



Ambulatory Surgery Centers

Financial benchmarking for your ASC

How many staff members should we have per case? Are our supply costs per case on target? How many employees do we need in our business office? Ambulatory surgery center (ASC) managers looking for answers can turn to financial benchmarking reports.

Benchmarking can be useful in seeing how your ASC measures up to peers. It can also be a catalyst that leads you to dig deeper.

"Benchmarking is a way to start a dialog," says Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers (AAASC). "Intuitively, you may know you want to improve in an area. A benchmarking report gives you a way to open the conversation."

Reports are available from ASC associations and private companies (sidebar). Other sources may include state ambulatory surgery associations and surgery center management companies. Don't overlook informal benchmarking—calling 4 or 5 peers can give you an idea of where you stand.

A basic point: If you're planning to submit data to a benchmarking study, seek assurances that your identity will be kept confidential and your ASC-specific data isn't shared with another company. Data should only be reported in the aggregate, advises Beverly Kirchner, RN, BSN, CNOR, CASC, President of Genesee Associates, Dallas.

Here's advice from experts on being a savvy benchmarker.

Know your center

"The most important thing is to know who you are. That way you can find the statistical set that is the most appropriate for you," says David Schlactus, MBA, CMPE, CEO of the Willamette Orthopedic Group and Willamette Surgery Center, Willamette, Ore. "If 97% of your cases are in ophthalmology and 3% are in GI, you're not really a multispecialty center." See if the benchmarking study you're using breaks information into categories that are useful to you.

He uses the benchmarking report from the Medical Group Management Association (MGMA) and AAASC (sidebar, p 29). (This relationship has ended with the latest report, issued in November. AAASC announced it will partner with InforMed Healthcare Media of Dallas for its next financial benchmarking report.)

Avoid the pitfall of thinking your ASC is unique so benchmarking can't be helpful.

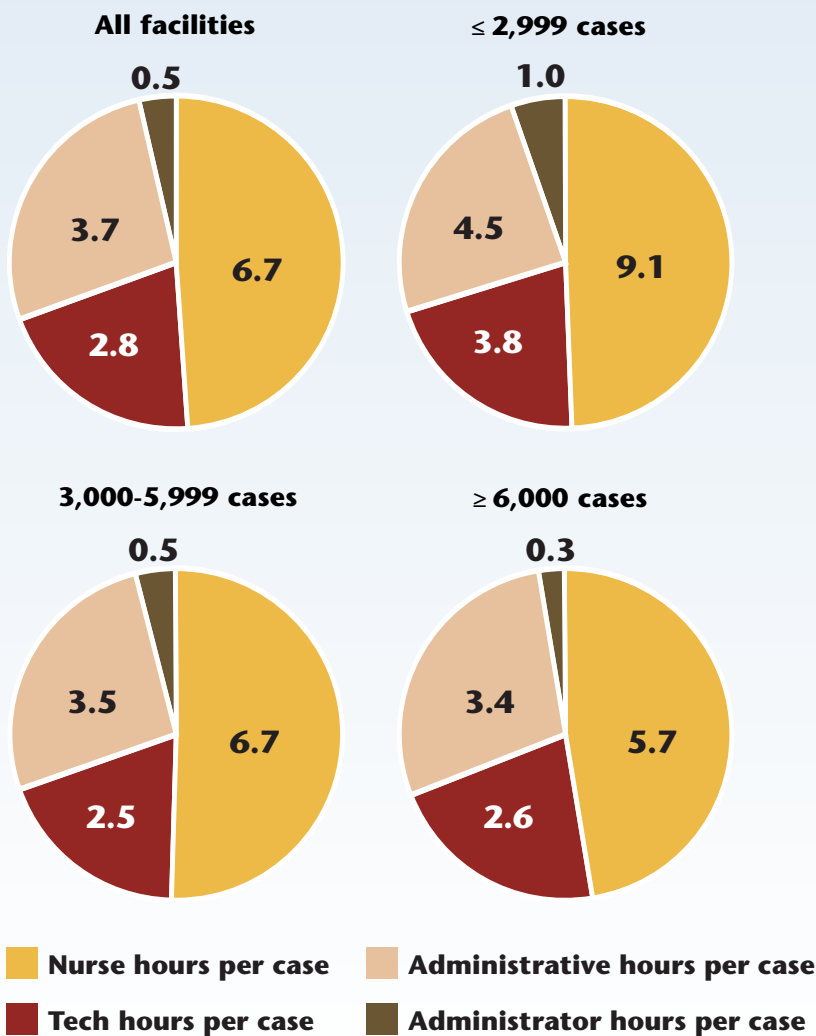
"There is some truth to that—we all have some differences," says Schlactus. "The comparison is never perfect, but we can identify a range." For example, say you're in a single-specialty orthopedic center. In the 2005 MGMA/AAASC report based on 2004 data, the median number of staff per 1,000 cases is 3.9 for RNs and 1.1 for surgical technologists.

If you do 6,000 cases a year, and the benchmark median is 3.9 RNs per 1,000 cases, you should employ about 3.9×6 , or 23.4 RNs in your center. Or conversely, if you employ 32 RNs, and you do 6,000 cases a year, you are using 5.33 RNs per 1,000 cases.

"You also have to look at the big picture," Schlactus says. "If you use more RNs but fewer nursing assistants than the median, and your total nursing staff is within range, it's not as bad as it might seem." Of course, you will be paying 50% to 100%

Staff hours per case by case volume

	All facilities	≤ 2,999	3,000 - 5,999	≥ 6,000
Nurse hours per case	6.7	9.1	6.7	5.7
Tech hours per case	2.8	3.8	2.5	2.6
Administrative hours per case	3.7	4.5	3.5	3.4
Administrator hours per case	0.5	1.0	0.5	0.3
Total hours per case	14.2	18.4	13.1	12.4



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more for RNs, so your salary budget will be high even though the staffing numbers may be within range.

Know how you're being compared

Gain an understanding of how the benchmarking data you're using was collected and analyzed. Kirchner suggested some aspects to look at:

- **Demographics.** Seek to be compared to ASCs in your same region or state performing the same number of cases with approximately the same mix of specialties and payers. If your center is in California and performs 1,000 cases a month, you don't want to be compared to a center in Indiana that performs 500 a month. Similarly, if you're a GI endoscopy center, you will want to be compared to other GI centers, not multispecialty ASCs.
- **Size of sample.** Consider how many centers the report represents. Are there enough so each category has a reasonable number of centers represented?

It may be best to look at several groups of centers, suggests Chad Coben of InforMed, which issued its first ASC benchmarking report this year.

For example, Coben suggested, a 2-OR facility in Arkansas performing about 3,000 cases annually might not only compare itself to the overall statistics but also to subgroups by region, number of ORs, and number of cases. That provides a better overview than looking at one group alone, he says.

- **Methodology.** Look at how the benchmarking information is collected. Does the report use a questionnaire or some other approach? The InforMed report is compiled by analyzing financial and operational information ASCs submit rather than ASCs filling out a questionnaire.

There is a tradeoff in using a questionnaire—the more detailed the questionnaire, the more specific the report can be. But a detailed questionnaire may also lower the return rate. So the report may have specific information on a relatively small number of ASCs.

- **Definitions.** Understand definitions the report uses. For example, the MGMA/AAASC report breaks down data by case and by procedure. A case is defined as one patient on a given day and may include multiple procedures. A procedure corresponds to a CPT code. For example, a podiatry case might include operations on the third, fourth, and fifth toes, or 3 procedures.

Also ask: Are the data elements clear, or could you interpret them in different ways? Would you understand what was being requested if you were supplying the data? If not, participants probably didn't either, and the data submitted may not be accurate.

Decide how to use the information

Set a goal for how you will use benchmarking information. Kirchner says she uses it for 2 purposes:

- to see how the ASC is generally compared with others—is it better, worse, or on target?
- to help in developing next year's budget.

"It gives me some idea how to set my goals. For instance, if I'm on the high end of a benchmark for cost per case, I know I have room for improvement. As I build my business plan and budget for next year, I try to align it as best I can with the median benchmark number," she says.

Kirchner says she is working with an ASC that is about 20% above MGMA's highest amount for cost per case.

"We can set goals to bring them down to where they need to be in a reasonable length of time," she says.

Dig deeper

Benchmarking reports are a jumping-off place—not a rigid measure of what your numbers should be.

"Benchmarking is a tool," says Coben. "The more you understand, the more you have the ability to make changes appropriately."

Multispecialty ASCs

Staffing (per 1,000 cases)

	10th %tile	25th %tile	Median	75th %tile	90th %tile
Total clinical support staff	2.94	3.57	4.35	5.53	6.30
Registered nurses	1.85	2.37	2.81	3.58	4.44
Licensed practical nurses	0.14	0.19	0.38	0.71	0.98
Operating room techs	0.30	0.54	0.76	1.14	1.47
Ancillary services techs	0.07	0.20	0.32	0.54	0.68

Note: Case equals one patient on a given day.

Source: Excerpted from table 2.7a. Ambulatory Surgery Center Performance Survey. 2005 Report based on 2004 Data. Medical Group Management Association. Conducted in collaboration with the American Association of Ambulatory Surgery Centers. Denver, MGMA, 2005.

Things to keep in mind when using benchmarking information:

- **Benchmarking is not a blame game.** If your numbers are out of line, it doesn't necessarily mean someone's at fault. It's an opportunity to identify what might be going on. There may be valid reasons why your center varies from the benchmark. On the other hand, you may need to make some changes. Perhaps a surgeon is using expensive supplies without being aware of the cost. Or maybe a large part of your payer mix is Medicare, resulting in lower revenue per case. You may want to look at increasing the mix of commercial payers.
- **Focus on the forest, not the trees.** "The biggest mistake people make with benchmarking is to get lost in the minutiae," says Coben.

An ASC's biggest costs are for staffing and supplies. Concentrating on those areas is likely to give you the greatest benefit.

If your supply cost per case is over the median, for example, you might want to conduct a small study to see why. Set up a spreadsheet for several of your high-volume procedures. For those procedures, record the supply costs for Surgeons A, B, C, and D. Share the report with the surgeons (with names omitted).

Those who have higher costs may be surprised and agree to help bring their costs down. Be sure to continue monitoring so costs don't creep back up.

Similarly, if the number of staff per case is higher than the median, dig in and ask why.

Schlactus found his center seemed to be significantly overstaffed compared to peers in the MGMA/AAASC report.

"Then we looked further and found we were grouped with ophthalmology and GI centers," he says. When he compared his center with other orthopedic ASCs, he found it was not significantly overstaffed.

But he wanted to know more. He called peers in the area to see what their staffing patterns were. He also got in the car and visited other centers.

"We found some of our inefficiencies were due to our construction—we're located in an old sorority house," he says. "We learned a lot. We were able to identify more specific targets to aim for."

Eventually, the center achieved leaner staffing through attrition.

"Benchmarking is not an end, it's a beginning," says Schlactus. "The whole process is to cause you to say, 'Hmmm, what's going on here?' and rethink your operations." ❖

ASC benchmarking resources

Ambulatory Surgery Centers Financial & Operational Benchmarking Study 2006.

InforMed Healthcare Media, Dallas

Published for the first time this year, the study analyzes over 250 freestanding multispecialty ASCs. The report was developed using financial and operational data from the centers participating in the study. Covers case mix, payer mix, revenue per case, staffing, operating expense, and margin analysis.

www.informedllc.com

214/866-0103, ext 402.

Price: Print: \$1,495 (\$495 for participants). Electronic: \$400 (all).

Ambulatory Surgery Center Performance Survey. 2006 Report based on 2005 Data.

Medical Group Management Association in collaboration with American Association of Ambulatory Surgery Centers

Based on a survey of ambulatory surgery centers. Includes single-specialty and multi-specialty ASCs. Has information on charges, accounts receivable, payer mix, staffing, and operating costs.

www.mgma.com

877/275-6462, ext 895.

Item no. 6630.

Price: \$220 MGMA members; \$380 nonmembers.

ASC Financial Benchmarking Survey 2006.

FASA Inc

Responses from ASCs nationwide on financial data such as medical supply expenditures, utility costs, accounts receivable outstanding, and claims denial. Single-specialty GI, orthopedic, and ophthalmic data available for some indicators.

www.fasa.org

703/836-8808.

Price: \$395 members; \$495 nonmembers.