vision correction (LVC) surgeries on days you are not performing Medicare surgeries, you’re better off providing space outside the ASC for a Laser Vision Correction Center (LVCC). When Medicare patients are in an ASC, all other patients in that ASC must be treated with a certain level of care. That level of care is above and beyond what’s needed to perform a safe LVC surgery. Therefore, if LVC surgery is performed concurrently with Medicare surgeries in an ASC, unneeded expenses are incurred. Financially you’re better off building an LVCC adjacent to but not within the ASC, or even as part of or adjacent to your practice.

Design Guidelines

The 2006 Guidelines for the Design and Construction of Health Care Facilities contains commonly accepted industry design standards for ASCs and largely determines the spaces that are required for ASCs. The Guidelines gives regulations and recommendations for the number and sizes of spaces within the ASC based on the functional needs of the facility (the functional program). The functional program is basically a description of how the facility will be used, the type and volume of surgeries that will be performed, and a policies and procedures manual for the center.

OR size depends on how the OR will be used and the type of sedation the patient will receive (Figure 3). There are three OR classifications: A, B and C.

- **Class A** is for minor procedures using topical and local infiltration blocks with or without oral or intramuscular preoperative sedation. Class A ORs must have a clear area of 150 SF with a minimum clear dimension of 12 feet.

- **Class B** is for minor or major procedures using oral, parenteral or intravenous sedation and those using analgesic or dissociative drugs. Class B ORs must have a clear area of 250 SF with a minimum clear dimension of 15 feet.

- **Class C** is for major procedures that require general or regional block anesthesia and support of vital bodily functions. Class C ORs must have a clear area of 400 SF and a minimum clear dimension of 18 feet.

Although most ophthalmologists are currently using topical anesthesia on cataract patients, that does not mean that a Class A 150 SF OR will be adequate. To accommodate the needed equipment and staff, a Class B 250 SF OR is the minimum. Experience has shown us that anything smaller does not provide enough space for everybody and everything required. That being said, many practices I have worked with have opted to build a larger Class C 400 SF OR even though they don’t need it themselves — they are planning now for growth later. Some retina, pediatric and cosmetic ophthalmic patients require general anesthesia, not to mention the potential for adding other specialties down the road. Adding medical gases and 150 SF to a Class B OR later is simply not cost effective. I recommend that you prepare your ASC now for additional surgeries, surgeons and resale potential.

With increases in technology and surgical complexity comes the need for larger ORs. What has traditionally been considered an inpatient case is now being done in an outpatient setting. Surgical complexity has come a long way in the past decade and shows no signs of stopping. I’ve noted that the minimum requirement for a Class C operating room in the current Guidelines is 400 SF — typically designed as a 20- by 20-foot room. Although this size works well for some specialties such as ophthalmology, otolaryngology and plastic surgery, our experience has shown that it is entirely too small for most of today’s complex surgeries. With all the anesthesia, equipment, lighting and monitoring booms as well as specialty equipment towers and even robotics, a 22- by 22-foot (484 SF) OR is a much more appropriate minimum, with a 24- by 24-foot (576 SF) or even a 25- by 25-foot (625 SF) OR being desirable. Designing your ASC to meet actual needs rather than simply to satisfy your jurisdiction’s minimum requirements is paramount to its success.

For ophthalmology cases (primarily cataracts), where several patients are blocked at once prior
to entering the operating room, additional prep stations should be provided. Alloting a little extra space initially could save you a lot of headaches later.

We also recommend that all Class B (250 SF; primarily used for minor cases like gastroenterology and pain management) and Class C operating rooms be at least piped (stubbed in) with nitrous oxide anesthesia capabilities. Although general anesthesia is not common in ophthalmic-only ASCs, other specialties require it. Having it ready to go will help in both ongoing utilization levels and resale.

All of these issues are relatively inexpensive to address during the initial design process. Taking care of them at the outset can save you a lot of future stress and potentially make your ASC more profitable.

**Special Design Solutions**

The floor plans in Figures 4 through 6 and the text that follows illustrate some unique design solutions we employ in laying out functional ASCs. Most ASC owners and their architects will face decisions about issues such as these during facility planning.

**Covered Patient Drop-off Area**

CMS mandates a covered area for ASC patient pickup, but not for patient drop-off. However, I recommend covered areas for both pickup and drop-off (see Figure 4, area IA) because many ophthalmic ASC patients and their family members are elderly and potentially frail. A covered, calm and dry area where patients can exit their vehicle and enter the ASC is a nice feature that will lessen everyone’s concerns.

**Front-Desk Privacy for Patients**

Even with the best pre-arrival procedures, additional personal information sometimes needs to be gathered from patients before their surgery. Discussing such information with the patient at the front desk, where others in the nearby waiting room can overhear, is inappropriate. We often design a private alcove to one side of the front desk to accommodate such encounters (see Figure 4, area IB). Our design allows the same receptionist to greet an incoming patient and to have a private sit-down conversation with a second patient, maximizing the receptionist’s efficiency and the patient’s privacy.

**Access to Postop Recovery for Family**

Most ASCs encourage a family member or other caregiver to join the patient once he or she has been moved out of the post-anesthesia care unit (PACU) into step-down recovery. Because postop instructions are typically given at this time, it is important that both the patient and the patient’s caregiver be present. Many architects design flow patterns that require the caregiver to walk adjacent to the prep/PACU areas to reach the step-down recovery area. However, this gives caregivers visual access to other pre- and postoperative patients, which is neither dignified for those patients nor necessary with a good design. The best ASC layouts allow caregivers easy, private access between the waiting room and step-down recovery without exposing other patients to view (see Figure 4, area IC). Access to the consultation and laser room(s) can occur privately along this corridor as well.

**Centralized Nursing Station**

Although CMS requires that ASCs have separate prep and recovery areas, that doesn’t mean that these areas must be designed so as to isolate the staff of each area. Although architects often design physically separated prep and recovery areas, each with their own nursing station, doing so prevents staff from helping one another out if the patient load at a particular time calls for it. It is a certainty that mornings will be more prep oriented, whereas afternoons will be more recovery oriented. In addition, during the day there tends to be a natural ebb and flow through the prep and recovery areas. A design that centralizes the only nursing station between the