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A Public/Private Partnership: The Royal Ottawa Hospital Experience

David Laird and George Langill

Introduction

The last few years have seen some provincial governments introduce public/private partnerships (P3s) for the development and operation of healthcare facilities.

One such case involves the redevelopment of the Royal Ottawa Hospital (ROH). In 1997, the ROH was mandated by the Government of Ontario and the Health Services Restructuring Commission to be the Champlain Health District's Tertiary, Academic Mental Health Centre. This has driven a variety of transition plans over the last five years aimed at realizing this mandate.

The ROH's new mandate required an evaluation of the existing facility against the programs to be delivered. The existing facility dates back to the early 1900s and is comprised of approximately eight buildings on a 26-acre campus. The buildings are inefficient and expensive to operate and to keep in acceptable repair. They are also totally dysfunctional for the effective treatment of persons with mental illness and inconsistent with the new mandate. The initial direction from the Health Services Restructuring Commission was to renovate the existing facility. The ROH commissioned a study that determined:

- renovation of the existing facility would cost more than a new facility, and
- the ROH would not be able to fully discharge its new mandate in the existing facility, even after expensive renovations.

The decision was made in December of 2001 to build a new facility adjacent to the existing facility. The redevelopment of the ROH was to be structured as a P3 project roughly modelled on the U.K.'s Private Finance Initiatives (PFIs).

The term P3 is used to describe a broad range of contractual arrangements between government and private enterprise that share, in varying amounts, the role traditionally played exclusively by the public sector. It involves a redistribution of risk between the public and private sector based on who has the greatest capacity to manage respective risks. In this model, much of the redevelopment and operating risk shifts to the private sector provider. This represents a new operating platform that integrates the developer, designer, operator and financier into all aspects of the project from schematics into full operations, usually over the life of a long-term lease. Examples of P3 arrangements that have been used for healthcare include transactions where the private sector:

1. Finances, builds and leases facilities
2. Finances, designs, builds and leases facilities

3. Finances, designs, builds leases and operates facilities
4. Finances, builds, leases and operates facilities and provides non-clinical services such as food preparation, security and laundry services

In the case of the ROH, the structure of the P3 transaction is consistent with Alternative 4 above.

This story starts well before the December 2001 announcement. It has its genesis in a decision made a decade ago by the ROH to outsource all its facility management and related services to a private sector partner. This experience formed a positive and constructive base to build on in the P3 approach at the ROH, which included a facility management component. Those starting such a project without the benefit of this experience may face a more difficult and politically charged transition, where the focus may be on labour issues in addition to a complex financial structure.

Why the ROH Went this Route

There are several reasons why the ROH went this route. The key ones include:

- The previously mentioned positive experience with the outsourcing of its facility management services.
- The realization that traditional funding approaches would not provide a timely solution. The gap between healthcare infrastructure need and its supply is well known. Government's ability to narrow this gap through traditional capital funding grants was perceived as very limited.
- With the development of Superbuild in Ontario, the timing was right to consider this approach in the healthcare arena. Superbuild was established to foster the development of such public projects by leveraging limited public capital and having the private sector take on the main financing and development risk.
- The ROH and government's decision to do a complete rebuild of the antiquated plant made the project of a scope and size that was attractive to private development and operation. This decision was based on a carefully articulated business case anchored in the cost benefits of rebuild versus renovation.
- The positive experiences of other countries, mainly the U.K., provided a supportive background for government and the Board of the ROH (Board).
- The realization that the private sector may be in a better position to manage the risks of building and operating a complex facility.

All these forces converged at the same time, and combined with the Hospital's vision, values and needs, provided a high level of comfort in moving to pioneer the application of this approach in Canadian healthcare.

Ultimately, this project was a highly successful one. While the process was long, each of the steps was well thought out. The bulk of the remainder of this article discusses some of the key critical success factors (also summarized in the chart to the right).

Key Success Factor Checklist

Setting the Stage
- The Functional Plan/Program
- A Master Site Plan
- Planning for Governance and Management of the Project
- The Value for Money Benchmark (VFMB)
- Determine What Risks to Transfer
- Project Work Plan and Budget
- Proactive Communications Plans
- Manage Government/Hospital relations

The Selection of Private Sector Partner
- Communications
- The Selection Process
- The RFQ
  - Allow financially strong players to guarantee key technical players
  - Publish the VFMB
  - Invite preliminary design
- The RFP: Balancing Cost versus Benefit
  - The Scoring
  - Security of cash flow to the proponent
  - Performance standards
  - Performance Penalties
  - Opportunity for lenders to step in
  - Contract termination provisions
  - Change orders
  - Contract with one party
- Closing

Setting the Stage

Following the announcement in December, 2001, the ROH had to gear up to move the project forward in the absence of government policy, funding methodologies and proven practices and work plans. What follows are some of the critical starting steps or factors that were put in place to prepare for the next important step of selecting a partner.

The Functional Plan/Program

Unlike a traditional fixed sum tender with its well-defined specifications and working drawings, the functional program becomes the important first link in the P3 process. The translation of the functional plan into output specifications represents the foundation for the eventual qualifying consortia to build their case and for the hospital to evaluate their proposed

solutions. Rather than being completely prescriptive, as we would under a traditional capital program, we were challenged to limit our prescriptive specifications to safety and security issues. The trick is to strike a balance in your output specifications, which allows for maximum creativity in the design response, without compromising safety concerns. Each organization has to decide on the right balance in this respect. Setting these output specifications requires clinical and support teams to think of the desired outcome of the design rather specifying a solution or specific dimensions.

A Master Site Plan

One of the earliest decisions we faced was whether to build on the existing campus, or to sell it and build on a new site. A new site may have been less expensive (after disposing of the current site) but would have required a longer period of time to find and obtain the necessary zoning. In addition, a new site would have required additional financing until the new facility was complete and the existing site disposed. With the benefit of the scoping provided by the Functional Program, an overall Master Site Plan was developed to guide the general sitting, fit and configuration of the new facility to temporarily coexist with the current facility. A pure "Greenfield" P3 solution, where building sitting is flexible, could reduce the need for such a master plan. In our case, it was required in order to determine the general sitting and fit of a new facility on the existing campus, while allowing existing facilities to operate during the construction phase. This would categorize it as a "Brownfield" site and solution for purposes of the P3. This highlights one of the main differences from the traditional approach. Land has value as an asset to be either sold or leased as part of the range of P3 possibilities.

Planning for Governance and Management of the Project

The P3 approach required a major realignment of our governance and management resources, their organization and traditional processes of project planning, review and approval. In the early stages it was most important for the Board of the ROH (Board) to set out Guiding Principles to reflect key values and parameters to guide the project through its various stages. The issues addressed in the Guiding Principles we employed are:

- a publicly administered model
- focus at all times on excellent quality specialized services
- optimize cost and quality objectives
- demonstrate "value for money" against traditional approaches
- employ best-practices model for delivery of healthcare
- deliver client-centred healthcare
- transparent accountability and effective risk management
- co-location only with activities complementary to the hospital's mission
- partner with strong community commitment
- protection of direct healthcare clinical funding

In addition, the P3 approach requires a reassessment of the governance and management resources to ensure knowledge and familiarity with all major elements of the P3 approach. Board expertise in the financial, development and legal components are critical. The same applies to the management team. The early recruitment of an experienced project manager was critical to ensuring appropriate processes were put into place early in the project. Subsequently, we added financial, legal and design expertise to the project team through an RFP process. The use of external experts is key, as it allows the hospital to focus on its core responsibilities, through the long and complicated process.

An organizational schema that clarified the Board/Management/Project team relationship was developed and sanctioned by the Board. This resulted in the creation of a new standing committee of the Board – the Expansion and Redevelopment Committee – a joint management/project team steering committee chaired by the hospital CEO, a project team office on site as well as the necessary rules of engagement that clarified respective authorities and accountabilities throughout the project.

The Value for Money Benchmark (VFMB)

A key component in this approach is the VFMB. This is used by governments to make decisions by testing "whether a private investment proposal offers value for money in comparison with the most efficient form of public procurement." (Partnerships Victoria Public Sector Comparator technical note, Dept. of Treasury and Finance, State of Victoria, 2001, Page 1, section 1.1.)

The VFMB not only becomes an important rationale in the justification of alternate financing approaches but also provides a threshold for the evaluation of proposals. This also puts into proper context the cost of borrowing to government versus to the private sector, which is merely a component of the total VFMB cost.

The VFMB is developed based on researching similar hospital construction projects locally and internationally, with significant input from government officials based on their public procurement experiences and financial consultants familiar with this methodology.

It estimates the expected risk adjusted cost of redeveloping and providing facility arrangement services under a traditional procurement scenario against the alternate finance approach. It fully integrates life cycle costs into an equation that produces a net present value for each option.

Determine What Risks to Transfer

When preparing the VFMB it is critical to categorize risk into one of three areas:

- those that the hospital or Ministry is in a better position to manage (such as change of healthcare regulation or law),
- those that the proponent is in a better position to manage (such as construction schedule) and
- those that were essentially unmanageable (such as energy prices).

Only those that the proponent was in a better position to manage should be allocated to the proponent (and included in the VFMB). An example of this is energy cost. Energy cost is made up of two components: amount of energy consumed and the price of energy. We determined that the proponent was able to manage the consumption of energy principally by the design of the building and its operating systems. The proponent was not in a position to manage energy prices any better than the hospital was. We believed that transferring the risk of energy prices to the proponent would be more costly for the hospital since the proponent would add a risk premium, as would the lenders. Accordingly, the hospital retained the risk of energy prices.

Project Work Plan and Budget

Concurrent with the initial activities was the creation of a broad work plan and project budget. Our project was a pilot, and as such we did not have a blueprint to follow through the various stages of the transaction. This was probably the most difficult aspect of the project's early life. As a pilot project, the development of information to guide future projects became a shared agenda with government, with the understanding that flexibility in work plans and budgets would have to prevail as we mapped out the P3 route together. To guide us through these uncertainties, it was critical to have established charge out rates for our consultants, clear and understood processes for changing work plans and budgets with clear reporting and accountability frameworks both internal to the hospital and with the government representatives.

Proactive Communications Plans

New approaches to healthcare delivery in Canada, especially when they involve the private sector, require early communications planning. This applies to communications to your community, the government, media and staff and volunteers. To counteract the negative opinions of those who are opposed to any private sector participation in healthcare, it is necessary to keep before the community the objective of the exercise – a badly needed new hospital facility that may

not be built using the traditional approach. We always found that where possible, it was much more effective to be proactive and get out in front of the parade with communications. Transparency was the order of the day and as far as was practically possible, we went out of our way to share information. For example, we created a special project web site that provided the community with timely information on our progress. We also had numerous staff, community and media briefings. This paid off throughout the project by having a knowledgeable community that was in support of the project.

Even with our extensive prior experience with facility management outsourcing, it was important to regularly and frequently assure staff that their interests were being well represented in the project planning. This was especially true for those directly affected in the facility management areas. It became more critical following the selection of our private sector partner because it involved a change in the facility management provider. Our experience is that proactive communication can head off negative rumours that might otherwise escalate unnecessarily.

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Manage Government/Hospital Relations

In this environment of pioneering change, the relationship with government is critical at all levels. In the early stages of our project, it was not clear to us what roles several government departments/agencies were required to play. With experience it settled to a core team of senior Ministry of Health Staff with their consulting team. Although government is not a signatory to the project agreements, they were required to authorize all aspects of the project, including the project legal agreements and funding.

The pace and direction of the project was largely determined by government decision-making. Knowing up front what you do and do not have in place is an important understanding to reach. Since a P3 approach to hospital facilities had never been done before in Ontario, the absence of policy and process created uncertainty as to how to move the project forward.

There are forces beyond the control of a hospital that simply require a renewed focus on what you are trying to achieve and patience in making adjustments to accommodate a changing landscape. In our case, the change in government in the fall of 2003 represented a schedule setback while the new government reviewed the P3 approach. When the cost, schedule and risk transfer advantages became clear to the new government, and after certain clarifications and reinforcements of consistency with the Canada Health Act and public paramountcy were achieved, progress under the new government continued. Our communications policy again paid dividends since the broad community support for the project made it politically advantageous for the project to be supported by the new government.

With all these elements in place, we were now poised to enter the stage of selecting our partner.

The Selection of the Private Sector Partner

The ROH was now prepared to solicit proposals from qualified private sector suppliers for the facility and services it required to fulfill its new mandate. As a pilot project with an evolving process of project management that was not reflected in existing government policies or practices, the government encouraged the hospital early in the partner selection stage to acquire the services of a Process Auditor. This was aimed at ensuring the integrity of the selection process. This proved to be a value added decision, providing not only the effective monitoring of ongoing events but a source of advice and counsel to both the hospital and government on a proactive, ongoing basis.

Communications During the Partner Selection Process

As noted in the getting started phase, communications planning and strategies were equally if not more important in this phase. External forces opposed to this approach stepped up their activity, including a legal challenge on the government's authority to undertake such an approach. In addition, the very serious work of ensuring a consistent and fair competitive selection process added another dimension that called for careful and thoughtful discussion of when and what could be communicated.

The Selection Process

We decided to use a two stage process, an RFQ followed by and RFP, for the following reasons:

- to test the market to determine if there was sufficient interest and ability to have a competitive procurement
- to limit our detailed review and scoring at the RFP stage to only qualified parties
- to obtain feedback from prospective proponents

The RFQ

The RFQ was intended to solicit expressions of interest from the private sector and to ensure that they had met minimum qualification standards in criteria considered most important to the project, including:

- property development
- facility design
- construction
- property management and leasing
- financial capacity

There are several factors that were critical and/or that we would have done differently, to ensure success. The key ones are described below.

Ensure There Is a Competitive Market

We set out to design a proposed transaction that the market would find attractive and respond to. We believed that without a minimum of three qualified proponents we could not depend on a competitive market to keep costs down. We received responses to the RFQ from three consortia, all of which had excellent qualifications to build the facility and provide the services. If we had not received responses from three proponents, we would have considered interviewing parties that had decided not to respond to find out why and what if anything could be changed to increase their interest.

Publish the VFMB in the RFQ

We did not publish the VFMB with our RFQ, so potential proponents did not know the budget range to which they were expected to work. Although this did not prove to be an issue in our process, we did run the risk of having three proposals that exceeded the VFMB. This could have caused a costly delay. With hindsight we would recommend publishing a summary of the VFMB that identifies the risks transferred and the price range that the bids were expected to meet.

One frequent concern with publishing the VFMB is that it will minimize the likelihood of proponents developing more cost-effective solutions. So long as there are real competitive threats between the proponents, this should not be the case.

Invite Preliminary Design in the RFQ

One of our proponents was eliminated at the RFP stage because their design did not meet the output specifications. This issue might have been averted if proponents were afforded the opportunity to submit a preliminary design at the RFQ stage and to receive preliminary feedback before submitting the formal proposal.

The RFP: Balancing Cost vs. Benefit

The RFP was intended to

- outline what the hospital was intending to buy,
- prescribe the format and required content of responses, and
- set out how responses would be compared and evaluated.

The ROH, through this process, was able to contract for its new facility and services at a very attractive price, driven partially by the financing rates the selected proponent was able to secure. There are a number of factors that were under the hospital's control, or partial control, that we believe had a significant impact on keeping costs and risks, including financial risks, to a minimum that directly benefitted the hospital through project cost.

The Scoring

We spent considerable effort on deciding which criteria should be mandatory and which should be point scored. In the end we determined there was really only one determining factor; if a criteria was indeed a "deal breaker," then it was mandatory. If it was possible to have a quality proposal from (an already qualified) proponent, then it should be point rated. This eliminated many criteria from the "mandatory" category and provided for more diversity in responses.

Our scoring mechanism can be summarized as follows:

- All mandatory criteria must be met
- Point scored criteria were divided into four categories
  - design and construction – 20%
  - services – 30%
  - management and governance – 15%
  - master plan for the site – 15%
  - financial management – 20%

Proponents must have achieved a minimum of 60% of the points available in each category. A Quality Adjusted Net Present Value was calculated by discounting the net present value of all costs by the rated score. RFP proponents' net present value was to be discounted by one quarter of a percent for every percentage point above 60% on the rating scheme, up to a maximum discount of 10%. The adjustment down was limited to 10% of the bid price; this being the maximum, we believed the hospital could afford to pay for a premium proposal.

Based on this process, a preferred proponent was selected, together with the second ranked proponent as a backup in case a transaction could not be concluded with the preferred proponent.

One change we would make to our scoring and evaluation criteria is in the area of Management and Governance. We do not believe we gave this category sufficient weight when considering that we were asking the proponents to not only build a facility but to manage it and nonclinical services for a 20+ year term. We believe our RFP could have been improved in this area by assigning a greater value to the scoring of this area. We would have reduced the scoring allocated to services, based on the rationale that if the management and governance principles are solid, any shortfall in services that does occur during the contract can be better dealt with.

The Extent the Hospital Could Provide Security of Cash Flow to Proponent

Proponents needed to determine the risk of not being paid after investing $150 million. The ultimate security would have been a contract directly with the provincial government or a provincial government guarantee. Neither of those alternatives was available for our project and the covenant of the hospital was not likely to provide much comfort to the lenders. In the end, we satisfied the lenders that the provincial government had authorized the transaction and that it had signed a Funding Agreement with the hospital. The terms of the funding agreement were required to be confidential between the Ministry of Health and the hospital. We did confirm that there was a Funding Agreement between the hospital and the Ministry for funding for the project.

Performance Standards

When setting output specifications you must guard against the temptation of setting a higher standard for the private sector partner than what the hospital itself could reasonably achieve on its own. The temptation exists perhaps out of the hospital's goal of delivering that level of service, but can't afford to, or to set standards for the private sector partner where no standards currently exist. Whatever the reason, if you require higher standards it will cost more and the comparison against the VFMB will not be valid and may result in the project being cancelled, as it may appear that the private sector costs more than the public sector.

Set Appropriate Performance Penalties

Excessively punitive penalties, especially when combined with higher performance standards, will add cost to the project because the proponent will add in an element of cost to the hospital to offset the penalty. For our project we decided to keep penalties relative to the cost of the service for which the penalty was being imposed. We also allowed for time for the proponent to fix the problem after it is identified, before the penalty is imposed. However if the problem persists, the penalties become increasingly expensive and can result in the service provider being replaced.

Provide Opportunity for Lenders to Step in to Fix Problems

One of the advantages of using private capital to finance infrastructure and deliver services is the expectation of the lenders for disciplined debt service payments. Since the proponent is likely to be a special purpose vehicle whose only purpose is to meet the obligations of the consortium to the hospital, the cash flow through the SPV is limited to the hospital's payments. If penalties are imposed, debt service may be jeopardized. The hospital can use the private sector lenders to their advantage; by informing the lenders of problems once they reach a certain level of seriousness, the hospital can rely on the lenders to exert pressure to have the issue resolved before it affects consortium cash flow.

Contract Termination Provisions

Our contract is expected to last for approximately 23 years and it will take that long for the lenders and equity investors to receive the full return of their capital and expected returns. Because of the long term of the contract, it is prudent to decide in advance what will happen if the contract is terminated. The contract may be terminated in one of three scenarios:

- termination where the proponent is at fault
- termination where the hospital is at fault
- termination for "force majeure"

Although the return to the equity participants in the consortium was different in each of the above circumstances, we decided that exposing the lenders to the consortia to losses of capital when default was due to the hospital or for force majeure would be reflected in higher interest costs for the project and chose not to transfer this risk.

Change Orders

To instill a high level of discipline in the management of design changes, the hospital, together with the Ministry, required that all design changes not authorized by the Ministry be financed by the hospital's funds. Since the hospital was already required to raise a significant amount for the "local share" of the capital cost, the approval by the Board or senior management of the hospital was required for any hospital initiated design modifications. This measure effectively added a high level of discipline to the design signoff phase.

Contract with One Party

One of the tremendous advantages of setting output specifications for the facility that must be met for 23 years, and having contracted with one group for services for the

same term, is that all of the parties in the consortium are tied together. It forces them to seek the most cost-effective solutions and partners. This lifecycle cost approach can provide significant savings over the long term, by forcing the consortium to choose the design, lifecycle management and service package that is most efficient.

This approach also allowed us to obtain financial guarantees for the consortium's obligation to deliver to the output specifications for the entire term. We did this by

a) signing contracts with one party – the special purpose corporation set up by the consortium – for all of the facility and services to be provided over the 20-year term of the contract, and by
b) requiring the construction partner and the services partner to cross-guarantee the work of the other partner for the operating term of the contract.

This meant if poor building design resulted in higher energy consumption costs as the building matures, we will still be dealing with the same consortium and will have the building partner's as well as the services partner's financial guarantee to draw upon over the entire term.

Closing the Transaction

After selecting the preferred proponent final contract, negotiations were commenced. In our case they were interrupted by a provincial election, change of governing party and subsequent review by the new government of the proposed transaction. We were required to make certain amendments to the project's legal agreements to meet the needs of the new government. Negotiations concluded in July 2004, when the project agreements were signed with the selected proponent. This represented "Commercial Close" of the transaction. The selected proponent then had a period of time to secure the financing for the transaction based on the signed project agreements. This was completed in December 2004. This was a long and challenging process and ensuring that the Board and the project management team were fully committed was critical to achieving close.

The New Operating Paradigm

Alternate financing means alternate approaches to how government funds such developments. The principal change is the blending of what have typically been traditionally isolated functions—capital planning and funding and operation funding.

All this collapses into a new operating equation that blends capital and operating components into an ongoing part of your operating plan. This manifested itself in a special Funding Agreement to reflect these new arrangements between the government and hospital.

The hospital's share responsibility still existed as it would under a traditional approach. It allowed for new and innovative ways of managing share, including the cash value of land leases and annual incentives to acquire full share up front as opposed to over the life of the lease. Normal processes for Post Construction Operating Planning (PCOP) are still utilized by government but springboard from the Funding Agreement to focus predominantly on direct clinical costs and volumes.

Areas like Furnishings and Equipment and Information Technology require careful consideration regarding their positioning in these approaches. The hospital favoured building these into the Alternate Finance approach using the lifecycle costing principle and establishing appropriate allowances up front in the project agreements. Based on feedback from past experiences, such as those in the UK, this was perceived to be a sound approach. After extensive deliberation with government on this, there was a preference expressed to deal with the Furnishings and Equipment on a traditional basis. The Information Technology was planned on a similar model to the overall project but in parallel with it. The planning of Furnishings and Equipment became a question of figuring out what could be transferred from current operations, what was eligible for government funding and what the hospital was responsible for. This is an area that needs further discussion and consideration for future approaches like this.

Conclusions

As we look back over this unique experience in Canadian healthcare, there are many conclusions that can be made, but the main ones, in our opinion, are the following:

- This approach represents a new and viable option for procurement of healthcare infrastructure and its operation. In a world of limited government and philanthropic funds and continued restraint on operating dollars, such arrangements can help manage such situations.
- Such approaches do not compromise or put at risk the organization's ability or responsibility as a publicly administered body. The values of Medicare as defined under the Canada Health Act and the governance and management requirements as detailed under public hospital legislation are fully respected.
- It distributes risk to where it is best managed, leading to increased probability of better risk management than traditional capital funding approaches.
- With the effective bundling of the design, build, operate and finance components over the life of the lease, it better integrates the creative intelligence of all these elements into new and better solutions that employ the best that each sector brings to the table. Through the 'joint and several' nature of the consortium, fed by partner equity in the project, there is guaranteed interest, rigour and incentives to make the longer

term relationship work for the benefit of the healthcare organization.
- Most importantly, such an approach is now delivering a badly needed new facility and related service systems to our community on time, within budget and more efficiently and effectively than a traditional approach would have allowed. Having more options to narrow this public health gap without compromising our national values is an important development in the sustainability of Medicare as we know it.

References

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About the Author

David Laird is a Director of PricewaterhouseCoopers LLP in Ottawa. David advised the Royal Ottawa Health Care Group on the financial aspects of the P3 transaction which included the RFP and selection of preferred proponent and negotiation and closing of the transaction. Email: david.s.laird@ca.pwc.com

George Langill is Executive in Residence at the School of Management at the University of Ottawa and operates a private consulting practice following his retirement as CEO of the Royal Ottawa Health Care Group in Dec.2004. Email: glangill@sympatico.ca

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Ontario Creates a Centralized RFP Process: All Participants Win

Peter Finkle and Barbara Edwards

In late November 2004, Ontario's Ministry of Health and Long-Term Care launched an inaugural bulk purchase initiative for the replacement of 28 Computed Tomography (CT) scanners and 8 Magnetic Resonance Imaging (MRI) machines across the province. The original intent was to leverage volumes to achieve cost-savings on equipment pricing for participating hospitals. The success experienced by the venture has led to consideration of the process as a model for many future ministry funded health care procurement initiatives. In fact, this model sparked the interest of other provinces and dialogue has begun on adapting the process on a national scale.

Designing an Efficient Hospital Porter System

Li Chen, Mats Gerschman, Fredrik Odegaard, David K. Puterman, Martin L. Puterman and Ryan Quee

This paper describes ten steps necessary to develop a centralized managed porter system. They are the outcome of a comparative study of porter operations at two Vancouver area hospitals. The needs for analytical capabilities, feedback, wide in put and data collection and analysis are emphasized.

Infrastructure for Board Accountability Governance Structures and Processes for a Community Hospital

Sandra "Sam" Kearns, David Vigar and Katherine Scimmi

Healthcare organizations in Canada have board structures and processes in place to guide and direct decision-making. Responsibilities of governing and managing the affairs of a healthcare organization have been in the forefront of Ontario Hospitals with the introduction of Bill 8, The Commitment to the Future of Medicare Act, 2003.

In light of the rapid and significant change that has been imposed on healthcare, the structures and processes for effective governance from 20 years ago do not meet the needs of the trustee today. This article reflects the structure and processes that Bluewater Health in Sarnia, Ontario has adopted during its restructuring, to ensure public accountability.

Good Shepherd Memorial Hospital: The Women's Health Relocation Proposal

Kent V. Rondeau

Jack Hennessey, President and Chief Executive Officer of Good Shepherd Memorial Hospital, is asked if his organization would like to become the new home for gynecology services for the region, including the provision of second-trimester abortions for women with unwanted children. Hennessey believes that the relocation of these services to his hospital would be propitious given the organization's new mandate in women's healthcare. Created by the merger of a Catholic maternity hospital and a pediatric hospital, Good Shepherd Memorial Hospital is involved in a strategic planning exercise to determine the newly merged hospital's new role. It is uncertain how the relocation decision will fit with the new strategic direction taken by the hospital. Various internal and external stakeholders make conflicting demands about where they want the hospital to position itself; some support the decision, while others are vociferously opposed. Hennessey wants to assist his board to make the best possible decision now and for the future, while maintaining board unity, the morale of his staff and effective external relations.

Reducing Patient Transportation Costs

Lynda A. Monik

Hotel-Dieu Grace Hospital (HDGH) in Windsor, Ontario was faced with a $20 million deficit in 2002-2003. In an effort to reduce and/or eliminate this deficit, cost-cutting strategies were explored. Patient transportation costs were identified as one of the areas where cost-cutting opportunities could be realized. In 2003-2004, HDGH reduced patient transport costs by $46,000.00. Cost-cutting strategies included a scripted dialogue for approaching patients and families, clear communication about the importance of cutting costs and progress updates on the cost-savings. Suggesting to patients and families that they could pay for the transport has resulted in better outcomes for patients and families, the hospital and the community.

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ANSWER ▶

The hospital on page 52 is in the town of Owen Sound (estimated population is 21,950). It is the regional referral centre for Grey and Bruce Counties. Pat Campbell is CEO. The hospital's focus is on growth and complex care. It is also a recent recipient of a Best Practices Award granted by the Ontario Hospital Association in collaboration with the editors of Healthcare Quarterly. This display is in the main reception area.