Foreword

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What you think becomes brick. What you imagine becomes steel and glass. What you visualize becomes technologies deployed, people hired, cars in the parking lot, lights on.

Across healthcare, organizations are changing shape, consolidating, affiliating, changing business models and revenue streams—and launching strategic plans, capital programs, and technology deployments to match. If you have not thought deeply enough, contrarily enough, questioning enough assumptions, you will end up with a capital program that fetters rather than launches your transformation.

Your assumptions about the nature of your organization, what you are actually doing to "make a living," what your "community of practice" is, end up baked into the steel and concrete and glass, the WiFi network, the heat recovery systems, the art collection—and the bond debt. You end up servicing your capitalized building stock and technology platform instead of the other way around.

What will your organization actually be like in five years or ten years? What tasks will it be doing? In what kind of environment?

Sure, we will still be doing surgery on messy compound fractures. But will we be doing as many amputations from sequelae of diabetes?

Sure, we will still need a neonatal intensive care unit. But will we be seeing as many preemies?

Sure, we will still have an intensive care unit. But when we step patients down, will we be putting them in a med-surg bed? Or sending them home with an electronic ICU tracking system strapped to their wrist, feeding back into our 24-hour monitoring system?

The future is impossible to predict. But it is not impossible to think about, because we know the broad trends that will produce it, and examples of what it will look like. As William Gibson (1999) famously remarked, "The future is already here. It is just not very evenly distributed."

What will the future of healthcare look like?

Cheaper. Prices, costs, and acute utilization rates can all be expected to drop over time, constraining healthcare budgets and the ability to support capital programs, but at the same time requiring dramatic rethinking of how healthcare can be delivered.

More distributed. Healthcare organizations will be dramatically reshaped under these efficiency pressures, not only consolidating but decentralizing, especially at the primary level.

More tech. New mobile technologies and "big data" will play a big part in reshaping what kind of care we give, when, where, with what kind of capital needs—which in turn will reshape the organizations themselves and the buildings and technological environments in which they work.

Less top-heavy. The center of gravity of healthcare has typically been giving the high-end specialists, particularly "the procedure guys," the machines, space, and support they need to do their stuff, to our mutual profit through the magic of fee-for-service billing. Any payment scheme that moves the provider from volume to value causes a revaluation and a re-evaluation of the need to build more resources for the primary care base of the institution and fewer for the top-end specialists.

Can you think through the implications of all this by yourself? Not likely. Think for a moment about how people think—indeed, about how *you* think.

Being more experienced does not necessarily exempt us from illusion, unless something in our process constantly and directly

tests the results of our judgments (the way, say, a robust retail market does on price setting). Even if our judgments are correct, they are based on an environment that formed our skills: in the jungle or the savannah, in a controlled market or a retail market, in a risk-bearing business arrangement or an endowed business arrangement. When our environment shifts, our illusions, biases, and assumptions persist, even though they may be dangerously out of date.

We are in a rapidly shifting environment. Over the next several years, all healthcare leaders will be called on to make numerous strategic decisions and tactical choices that will be fundamentally different from decisions they are used to making. But they will be making those decisions with a mental apparatus formed in the old environment.

So thinking about the strategic future, and what that means for a capital program, is hard. We have to use those broad trends to think through the problem in detail, from C-suite decision making through financing, planning, and design to technological advances. That is what this book does, bringing together experts from a variety of fields to get down into the roots and soil of the question. This is the book you need to help you think through the question: How do we do capital planning that works in this rapidly shifting environment?

This is heroic work. It is boring to all except those who do it. Much of it is invisible to most of the people it affects. But all this study and thought, and turning the thought into actual capital programs and real buildings and technologies—hard, detailed, tough-minded, relentless labor—ultimately will save lives, reduce suffering, and make healthcare more available to all by reducing costs.

REFERENCE

Gibson, W. 1999. "The Science in Science Fiction." *Talk of the Nation.* National Public Radio. Broadcast November 30.