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Ambulatory Specialty Center Construction

Finding the intended purpose

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The father of the modern skyscraper, Louis Henry Sullivan, is credited with the maxim, "form follows function". Sullivan believed that a building should enable its intended purpose. Finding "the intended purpose" of an ambulatory medical specialty center should precede facility design and construction. The balance of this article focuses on the presentation of a blueprint for the thinking that leads to consensus on form and function of the integrative ambulatory specialty center.

First, the definition of an integrative ambulatory specialty medical center is followed by a rationale for their importance in the delivery of community-based health services into the future. Here "integrative" refers to the aggregation, coordination and collaboration of multiple clinical specialties under one roof. When these specialties are brought together, they serve a wide range of clinical, health, health status and functional needs of defined populations. These services are rendered cost effectively by facilitating an integrative care vision, mission and collaborative patient services strategy between and among provider partners. Primary care is included in the definition of medical specialties, for purposes of this article.

Examining the rationale

The rationale for such larger sized, intentionally integrative ambulatory care delivery environments is supported by five key assumptions pertaining to the near and longer term future of community health care:

- An increasing proportion of all specialty health care services will be supplied in ambulatory settings, not hospitals.
- The ability to provide a satisfying and effective clinical experience for patients, economically, requires the aggregation of a critical mass of collaborating clinical partners, with the potential to generate sufficient demand for facility design.
- The leveraging of the revenue productivity opportunities beyond professional services is necessary to make the facility's and the supporting infrastructure's cost base financially productive and affordable. Larger, well-designed ambulatory specialty centers permit and facilitate "smart" revenue stream diversification strategies. Physician professional work unit productivity (WRVU) is typically highly predictive of "downstream" services demand, imaging diagnostics, surgical and procedural services and consumption of other specific services and products.
- Patients will prefer an environment that provides many needed health services within a single facility, designed to coordinate and manage care by specialized provider teams of collaborating providers.
- An increasing proportion of direct patient care will be provided by sub-specialized non-physician professionals who will require accommodative work environment designs to practice their professions efficiently and productively.

Reorganizing and reorienting the thinking behind specialty ambulatory facilities

The aggregation of doctors under one roof is nothing new. Medical office buildings (MOBs) have existed for decades. Their intended purpose has largely been the collection of physicians of varying specialties, operating from similar, but different organizational and business models, practice "brands" and strategic plans. Occupants of these generic MOBs may or may not share patients or even know many of the other physicians in the building. The singular goal of simply aggregating doctors in one place has led to the design and construction of millions of square feet of nondescript, non-branded, cuboid, generic physician office buildings that offer the patient the opportunity to enter the facility, locate their doctor's office on the lobby directory, ride an elevator to a designated floor, exit and turn left or right to proceed down a long corridor to a labeled door labeled with a practice name.

This traditional "office-based, MOB ecosystem" design requires referrals out for routine and complex imaging diagnostics, outpatient surgery, rehabilitation services and other ambulatory services. These referrals are often made to one or several hospital campuses or to physicians and practices located off the MOB campus. Real urgent care is rarely available, although physician occupants may claim to serve "add-ons" to their practice, and physicians in the facility may admit to a variety of hospitals which can confuse patients. For MOBs located on a hospital campus, patients may reasonably presume that "their doctor" is closely affiliated with the hospital and all other physicians in the building, and by extension all share a common medical record, participate with the same health insurance providers, integrate and coordinate services that keep billing and record keeping together and have a centralized and integrated approach to services scheduling. For off-campus MOBs, patients can often presume, incorrectly, that all the doctors in the facility know each other refer to each other, and coordinate care together. The important lesson here is mere co-location in an MOB does not guarantee the delivery of integrative care, despite what patients might reasonably presume to believe and want.

Integrative ambulatory specialty center design begins with clarity of intended purpose.

Integrated ambulatory specialty medical centers can be successful strategies for independent, single specialty medical groups, for larger independent multi-specialty medical groups, for collections of independent medical groups of varying specialties and for community-based health systems that elect to aggregate employed and/or affiliated independent physicians as partners in ambulatory specialty centers. For purposes of the positions that follow, primary care is included among the array of clinical specialties that lend well to incorporation with an integrated ambulatory specialty center.

What's in a name

Integrated collaborative ambulatory specialty centers are defined here as larger ambulatory facilities (often ranging from 50,000-200,00 square feet in size). They're designed to aggregate and integrate multiple clinical specialties and

sub-specialties within a specific classification of related clinical service lines, such as orthopedics, spine care, sports medicine and connective tissues disorders. Participating providers are supported by a range of ancillary service capabilities, e.g., diagnostic imaging, surgical/procedural care, rehabilitation, urgent care, virtual care and over-night care suite capabilities. While the facility may house a range of independent practices or separately identifiable practice brands, the facility itself has its own brand which is associated strategically with all the practices represented within the facility. Included providers agree to cooperation and collaboration based upon a shared patient care compact and refer within the group, as appropriate.

Principal driving goals of such strategies are "one stop shopping" for a broader range of ambulatory medical, surgical and rehabilitative care; collaboration among aggregated providers to improve quality of care and the patient experience; to make sophisticated diagnostic, surgical and procedural services available and affordable and to effectively manage total costs of care for patients served. Likewise, participating groups may own the facility together and invest jointly in future facility enhancements. Participating providers may also form "clinically integrated networks" for purposes of third party payer contracting, including bundle pricing for specific care plans and financial risk sharing for defined populations.

Rarely is an ambulatory specialty center ever over-built the complexity of care delivered in ambulatory settings will increase.

The art of the possible

While the facility's form and function certainly contributes to the strategic and economic success of the participants, the "magic" derives from a shared belief in a communal orientation to mission, vision and strategic goals. The project planning exercise that follows is a first test of a buy-in to the "art of the possible." For a group of partners in the initial stages of a proposed integrative ambulatory specialty center here are some important questions and thoughts about them to consider:

What are the compelling reasons to pursue a larger ambulatory specialty center?

Categories of response typically include: an improved patient experience, the improved economics for the partners, the ability to create a larger, more powerful market brand, market share expansion, provision of an attractive platform for provider and staff recruiting, expanded scope of services, provider efficiency and productivity, the aggregation and sharing of the financial productivity of right-sized ancillary services and the market and brand statement and brand promise made by the larger, well appointed specialty center facility.

What composes the critical mass required to get started, i.e., are there "must have" partners and specialties?

Categories of responses typically include: clinical specialties that, when aggregated under one roof, create market and clinical care collaboration synergies, providers who bring an existing patient base to the partnership, and who with a show of collaboration, stimulate interest from other referral-based specialties that find the opportunity to join and affiliate irresistible.

What are opportunities to develop ancillary revenue streams controllable by the owners; what services provide an improved patient experience; create cost and pricing advantages when contracting with third parties; create high barriers of entry for smaller, less well-developed competitors?

Categories of responses include: ambulatory, single or multi-specialty surgery centers, sophisticated imaging centers, rehabilitation services, pharmaceutical infusion capabilities and dialysis and related retail products, such as eyeware and orthopedic appliances.

Aside from the facility itself, what strategy and support services can be shared to create scaled economies and improved capital investment returns?

Categories of response include: marketing and brand development design, efforts recognizing each participating partner retains their own practice brands, clinical technologies and equipment, information systems, group purchasing on supplies, joint third party payer contracting (with the creation of a suitable clinically integrated network partnership), facilities management, self-insurance opportunities through co- ownership of a captive insurance company, health insurance addressing professional liability and workers compensation coverages, and bundled clinical services packages.

What are methods for real estate and facility asset ownership and management?

Categories of response address: the nature of the model design permits the participants to collectively afford a larger, more sophisticated facility, which creates an enhanced brand and market statement opportunity. Integration of co-owned, profitable "ancillary services" opportunity expands the collective balance sheet positions and potential for practice growth and development of participating owners, i.e., the ability to expand the practice profitability of the participating practices beyond the potential of smaller groups operating independently. Facilities that are "pre-leased" bring sophisticated medical real estate developers to the game as potential co-investors and asset and property managers. The developer can then serve as the manager of the real estate holdings of the owners, providing a source of liquidity as individual investors retire from their practice and exit facility ownership with a guaranteed buy-out.

Lessons learned

Rarely is an ambulatory specialty center ever over-built. More often than not, they are under-built by as much as 25%. Why? The main reason is prospective, independent physicians interested in participation are often reluctant to risk capital for growth of their independent practice. Likewise, independent physicians and even health system executives often look at operating lease costs for larger Class A medical facilities as being too high. While it's true that larger, sophisticated ambulatory centers are almost always more expensive per square foot of space, when compared with older facilities occupied by smaller single specialty or multi-specialty practices, what is often missed are the value propositions that inure from co-locating with other providers in a facility specifically designed for a collaborative ambulatory strategy. Such benefits include the ability to design and build for practice growth economically, co-ownership in various revenue producing services, affiliation with an umbrella brand positioning strategy (including a high visibility location), practicing in an environment with increased foot traffic through the facility, participation in group purchasing, shared facilities management and managed ownership of the facility where partners have a guaranteed, qualified buyer of individuals' interests when they wish to sell.

Another learning from the development of such centers often goes unappreciated, which is while absolute space costs per square foot are almost always higher than a practice is paying currently, the ability to design a new space that improves efficiency, patient flows and enhanced provider productivity results in increased revenue per square foot of usable space. These benefits make the ostensibly more expensive space incrementally more economical and financially productive over the full term of the lease.

Independent practitioners who own their own real estate and prefer a small facility that is wholly owned by the physicians in the practice often find that real estate ownership can become a mill stone around their collective necks. How? New physicians offered partnership are often obligated to buy into the real estate, along with the practice, adding more debt to an already over-burdened personal balance sheet. Moreover, when a partner retires, one of two problems typically occurs. The retiring physician has an automatic "put"; meaning the buyout of the real estate by the other owners is mandatory. If retired partners individually or collectively hold the deed to the facility, new partners may become trapped as lessees in practice real estate that is old and inadequate, and the landlord won't reinvest. As was

cited previously, with larger facilities, there are many more models that permit individuals opportunities for ownership while in active practice, and provide for efficient and affordable avenues for liquidity at a reasonable price when retiring or leaving the practice.

Summation and Discussion

There is an abundance of evidence to support the assertion that an increasing proportion of medical and surgical health care services will be delivered in ambulatory settings. Likewise, the complexity of care delivered in ambulatory settings will increase. As such, the intended purpose of ambulatory specialty center designs will likely take two paths, going forward. On one path, they will house single specialty, integrated focused factory strategies. This model will aggregate multiple clinical sub-specialties working together to serve constellations of related clinical conditions, for example, orthopedics and connective tissues, injuries and disorders. The other path will aggregate providers from multiple clinical specialties. With this path, the commonalities to be rationalized within facility design include: the potential for inter-group referrals, utilization of imaging diagnostics, projected demand for surgical/procedural services, sophisticated urgent care, drug infusion therapies, rehabilitation services, specialized pharmacy needs, virtual care delivery space and related technologies and areas for staff training and patient group education.

In either case, integrative ambulatory specialty center design begins with clarity of intended purpose. From purpose comes function; form is next and strategy follows. Design "wraps" around function and strategy to create a facility that enables realization of the shared mission and vision.

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