

Healthcare FINANCIAL MANAGEMENT

Ambulatory Surgery: Next-Generation Strategies for Physicians and Hospitals

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Physicians' interest in investing and practicing in independent ambulatory surgery centers (ASCs) has grown. In the face of physician involvement in ASC development, healthcare organizations must contend with possible loss of surgical volume and revenues as well as decreased physician support and loyalty to the organization. Healthcare organizations can encourage physicians to remain in the organization by addressing physician's concerns about the financial prospects and efficiency of independent and hospital-based ambulatory surgical arenas.

With advances in anesthesia and surgery techniques, surgery has continued to evolve into a predominantly outpatient practice for many surgical specialties. Outpatient surgical procedures reached over 60 percent of all hospital-based surgeries in 1997.^a This figure reaches 70 percent when the migration of many outpatient procedures from the hospital to free-standing ambulatory surgery centers (ASCs) is taken into consideration.

Surgeons with a significant outpatient case mix (eg, ophthalmology; ear, nose, and throat; cosmetic surgery; orthopedics; podiatry) often are interested in investing and practicing in independent ASCs for several reasons. The decline in physician incomes has fueled interest in

supplementing professional fees with the technical fees associated with facility ownership. Physicians also may realize a significant equity return on their facility investments. Some insurers have set professional fees for cases performed in an ASC at higher levels than those for hospital-based surgery to foster the use of lower-cost sites.

Some surgeons want to sever ties with hospitals due to poor hospital-physician relations or an unresponsive management attitude. Surgeons operating in an independent ASC often are able to exercise more control over their cases, time, and staff. Surgeons also often feel they can operate more efficiently in a dedicated outpatient setting than in the hospital's surgery suite, enabling them to perform more surgeries and thereby optimizing their incomes.

ASCs also may serve hospitals' strategic purposes if existing OR capacity is inadequate and additional capacity is desirable or if an ASC located on the periphery of the existing service area supports the geographic expansion of the health system and improves market share. While payments to hospitals for outpatient surgical services will decline under the proposed prospective payment system (PPS) for hospital outpatient services, the hospital payment is still higher than the ASC payment for many of the highest-volume procedures. Nevertheless, the differential varies by procedure and, in some cases, the ASC payment is higher. The impact of PPS on ASC development will vary depending on the procedures involved.

The development of independent ASCs has presented several issues for hospitals and healthcare systems, including:

a. AHA *Hospital Statistics*, Chicago, Illinois: American Hospital Association Health Forum, 1999, p. 9.

To counter physician investment in independent ambulatory surgery centers, healthcare organizations should promote the advantages of remaining within the organization.

- The creation of excess operating room capacity in the market, reducing utilization and productivity within the hospital surgery suite;
- The perception by hospitals that physicians skim the most profitable cases for their own, independent ASCs, thus reducing hospital margins and driving up the hospital's unit costs per procedure; and
- The loss of surgeon loyalty to and support for the healthcare organization.

To mitigate the impact of some of these concerns, hospitals and healthcare systems frequently join physicians as co-owners of ASCs. This allows hospitals to retain some control over revenues and access to outpatient surgery capability for continuum of care and managed care contracting purposes. But even this partial ownership may not stem the loss of surgical volume and revenue. Perhaps the best defense hospital and healthcare system managers can mount is to find ways to encourage surgeons to remain within the organization. Healthcare organizations can address the needs and interests of their surgeons and encourage surgeons to think more positively about practicing in a hospital setting by using the following strategies:

- Help surgeons assess the existing and emerging risks of independent ASC development;
- Educate physicians about the benefits of working within the healthcare organization;
- Maximize surgeon productivity by improving ambulatory surgery operations within the surgery suite; and
- Provide incentives to physicians to improve clinical and operational performance through the use of joint operating agreements.

Risks of ASC Development

The evolving healthcare market and changing reimbursement climate for ASCs have resulted in new risks to surgeons who practice in an independent ASC. The risks may offset some of the benefits of ASC development and may lead to poorer-than-projected return on physicians' investments in some markets, especially if market projections for an ASC are too optimistic. The healthcare organization should review the following risks with surgeons:

Capital investment requirements. Most freestanding ASCs require capital investments by surgeons, tying up funds and putting the surgeons at risk for capital losses.

Limitations of physician practice management companies (PPMCs). PPMC that tout their ability to expedite

ASC development may be hampered in realizing this goal if their knowledge of the community and experience in managing for-profit ventures is weak. Also, many PPMCs require their management fees be paid before net income is distributed to investors.

Regulatory trends. In general, the regulatory trend has been moving toward limiting the conditions under which physicians can own and operate healthcare entities. In the future, therefore, independent ASCs may be subject to increased scrutiny for fraud and abuse violations.

Prospective payment system for ASCs. The outpatient prospective payment system to be implemented by HCFA in 2000 will significantly affect the profitability of several surgical procedures frequently performed in an ASC, particularly ophthalmology, gastroenterology, and urology procedures.

Excess ambulatory surgery capacity. ASCs often create additional capacity in markets already characterized by excess capacity, leading to underutilization and poor financial performance.

Lack of access to managed care contracts. ASCs may lack the scale and clout needed to ensure access to managed care contracts.

Benefits of Working with the Hospital or Healthcare System

Among the benefits for surgeons who work within a hospital or healthcare system are:

- Avoidance of duplication of resources and capacity, because physicians are not put in a competitive relationship with hospitals to the benefit of neither party;
- The security of likely long-term viability and access to the resources, including capital, high-tech equipment, and support services, of an established healthcare partner committed to its community and medical staff;
- Access to contracts and referrals from primary care networks associated with the healthcare organization; and
- Reduced financial risk because little or no capitalization by surgeons is required.

The independent ASC development phenomenon is a clear indication that a collaborative working relationship must cater to physician needs and interests in return for physicians working with existing hospitals and systems. Most notable is the ability to supplement declining reimbursement and a greater ability to control and influence day-to-day surgical operations and systems.

Although physicians may realize a more attractive economic return by building an ASC than by working within a

hospital, even when the hospital has implemented efficiency measures, they may appreciate the concomitant benefits of reduced financial risk and improved outcomes that the hospital or healthcare organization is likely to achieve because it is often subject to greater regulatory scrutiny than is an ASC.

Strategies to Improve Ambulatory Surgery Operations

To retain surgeons, the hospital or healthcare system needs to address the management issues that have driven many surgeons out of the hospital in the first place. The central issue often is lower efficiency in the hospital surgery suite compared with the efficiency of a facility dedicated only to outpatient surgery, and often to only one type of procedure or surgical specialty. Reduced efficiency leads to longer turnaround times in the hospital operating room, which means surgeons spend more time on fewer cases. This, in turn, affects their ability to optimize their incomes.

In addition to greater efficiency, surgeons want more control over staffing, scheduling, and procedural issues. This wish can conflict with hospitals' need to control costs to compete more effectively for managed care contracts. Measures can be taken, however, to provide the streamlined operating room functions surgeons desire while still reducing costs. These measures may include:

Providing dedicated staff, facilities, and procedures for outpatient surgery. Studies have shown that using the same staff for specialty procedures increases efficiency through familiarity with the procedure, thereby reducing costs by as much as 35 percent.^b It may make sense to aggregate and focus ambulatory surgery activity within a system, either for all or most specialties or for single-specialty surgery centers (eg, eye center, orthopedic center, women's center for gynecology). Moreover, dedicated outpatient nursing staff and ancillary personnel can be put in an environment dedicated to that specialty, creating a perspective on their part that expects and delivers quick turnaround.

b. Harris, Robert M.; Sheldon, Robert; Cuda, Darryl; Volgas, David; and Patel, Rajne, U.S. Army Institute of Surgical Research, San Antonio, Texas, 1998, at www.aaos.org/wordhtml/98news/surgtm1.htm.

Dedicated operating rooms for ambulatory surgery can allow greater control over the surgical environment and schedule than integrated operating rooms that also handle inpatient surgery where unusual or emergency procedures contribute to delays and lost efficiency.

In addition, it makes sense to dedicate more than one operating room to certain specialty procedures, particularly shorter procedures in which special equipment is used (eg, technology for outpatient ophthalmic procedures). While the surgeon is finishing one case, another patient can be prepped in the second operating room, significantly reducing the time the surgeon spends on each procedure.

In multihospital systems, ambulatory surgery for all or most specialties may need to be combined in one location to realize economies of scale and create the volume needed to justify the use of dedicated, specially trained staff and other resources. It also is easier to implement clinical protocols and other cost-reduction strategies in one location for a larger volume of cases than for a smaller case-load in several distinct locations.

Eliminating unnecessary supplies and standardizing equipment for high-volume procedures. Surgeons may not be aware of the high cost of their preferred types of equipment and supplies or the availability of lower-cost alternatives that perform just as well. A specific set of instruments may be prepared routinely for certain cases, but such sets often include several items that are rarely, if ever, used by some of the surgeons. Significant cost and time savings can be realized by standardizing equipment and supplies for high-volume procedures.

Implementing best-practice and least-invasive medication and anesthesia protocols. Opportunities to reduce medication amounts may have been overlooked. For example, it may be possible to eliminate most sedation or eye blocks for cataract procedures in favor of eyedrops only, thereby reducing costs of anesthesia supplies and staff time.

Eliminating unnecessary steps in the ambulatory surgery process. Evaluating the management process for ambulatory patients may disclose unnecessary or time-consuming steps that could negatively affect operating-room efficiency. For example, eyedrops could be administered to a patient having cataract surgery in a preoperative holding area rather than in the operating room.

EXHIBIT 1: BEST PRACTICE/HIGH PERFORMANCE STANDARDS

| Factor | Outpatient Surgery Best Practice |
|---|----------------------------------|
| • Operating department utilization | 80%+ |
| • Outpatient surgery cases that begin on time | 75%+ |
| • Time to register patient | |
| - Preregistered patient | <5 minutes |
| - Nonregistered patient | <13 minutes |
| • Percentage of outpatient cases within 10 minutes of scheduled length | 90%+ |
| • Time from patient arrival to time of actual surgery | <60 minutes |
| • Room turnaround time | <15 minutes |
| • Paid hours/surgical case hour (including preoperative and postoperative care) | 12-15 hours |

Source: Health Strategies & Solutions, Inc., 1999.

Several key productivity benchmarks are provided in Exhibit 1. Prior to implementing changes in operating room functioning, the organization should include staff physicians in the process to ensure acceptance of new protocols.

Joint Operating Agreements to Improve Productivity

Since the July 1999 ban on gainsharing by the Office of Inspector General (OIG) due to concerns that such arrangements could lead to the reduction of patient care, joint operating agreements are drawing increased interest as a way to align physician and hospital financial interests to improve productivity and reduce costs. Gainsharing was developed to encourage surgeons, as key decision makers regarding the surgical process and the types of equipment used, to implement strategies for improving surgery suite operations. Essentially, gainsharing allowed hospitals and surgeons to share in any cost savings that result from improving operations. Joint operating agreements can be used to achieve the major benefit of gainsharing—the alignment of clinical and operational incentives—while putting less explicit emphasis on direct expense reductions.

A joint operating agreement between participating surgeons and the hospital should include the following:

- Development, adherence to, and improvement of clinical protocols;
- Standardization of supplies, equipment, and staffing;
- Adherence to scheduling protocols;
- Commitment of a certain level of time and effort;
- Physician payments based on the fair market value of their time and effort spent; and
- Other stipulations that are incorporated after consultation with hospital and/or physician legal counsel (since new rulings and interpretations emerge frequently).

The joint operating agreement should be developed with the help of an experienced healthcare lawyer. Parties to the agreement can be individual physicians or a group of surgeons, although individual agreements may reduce the amount of standardization and adherence to protocols that can be realized, thereby reducing expected cost savings and potential clinical improvements. Individual agreements also may, in some circumstances, increase legal risk. In contrast, a group agreement facilitates compliance with safe-harbor regulations and likely will result in greater surgeon compliance, leading to greater potential improvement in operations and outcomes.

To avoid the possibility of violating fraud and abuse

regulations, it is critical that the operating agreement not, directly or indirectly, base the surgeon's potential payments on the volume of patients the surgeon brings to the hospital. In addition, the size of the payments must be proportional to the fair-market value of the surgeon's agreement to adhere to the clinical and operational protocols on which the joint operating agreement is based. Generally, the larger the payment to surgeons, the more regulatory scrutiny the agreement is likely to attract.

Payments to physicians for adherence to protocols generally are a shorter-term benefit that will diminish after one to two years. The longer-term benefits include improvement in quality of care through implementation of clinical protocols and, ultimately, development of the infrastructure to jointly pursue risk contracts. These items can be incorporated into a joint operating agreement.

Conclusion

Surgeons often do not have the time or the business training needed to fully examine potential changes in the healthcare system that will affect their practices and to evaluate the reasonableness of ASC proposals submitted by developers. Financial managers of healthcare organizations can provide important information that will aid in the assessment of these proposals.

Ultimately, the success of any relationship between physicians and hospitals or healthcare organizations depends upon the level of trust between the organization's management and the physicians and the sense of added value the organization provides to physicians. By tailoring the strategies outlined above to individual circumstances, hospitals and healthcare systems can develop positive partnerships with surgeons. ■

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