Inside the Real World of Capital Allocation

"Ask, and you shall receive" isn't a motto you're likely to find framed on the wall of a healthcare finance manager's office. Although there's no shortage of routine or strategic requests for capital funds, access to capital is still tight. Never before have CFOs had to manage such critical capital spending decisions. They realize that capital can help their hospitals make do-or-die expansions, equipment purchases, renovations, and technology investments. But the process for making such allocations can be more art than science. And there's always another big-ticket item on the horizon, such as new technology, enhancements to information systems, and other projects that can quickly drain allocated capital.

In this roundtable, veteran healthcare executives offer advice and best practices on how hospitals can overcome some of the common issues concerning capital allocation.
Let's talk about the process of collecting requests for capital projects. How should the process work? How does it work at your health system?

Byorick: For routine capital planning each year, we rely on our VP team to gather requests and come to a consensus on what the spending is going to be. Our problem, like most hospitals, is that our capital requests typically exceed what we want to spend. And we are generous, we think, by spending $25 to $40 million a year for routine capital. Our VP team has the authority to work with senior management to get routine capital requests approved. For larger projects, such as construction or expansion, we rely on a focused team of management and staff leadership, as well as key members of the medical staff. The process may take longer—as much as six months—while we try to quantify the financial impact and ROI of a project. Regardless of the ROI, though, we may still make the investment. Sometimes, we can't let the financials drive it.

Costello: We send out solicitations for any financial analysis that needs to be done for projects exceeding $200,000. This might be a new CT scanner or a new service of some sort, such as bariatric surgery, which we got into this year. We also segregate our capital budget into several categories. The over-$200,000 category I just mentioned is labeled "strategic capital." Other allocation categories include IT, divisional capital for the divisions to spend at their discretion, capital leases, and contingency dollars for the hospital and nonhospital parts of our organization. We also have a special allocation for construction. For example, right now we are building a $40-million heart and vascular center, which we treat separately from a capital perspective.

Duncan: For routine capital requests, our department managers, in consultation with our vice presidents and physician leaders, create a wish list of items that are necessary for normal replacement and expansion for new services. This list is processed through our materials management department, and a comprehensive list of requests is presented at budget time to our
Requests for strategic purchases, such as new construction, are made directly by the manager, VP, and any related physicians, to the board. Some of our recent strategic purchases have included a medical office building, an ED renovation project, parking decks, a radiology PACS system, a new women's pavilion, a new cath lab, and IT infrastructure projects totaling $16 million over a three-year period.

**Downing:** What we have found in working with our members at VHA is that most hospitals tend to have a better process in place to collect requests that are part of the annual budgeting process, whereas project-based planning is more of an ad hoc process and is a lot less consistent. Managing the process at the systems level can be very difficult for CFOs. Part of the dilemma is the disparity in who the stakeholders are. Trying to aggregate requests across a multihospital system can seem next to impossible.

**Clarke:** The organization's strategic plan should drive the categories of capital projects. What are the organization's broad-based goals? Three possible categories might be new strategic initiatives, expansion or enhancement of existing business opportunities, and infrastructure. Requests should be assigned to the predetermined categories as they come in. Department managers need to be very much aware of the strategic plan. As part of the request process, managers should try to draw a line between what the strategic plan is calling for and the capital project they're requesting. Not all capital requests will relate directly to the strategic plan, but it's helpful to know what projects being proposed by departments are going to be consistent or additive to the organization's strategy.

**Once you've collected these requests, how do you go about analyzing and prioritizing them?**

**Clarke:** The organization's strategies should drive the way they think about the requests and the methods by which requests are analyzed and prioritized. The financial analysis for a project that directly relates to strategy should employ different standards than the analysis for a project that is purely related to a business enterprise. For example, it might be acceptable to run a new service center at a loss for a time if getting into that market represents a strategy of the organization. In contrast, maybe purchase of new diagnostic equipment could require a very set, rigid payback period.

**Robb:** We try to relate decisions to our five-year strategic plan, which has a full set of projections, including operating capital. Any major initiative has to be tested against that plan. If additional capital is needed, we will analyze the impact of that on our projections and how it might affect our rating category.

**Costello:** Every September, our leadership team has a four-hour capital planning meeting, during which we allocate 20 minutes to each project. We'll invite each of the division representatives, such as executive directors or vice presidents, to talk about their project. Sometimes they will bring in physicians or props to demonstrate their case. They talk about the qualitative aspects, since the quantitative aspects have already been evaluated. Then, each member of our leadership team ranks each project on a scale of 1 to 5. Finance compiles the results, and then we talk about them. Based on that, we make our decisions.

**Duncan:** We use a number of criteria to evaluate and prioritize requests. First, if an item needs to be replaced, it goes to the top of the list. We assume that if an item is not replaced, then we won't be able to continue our high level of care. A second criterion is related to standard of care. If we determine that we need to fulfill a request to maintain a standard of care and to attract patients, then it is certainly a high priority. A third priority is related to ROI. A lot of the clinical pieces might not have an ROI per se, but they may be related to better productivity or reduction of cost—factors that are hard to quantify.

**Byorick:** When we replace technology, we focus on ROI only if it is a new product line or we really need to know the financial impact. We understand the profitability of our departments by DRG, service, doctor—however you want to look at it. But we rely on the judgment of our VPs and management team—many of whom have been here for 10, 20, or 30 years—to guide us when something needs to be replaced. The point is
The classic phrase about ROI is right: If it seems too good to be true, it probably is. And not everything that you need to replace or that’s good for patient care can have a strong positive ROI.

that we don’t spend a lot of time doing paper ROIs on everything. In many cases, we can accomplish ranking based on clinical needs and save the significant ROI work for some of the larger projects, such as large facility expansions.

► How should decisions about capital requests be communicated?

► Duncan: In the past, we have had a capital request committee, composed of four administrators and four physicians, hear the managers’ justification for their request. That committee has been disbanded, and our administrative staff, which consists of the CEO and eight vice presidents, now handles the prioritization. We found that going through all of the requests required too much of the physicians’ time. Now, our managers can communicate priority decisions back to the physicians and make adjustments if needed. At the same time, we as administrators are able to understand cash flow needs better and not make unnecessary promises at capital request time.

► Costello: We look at the communication as a natural part of our capital budgeting process. Once the board approves the capital budget, it is up to the involved parties to carry out the requisitioning and procurement processes associated with the allocated capital. But there is some flexibility. If there is something strategic that we need to do, we might consider a special allocation that doesn’t go through this process. For example, the medical staff asked us to add another cath lab, based on construction of our new heart and vascular center. So we did a special allocation for that. Of course, you don’t want that to get out of hand because then the whole process could become political. But we do allow for such allocations occasionally.

► Clarke: I found putting a context around the process is helpful. This allows departments to relate what they’re requesting to broader-based plans. I think communication has to start with the strategic direction and the broad-based strategic plan of the organization. Frankly, the strategic plan should stimulate thinking about what types of projects should be requested. An individual should be able to say, “I need to provide input on what strategic assets are necessary to meet the organization’s direction.” Then that individual should categorize his or her requests and show which ones align with the strategic plan and which ones represent other types of needs.

► How do you monitor the use of allocated capital funds?

► Costello: If we don’t monitor capital projects, we’re sunk. So in the invoicing process, we assign tracking numbers, and/or project identifiers, to every capital expenditure. Divisional requisitions have to flow through finance before purchasing will issue purchase orders against it. All of our construction and IT projects are also assigned project numbers so that they can be tracked in our systems. In addition, we do budget-to-actual reporting for all projects, including divisional capital. We actually had to learn the hard way on that one. If you don’t do it that way, administrative directors often lose track of spending and will overspend on a project. This also allows us to reallocate unused funds on the fly at the end of the year.

► Byorick: We have a finance person dedicated to tracking every project. Spending has to be monitored precisely because you may be drawing money from bonds or some kind of debt instrument. So, you have
to make sure you are requesting funds covered by the bonds. We have an electronic approval process where we get the IPO [internal purchase order] on paper and, once approved, finance monitors the dollars spent. It is fairly rigorous, and we find times when we have to send projects back for additional funding approvals because they are not within the original authorized request.

**Clarke:** As the project is moving forward, there should be a crosscheck to ascertain whether it is meeting the targets that were established. For infrastructure-related projects, the criteria for the assessment might simply be that the cost of the project is kept within the projected parameters. For strategy-related projects, the assessment needs to look at how the project moves the organization closer to the goals of the strategy. That may be a return on investment measure, a market share measure, a throughput measure, a volume measure, or perhaps a cost-saving measure, depending on the strategy. In any case, accountability needs to be built into the process.

**Robb:** In terms of reporting, we have detailed monthly capital reports on every project to help us monitor and make sure it is on budget and on time. If everything is going as planned, there is very little intervention on our part. But if something appears to have gotten off track and that it might become over budget, we’ll intervene. If it was determined that a project needed more dollars, we would go back to the finance committee for additional budgeting authority. But if we budgeted for a project, such as a GI lab, and decided not to move forward, we wouldn’t require further board approval—unless we decided that money was better spent somewhere else. In that case, we could go back to the board finance committee for approvals.

**Would you share some of the more difficult experiences you’ve had with capital allocation and what you learned from them?**

**Robb:** The most common capital allocation problem is determining a realistic return on investment calculation. The classic phrase about ROI is right: If it seems too good to be true, it probably is. And not everything that you need to replace or that’s good for patient care can have a strong positive ROI. We’re working on a major initiative to roll out an electronic ICU, where we will have a centralized area with intensivists stationed 24 hours a day to monitor patients at all of our hospitals. This is something that is very good for patients, and studies suggest there are enormous cost savings to be had through more efficient use of your actual ICU facility. We have tried to factor some of that in, but we have been very conservative.

**Duncan:** What continues to be a difficult challenge is that our payments from federal and state programs and managed care fail to recognize the significant investment that we have to make in technology. From an administrative standpoint, the hospital is caught in a catch-22. To be competitive, it must have state-of-the-art equipment. In the absence of that, utilization drops or the hospital is sued for malpractice because it doesn’t have the standard of care.

**Downing:** Access to capital is still top of mind at hospitals. Also, a struggle for hospitals is having a common information tool or platform by which to collect requests. In most systems today, the individual hospitals continue to budget and allocate based on the individual needs at that facility, as opposed to taking a systemwide approach. They need to have tools and a platform by which to compare what is budgeted with what is actually spent and have more of a systemwide process and perspective.

**Costello:** For us, the most challenging issue has been IT. The dollars you can spend on IT are just mind-boggling. So we created a technology assessment group split into three areas: clinical, financial, and infrastructure. We learned the hard way that if you don’t plan, you can blow your budget quickly. Now, we detail every component of cost, including capitalized staff, before we go to the board with it. The downside is that we cannot necessarily pull the trigger to start the project from day one of signing the contract, but the upside is that we know what we are getting into from a cost perspective. We think the time it takes to do the appropriate amount of due diligence upfront pays for itself in the long run in terms of making sure the project is on time, on budget, and within scope.
Byorick: Technology is also the area where we struggle with capital the most. We'll have $20 million of fantastic ideas, but we may want to spend only $15 million. It is very difficult for the management group to sort through it. For example, we have a very large investment in IT and consider it a major, renewable capital cost every three to five years. When it comes to the capital allocation process in general, the timeline is the hardest thing for people to understand. A major issue is getting the management team to accept the fact that a specific project can't be done or a renewal can't occur this year and that a project may be delayed as much as 24 months. There's also the issue of financial modeling. We learned after we opened a new maternity hospital in 2000 that you may be more successful than you think. Even though we did a significant amount of modeling, we didn't anticipate taking control of the market, which was what happened. During the first year of operations, we reached capacity. We did not build the hospital big enough or anticipate the right level of growth. But we used what we learned from that experience to help us plan our new orthopedic hospital, which will open at the end of this year. We wanted to be very precise about what our impact on the marketplace might be. We did not want to underbuild it, and we had very good data on our patients so that we could anticipate the right level of growth.

Clarke: I think it's important to remember that there is another component of capital allocation—that is, rationalization of existing assets. The process of categorizing and prioritizing capital requests could also be used, in reverse, to assess whether existing assets meet strategic objectives. Nonstrategic assets can be a source of financial capital. An example would be a medical office building. Typically, such an investment produces lower ROI than, for example, an upgrade in a medical treatment area. So it's worthwhile to look at the process in reverse to determine whether you should sell an asset. What category should the asset be in? If it's not meeting the measures or goals of that category, you might want to begin the process of selling that asset. That's when the capital process, in reverse, can be a source of funding, much like cash flow from operations or borrowing. It should be part of the process.

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