Centralized Capital Planning Process Prioritizes Needs

Jill S. Williams

At many healthcare organizations, the capital planning process is a decentralized affair, with decisions on medical equipment purchases made on a case-by-case basis, often swayed by heavy lobbying from medical departments. Efficiency and cost effectiveness are typically not well served by such a system. When the Group Health Cooperative (GHC) found itself in a financial crunch in the mid-1990s, senior management decided that they needed to do a better job at capital planning. They created a centralized system to prioritize needs, save money, and improve planning across the system.

Subject: Group Health Cooperative, a consumer-governed, nonprofit healthcare system that coordinates care and coverage
Location: Seattle, WA
Size: System includes two hospitals with a total of 505 beds, 25 primary care medical centers, six specialty care units, and nine behavioral health clinics
Staff: More than 9,000 employees

The Challenge

Suzanne Williams, director of service delivery planning for GHC, has been with the organization for 15 years. "In the early days, the organization was simpler. Equipment planning was decentralized. There was no organized way to capture needs, no automated system, and we didn't bring groups together to set priorities."

But as GHC's financial position deteriorated in the early to mid-90s, less capital was available and it became essential to identify the organization's most important needs. This financial pressure led to the new capital planning system.

"We needed a system to hear what the doctors and nurses were requesting and balance their needs against needs for a new roof or IT equipment," says Sally Jackson, GHC's manager of capital allocation. "We wanted to develop a system to remove the subjectivity as much as possible, getting the highest priorities met first, and giving us the biggest bang for the buck."

Solution

Jackson says that they created a system to look at all aspects of the capital budget simultaneously. "When we were under that financial pressure, we used the system to categorize equipment into brackets and set priorities, considering which purchases were key and which were discretionary. We only did the must-do projects."

The first step was to centralize decision making on all facility projects. IT purchases were next, and medical equipment purchases were the last to be brought under the centralized system. Now, GHC annually collects needs from all areas of the organization and captures them in a centralized database. Key information from other sources, including a separate equipment maintenance database, is manually fed into this capital needs database to help planners in prioritizing projects.

The planning process looks ahead three to five years. With 15 different service line directors and 25 sites, that is no small task. Requests are collected at the department level and each is categorized as to whether it is a safety issue, system failure, code violation, enhancement, or new initiative. By using the database, these requests can be sorted in several ways. "Hard" prioritization numbers

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Check Points

What if your facility experiences a financial crunch? Are you prepared to offer potential solutions?

- ✓ Create a capital budget system that categorizes and prioritizes equipment purchases.
- ✓ Ensure a biomed department representative is active in capital planning meetings.

are developed to limit subjectivity.

Representatives from each department participate on multidisciplinary planning teams. Planners can see all medical equipment requests, identifying urgent requests to be met immediately, or assigning a timeline to less urgent requests. For enhancements or new initiatives, requesters and the planning team work together to develop a financial analysis detailing the return on investment of the purchase. At this first step, the service line director has the final say in prioritizing all requests and submits them to the finance department, which coordinates the rest of the process.

Once requests have been collected and analyzed at the department level, they are reprioritized multiple times: first at the subdivision level, then at the division level, and finally systemwide. At each step, a new set of priorities emerges until an overall plan is presented for finalization at executive meetings and at the board level. This process, begun in June, is typically finished by October.

While the priority system is centralized, Williams emphasizes that the capital planning process doesn't dictate to the department level. For example, the planners don't pick vendors. "We want to agree on priorities, and leave it to the folks on the front line to control the decision from there."

Like all departments, GHC's biomedical services division has input to the planning system. The department, outsourced to ARAMARK, has 15 staff members, including four imaging engineers and seven biomedical engineers. The group's role in capital planning is rapidly evolving.

"Our frontline technicians have always played a big role in capital planning," says Nidal Alammari, director of biomedical services. "They supply information to the capital planning team as well as to the department-level clinicians on equipment life expectancy, repair history, and new technology options."

In May 2004, ARAMARK added a new member to its team: a technology assessment manager. "The goal was to have a person dedicated to the process, to be a source of information and collaboration on capital equipment," says Alammari. This person pools information from technicians, vendors, customers, ARAMARK, and ECRI and feeds it to the capital planning team.

Outcome

Jackson reports that the capital planning process saved GHC $5 million in medical equipment purchases last year. She calculates this figure by adding savings in the area of service costs and savings from group buys of equipment. "By getting all of our projected needs into one place, we can sort and use group buys to maximize our purchasing power," she says. Because GHC is currently "catching up" on equipment purchases delayed during the lean years, it is difficult to compare one year's capital budget to another.

"We've developed an objective system that gives us the biggest bang for our buck, and allows us to meet the highest priorities first," says Jackson. "We don't want any lobbying, and by preventing that we allow the doctors to focus on patient care rather than equipment purchases."

Alammari says that GHC's capital planning system is one of the best he's seen. He says it is more structured and more defined, and better addresses the needs of users. Plus, looking at equipment needs across the entire system helps to standardize equipment.

Williams also reports that now that the group's financial position has recovered, they are moving toward more decentralized decision making. "During the lean times, any equipment over $25,000 had to be centrally approved. That level has now been changed to $250,000."

"They key is to have a centralized database of needs and a group of people looking at patterns of what's coming down the pike," says Jackson. "You can't ask the end user to have all the data. Ultimately, senior management has to look at the whole picture." ■