

Capital Planning: How Strategic Is Your Organization?

Effective capital planning is increasingly important for providers as they face tighter access to shrinking sources of capital. At the same, they struggle with aging facilities, intensifying regulatory pressures, and ever-changing technology needs. Such a complex process can be prone to missteps, delays, and inefficiencies, particularly in systems that historically have applied a looser approach to capital planning. In the following roundtable, HFMA, with sponsorship from VHA Inc., asks six senior financial experts to review the fundamentals of their capital planning strategy and share some of the lessons they've learned along the way.

In your view, what are the key stages necessary for effective capital planning?

Nik Fincher: Before you build a capital plan, you need a strategic business plan that is well thought-out and addresses where you want to be 10 years from now. That is the first piece. The second piece is a facility master plan. Then, you can use the business plan and the facility master plan to build a five-year capital equipment plan. Without all three of these pieces, you may be doing capital planning based on competitive, anecdotal, or subjective issues that may not reflect the reality of where your business is headed.

As part of your capital plan, it makes sense to invest time in what I call a 'strategic capital plan.' Organizations can start by building or updating their current equipment ledger or inventory of equipment, especially for items of more than \$5,000. Then, rank these items technologically and project out how long they will last and how much it will cost to replace them.

Generally, CFOs aren't going to have the baseline clinical knowledge they need to set priorities. On the other hand, clinicians who possess this knowledge may have unrealistic expectations. Thus, a five-year equipment plan that details what the organization has and when it needs to be replaced gives everyone an unbiased frame of reference.

Blaine O'Connell: Our capital and strategic planning are all one process. We have a 14-month process. It starts in November and carries through the January that falls

14 months later. In November, we do our environmental assessment and begin to develop our systemwide strategic plan. At the end of March, we begin to direct more attention and resources to the financial side of the coin. By the time we reach mid-June, we have done a preliminary, mid-year, five-year forecast of our finances, and we have identified our targets for liquidity, cash, and investments in five years. From that, we determine what we need in terms of cash flow for the coming year and each subsequent year. By doing this, we can better define the dollars that will be available for capital allocation in the first year of our five-year plan.

As we go through summer, we have a core group from our two hospitals—an academic medical center and a community hospital—that work diligently on our capital requests greater than \$250,000. We call these our threshold capital requests, which represent about 30 percent of our requests. These requests undergo a complete ROI analysis, in addition to an overall review for merit. By late September, we have one meeting at which all capital requests go head-to-head in front of a committee of system and hospital senior management. We limit our planned purchases to no more than the capital allocation amount that had been calculated in June. In November, we go to the various finance committees and boards with our allocated capital as part of the annual budget for the coming year.

In the six years that we've had this process, it has worked well, helping us to grow our net worth and our days cash on hand.

Who needs to be involved in these capital planning efforts?

Nik Fincher: All of the constituencies need to be represented: administrative, clinical, biomedical engineering, IT, etc. Of course, not everyone is going to agree on the direction of the plan, and not everyone is looking out for the best interests of the facility. For example, some may see the organization moving toward OB/GYN care, while others may want to ramp up cardiac care.

In terms of calling on outside assistance, certain functions are better suited than others. When working on their strategic plans, healthcare administrators might consider bringing in outside experts that specialize in setting the ground rules and helping to arbitrate. To assist with the facility master plan, organizations may want to hire a space planner, programmer, or architectural firm. For the capital plan, there are outside firms that can help assess current equipment and what additional equipment might be needed. They can also provide some guidance on what technology is coming in the future that may impact a later purchase.

Blaine O'Connell: No matter who is involved in the process, the real key is to have the CEO on board and not let people slip into the CEO's office to make requests and undermine the process. You have to be wedded to your process. And as soon as you start letting people go out of cycle, then it becomes very difficult to say no to anyone.

How do you make sure you are providing a fair evaluation of competing capital needs?

Jack Morris: We request a lot of information on our capital requests upfront. This includes the price of the product, why the product is needed, and how it will enhance customer quality. We also determine how the purchase will affect

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Robert H. Lux, CPA, FHFMA, is the CFO at Temple University Health System, which operates five hospitals in Philadelphia.

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Blaine O'Connell is senior vice president of finance and CFO for Froedtert & Community Health, a Milwaukee-based partnership of 434-bed Froedtert Hospital and 237-bed Community Memorial Hospital in Menomonee Falls, Wis.

John Wiest is chief financial and institutional services officer for Lee Memorial Health System, which operates five hospitals at three locations in southwestern Florida.

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the department's annual operating costs and then analyze its ROI, if the equipment generates revenue. And each capital request form is prioritized by the department director. Prioritization is important, since a big user like surgery may submit 40 capital request forms.

Bob Lux: Here at Temple, we have three pools of allocated capital. One is for items that cost less than \$250,000, and our hospital CEOs have quite a bit of discretion in how this money is spent. A second pool covers items greater than \$250,000, and it is in this capital pool that the hospital CEOs present their proposed projects to their colleagues and the health system executive management. Allocations of capital from this pool are rigorously evaluated with recommendations ultimately presented to our chairman and CEO for approval. A third pool contains everything related to IT. These items go through a process similar to the clinical items that are greater than \$250,000 with regard to recommendations and selections.

We decided that it was critical to put some boundaries around IT. If you set up your process without boundaries so that IT competes with clinical equipment for limited capital, IT usually loses. Overtime, you under-invest in what is a critical part of your service delivery. At my organization, the health system's president and CEO and I are the only two people who can move money between these capital pools.

Blaine O'Connell: When we introduced our capital planning process at Froedtert & Community Health, we had a new system that included an academic medical center and a community hospital with different missions and different markets. Initially, there was concern that the process would pit 'my hospital versus your hospital.' But that faded as we got better at developing tactics and were able to tie our decisions to our strategy.

With this said, one pitfall that finance people often fall into is trying to weigh the subjective against the objective. There are so many projects for which it is difficult to do an analysis of net present value. Still, there is often a way to evaluate the impact of a decision. For example, if physicians stop admitting to a unit because broken beds aren't replaced, the consequence of not replacing those beds is the incremental lost revenue.

The bottom line is this: An individual project can have a negative net present value, but the overall portfolio for any given year must have a positive net present value.

John Wiest: In my experience, there aren't frivolous ideas. Almost every project needs to be done. But it is a matter of prioritizing these competing capital items with our ability to fund them. At Lee Memorial, we test whether they fit within our strategic plan and our mission. We run ROI and determine if a tactic is financially viable. We also

examine if it would appeal to potential donors and if funds could be raised through our foundation. That piece is becoming increasingly important.

How do you “time” your capital planning efforts so they are most effective?

John Wiest: First, planning needs to happen year-round. Our fiscal year begins on October 1. We have a strategic planning retreat each year during which we invite key leaders, medical staff members, and members of the community. Then we have our tactics conference in March or April. By the end of April, we begin the senior finance review of capital requests. Then we seek approval of the budget in August.

Bob Lux: Our health system is only 10 years old, and we have been engaged in this level of capital planning for about three years. It takes us about six months to complete our capital planning process. We would like to get to the point in the evolution of our system where this process is continuous.

Jack Morris: Capital planning never really stops. The day you have to call a repairman to fix a piece of equipment, you have to evaluate if this equipment needs to be replaced next year or later on. What we ask of our directors is that they do budget planning all year long. We ask them to keep a list prior to budget planning that contains items that may need to be replaced or repaired. We also ask them to gather data on what new options and functionality are available in the equipment that is out there now.

What technology tools can help capture and organize information related to capital planning?

Nik Fincher: Part of the problem organizations run into is that equipment goes by different names. A cauterizing device could be called a cauterizer, a “Bovie,” or an electric scalpel. So, you need to standardize the nomenclature. Equipment planning and naming software helps our members with this issue. The Web-based application is based on universally accepted nomenclature for equipment and includes access to our GPO contracted pricing. Facilities that use the software help ensure that the data they are feeding into their central finance software—which is often linked to their materials management and capital management modules—is as clean as possible.

Let’s say an organization authorizes a \$10 million capital equipment budget for FY07, based on its business plan and facility master plan. In the traditional budgeting method, clinicians often relied solely on suppliers’ prices to build a budget. With access to GPO contracted prices, users can improve a budget’s accuracy by 30 percent to 35 percent.

The software also is useful when forecasting needs and finding opportunities to aggregate purchases to get a better price.

Clay Frederick: At Sutter Health, we are a community-based network, so our organization’s structure is very much like a federation. Each hospital has its own board and C-level management structure. Together we are working on a multibillion-dollar capital investment plan to expand and improve our services and facilities. Much of this activity is related to improved seismic safety requirements that require California hospitals to evaluate, retrofit, and rebuild all hospitals by defined dates. The state’s first goal is that every hospital will remain standing after a major earthquake. In addition, by 2030, the regulations require that every hospital building will be fully operational after an earthquake.

In our current “federated” structure, decisions on equipment are being handled individually. We have a desire to maintain the independence and flexibility of our current structure, but also to coordinate and consolidate our capital purchasing activity, and take advantage of the significant financial benefits of doing so. At Sutter Health, we are not advocating rigid, centralized standards. Rather, we want to consolidate information so that our teams can make decisions in an informed way, and allow for coordination, cooperation, and even consolidation.

We are using software that supports standard naming conventions, and information is stored in one place. This will allow us to easily look at data across projects, recognize volume, and help us make suggestions about appropriate substitutions. Such functionality is critical for us to consolidate our forward-looking purchase plans, and share the result with our GPO so they can negotiate better prices. Ultimately, our goal as a not-for-profit entity is to help us reduce costs so we can expand our services to the community.



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Jack Morris: At Washington Regional Medical Center, one Web-based tool we use gives us the capability to look at the products that we buy and evaluate whether we are getting value for those products. The on-line tool provides full intelligence reports on which suppliers offer these types of products, what we can expect to pay, and what is new in the environment. Such data help inform decisions we make on product purchases.

How do you handle contingencies?

Jack Morris: We retain some money in contingencies. If we do have savings on a purchase or project, the savings are not retained within the department—they go to the CFO's contingency fund. And because we require directors to provide us with intelligence reports on the equipment they request, they won't request \$12,000 for a \$4,000 item. This way, the process is more transparent, and we are budgeting for what we need. It gets rid of fluff in the capital budget.

Bob Lux: Each year, we will provide a capital contingency amount that is held at the health system. With the approval of our chairman and CEO, these funds can be reallocated to member hospitals. The contingency account also serves as a clearing account for any savings realized in budget projects greater than \$200,000. Let me give you an example. If we agree to fund a project at \$400,000 and that project comes in at \$350,000, the CEO of that facility does not get to spend the remaining \$50,000. Instead, that money gets circulated back into a corporate contingency account every quarter. Each quarter, we do a complete evaluation of the capital spending with the hospital CEOs and CFOs. It is during this process where we consider funding requests that were not anticipated in the budget.

How should organizations monitor their ongoing capital projects?

Bob Lux: With large projects that involve clinical investments, you have to develop a culture of conducting post-investment reviews. You need to bring in the objectivity of finance, and you have to build accountability and discipline in the process by coming in six months after you initiated the project. It is not a difficult process to develop, but it is a difficult process to sustain. And while it doesn't happen

often, you have to be organizationally prepared to pull funding from a project.

Nik Fincher: The capital allocation team has to meet regularly and frequently to assess the plan and have input on how the plan is executed. Let's assume that an organization has a 10-year business plan, a 10-year equipment plan, and a five-year capital plan. The team does not want to assess the implementation of those plans in these time increments. The capital plan is a tool that needs to be flexible the same way a business plan is. An organization should be implementing the plan in one-year intervals, so they can switch directions if needed.

Any parting words of advice you would offer to CFOs and other senior financial executives on making capital planning more effective?

Bob Lux: Start the process as early as you can, and focus on building trust through communication and transparency. This process requires the underpinnings of trust to be successful over time.

Clay Frederick: Collect three blocks of information: large capital construction projects, small capital construction projects, and annual repair and replace projects in a common dataset. Capital decisions should be considered part of an enterprise, not individual transactions.

Jack Morris: Even though the capital planning process demands a lot of structure, financial executives should try not to make it any more intimidating than need be, especially if the process has been a lot looser in the past. Early on, we would take care of filling out capital requests when a department director was overburdened. We realized that some departments, particularly the heavy users like surgery, had to put a new structure in place so their requests could be done in a timely fashion.

John Wiest: I would emphasize the importance of making sure that the overall capital budget is going to generate a positive return. If there are too many items driven by mission that aren't going to generate a positive return, then your future years will be jeopardized. Once the dust settles, you have to look at expenditures in their totality and make sure that they will generate a positive return. Don't get into trouble by trying to do too much at once.



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