting with architect who has designed surgery centers prior to designing other facilities. It is a complicated business, and it is not something for a residential architect to tackle.

Finally, several issues should be considered regarding conversion of existing ambulatory surgery centers. Today, many existing single-specialty ASCs are being converted to multispecialty ones, and in these situations, state licensure and architectural considerations come into play. To use a facility for only one practice puts the ASC into one category. To allow it to be used for others often requires that the facility be licensed by the state. As stated earlier, there are significant construction and architectural issues related to this.

An analysis should be performed of whether it would be better to leave the facility in its current location or move to a new location. Typically, schematics have been developed by architects for both scenarios and pricing has occurred on a big basis with local contractors. The group can then objectively look at the financial implications of both scenarios.

The same issues described earlier regarding equipment and design based on the specialties anticipated also apply for the conversion of an existing ASC. Also, many facilities are located in a medical office building. It is very common for facilities to have a joint waiting room that serves various ambulatory services. It is not uncommon to try to gain efficiencies of space in co-utilizing the waiting room, registration desk, electrical and mechanical rooms, and storage space. Strong consideration should be given to separate entrances with new signs and a new name on the facility, particularly if it is going to be used by multiple physicians.

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