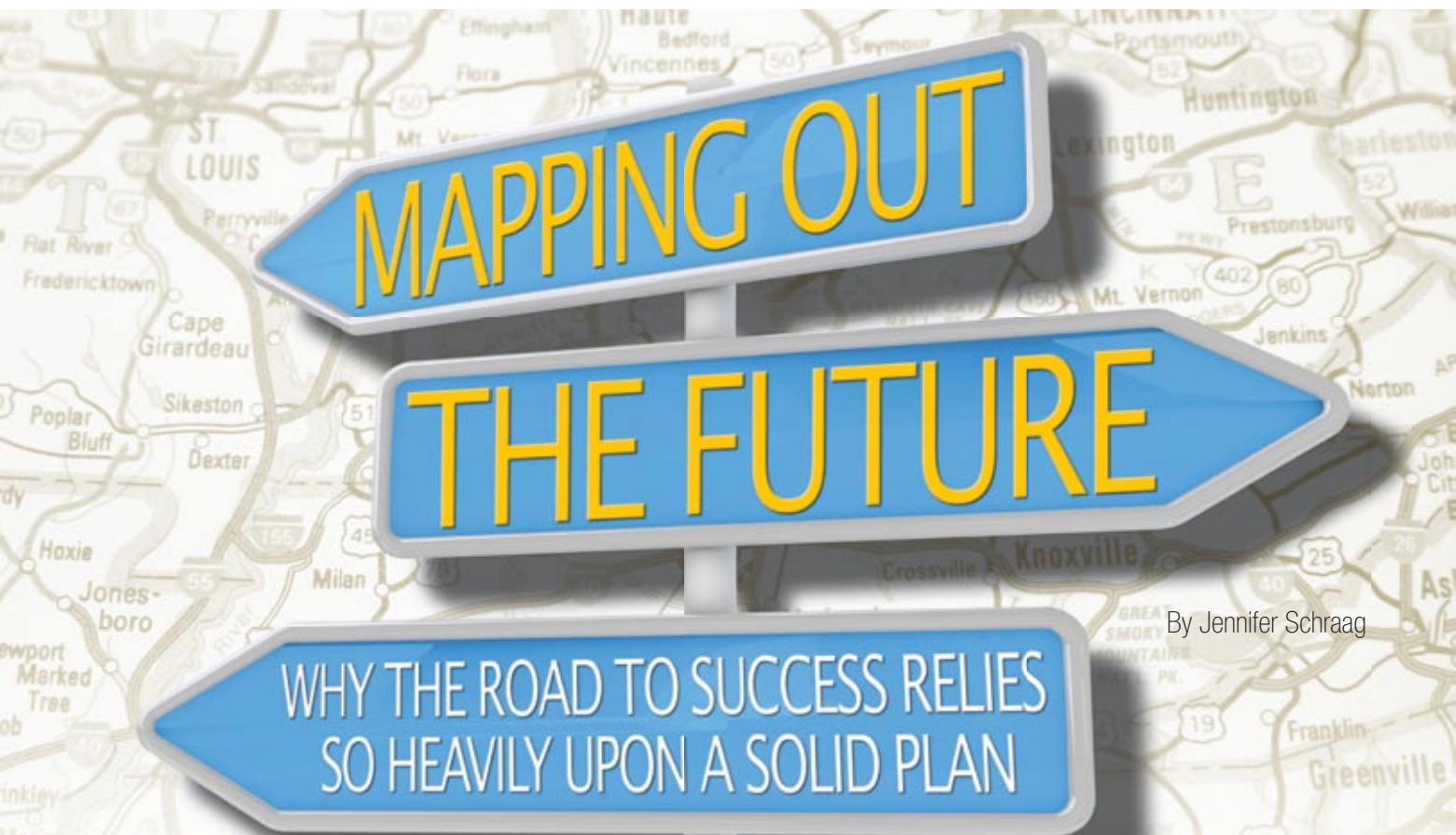


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BUSINESS AND CLINICAL SOLUTIONS FOR THE ASC



By Jennifer Schraag

Everyone wants that magical crystal ball to provide a true road-map of the future. Be it marriage, accepting a new job or starting a new business venture, we'd all love to be able to foresee the results of our choices — before we become so heavily invested. Unfortunately, that magical crystal ball, and its matching measure of security, simply do not exist. All we can really count on is thorough thought, extensive planning, and arming ourselves with as much knowledge as possible. It is no different when launching a new ambulatory surgery center (ASC).

The closest thing to that crystal ball — when planning the future of an ASC — is the feasibility analysis used to investigate the initial likelihood of success of the brewing business model. Frankly, exploring the likelihood of the success of a potential venture is no easy task, but it is a necessary evil, and there is nothing that the feasibility study should not include.

“The most important part of the feasibility study, to me, is making sure that you actually do one,” asserts Robert Carrera, president of Fort Collins, Colo.-based Pinnacle III. Carrera says the study must be adequately done, and, he says, it is imperative that it is done thoroughly.

Carrera shares that he has been involved with projects that had participants who felt there simply was no need for a feasibility study. He notes however that this is a quick path to sure disaster, and finds it crucial to explain the benefits of these studies to his clients. “Getting it out there, the concept of what it is and why it is important to do it,” is imperative, he says.

Perhaps William L. MacKnight, managing partner with Physicians Health Resources (PHR), explains the importance of a feasibility study best when he points out, “The feasibility plan is the first part of any business plan, since if it is not viable, there is no business.”

This initial stage must be all-encircling. Carrera advises, for example, gathering input from all of the stakeholders of the project and ensuring all aspects of the venture are addressed: managed care, potential volumes, potential partners, any competitive issues in the marketplace, etc. “Get in as much information as possible and make sure it is as thorough as possible,” he asserts.

The various demographics of the area in which the business will be built are important to consider in the analysis. Whether or not the state is a certificate of need (CON) state will in itself play a key role in a venture's potential for success.



“It really depends on the environment,” shares Doug Dorrell, a healthcare consultant with Health Evolutions Inc. “If you have a very competitive managed care market, the payor contracts become very important. If you have a lot of competition in the area with regard to outpatient ambulatory surgeries, than those allegiances that the physicians have or those ‘patterns’ are difficult to break sometimes. The imperative really depends on the circumstances,” he adds.

MacKnight says the key success factors for an ASC are volume and reimbursement levels. “The most often overlooked item is the macro perspective of the business taking into consideration job creation, housing starts, and general economic wealth of the marketplace,” he explains. “The ASC will succeed by existing surgeons transferring their business, but will flourish only with incremental long-term volume which is dependent on the local economy, as well as the specifics of the practice specialties that will be participating (stage of practice is key).

“Since the ASC business is based on existing volume of a select number of physician users/investors, the key is securing their commitment of volume to make the venture viable, based on prevailing reimbursement rates for the mix of procedures to be performed at the ASC,” MacKnight continues. “The size of the project should be scaled appropriately to this volume to ensure that fixed costs do not financially encumber the business — resulting in continued losses.”

Dorrell’s colleague at Health Evolutions Inc., Jane Pratt, RN, MS, CNOR, agrees that volume and case mix are important aspects to have secured. She builds upon the role of the partnered physicians and adds that physician buy-in will truly make or break a successful center. “You have to have some pretty good insurance from your physicians that they are going to participate,” she asserts. “It sounds naive that they wouldn’t, but physicians get pretty accustomed to working where they like to work and working where they know certain people, and even though they want to become owners and investors, it is sometimes hard for them to break their practice patterns. So you really need that buy-in from them that they are going to move volume from one place to another, and fully develop the volume as they’ve projected.”

Do and Redo

The feasibility stage is also the perfect place to crunch and re-crunch all the numbers for the venture. “At best an initial feasibility — no matter how elegantly built by diagnosis and payment levels — gives a glimpse of when a center would break even and earn incrementally under presumed utilization, capitalization, and operating conditions,” explains Justine B. Corday, chief development officer of PHR. “When payor reimbursement might come on line and when expected key users can and will transfer the preponderance of their volume to a new facility can critically affect feasibility, and these are very much local factors, not generic ones.

“A preliminary feasibility study always should be recast as a cash flow statement vs. a simple accrual profit and loss statement, based on a full business plan. Only then can there be reasonable assurances that a venture organization and capitalization approach would minimize risk. Beware relying solely on a first feasibility look for an expectation of when an investment will be fully returned or how much the facility will earn per case at certain volume levels. Additionally, create several sets of projections to highlight most probable, worse, and better circumstances.”

What Corday leads to here is often termed a “sensitivity study” which primarily focuses around the financial component of a venture. Dorrell says that in the projects that Health Evolutions are involved

with, they usually will run three scenarios: minimal case, best case, and most likely. “It is centered around the economics — we usually do return on investment (ROI) on all three of those scenarios,” he adds.

Taking the Next Step

The actual business plan for the venture will cultivate from this feasibility analysis. This is the stage where Dorrell says you really craft your rationale and get to a point where your plan is presentable to either an approval body or to be incorporated into an offering memorandum.

According to Corday, a sound business plan begins after it’s foreseeable that reasonable volume and revenue mix can be achieved. “It eschews the ‘if-you-build-it-they-will-come’ leap of faith,” she says, and asks the following questions:

- Given this group of potential users, what’s the best way to organize a new entity to forge and implement strategy?
- How will this facility differently or uniquely fit into the local community?
- How will it cost-effectively serve doctors and patients from scheduling, through admitting, treatment, discharge, and follow up?
- What capital expenditure and working capital needs stem from these considerations?
- What operating tactics are essential at key points to implement the plan?

Just as the feasibility analysis had to be complete, so does the business plan. The base plan is already in place, but many aspects need to be fine-tuned and expanded. Volume, revenue, reimbursement ... the considerations go on and on — and every one of them hold their weight in importance.

But there is hope for help and ease in this part of the project. As Corday points out, the increase in electronic database use can help in gathering much of the needed information for each of the involved physicians. This is because they generally have readily available historical records of use by procedure and by payor.

MacKnight also mentions gathering the numbers for presumed volume much in the same manner. “Volume can be obtained from any interested physician from their existing billing system by identifying what cases could be done in an ASC while considering that some may not be transferred because of reimbursement or case complexity,” he explains. “Reimbursement can be obtained by contacting the interested physician’s payors or by taking geographical reimbursement rates for different payors, particularly those that pay from specific payment schedules.

“Workable vs. unworkable is a function of what specific procedures are being performed,” he continues. “Most are paid from defined payment schedules which need to be reviewed as to whether they will earn considering the incremental supply costs. Cases should be tied to the specific physician investors’/users’ billing system data from which the appropriate caseload and types can be identified and used to get the reimbursement rates.”

Corday says that the degree to which a contract is workable ultimately relies on typical payment ranges or caps. She also adds that timing to bring that contract on line is a crucial consideration. “Caseload often is correctly seen as building gradually,” she adds, “since it takes time to shift patterns of practice among admitting facilities. However, shifts by a key practitioner whose decisions influence the opinions of other physicians can either jump start volume movement toward the facility or curtail it.



“Computing a breakeven is the easy part; attracting key, potentially high-volume users and identifying reasonable timing assumptions for gaining their volume is a more critical, but ultimately, a necessarily imprecise part of the analysis,” she asserts.

MacKnight makes a good point when he adds that those procedures with low reimbursement require carve-outs with the payors to reimburse separately for the additional cost of supplies and implants, for example.

Carrera builds upon the topic. “You have markets around the country where your net revenue per case is incredibly high. I’ve had facilities doing eight cases a day that ran on a 40 percent margin and returned close to a million dollars a year for its investors. On the other hand, there are the facilities that, because of the reimbursement, required 15, 16 or 20 cases a day to make any type of return. There is such a wide range of what can work and what doesn’t work. It goes back to that feasibility study and making sure it is as thorough as possible because there is such a wide range.”

What also must be taken into account is suitability of the ASC environment for various cases. According to Corday, it is not just from the viewpoint of whether a procedure is reimbursed, “but also what comfort level the physician has with an ASC vs. a hospital and, potentially, with this new ASC vs. an established one. Also, it’s essential to determine directly from surgeons and proceduralists their expectations and concerns on how moving volume to the new facility might be viewed by the referral sources on whom they rely,” she adds.

These futuristic views of case loads and expected revenues can be a very dangerous path to travel. MacKnight shares that he was familiar with a project in which a single physician built on his expected future volume and the revenues that fellow specialists had touted. “His volume was never sufficient to cover the overhead of his two OR facility

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— William L. MacKnight, *Physicians Health Resources*

and the revenues never materialized as he had been told by other physicians,” MacKnight warns. “After three years of construction delays, he is now trying to sell the ASC to other interested physicians.”

A Rush to Beat the Clock

Timelines, of course, are needed in such a vast project as launching a new surgery center, and snags can occur in countless aspects if they are not properly considered. Corday says such timelines are often even skipped, causing resounding damage that often outlasts the planning stages. She suggests that the best person to create and manage such an overview is someone knowledgeable about all aspects of ASC start-ups. These aspects include financing; functional design; special-use construction; inspection, licensing, and certification processes and timeframes in that state; and determination of the optimal time to begin staff recruitment, training, and payroll commitments.

Pratt adds that depending upon the geographic location (i.e. whether it is a CON state or not, for example), it can take up to a year to a year and a half to make the dream a realization.

At Pinnacle III, Carrera says they usually look at six to 12 months to complete a project. “We’ve seen projects fast track if some of the pre-work has been done by people ahead of time; you’ve picked a site; you have an idea of who your partners are going to be when we are brought in to really complete the business plan and the feasibility study; etc. When some of those things are done ahead of time, we’ve seen projects that can fast-track six to eight months and that’s a ground-up situation, you may be able to do it even quicker than that if it is a tenant improvement situation too. We have also seen projects that are 12 to 18 months,” he adds.

Carrera continues, “I think a reasonable time frame is dependent upon where you are (in the process). Most payors won’t do a whole lot with you unless you are close to opening. You can have some preliminary discussions early on, but until the facility is 60, 90 days out, there’s really not a lot to be done, besides identifying your payors and coming up with what your fee schedule and your desired revenues are going to look like. So many of those payors, until you get that Medicare number, may not even send you a contract.”

Getting all of the involved parties of the venture in agreement and on the same page is another difficult challenge. Pratt says this can sometimes be difficult, and that “It really depends on who the investors are and how complex the center is going to be.”

MacKnight agrees, adding, “It always takes longer than you could ever imagine to do it right. The most important part is planning the venture, but the time spent upfront in defining the project, timeframe, and investment will pay dividends in the future,” he says.

Don’t Throw That Money Away!

Keeping within budget throughout the project can perhaps be one of the biggest challenges of all the hurdles faced. ASC development is an expensive project by nature, obviously, but there are ways to keep costs down and stay on track.

Pratt points out that there are a lot of start-up costs, and even though you have a budget prepared for this, there will always be aspects that pop up that were not initially taken into consideration. “Depending upon your case mix and what procedures you are going to do, that is really going to dictate what your start-up costs are going to be. Instruments, supplies, telecommunications, and IT (information technologies) expenses are often underestimated.”

To help soften the blow, one person should be deemed the project lead and this person is charged with keeping track of the expenditures. “They know what the budget is and they ‘pull in the reins’ of those folks that are managing various pieces of the project,” Dorrell says, adding that things can very quickly and unexpectedly spiral out of control in one area or another.

Corday suggests having a defined timeline in place to keep costs on track. “Failure to have a master timeline identifying when key steps for all aspects of a project must start, continue, and be wrapped up can have an adverse, domino effect on budget adequacy,” she notes. “This timeline must take into account reasonable contingencies not just on construction, but on all phases of start-up for reasonable confidence in the budget.”

MacKnight says it is always best to define the project scope upfront and make sure that it is adhered to. “When construction begins, avoid



change orders or project creep, which occurs as additional items are thought of after the start,” he adds. He notes that things can always be added later once the business is proven to be viable, vs. having all the “bells and whistles” upfront, “which burdens the project with costs that require additional volume for profitability,” he remarks.

Carrera further explains that these budget-draining changes have very real adverse effects. “Change orders, problems with decision making, anything that delays the project is going to be draining to the project,” he asserts. “Really hammering it home to the physicians that the less money we spend on ‘bells and whistles,’ the better project it is going to be. Make an effort to make them realize that the more cost conscious you can be in the project, the better a project it is going to be. By having those discussions early and often, and keeping that group involved through the entire process, you can stay on budget.

“You already have your line of credit, you’re operating off that line of credit, you’ve got your loans set up — there’s a window for when you have to start making payments for those things,” he points out, adding, “Again, it goes back to that feasibility study and having a really good dialogue with your investors.”

Corday offers a good example of this. “We have had the pleasure of working with physician groups who understood the benefits of gradually creating cohesion as a company, rather than as individual participants in a venture. They’ve taken on capital, timeline, and operating decisions through regular meetings, where discussion starts facilitated with defined information and contingencies. These projects weren’t free of changes or circumstances that appeared unlikely or were expected to occur differently, but, when assessed, they were amenable to solutions, rather than occasioning investors’ remorse and crippling conflict among participants.

“We’ve also seen projects where these steps weren’t addressed or where the interests of one participant increasingly dominated decisions, and investors and/or potential users have defected before construction started, while it was underway, or early in start-up. In these situations, groups who sought to economize on venture organization and start-up expertise pay a high price in interim interest costs, negative working capital needs, and turnaround services.”

Corday also points out that physicians who have the interest and existing or learned experience to be their own developers and project managers still confront time constraints imposed by their practices, and this can often cause expensive delays. She points out that a crucial portion of the timeline may be neglected and as a result, this lateness can cause long lags before an asset — such as a new building — can become an earning asset.

Viewing planning and overall coordination as a ‘soft cost’ that can be economized can be a costly mistake as well, she adds. “Most lenders gain comfort with a business plan and with proposed project manage-

ment when it’s associated with experienced developers who are guiding design of this venture to suit a particular community, and not imposing a cookie-cutter approach. Moreover, the fees for such expertise can be included as a financed project cost,” she adds.

Overprojecting income and volume and underprojecting expenses can be a result of a poor or inadequate feasibility study, which is an indication of a lack in forethought. Another aspect that can commonly be overlooked is that of competitive staffing costs, adds Pratt. “As the healthcare personnel shortage continues to increase, it is really important to budget the correct amount of dollars for staffing. You have to be sure you have competitive salaries and benefits to be able to attract — and mostly retain — a good staff.”

As MacKnight points out, in the beginning stages of an ASC venture, “no question is a dumb one to ask.”

“All issues should be reviewed so all aspects of a project can be discussed before entering the execution mode,” he adds. “It is much harder to change paths, both in time and money, once the project is under development.

While Corday agrees, she adds that continually questioning the viability of every aspect of the venture also will help to squeeze out any existing demons. “Addressing ongoing plan-

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— Justine Corday, *Physicians Health Resources*

ning needs is an essential and integral part of any project, but what is equally vital is approaching multiple, uncertain factors at key points aided by knowledge of how all start-up steps interrelate,” she shares.

“There’s no such thing as a reliable start-up manual suitable for all projects. Pick well-founded strategies, implement them diligently by executing sensible tactics timely, and frequently review to identify need for intervention or change. Question the process continually to prevent glitches or to facilitate resolution of the unforeseen.”

Above all, Pratt suggests ASC entrepreneurs should stick to their root cause for beginning the venture to begin with. “You can never talk about patient care or surgery unless you mention the word ‘quality.’ You can have a great business plan, you can build the facility, you can have all the equipment, but when it comes to the care, if you don’t have competent and helpful staff and your patients aren’t satisfied, then you’re not having quality outcomes,” she concludes. □