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Key Takeaways from the Minneapolis Hospital, Outpatient Facilities & Medical Office Buildings Summit

*Reported by **Dan Emerson,** a freelance writer based in Minneapolis. Emerson also writes for Healthcare Real Estate Insights.*

▶ Inside the Head of Healthcare CEOs – What they're Thinking, What They're Prioritizing

***Charisse Oland,** President, Oland Consulting*

- **In 1980, healthcare accounted for 8 percent of total spending** in the country. Now we're at almost 20 percent. "People used to say that when healthcare cost hits 20 percent of the GNP, 'we're 'done,' we're going to have to change' -- but we're not changing enough to bend the cost curve."
- **To lower costs,** health systems try to push people out of the most expensive place, hospitals, into outpatient centers and home. "The solution always seems to be to build another building." While the alternatives have value, how does spreading out systems reduce costs?
- **Thirty-two percent of healthcare costs are still in the hospital,** where specialists reside. A lot of money is spent on end of life care and expensive pharmaceuticals. Everybody wants to build for the profitable consumer sector, where the money is... but when someone can't pay, where do they go? The emergency department. So, hospitals continue to carry the debt for unfunded care.

- **In the "old days," physicians** weren't employed by hospitals. But by 2000, 15 percent of physicians were employed by hospitals/health systems. Today in Minnesota, 80 percent of physicians are employed by hospitals who also own insurance companies and carry the full risk of population health. That's not all that's changing. Many self-employed physicians don't have money to buy the latest technology and younger physicians aren't working 24-7, as used to be the expectation. Now, baby boomer aging is adding 10,000 (seniors) a day to the healthcare market. And consumers have big expectations for customer service.
- **Knowing who is at the table is critically important.** When you create a design team, make sure you have all of your users at the table, not just the doctors. You need to include all of the people including supply chain, facilities, consumers, etc. Early involvement reduces the likelihood of the 80% of change orders come after the project is done.
- **Everybody focuses on whether the project is on-time and on-budget.** What we really want is on-target -- the right solution for the problem.
- **As hospitals acquire physician groups, they are rethinking design.** Facility designers need to know the system's resources, system network, geography, demographics, and brand.
- **Site-neutral payment reform is growing** but that doesn't change the basic equation. Team-based care is starting to impact facility design—where instead of the doctor simply being the boss, she/he provides care within a team which enhances quality, efficiency, and effectiveness.
- **Only 10 percent of being healthy** is attributed to healthcare access. Forty percent of being healthy comes from decisions we make; another 20 to 25 percent is the social environment. Consider: obesity has grown from 13 percent of the population to about 35 percent. In nine states it's over 40 percent; about 30 chronic diseases are directly linked to obesity. We're exercising less. Among children, obesity is at 18 percent; it's 13 percent of 2-year-olds. The unhealthy trend is frightening. How then will healthcare systems manage population health?
- **We are seeing the first generation to reverse the longevity trend** and becoming less healthy. In addition to the health-related problems associated with obesity, in 2014 opioid addiction caused 25,000 deaths a year, now we're at 50,000 a year and growing. We need to change the narrative from treating healthcare to maintaining wellness.
- **We've been behind the technology curve with digital health.** Some innovators are now collecting biological data through smart watches and other devices to predict episodes of illness and care concerns. In the late '90s, biotech proved that if you can manage the vagus nerve you can manage all kinds of disease. Biodesign, or biotechnology and bioengineering analytics are coming together to find new solutions to health problems and reducing reliance on medication for treatment.

Attendee Comments

"Convenience Care Explosion Session: Practitioners were great -UCP insight was excellent. Panel format is nice to hear a variety of voices"

"Great variety of real world topics"

"Relevant!"

"Interactions between speakers/attendees throughout the day"

"Understanding deeper how strategic planning is done for HC projects"

"3 morning sessions"

"Diversity in topics"

"Excellent challenges to traditional thoughts"

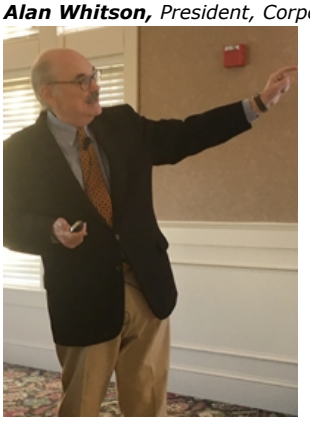
"Rise of Women in Healthcare Leadership was great - topical content, articulate panel and moderator, and relatable"

Industry Partners

- **Ambulatory care poses an amazing opportunity.** We're now intentionally designing clinics and retail spaces for access, safety, convenience and efficiency.
- **A survey of Midwestern CEOs found the number one concern** was margins shrinking, due to end of life care, Medicare withhold, Pharma, ED primary care for the uninsured, insurance network risks, and workforce costs. Most of these health systems say their margins are running about 4 percent, with about 50 percent also dealing with the 2 percent Medicare withhold for not meeting CMS quality metric requirements.
- **Buildings are another issue:** should we double down on the old buildings that hold extensive and expensive HVAC and technology infrastructure or build something new and more efficient?
- **There is a regional and national workforce shortage of MDs,** as we are training more specialists and fewer primary care doctors, leaving an even deeper rural shortage. Far fewer surgical procedures are done in rural hospitals anymore, as more complex patients are referred to urban hospitals for subspecialty care. Rural hospitals are relying more on telemedicine to maintain care locally.
- **Now when you go to the primary care doctor,** you typically see an advanced practice nurse; they can take care of about 80 percent of problems, so doctors can handle patients with more complex issues. But nurses are being overextended as well as aging out and fewer young people choosing hospital nursing. There are inadequate numbers of professionals overall to care for the Boomers. As a result, care delivery continues to change.

▶ What's Really Driving Demand for More Medical Facilities

Alan Whitson, *President, Corporate Realty, Design and Management Institute*



- **Healthcare now is all about politics.** In a recent consumer poll, 56% of survey respondents supported Medicare for all, 71% supported guaranteed health insurance, 67% supported eliminating premiums and out of pocket costs. If Medicare for All comes in, your life as a healthcare professional or facility designer will be miserable for a while.
- **Accountable care organizations,** bundled payments, value-based payment, etc. are all starting to change healthcare. Hospitals are becoming smaller centers of excellence. Health system strategy today is like building with Lego blocks: you can put things together in really interesting combinations.
- **Consumerism and care management are leading to new care sites,** including urgent care, micro hospitals and freestanding ERs.
- **There are two forms of hospital out-migration:** The percentage of inpatient surgery procedures will continue to decline; care is also moving from hospital outpatient centers to off-campus ambulatory care centers. So, the care being provided in the hospital is getting more complex. There are incentives for the shift for payment systems: outpatient surgery is lower cost, more convenient, and physicians make more money.
- **New competitors are emerging,** including CVS Healthcare and Aetna. Because Amazon can now provide home delivery of pharmaceuticals for lower cost, there's a smaller share of Pharma business for drug store chains. Plus, insurers like Aetna are building "hospital-less" delivery networks.
- **Traditional hospitals are not going away.** Older boomers will still need high-value services and that will money into hospitals. But the old Boomer generation will strain future provider economics.
- **Hospitals will experience increasing demand** across all service lines. They will enhance networks to triage lower risk patients out to "spokes" of the system, driving more complex, higher-cost cases to the hub.
- **Non-hospital services will continue to expand,** because we are going to push as many services as we can outside of the hospital. The Urgent Care Center Association reported 8,744 centers in 2018, up from 6,000 just a few years earlier. Thirty-nine percent are corporate-owned; 16 percent are joint ventures with hospitals; 15 percent are hospital-owned. Ninety percent of urgent care centers anticipate growth; they'll average 15,000 patient visits a year, 50 patient visits per day. Only 2 percent of those are ever diverted to an emergency department.

▶ Moving Forward: Strategic Planning in Uncertain Times

(left to right)
Phil DeBruzzi, *President, ACHE Minnesota; Principal, Innova Group*
Ann Duginske Cibulka, *Director of Real Estate Development, Healthcare, Ryan Cos.*
Tom Emison, *Vice President, Strategy & Innovation, Kraus-Anderson*

- **Twenty years ago, strategic planning was a "C-suite only" event,** DeBruzzi said. That has changed a lot. We're now in a more rapid evolution in healthcare. Strategic planning has become a very different process and must go deeper in the organization.
- **Real estate companies are becoming advisers** and facilitators much more often than just vendors and providers, Duginske-Cibulka said. That is happening because not only is there strategic planning but there is strategic doing. She added, real estate is not a strategy. It is a tool to implement your strategy.
- **Health systems are moving capital spending** and decisions outside of the individual facilities, into the overall system, under the finance department. That is leading to much deeper thinking, Duginske-Cibulka said.
- **Strategic planning has changed.** In the past, most strategic plans were 3- to 5-year plans about how to compete better. In today's volatile and uncertain world, it is about competing differently, not better. The challenge, Emison said, is that few executives in the healthcare boardroom are prepared to think strategically outside of their experience, so most strategic plans remain focused on "how can we get better than last year" or "better than so and so down the street." That isn't going to be enough.
- **Organizations can become paralyzed** around policy change and limited reimbursement, but it's important to take action and push boundaries to evolve in the new healthcare market, DeBruzzi said.
- **Looking for your next site?** Anybody can take a map and find where populations are growing, Duginske-Cibulka said. The magic comes in thinking deeper about strategic doing. For example, which service lines are the most revenue-generating services? Consider multiple data, define good data from bad data, generate primary research from your own financials to define where your true revenue opportunities lie.
- **We used to think of the hospital as our billboard,** Betti said. It still is, but the billboard of the future might include MOBs, hospitals, and even kiosks in gas stations if telemedicine continues to grow.
- **Hospitals must start finding ways to reduce waste.** JAMA reported that 25 to 30 percent of healthcare costs is waste; $30 billion of that is due to lack of coordinated care. According to Duginske-Cibulka, that translates to a need for more connected spaces. One system is changing its mindset from having the patient travel to different providers to having multiple specialists and providers come to the patient sitting in one exam room.
- **One health system is eliminating the concept of discharges,** Emison shared. The organization Is focused on creating lifelong affiliations and moving from "sick care" to "well care." Still learning how that impacts facilities.

► The Rise of Women in Healthcare Leadership Roles

(left to right)
Kathy Kummer, *Strategic Leadership Advisor and Improvement System Executive*
Rachel Bartling, *Healthcare Principal, HDR Health System*
Jennifer Myster, *President, Park Nicollet Methodist Hospital; Vice President, Health Partners Community-Based Services*
Danielle Gathje, *Director of Plant Operations, St. John's/St. Joseph's/Woodwinds/HealthEast/Fairview Health*

- "We should be defining ourselves by how we make a difference in this world, not by race, gender, etc.," Bartling said. "Being a great leader is an art form. [The panelists] have all shown what great leaders can be. Developing leadership skills is something that is often done off the clock."
- "One thing to remember is that it's important to take care of yourself first: good exercise, eat well, get enough sleep and make sure those relationships in your life are strong," Myster advised. "When everything is working well in your personal life, you are going to be much more effective in your career.
- "It's about energy; how much gas is in that tank every day is what allows us to be leaders," Kummer agreed. "Being able to understand and monitor that is really critical. I have three young children, it's important that I understand what part of my relationship-building with them is contributing in filling that gas tank, as well as with my spouse. I'm thinking about myself being able to contribute not only at work but also inside of communities."
- "Becoming more involved in Minnesota and Twin Cities healthcare groups helps my network because I can't know everything," Gathje added. Having that network or 'village' to continue to learn from other people really helps me be successful in my roles."
- Who has inspired you?
    - "In my role as a leader, I often think of my grandmother," Bartling shared. "She told me find something I love and be true to yourself and always be kind to people no matter how important you are or think you are. She has been a staple in how I have become a leader today."
    - "A gentleman who ran the entire lab operation at Mayo taught me the importance of 'rounding' on the entire facility to find out what is going on, what is going well," Myster said. "Decisions we make every day impact the folks at bedside; if you don't know what is going on with them, you don't know what is going on. I am also inspired by caregivers, so I try to spend as much time with them as I can so I can understand what they are doing."
    - "I've been inspired by my mother, who taught me the importance of leadership in serving others," Kummer said. "My father was an entrepreneur who taught me about the grit and hard work it takes every day. Really taught me what my principles and values are. When I reflect on what my purpose is, it's to inspire others to lead, grow, and influence."
- Bartling encouraged the audience, "We all need to pass on what we've learned to keep the continuation of strong leaders growing."

► The Convenience Care Explosion

(left to right)
David Chamberlain, *Managing Partner, Urgent Care Partnerships*
Lindsey Niswanger, *Director of Operations Urgent and Convenience Care, Park Nicollet Clinic and HealthPartners*
Tom Betti, *AIA NCARB, 292 Design Group*

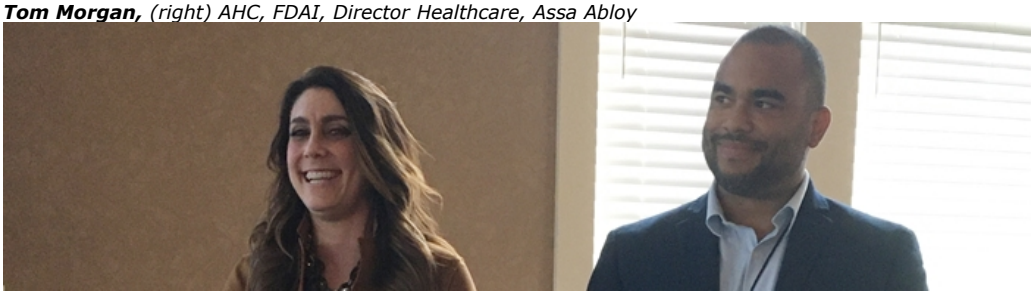


- **Demand for convenience care is growing fast.** These facilities are typically situated inside or adjacent to a large retailer or pharmacy, to maximize patient convenience for getting walk-in care for minor injuries, health screenings, coughs or colds or other routine conditions.
- **The shortage of primary care physicians is one driver** of the growth in convenience care. In some markets, Chamberlain said, the cost of living has gotten so high that primary physicians can't afford to live there.

- **Health systems are using convenience care to attract people to their brand.** Chamberlain points out that hospitals are having to shift from their traditional focus on patients, older people and the sick to market to the young, healthy person. With an urgent care platform, systems have many more opportunities to position interactions with potential patients.
- **Many entrants are coming into the market to respond to demands for more consumer convenience,** Niswanger said. The desire to introduce new patients to the system is core to this strategy. Urgent care and convenience care have demonstrated themselves as a way to introduce patients to the system, including the young patients with whom they want to cultivate relationships over time.
- **Defining clear circulation** in the renovation of Park Nicollet's busiest urgent care center helped with on-staff resiliency, improved efficiency and moved patients through faster, Betti said. The center was built more than 40 years ago, with long hallways and rooms in the back where clinicians would sit to do their paperwork. The design team has re-configured how it does clinics so that the care teams is situated in the middle and all of the patient care rooms are around them. By moving caregivers to the center of the building, they gained better sightlines and reduced in door-to-discharge time by about 10 percent.
- **Park Nicollet has been working toward a leaner footprint for future urgent care locations,** Niswanger said. The team has innovated within retail spaces of 400 to 600 square feet, with two exam rooms and a front-desk check-in area. It's nimbler and more patient-centered.

▶ How to Effectively Analyze First Cost vs. Life Cycle Cost Issues

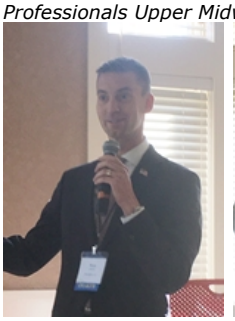
Julie Stegeman, *(left) Healthcare Segment Manager/Midwest, nora by Interface*
Tom Morgan, *(right) AHC, FDAI, Director Healthcare, Assa Abloy*



- It's important to understand first cost versus life cycle cost. To do that, get all the stakeholders—from architects to end-users—together in one room.
- Flooring failures can be a very costly issue to deal with as they lead to down time. Have conversations early to understand the design drivers and the current challenges to customize the best solution.
- Do you always need premium products in a medical office building compared to an acute care facility? Probably not, Morgan says. Being able to value engineer is important to life safety and fire safety, and to patients, visitors and staff. Identify necessary items versus cost saving opportunities early on with the right people.
- One of the biggest construction challenges today is the need to build buildings quicker and faster—even when decisions aren't always made within the same timeline, Stegeman says. For renovations, mitigating risk is the biggest issue.
- People sometimes try to write specs themselves, without having the necessary product license, Morgan cautions. People sometimes underestimate the complexity of doors, frames, and door hardware. You need to know building codes, life safety codes and ADA codes.

▶ Why Put Medical Specialties Under One Roof Closer to Patients?

Ross Hedlund, *(left) Senior Vice President, Frauenshuh, Inc.*
Troy Stutz, *(right) Vice President, RJM Construction; President, Association of Medical Facility Professionals Upper Midwest Chapter*



- **Pros of multi-specialty buildings:** Shared infrastructure, access, cost savings, more potential sites, patient drivers, design efficiencies, collaboration, long term flexibility. Cons: Signage becomes more complicated; patient accessibility becomes more difficult; loss of control of image and building.
- **Providers are no longer looking at B or C sites** to build clinics. Now, they are looking for the highest possible visibility. Instead of spending $4 to $6 per square foot, they might pay $14, $20, $30 per square foot.

- **Frauenshuh is seeing higher costs of occupancy**. It has been a favorable market for borrowing, which is driving changes in cost of occupancy.
- **If you pay more for land,** you want to use less of it. Generally, providers are needing eight square feet of land per square foot of building.
- **There are fewer good sites around** so costs for those sites continue to go up, Stutz says. For a 10,000 square foot building, expect to pay $170-$190 per square foot; for 20,000 square feet, $150 to $170/square foot; for 50,000 square feet, $135 to $150 per square foot. But what really drives costs is what the exterior of the building is made of: steel, brick, concrete, etc.
- **Average tenant improvement costs** by specialty: $90 to $100 per square foot for primary care; orthopedic, $80 to $100; ambulatory surgery, $180 to $200 per square foot.
- **Costs really go up** if you try to put ambulatory surgery into a building that is not set up for that.
- **Construction costs have been rising about 4 percent** per year. The biggest driver is labor shortages. There's a big push to get trades education into high school and middle school to encourage people to get into construction.
- **Contractors are so busy,** college graduates are getting a premium. But that becomes unsustainable; the industry can't continue to bring people who don't have experience and pay a premium for them. Construction schedules are being extended because we don't have enough people. Plus, we're starting to experience long lead times on precast material and the cost of concrete is going up.
- **We are seeing a strong 2020** for the overall construction industry. Most healthcare projects now are remodels, and infrastructure projects.

► How To get What You Want and Really Need From the Healthcare I.T. Department When Planning Your Next Project

Chris Jones, *(left) Applications Manager, HealthPartners*
Rhonda Rezac, *(right) Senior Associate, RSP, i_SPACE*


The speakers discussed a case study around Regions Hospital, which sought to get HealthPartners' other hospitals wanted to get on the same system. They wanted to add more data and more users without adding complexity, with just one app.

- **With a larger company like HealthPartners, there is a good chance there is a lot of compartmentalization** behind the scenes, with people divided up into teams. In a situation like that, it's important to know which team and specialist you need to deal with.
- Even if the IT person you are working with has changed over the course of the project, you need to **make sure they are invested in the project as you are**. Make it a little personal if you can, Rezac advises. Have a "dedicated asset." Find that one person and make them your friend so they can understand what you are doing.
- **Each IT person will have one section of a project; nobody covers the whole thing.** So, make one person a point of contact. That opens up a tremendous line of communication. If you have a dedicated person at one point you don't have to keep explaining what you are trying to do. Give them the big picture and make sure they understand the defined end-game.
- **IT is like a giant house with 10 owners,** and none them talk to one another or explain what they are trying to do. So, there is often confusion. Setting a clear expectation of what you expect from them is really important.
- **IT can have its own language;** it's important to ask for clarification.
- **It's important to have adjustable timelines** for getting things done on a project, because not everything can be done instantly. Security protocols are constantly changing; it's important to know that your timelines are going to change.
- **Often IT personnel are narrowly focused.** Most IT personnel are not flexible with their area of expertise. But it is important to have an agreed-upon language to implement, from vendors all the way down to your end-users.