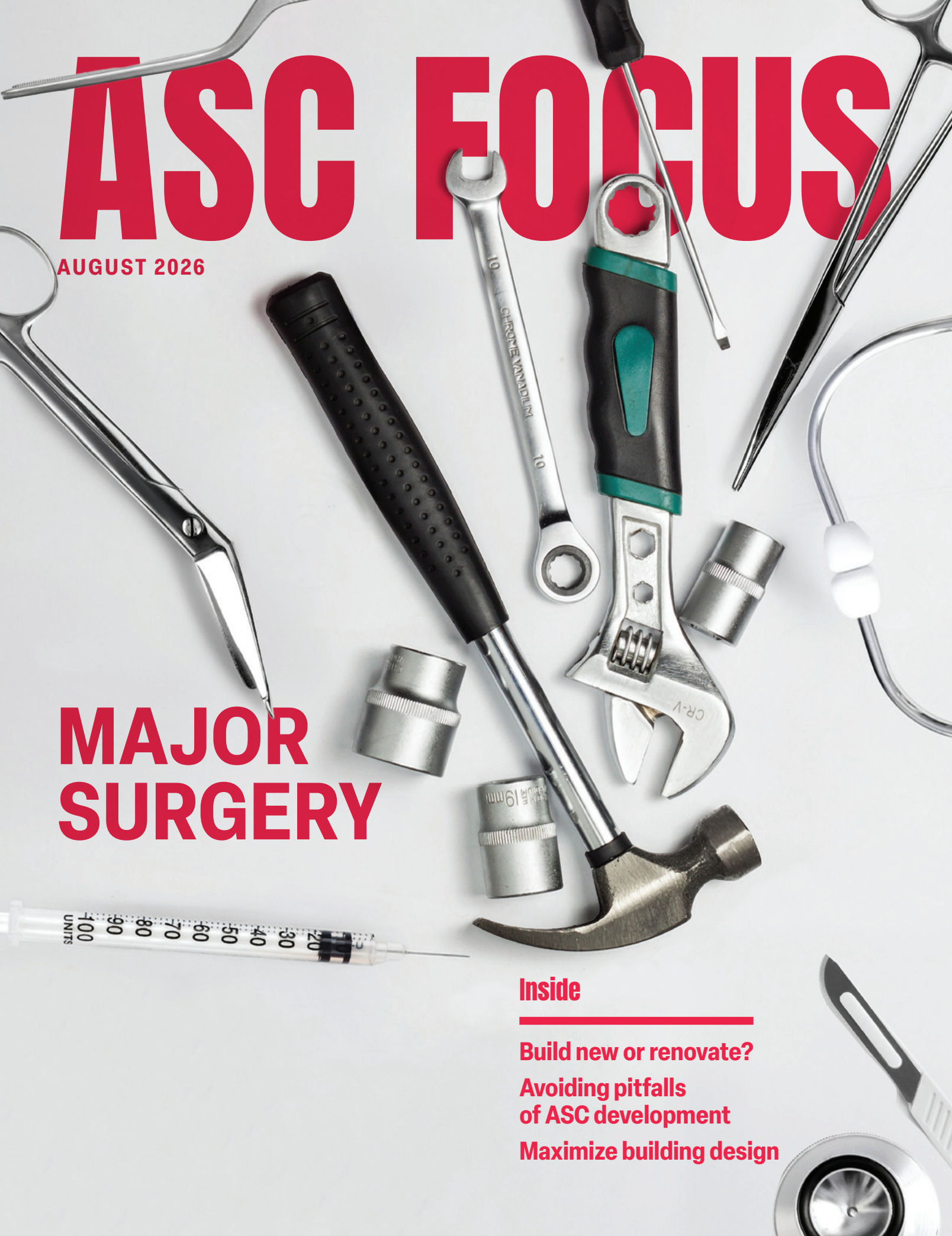


ASC FOCUS



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MAJOR SURGERY

Inside

Build new or renovate?

**Avoiding pitfalls
of ASC development**

Maximize building design

Experts share
strategies
for success
in new ASC
development

BY ROBERT KURTZ

KEY TAKEAWAYS

Hire experts with
ASC experience

Watch out
for procurement
challenges

Have contingency
plans in place

AVOIDING PITFALLS



Opening a new ASC can feel overwhelming, says Amy Swaffer, RN, director of Knoxville Spine Surgery in Tennessee, who helped with the development and opening of the center in 2024. “It can feel like you are building the plane while you are flying it. There are so many moving parts and so much you need to consider, and you never know what is going to go wrong.”

The ASC development process typically runs 12 to 18 months or more, and the margin for error is thin, says Akshay Tavkar, CASC, senior adviser at Avanza + MedHQ in Westchester, Illinois. “Anything that does not go according to plan adds time and cost to a project that is already significant in scope,” he says.

Potential problem areas

One of the most common mistakes Tavkar has seen those building new ASCs make is not engaging the right experts early enough. Selecting individuals like architects, HVAC specialists, engineers, legal counsel and consultants with ASC experience is critical. “If you do not know anything about ASC regulation or compliance, it becomes easier to not ask the right questions at the beginning of a project,” he says.

Swaffer saw the value of that early engagement. The physicians behind Knoxville Spine reviewed blueprints with their construction and design team during the development process, revising patient flow plans multiple times. “You have to think about your staff, too, like how the locker room is going to look and whether the break room is big enough,” Swaffer says.

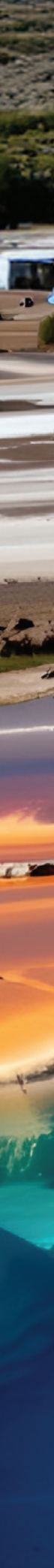
Engaging experts is only part of the equation. Jessica Mountjoy, RN, administrator at Northern Virginia Heart & Vascular Center in Woodbridge, Virginia, learned during construction of her center that even experienced contractors can miss important details. After reading through life

safety codes, she flagged a pane of glass the construction team insisted was fire-rated. It was not. “You cannot assume the people working on your ASC know and are following all the rules,” she says. “I knew if something was in the code, a surveyor was going to ask for it.” She also found fire-rated doors with signs screwed through them — a violation that required correction.

Procurement timelines and capital costs have a way of surprising even well-prepared teams, Tavkar says. Equipment that centers expect to arrive in days can take months, and costs that seemed fixed rarely stay that way. Beyond construction, the fees and expenses required to get an ASC open — medical equipment, supplies and licensing — can catch leaders off guard, he says. “What you plan today is a roadmap, but you need to be nimble and understand that you need flexibility. In all likelihood, some of what you are budgeting will increase in cost.”

Swaffer experienced procurement challenges firsthand. “We did not realize how long it was going to take to get certain pieces of equipment,” she says. Mountjoy’s ASC encountered similar delays, including a critical air conditioner that held up construction. Tavkar recommends starting vendor and equipment research as early as possible and building timeline buffers. “You cannot control your state and when an inspector may come in to grant your license,” he says. “You cannot control a vendor and when they can manufacture a piece of equipment. Anticipating a delay in timeline has to be part of your entire project plan.”

Staffing a new ASC is another area where centers routinely underestimate what is required, Tavkar says. He has seen ASCs try to get by with a single person responsible for opening the facility, including writing policies and procedures, working with architects, ordering supplies, negotiating contracts and preparing for accreditation all at once.



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“It becomes impossible,” Tavkar says. He recommends putting together a core team with at least a nurse/clinical administrator, surgical technician, central sterile processing department leader and an RN with prior ASC experience or at least surgical experience to keep a new center on track. “If you want to open and see patients safely and stay on time with accreditation, you need that team,” he says.

Quality matters when it comes to staffing, adds Swaffer, who was intentional about building a strong team. “We knew there were going to be a lot of changes, and we wanted good people to execute transitions when we encountered challenges.”

Swaffer made sterile processing an early priority and urges other ASCs to do the same. She helped plan Knoxville Spine’s sterile processing department around meeting the ANSI/AAMI ST108:2023 — Water for the Processing of Medical Devices standard. It establishes requirements for water quality in the processing of medical devices. Though not yet mandatory, Swaffer expects it to eventually become a requirement. “We put a lot of money and time into planning our SPD,” she says. “If that is not running well, your ASC is not running well.”

Sterile processing also is the most commonly underdesigned area Tavkar sees in new centers. “Successful ASCs have right-sized their sterile processing areas,” he says. “If you want to add a service line like orthopedics down the road but you have no physical space, or your plumbing infrastructure cannot accommodate what you need, that becomes a huge expense.”

Mountjoy adds a recommendation for the development phase: build physical walkthroughs into the process. When she and her team used a stretcher loaded with supply boxes to simulate a patient evacuation, they found they could not make the turn through a fire exit with the railings up. She suggests bringing a diverse group into those exercises, including nurses,

techs and physicians. “One person is going to miss things,” she says.

Mountjoy encourages developing ASCs to welcome outside regulatory eyes before opening. In Virginia, she invited state infection prevention specialists to tour the center before it was complete — a free resource that caught issues early. “I was very open to having people come in before we finished,” she says. “Let them find the problems now so we can fix them before we are open.”

Careful planning pays off

Developing ASCs would be wise to have contingency plans in place, both financially and operationally, Swaffer says. “You just never know what is going to break or what is going to need to be renovated,” she says. Preparation also can mean learning from others. “Visit other ASCs before you start building your own,” she says. “It can really help give you some insight into what you are trying to do.”

Mountjoy learned the need for financial contingency when a federal government shutdown froze Northern Virginia Heart & Vascular Center’s Medicare application for nearly two months. “It was unexpected, but it is exactly the kind of thing you have to plan for,” she says. Commercial payer contracting adds a layer of uncertainty, she notes, often taking several months or longer to complete after a Medicare number is secured.

Tavkar advises ASC leaders to think beyond opening day. “Understanding what your long-term scalability looks like will influence your infrastructure, the way rooms are set up and the additional space you will eventually need,” he says. “Your new center has to be efficient, it has to be patient-centered and it has to be able to scale over time. It cannot just be a pretty building.” ■

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