There are a number of reasons why an ambulatory surgery center (ASC) might want to benchmark—physician owners want to know if revenue is on target, you think you need more staffing, or your accreditation survey is coming up. You want to know where you stand, and someone suggests signing up for a benchmarking program.

Before jumping in, you need a good understanding of what benchmarking can do and can’t do for your ASC. You need to know the benefits and limitations so you know you are being compared appropriately.

Independent ambulatory surgery centers (ASCs) are small businesses that need a basis for comparison, and benchmarking is a good way to achieve that, says Susan Kizirian, RN, MBA, director of the Southeastern Surgery Center in Tallahassee, Fla.

Benchmarking can provide guideposts for budgeting and forecasting. For example, the Ambulatory Surgery Performance Survey by the Medical Group Management Association (MGMA), conducted in collaboration with the American Association of Ambulatory Surgery Centers (AAASC), has data on measures such as revenue per case and total operating cost per case.

The Federated Ambulatory Surgery Association (FASA) provides benchmarking to its members on financial as well as clinical indicators.

Learning from others

Probably the most important benefit—and best reason to benchmark—is to learn from others so you can improve.

“If you’re benchmarking just because of accreditation standards, you’re not getting out of it all that you could. The reason to benchmark is to find out who’s doing things differently and getting better results,” comments Jennifer Green of Surgical Outcomes Information Exchange (SOIX), a not-for-profit organization that provides benchmarking for ASCs.

Benchmarking can also help with insurance contracting, particularly if your ASC does especially well on measures such as complication rates or efficient patient flow.

Another benefit is to build stronger working relationships within the ASC.

“Like QI, benchmarking can be a teambuilding activity,” says Naomi Kuznets, PhD, director of the Accreditation Association for Ambulatory Healthcare’s Institute for Quality Improvement (AAAHC-IQI), a nonprofit organization that provides clinical benchmarking for ASC procedures. Comparing your center’s performance with others injects a spirit of competition that motivates people to work together.

Benchmarking can also be a manager’s ally. Perhaps you have started reporting to a new boss who is not from the ASC industry, and you need to provide information on the median days in accounts receivable and other business measures. Or a new investor has signed on, and you want to educate that person about ambulatory surgery.

There may be the need to counter what Kizirian calls “fish stories,” tales about how much money someone has made investing in another ASC or how low someone else’s supply costs are. Benchmarking can give you a factual basis for responding to anecdotes.

Of course, benchmarking and quality improvement are also accreditation requirements of AAAHC and the Joint Commission on Accreditation of Healthcare Organizations.

What to look for

Independent ASCs have several benchmarking programs to choose from (side-
Corporate-owned centers usually participate in their company’s own program. Some consultants and management companies also have their own benchmarks.

Criteria to consider in assessing a benchmarking program:

1. **Will the program protect your facility’s confidentiality?**
   
   A benchmarking organization should be able to assure you that only aggregate results will be reported, and individual participants’ identities will be protected.

2. **Are facilities participating similar to yours in size and patient population?**
   
   “There are organizations that will give you broad-brush measures,” says Kuznets. But that may not provide an accurate comparison. Comparing multispecialty centers to single-specialty centers, for example, may not be useful.
   
   “If you are looking at turnover time for knee arthroscopy in a multispecialty center, results will be different than in an orthopedic center,” she notes.
   
   AAAHC is developing some nonclinical measures such as staffing costs. The aim is to break these down by the type of procedure, specifically by CPT code.
   
   “If you are looking at staffing costs, you don’t want to compare cataract procedures with knee arthroscopy or colonoscopy,” she notes, because these procedures may be staffed differently.
   
   The AAAHC IQI studies have focused on the top 3 ASC procedures—cataract removal, arthroscopy, and colonoscopy—because most facilities have enough data on those to be able to participate in benchmarking. SOIX provides benchmarking in 35 procedural categories and is launching facility-level benchmarking.

3. **Does the program focus on topics that are relevant to you?**
   
   Are you looking for clinical measures, financial measures, or both? Which programs focus on topics that are in line with your improvement objectives? Kizirian described how some centers have used information from the MGMA report (sidebar).

4. **Is the data relatively easy to obtain?**
   
   How much time will it take to collect information for benchmarking? Will you have to go back to patient charts to collect data, or will the study be prospective? Will you be able to obtain the financial data from your accounting system and standard reports?
   
   The MGMA benchmarking questionnaire requires financial data and other statistics on performance. Though the association believes the questionnaire is straightforward, some ASCs say they have found it time-consuming to complete. In all, 120 facilities out of 1,138 returned the questionnaire for the latest report, for a return rate of 9.5%, which MGMA is trying to improve. Kizirian notes that MGMA has been working to simplify the survey tool. She has given presentations at national meetings to coach ASCs on how to organize their information for the survey instrument.

5. **Will the organization provide a sample report you can look at?**
   
   Is the information reported in a way that will be useful to you? Ask for a sample report to see whether the information would assist your center in making changes.

6. **Do the reports include information about best performers?**
   
   Learning from best performers about how they achieved their results is one of the chief benefits of benchmarking. AAAHC IQI includes information from best performers in its reports. SOIX facilitates networking among its members so they can learn, for example, how a best-performing center achieved its outcomes for pain management after arthroscopy.

**Fear factors**

Managers may feel their anxiety levels rising when the subject of benchmarking is raised. What if the center’s performance isn’t in line with others? Will they be held accountable?

Kuznets cautions against using benchmarking results for accountability because most studies aren’t large enough to provide statistical power. Instead, the focus
should be on quality improvement.

Kizirian recommends that managers prepare by understanding how the benchmarking study is conducted and what the results mean. For example, she is director of a urology center, and only 3 urology centers participated in the current MGMA report.

“The data for the urology centers is so skewed that it is not useful for me,” she says. If her center’s board members asked about the data, she would explain that not enough urology centers participated for it to be meaningful.

“Eventually, more urology centers will participate, and the data will be more useful to me,” she says.

She does find the MGMA survey helpful for aggregate numbers, such as staffing levels per OR or accounts receivable data per 1,000 cases.

**A benchmarking conundrum**

A dilemma in benchmarking is balancing the need for detailed data with the limited time and resources ASCs have for filling out questionnaires.

“Regardless of how you do it, performance measurement takes time,” says Green. “Some centers have made performance measurement part of their day-to-day activities with regular feedback to the staff” to see if the center’s performance stacks up with others’. For example, your revenues may be up and complication rates down. But you might find your recovery time is longer than others’, and you may still find room for improvement.

Participating in benchmarking creates a conundrum, Kizirian notes: The more detailed the data a report requires, the more useful a report can be. To achieve that level of detail, participants must be willing to collect the information. But the more data they must look up, the less likely they are to want to participate—and the less valid the results.

One barrier is the variation in ASCs’ accounting systems.

“The most common obstacle is that people don’t collect their financial data in such a way that they can report it easily on our survey,” Kizirian says.

She is helping to address this in presentations at AAASC and MGMA meetings.

If your center plans to participate in benchmarking, the best advice is to look at the program in depth so you understand how you will be compared and how you can be prepared to understand and explain the results.

It’s also helpful if you accept a QI philosophy, seeing benchmarking as one piece in the continuing effort to improve your center’s performance. ❖

AAAHC IQI has a new publication to guide ASCs in quality improvement and benchmarking at the basic, intermediate, or expert level. **Quality Improvement and Benchmarking: A Workbook of Strategies and Tools for Success** can be ordered by phoning 847/853-6079 or visiting www.aaahciqi.org. Price is $85.
Benchmarking success stories

How 3 ASCs used benchmarking results:

**Support for more nursing staff**

The nurse manager of an independent multispecialty ASC with 4 ORs performing 6,000 cases a year was having difficulty staffing the ORs during vacations and providing lunch relief. Turnover time was slowing on busy days. Surgeon satisfaction was dropping, and morale was sinking. Younger Gen X and Y employees wanted a more balanced life, with more time off and less overtime.

Using data from a benchmarking report, she showed the center’s board that the center’s staffing was below the median by 2.5 FTEs for the size and type of facility. The board agreed to increase staffing.

**How many staff for the business office?**

An ASC administrator hired a new business manager from another setting who wanted to hire more employees for the business office because that is what she was used to. He showed her the benchmarking report, which showed the center actually was staffed at the 75th percentile for centers of its same surgical volume. The business manager agreed to make adjustments.

**Getting real on revenue**

The administrator of a large multispecialty ASC was being held to unrealistic goals for gross revenue and net profit by the center’s governing board. He was restricted in the new surgeons he could recruit to bring in more revenue. The administrator showed the board a benchmarking report showing that the center’s gross revenue was at the 75th percentile, net income was at the 90th percentile, and operating costs were below the median. The board accepted the findings and reset the goals to more realistic levels.

*Source: Susan Kizirian, RN, MBA, interviewed on use of the Medical Group Management Association’s Ambulatory Surgery Center Performance Survey.*

Benchmarking programs

The following programs provide benchmarking for ambulatory surgery centers.

**Accreditation Association for Ambulatory Health Care.**

Institute for Quality Improvement

Clinical benchmarking studies for surgery centers include cataract extraction and lens insertion, colonoscopy, knee arthroscopy, and liposuction. Studies are open to all ambulatory care organizations, whether AAAHC accredited or not. 847/853-6079. www.aaahciqi.org

**Federated Ambulatory Surgery Association**

The Outcome Monitoring Project is a free quarterly benchmarking study for FASA members. Studies include staffing, financial, and procedural indicators as well as patient satisfaction. Breakdowns for multispecialty and single-specialty facilities. 703/836-8808. www.fasa.org

**Medical Group Management Association**


Survey conducted in collaboration with the American Association of Ambulatory Surgery Centers. Information on staffing, accounts receivable, clinical facility, charges, revenue, and expenses. Participants include MGMA and AAASC
members.
877/275-6462. www.mgma.com

OR Benchmarks
A service of OR Manager, Inc. Surgical procedure studies look at direct costs for supplies, anesthesia, and labor and procedure and turnover times. Also conducts surgeon satisfaction surveys.
800/442-9918.
www.orbenchmarks.com

Surgical Outcomes Information Exchange
Benchmarking studies for ASCs compare information on 10 quality indicators for 35 procedural categories. Indicators range from complication rates to overall patient satisfaction. Membership includes networking with best performers.
877/602-0156. www.soix.com