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Trends in Healthcare Facilities:

Value-based purchasing and how the Affordable Care Act affects technology-buying decisions

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Healthcare is changing. Hospital inpatient volume is steady for now but should eventually see some decline (except safety net hospitals). Ambulatory centers/outpatient centers are seeing volume increasing and may continue to do so. Consequently, many facilities' department budgets have been cut — and more cuts should be expected. This white paper will guide facility managers to a better understanding of the current climate and enable better planning. Managers will find a description of the relevant aspects of healthcare reform, recommendations for demonstrating value in facilities management, and suggestions for supporting organizational goals to ensure comfort, energy efficiency, safety, and security in all rooms. Finally, managers will be able to make connections to the emerging requirements of service-line managers as a driving force of the healthcare delivery changes at the facility level.

Introduction

Today, healthcare providers are grappling with changes in government regulations, payer requirements, and patient expectations. We call this the "New Normal." The New Normal means a more austere approach to healthcare delivery in the U.S. and the rest of the developed world. The situation is the result of a confluence of shocks to the economy, including the global financial crisis, credit, stock market volatility, and an aging population. These events and trends have forced healthcare providers to shifts in patient volumes, profitability, and project initiation. The New Normal means leadership teams are taking an increasingly conservative approach to operations management; their risk tolerance is lower, available resources are fewer, and the consequences of decisions are greater.

The challenging structure of healthcare

To understand the implications of healthcare reform, it is important to review the situation that the Patient Protection and Affordable Care Act (ACA) was designed to fix. The ACA changed the pillars of the current payment and delivery system — including incentives, responsibilities, accountabilities, and authority — because the system's problems are fundamental, as consumers (patients), payers, and physicians/providers interact and reconcile unaligned interests. Because of the structure of the healthcare system, costs were destined to rise interminably without reform.

A unique marketplace prone to cost escalation

Policymakers and the public often call for "common sense" reforms. All agree that costs are too high and something must be done. Unfortunately, solutions are difficult because healthcare consumers, providers, and payers do not behave in familiar ways and the market defies common sense.

Unlike other markets, healthcare consumers are neither payers nor decision-makers in healthcare utilization. Healthcare consumers lack (and many are disinterested in gaining) a significant direct economic interest in the cost of their healthcare. The economic interest belongs to the third-party payers — insurance companies and the government. These payers are the customers even though they aren't the consumers. Payers have the primary role in price determinations and reimbursement of most care delivery costs.

Insurance companies actually have only a minor economic interest in healthcare costs because they pass along these costs to employers who sponsor health insurance. As long as an acceptable margin is maintained, cost increases are in the insurers' self-interest because higher costs lead to higher premiums and more profit. Cost constraints only gain significant traction among insurers when the willingness to pay higher premiums is strained.

Recently, insurance rates have approached the limits of employers' willingness to pay, and costs are shifting to employees through higher deductibles and defined-contribution plans. In the extreme, limiting employers' insurance costs has resulted in the re-categorizing of large numbers of employees as part-time. These actions have created a big group of under- and uninsured Americans, which has led to a core of the ACA regulations.

Many healthcare providers cheered the passage of the ACA because it promised to increase health insurance coverage for millions of Americans. By covering the uninsured, ACA authors said that health system costs would go down because more healthy individuals would be paying into the system.

Also, for providers, the ACA may mean their margins will improve as they are writing off less bad debt and providing less charity care to patients who may now be covered. Regardless of the political climate, more patients being covered by some form of insurance — Medicare, Medicaid, or through the healthcare exchanges — is a better economic scenerio for health systems and hospitals.

With reimbursement protected, consumer choice and access to healthcare could also be preserved and the system would be saved. These outcomes are viable and desirable, but their achievement is a long-term prospect. The authors of the ACA were focused on creating a progressive and digestible change that protects consumers' access to healthcare.

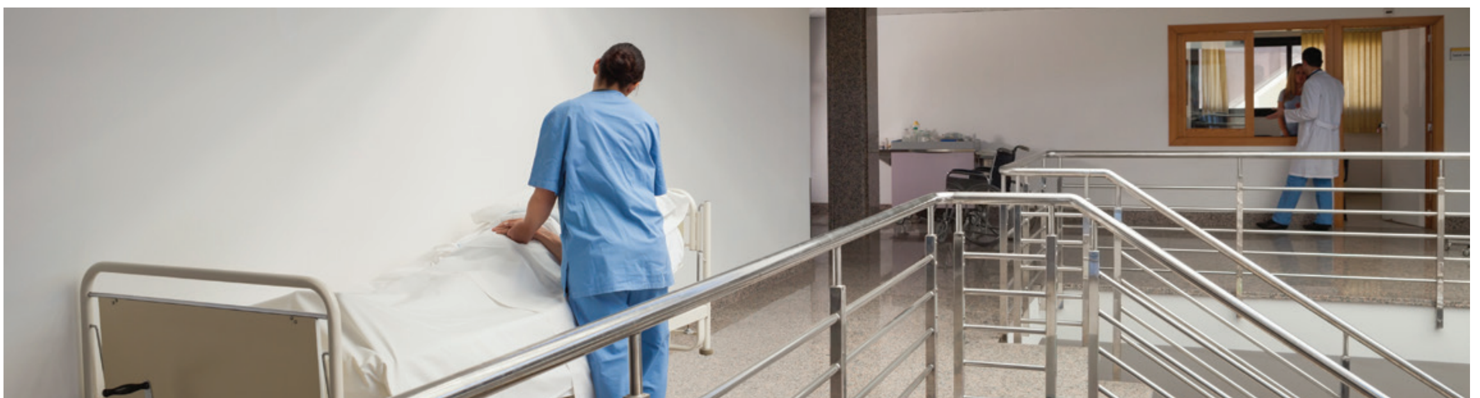
Today, most insured consumers have adequate access to healthcare, but consumer choice in healthcare differs from other markets. While the costs and consequences of healthcare consumption affect both payers and consumers, neither of these groups makes the pivotal decisions in healthcare utilization. Payers and consumers have influence; but only providers (physicians) decide which diagnostic, drug, or therapy is used. Physicians have a primary role in affecting healthcare utilization and cost.

Physician-driven costs have long been an area of scrutiny and threatened reimbursement cuts, even though few cuts have been implemented. Because physician fees are directly proportional to patient care, doctors have a significant financial incentive to see as many patients as possible and to do everything for those patients that is reasonably necessary.

Doctors go to great lengths to ensure patient satisfaction, so consumers have been trained by the modern healthcare system to expect the best care. Many consumers feel entitled to have almost immediate access to the best doctors and hospitals.

Similarly, the best doctors want the best facilities, diagnostics, drugs, and therapies. Both patients and providers expect payers to cover whatever is prescribed. These expectations and the demand for advanced medicine have driven profits and facility expansion.

At the same time, employers' profit motive and government budget shortfalls have mandated healthcare-cost restraint. Insurance companies and their government counterparts (Medicare and Medicaid) have responded by reducing reimbursement rates and limiting coverage for some procedures.



Payment adjustment has been a powerful tool in shaping physician behavior. Payment as a physician behavior-modification tool is effective because doctors naturally prefer to do reimbursed procedures. When doctors disagree with payers' reimbursement policies and the consumer is able, non-covered procedures are paid out-of-pocket. Under healthcare insurance reform, more insurance plans are built around higher co-insurance deductibles to make policies affordable. Consequently, in the New Normal, consumers are increasingly required to fill the payment gaps caused by lack of coverage or high co-insurance deductibles.

However, many chronic-disease sufferers are unable to afford significant payment responsibility because of poverty and diminished socio-economic status. The treatment costs for the poor and indigent chronic disease sufferers are passed along to employers and the government. Government payers are also subject to lobbying influences and public opinion, so the incentive to expand coverage is strong.

The lack of shared incentives among consumers, providers, and payers continues to escalate costs and have resulted in an unsustainable situation. Consequently, healthcare reform was passed. With its implementation, costs should be reduced by billions of dollars per year.

The role of hospitals

Healthcare is generally organized in a hub-and-spoke system with hospitals at the center. Hospitals have some of the highest fixed-cost infrastructures, and running a hospital is particularly complex because the costs of care are difficult to determine prospectively. The complexity involved in running a hospital has been used to justify the relatively high salaries earned by not-for-profit hospital executives. Hospital executives must balance competing priorities, scarce resources, and increasing regulatory pressures. Generating an operating income in a hospital today is a significant challenge, requiring diligent operations management, quality improvement, and cost cutting.

While the costs and consequences of healthcare consumption affect both payers and consumers, neither of these groups makes the pivotal decisions in healthcare utilization.

In non-healthcare organizations, costs are largely known before the goods or services are marketed and sold. Hospitals only understand their costs retrospectively through their charges. Hospital managers cannot directly control costs because physicians diagnose and treat patients. Except for elective procedures that proceed without complication, no one knows how much a hospital visit will cost before the patient is discharged.

Today, cost reductions are a requirement, and physician behavior must be controlled and monitored. Hospital administrators have prioritized and implemented cost-reduction initiatives around clinical integration and physician practice alignment. Standard initiatives aimed at reducing cost include driving standardization and improving utilization of products/services and improving clinical outcomes. Many organizations are also scrutinizing spending and enacting supply-chain management cost-reduction initiatives around standardization, utilization management, and quality improvement.

Another big trend in healthcare operations management is the rise of service-line management. By organizing hospital services into service-lines, the hospital can achieve economies of scale, staffing critical mass, and competitive advantage. Effective service-line management requires a focus on clinical integration (i.e. the alignment of physicians and clinical resources). The rise of clinical integration can be seen in the pace of physician-practice acquisition by hospitals. The construction of medical office buildings on hospital campuses and electronic medical record (EMR) subsidies are also indicators of the growing emphasis on physician practice alignment.

Characterization, effects, and implications of the New Normal

The New Normal is characterized by two transitions:

First, a shift from volume-driven to value-based healthcare. Value-driven healthcare emphasizes quality improvement and cost reduction. The ability to improve quality and reduce cost requires providers to have increased visibility of performance indicators of quality and cost (i.e. a strong analytical focus and data-driven decision-making).

Second, the focus of innovation is moving from technology to processes. Process re-engineering, Lean, six-sigma, and other initiatives underway at many facilities are indicators of

process innovation. Processes cannot be improved without diligent focus on standardization, utilization, care-pattern management, and monitoring of outcomes. Facility-wide initiatives on finding ways to reduce duplication, minimize back-office work, and avoid wasted space are additional indicators of process-based innovation. These two transitions have direct implications for facility managers, as well as product and service suppliers. They create a framework for healthcare reform, which will be discussed on the next pages.

The shift from volume to value

Healthcare providers have strong incentives to increase patient and procedure volume. Reimbursement is structured by a fee schedule that applies to healthcare delivery; doing things for people to generate revenue in the "Old Normal." With healthcare reform, payment mechanisms are changing in a few important ways:

First, providers are increasingly subject to penalties for increasing volume. Value-based purchasing (VBP) is one of the primary programs that reduce payments for "avoidable" services. VBP also penalizes providers for medical complications they may have caused. Before VBP, if a patient suffered a hospital-acquired infection (HAI), the hospital was paid more to treat it. Under VBP, not only is the hospital not paid for treating the complication, it is penalized for frequent HAIs through lower reimbursements.

Second, providers are being paid lump sums for procedures under an episode-based (bundled) payment system. The traditional reimbursement system pays each provider separately for his or her services. The surgeon receives a fee, as does the anesthesiologist, the facility, and so on. In an episode-based payment program, the providers receive a single payment. In this way, the entire care team is rewarded for cooperating and reducing cost. By aligning incentives, bundled payments are a powerful tool to reduce utilization and cost.

Third, utilization patterns and the intensity of procedures are being scrutinized. Today, government payers are auditing claims and questioning the necessity of expensive procedures. If a provider is found to be using a more costly procedure where a less expensive one would suffice, reimbursement can be taken back. Utilization reviews and payment adjustments are controversial because they can override physician judgement, but reviews rely on published standards of care and customary treatment patterns. Therefore, physicians have an incentive to reduce their non-standard treatment practices.

Finally, providers are being exposed to population cost-risk through the formation of accountable care organizations (ACOs). ACOs make money by reducing the cost and utilization of covered patient populations, much like HMOs. Instead of being rewarded with higher fees for higher complexity procedures, providers have a strong incentive to avoid high-cost interventions. By reducing the cost of treating a population, the provider can share in the savings enjoyed by the payer.

Taken together, these methods are encouraging lower utilization and cost. Navigating this transition from volume- to value-based healthcare is forcing providers to innovate. Today, meaningful innovation is powered by data, analytics, and a focus on informatics. Without data-driven decision-making, many initiatives suffer from unforeseen confounds and obstacles.

The focal point of innovation

The shift in the focus to innovation is another important feature of healthcare reform. To adapt to its requirements, care delivery must be re-tooled to manage patient transitions, leverage multiple care settings (like outpatient and home care), and streamline acute-care episodes. This is a departure from the former emphasis on more advanced technology and treatments in pursuit of reimbursement.

Instead of adopting new technology, providers have an incentive to improve the efficiency of care delivery. Instead of sending patients to hospitals, providers are now turning to outpatient centers. Maintaining patient care at a less intense level — as in a doctor's office — and ensuring that care-setting transitions are smooth and efficient, are now the priority. Driving patient volume from the hospital to the clinic

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without sacrificing quality is the essence of process-based innovation.

At the same time, the cost of operating a healthcare facility is increasing. The financial crisis caused providers to defer many capital investments, but many of these projects can't be delayed any longer. Providers must modernize facilities and upgrade information technology to gain efficiency just as the available skilled-labor pool shrinks and becomes more expensive. Connecting an entire campus and enabling better transitions to non-acute facilities is the priority, but it requires investment.

Unfortunately, many hospitals were constructed under the Hill-Burton Act as Medicare funded the expansion of acute-care facilities in the 1960s-'80s. These facilities were built in a different environment, and current information technology, imaging capabilities, laboratory tests, minimally invasive techniques, patient demographics, and chronic-disease rates have changed space requirements. Many hospital infrastructures have built-in inefficiency and must be refreshed.

What facility managers can do

The role of facility managers in supporting the transitions from volume to value and toward process innovation is key. First, facility managers must ensure that all buildings are operating at their most efficient level. Building automation — including security, fire control, and climate control systems — are essential in driving efficiency. Hospitals are major consumers of utilities. Innovative facility management can deliver significant value by modernizing in these areas.

Healthcare delivery generates a lot of bulk and hazardous waste, and facility managers have a never-ending list of repairs and maintenance. Improving the environmental impact of a hospital while supporting a busy organization will require managers to take a long-term view. Repetitive behaviors like recycling can support a cultural change. Facility managers are in a prime position to lead initiatives that make incremental changes toward sustainability and efficiency.

The facility manager is encouraged to approach contemplated changes by focusing on standardization, utilization (space, energy, work-effort) management, and outcomes (operating cost, quality, and patient satisfaction) management.

Suggestions for managers in the transition to VBP

Managers can improve their organization's performance under VBP in the following ways:

1. Building Automation System (BAS) providers have the responsibility of ensuring patient comfort through room control of temperature, humidity, and lighting. These environmental variables are increasingly important as patient satisfaction is one of the primary drivers of improvement in VBP performance ranking. Patient comfort is directly related to one of the most reactive measures in the HCAHPS survey (i.e. The Overall Rating of the Hospital.)

Other research has shown that the most effective tool in improving consumers' assessment is the organization's brand. Therefore, having an up-to-date and functioning building and organization brand identification is very important. The way the interior of the facility reinforces the brand is important in determining consumers' perception of the quality of care.

Some facilities have entered into co-branding arrangements with nationally-known providers like the Cleveland Clinic and MD Anderson Cancer Care. These contracts stipulate specific logo and building identification guidelines. Facility managers can take a page from this playbook by focusing on the aesthetic appeal of their organization's name and brand identification.

2. Not all facilities are located in ideal neighborhoods. Perceptions of a lack of safety can result in poor consumer assessments of the facility brand and the quality of care. Facility managers can help counteract these perceptions by increasing a sense of security.

Visible cameras and security personnel and signs related to campus patrolling are strong peripheral cues of quality and safety. Increasing the intensity and coverage of lighting in parking garages and campus walkways, as well as placing emergency response posts and offering escorts to parking garages and remote areas after dark, can also reinforce a sense of safety. Internal access control and a streamlined registration process are also important signals of quality and security.

3. In any location, the exterior environment makes the first impression and has an anchoring effect on quality perceptions. Facility managers can affect these perceptions by ensuring cleanliness, lack of graffiti, and the clarity and legibility of identification and directional signage. Ease of campus navigation is a strong contributor to positive consumer assessments. Feature lighting and colored filters on building lights can also add interest. The use of landscaping can further these positive impressions, as can the involvement of charitable giving. Gardens, for instance, can be sponsored by benefactors or clubs.

4. One frequently overlooked patient satisfaction area is parking. Few people rave about good parking, but parking problems are a potent irritant. To minimize this, some facilities offer valet parking. Others offer a shuttle service for patients with limited mobility. Facility managers should look at transportation from a campus-wide perspective and look for opportunities to stimulate patient satisfaction.

Sometimes large changes are required. Many improvements involve retrofits and new technology at significant expense. Departing from self-operation approaches to outside plant management and maintenance is worth considering because specialist organizations have economies of scale that cannot be easily matched by stand-alone providers.

Options for facility managers include the development of public-private partnerships with city and state governments. These arrangements can create a more efficient utilization of bulk-waste hauling and incineration facilities. Rebidding contracts for maintenance, construction, and even lean distribution are also prime opportunities for facility managers to make a sustainability impact. Partnering with warehousing and logistics companies or distribution specialists can also improve savings and efficiency. Facility managers can also look to Group Purchasing Organizations (GPOs) to reduce search effort for suitable suppliers and appropriate pricing. Some GPOs have specialized departments that focus on facilities- and construction-related services and supplier contract management that can help speed standardization, benchmark utilization, and forecast cost and other outcomes.

Much of a healthcare facility manager's focus is on compliance with constantly-evolving regulatory requirements. Complying with fire codes and security regulations can be less expensive with peer-organization benchmarking and collaboration. Current deficits and emerging requirements also can be determined by asking vendors for recommendations. BAS manufacturers, for instance, are on the front lines of standard development. These vendors can offer modular systems, and many provide an upgrade pathway to achieve compliance. New systems also have greater capabilities to monitor and provide support with lower labor requirements. Facility managers should assess and benchmark legacy systems to detect hidden labor costs and future obstacles to sustainability.

In a cost-pressured environment, the consequences of The Joint Commission's increased security requirements are best dealt with proactively. Increasing requirements for safeguarding vulnerable patients, such as infants, the cognitively impaired, and the mentally or critically ill are evident in draft compliance bulletins.

5. A children's play area is another way to increase the attractiveness of a care setting. Some studies have shown that play areas even increase positive evaluations from patients without children. There are specially-designed indoor play-area vendors that have solutions for hospitals and medical office buildings. This is another area where charitable giving can offset expenses.

6. Hospital-acquired conditions (HACs) are penalized under VBP and suggest quality deficits. Infections, for instance, can mean significant reimbursement cuts for a facility and require remedial action. Facility managers can help avoid these by safeguarding patients from the effects of construction.

Enhanced ventilation and particulate suppression may be required as construction dust can cause respiratory, surgical site, and wound infections. During construction, facility managers also should remain vigilant about airflow and possible fiber, particulate, and biological aerosols. For immuno-compromised, asthmatic, and obstructive pulmonary disease patient populations, even mild irritants, such as waterbased-paint fumes, can affect health outcomes. Some of these irritants are unavoidable, but planning and engaging the clinical staff can minimize these issues.

7. Multiple drug resistant organisms (MDROs) are a persistent problem for healthcare facilities. Many hospital-acquired infections (HAIs) are caused by MDROs, and controlling them is becoming a public health issue. Antimicrobial management systems for facilities are increasing in number and declining in cost.

Both plastic and metallic surfaces can now reduce cleaning effort and chemical loads for facility operators. Direct ultraviolet pulse disinfection systems are on the market, and indirect UV disinfection systems remain viable. Copper-infused metallic surfaces in high-traffic and critical care areas have also been shown to reduce microbial colonization and transmission of HAIs. As equipment and work surfaces age, facility managers should consider where copper doorknobs, handles, IV poles, laundry bins, and other antimicrobial metallic surfaces can be used.

8. Noise reduction has recently been shown to improve patient recovery, healing, and satisfaction. Facility managers can use airflow baffles, white noise generators and sound-barrier walls around construction. Active noise canceling devices are also increasing in popularity and affordability for use in critical-care environments.

9. Facility managers can aid in the improvement of patient flow by considering patients' vision, mobility, and other physical limitations when planning a facility redesign, modernization, or new construction. Wayfinding is a significant cause of patient dissatisfaction, and facilities and IT managers have discovered and addressed some of these issues with printable facility maps coordinated to the appointment and department to be visited.

Furthermore, adequate contrast and letter size on signs and directional aids continue to be essential for patient wayfinding. Sign placement around entrances can also improve the patient experience by reinforcing the brand of the organization. High-visibility paint and grip surfaces on stairs and in patient lavatories require continuous upkeep to avoid injury and potential harm. Continuously assessing

Without improvements in the technology used to monitor and secure these patients, facility managers may be required to increase documentation. The implementation of a current-generation system can avoid regulatory and legal liabilities.

Healthcare reform requirements have created additional opportunities for facility managers to improve organizational capabilities. To explain where improvements are possible, reform must be described in greater detail.

Healthcare reform simplified

The ACA stands as a landmark of change in the U.S. healthcare marketplace. The causes and consequences of this law are many, and untangling the implications for facility managers requires an abbreviated overview of the law.

The ACA has two significant parts. The first is a series of regulations that affect insurance coverage and government subsidies for qualified individuals to purchase coverage on a healthcare exchange. The second part of the law deals with provider-based reform and is grounded in VBP.

Insurance reform

This part of the law was created to make healthcare available to millions of uninsured Americans. Reasons for this coverage gap are many, but many individuals — such as the self-employed — have trouble finding coverage without being part of a group. Also, young employees would frequently forego insurance coverage because of low wages or a lack of benefits. Finally, there are part-time workers who do not qualify for benefits.

Healthcare providers welcomed the addition of insurance reform to the law because of the anticipation of additional insured patients. More covered patients could reduce bad-debt and charity-care expenses.

Insurance reform regulations have affected providers in many ways. The rise of high-deductible plans has required more point-of-service payments for hospital and physician services. Additionally, insurance companies have established narrower provider networks, in which a small number of providers accept contracts from insurers at lower payment rates in exchange for higher patient volumes. These changes have driven patient volumes down at other organizations.

and addressing the limitations of the physical plant is imperative for facility managers to improve patient satisfaction.

10. Indoor foliage has been shown to improve patient outcomes and satisfaction. Researchers have noted the therapeutic value of indoor plants as cost-effective and non-invasive complements to patient recovery. Introducing plants into patient care and waiting areas can reduce anxiety and stress and convey positive impressions about the hospital.

11. Environmental and sustainable business practice certification and energy efficiency certifications are other areas of potential improvement. The qualifications for sustainable business operations are numerous, but the cost-benefit ratio of energy efficiency and waste reduction is high. Many vendors have solutions available, including financing to reduce the cost of adopting greater energy efficiency methods. Consumer preferences add to the benefits of government incentives to pursue a sustainable business model.

The implication of this section of the law for facility managers is twofold:

First, patient volume is expected to increase but revenues per patient are expected to decrease. Plus, the profitability of care delivery is strained by legacy costs. Therefore, lower costs and greater efficiency are required.

Newly-insured individuals covered under a narrow-network plan are more tolerant of wait times and just-adequate facilities because their out-of-pocket expenses are reduced by "in-network" utilization. However, attracting more profitable patients requires organizations to improve aesthetics and service levels to cater to a more demanding population.

Second, the cost to insure and support the facilities management employee pool is increasing. Budget reductions collide with cost increases for the labor force. Finding, affording, and retaining talented personnel are more difficult in the current environment.

Provider-focused reform

The other side of healthcare reform requires providers to deliver increased value. Because value is an ambiguous term, regulators have created an equation.

Value = Quality/Cost

To deliver value, providers need to improve the quality of care and deliver it at a lower cost. Improving quality through cost reduction is not a reliable strategy. However, sustainable cost reductions are achievable through quality improvement. Reducing inefficiency, improving outcomes, and growing patient satisfaction will all reduce cost. Both patient-centered care models taking form in the marketplace can be seen in Medicare's VBP orientation.

Making the transition to VBP with facilities management

VBP is both an orientation and a program in the ACA. As an orientation, VBP is the manifestation of the value equation designed to transform Medicare from a passive payer of claims to an active purchaser of value. Through this orientation, Medicare wants more value from providers for the same or lower cost.

The VBP program refers to pay-for-performance reimbursement. The program is built upon a standardized quality-measurement set and incorporates public reporting of quality. Under VBP, all non-exempt providers (most non-critical access hospitals) are measured and ranked nationally based on quality metrics that chart performance on process and outcome of care.

An organization's performance is then scored, and Medicare incentive payments are apportioned based on a percentile ranking. Facilities that score above the 50th percentile are eligible to receive incentive payments, and those below that cutoff receive no incentive payments. In the current period, organizational rankings are calculated using a 70/30 weighted combination of "core measures" (CMS Quality Measures) and the Hospital Consumer Assessment of Healthcare Providers and Systems Service (HCAHPS) survey results. The final ranking is determined through a complicated calculation of relative performance and improvement compared to national averages and prior-year performance.

The term "incentive payments" can be misleading. Incentives are actually earn-backs of reimbursement cuts. Beginning in Federal Fiscal Year (FFY) 2013 (October 1, 2012), non-exempt providers' Medicare reimbursement was cut by 1%, and each provider had the opportunity to earn back a portion of the cut through performance and improvement compared to the national peer group. In each successive year through FFY 2016, the reimbursement cuts will increase by 0.25% annually. The earn-back is contingent upon increasing performance requirements in quality, cost, and patient outcomes.

How the ACA affects technology-buying decisions

Technology acquisition in the New Normal requires a strong business case and a realistic expectation of increased quality and lower cost. Without a business case, few capital requests are being funded in the New Normal. Because the standard response to capital requests is deferral or delay, facility managers seeking new technology must consider the hierarchy of priorities for their organizations. Recognizing and using the hierarchy can improve the effectiveness of project requests.

In the hierarchy of project approval, life safety is the first priority. The second level of priority is repairing or replacing something that is broken or causing a service failure. The third level is avoiding liability or adhering to the standard of care if current processes are sub-standard. The fourth level is the support of an organization's strategic direction — like implementing a service-line strategy. Finally, the last level is a normal request.

Life safety

Ensuring life safety for patients and visitors is a foundational activity. Despite best efforts, however, adverse events happen. Technology that ensures life safety will always be prioritized, especially when addressing a deficit that can avoid enforcement of compliance mandates or a sentinel event. Ignoring life-safety issues can lead to regulatory enforcement and loss of accreditation, so managers must connect a contemplated project to safety preservation. Solutions in this area start with building automation, fire, security, and climate control, but extend to construction planning and implementation. Thinking carefully about the ways facilities affect the basic health and security of patients is increasingly important.

Service failures

If something breaks, malfunctions, or causes a service failure, it can usually be replaced without a budget meeting. If the failure does not impact life safety, a simple replacement is often sufficient. However, facility managers should consider the lifelong cost of a piece of technology. Pricing of new equipment varies widely and sometimes the reasons for price differences are not obvious. Similarly, warrantees and performance guarantees are sometimes

ambiguous or filled with exclusions. Facility managers should consider using a third party for equipment or technology rating. Buying current-generation technology from reputable manufacturers is usually safe. However, determining the country and factory of origin for equipment is increasingly important. Furthermore, the anticipated life span of the equipment should be known or conservatively estimated.

Emergent liabilities and deficits in the standards of care

Where emergent liabilities or deficits in the standard of care are discovered, facility managers should be proactive. Avoiding potential liabilities is less costly than responding to an emergency or sentinel event. Therefore, facility managers should ensure that technology recommendations align with regulatory, accreditation, and peer-reviewed best practices. The best defense against liability is conformance with industry standards. Furthermore, as healthcare providers seek to integrate multiple care settings and processes, facility managers can leverage their experience in the acute-care environment to improve operations in new settings.

Supporting service lines

If the organization is embarking on a strategic direction, the facilities component must be carefully considered. Service-line management is the new organizing force in healthcare, and service lines require specific profiles of technology, equipment, space, and logistical support. Facility managers must focus on making each service line operate efficiently through standardization, utilization, and (improved) clinical outcomes. Unfortunately, communications between service-line and facility managers is sometimes lacking. In some cases, better coordination between these parties can speed up new construction, as well as reduce costs. Ensuring that facilities remain a trusted resource to guide the development of organizational capabilities should be a priority.

Regular requests

The standard capital budgeting and planning cycle has suffered from defunding and re-prioritization of projects according to the hierarchy presented here. The New Normal of healthcare has strained the ability to earmark funds for redevelopment, modernization, or new construction. This situation can be improved with clear project rationalizations. If the organization needs new technology, facility managers should develop a coherent cost-benefit analysis with the assistance of finance. Without a cost-benefit analysis, organizational leaders may pass on a project that actually pays back or supports a strategic initiative.

Conclusion

As the “New Normal” emerges, a facility manager’s ability to demonstrate value will become increasingly important. While the facility department continues to ensure the comfort and safety of patients and staff, connections to the requirements of service-line managers must be maintained and strengthened even as healthcare evolves. The information in this paper will help managers keep on top of today’s and tomorrow’s healthcare climate.

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