

I HEART I WAS IN TOWN—MEASURING ASC STAFFING COSTS

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We received numerous responses regarding a quote in a recent edition of this newsletter. The statement generated interesting questions and responses. A paraphrase of the quote is:

Staffing costs should be 20% of net revenue or lower. If not, it is an indicator of mismanagement.

As the author of this statement, the responses were surprising since there is at best a vague recollection of the quote and the interview. In fact, I had to research back issues of this periodical to find the quote. The whole scenario reminded me of the Jimmy Buffet song, "I Heard I was in Town." Interestingly, at the risk of sounding like Charles Barkley who said he was misquoted in his autobiography, I do not necessarily agree with "my own" statement since it is accurate in some instances, but potentially misleading in others. In this instance, the problem may be that the statement was not expanded on in its proper context. Nevertheless, the responses are appreciated since it provides a good basis for this article and allows us to examine the very important issue of measuring staffing costs in ambulatory surgery centers.

The Inherent Dilemma

Staffing costs are the first or second highest expenditure in a surgery center and effective management of this cost is a key function of effective administration. The challenge is that staffing is not a variable cost in the traditional sense whereby the more patients at the center, the more staff are hired. Rather, the ASC industry consists of generally small businesses that we estimate, on average, perform 200 cases per month. In fact, 64% of all ASC's have 20 or fewer employees. Source: Federated Ambulatory Surgery Association. This means that surgery centers do not initially generate significant economies of scale that lend themselves to formula driven sliding scale measures. The reason is that a center must employ a core group of staff in order to operate. As an example, a surgery center will have relatively the same number of staff to perform 100 cases per month that it will to perform 175 cases per month. This creates a measurement dilemma because staffing costs are fixed for a base level of cases, and become somewhat variable once the center performs additional cases. Thus, there is no sliding scale or easy measure that states for each additional case, staffing should be "x." The fact remains that staffing is a "quasi-variable" cost. A core staff is required to operate a center regardless of the number of cases, but a variable element is introduced once the center meets a base level of volume each month. Using the previous example, a surgery center may have 11.0 FTEs to perform 125 cases, 12.0 FTEs for 150 cases, and 13.0 FTEs for 200

cases per month. Therefore, in this example, economies of scale begin to be derived after the initial 150 cases per month and do not play a significant part in staffing options until the center reaches 200 or more cases a month.

Slicing the Data

With this dichotomy between fixed and variable costs, how does a manager effectively measure and control this cost? We suggest that: *Staffing costs are measured based on the relative size of the ambulatory surgery center as determined by its average number of cases performed relative to its case mix, market conditions and reimbursement.*

This means that surgery centers should be "sliced" based on:

- 1.** The number of cases performed per year.
- 2.** The type of cases performed by specialty, or the case mix.
- 3.** The market conditions in terms of wages paid to employees; and
- 4.** The amount of reimbursement on the cases performed by each specialty.

As discussed previously, there are few economies of scale until a center generates at least 200 cases per month, or 2,400 cases per year. These centers (less than 2,400 annual cases) should be grouped together and compared against one another since their data is significantly different than the larger centers. For example, a multi-specialty surgery center that performs 150 cases per month must have higher staffing cost per case than a center with the same mix performing 500 cases per month since there are few economies of scale generated. See above.

Second, and perhaps more importantly, centers should be grouped based on the type of cases performed. A plastic surgery center will have radically different ratios than an endoscopy center. Thus, the data must be sorted based on case mix.

Third, the common measurement tools shown below will be skewed if the market conditions are abnormal. For example, the wage paid to a registered nurse in San Francisco will be significantly different than the wage to the same nurse paid in Thibodaux, Louisiana. The annual FASA Salary Survey is a good tool to assess the relative impact of this since it is sorted by region.

Finally, payer reimbursement also radically impacts the ratio analysis. This is best illustrated by comparing a center that performs the majority of its cases at contracted rates with a center that performs a majority of its cases out of network. While being out of network impacts the number of cases, the reimbursement per case is typically higher. This will skew the ratios and must be factored into the analysis.

Dicing – Key Measurement Tools

Once the surgery center is categorized with its peers, it should be further “diced” using key measurement tools to assess staffing.

Prior to using the measuring tools, an agreed upon definition of staffing costs must be determined in order to best analyze the data. We suggest hours worked at the surgery center for the period (exclusive of bonuses, paid time off and vacations) is best for operational measures such as staffing hours per patient and staffing cost per patient. The benefits and bonuses should be separated on the income statement and measured separately using easily found benchmarks that are beyond the scope of this article. Additionally, business office staff must be included in the measure along with administrative staff. The following are key measures along with some general guidelines:

1. Staffing as Percentage of Net Revenue - the total staffing cost (defined above) divided by the net revenue. Again, this should be interpreted based on the type of cases performed, the number of cases (small or large center), and the payer mix. For a large multi-specialty center, a range of between 23-25% is normal. For a high volume, high turnover center (i.e. endoscopy) this number is typically lower.

2. Staffing Cost Per Patient – the total staffing cost divided by the number of patients. This is a good measure, but must be interpreted properly. Again, the type of cases performed will be the major factor in determining an appropriate benchmark. Market salary conditions are also important. For a multi-specialty center performing 3,000 cases per year in a normal market, we like to see this below \$325.00 per case.

3. Staffing Hours Per Patient – this is one of the best tools. It is the total hours worked divided by the number of cases. This filters salary anomalies and revenue anomalies and measures productivity. Again, it is a per-patient measure and this necessitates that the data be interpreted based on the type of cases performed i.e. a pediatric center may have a slightly higher number than a center with an adult base with the same volume. Again for a multi-specialty center, 10.0 to 11.5 hours worked per patient is reasonable.

Summary

It is important to measure staffing costs to determine if a center is being operated efficiently. Since staffing is not a static measure and is a mix of fixed and variable costs, benchmarking is the best way to assess a center. However, in order to obtain meaningful benchmark data, the surgery center must be measured against similar centers with the same or similar number of cases, payer mix, type of cases, and surgical specialties within its region. Once complete, there are several ratio measures that can be used to assess

the staffing performance. Data measurement and benchmarking provides an objective assessment of operations, but it is only one of many devices that an effective manager uses. On site assessment and in depth understanding of operations cannot be replaced. Effective managers use the data as a tool to “know where to look.” The best managers are aware that each center is unique and should not be operated off a spreadsheet. Notwithstanding, the most effective managers use the staffing data as a valuable tool to augment on-site assessment of operations and drive efficiencies at their surgery centers.

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