



## Common Mistakes & Misdirection in the ASC development process

By: John A. Marasco, AIA, NCARB

Marasco & Associates

As published in Today's SurgiCenter Magazine, April, 2005

This article will address issues that are commonly completed incorrectly or with minimal knowledge during the development process of an ASC. Our hope is that prior knowledge of these potential pitfalls will help you develop a better ASC.

Although it is inconceivable to me, after designing over 250 ASC's in 43 states, we've actually encountered several facilities that have neglected to consult their



State Department of Health until after completing construction (unfortunately in some states this is your only option, so follow their guidelines closely). Ultimately it is your State Department of Health officials that will either grant or deny your ASC state licensure and/or Medicare certification. As strange as it sounds it is

actually your State Department of Health, not a Federal official, which will approve your ASC Medicare certification and issue you your Federal billing number. Without licensure or certification you cannot be reimbursed for performing surgery in your ASC and thus cannot bill nor collect facility fees – lack of revenue is a very bad thing. Depending on how you treat them, these officials can be your friend or your foe. Either way make sure your architect consults them early and often during the design/construction process and follows their recommendations strictly, even if they don't make any sense. Make sure they follow up any meetings, phone conversations or changes in the design with signed memos to and from the State Department of Health officials. Simply put, without your State Department of Health officials' approval you have a very expensive office procedure environment not an ASC. Trust me, you do not want to make this easily correctable mistake and suffer the potentially expensive





consequences. We always make sure that the State Department of Health officials know your project as well as you do by the time they perform their on-site licensure/certification visit. This will ensure your facility passes with flying colors.

Another primary facility complaint we hear about is that ASC's are not being designed to integrate with other potential specialties. Although your facility may



begin life as, let's assume, an ophthalmic only ASC, from a resale and/or optimum utilization perspective, looking at the needs of a multi-specialty ASC up front can save you a lot of headaches down the road. Let's also assume that five years after the development of your ophthalmic only ASC your group has become so successful that it outstrips the capacity of its current facility and moving to a new, larger capacity, location is your only option. If your ASC

was designed for ophthalmology cases only, thus not fitting the needs of many other specialties, you have significantly decreased your market for a potential resale. This will make it difficult to sell your facility as an ASC. If you don't already know it, you soon will, constructing an ASC is much more expensive than constructing basic medical office space. If you end up having to sell the facility as anything other than an ASC, the value of this increased construction cost will be lost.

In addition to resale issues, many single specialty ASC's have considerable down time that could be used by other surgeons. As attracting your competition to use your ophthalmic only, or any other specialty for that matter, ASC will be difficult at best; other specialty surgeons are your potential caseload fillers. By spreading the fixed costs, primarily rent and equipment, over as many cases as possible, each case becomes more profitable.



Therefore maximizing your operating room utilization is a good goal to have. The best-case scenario would be to attract other users without having to sell them any ownership. This would allow the profits generated from their cases to go directly to your group as well as having the ability to take back their operating room time if your group needs it down the road. The down side is that these potential surgeons have special needs that must be addressed with your initial design process. For example gastroenterology and pain management surgeons do not want to deal with the sterility issues associated with a full fledged Class "C" operating room. As these cases are non-sterile in nature, and treating them

process. Accessibility to the operating room should therefore not be off of the sterile corridor, but instead directly from the prep/recovery area. This can easily be accomplished in a primarily ophthalmic ASC by simply placing the operating room between the prep/recovery area and the sterile corridor, not on the other side of the sterile corridor as is often designed. Then by placing doors into the operating room from both the sterile and non-sterile sides the design can allow the operating room to “swing” back & forth depending on the cases that are being



performed and what access door remains unlocked. We call this a Swing Operating Room. Of course this transition does not occur per case, but instead per surgical block period. For instance an ophthalmologist may use the operating room in the morning as a sterile environment with the operating room “swinging” in the afternoon to be used by a gastroenterologist as a non-sterile

environment. This design technique takes no additional space allowing your ASC to be much more flexible – a win-win situation.

For more complex orthopedic cases (arthroscopies, rotator cuffs, etc...); at least a class “C” 400 square foot, if not even a 450 square foot, operating room and plenty of equipment storage should be provided. For ENT cases and their adolescent patient base (crying patients with 3 hour recovery periods), additional privatized recovery stations should be provided. For ophthalmology cases (primarily cataracts) where several patients are blocked at once prior to entering the operating room; additional prep stations should be provided. A little extra space now could save you a lot of headaches later. In addition to the above mentioned design issues, we recommend that any class “B” operating room (250 square feet - primarily used for minor cases like gastroenterology & pain management) or above be at least piped (stubbed in) with nitrous oxide anesthesia capabilities.

Although general anesthesia is not common in ophthalmic only ASC's, other specialties will require it and having it ready to go will help on both the resale as well as utilization levels. The above-mentioned issues are relatively inexpensive to address during the initial design process and they can save you a lot of stress and potentially make you more money in the future.





Temperature & humidity control in the operating room is another top complaint we hear about. Although Medicare and State Departments of Health requirements allow for a 68-degree minimum temperature, to most surgeons this



is unacceptably high. They typically like to have their operating rooms at 65 or even 62 degrees. Depending on where you are located in the country this is often difficult to achieve with a standard roof top HVAC mechanical unit, while maintaining the required humidity level. Upgrading your HVAC system should be explored prior to completing the construction documents to allow for this control to be integrated into your

ASC. Do not let your architect and/or engineer design around the minimum requirements, which is typically their inclination, but instead use an experienced team that understands what levels your facility should meet in order to have happy users.

As an informed consumer you should understand the various design & construction methods you have at your disposal and their associated pros & cons. The most prevalent method is called Design/Bid/Build. This is when an architect is selected by the client, completes a design/construction document set, has this set bid by several experienced general contractors and selects the appropriate bidder. This gives the client the most competition and therefore typically the lowest price. However, you are putting your trust solely into the architects' hands as it negates any contractor input on how to better construct the facility for less money, without sacrificing its quality. On the plus side, during the construction process the architect acts as your quality assurance agent, guarantying that the contractor remains on the up & up.

Another often-used method is called Design/Build. This is when a contractor and architect form a team at the inception of the project and are selected by the client as such. Because the team is set from the beginning and work can commence even as the construction documents are being finalized, technically 2-3 months can be shaved off the typical construction timeline.



Unfortunately, because of fixed lead times with various building materials we generally do not see this timesavings materialize. Since the contractor is on board from the beginning their input can be included in the construction documents as well, giving the client a value



engineered facility. However, as the contractor employs the architect your quality assurance agent is lost, therefore you must be completely comfortable with the teams ethical level before you chose this method.

There is yet another option we developed that fuses the pros of both of the above



methods together. We call it Design/Bid/Design/Bid/Build. This is when an architect is selected by the client, completes a preliminary design/construction document set, has this set bid by several experienced general contractors and preliminarily selects the appropriate bidder. The contractors input is gathered, value engineered, then applied to the final construction document set and re-bid to them alone. If the contractor meets the original bid, minus the pre-determined value engineered savings, they are issued the final contract. If they bust the bid, the client reserves the right to re-bid the other original

general constructors in order to reduce the construction price. This method gives the client maximum competition & cost control, contractor input and quality assurance during the construction process by their architect – all in one neat package.

### ***Marasco & Associates - #1 in Healthcare Design***

*We have helped develop more than 300 Ambulatory Surgery Centers and over 1,500 Healthcare Facilities nation wide. During our 30+ year history, Marasco & Associates has distinguished itself as the industry leader in healthcare architectural services. With our unparalleled experience and dedication to our clients we can help move your project down the path to success. Through our intense collaborative design process our facilities maximize functional and operational efficiencies while providing your patients with the environment they deserve. For more information, please contact:*

John A. Marasco, AIA, NCARB  
Marasco & Associates, Inc.  
1660 Wynkoop Street, Suite 925  
Denver, CO 80202  
(877) 728-6808  
[www.marasco-associates.com](http://www.marasco-associates.com)