

The changing healthcare space

Capitalizing on better patient care

Edited by Marc Richards

The dynamic forces driving the delivery of healthcare—including advancements in medical technology, reconfiguration of healthcare facilities designed around service lines, and a more streamlined and connected system through efficient use of information technology—add up to better patient care, shorter recovery time, and a positive prognosis for healthcare consumers.

The question remains: How will management at hospitals and long-term care facilities adjust to changing conditions and ensure continued quality care in the future?

Will Roberson: How is the delivery of healthcare services changing, and what are the technology advances driving this shift?

Scott Kellman: The best way to truly appreciate recent changes in the delivery of healthcare services is to look at how our common experience as consumers of medical services is evolving in today's world. Until recently, almost all of our diagnostics, treatments and surgical procedures were performed in acute care hospitals. Now, unless we or a family member suffers a major trauma or contracts a serious infectious disease, we rarely set foot in a hospital setting. Generally, we receive our healthcare in our doctor's offices or stand-alone diagnostic centers, ambulatory surgery centers, short-stay surgical hospitals, and specialized facilities such as oncology treatment centers.

Because these facilities are newer and are designed to deliver specific services with a staff of specialized personnel, wait times are shorter, outcomes are far better, and satisfaction is much higher in these new venues. There are numerous technologies that support the migration of healthcare delivery to specialized sites. But two major drivers of this phenomenon include

the increase of electronic interconnectivity among medical professionals and advances in minimally invasive diagnostic and treatment techniques.

We're seeing tremendous progress in both of these areas daily. Microsoft recently launched a free Internet portal for storage and sharing of medical records with physicians. The ability to download X-ray and lab reports along with other medical records, and to instantaneously transmit them off-site greatly enhances the provider's ability to deliver care in nontraditional settings.

Roberson: With more treatments taking place in primary outpatient settings, what impact has this trend had on the development of healthcare facilities?

Dave Ashworth: The design and functionality of newer facilities have reflected the impressive potential and capabilities of new technologies and increasing skills of caregivers. Minimally invasive techniques are a great example of how a patient's recovery time has been reduced from a two to five-day length of stay to two days or less. That has many benefits to the patient. Exposure to infectious risk can be decreased, blood loss can be reduced,

cost to the patient can be lowered, and the patient's return to a productive lifestyle can be accelerated.

The facilities that are being built today are designed around their functionality. It's evident by the design of the ORs, the admitting processes, and the reduced reliance on inpatient beds. Even the ergonomics of the facility reflect its focus, taking into account the placement and relative location of equipment, utilities, storage, and people as ways to facilitate teamwork in a safe environment.

These facilities can be less expensive to build and operate. They can be brought online more rapidly than traditional hospital construction projects. And because of their efficiency and ease of use, we've noticed that patients, staff and caregiver satisfaction scores are very, very good.

We've also used these short-stay facilities to decompress existing hospital operations. It is a quicker and less costly way to bring on specialized facilities and reduce backlogs of cases.

Roberson: The transition of certain medical services to nonacute care settings obviously has ramifications for traditional hospitals. Do these changes



Panelists

Left to right:

Will Roberson, Director, CIT Healthcare;

Scott Kellman, President and CEO, CARE Investment Trust, and Managing Director, CIT Healthcare;

Dave Ashworth, President, Cambridge Holdings, Inc.;

Joseph W. "Chip" Marshall, CEO and Chairman, Temple University Health System;

Michael Goldenberg, President, Health Realty Advisors, Inc.;

Stuart Shapiro, President and CEO, Pennsylvania Health Care Association

provide opportunities for hospitals to reconfigure their operations and more effectively utilize their physical space?

Chip Marshall: Definitely. The days of two patients in a room in various units are over. The ability to leverage technology with construction and design of new physical spaces has opened a whole new world of opportunity for hospital operations. New to markets across the country are unique ideas such as universal beds. This requires the development of single patient rooms that provide the infrastructure and technology to provide ICU through medical surgical levels of care. To implement such a model, the paradigm of bedside patient care shifts considerably. Instead of moving the patient to different units, we move the staff around the patient.

You are also seeing more hospitals organizing their physical space around service lines. Service Lines are organizational models that realign clinical, administrative and physician services around a continuum of care as opposed to a typical departmental or specialty model. You might put CT-surgery with cardiology. You might put neurology and neurosurgery together. GI needs procedure rooms. The Service Line requires that physicians begin to practice more often in a multispecialty group practice model. Neurosurgery needs access to the operating room, but in a complementary way with neurology and physicians' offices. We're seeing major efforts around

reconfiguration. It allows for higher quality, better safety, greater patient satisfaction, and a more focused, interventional and successful approach to treating the patient.

It allows us to centralize some of the more typical backroom or even administrative components, access centers, and central registrations. We create a lot of new space by integrating waiting rooms and registration areas for those services now co-located geographically. It allows us to efficiently and effectively schedule visits and procedures. Other than maybe the ORs, which have to be centralized, the rest of the hospital is open and you're seeing much better patient flow which redounds to the bottom line.

It's the way we have to compete with short-term hospitals and surgery centers that didn't exist 50 years ago, but which are at the forefront in the competitive environment today.

Roberson: What changes have you observed in the acuity level of long-term care patients? Has technology played a role in the level of service being provided in skilled nursing facilities today?

Stuart Shapiro: Let me begin by giving my answer a little context. In America, we have about 35 million people over age 65. By 2030, we'll have more than 70 million. Today, approximately 12% of the population is 65 or older. That segment will account for 20% of the population by 2030. As this

is happening, nursing homes are moving from "the old days" to the "new day." There's now an increasing focus on rehabilitation, with shorter lengths of stay and the patient returning home. Thus, nursing homes are seeing a lot more people coming in under Medicare or Medicaid managed care for shorter stays.

Site-neutral Medicare and Medicaid payment policies are driving people out of the expensive acute care hospital setting into the more cost effective nursing home for post-acute care and rehabilitation. Data from several outcome studies has shown unequivocally that the rehab in nursing facilities is absolutely comparable and, in some studies, superior to that of rehabilitation facilities. Thus, you're seeing an entire shift in the marketplace of post-acute care. This is having a positive economic impact on nursing facilities.

Roberson: All of these changes are driving growth in the development and configuration of medical real estate. How are these projects being structured? Who are the stakeholders? And where is the capital coming from to finance these projects?

Michael Goldenberg: Historically, the capital came from the hospitals. Whether they incurred taxable or tax exempt debt, it was the traditional means of doing things. There are two reasons why hospitals shouldn't invest their own money in ambu-

latory projects today. First, hospitals are not very good at executing these kinds of projects, and, when a hospital is dealing with its own physicians, there's a level of distrust among the physicians and the hospital. An experienced third party can better deal with physicians. Secondly, burying capital into this real estate is bad use of their capital.

The trend today is having third parties, such as developers or other types of firms, translate the needs of both the hospital and physicians into a single project. More private capital such as REITs is being accessed, which can provide a lot of flexibility to some of these projects that even a traditional bank cannot bring.

Let me give you an example of what most of these ambulatory projects become. They're physician-driven. What's normally in an ambulatory building is a surgery center as an anchor of the facility. Then there are various service lines, such as cancer treatment, orthopedics or other specialties that surround this surgery center. These buildings become everything but a hospital. Everything but beds. And the technology allows that to happen.

The ability to take ambulatory care and transport it allows you to put this building into a geography where you might want to locate it as opposed to where you chose to be 30, 40 or 50 years ago.

Capital for ambulatory care facilities is readily accessible today. Investors look at hospitals, physician medical office buildings and ambulatory care facilities to be conservative kinds of products. Nationally, the average occupancy of a medical office building by a physician is in excess of 12 years. And that's a very safe investment for a lender and/or an investor. The difference in the marketplace today is that there's capital that can come from outside of the hospital to fund these ventures.

Roberson: What has been the impact of the recent liquidity and current turmoil in the debt markets on accessing capital for new projects?

Kellman: The liquidity crunch that has spread from the subprime mortgage market to the broader debt markets is definitely impacting deal execution. Deal structures and underwriting standards for new projects are becoming more conservative. And that's

probably a good thing. To quote Alan Greenspan, the market had exhibited a touch of "irrational exuberance" that manifested itself in overly aggressive financing structures.

Healthcare real estate is somewhat of a sanctuary in these troubled times. The need for healthcare services is growing. The statistics mentioned are compelling when you consider that the largest consumers of healthcare services are the elderly,

compared to Medicare. That's because Medicare is driving people from hospitals into nursing facilities since their cost/delivery models are far less expensive. And Medicare will continue to do so as long as nursing facilities can maintain quality.

Goldenberg: The nursing homes, long ago, understood that it was what's inside the walls and under the roof that makes

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-Scott Kellman

which comprise the most rapidly growing population cohort in our society. Expanding demand will dictate that more ancillary service sites be built in the future. The next decade will see more capital flow to healthcare real estate and the development of these facilities because of their sustainable cash flows compared to more speculative types of real estate.

Marshall: Another factor influencing the capital markets is the evolution of hospital management. A staid type of management has been flushed out of the system. Hospitals and big healthcare organizations have gone from sleepy nonprofit mom and pop operations to billion dollar-plus enterprises. We've been able to attract talent to operate them.

Shapiro: The same trends for hospitals are clearly taking place along in the entire spectrum of long-term care, including nursing homes and assisted living facilities where the trend in financing, developing and expanding real estate is clearly moving to quality. And those providers, especially in the nursing facilities that are looking to become high intensity rehabilitation by using technology and performing such services as IV therapy, post-surgical recovery and advanced therapy modalities are having less difficulty meeting their real estate and other capital needs. We're seeing this shift to quality in the long-term care industry. This is especially true for facilities that do not depend on Medicaid, a program that is feeling greater resource constraint

money. Therefore, they've been much more liberal in selling and leasing back their real estate and unlocking themselves from some of those burdens.

As we go forward and capital constraint remains for hospitals, there are other ways hospitals can achieve things without utilizing their own capital. Hospitals typically access capital one of three ways: They make it from operations. That's what I call the hard way. They incur debt, or they raise capital through fund raising. Two other sources hospitals are not very familiar with are selling noncore assets such as ancillary real estate they don't need to own, and using other people's money to achieve their strategic objectives. A third party developer, if they're the right people, can provide that opportunity.

If these kinds of projects are being financed in the real estate part of a bank, then you're in trouble. People who are knowledgeable in healthcare financing should be working on these projects, including financing them.

Ashworth: I don't believe the tax exempt bond market fully understands yet how they want to handle joint venture type development that nonprofit tax exempt hospitals are involved with. Even if the funding of those facilities comes from other sources than operating income, philanthropy or the tax exempt market, there is still a consolidation issue the bond rating agencies are being very conservative on. Whether it's done through a capital lease or some other mechanism, the impact to the facility itself can be as dramatic as if the thing was

funded through tax exempt debt on its own.

Hospitals used to be the funding source of all of this and have been losing that position to traditional commercial debt financing, venture capitalists, private equity firms and developers. The healthcare delivery system needs aligned, integrated components, which bring together the providers of care in a coordinated way. The financing schemes for many of these projects, with the movement of services out of the hospital into community-based ambulatory settings, create corporate entities and financing structures that can become actually very disintegrating to the coordination and management of care across the continuum.

It is very important that financing institutions look at ways of designing financing packages and strategies that help align the caregivers across the continuum as opposed to disintegrate them through their various structures and processes. This is an

for healthcare services is going to be insatiable. And healthcare is very difficult to do on an incremental basis. You can't give somebody 60% of what they need. Patients will receive the services they need—you can't treat half a broken leg.

Kellman: With healthcare expenditures accounting for 16% of the gross domestic product today and rapidly moving to 20%, more institutional investors are focusing on the healthcare space. These institutions are beginning to understand the need that this panel has articulated as we move into the next phase of healthcare delivery. They are also seeing opportunities for returns that exceed those they can command in other areas of real estate investment.

The question becomes, is the leadership of the various major not-for-profits and other healthcare providers willing to explore these types of financing alternatives?

properly balanced? Are they making decisions that are not overly weighted on one side or the other, but taking a long view and balancing their decision-making and capital allocations?

Goldenberg: A lot of it is related to the ability of nonprofit organizations to make decisions. With its layers of committees, it could take a year for a nonprofit to make a decision over something that a for-profit could decide on in a month. There's a real strategic advantage to being able to make decisions quickly. Even if they're a high quality provider, the ability to streamline the decision-making process and get comfortable with new structures and approaches are part of what's going to help make them successful.

Kellman: Anyone who's financed this industry certainly has concluded that the first order of business is to provide quality care. And the economics and cash flow from those institutions doing a good job is typically more than enough to cover their capital costs and sustain the growth of those institutions.

I think evaluation of real estate is essential, but evaluation of management is incrementally more important. You have to examine the management team and the quality of the institutional care that's being provided because you can't separate the quality from the financial results.

Shapiro: Putting an underbelly of quality systems in place ultimately can improve the bottom line in a significant way. We've seen that in several large nursing home chains where their cost structure is based on the resources that they need to deliver quality care to the acuity levels that they serve. It's not quality at any cost. It's about efficient quality.

Marshall: I see a nationwide conversation about quality of care taking place over the next five to 10 years. I think we're moving in the right direction. If I were lending money, one of the things I would try to get a handle on is whether that organization provides safe, quality care. ♦

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opportunity as we move forward towards electronic health records, greater collaboration amongst all caregivers, wireless backbones between all of our facilities, and the linkage of pharmacies, ambulatory centers, traditional physician's offices, and home care programs and hospitals. Eventually all of these will be linked up with a portable medical record that will follow the patient.

Marshall: I agree. Instead of building all these various patient care settings, we're now moving toward the notion of a universal room, where we create a site incorporating appropriate technology to allow the patient to be treated in the room or in that setting for the length of their stay. Large academic hospitals will face the imperative to re-design infrastructure, add complex technology, and reorganize care within the current financial market models and debt service limits. The majority of us will need multimillion dollar, multi-year investment and capital spending plans. The demand

Shapiro: I want to just come back to the need for capital and management's willingness to be flexible in the long-term care market, which I think is very different than the hospital industry.

I think that you're going to see careful and conservative financing of quality providers who can guarantee the cash flow. I'm not convinced that the nonprofit providers are making the strides that they will need to make to stay in business a decade from now. Historically, they have been comfortable operating with funding by Medicaid as well as charitable donations. I don't think that can continue, especially as government payments come down and the government is looking for efficient yet high quality providers.

Ashworth: At the end of the day you've got to look at the management team to make sure they have an eye towards the direction of healthcare in the long term. Do they seem to be making decisions that are