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Real value in a changing world

Perspectives on Healthcare

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A model built to improve quality and financial well-being

If hospitals were themselves financial patients, many would require acute care. It's not difficult to understand why. Hospitals and physician offices, a $1.27 trillion-a-year sector of the economy, have been hammered by the recession as of late. A 2008 study of more than 400 U.S. hospitals of all sizes found that half were unprofitable and the median profit margin was zero, compared with 33 percent of hospitals that suffered operating losses and a four percent profit margin just two years earlier.[1]

Fueled by the spiraling cost of medical breakthroughs and the graying of American Baby Boomers, financial pressures will likely get worse, not better. The number of Americans age 65 to 75 is expected to increase 72% by 2040, according to the U.S. Census Bureau, with the number of people over 75 years old more than doubling.

The percentage of uncollectable payments to hospitals is yet another major problem. According the Advisory Board, bad debt as a percentage of operating expenses rose from 5.7% to 6.3% from November 2008 to November 2009.[2] By most measures, the healthcare system is financially in a crisis state.

The uptapped potential of real estate

One of the best prospects for healthcare networks to make ends meet while supporting their care mission is as large as it is overlooked: the portfolio of owned and leased real estate. An average of over 40 percent—and in some cases, up to 70 percent—of healthcare system assets are tied up in real estate and facilities. Managing the portfolio of hospitals, clinics and other facilities to best financial advantage helps offset consequences that are out of the organization's control.

Jones Lang LaSalle conducted research in 2011 with 40 healthcare for-profit and non-profit systems that collectively account for more than $140 billion in annual revenue—about 11% of the total spent at U.S. hospitals and clinics. Most of these organizations earn over $1 billion in revenue, and rank among national leaders. Our research found that the way these organizations manage their real estate and facilities is critical to whether they can accomplish today's key mandates. Systems with a centralized, consistent focus on how real estate can facilitate strategic improvements will enhance competitive positions, build financial strength and become industry leaders. Those that manage real estate on an inconsistent, ad hoc basis at each location will struggle to remain competitive and survive in today's healthcare environment.

[1]Statistics from Irving Levin Associates Inc., as cited in Financial News. http://www.yrth.net/financial-news/hospital-ma-activity-jumped-33-percent-in-2010
[2]Advisory Board Co. presentation, "Future Strategy, Future Growth," 2010.

Unleashing healthcare portfolio power

The Jones Lang LaSalle study found that less than 20 percent of the interviewed health systems have fully integrated management and centralized control over decisions involving their critical and costly real estate assets. However, the good news is that the organizations with the best practices enjoy much stronger financial health. Networks with a locally managed focus had average operating margins of negative 0.28 percent, while those with a strategically managed focus had an average operating margin of 3.89 percent-- a full percentage point higher than the industry's average margin.

Among the leaders, we found real estate and facilities practices that cut costs and free up funds for clinical investments, simultaneously helping to improve the quality of care. We've organized these best practices into four basic areas of real estate management:

- *Transaction Management*: The most progressive systems are striking better leases and determining which properties should be owned versus leased, and using the lease/own mix to be help stay flexible and accommodate future strategic changes. For example, Memphis-based Baptist Memorial Health Care has shifted from owning to leasing medical office buildings, which reduces the risk of being saddled with unproductive assets if a physician group partnership falls apart. Duke Health System in North Carolina has shifted to 90 percent lease, 10 percent own of such properties for greater flexibility to quickly change their real estate footprint.
- *Project Management*: The most successful organizations have gained economies of scale by centralizing facility and construction management functions. The tri-state Catholic Healthcare West has cut energy consumption 26 percent over six years—a $5 million annual savings—by centralizing energy management. Another system saved $1.5 million alone over the last five years by using one elevator maintenance firm for its seven acute-care hospitals.
- *Strategy Planning*: Forward-thinking systems are taking a strategic approach to fully analyzing the viability and impact of existing outpatient facilities and medical office buildings. Many are taking real estate decisions out of the hands of local hospitals so that they could be made to benefit the system as a whole. BayCare Health System opened a dedicated long-term acute care area in one of its Tampa Bay area hospitals, which has helped free up space at other BayCare hospitals for patients with shorter stays. Renown Health has implemented a planning process that takes into account all of its real estate-- leased and owned-- and the growth and demographics in its Reno/Northern California service area.
- *Facility Management*: By centrally managing design and construction, several networks are lowering construction costs, reducing the risk of project overruns, and building a strong brand image for their facilities. Geisinger Health System introduced standard construction designs across facilities in the 42 Pennsylvania counties that it serves. They believe that such standardization has helped boost care quality and growth from $955 million to $2.3 billion in less than 10 years.

Our model to benchmark healthcare performance

Our research found that whether a healthcare system achieves optimal benefits depends largely on how it organizes its real estate and facilities operations. Combining our recent research with our longtime healthcare client experience, we developed a model that organizations can use to benchmark how effectively they manage their portfolio for maximum quality and financial success. Using four levels ranging from "Inadequate" to "Best," the Jones Lang LaSalle Real Estate Performance Model creates a continuum on which property management moves from being a decentralized, tactical function to a centralized, strategic one. The categories in our model are:

Inadequate – Locally managed: Real estate and facilities decisions are made at the local level—the community hospital and its satellites, or even at each building. When most or all property decisions are made at the facility level, every contract—whether for building lease, elevator maintenance, food service, or HVAC repair—is struck individually. This gives a network little ability to pool its purchasing clout, and no potential to otherwise coordinate its property-related activities. Under this system, hospitals that could advantageously share expensive facilities are not likely to do so.

Fortunately, we found only a few of the 40 healthcare systems we interviewed to be managing their property assets entirely locally, although many of them did so only 10 years ago.

Improved –Centrally administered: A headquarters real estate and/or facilities function oversees plans developed and implemented at the local level, improving decisions that were once made independently, without regard for the system as a whole. Office and clinic space leases and titles—even if written locally—are administered centrally to ensure maximum value. Hospital systems consolidate power purchases, facilities maintenance and other services and supplies for major cost savings. A centrally-administrated system can set construction standards in legal contracts, design guidelines, and project management approaches, reducing the risk of cost overruns. There is a system-wide process for prioritizing capital needs, reducing expenditures less important to the organizational mission, while enabling worthy local facility upgrades that might otherwise have lacked funding.

While a centrally administered portfolio is a step up from completely decentralized facility management, it is less than ideal. Since real estate and property plans still emanate from the field up, they reflect local priorities rather than the greatest good for the overall healthcare system. Holistic strategies such as sharing facilities and shifting certain medical services for maximum efficiency and effectiveness are not likely to be ventured from the field.

Better – Centrally managed: A headquarters real estate and facilities function completely develops and implements the system's portfolio property plans. We found that many organizations have centralized some—if not all—aspects of portfolio decision making, such as construction, facilities or non-hospital office management. Such networks are able to consolidate purchases and extract large cost savings for needs ranging from electricity to architectural designs. And because they exert system-wide controls, they can ensure that best design and operational standards are implemented consistently across the organization, improving the "look and feel" of patient care and strengthening the system's brand image.

Centrally managed systems are better able to make real estate decisions with major consequences, including hospitals that should be closed and service specialties that should be redeployed to improve quality, increase volume and reduce costs.

Best – Strategically managed: The headquarters real estate and facilities functions not only develop and implement plans, but they cultivate them in close coordination with the system's C-suite business and care strategies. This enables a nimbleness to rapidly redeploy and reconfigure medical services to best support the overall healthcare mission. Capital invested in unessential properties is liberated and reinvested, such as leasing rather than owning offices and clinics or shutting down facilities that are no longer financially viable. Each piece of real estate and facility is "owned" by the system—not a hospital or region—facilitating quick changes due to acquisitions and consolidations, shifts in local demographics, competitive moves, and expanding into new geographic areas or service capabilities.

In this best-case model, real estate management completely shifts from a reactive mode to one of anticipating organizational needs through strategies such as structuring maximum-flexibility leases, monetizing underutilized owned properties and banking land for future growth. Not surprisingly, we found only a few systems consistently performing at this level.

Step-by-step improvement

Our model provides almost every healthcare organization room to optimize their operational structure and procedures for maximum service quality and financial performance. Though it is unrealistic to expect to make the quantum leap from "locally managed" to "strategically managed" overnight, every system should aim for gradual, continuous improvement using these benchmarks. Determine which operational standard best characterizes your organization, and then develop a plan to raise your performance to the next level. Once there, focus on the next level after that.

Jones Lang LaSalle's Healthcare Solutions group stands ready to help you tap the unrealized potential of real estate assets and infrastructure to drive efficiencies, enhance quality and maximize financial success; all in a fashion that best supports your overall mission.

The healthcare real estate performance model

	Locally Managed	Centrally Administered	Centrally Managed	Strategically Managed
Transaction Management	Leases and titles are managed locally	Leases and titles are administered centrally There is a single repository All leases are compliant, arms-length agreements	Transactions are negotiated centrally	The portfolio is managed to – Preserve future flexibility – Liberate capital for clinical purposes
Project Management	Real estate and facilities are managed locally	Real estate and facilities are administered centrally Processes are standardized Purchasing power is consolidated There is a system-wide process for prioritizing needs	Property assets are appraised annually Total required spend is understood Utilities costs are further reduced with unconventional approaches	A system-wide facilities master plan aligned with the overall strategy Adequate funds are forecast and allocated for real estate and facilities operations
Strategy Planning	Real estate and facilities are planned locally Decisions are optimized for local organizations	Plans are submitted locally, vetted and prioritized centrally There is central visibility of all real estate and facilities, but decisions are still optimized for local organizations	A system wide real estate and facilities plan tied to the clinical and business plan There are shared facilities for the whole system There are strategies for repurposing space that becomes redundant	Real estate and facilities decisions are optimized for the system as a whole The real estate and property strategy facilitates the business and clinical strategies Real estate and facilities strategies are explicitly tied to healthcare reform makes
Facility Management	New design and build projects are proposed and managed locally	Design and build projects are proposed and managed locally, with some degree of central vetting and control There are standards and preferred suppliers for design and build	Projects are managed centrally and incorporate Repeatable designs Standard look and feel Best design practices	Projects are developed consistent with the system mission A rigor to the business case that drives prior clinical redesign

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