

**EXECUTIVE INSIGHTS**

**RESILIENCY + RECOVERY**



## **STRATEGIES FOR SUCCESS IN A GROWING AMBULATORY SURGERY CENTER MARKET**

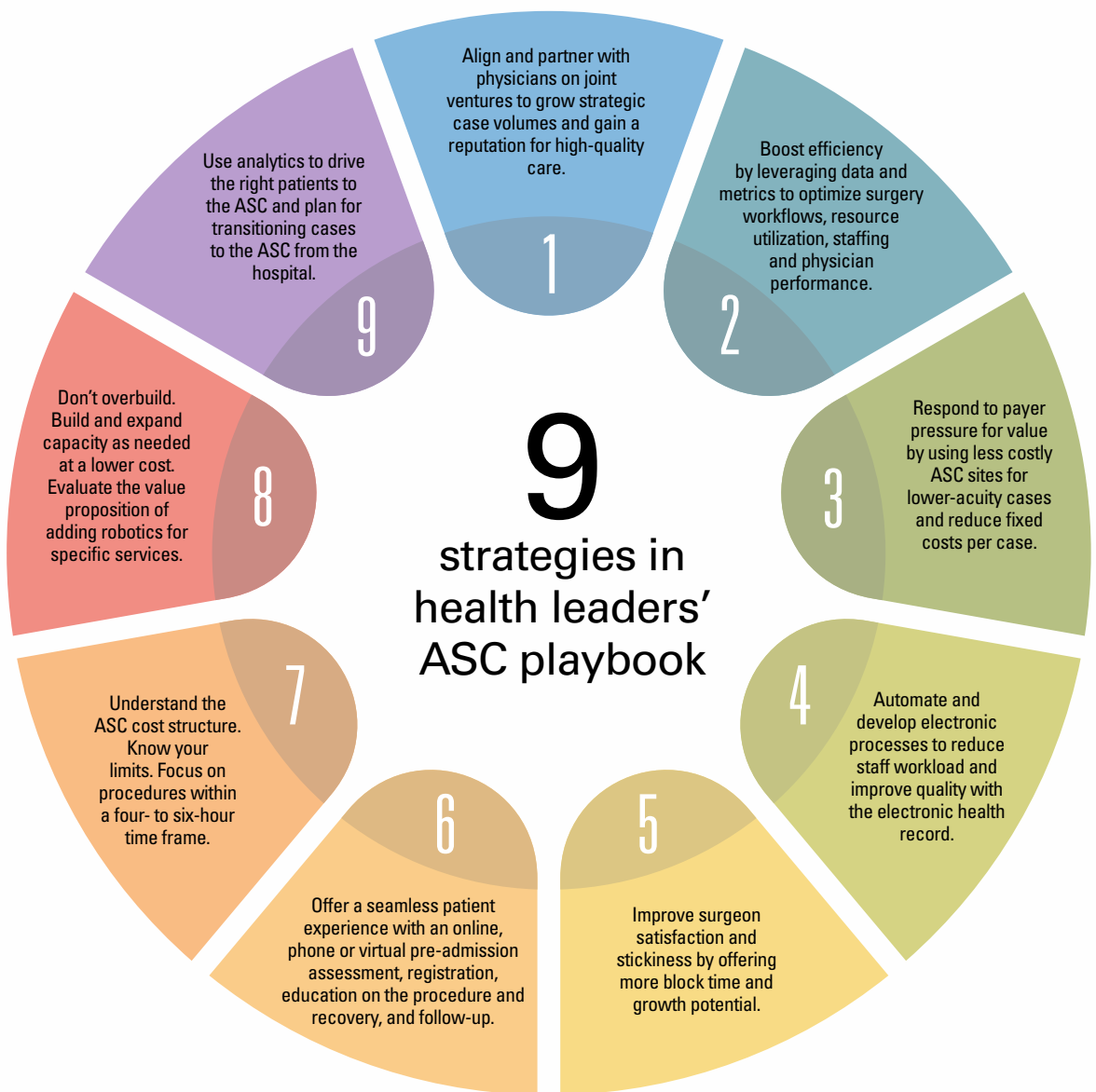
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Improving clinical efficiency, operations and the  
overall ASC experience for patients

# Strategies for success in a growing ambulatory surgery center market

Improving clinical efficiency, operations and the overall ASC experience for patients

**The outpatient surgical care landscape is shifting.** Patients want greater affordability, efficiency and convenience in the care they receive. Payers expect the same. To increase surgical capacity and address pent-up demand, hospitals and health systems are responding by making significant investments in ambulatory surgery centers (ASCs). Surgical procedures performed in ASCs can cost significantly less, help to preserve operating rooms and other spaces for more emergency procedures and provide quicker turnaround compared with hospital outpatient departments. Well-managed, technologically advanced ASCs also can contribute positively to organizational objectives. This executive dialogue explores the shift to ASCs and focuses on the impact of technology and successful strategies that bolster financial resources, efficiency and positive patient outcomes.



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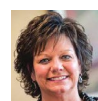
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## STRATEGIES FOR SUCCESS IN A GROWING AMBULATORY SURGERY CENTER MARKET

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**MODERATOR** (*Bob Kehoe, American Hospital Association*): **How is your organization growing its footprint in the ambulatory surgery center (ASC) market, and what key strategies are fueling this growth?**

**RAY MOSS** (*Cleveland Area Hospital*): We're working on our last phase of USDA approval for a replacement facility. We've gone through all the processes as far as market analysis, feasibility study, deployment of architecture designs to build space to accommodate at least the next five years' worth of market share that we can expect to capture.

**TREY WICKE** (*Baylor Scott & White Heart and Vascular Hospital*): For our ASC strategies, we have been part of a joint venture. We're a minority partner with several of the United Surgical Partners International centers in the area. We have not gone out and directly done anything with ASCs as a hospital ourselves, but we hear a lot of discussion around the use of or the treatment of heart conditions via cardiac catheterization labs starting up in the ASC environment.

**DEBRA FOX** (*AtlantiCare*): A couple of months ago, we celebrated the 25th anniversary of our first ambulatory surgery center, a multispecialty ASC, and we have two other multispecialty ASCs. In the middle of COVID-19, we opened a fourth — AtlantiCare Center for Orthopaedic Surgery, an orthopedic-only ASC. We have a strong relationship with a large orthopedic group in our market. We have been transitioning joint replacement and other orthopedic and sports medicine-related cases from our hospital sites and our other ASC to the Center for Orthopaedic Surgery. That center is a joint venture with the orthopedic group and this is our second full year of operations; we are exceeding our budget for what we anticipated there.

**JIGAR PATEL** (*Oracle Cerner*): Mark and I are seeing a fair number of joint ventures and, as Deb mentioned, aligned to physicians. Is that a general strategy and

outlook we're seeing across the ASC markets?

**SABRINA GILBERT** (*OhioHealth*): Our oldest joint venture is 30 years old. Our newest one was acquired last month. We have 11 ASCs, which are all partnered joint ventures and predominantly in central Ohio. They have proven to be successful given our mixed market of employed and independent surgeons. Our ASCs are almost exclusively for the independent providers in the market. We have a small team dedicated to our joint ventures and have 26 joint ventures across multiple service lines, with ASCs as one of our biggest focus areas.

**FOX**: I would like to add that our Center for Orthopaedic Surgery is our only joint venture surgery center. Similar to what Sabrina describes, our three other ASCs are largely filled with cases from our independent providers in the market. Some of our employee physicians are also doing surgeries there, but it's largely the independents.

**GARY BAKER** (*HonorHealth*): We have both a hospital-based outpatient department (HOPD) on campus, surgery centers at a couple of our campuses as well as three joint ventures for multispecialty. One is orthopedics, the other is geared toward pain management. We're also looking to expand into hybrid office-based lab and ASC, which is prominent in Phoenix. We're a little late to the game in some of the market movement and have included it in the multispecialties that we have. We also do a fair amount of endoscopy routine gastrointestinal (GI) work. Our strategy is to work with a management partner who really facilitates the physician syndication.

It's doctors we know and doctors who are motivated to be in the relationship that maybe hadn't previously practiced at one of our six hospitals. We're active in the space and we have a couple more on the drawing board. One will be dedicated to neurosciences. In Phoenix, there's a lot of ASC

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competition as well as hospital competition in the marketplace.

**JOANNE SCHROEDER** (*Munson Healthcare Charlevoix Hospital*): We are not in the ASC business in Charlevoix, however as we investigate what impact an ASC would have on any hospital I wanted to ask the group if anyone could share how building an ASC affected their hospital surgical volume and what were the countermeasures they put in place to prevent negatively impacting the hospital financially? How did you deal with that or address that concern?

**BAKER:** There are two ways to look at it. One is that if a competitor were to come in and build an ASC, you would lose all the volume. In a joint venture arrangement, you maintain some of the revenue. You have seats on the governing board, so you have some oversight on quality and physician relationships. Second, this is a physician-alignment strategy. It depends on the maturity of the market. We've approached joint ventures to stay competitive and as a defensive strategy, so as not to lose 100%. However, we have maintained majority interest in all these joint ventures. We bring some value to the table for the partners.

I think you must evaluate the potential loss, and what your insurers require. Are they starting to direct members to lower costs of care? At some point, you'll want to get to a lower fixed cost per case. When it comes to reimbursement, right now we're successful with joint ventures in both HOPD and in the ASC space, but that's probably threatened a little on the HOPD side for the future.

**MODERATOR:** What challenges do you face in medical record documentation in your ASCs and, in terms of using paper processes, what are barriers to moving to the electronic health record (EHR)?

**GILBERT:** All our centers are still using paper. It's been a constant topic of interest. However, the barrier to entry is cost in almost every instance. As a health system, we use Epic and we've found over the years that the ambulatory option within Epic does not currently allow for the speed and efficiency that we're looking for in outpatient ORs. We would need several enhancements to that platform before we'd extend it to our surgery centers. At some point, we know we must switch given the digital era, but how do we do it so that it doesn't hurt our profitability or, most importantly, the efficiency or even the quality of the center?

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— Sabrina Gilbert —  
OhioHealth

**MOSS:** I'm tackling this as part of a two-year process. I have quality and health information management (HIM) reporting to me. In Phase 1, we've installed RightFax in each department as a separate modality so that as we receive referrals, it goes directly into the department's individual mailbox through Outlook. The faxes are received electronically and we use Cerner as the EHR. We also have the ability via Cerner to fax into RightFax electronically. From a case-management quality perspective, we are able to send medical records without printing, and our hospitalists and primary care physicians can

retrieve them without printing as well. We have Athena in our primary care clinics, so they're able to take that electronic document out of Cerner and then upload it into Athena.

From a usability standpoint, it's the same simple process as if you were printing a PDF out of a print driver. In the second phase, to reduce congestion in the hospital for nonmedical-related services, we are testing different platforms to host medical records online. From the website, when patients submit a medical record request, they're given an email or a text with an access code. That access code goes

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to a specialized link, which has an expiration, and they're able to retrieve their images. Patients can retrieve both their medical records and primary care records, all electronically via email in a PDF or JPEG format depending on the image.

We're trying to make patient access to records as paperless as possible. Prior to this initiative, we were still burning images on a CD-ROM. Many people had difficulty even finding a laptop or a computer that had CD-ROM capability; I had to buy an external one for myself. That's what we're doing to integrate all our EHRs and processes.

**FOX:** In our acute hospital environment and in our ambulatory environment, we use Cerner. However, there was no EHR to meet our needs in the ambulatory surgery environment. We implemented an EHR in all four of our ASCs that does not integrate well with Cerner. So, while we have automated and electronic processes in both environments, it's a lot of work to get the reports out of our ASC into the chart prep and into the EHR for Cerner on the physician practice side.

**BAKER:** We haven't adopted Epic for several reasons: cost in the joint ventures and it's more cumbersome trying to put a hospital chassis into an ambulatory surgery center for documentation.

**MODERATOR:** What financial impact has your ASC had from an organizational perspective, whether it's positive or negative, and what factors contribute to that performance?

**MOSS:** We're a critical access hospital. We hope to have outpatient surgical suites up and running within three years. With the increase in fuel prices, we are looking to provide low-acuity outpatient procedures within our market service

area. Appropriately, for an ASC, we want patients recovered and ready for discharge within four to six hours. Strategically, that's the procedural market that we're trying to target on our ASC rather than trying to be all things to all people.

**SARA SORTAL** (*Advocate Aurora Health*): Both the provider and payer pressure to move is a situation we're encountering and it is market-specific. We're finding win-win scenarios for the hospital and a new ASC partnership where there are capacity needs — where we want to build and expand capacity, but at a lower cost so that we can continue

to grow higher-acuity services at the hospital. Where we have a significant and growing population of risk-based arrangements, we can also create value by getting patients to lower-cost sites.

**MARK SEELAN** (*Northern Light Mercy Hospital*): For us, it's been positive, particularly around increasing capacity. In our southern Maine market, there's a lot of pent-up demand. So for us, it's about shifting some of the high-complexity procedures we do in the hospital into our HOPD outpatient surgery center, while backfilling with more acute cases in the hospital. We're about 50/50 employed versus nonemployed physicians, so we're

also marketing our surgery center to those nonemployee physicians.

We are a community hospital and there's a larger medical center next door where some of these nonemployed surgeons also operate, so for us, it's about creating a frictionless experience for the surgeons.

**PATEL:** Mark, you bring up a couple good points. You talk about stickiness with your independent physicians and the push into ASCs as a branding

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tool from Northern Light in the market to make sure your patients are loyal and engaged with the health system by offering them another level of service.

**SEELEN:** Some of these nonemployed physicians have ASCs that they own. Still, a lot of them are looking for more block time. We've been able to give that to them, and that's been an opportunity for us. To your point, we're recruiting not only surgeons, but also patients and staff. We do whatever we can to retain and recruit great people and to make it a seamless and positive patient experience. For patients to be able to arrive, park, enter, get their procedure, and go home within that four to six hours you're talking about, that's been part of our value proposition in this market as well.

**BRIAN DIETER** (*Mary Greeley Medical Center*): We're in the planning phases. We expect to open and do our first 10 cases for accreditation in the summer of 2024. Ours will be a joint venture with a large multispecialty clinic. We expect that it will significantly affect our HOPD business, so we're actively looking for opportunities to backfill that and focus on some acute, more intensive surgical procedures in the hospital because we'll have both inpatient and outpatient operating room capacity on our main campus.

Our proposed surgery center is about two and a half miles off campus. We're going to look at some of the major orthopedics, ophthalmology, urology and gynecologic surgery. We believe our routine GI procedures will go there as well.

**PATEL:** What are some key lessons learned for those who stood up brand-new ASCs recently?

**KATY BRENNAN** (*OhioHealth*): When you're standing up a new center, there's a tendency to build it

larger than you need because everybody's focused on growth. Physicians tend to have the hospital mindset and not necessarily the ASC mindset.

We've had a lot of success because we have mostly joint ventures. We have a couple HOPDs that are less successful financially for our health system because we bring a lot of the hospital mentality to room turnover, and those types of things that have to be completely different from the hospital for an ASC to work efficiently and effectively.

**"In a joint venture, having the physicians have some skin in the game, and then understanding that in most of the places we have an ability to add a room if the growth comes."**

— Katy Brennan —  
OhioHealth

In a joint venture, having the physicians have some skin in the game, and then understanding that in most of the places we have an ability to add a room if the growth comes. We work with the physicians to understand that in an ASC, we don't want 40 minutes between cases, even though that may be OK in the hospital setting.

**FOX:** Our ASCs have had a positive financial impact on our organization and, in many respects, have accelerated our journey of moving appropriate cases from the hospital to the ambulatory setting. At the same time, the reimbursement for those same

cases is much less in the ambulatory surgery center compared with the hospital, so we are challenged to find ways to backfill that volume with more hospital cases.

Our organization uses advanced robotics and our orthopedic surgeons enjoy doing robotic surgery in the hospital. As we opened our Center for Orthopaedic Surgery and began transitioning cases, the surgeons wanted to do their robotic surgery in the ASC. What that adds to your cost structure in an ASC is much different from what it looks like when you have all the overhead and other components on the hospital side.

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Not all orthopedic surgeons use the same robot. Managing the expectations of the surgeons was challenging — if you want the robot in the surgery center, then we will move it, but then you can't also have it at the hospital. Then there's the complexity of trying to develop algorithms for which patients can be seen in which center and who may be appropriate for robotic surgery versus conventional surgery. It created another level of complexity that we didn't anticipate or think through in advance.

**MODERATOR:** Is it feasible to have robotics in the ASC?

**FOX:** We do have one robot now in our Center for Orthopaedic Surgery, but it is not the robot of choice for several of the other orthopedic surgeons. They prefer a different robot and there are many reasons why they use different robots.

**GILBERT:** We have a few robots in our portfolio. There are a handful of centers in town with a variety of robot models — we have DaVinci, Mako, etc. We have been looking at the differences in the type of robot we're placing. We've learned that the Mercedes version that we use at our hospitals often have a slightly lower-grade model and can do a great job in the ASCs. The same vendors are offering competitive pricing to get these robots into our ASCs because they know we are not going to make any more money when we do a robotic case. From a physician recruiting standpoint, many of the new physicians coming in are being trained on robots. We need to think about the millennial provider and what their training looks like versus historical training methods, and how we're going to keep up with those ever changing shifts.

**DAVID WILSON** (*North Mississippi Health Services*): In Tupelo, Mississippi, we're the hub of a seven-

hospital system and have a joint-ventured diagnostic center, GI center and ambulatory surgery center. We have four robots in the hospital and our women's hospital, but we have not deployed any to our ASC and we are looking at that. Our surgeon owners have been resistant for fear of the added cost.

**MODERATOR:** What has the clinical experience been like so far in your ASCs and what strategies are you implementing to prepare for future growth, whether it's clinical protocol, best practices, staffing, technology or analytics?

**WILSON:** We just renegotiated a contract with Blue Cross and a significant portion of that is going to be our first value-based model for orthopedics. Starting next week, those surgeries will be performed at our ASC. We've had about three months to prepare for that bundled payment, but we asked for it. We have a competing ASC in town, and we wanted to grab the opportunity that presented itself. I will add that we have Allscripts Sunrise Clinical Manager. We have not deployed that EHR at our ASC because it slows down the surgeons and they are not keen on adding the time. We'll be converting all our inpatient facilities to Epic in early 2024. Our information technology staff are pushing us to look at that for our ASC but our surgeons are pushing back.

“One of the advantages of having an electronic system is the clinical quality and analytics that go with it. We've talked about how you could potentially use analytics to drive the right patients to the ASCs versus the hospital.”

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Oracle Cerner

**PATEL:** One of the advantages of having an electronic system is the clinical quality and analytics that go with it. We've talked about how you could potentially use analytics to drive the right patients to the ASCs versus the hospital. What are the barriers or successes that you've experienced in those spaces?

**WILSON:** In our Blue Cross bundle, it is an expectation from Blue Cross that we will have an EHR in our



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ASC. However, we have told them that we currently don't and that we are working our way around that. Ultimately, Blue Cross or other payers may have a mandate for their ease of collecting information as well as making sure that we have good access to data.

**DREITZLER:** Sabrina, you made an interesting comment earlier around cost being the barrier for putting an EHR into the ASC. The market doesn't look all that dissimilar from the acute hospital space 20-plus years ago when EHRs were not widely adopted. While everybody knew it was the right thing to do, there wasn't the financial incentive or penalty at that point to put in EHRs. There's so much growth from an ASC perspective, both with acute provider health systems that are adding ASCs to their line of service and large ASC chain management companies growing at rapid rate.

We are looking critically at how we reduce the cost so that ASCs will adopt EHRs. We also believe that there must be less of the hospital mentality as it relates to the design and configuration of the EHR that goes into the ASCs. Let's make sure all the must-haves are included from a workflow perspective, but fewer of the nice-to-haves and get the cost down. Ultimately, if we get the cost at the right target, we're confident that the surgeons and the joint venture partners also will see the value in it.

**MODERATOR:** What steps are you taking to improve the patient experience in your ASCs in terms of patient engagement, safety and convenience?

**FOX:** We're preparing to flip our survey over to the outpatient ambulatory surgery CAHPS survey. We've been using a different tool. This is something that we put on our staff's quality dashboard. Our staff members are incentivized in a different manner than the rest of our health system. They earn a quarterly bonus versus achieving certain measures of performance. The patient experience is one of the most important things that they look at. Providing them with ease of scheduling, making sure that we do their pre-admission assessment virtually to make the process easier for them versus having to physically go somewhere to have that assessment done.

We put all our staff through rigorous customer experience training. It is a mandatory eight-hour day. A lot of it is geared toward putting themselves in the shoes of the patient so that they understand it from the patient's perspective. It's important that we follow up with our patients afterward. Generally, 48 hours after their surgical event, we contact them not only to ask how they feel physically, but also about their experience. If there are things that they found unsatisfactory, we can make real-time adjustments.

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