3 Procurement Strategies that Set Healthcare Projects Up for Success

Healthcare construction costs aren't slowing down. And with tighter reimbursement models and rising patient expectations, every dollar in your capital plan has to work harder.

The good news? The decisions you make before design even starts—specifically, how you procure your design team—can be the difference between a project that delivers long-term value and one that bleeds budget in change orders.

Let's explore three procurement strategies we've seen set healthcare projects up for success.

1 Bring the Users to the Table Early, and Keep Them There

The best healthcare projects we've seen share one thing in common: Clinical users have a seat at the table from the start. Not just in programming, but in design partner selection, too.

When procurement teams make selection decisions in isolation, the design team can miss critical operational insights only insiders like nurses, physicians, and department heads can provide.

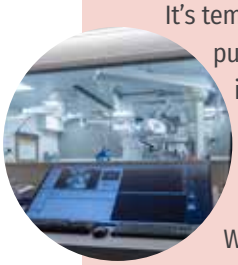
That misalignment shows up later as redesign, value engineering, and facilities that don't support the care model.

Research on government healthcare facilities found owner-requested changes during design and construction, often the result of stakeholders not being engaged early enough, are a leading driver of budget and schedule overruns.[1]

Healthcare institutions must take necessary time to plan and coordinate all team members before construction begins, a process that starts with the right people in the room during procurement.[2]

The real cost equation: Including end-users in A/E selection leads to better-aligned design teams and fewer costly mid-project pivots.

2 Choose Qualifications Over Low Bid, Especially for Complex Facilities



It's tempting to treat A/E selection like a commodity purchase. But healthcare isn't a commodity. An inpatient unit can have 15+ utilities running to a single room. Surgery suites require designing for technology that won't exist for another decade.

When procurement defaults to lowest fee, the savings on design often get erased (and then some) during construction. A landmark study commissioned by AIA found that projects using qualifications-based selection (QBS) experienced just 3% cost growth compared to 6% nationally, and QBS projects were 50% more likely to meet schedule milestones than those selected on fee alone.[3] A separate two-year university study confirmed that public agencies using QBS achieve better cost control and higher project satisfaction than those using other procurement methods.[4]

The firms understanding your clinical workflows, patient populations, and regulatory environment will catch problems in programming, not in the field. There's a reason over 46 states have adopted mini-Brooks acts requiring QBS for design services[5], treating A/E selection as a commodity runs counter to industry best practice and federal law.

The real cost equation: QBS for complex healthcare projects consistently yields lower total project cost, not just lower design fees.

3 Invest in Upfront Programming—it's the Highest-ROI Phase You'll Ever Fund

Healthcare systems that shortchange the programming and planning phase almost always pay for it later. This is where budgets get validated, consensus gets built, and the design team captures every clinical, operational, and infrastructure requirement before a single line gets drawn.

Consider this: A/E fees typically represent less than 2% of a building's total lifecycle costs, yet they profoundly influence the other 98%, including construction (~12%) and operations and maintenance (~86%).[6] Shortchanging the phase with the highest leverage on total cost of ownership is a false economy.

For larger-scale projects—such as acute care facilities, ambulatory surgery centers, behavioral health, and other diagnostic and treatment environments—a significant investment of time, expertise, and resources is required from all stakeholders to successfully plan, design, and deliver these complex projects. Because the facilities being designed today need to serve care models 10–20 years from now.

Studies of healthcare facility projects have found that owner-requested changes are a leading driver of cost and schedule overruns, reinforcing the value of early stakeholder engagement and thorough predesign planning.[1] Spending an appropriate percentage on robust predesign isn't a luxury; it's the most effective hedge against scope creep and budget overruns.

The real cost equation: Every dollar invested in programming saves multiples during design and construction. Healthcare systems embracing this consistently report better budget outcomes.

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Decisions Shaping Decades

Healthcare procurement is evolving. The systems that treat design partner selection as a strategic decision, not just a purchasing transaction, are the ones building facilities performing for decades.

At SSOE, we've spent 20+ years designing patient care environments using Lean principles, Evidence-Based Design, sustainable design practices that cut costs long term, and an integrated A/E approach that's delivered more than $35.5 million in documented cost savings for our healthcare clients.

If your next project is still in the planning stages, that's *exactly* the right time to talk.

Where design leads, operations follow. Let's take a closer look together.

David Schoonmaker
dschoonmaker@ssoe.com

Jeff Falzon, RA, NCARB
jfalzon@ssoe.com

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