**ASC Best Business Practices**

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**OVERVIEW**

Although day-to-day operations often demand immediate attention, ASC leaders cannot ignore standard best business practices to sustain long term goals. Standard models for business best practices are often designed to address hospital settings but can be applied easily to ASC settings when the underlying principles are understood. In addition to meeting cost and efficiency demands, ASC administrators should have a big-picture perspective of their environment. A combination of strategic models may be incorporated as part of the ASC’s defined best business practices. When leaders prioritize continual reviews of their facility’s practices and commit to incremental improvements based on those reviews, they will achieve successful outcomes.

**OBJECTIVES**

1. Discuss two challenges that ASC administrators typically encounter.

2. Summarize standard models used for best business practices in healthcare organizations.

3. Describe how standard models for best business practices can be applied to ASC settings.

**INTRODUCTION**

Ambulatory surgery center (ASC) administrators have many different responsibilities, often shifting between multiple roles in the same day. Meeting cost and efficiency demands are critical parts of each administrator’s role.1 ASC administrators should have a big-picture perspective of their environment by understanding their ownership model, the way their board governs, future strategic plans, and available support services.1

***ASC Ownership-Model Overview***

Outpatient surgery continues to expand and grow. In 2019, the industry was growing at approximately 5% annually and estimated to be over $30 billion and growing. It is a fragmented industry with various ASC ownership models.

The five largest ASC management companies only own about 15% of all US ASCs. Hospital-owned ASC ownerships are on the rise. These scenarios typically place physicians in co-management roles.2 Hospitals often include ASC ownership as part of a strategic plan to offer efficient alternative care delivery settings. ASC administrators in this business model are often part of the management structure with the full hospital resources behind them.1

Most ASCs are at least partially physician-owned, often as joint ventures with management companies or hospitals. Joint ventures between ASC management companies, hospital systems, and physicians, or a combination thereof, may provide a better balance of physician influence and management expertise.2 Hospitals often partner with management companies to have access to their freestanding facility operational expertise. Joint ventures offer administrators multiple resources (i.e., government regulation and reimbursement information), regardless of which partners are involved.1

Of the 6,000 Medicare-licensed ASCs in the US in 2021, 60% are fully physician-owned.3 This ownership model has its benefit of maximum control. However, contracting and management challenges may be an issue.2 Single surgeon/sole proprietor ownership is the least common type of ownership model in the ASC market. This model may have difficulties with payer negotiations and requires an administrator who is capable of ensuring the business is successful.1

As key players seek the right combination to maximize clinical success and efficiency, ASCs and alternative business models will continue to grow.2

***What Differentiates ASCs from Other Healthcare Settings?***

Outpatient surgeries have clinical advantages and operational advantages. ASC efficiencies lead to greater productivity and may lead to lower costs, a significant effect on all relevant stakeholders. ASCs allow the healthcare industry to decrease spending without sacrificing quality of care, and patients to benefit.2

ASCs have greater autonomy than hospitals, and therefore greater capacity to determine which procedures they perform, what administrative and clinical processes will be used, and who their patients are. Autonomy leads to proportionately far less overhead for an ASC when compared to a hospital. Further benefits can come from specialization. With smaller sizes and less hierarchy than hospitals, ASCs can have more consistent management goals and better align manager and provider incentives.2 Because of autonomy, less hierarchy, and often collegial relationships in their culture, ASC administrators and staff often exhibit more innovative tendencies.

Limiting the scope of procedures through specialization allows ASCs the opportunity to increase efficiencies. When many surgical procedures can be performed in more efficient outpatient centers that provide quality care to patients, there is less reason to perform the same procedures in the inpatient setting.2

Patients, physicians, regulatory agencies, and insurers expect ASCs to keep up with the demand for high-quality, cost-effective healthcare. Patients are becoming more educated about their healthcare options.4 This positions ASCs to be a priority option for consumers from both the insurance and patient perspective.

**CHALLENGES IN ASC SETTINGS**

To provide high-quality, cost-effective healthcare, ASCs face multiple challenges from a business perspective, including declining physician engagement, reimbursement issues, and rising costs related to the surgical procedures (eg, supplies, equipment) and staffing. See Table 1 for examples related to these challenges.

**Table 1 – Examples of Challenges in ASC Settings**

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| --- | --- |
| **Challenge** | **Threat to the ASC** |
| Declining Physician Engagement | Without the ability to offer enough procedures, ASCs cannot survive. |
| Reimbursement Issues | The amount of reimbursement for procedures is limited by the Centers for Medicare & Medicaid Services (CMS) bundled payment model, often not even covering an ASC’s cost to provide patient care. |
| Rising Costs | Insurance reimbursements continue to decrease while supply and equipment costs continue to rise.  To attract quality staff members, ASCs must remain competitive with hospital salaries and benefits. |
| **Source**  Ubaldi K. Challenges facing the ambulatory surgery center market. *AORN J.* 2019. doi.org/10/1002/aorn.12656 | |

From an operations perspective, typical ASC challenges include

* succession planning for ASC leadership,
* staff recruitment and retention,
* infection prevention expertise,
* addressing patient safety priorities,
* identifying methods to measure performance improvement, and
* establishing effective procedure scheduling.

***Succession Plan for ASC Leadership***

Clinical leaders have traditionally not learned the skills required to manage an ASC. Outpatient surgery is more complex than just scheduling and performing a procedure outside a hospital setting. To progress into ASC management or administration, ASC clinical leaders are required to acquire skills that includes financial, regulatory, and legal knowledge, human resource experience, information technology expertise, supply chain insight, and marketing abilities. Historically, many clinical administrators have learned these roles and responsibilities on the job. To ensure ASC managers have achieved a grasp of business knowledge, the ASC may decide to require clinical managers who want to progress to administrators to get the Certified Ambulatory Surgery Center Credential (CASC) designation [[CASC - Ambulatory Surgery Center Association (ASCA) (ascassociation.org)](https://www.ascassociation.org/educationevents/casc)]. This designation includes topics such as patient care delivery, human resources, quality management, and knowledge of regulatory, legal, and financial issues. Webinars, ASC-specific conferences, AAAHC manuals, research articles, and establishing a network of peer experts are also valuable sources of information for administrators that can be available through affiliations with national associations such as the Association of periOperative Registered Nurses (AORN), the Ambulatory Surgery Center Association (ASCA).

***Staff Recruitment and Retention1***

ASCs must compete with hospitals for quality, experienced staff members. Experienced OR nurses are hard to find and when one is hired, retention is critical. Workplace culture, including surgeon relationships, respect given to staff members, and establishing a fun, innovative work environment, is important to ensure staff member satisfaction. When staffing an ASC, job descriptions should be realistic and refined to include multitasking and expectations that flexibility and frequent role shifts will be required. Tasks should be assigned to match the best staff members with the appropriate strengths, experience, and skill sets. Many tasks are time sensitive (ie, CMS certification, supply orders, accreditation) and should be assigned appropriately. Timelines should be established for each assigned task and role, progress should be tracked, and staff members should be held accountable.1 Establishing professional growth opportunities for staff is another important component for staff retention.

***Infection Prevention Expertise***

Infection prevention and control practices are crucial for workplace safety and to ensure the delivery of the highest-quality patient care. Accrediting and regulatory organizations like CMS place the highest priority on infection prevention standards. To demonstrate their understanding of the skills required to fill the role of an infection preventionist, licensed ASC healthcare professionals can earn a Certified Ambulatory Infection Preventionist (CAIP) credential. This certification focuses on five major content areas, including infection prevention strategies; education and training; infection control program development; surveillance, data collection, and analysis; and instrument cleaning, disinfection, and sterilization.7 Similar to establishing succession planning for ASC leaders, encouraging experienced clinical staff members to seek increasing levels of experience with infection prevention practices and working toward acquiring a CAIP can help to retain talented staff members.

***Patient Safety Priorities***

With the ability to specialize in the procedures they perform, ASCs have a better chance to concentrate on patient safety and the patient experience. Medical professionals in ASCs must follow very specific protocols and procedures to ensure excellent results for surgical patients.9 Credentialing, preventing Surgical Site Infections (SSIs), and providing adequate staffing are among the priorities to ensure patient safety.

**Credentialing**

In addition to building in professional credentials to document expertise in ASC business practices and infection prevention, it is critical to protect patients by having a reliable process for confirming clinical credentials for all professionals who are involved in ASC clinical procedures. Healthcare facilities must have appropriate physician and anesthesia professional credentialing processes to ensure providers maintain privileges to contribute to safe patient care. Procedures must also be in place to ensure revocation of privileges when necessary. Facilities should use the National Committee for Quality Assurance standards to determine their credentialing processes.10

**Preventing SSIs**

When compared to their hospital outpatient department counterparts, ASCs were found to have lower SSI rates. According to the *Journal of the American Medical Association* (*JAMA*), SSI rates range from 3.09 post-surgical care visits per 1,000 at 14 days post-op to 33.62 all-cause visits per 1,000 at 30 days. Closing the SSI rate gap requires standard metrics that track infection rates over time.8

To help close the gap, CMS developed a series of SSI measurements, and the mandatory ASC infection prevention and control program is detailed in their Conditions for Coverage. The Agency for Healthcare Research and Quality (AHRQ) developed the Comprehensive Unit-based Safety Program (CUSP), a proven method for reducing SSIs. Surgical safety checklists are also an important tool for SSI prevention. Data collection and monitoring should be prioritized. Standardizing as many processes as possible and implementing behaviors that mitigate surgical risk factors should be included in all staff education.8

Infection risk may be reduced, and patient care quality may be improved by monitoring compliance and deploying clinicians and consultants to observe infection prevention measures. The increase in ASC procedure volume and the growing complexity of approved ASC procedures intensifies the need for flawless infection control. It requires fostering a positive culture among surgical team members and tracking guidelines, regulations, and checklists.8

Formal infection prevention and control programs are critical components of broader efforts to ensure patient safety. 11 These programs help prevent healthcare associated infections in both patients and healthcare workers. Infection control programs should encompass all infection prevention patient safety areas, including tracking and responding to virulent and contagious pathogens (i.e., multidrug resistant organisms, influenza, *C. difficile*); providing relevant precautions (i.e., droplet, contact, airborne protection) and personal protective equipment; instituting prevention and surveillance of device-associated infections (i.e., urinary catheters, central lines, ventilators) and SSIs; implementing infectious exposure response; vaccinating healthcare workers; conducting proper infection prevention for cleaning disinfection, sterilization, and reprocessing; instituting environmental cleaning; monitoring compliance; mandatory reporting; and ensuring emergency and pandemic preparedness.11 Programs that include national surveillance systems, federal investments, transparency, and patient advocacy can lead to important gains in efforts to eliminate emerging and existing infection threats to patients and healthcare facilities. 11

**Adequate Staffing**12

The association between staffing ratios and patient safety has been the focus of the Patient Safety Network with documentation that the risk of patient safety events, morbidity, and mortality increases as patient to staff ratios increase. Nurse-to-patient ratios are only a piece of the nursing workload and patient safety relationship. Even when staffing was considered adequate, increased patient turnover has been associated with increased mortality risk. Adequate staffing is a complex process that changes on a shift-by-shift basis and requires close management and nursing coordination based on patient acuity and turnover, settings of care, and the availability of support staff and skill mix.

Working conditions also have an impact on patient safety. Staff members working longer shifts and overtime have been linked to increased error risks. Fatigue results in a decline in vigilance, poor judgement, inattention, and lack of concentration. Operational failures such as interruptions or equipment failures may also interfere with staff members’ ability to effectively perform necessary tasks. Studies have shown that interruptions have been tied to an increased risk of errors. While some interruptions are part of patient care, the link between interruptions and errors are an example of how daily work environment deficiencies are directly linked to patient safety. Staffing ratios, teamwork, personal accountability, practice environments, and transformational leadership each have relevance in ensuring patient safety.

***Measuring Performance Improvement***

Electronic healthcare records (EHR) were designed to improve the accuracy of patient information, support clinical decision-making, and improve information accessibility for continuity of patient care. However, according to a National Academy of Medicine report, nurses and doctors spend 50% of their workday treating a screen and not the patient. Screen use is often a common cause of healthcare worker burnout, thus affecting patient care.13 According to an AHRQ-funded study, hospitals using inadequate EHR technologies also have higher rates of nurse dissatisfaction, burnout, intent to leave, and have worsened patient outcomes and a higher likelihood of 30-day readmission. The study also indicated a previously undocumented association between EHR usability and an increased surgical patient mortality rate (21%), and significantly higher 30-day readmission odds.14

***Procedure Scheduling***15

Efficient use of space and staffing are important in this current climate of declining reimbursements and patient safety focus. A bottleneck in any phase of surgery, pre-, intra-, and postoperative, can result in long delays and staff member dissatisfaction. A priority scheduling algorithm based on bottleneck analysis may help solve the problems of long wait times and low medical resource utilization rates. These algorithms set up two graphs of medical service and resources and project them into a complex network model of medical resources factoring in characteristics such as betweenness, network efficiency, medical resource, and medical service characteristics to calculate the medical resource bottleneck. Bottleneck medical resources and medical services related to bottleneck resources are then determined based on the bottleneck analysis. Patient scheduling is then determined according to the bottleneck priority rules.

Inadequate scheduling affects the way nurses, physicians, and other practitioners provide patient care. Seventy percent of nursing managers worry about the impact that scheduling and staffing challenges have on the patient’s experience, and 94% agree that these issues negatively affect staff morale. Two common scheduling issues are understaffing and safe patient-staff ratios. A workforce management platform may help ASC administrators alleviate these patient safety issues.16

Having a patient-centric approach to scheduling and productivity may help administrators make the most of limited resources and ensure they deliver the highest quality care. This may require transitioning from a fixed budget to more flexible models centered around patient needs. Staffing levels should reflect that workloads fluctuate based on the number of patients and each patient’s needs. Variable budgets can be based on the number of patients or an individual patient workload and their required level of care.17

Productivity should be analyzed at every level of an organization and at the shortest possible time interval to capture patterns in fluctuations that might be significant. If productivity is only evaluated monthly, it may appear successful; however, evaluating and adjusting multiple times per shift may help ensure patients’ needs are met as they fluctuate throughout a shift while ensuring caregivers are not overworked. Accurately capturing patient demand, considering all its fluctuations over time between departments, shifts, and individual patients, is essential to patient-centric productivity. Missing possible inequities can lead to sub-optimal staffing and decreased staff satisfaction, patient care, and patient outcomes.17

**STANDARD MODELS FOR BEST BUSINESS PRACTICES IN HEALTHCARE ORGANIZATIONS**

Organizations use many different methods to attempt to improve performance, including mission statements, vision statements, goal setting, and strategic plans. To achieve their goals, organizations should practice continuous quality improvements that incorporate formalized best business practices focused on patient care, objective data, and processes. Best business practices are generally accepted, standardized techniques, methods or processes that have proven themselves over time.18 Standard models for business best practices are often designed to address hospital settings but can easily be applied to ASC settings when the underlying principles of these practices are understood.19

***Efficiency, Productivity, and Optimization***  
Healthcare administrators are continually faced with the challenge of reconciling the growing demand of healthcare services with available funds. Having a clear understanding of efficiency, productivity, and optimization can help to address ASC challenges.

**Efficiency** measures whether healthcare resources are being optimized. Efficiency is the relationship between resource inputs (i.e., labor, capital, or equipment costs) and either immediate outputs (i.e., number of patients treated, waiting times) or final health outcomes (i.e., lives saved, life years gained, quality of life adjusted years).20

**Healthcare productivity** is the ratio of outputs (i.e., quantity and quality of patient care) to inputs (i.e., staff, equipment, capital resources).21 ASC productivity (i.e., the number of surgical procedures performed in a given timeframe) is achieved by streamlining patient throughput (i.e., the elapsed time from patient arrival to discharge).22

**Optimization** is finding alternatives with the most cost effective or highest achievable performance under the given constraints by maximizing desired factors and minimizing undesired ones. Optimization methods can help improve the supply and distribution of healthcare providers to maximize service coverage, limit the number of facilities, minimize patient travel needs, and maximize health or access equality.23

***National Quality Strategy***

In 2011, the National Quality Strategy (NQS) was established to improve the delivery of healthcare services, patient health outcomes, and population health as a nationwide effort to improve health and healthcare across America. The NQS seeks to improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health; improve overall quality by making healthcare more patient-centered, reliable, accessible, and safe; and reduce the cost of quality healthcare for individuals, families, employers, and government.24 Table 2 summarizes the six priorities included in the NQS and provides examples of how they apply to ASC settings.

**Table 2 – National Quality Strategy Six Priorities**

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| --- | --- |
| **Priority** | **Application to ASC settings** |
| 1. Making care safer by reducing harm in the delivery of care. | ASCs can promote this priority by developing infection prevention programs and ensuring proper staffing and scheduling parameters. |
| 2. Ensuring that each person and family members are engaged as partners in their care | ASCs often incorporate preoperative and postoperative phone calls to help patients and families prepare for their surgery and to evaluate their pain status and progression in returning to diet and daily activities after discharge. |
| 3. Promoting effective communication and coordination of care. | ASCs often cross train staff to cover preoperative holding areas and post operative phases of care which helps to promote effective communication and coordination and breaks down potential barriers. |
| 4. Promoting the most effective preventative treatment practices for the leading causes of mortality, starting with cardiovascular disease. | One example may be implementing pulmonary embolism prevention programs or emergency preparedness. |
| 5. Working with communities to promote wide use of best practices to enable healthier living. | One example may be participating in health fairs, offering open houses to increase community awareness, or promoting healthy living and mobility education for patients through a wellness model rather than an illness model. |
| 6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models. | Based on the nature of their practice model, ASCs usually meet this priority, but may need to evaluate insurance contracts and cost cutting successes. ASCs can also ensure affordable care by making concentrated efforts to find ways to reduce waste and fraud. |
| **Source**  AHRQ. National Quality Strategy Overview. <https://www.ahrq.gov/sites/default/files/wysiwyg/NQS_overview_slides-2017.pdf>. January 2017. Accessed October 6, 2022. | |

***IHI Optimizing the Business Case for Safe Healthcare***

Similar to the National Quality Strategy, the Institute of Healthcare Improvement (IHI) Triple Aim was designed to improve the patient care experience, including quality and satisfaction, improve the health of populations, and reduce the per capita cost of healthcare.24 See Figures 1 and 2 for visuals that were developed to describe their initiatives.

**Figure 1 – Triple Aim Figure 2 – National Quality Strategy**

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Patients, physicians, regulatory agencies, and insurers expect ASCs to keep up with the demand for high-quality, cost-effective healthcare. Patients are becoming more educated about their healthcare options.4

Patient safety leaders can access tools like the IHI/National Patient Safety Foundation (NPSF) Patient Safety Coalition resource toolkit entitled “Optimizing a Business Case for Safe Health Care: an integrated approach to safety and finance.” 25 The toolkit emphasizes the value and return on investment for safer, quality care and focuses on three drivers for optimizing a patient safety focused business case, including25

* collaboration between safety and financial leaders; patients and other purchasers; and solution providers.
* strategic goals linked to the organizational mission, goals, and financial goals.
* data that incorporates safety and financial data, includes methods for looking at data in new ways, and ensures an organization uses the right data to tell the story they need to tell.

Figures 3 and 4 can be used by ASCs as a visual for adapting this structure to the ASC setting.

**Figure 3 Figure 4 - Complexity of Collaborators for**

Chart, diagram, bubble chart

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Description automatically generated**Hospital Setting can be Simplified to adapt**

**to ASC setting**

***Studer Program***26

The Studer program was designed for hospitals and healthcare organizations to offer a process template to help them attain their desired results. The program is based on pillars and principles that set the expectations and behaviors organizations can use to “create and sustain a culture of excellence where individuals choose to work and achieve at high levels.”27 The following pillars should be prioritized:

* **Quality.** Patient safety is at the forefront. An obstacle to meeting this pillar might be an inadequate EHR or a platform to track and measure important trends.
* **Service.** This includes retaining quality staff members and surgeons and maintaining a positive patient and family member perspective.
* **Financial.** Efficiency, productivity, and optimization techniques would fall under this pillar.
* **People.** Ensuring positive 3-way relationship perspectives with patients, staff members, and surgeons.
* **Growth.** Similar to the financial pillar, but also includes staff member coaching, development, and retention efforts.

As part of the overarching pillars, these nine Studer Model principles offer a roadmap an organization can use to develop a success-based culture using evidence and data. The nine principles are as follows:27

* **Commit to Excellence.**

Set high expectations to achieve results while living out mission and values like retaining quality staff members and surgeons.

* **Measure Important Things.**

Continuously track progress to achieve results with an improvement mindset, including innovative ways to track trends if an EHR system is unable to do so.

* **Build a Culture Around Service.**

Serve others with great care and concern. Healthcare facility culture is important not only for staff member and surgeon retention but also for patient satisfaction.

* **Develop Leaders to Develop People.**

Coach people to be their best at work. Professional development and quality education opportunities are key for staff member satisfaction and retention.

* **Focus on Employee Engagement.**

Attend to aspirations and desires in the workplace. Have the right people in the right positions and be mindful of their career goals.

* **Be Accountable.**

Commit to individual accountability to achieve organizational goals.

* **Align Behaviors with Goals and Values.**

Apply consistent practices to move the organization in a positive direction.

* **Communicate at All Levels.**

Ensure people understand why what they do matters.

* **Recognize and Reward Success.**

Value and appreciate people working together to get results.

Figures 6 and 7 include visuals that represent the Studer Model and how it is used in a clinical setting to make it come alive.

**Figure 6 – The Pillars of the Studer Model** **Figure 7 – Example of Using the Studer**

**Model in a Clinical Setting**

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**APPLYING STANDARD BUSINESS MODELS TO ASC SETTINGS**

Once an organization knows what the standard business models are, it’s important to find ways to apply them to their practice.

***Efficiencies***

The strategic goal to “Improve Efficiencies” directly relates to the NQS Priority 6, making quality care more affordable and seeking out new healthcare delivery models. However, efficiencies also can relate to NQS Priority 1 as new healthcare delivery models are identified, ASC administrators would need to ensure that they are still meeting the goal of making care safer and reducing harm

Based on the IHI Triple Aim, “Efficiencies” can be associated with reducing healthcare costs, but also can improve the patient experience depending on the initiatives that are being piloted or implemented. When looking at the three drivers identified in the IHI/NPSF Patient Safety Coalition resource toolkit, ASC leaders would need to link to the organization’s strategic financial goals, specify how and what data would need to be incorporated into the “efficiencies-focused” improvement project, and identify key safety and financial collaborators to build the business case for change.

Focusing on “Efficiencies” corresponds to the Financial pillar in the Studer Model, but also relates to the Service Pillar and the Quality Pillar.

**Application to ASC**

One example of an efficiency that may be beneficial to an ASC would be to focus on anesthesia services. Anesthesia is one of the costliest elements in healthcare delivery. Time-driven activity- based costing (TDABC) is a cost-accounting tool which uses resource consumption estimates to measure the cost of services and can be beneficial to help estimate anesthesia costs and identify the primary drivers of those costs. Staffing ratios between CRNAs and anesthesiologists may influence the cost of care. In a study of a head and neck center, TDABC estimated the cost of the 11 most performed outpatient oncologic surgical procedures. The objective of the study was to determine anesthesia costs for each outpatient oncologic procedure, define the distribution of those costs, and identify cost drivers. Personnel was defined as the predominant cost driver.28

It may also be beneficial for an ASC to access whether employed anesthesia providers or contracting outside anesthesia groups would be the best model for their facility. Employing anesthesia staff members may be practical if an ASC uses anesthesia often. Facility employment would allow an ASC to have qualified anesthesia staff members readily available without worrying about independent contractor schedules. ASCs who employ anesthesia care providers have an advantage in that they can avoid ongoing competition for what could be a scarce resource. However, employing anesthesia care providers also has its drawbacks including negotiating contracts, finding vacation coverage, and managing billing services. Overestimating how often anesthesia services are needed may lead to costly downtime of a salaried employee during periods of low volume.29

Outside anesthesia groups allow ASCs to have access to multiple providers and scheduling flexibility. However, this can present a challenge if an ASC handles emergent or urgent procedures that would need an on-site or on-call anesthesia team. Contracting with an outside group can also make an ASC more vulnerable to price increases if a region is experiencing anesthesia provider shortages. A relationship with an outside group can work well for a practice that rarely uses anesthesia but wants to have the option available.29

***Scheduling***

When applying the Studer Model, addressing scheduling challenges would relate to the pillar for Growth.

ASC executives and administrators may achieve advances in their center’s productivity and growth by accessing their scheduling processes and procedures as discussed in the following example.

**Application to ASC**

Using staff members properly is an important part of ASC efficiency and cost management. Every surgery center has a different patient volume and case mix; therefore, no exact staffing equation is possible. Staffing needs are generally based on the number and type of cases on a given day. Typical staffing plans consist of one scrub technician, one circulator, and one preoperative nurse for every scheduled OR. Post-anesthesia care unit staff members are typically scheduled based on the number of operating surgeons. Scheduling templates are generally built around individual surgeon’s typical incision start and end times. Cross-training employees helps fill various roles when needed and decreases the need to overstaff. This flexibility encourages teamwork, increases productivity, efficiency, and potentially adds to cost savings. To get the most out of staff member productivity, it may be necessary to ask staff members to perform additional tasks (i.e., make preoperative or postoperative patient calls, chart audits, prepare for upcoming cases, restock inventory) if there is downtime between procedures.

Other scheduling techniques such as block scheduling, starting room two before done in room one (i.e., 2 rooms, one surgeon), and subcontracting for certain days or portions of days may be beneficial business models to explore.

***Communication***

Communication is an important aspect of applying business best practices to an organization. Improving communication in the ASC setting can serve as an example of a project related to the People Pillar in the Studer Model. Good communication promotes efficiency in the continuum of care throughout the facility and therefore also relates to the Financial Pillar. Improving the continuum of care for patients also relates back to the Quality Pillar because effective handoff communication when transitioning a patient between phases of care can reduce the risk of errors.

**Application to ASC**

Timely, clear, and concise communication is important due to the diverse stakeholders involved in an ASC. It is important to have a good relationship with staff members, medical directors, owners, and the governing board.1 ASC leaders can observe for communication breakdowns or can ask staff members to participate in identifying areas for improvement. Surveying physician and anesthesia partners can also identify areas where communications could be improved. From an operations perspective, the surgeon preference cards are often a point of focus as they are a key in preparing adequately for the procedure to avoid delays.

**ADDRESSING POSSIBLE RESISTANCE**

Following established standard business models may seem like common sense to some administrators and staff members, however, to others it may not seem necessary, and leaders may be met with resistance. Following a standard business model is another example of an efficiency that can be achieved. As the old sayings go, why reinvent the wheel? Established models allow facilities to “work smarter, not harder”, in that facilities can spend less time in creation and development mode and more time in implementation mode which means the work is getting done more efficiently from the start.

In the 1960s, Edwin Locke introduced the theory that goal setting can motivate employees and lead to better workplace performance. Since that time, most organizations have made working toward clear and measurable objectives part of their strategic plans. Given the speed of constantly evolving employee expectations, realizing the full value of organizational goals is rarely cut and dry. Failure to regularly check in on strategic goals can lead to collective amnesia, and without a clear roadmap and established best practices in place, employees can become frustrated.31

Employees often claim to have little knowledge or understanding of their organization’s strategic plans. Even in high-performing organizations with clearly articulated strategies, only 29% of their employees knew what the strategic plan was. Strategic plans are often communicated to employees as a set of aspirations or good sounding platitudes; however, grand claims don’t provide the specific guidance employees need to feel confident in their organization’s direction.32 Applying established business models may help with this much needed communication, and in turn, increase employee morale and buy-in.

The May 2022 Harvard Business Review survey results indicate that survey respondents viewed goal fulfillment as central to business success, with 41% of respondents stating strategic goals were extremely critical and only 1% saying they weren’t critical at all. However, when asked which challenges organizations faced putting strategic goals into practice, the following results were reported:31

* 49% of respondents indicated that there wasn’t enough time or resources to work toward the goals as other work takes priority;
* 40% indicated the strategic goals roadmap wasn’t very clear or organized;
* 39% stated there were differing/conflicting goals for different areas of the organization;
* 36% shared concerns for the difficulty of embedding goals deeply into the company culture, difficulty; communicating/promoting goals effectively throughout the organization, and difficulty obtaining hard metrics that measured progress toward the goals;
* 31% indicated difficulty motivating employees to champion the strategic goals;
* 27% indicated leadership put little effort into checking in on/reassessing the strategic goals; and
* only 4% indicated no challenges putting strategic goals into practice.31

These results should be revelatory to administrative leaders, especially if they are deciding if they should use standard business models or if they are looking for ways to sustain long-term organizational goals and ensure employees are on board with strategic plans. ASC leaders should commit to an established business model, make it their own, clearly communicate the plan, ensure continuity across the organization, and find ways to motivate, promote, measure, and reassess the goals as needed.

**SUMMARY**

ASC administrators should anticipate ongoing growth as the ASC market continues to expand.1 Improving efficiencies are critical to the economic viability of an ASC. Providing resourceful solutions to common leadership challenges requires leaders to do internal and external research, evaluate their potential options, and implement new protocols. Implementation of any continuous quality-improvement program to achieve an organization’s strategic goals requires adequate financial resources and employee buy-in. When incorporating standard business models into an organization’s strategic plan, it is essential for ASC administrators to develop annual goals and frequent measurements of these goals to help sustain long-term organizational objectives. A combination of strategic models may be incorporated as part of the ASC’s defined best business practices. When leaders prioritize continual reviews of their facility’s practices and commit to incremental improvements based on those reviews, they will achieve successful outcomes.

**NOTE: This content has been created for Stryker by an independent, third-party medical writer. This is evidence-based research and is not intended to be legal or consulting advice.**

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