

IS IT TIME FOR PLAN B?

Why Hospitals Need to Re-Evaluate and Re-Prioritize their Master Facility Plans

Health Innovation

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By Paul T. Breslin, Noblis Center for Health Innovation

HEALTHCARE PROVIDERS ARE FACING A CAPITAL CRISIS

Healthcare organizations entered the recent economic downturn more heavily leveraged and more vulnerable than many other industries. Most hospitals today are being forced to scale back their spending as they scramble to protect their current cash positions. Tight credit markets are adding an unprecedented financial challenge for those hospitals willing to invest for the future since they rely on credit to fund major building projects and to maintain their overall liquidity.¹

Even with newly legislated stimulus initiatives out of Washington, it is likely that the credit market for hospitals could tighten even further in the near term and bond ratings will fall, which will limit even further hospitals' ability to access needed capital. Recent reports indicate that the final 2008 results for our nation's not-for-profit hospitals will show widespread weakening of credit measures including operating margin and days cash on hand with most hospitals experiencing a decline in liquidity from the effect of weakening investment income and these declining operating margins.²

THE FORECAST FOR THE IMMEDIATE FUTURE: NO RELIEF IN SIGHT

2009 promises to be a very challenging year for hospitals. Budgets will be trimmed and capital investments delayed. Operating margins will decline and investment income will shrink. The economic downturn will force most hospitals to trim their operating budgets for future years as well, resulting in hiring freezes, lay-offs, and other operating expense reductions. The recent increase in unemployment and consumers' concerns about the future of the economy has and will continue to decrease demand for some elective services. That segment of the industry that has historically relied on investment income, municipal funding of indigent and charity care, and/or low interest rate credit lines will see an increase in program closures if not whole hospital closures.³

The Noblis Center for Health Innovation conducted a survey of hospital executives in November 2008 regarding the impact of the economic crisis on their hospitals. This survey identified two major areas of concern with respect to the hospitals' plans for making investments in their facilities. The survey confirmed that access to capital was becoming a significant problem, with survey respondents indicating that "it is virtually impossible to get new capital", their "interest rates have increased" and they now "need collateral to get a loan." The survey also revealed that hospitals have already halted, re-sized, or changed major capital investment projects. Projects still being planned for implementation were those that were revenue-generating with a quick payback. Projects most often described as having been halted altogether were mainly facility-related investments.⁴

IS IT TIME FOR PLAN B?

Why Hospitals Need to Re-Evaluate and Re-Prioritize their Master Facility Plans

THE INDUSTRY'S RESPONSE TO-DATE HAS BEEN LARGELY REACTIVE

The short-term responses by many hospitals to this crisis are those needed to ensure their short-term financial viability. Efforts to increase cash flow such as pushing harder on collections and delaying payables are common. Hiring freezes on non-essential personnel and salary freezes or even salary cuts are being implemented, and operators are looking for cost savings in every department and service. This perfect economic storm has led some organizations to consider cutting back or even eliminating marginally successful service lines while others are reconsidering merger or affiliation. One common response has been to delay, defer or even cancel planned capital projects. However, healthcare organizations that only focus on the immediate crisis and not the longer-term strategic solutions that will need to be implemented to best position them for future success will not weather well through this current economic crisis.

THE TIME IS NOW TO PROACTIVELY RE-EVALUATE YOUR CAPITAL SPENDING PRIORITIES

In light of the current economic reality, hospitals today should be carefully reviewing their strategic plans to make sure that whatever capital is available for investment over the next few years is used to fund those initiatives that will improve their performance. These include needed investments in such critical resources as clinical technology and equipment, information technology, facilities and physician manpower.

In an AHA survey on the impact of the economic crisis on hospitals reported in November 2008, hospitals were asked whether they were reconsidering or postponing capital expenditures for clinical technology and equipment, information technology and/or facilities. Although 39 percent indicated “yes” for information technology and 45 percent indicated “yes” for clinical technology and equipment; fully 56 percent indicated “yes” for facilities.⁵ This response suggests that the master facility plan is probably the one area of planned future investments that is most at risk of being postponed indefinitely unless it is clearly determined to be critical to improving the organization's performance.

Healthcare providers realize that no organization, no matter how financially stable, can afford to do everything. However, hospitals must also realize that they need to have a strategic, financial and long-term master facility plan in place that will ensure they can properly maintain their current resources and selectively invest in those initiatives that will help to improve the organization's near-term financial performance.

RE-EVALUATING AND RE-PRIORITIZING YOUR MASTER FACILITY PLAN

Master facility planning is and should be a strategic exercise that every hospital and hospital system undertakes periodically to guide its short and long-term facility redevelopment and replenishment plans. The ideal process would routinely update the master facility plan as the strategic direction of the organization evolves over time using its strategic plan, its clinical service business plans and its long-term capital plans as input to the plan.

IS IT TIME FOR PLAN B?

Why Hospitals Need to Re-Evaluate and Re-Prioritize their Master Facility Plans

The master facility plan is a fairly comprehensive “blueprint” for meeting the near-term, intermediate-term, and long-term future physical needs of the organization’s entire operations. A master facility plan’s comprehensiveness and scope is at once its greatest asset as a long-range planning tool but it can also be its greatest potential liability to successful implementation when the economic climate changes. It needs to be understood that the “typical” master facility plan includes the proposed solution for many different types of facility requirements over an extended number of years into the future and is usually accompanied by a sobering if not overwhelming total capital cost to implement.

DE-CONSTRUCTING THE TYPICAL HOSPITAL MASTER FACILITY PLAN

When leadership is forced to quickly triage its investment needs, the master facility plan can be an easy target for postponement given its scope and price tag. From our experience as strategic facility planning advisors to the health care industry, we have learned that to make informed investment choices when capital is limited it is very useful to “deconstruct” the master facility plan into its major components to better understand where all that money is going. Figure 1 below provides a graphic illustration of the major components of a typical hospital’s master facility plan.

Figure 1
The 6 Major Building Blocks of Today’s Master Facility Plan

	Where does all the money go? ...The “Usual Suspects:”	Description	Some Examples
6	New Inpatient Units – All Single Rooms	Need to eventually replace the outdated and undersized units	<ul style="list-style-type: none"> ▪ Add new floors to existing bldg ▪ New bed tower
5	New On/Off-Campus Ambulatory Care Site	Strategic initiatives to compete effectively in outlying markets	<ul style="list-style-type: none"> ▪ Surgicenter ▪ POB + Imaging ▪ Cancer center
4	Needed Service Capacity Expansions	Adding capacity to key services where volumes are growing	<ul style="list-style-type: none"> ▪ ED beds ▪ O/P Surg ORs ▪ Monitored beds
3	Rightsizing of Existing Facilities	Increasing the size of undersized departments to meet new standards	<ul style="list-style-type: none"> ▪ ED undersized ▪ Main ORs too small ▪ Semis to privates
2	Necessary Site Enabling Actions	Projects needed to enable the site to begin the MFP	<ul style="list-style-type: none"> ▪ Add new parking ▪ Demolitions ▪ Add to power plant
1	Yesterday’s Infrastructure	Recapitalization of infrastructure you postponed in past	<ul style="list-style-type: none"> ▪ New power plant ▪ New chillers ▪ Fire protection

IS IT TIME FOR PLAN B?

Why Hospitals Need to Re-Evaluate and Re-Prioritize their Master Facility Plans

At their foundation many master facility plans include previously postponed investments in necessary infrastructure (see level 1 in Figure 1). Given the average age of plant of our nation's hospitals, considerable re-investment in basic building systems infrastructure on an annual basis is required to maintain the integrity of the buildings. If a hospital has been forced to underfund these routine facilities recapitalization needs due to limited capital or poor operating cash flows over the past five or ten years, it is not unusual for the physical facilities assessment to identify a significant amount of "catch up" investments that are required. These assessments examine mechanical, electrical and architectural building systems, assessing their remaining useful life and quantifying the cost to repair or replace these systems.

Another common element of most master facility plans (see level 2 in Figure 1) is one or more "enabling" projects that are required to be sequenced first in order to prepare the site for the implementation of the initial building phase of the plan. Parking additions are typical of this component of the plan, as are some necessary demolitions of older facilities. This is particularly true for constrained urban and suburban hospital campus sites. These first two components of most master facility plans, infrastructure upgrades and enabling actions, can be very significant investments that may well be necessary, but do not add productive facility capacity.

Facilities that are ten or more years old will almost undoubtedly be "undersized" for many services by today's standards. The total space requirement for health care services of all kinds has increased over time to accommodate new technologies, new care delivery practices and new building standards. The master space programming exercise that is part of a comprehensive master facility plan will assess the projected volumes and future capacity requirements for all departments and determine each department's future total space requirement. This often results in many departments requiring a significantly larger footprint than they have today even if their volumes are not projected to grow at all in the future. This cost of "rightsizing" existing services to meet today's standards (see level 3 in Figure 1) will often be a component of cost that is embedded in a hospital's master facility plan and can represent a significant investment.

For many hospitals there are some key services that are at or over capacity now and represent real opportunities for significant growth in volumes and revenues (see level 4 in Figure 1). These services, from an economic cost/benefit perspective, are some of the most critical areas for investment. Getting these services developed as quickly as possible is always desired, but in some master facility plans they need to be sequenced behind other initial phases.

Almost every hospital master facility plan developed over the past decade likely includes the planned development of a new or expanded on-site or off-site ambulatory care facility (see level 5 in Figure 1). In fact, the extent to which the hospital has sought to identify services that could move offsite to an ambulatory care service site will have had an impact on the extent of the level 2 enabling action investments required, e.g., new parking on campus.

Finally, it's probably not a hospital master facility plan today, if it doesn't include the "single-room with a view" imperative for tomorrow's inpatient units (see level 6 in Figure 1). This component often represents the longer-term phase of the master facility plan that could likely require a substantial new building or patient tower.

IS IT TIME FOR PLAN B?

Why Hospitals Need to Re-Evaluate and Re-Prioritize their Master Facility Plans

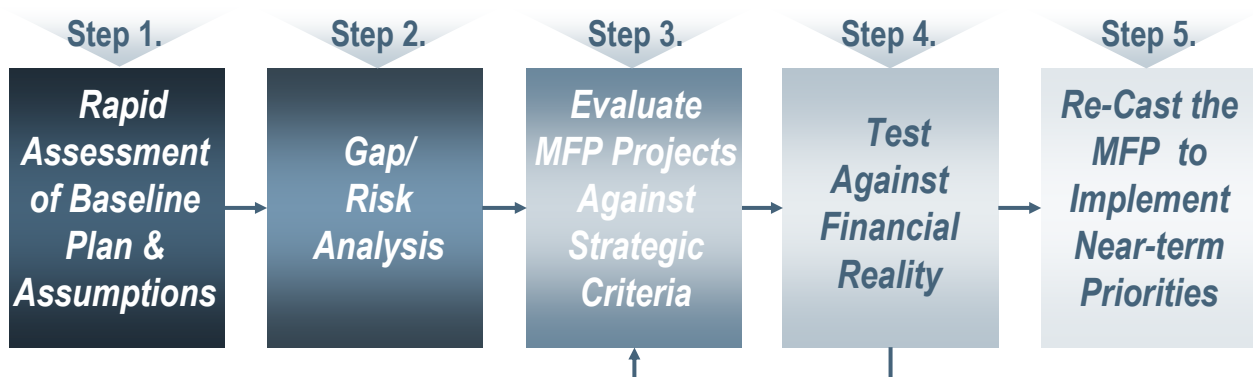
If these are characteristic components of your organization's current master facility plan, then you need to have a framework and a process to rapidly re-evaluate your facility capital investment strategy to meet today's realities. The financial realities have likely changed significantly since the master facility plan was developed and the need exists now to re-align the facility investment needs embedded in the master facility plan with a new short-list of strategic priorities and a "downsized" capital budget.

HOSPITALS NEED A FRAMEWORK AND PROCESS FOR RE-EVALUATING THEIR MASTER FACILITY PLANS

Given the variety of different facility needs typically bundled within a master facility plan, by simply shutting down all of their planned facility investments hospitals are running the risk of not properly sustaining critical infrastructure and they could be missing near-term windows of opportunity to implement priority projects that are needed to help grow their business. Hospitals today need to develop a strategic framework for re-evaluating their master facility plans to enable them to re-cast these plans so that their highest priority near-term projects can be implemented.

Noblis recommends a five-step process required to accomplish this. Figure 2 below illustrates these basic steps.

Figure 2
The Master Facility Plan Re-Assessment and Update Process



Step 1 entails updating the planning database. Future workload demand projections need to be re-visited to reflect updated demographics and use rate assumptions, most recent market share trends, the near-term impact of the economic downturn and the expected impact of the key strategic initiatives to which the organization is committed.

IS IT TIME FOR PLAN B?

Why Hospitals Need to Re-Evaluate and Re-Prioritize their Master Facility Plans

Step 2, the gap/risk analysis, tests the feasibility of the previously developed master facility plan’s implementation against updated financial projections that are based on updated demand forecasts in order to test current capital spending plans against today’s financial realities and revised estimates of capital availability.

Step 3 is critical. You need to “de-construct” the master facility plan into its major components and discreet facility projects and then evaluate each element against consistently and clearly defined strategic criteria. Figure 3 below illustrates a simple analytical framework for organizing this re-evaluation process.

Figure 3
Strategic Re-Prioritization of the Master Facility Plan:
Analytical Framework

Break out all the individual project elements within each major component of the MFP for this analysis

		Is it a quality/ safety requirement?	Is it a mission essential investment?	Will it improve productivity & lower costs?	Will it add new business & new revenue?
6	New Inpatient Units – All Single Rooms				
5	New On/Off -Campus Ambulatory Care Site				
4	Needed Service Capacity Expansions				
3	Rightsizing of Existing Facilities				
2	Necessary Site Enabling Actions				
1	Yesterday’s Infrastructure				

In the example matrix in Figure 3, we used the typical major components of a hospital master facility plan from Figure 1 as “placeholders” for this list of individual projects.

The key to success with this framework is to ensure that you use a consistent set of strategic criteria to evaluate the benefit to cost relationship for every project element within the master facility plan. This doesn’t mean that this is a purely financial assessment. Safety and quality imperatives and what’s most mission-critical are important criteria to be applied as well. These strategic criteria will need to be balanced and weighted based on each organization’s situation. This exercise encourages decision makers to think differently about what services are more “core” than others, what facility investment funding options might exist for some services and

IS IT TIME FOR PLAN B?

Why Hospitals Need to Re-Evaluate and Re-Prioritize their Master Facility Plans

not others, and what alternative facility solutions previously discarded - like renovating an existing service versus building new – are worth reconsidering. This exercise should force decision makers to re-examine their underlying assumptions and previously assumed constraints.

In *Step 4* the menu of re-prioritized and re-cast master facility plan projects that results from Step 3 needs to be tested with an updated financial projection model to evaluate the feasibility of the updated capital spending plans. It is likely that this will be an iterative process, going back through Step 3 more than once, to identify the optimal affordable plan that will ensure your highest priority near-term projects can be implemented, which is *Step 5*.

THE RESULT – A “CAPITAL RELIEF PLAN” FOR YOUR ORGANIZATION

The process and framework described above can facilitate a fairly rapid re-evaluation of a master facility plan. By necessity it will place greatest emphasis on your near-term (e.g., 1-3 year) high-priority needs and related facility projects. This type of re-evaluation process can and should be completed on an expedited basis, so that its results can be incorporated into the FY2010 planning and budgeting cycle.

Undertaking this type of a planning process will enable a hospital to develop what is essentially a much needed “capacity relief plan” for the next few years that considers the organization’s most critical near-term strategies to accommodate volume growth and identifies the optimal combination of near-term facility investments and operational throughput improvements that will enable this needed growth.

Footnotes:

1. Disappearing Credit Forces Hospitals to Delay Improvements, New York Times, October 14, 2008
2. Preliminary Not-for-Profit Healthcare Medians Show Widespread Weakening, HFMA NEWS, March 13, 2009
3. The Noblis Center for Health Innovation Forecasts 2009 Trends In Provider Health Care Delivery, December 2008.
4. The Noblis Center for Health Innovation Economic Impact Survey, November 2008.
5. American Hospital Association Survey, November 2008.