The last 20 years have yielded significant change in the delivery of ambulatory surgery and ambulatory care services. Many initial surgery centers struggled between 1972 and 1982 with challenges such as reimbursement, establishing themselves as perceived, high quality facilities and establishing the trend that a facility could be run on a profitable basis and still provide a good quality of care. These early pioneers laid a solid foundation for many of us who have been involved in the surgery center movement for the last 25 years. After 1982 and the approval of Medicare reimbursement for surgery centers came significant growth in the number of centers. This growth has occurred both in single specialty centers such as ophthalmology, plastic and gastroenterology centers as well as multi-speciality centers. Today there are well over 2,500 ambulatory surgery centers (ASCs) throughout the U.S. However, in the past three years there has been significant change in reimbursement, competition and in the delivery of ambulatory surgery services. These changes have had a profound effect on ASC operations, and will significantly impact the way that the facilities will be developed, built and operated in the future.

The purpose of this article is to highlight certain ambulatory care trends that are occurring within the U.S. and to note some of the solutions being developed to respond to these trends.

What we are seeing in healthcare is basically implementation of a regional mall concept, with smaller individual physician office practices being closed.

The first trend is that fewer free standing surgery centers are being built, and more centers are built within a larger facility that offers a wider array of ambulatory care services. Many health organizations such as large group practices, healthcare systems and some HMOs are developing multiple facilities within a 30 to 40 mile radius of their primary facilities. ASCs are being opened within such facilities. Such facilities help healthcare organizations solidify or gain market share. The trend of garnering market share continues to be a strong one in the U.S. Having a strong market share converts to a stronger position when negotiating with managed care payers. It certainly allows a facility to grow at a faster pace and secure its future in the increasingly competitive healthcare market. Those who do not gain a strong market share are experiencing either merger or acquisition and will certainly be faced with dwindling revenues in the near future. To avoid that trend, many health organizations have purchased individual physician practices. Many have paid too much for these practices. Many have too many locations, and the logistics to service all of the locations have become problematic. There are several solutions to this. The first is to develop more of a regional center that is still convenient for patients but at the same time allows providers to gain economies of scale in staffing, supply costs and group purchasing. Secondly, regionalized facilities provide one attractive location that can serve as a gathering place for all of the professionals. This results in more referrals between the professionals, as well as use of ancillary services that are now available due to the fact that there is critical mass within the facility to support them. There tends to be a more sophisticated group of ancillary services available in the regional facilities than can typically be economically supported in the individual physician’s office. Thirdly, consolidation of real estate for healthcare providers becomes a great incentive to sell off small, individual offices and consolidate providers into a smaller number of larger regional facilities. What we are seeing in healthcare is basically implementation of a regional mall concept, with smaller individual physician office practices being closed. This consolidation is being done while still keeping in mind the convenience factor for patients. This trend is certainly mitigated by specific market conditions, whereas in some areas this single office will remain due to its critical importance to servicing a particular community. However, in the future, this will be more an exception than the norm.
These regional centers create more visual presence and have a tendency to be more attractive to patients. They typically have an “architectural signature” that reminds the patient that the facility is affiliated with a particular healthcare organization. Many healthcare organizations try to develop four or five major sites within a community, depending upon the size of the market and the number of counties serviced. Our firm calls these facilities Big MACCs (Multiple-service Ambulatory Care Centers). Big MACCs typically have the critical mass to support multiple services such as ambulatory surgery centers. Following is a list of common services found in a Big MACC.

Most Big MACCs are located in secondary markets and are at least 20 to 30 minutes away from the host facility. They typically include a number of rotating offices for specialists as well as permanent offices for primary care physicians, including family practice, internal medicine, pediatrics, etc.

Due to the fact that many healthcare organizations are developing or purchasing multiple sites and ambulatory care is reimbursed less than hospital outpatient services, the sites need to be developed very efficiently, not oversized and must be planned for expansion in phases. It is critical to not overbuild or over-spec these facilities from an architectural standpoint. The facilities should not be over-equipped, either. If the facility is over-equipped, built too large or built to standards way above the norm and need for ambulatory care services, the fixed costs to be covered by the lesser amounts of ambulatory care reimbursement become prohibitive. These are highly specialized buildings that need to be developed in a very cost effective way and equipped similarly.

These Big MACCs are different than hospital facilities in that they require excellent traffic flow due to their ambulatory care nature, and a significant amount of parking space due to the large volume of in and out traffic which occurs within such facilities. The layout should be functional and efficient, with good design and nicely finished. There is nothing inconsistent about having a high quality, cost-effective facility and delivering good ambulatory care. In fact, the two are complimentary and necessary given the lower reimbursement which is experienced for ambulatory vs. hospital care. For that reason, many healthcare organizations are now turning to ambulatory care design/build and architectural firms that specialize in such buildings due to their proven expertise to deliver in a cost effective, functional and high quality, architecturally-designed manner.

The second trend is that of building smaller, single-speciality ASCs. Plastic, GI, eye and urology centers have exploded in number over the last several years. Physician practice management companies are also driving this. They want an ASC in their multi-speciality clinic. Many of the companies are building surgery centers within their medical clinics for the specialities as mentioned above, or are consolidating to form larger multi-speciality surgery centers. This trend is fueled by the growth needed by the physician management companies, which is mostly arising from ancillary service growth. In addition, as these companies develop more capitated rates for a variety of services, capturing the profits and controlling the costs from outpatient surgery will grow to be more important. Other areas they are investigating are birthing centers, diagnostic centers and other services that can be legally owned by the group under the group practice exemption of the Stark I and II regulations.

The third trend is that ASCs are being built “leaner and meaner.” Over the last three years, reimbursement for outpatient surgery has dropped by 25 percent. This is due to the HMOs, PPOs and other managed care players gaining larger discounts from ASCs. Medicare has had a freeze on rate increases in surgery centers over the last two years, as well. Lower reimbursement means that ASCs have to lower costs, and one way of doing so is to reduce initial capital costs such as building smaller, more efficient space or “refining” the space.

“Just in time” inventory reduces the bulk storage requirements of surgery centers, which has also tended to reduce some of the storage problems noted by many surgical nurses. The amount of storage space is simply not needed as it was three years ago, before implementation of this very cost effective management tool.

Operating room size is being revisited. Many architects are downsizing ORs or building one very large room for orthopaedics or other specialties that need a lot of equipment. Another concept is that of placing the table on an angle, using the deep corners of the room for additional storage space rather than positioning the table as parallel to the back wall. This innovative technique allows equipment to be stored in the room safely, but clearly out of the way of OR personnel, anesthesiologist and surgeon. Additionally, better anesthesia drugs are available that allow patients to be semi-awake while wheeled out of the OR. Since this aids in significantly increasing the output of the OR, ASCs require more recovery room spaces per facility. Also notable is the fact that many other procedures are performed in an outpatient surgery center that had previously been performed in a hospital. The mix of services
also has a great deal to do with the number of recovery room spaces necessary. When a lot of children are having ear tubes or tonsillectomies done, these cases are completed in a relatively short time within the OR and have the tendency to easily impact a recovery room in a short period of time. Likewise, if there is a heavy cataract or GI caseload on a particular day, these patients are cared for quickly in the procedure area and are then in the recovery room within a very short period of time. If a facility is planning for heavy caseloads in these specialties areas, it may need more recovery space than a normal surgery center. We are now encouraging our clients to develop four recovery spaces per OR.

In short, the nature of outpatient surgery has changed radically over the last three years and this is impacting the design of the centers. With reduced reimbursement, it is important that facilities not be built too small; however, they must be built much more efficiently than in the past. Construction, build out and equipment costs are heavy fixed costs. Though they are amortized over a long period of time, they form a large amount of money that needs to be paid each month and raised as start-up capital. If these costs can be controlled properly and appropriately on the front end, it helps insure the success of the surgery center and financial return to the owners.

The fourth trend is that birthing centers are becoming more popular on a free-standing basis. There is an increasing trend to develop labor delivery rooms with postpartum rooms located next to surgery centers, particularly in Big MACCs. Prenatal screening is performed in a birthing center now much more than ever before, significantly reducing the risk of problems for the mother during delivery. There is an accreditation association for birthing centers with formal criteria for such facilities. A great deal has been done to help standardize and raise the level of service and design related to such facilities. Typically, such facilities are developed with three or four 72-hour beds. These allow the patient to stay if it is necessary or appropriate for the mother’s physical well-being. The ORs of the surgery center can be used in case of severe emergency. The ASC can serve as a backup for this particular service when they are both found in a multi-service Ambulatory Care Center.

The fifth trend is that of developing Big MACCs as replacement hospitals. In the past, in rural areas, a large number of small facilities were built that currently cannot be converted to meet fire safety code requirements. There is a trend to convert these older set-ups into nursing homes or assisted living facilities. In addition, there is a trend to build a new facility that has primarily an ambulatory care focus, but with some 72-hour observation and recovery beds available. Typical services include urgent care and extended hours, or a full-blown emergency department, CT and other diagnostic X-ray services, mammography, ultrasound, a phase I laboratory, a surgery center, four to six medical observation 72-hour beds and a birthing center with postpartum backup (using the 72-hour beds). Typically, these facilities also feature permanent offices for Primary Care Physicians, time share space for specialists, EKG stress testing and cardiac diagnostic areas, a small pharmacy, an optical area for refractions and glasses, dental space and often some type of physical therapy, wellness or cardiac rehab area in the building. Geriatric psych programs, behavioral programs for clinical depression and alcohol and substance abuse are also popular services to include in such facilities. The services are very market-specific. They depend upon the distance between the main provider’s facility and the location, population and physician demographics of the area, as well as competition in the area.

A greater number of healthcare organizations are refining their market assessment to understand which ambulatory services are feasible and necessary to deliver to these specific market areas. Population demographics, physician demographics and utilization for outpatient services are typically analyzed by healthcare organizations to develop specific plans to service the medical needs of these secondary markets. Location is critical for these facilities. The traffic count must be in the 60,000 to 80,000 range per day, and the location must be easily accessible to interstates and other major thoroughfares within the area. New ambulatory care facilities basically house “retail” healthcare services. They have many of the attributes of a mall. In fact, many of them are located next to a mall, a Wendy’s, McDonalds or other fast food restaurants that have significant traffic. Such market assessment and good financial projections are critical before developing Big MACCs on campus or in secondary markets. It is imperative to know which services in a given market area have the best chance of succeeding, and what is the expected economic return for the services if established.

A greater number of healthcare organizations are refining their market assessment to understand which ambulatory services are feasible and necessary to deliver to specific market areas.
of procedure and profit and loss statements are essential for proper planning. This is particularly true for surgery centers being developed off of the campus of the main hospital. Surgery centers are typically not a primary care service or one that flourishes in a satellite clinic. Unless there is a significant critical mass of surgeons, the surgery center is not a good service to put into a satellite clinic. However, if there are significant number of rotating specialists, and the Primary Care Physicians are properly trained to do appropriate gastroenterology procedures (that are typically done by a GI physician), and there are existing surgeons in the secondary market that will now utilize the surgery center if one is available, the surgery center may in fact be feasible. It is imperative that an accurate case count be performed and projected before developing a surgery center in such a facility. Many other ambulatory care services leave similar specific requirements that need to be met for them to be financially successful.

Good experience in development, joint venturing and managing facilities is required by the individual performing such projections. Surgery centers and many other ambulatory care services are very volume sensitive. It is imperative that projections be done accurately and are operationally sound. For that reason, it is good to include an advisor who has experience in operating these facilities and the management thereof to review or prepare the projections to assure that the cases are not overstated nor the expenses understated. Planning such ambulatory care facilities also requires those who have had extensive experience in the development of newer model, cost effective facilities. Significant cost savings in land, construction, design and equipment costs can be gained by using such a firm for planning and design/build functions. Many of the same recommendations apply for the planning and development of birthing centers. Participation by key obstetric care givers is also essential. Use of specialized design/build firms or architects that specialize in ambulatory care facilities is a growing response to the trends in specialized surgery/ambulatory care services and “leaner and meaner” facilities. Many of these firms are spending significant internal time and resources to further refine their ambulatory care facility space programs, patient flow pattern, clinical spaces, building specifications and building costs.

In summary, there has been a significant amount of change in the healthcare landscape over the last three years that particularly impacts Ambulatory Surgery and Ambulatory Care services and facilities in feasibility, development, construction, design and operations. Healthcare organizations are moving quickly to capture the ambulatory care market share within secondary markets surrounding their facilities. It is imperative that they do so in order to sustain strong future growth, and continue to obtain key managed care contracts that are important in the future. However, as they do so, they must implement their plans, keeping in mind the new trends within the ambulatory care field in order to successfully implement such strategies.

Robert Zasa is a Principal in Woodrum/Ambulatory Systems Development, LLC, ambulatory business developers who have consulted, owned and managed ASCs throughout the U.S. for over 20 years with offices in Los Angeles, Chicago and Dallas. He can be reached at bzasa@woodrumasd.com.