

# SpaceMed Feature

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## Consolidating Healthcare Facilities Requires a Unique Facility Planning Process



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### Background

In the ten-year period from 1998 to 2008, 28 percent of the hospitals in the United States were involved in mergers and acquisitions according to the American Hospital Association's *Trend Watch Chartbook 2010*. One of the many challenges that newly merged healthcare systems face is eliminating redundant services and surplus capacity. Realigning services and reallocating resources among multiple campuses requires a unique strategic, operations improvement, and facility planning process. Alternate ways of allocating resources need to be thoroughly evaluated and the impact on operational costs fully understood, before a healthcare system spends money on bricks and mortar. It also needs to understand the market and patient population served at each of the individual hospital campuses. A different facility planning approach is required when two or more campuses (sites) share the same market versus when they have distinctly separate markets. Planning at the clinical service line level — such as for obstetrics, pediatrics, cardiology, and cancer care — is also required because some service lines may share the same market and others may not. For example, consolidating two obstetrics programs at a single location could negatively impact the health system's market share for this service line if the new location is deemed inconvenient for the referring physicians and patients.

### Opportunities to Improve Efficiency and Eliminate Surplus Capacity

Historically, hospitals have had a reputation for being inefficient with rigid, compartmentalized organization structures and inflexible employees. Departmental turf wars for space, staff, and equipment are still common. These problems only get worse when two hospitals try to merge their operations. However, the creation of a leaner, downsized, more nimble, bottom-line oriented business is commonly cited as the rationale for the merger.

Although there are many opportunities to improve efficiency and eliminate surplus capacity, the following key areas represent the most significant opportunities:

- **Eliminating empty beds.** Consolidating occupied beds into larger nursing units and closing or converting complete floors of beds to an alternate use can have some impact on operational costs. Conversion of some surplus acute care bed capacity for same-day stay patients or post-acute services may also be an option depending on the overall condition of the infrastructure and code compliance of the facility. However, the real operational cost savings occur when an entire hospital is closed or when 24-7 operation is discontinued (e.g., conversion to an outpatient facility).
- **Integrating and restructuring clinical services.** Opportunities to reduce surplus capacity through clinical service integration include:
  - Consolidating diagnostic and treatment services that require expensive equipment, unique space, and specialized staff thus reducing future capital investment and operational costs
  - Identifying the lowest cost, most appropriate setting to deliver outpatient and chronic or recurring care

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- Evaluating extended hours of operation — in lieu of equipment acquisition and more space — to further improve utilization of expensive resources and increase capacity
- Investigating the “center of excellence” or “institute” concept as an alternative to traditional organizational models
- Restructuring routine, high-volume, quick-turnaround testing to improve patient access and to cross-utilize staffing and space
- **Consolidating physician practices.** As more physician practices become part of larger specialty groups, there is an opportunity to reduce operating costs by sharing resources. Some opportunities include: sharing reception/registration, waiting space, and other patient and staff amenities; sharing of support staff thus reducing the need for offices and workstations; and sharing specialized staff and expensive treatment and special procedure rooms and diagnostic facilities. The number of exam rooms can also be reduced by improved utilization through time-sharing and planning more generic, flexible space.
- **Reducing building support space.** Many of today’s hospitals were designed with a chassis to support a much larger number of inpatient beds than are currently being occupied. Space for support services is commonly located in the basement or below-grade. When two organizations merge, the surplus space increases further. Many multihospital systems have implemented the “mosaic” approach by designating specific campuses for consolidation of specific services, thus reducing the investment in duplicate and redundant resources. For example a single kitchen may be located at one site — with the cook-chill system used to deliver food to the remaining sites — and a single warehouse located at another site from which supplies are distributed.

### Nature Abhors a Vacuum

When there is ample surplus space, hospital departments tend to metastasize into the space available whether or not all the space is needed. This may result in an exaggerated space allocation when the department is relocated to leased space or an alternate facility. For example, the new space may be oversized if it is based on the incremental need beyond the existing (already too large) space allocation.

### Separating Major Consolidation Issues From Non-Issues

Paralysis often sets in when recently merged institutions begin planning to integrate or consolidate redundant services. Assuming that market dynamics and demographics have been carefully considered, the key is to quickly separate actual facility consolidation issues from non-issues. Questions that should be initially addressed when considering the consolidation of two or more acute care hospitals at a single site include:

- Are there contemporary inpatient nursing units in a modern physical plant with code-compliant, appropriately-sized patient rooms and adjoining toilet/shower facilities? What percent of the beds are in private patient rooms? How many total patient “rooms” are available? Are the beds configured to allow for efficient staffing patterns?

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- Are there updated and adequately-sized surgical operating rooms and support space? What is the capacity (considering extended hours of operation)?
- Are there contemporary perinatal facilities and what is the capacity assuming varying operational models (e.g., single-room maternity model versus use of postpartum beds)?
- What is the size and number of specialty imaging procedure rooms and is the technology state-of-art (e.g., MRI, CT, angiography/cardiac cath, radiation therapy)?
- What is the customer's first impression of each facility? Is there convenient patient access, parking, and a welcoming entrance lobby?
- Is there room on the site for building or parking expansion? Are there other site expansion constraints such as zoning restrictions or adversarial neighbors?
- What is the amount, proximity, and ownership of specialty physician offices at each site, particularly if one site will potentially be abandoned?
- How much money will be required for immediate, short-term, and long-range infrastructure upgrading of the facilities? Are there code non-compliances that must be addressed?

Less important issues that often are given more attention than warranted include outpatient services that do not involve large fixed equipment or require unique design requirements — such as ultrasound, physical therapy, primary care clinics, and any department whose space is primarily administrative staff offices and workstations — since these services can be readily moved into leased space on an interim or permanent basis.

### Political, Emotional, and Regulatory Issues

Consolidating healthcare facilities may disrupt deeply entrenched economic interests and involve a number of issues including: state regulatory concerns; community opposition and public relations problems; displaced workers, unions, and the economic impact on the community; and the impact on local philanthropy when a hospital becomes part of a larger health system. Abandoning facilities with new additions or recently renovated space can create emotional, political, and legal issues. For example, there may be covenants associated with buildings funded with donated money. Physician ownership of office space and diagnostic facilities on or near a hospital site to be abandoned further complicates the equation.

### Conclusion

Despite the difficulties in consolidating two or more healthcare facilities to eliminate surplus capacity, the opportunities for cost savings are significant. Funds used to support surplus capacity could be deployed for a long list of alternate purposes including the eventual replacement of the core physical plants and technology of the surviving institutions.

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