

Adding Outpatient Spine to Multi-Specialty ASCs

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About one year ago, my partners and I decided to add spine cases to our outpatient surgery center, the East Portland Surgical Center (EPSC). It was a big decision, with important clinical and operational implications, and we thoroughly assessed the risks and opportunities before moving forward. I'm pleased to report that our decision has worked out very well.

Of course, our surgery center was in very solid shape before adding outpatient spine. That may be the most important conclusion to draw from our experience. Yes, spine cases offer great revenue potential and can be profitably added to existing multi-specialty ASCs – but only if surgeon-owners proceed carefully and clearly understand a few key issues. At a minimum, existing surgery centers that want to add spine should have:

- An efficient operational environment (with excellent scheduling practices),
- Good working rapport with the new spine surgeons (whether or not they are investors),
- A strong and highly skilled team, and
- The ability to contract effectively.

In other words, a surgery center with a strong backbone can add spine cases without disrupting clinical operations or taking on unnecessary risk. Conversely, ownership of underutilized centers should think twice if they view new revenue from spine as a means to save their businesses. Again, it's a huge decision.

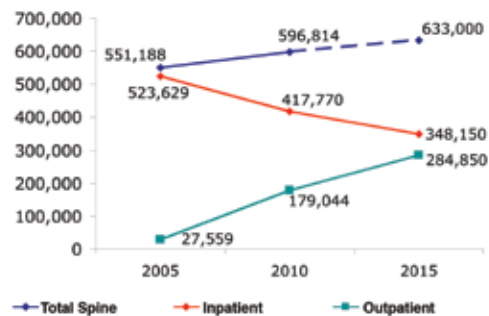
Starting from Strength

As a physician, I'm very proud of our surgery center. We have an outstanding clinical staff committed to the highest standards of care and patient satisfaction. Patients love the environment, which is convenient, comfortable and welcoming and therefore helps lessen the anxiety felt by patients and their families regarding surgical care. My partners at EPSC feel we're more productive at our center and, better yet, able to focus fully and completely on patients.

As a business, we have enjoyed a healthy run of profitability in the few years since the physicians teamed with Blue Chip to purchase an underperforming business from a large national ASC chain. In establishing new management procedures and clinical processes, we generated outstanding returns –100% ROI in the first year and 200% in the second. Today, we see a large and consistent number of patients, including eye, GI, orthopedic, ENT, general surgery and pain management cases, in our three operating rooms and two procedure rooms. We have good working relationships with the major payers.

Overall, my partners and I are happy – both clinically and financially – with what we've developed at EPSC. It's gratifying to be a part of an efficient, well-managed operation, where people like coming to work, trust their colleagues and can provide great care. So, when it came to adding spine cases, we were confident and had a lot working in our favor.

Spine Surgery Volumes | 2005 - 2015



Note: Inpatient Spine Procedures defined on historical base of DRGs 4, 496-500, 519-520. Source: Solucient (Traditional) and NeuroSource/NeuStrategy, 2005

Opportunities & Issues

Still, we proceeded deliberately, because spine presents unique challenges. We looked carefully at the clinical literature, which made clear that complication rates for appropriate spine cases are no higher in ASCs than in hospitals. On the business side, we knew that spine offered a lot of revenue for a relatively small number of cases, but also that the contracting was complicated.

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Since we would be competing with hospitals on spine cases (as opposed to other ASCs), we were confident that we could offer lower costs. Our goal was to capture some of that savings for our surgery center, but have the bulk of the savings accrue to patients and payers.

Outpatient spine can be highly profitable, provided ASCs understand the issues.

Still, there were important questions to ask: Did existing agreements keep us from out-of-network reimbursement, which was higher? What about implants and supplies? The regulatory issues can be just as problematic. For instance, some states prohibit overnight stays or require minimum post-operative stays. Though these policies can be “dealbreakers,” they weren’t a major obstacle for us, but rather more practical details that had to be worked out.

The Right Surgeons

After working through contracting and regulatory issues, we next addressed an equally important consideration: who will bring the cases and perform the surgeries. It’s possible that existing partners can bring spine cases, but it’s more likely that new relationships with individual spine specialists or neurosurgery practices will be necessary.

In identifying new surgeons to invite to EPSC, there was healthy dialogue among our ownership group. We sought clinically distinguished physicians with excellent reputations, but we also wanted hard workers and team players. These qualities make for excellent partners in any type of surgery center. But the most important criterion was a high level of caution in patient selection. Not every spine case is appropriate for outpatient facilities. Surgeons must carefully examine patient weight and respiratory history, incision routes and other factors before choosing between the ASCs or hospitals for specific procedures.

We first engaged with one neurosurgeon we knew and regarded highly and, several months later, invited a few more to bring cases to our surgery center. So far, it’s been a very good fit. I think what these physicians like most about operating at EPSC is that their patients are more comfortable and that it’s so easy to check up on them after procedures are complete. Of course, these benefits apply to all specialties, not just spine.

To smooth their transition, we encouraged our new colleagues to start with the easiest, most straightforward cases (e.g., carpal tunnel, ulnar nerve and laminectomies). Once the surgeons grew comfortable with the people, equipment and procedures at our center, they began transferring cervical ACDFs and other more challenging cases.

This gradual transition also gave everybody a chance to get to know each other. It’s not necessary that everybody at an ASC become great friends; it is necessary, however, for everyone to get along generally, share similar standards for clinical quality and respect basic business requirements and operating policies.

And there will be occasional issues to address. For instance, one of the new neurosurgeons was wedded to a specific set of instruments, which was much more expensive than what we already had. One of our surgeon-partners met with him to hear his concerns and discuss the issue of standardization. Once the new surgeon understood the financial impact – our costs would have been several times higher for each patient – and tried our standard equipment, he agreed to switch.

Whether or not the new surgeons ultimately become owners in EPSC remains to be seen. But the “try before you buy” approach has been mutually beneficial; the spine surgeons now operating at EPSC have seen our staff in action and what we offer in terms of patient experience; at the same time, our center benefits from more revenue, increased exposure in the community and the opportunity to vet future partners.

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Preparation & Training

Staff preparation, especially in anesthesia protocols and discharge policies, is another critical element in successfully adding spine. Patient care and safety is the absolute #1 priority at our center. Thus, we had to ensure we had the formal procedures in place for recovery and discharge, and appropriate staff on hand at all times. We developed detailed plans for patient transfer in the event of complications. In terms of anesthesia, I was comfortable handling many types of spine cases in an outpatient setting, but I had to ensure everybody else shared my confidence. In particular, the lower sedation levels dictated by shorter recovery times were an adjustment for some anesthesiologists and nurses. We did a fair amount of education and communication on the clinical side before taking our first spine case.

And it wasn't just our surgery center staff that needed training and education. Because outpatient spine is a relatively new phenomenon, it's important that everybody patients interact with – referring doctors and primary care physicians and their office staffs and schedulers – believe in it. If one person says, "Usually these procedures require overnight stays," patient anxiety can go up.

For that reason, my partners and I proactively reached out to the local medical community, sharing outcome data, detailed post-op protocols and other relevant information. We also expressed our confidence in the entire team at EPSC. And, again, we emphasized that referring the simplest cases first was a good idea.

Getting Practical

Adding spine cases to our already busy schedule required us to make some adjustments. Some of my partners gave up their preferred slots early in the day to give the new surgeons ample block times. Spine cases need to be done in the morning to ensure there's ample recovery time. Here again, the partners led the effort to

educate staff and other surgeons who use our center of the changes to come, and why they made sense. That helped ensure the new stream of cases was quickly and smoothly integrated into operations.

Equipment was another question we addressed. We already had a C-arm, but decided to add a second to eliminate potential scheduling conflicts. We also plan to add a second set of neurological instruments. These decisions were not taken lightly. We drew up a clear business case establishing the link between new equipment and increased revenue, negotiated with our supplier and made the purchase in cash. We didn't want to compromise our new revenue stream with unnecessary capital investments.

The Bottom Line: The Promise of Outpatient Spine

Given the growth rate in case volumes and attractive reimbursement rates, it's clear that more multi-specialty surgery centers will want to add spine cases in the future. Our experience shows it can be profitably done – provided center management proceeds carefully and understands both clinical and business impacts. We also benefited from having efficient operations, a strong team and trusting partnership group, rock-solid contracts and a thoughtful approach to identifying spine surgeons to invite to our center. In other words, it was our strong business and clinical backbone that allowed us to add lucrative spine cases to our already profitable center.

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